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Sex Trafficking and Mental Health Treatments

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A Thesis Presented in Partial Fulfillment of the Requirements for the Degree of

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Maria Ana Georgescu

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This Thesis has been presented to and accepted by the Office of Graduate Studies, John Jay College of Criminal Justice in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Forensic Psychology.

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Abstract

Currently there is no agreement amongst professionals on a specific approach for providing for victims of sex trafficking. A two-part study was conducted in order to screen mental health professionals who have experience providing for victims of sex trafficking to participate in a semi-structured qualitative interview. Through a grounded theory approach, light is shed on what mental health providers experienced with providing for victims of sex trafficking find effective.

The main findings highlight how being forced into sex trafficking young (under 18) is impactful for the course of treatment according to 100 % (n=6) of participants, meeting the patient where they are at and being non-judgmental are effective in building therapeutic alliance and trust by 100 % (n=6). The common diagnosis from sex trafficking is PTSD according to 83 % (n=5) of participants. Psychodynamic approaches were reported by 67 % (n=4) of participants. Of participants who make unique treatment accommodations for victims of sex trafficking 100 % (n=5) made accommodations addressing shame. Body awareness coping skills were reported by 67 % (n=4) of participants. Racism and sexism were addressed by 83 % (n=5) of participants. Success was defined as taking care of one's mental health by 83 % (n=5) of participants and by 50 % (n=3) of participants as having greater control in their lives, implementing protective factors, and that success varies depending on the patient. Beginning the therapeutic relationship discussing termination of treatment and evaluating emotional preparedness for termination was reported by 67 % (n=4) of participants.

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Introduction

Problem Statement

In the Trafficking Victims Protection Act of 2000, human trafficking is defined as the "recruitment, harboring, transportation, provision, or obtaining of a person for labor or other services, through the use of force, fraud, or coercion, for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. It includes sex trafficking, in which a commercial sex act is induced by force, fraud, or coercion, or in which the victim is under 18 years of age" (Office of Justice Programs, 2011). According to the International Labor Organization, researchers found that, in 2016, around 71 % of the 40 million people exploited were female, with 25 million being exploited for labor while 15 million were forced into marriages (2017). Of those who were being exploited for labor, 4.8 million were being sex trafficked, and of those who were being sexually exploited, around 99 % of those individuals were women and girls (International Labor Organization, 2017).

Literature surrounding the experiences of survivors of sex trafficking notes that they often experience many physical risks (Beyrer, & Stachowiak, 2003). Physical risks disproportionately confronted by sex trafficking victims include an increased risk of contracting sexually transmitted diseases (STDs) such as HIV (Beyrer, & Stachowiak, 2003). Additional physical risks can be attributed to a lack of access to health care services, which can exacerbate their physical conditions for STDs such as syphilis which, when left untreated, can cause long term implications (Beyrer, & Stachowiak, 2003). Literature and research on sex trafficking has also highlighted violence as an additional prominent risk that many victims of sex trafficking

have experienced; according to researchers, around 86 % of American prostituted persons experienced physical violence from individuals who purchased sex, and 80 % experienced sexual assault from those who purchased sex (Territo, & Kirkham, 2010).

Significance of Adequate Mental Health Services

In addition to the plethora of physical risks disproportionately experienced by victims of sex trafficking, the mental health of sex trafficking survivors is an area that requires further research in order for treatment to adequately address the unique needs of this population (Litam, 2017). Research from the United States Department of Health and Human Services asserts that those who are victims of human trafficking often have experienced and witnessed substantial trauma such as violence, injury, and even death which results in victims having high rates of post-traumatic stress disorder (PTSD) (Williamson et al., 2010). A study on female survivors of sex trafficking found that approximately 40 % of the survivors experienced symptoms of suicidality (Zimmerman, & Pocock, 2013). Hossain and collogues (2010) examined traumatic experiences of women and girls who were trafficked and found that over 80 percent of their sample had experienced threats of violence, sexual violence, and limited autonomy. Furthermore, around 77 % of the sample showed symptoms of PTSD based upon the Harvard Trauma Questionnaire, around 55 % showed symptoms of depression, and 48 % showed symptoms of anxiety based upon the Brief Symptom Inventory (Hossain et al., 2010). The mental distress of victims of sex trafficking can also be exacerbated by structural factors such as poverty, insufficient and/or housing insecurity, risk for deportation, lack of social support, being a part of

the LGBTQ+ community, being a racial/ethnic minority and/or experiencing racial trauma (Domoney et al., 2015; Butler, 2015a; Bryant-Davis, & Ocampo, 2005).

Theoretical Framework to Understand Sex Trafficking

This study understands sex trafficking through 5 theoretical frameworks, (1) life course theory, (2) Biderman's framework of coercion, (3) Evan Starks' theory of coercive control, (4) critical feminism theory, and (5) critical race theory. Examining the experience that sex trafficking victims have through the lens of these 5 theoretical frameworks provides an in-depth understanding of the kind of vulnerabilities and abuse histories of patients that clinicians may be confronted with when providing treatment. These theoretical frameworks provide insight into different kinds of trauma sex trafficking victims may have experienced, such as structural inequality, poverty, domestic violence, psychological abuse, sexism, and/or racism. Through the examination of sex trafficking guided by these theories, mental health professionals may have the opportunity to obtain greater understanding of the multidimensionality of a patient's experiences that impact treatment.

Life Course Theory

Life course theory provides an explanation of how some persons may be more vulnerable to sex trafficking. According to scholars, there are four main factors that influence an individual's life course such as environmental factors, historical factors, the timing of life events/changes, social cohesiveness, and the individual's autonomy to control their life and make choices (Reid, 2012). The risk factors that an individual is exposed to throughout their life can increase the likelihood that they may be sex trafficked. Specific risk factors that increase

vulnerability to sex trafficking include being in an impoverished environment, having a history of experiencing abuse, being young, and having a poor social support system (Reid, 2012).

The environmental factors where sex trafficking is more prominent include the following: a lack of adequate resources for youth to engage in, such as community center activities, living in a financially impoverished community (Clawson et al., 2009a). Environmental factors include anti-crime and policing, such as communities with poor training for law enforcement to be consistent in how they identify and respond to incidents of sex trafficking, as well as increased gang activity (Clawson et al., 2009b; Estes, & Weiner, 2001).

The timing of life events can also make an individual more vulnerable to being sex trafficked (Reid, 2012). One's risk of being sex trafficking can increase when an individual is experiencing domestic violence, struggling to provide for their children, abandoned by their partner, an undocumented immigrant, or unemployed (Reid, 2012). Research indicates that factors such as a strong desire to want to be loved and to have a sense of belonging can increase one's risk and are often exploited by traffickers (Reid, 2012). Through the life course theory perspective, it seems that there is a substantial number of risk factors related to their environmental, social, and experiential vulnerabilities that can increase the risk of someone being sex trafficked.

Social factors have been found to increase the risk of an individual being sex trafficked, such as the intersectionality surrounding the proponents of their home life, family, and social circle (Estes, & Weiner, 2001). One's risk of being sex trafficked increases when they are exposed to violence, sexual abuse, rejection because of their sexual orientation and/or

orientation, having a romantic partner that is engaged in sex trafficking, or a family member or friend that is engaged in sex trafficking, and being a runaway (Estes, & Weiner, 2001). For example, according to researchers, experiencing sexual abuse has been found to be one of the main reasons why juveniles run away from their homes (Rotheram-Borus et al., 1996). Amongst those who are runaway youth, researchers have found that the prominence of sexual abuse increases 5-fold in comparison to the rates of sexual abuse reported amongst the general public (McCormack et al., 1986). Scholars indicate that around 75 % of youth will run away from home due to experiencing physical abuse in their home (Welsh et al., 1995). Homelessness can be an additional significant risk factor as there is an estimated to be around 70,000 children and young persons that are vulnerable to exploitation through sex trafficking (Estes, & Weiner, 2001). Furthermore, the LGBTQ+ population is at a particularly vulnerable risk for being sex trafficking, with many experiencing rejections from their family and peers due to their sexual orientation and/or sexual identity being discovered. According to research, the LGBTQ+ community makes up around 20 to 40 % of the homeless population in the United States (Fraser et al., 2019). According to researchers Martinez and Kelle (2013), of the LGBTQ+ homeless youth population, around 59 % have been sex trafficked in contrast to heterosexual homeless youth who are sex trafficked at a rate of around 33 %.

Biderman's Framework of Coercion

Trafficking Victims Protection Act recognizes that psychological coercion is a powerful method in how traffickers control their victims as it states that traffickers are likely to only use physical violence when absolutely necessary to get their way and contrarily use the threat of

violence as a tool more frequently (Hopper, & Hidalgo, 2006). According to scholars, there has been a notable number of findings concerning the kinds of coercion that victims of sex trafficking experience that their abusers perpetrate in order to confine them into being sex trafficked (Baldwin et al., 2015). Many researchers have pointed towards Albert Biderman's sociological framework of coercion which he had developed after researching prisoners of war and the tactics that their imprisoners used on their victims (Amnesty International, 1973). According to Biderman's framework of coercion, there are eight main methods: (1) isolation, (2) monopolization of perception, (3) induced debility exhaustion, (4) threats, (5) occasional indulgences, (6) demonstrating omnipotence of control, (7) degradation, and (8) enforcing trivial demands (Amnesty International, 1973). Understanding the kinds of abuse that traffickers perpetrate can help mental health professionals better understand sex trafficking survivors' experiences and better therapeutically address their patients' traumas.

Isolation is a substantial proponent that many victims of sex trafficking experience. This is defined as victims of human trafficking being completely cut off from their family, having their cell phones taken away from them, as well as alienated from members of the public and religious communities, including being prevented from going to church (Logan, 2007; Baldwin, Fehrenbacher, & Eisenman, 2014). Traffickers isolate their victims so that there is a decreased likelihood that they will be able to get help from others to get out of their exploitative situation, or notify authorities for assistance and resources (Baldwin, Fehrenbacher, & Eisenman, 2014). Being coerced by their trafficker to lie about their situation as well as frequently going to different locations has been identified by scholars as an additional form of isolation experienced

by victims of sex trafficking in that it blocks the victims from being able to stay in one place and build relationships in that community (Logan, 2007).

Monopolization of perception occurs when the individual's entire life essentially becomes being sex trafficked as the stimuli that they are being exposed to on a regular basis is a reminder that there are essentially confined (Logan, 2007). An example of monopolization of perception physically can be seen in situations where the victim is made to live in the same place that they are being forced to work, such as in the hotel room where they are being sex trafficked (Logan, 2007). Monopolization of perception also includes controlling whatever communication that the victim does engage in, such as monitoring any conversations that they have with others as well as not letting them go anywhere unless they are present (Logan, 2007). This kind of monopolization of perception is also practiced when the trafficker prevents the victim from learning English, thus making them dependent upon them (Logan, 2007). The individuals may have to ask for permission for even the most basic necessities; this places the trafficker in a position where again, they control what the victim is exposed to as well as making them dependent upon them (Logan, 2007). This can be powerful even when the trafficker is not present as the trafficker instilled a sense of dependency upon the victim even for basic things such as having to go to the bathroom, needing money, wanting to make a phone call, and having to account for even the smallest details of what they are doing throughout the day (Logan, 2007; Baldwin, Fehrenbacher, & Eisenman, 2014).

Induced debility and exhaustion is a method that is commonly practiced by traffickers in which they exploit their victims by making them work long hours for days without giving them

breaks, keeping them in a state of constant exhaustion and sleep deprivation (Baldwin, Fehrenbacher, & Eisenman, 2014). Victims of sex trafficking may experience poor nutritional nourishment, being inappropriately dressed for the weather, such as wearing a miniskirt in the winter, as well as not getting medical attention when they need it or in a timely manner (Baldwin, Fehrenbacher, & Eisenman, 2014; Logan, 2007). Some traffickers will also get their victims dependent on a substance and have them perform sexual acts in order to obtain that substance or exploit their substance addiction if already present (Reid, Huard, & Haskell, 2015). When experiencing induced debility and exhaustion, the sex-trafficked individual has a more difficult time resisting their trafficker as they are not only mentally exhausted from stress but also physically burdened and overexerted (Logan, 2007).

Threats are another common form of coercion that those who are sex trafficked experience. Threatening behavior consists of coercion of or forcing victims to meet the demands of their trafficker due to fear of harm such as sexual assault, other physical attacks, and even death (Logan, 2007). Other threats that sex trafficking victims experience can include being threatened with their immigration status and fear of deportation, as well as their fear of the police and threaten them with reporting that they are engaging in prostitution to law enforcement and exploiting their lack of knowledge of sex trafficking against them (Logan, 2007; Baldwin, Fehrenbacher, & Eisenman, 2014). In addition, traffickers may threaten the safety of family members or threaten to harm or kill the victims' children (Baldwin, Fehrenbacher, & Eisenman, 2014). An additional form of threats that traffickers may engage in is threatening their safety through deception. In one study, a survivor described how the trafficker told them that they could

not trust others, including the police, priests, and strangers, because they could be dangerous people in disguise and could hurt the victim and even kill them (Baldwin, Fehrenbacher, & Eisenman, 2014).

Occasional indulgences occur when the trafficker may provide some rewards to their victim if they meet their demands (Baldwin, Fehrenbacher, & Eisenman, 2014). However, these kinds of indulgences are often unable to be predicted by the victim, and when they engage in these indulgences, it is when the trafficker goes against the constant abusive behavior that they engage in, such as giving them more food than usual or getting them medication that they need (Baldwin, Fehrenbacher, & Eisenman, 2014). Additional forms of occasional indulgences may include telling the victim that they can see their family, that they are getting closer to paying off their debt, or not fulfilling a threat when they said they would (Logan, 2004; Baldwin, Fehrenbacher, & Eisenman, 2014). This kind of method of coercion motivates the victim to meet the demands of the trafficker in hopes of receiving an occasional indulgence as an incentive (Logan, 2007).

The demonstration of omnipotent control is carried out as a method of coercion by telling the victim that they have complete control over their life and that it is pointless to even attempt to escape their circumstance (Amnesty International, 1973). A trafficker would implement omnipotent control through convincing the victim that they know people who could go after their children or family if they do try to escape, as well as telling them that they always have someone watching them when they are not around and would know if they tried to escape or contact help (Baldwin, Fehrenbacher, & Eisenman, 2014). Demonstrating omnipotence can also be carried

out by telling the victim that, even if they escaped, that no one will believe their account of what happened to them (Logan, 2007).

Degradation is experienced by those who are sex trafficked in many forms, such as being denied privacy, denied the maintenance of hygiene such as feminine products or regular showers, and calling them inappropriate and offensive names to diminish their sense of self-worth (Baldwin, Fehrenbacher, & Eisenman, 2014). Humiliation is also used as a coercive method, such as throwing objects at the individual being trafficked as well as making them carry out acts that are known to make the individual feel humiliated such as having to engage in commercial sex while on their period (Baldwin, Fehrenbacher, & Eisenman, 2014).

Enforcing trivial demands is a coercion tactic carried out by the trafficker, which involves the victim carrying out menial tasks throughout the day or following certain rules made by the trafficker (Amnesty International, 1973). The enforcement of these demands can be used as a way to keep the victim tired throughout the day; the rules and the lack of fulfillment of these demands can be used against them as a way to increase the debt that they need to pay to the trafficker in years of labor or money due (Logan, 2007). Menial demands are also often ever-changing, as the intention behind them is to essentially keep the victim in debt bondage (Logan, 2007). The enforcement of trivial demands are also a way that they demonstrate their power over the victim (Logan, 2007).

Coercive Control

According to Evan Stark's theory of coercive control, domestic violence is not specific to just the physical aspects of abuse that occur, as the methods of coercion and control are implemented in a way that the abuser strips the freedom of the victim away (2006). Similarly, in cases of domestic violence, a notable amount of research has indicated that traffickers implement a coercive control framework in how they abuse their victims in sex trafficking (Doychak, & Raghavan, 2020). Coercion has been described by researchers as making a demand with a threat (Dutton, & Goodman, 2005). According to the theory of coercive control, the threat that is associated with the demand should be one that the victim can be certain of the abuser following through with (Dutton, & Goodman, 2005). Moreover, there are points in which the coercive relationship can develop to the point where the threats do not need to be stated in order for the threats to be communicated and known by the victim as the threat can be demonstrated by body language, as well as demonstrated by the abuser's pattern of behaviors (Dutton, & Goodman, 2005).

According to Reid, Huard, and Haskell (2015), there are many cases of sex trafficking where domestic violence is a driver to their victimization; for example, in a sample of young girls' 36 % were sex trafficked by a romantic partner. According to researchers Doychak and Raghavan (2020), the phenomenon of trauma-coerced attachments between a sex trafficking victim and their trafficker can look on the surface as the victim being prostituted by the trafficker consensually; however, these kinds of trauma bonding dynamics have been recognized to occur in other extremely abusive relationships such as in hostage situations and prisoners of war. When

traffickers are looking for potential victims, they are often intentional in picking young girls who are particularly vulnerable such as coming from poverty, having low self-esteem, socially rejected from others, and exploit their needs for love and acceptance, shelter, financial support, and protection (Reid, 2016). Some of the ways in which traffickers carry out fraud are not monetary, such as fraudulent promises of getting a good job or the fraudulent promise of a better life with companionship, love, and protection (Reid, 2016). According to researchers, entrapment of young girls is carried out through a tactic called "Love Bombing," which is widely practiced in recruiting girls by gangs as well as in religious cults (Dorias, & Corriveau, 2009, p. 35). Love bombing may occur in the beginning of the relationship, where traffickers pose as the victim's boyfriend and give them love, attention, and gifts as a form of manipulation to lure them into being prostituted (Dorias, & Corriveau, 2009). Once the trafficker has been able to carry out their "Love Bombing" successfully, they then begin to continuously push the boundaries of the victim, and use other manipulation tactics, such as deception into debts, to coerce their victim into sex trafficking (Dorias, Corriveau, 2009).

Critical Feminist Theory

Critical feminist theory is taking into examining issues through the lens of gendered inequalities that women experience due to the history of the oppression of women, and patriarchal structural and systemic violence (Keedle et al., 2019). Expanding upon the framework of feminism can be further examined by Bell Hooks theory of feminism, she challenged the understanding of feminism through examining the challenges experienced by white women, and shaped the framework of feminism by including the combating of oppression

of all persons who are oppressed, being exploited, and experiencing inequalities such as racism and classism (Hooks, 2000). Hooks also acknowledges that other women can be sexist, particularly the privileged white woman, in disregarding the different barriers and forms of discrimination that women of color experience (Hooks, 2000). Evan Stark wrote, “The lack of sexual symmetry in [Coercive Control] reflects its origins in sexual inequality: Because men cannot be unequal to women at the same time and in the same way that women are unequal to them, there is no counterpart to this type of coercive microregulation in men’s lives, another cause of its invisibility.” (Stark, 2006, p. 1022). The method of coercive control pervasively implemented against women who are victims of sex trafficking is a reflection of how men dispense their power and privilege in a patriarchal society to commoditize women’s bodies and to exploit them for their own financial and sexual gratification (Stark, 2006).

According to feminist scholars, the vulnerabilities of women in sex trafficking can be broken down into the proponents of the patriarchy comprised of sex discrimination, sexism, and misogyny (Dempsey, 2009, p. 1733). Sex discrimination has been described by scholars as placed limitations and barriers upon the number of resources available to women to not have to engage in things such as survival sex, as well as the failure to appreciate the women’s body and their needs as that of a human being’s needs and life, as well as the warped perception of their experiences that diminishes their needs and wants (Dempsey, 2009). Sexism has been described as either through the lack of education or understanding as a failure to recognize and appreciate women as human beings and resources that they should be permitted to; sexism creates an environment where the harms experienced by women create a vicious cycle of harms

experienced by other women due to the pervasiveness of sexism which maintains oppression in the patriarchal society (Dempsey, 2009). Misogyny has been described by researchers as the intentional oppression of women in contrast to oppressing women through ignorance or complacency (Dempsey, 2009). Misogyny often is an additional proponent of the patriarchy that compels violence against women and reflects a hatred that the perpetrators of abuse and violence have against women (Dempsey, 2009). Examples of patriarchal structural violence can be seen in the accounts of those who have survived sex trafficking.

The patriarchal structural violence experienced by those who are sex trafficked are disproportionately women as a form of sex discrimination, and sexism is by normalizing the sexualization and objectification of women and complacency to a system that permits conceptualization of rape as anything other than *not consensual* (Dempsey, 2009; Miriam, 2005). By ignoring patriarchal structural violence, it becomes easy to dismiss victims of sex trafficking as willfully prostituting themselves. According to interviews with men who would purchase commercial sex from prostituted persons, many of the buyers expressed aggression and hatred towards women, saying that when they buy a woman for sex, she forfeits her “right to say no” (Farley, 2006, p. 131). Moreover, those who dismiss the coercion and control of women being prostituted in sex trafficking often rationalize their participation in the commercial sex industry as a “choice”. However, given the structural inequality and lack of options that victims have in order to survive when the constrained options presented to an individual are their only choice, they do not really have a choice (Farley, 2006, p. 109).

Critical Race Theory

A growing number of scholars have encouraged sex trafficking to be examined through a critical race theoretical lens (Butler, 2015a). Critical race theory was developed by Kimberlé Crenshaw; this theoretical framework is based on the five main proponents (Crenshaw, Gotanda, Peller, & Thomas, 1995). The first proponent of critical race theory is based around the idea that racism is commonplace and not unusual (Crenshaw, Gotanda, Peller, & Thomas, 1995). The second proponent of critical race theory is reflective of the Interest convergence theory of developed by Derrick Bell, which is the notion that the white majority will not support the progression of social and racial justice unless there is something they benefit from supporting it (Crenshaw, Gotanda, Peller, & Thomas, 1995). The third proponent of critical race theory recognizes the social construct of race to disadvantage people of color (Crenshaw, Gotanda, Peller, & Thomas, 1995). The fourth proponent of critical race theory is the consequences of storytelling and how a white supremacist narrative of history and the experiences of people of color are told as if they are neutral and that there needs to be a counter-storytelling engagement to set the narrative straight (Crenshaw, Gotanda, Peller, & Thomas, 1995). The fifth proponent of critical race theory recognizes that often times when civil rights legislation is passed, it also benefits white people and often do not service people of color whom it is meant to benefit as it should (Crenshaw, Gotanda, Peller, & Thomas, 1995). The implementation of critical race theory when exploring the experiences of sex trafficking victims, examines the role that the historical oppression of people of color and the structural and institutional factors that entrap women of color in sex trafficking and coerce and force them into commercial sexual exploitation (Butler, 2015a). According to researchers, similarly, as patriarchal structural inequality makes

women vulnerable to being sex trafficked, the structural inequality and history of racism has put women of color particularly vulnerable to sex trafficking (Butler, 2015b). Women of color are disproportionately vulnerable to sex trafficking as a result of the intersectionality of racism and sexism. Women of color have unique experiences that contribute to the sexual violence that they are subject to when sex-trafficked such as fetishization, verbal abuse with racial slurs, and disproportionately experience criminalization.

Many victims of sex trafficking have experienced racialized violence at the hands who those who purchase sex. According to scholars, when an individual is bought for sex, they are using their "economic power to transform another human being into the living embodiment of a masturbation fantasy" (Davidson, 1998, p. 209). In Western societies such as the United States of America, women of color are pursued and fetishized to their buyers, such as hyper sexualizing Black women as the "Jezebel" stereotype, purchasing indigenous women and those of a Latin American background for sex as an additional form of colonizing their bodies and giving the buyers the opportunity to live out their fantasy of subordinating people of color (Butler, 2015b). Asian women are also fetishized by sex traffickers as according to the accounts of Asian women who were trafficked in New York City; they were told to behave according to the racial stereotypes of Asian women in America, such as pretending to not know English even though they had grown up in New York City (Farley, 2006). In instances such as the fetishization of Asian women, the buyers are also fulfilling their racist and sexist fantasies of sexually dominating the stereotyped "submissive" individual (Farley, 2006, p. 119).

Racial trauma is an additional aspect of treating victims of sex trafficking that impacts many, as a disproportionate number of those who are sex trafficked are women of color (Bryant-Davis, & Ocampo, 2005). Racial trauma develops through the experience of race-based stress that is endured vicariously or directly by the individual (Hargons et al., 2021). The symptoms of race-based traumatic stress injury include symptoms that are similarly seen in those who have post-traumatic stress disorder, such as cognitive, affective, and somatic disturbances such as difficulties remembering and focusing, depression and anxiety, and/or fatigue and headaches (Bryant-Davis, 2007).

Racism can be perpetrated through covert and overt racism; covert racism has been described by scholars as more ambiguous in comparison to overt racism, however often times covert racism occurs repeatedly in different ways, such as microaggressions, throughout the life of the individual (Bryant-Davis, & Ocampo, 2005). According to researchers, while covert racism may not appear as extreme as overt racism, the traumatic experience can still elicit a similar response from the one receiving either form of racism (Bryant-Davis, & Ocampo, 2005). Many victims of sex trafficking who are women of color receive overt and covert forms of racism on a regular basis from the abusers who purchase sex as well as from their traffickers (Farley, 2006). According to the accounts of data gathered on 126 prostituted persons, it was found that the women of color were more likely to experience more violence as well as more severe circumstances as a prostituted person (Hankel, Dewey, & Martinez, 2016). Black women are more likely to be sex trafficked as a minor, have a history of child sex abuse and physical abuse, as well as be prostituted under a pimp or trafficker (Hankel, Dewey, & Martinez, 2016).

Hispanic women were found to have experienced the most rates of domestic violence, as well as witnessing violence, and adult sexual, emotional, and physical abuse (Hankel, Dewey, & Martinez, 2016). According to the accounts of victims of sex trafficking, they would often experience racism at the hands of those who purchased sex and be called racial slurs (Farley, 2006). This kind of racial aggression, as seen by the data of the disproportionate violence and abuse experienced by women of color, makes the experiences that they have added the kinds of trauma that they carry (Farley, 2006).

A significant source of trauma that many women of color who are victims of sex trafficking experience is trauma from their experience with the criminal justice system (Brooks, 2021). According to data from the Federal Bureau of Investigation, Black women are disproportionately arrested on prostitution charges; for example, in 2013, 41.4 % of those arrested were Black, even though Black individuals make up around 13.2 % of the population in the United States of America (Brooks, 2021). In general, while white women are often recognized as victims of sex trafficking and sexual exploitation, many women of color, particularly Black women, are criminalized for being prostituted persons (Brooks, 2021). The intersectionality of race and sex has been found to be a substantial impediment to the ability of those who are being prostituted to escape from such circumstances as structural barriers such as inadequate housing, education, and employment opportunities can make the possibility of a better life almost unimaginable (Brooks, 2021). Furthermore, these structural barriers towards escaping sexual exploitation can exacerbate the challenges in the victim's life, especially if they have a criminal record due to prostitution charges, on top of the barriers that they experience

being a woman and a person of color. While there are some states that have allowed those who are found to be sex trafficking victims to have their prostitution charges dropped (Barnard, 2014). Many victims of sex trafficking may have been forced and/or coerced to carry out other offenses such as drug offenses, resisting arrest, assaulting an officer, or have other convictions associated with their victimization that they are deprived of having their record cleared (Barnard, 2014). As a consequence, the oppression of their experience being sex trafficked can follow them in the form of a criminal record for the rest of their life (Barnard, 2014). While there may be resources available to victims of sex trafficking, many victims of sex trafficking are not educated on their rights and do not know that they are being sex trafficked; in New York City in 2011, 85 % of arrests related to prostitution ended in a conviction, while around a third of them being incarcerated to serve their sentence (Barnard, 2014). Sometimes victims of sex trafficking are arrested on prostitution charges multiple times before they are finally recognized as sex trafficking victims (Ditmore, 2009). With many law enforcement officers having biases against prostituted persons, many officers arrest and re-arrest these victims, and with having a criminal record, when the individual comes in contact with the criminal justice system after already having been arrested and obtaining a record, they are more likely to be treated like a criminal in the future (Bejinariu, Kennedy, & Cimino, 2020).

For many victims of sex trafficking, not only do they express having experienced trauma from their traffickers and those who had abused them for purchased sex, but also law enforcement. The experience of being arrested and incarcerated is often an additional traumatic experience. Additionally, the accounts of those who had experienced sex trafficking have

described being subject to police brutality in police raids, such as being subject to a strike on the head with a gun (Ditmore, 2009). Especially as an unrecognized victim of trafficking, the experience of being treated like a criminal, such as being handcuffed, fingerprinted, and aggressively interrogated as if they are perpetrators, can be further traumatizing (Ditmore, 2009). Not only does this experience deteriorate the amount of cooperation that the victim may provide with law enforcement, but also the amount of trust that they have in the police, which likely is already fragile. The experience of being incarcerated can also place the sex trafficking victim in a state of guilt, where they essentially blame themselves for being trafficked because they are being punished and held responsible for what was of out of their control (Ditmore, 2009). Victims of sex trafficking also have described having negative experiences when interacting with law enforcement, such as victim-blaming and derogatory name-calling (e.g., “dirty hoes”) (Bejinariu, Kennedy, & Cimino, 2020, p. 7). Additionally, many women of color are arrested without being referred to victim resource organizations, while most referred to resources are young white women or individuals who already identify as a victim of sex trafficking (Bejinariu, Kennedy, & Cimino, 2020).

Treatment Models for Victims and Survivors of Sex Trafficking

Currently, there is not a specific treatment model that has been recognized to be specifically effective for victims of sex trafficking. While there is not a specified treatment model for victims of sex trafficking, considering the widespread abuse and trauma they experience, the literature suggests that trauma-informed treatment, trauma-focused cognitive behavioral therapy, psychoeducation, prolonged exposure therapy, eye movement

desensitization and reprocessing, dialectical behavioral therapy, treating ethno-racial trauma through a liberational psychology approach, may be effective (Litam, 2017; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013; Countryman-Roswurm, & Bolin, 2014; Kenny, Helpingstine, & Webber, 2019; Hepburn, 2017; Steil, Dyer, Priebe, Kleindienst, & Bohus, 2011; Duran, Firehammer, & Gonzalez, 2008).

Trauma-Informed Treatment

The utilization of trauma-informed treatment has been noted as an essential approach for clinicians to take when working with a patient population that experienced violence and abuse (Elliott et al., 2005; Courtois, 2004). Trauma-informed treatment is an approach that is geared toward an understanding of the consequences of the violence and abuse endured by the patient and what coping skills can be implemented in treatment to encourage the regulation of symptoms (Elliott et al., 2005). The goals of treatment are framed around the patients' recovery from trauma as well as a coexisting diagnosis that is aggravated or even manifested from the trauma experienced (Elliott et al., 2005). Trauma-informed treatment also facilitates the empowerment of the patient to support their independence and engagement in advocacy for other victims of violence and abuse (Elliott et al., 2005). The goals of recovery from trauma also include the minimization of the risk of re-traumatization, thus encouraging a well-paced treatment plan (Elliott et al., 2005).

When it comes to treating victims of sex trafficking, it is important for mental health professionals to have an understanding of different kinds of trauma, such as acute trauma and chronic trauma. Acute trauma is often a consequence of a single traumatic incident. However,

many victims of sex trafficking experience physical, sexual, emotional, and/or psychological abuse on a regular basis over an extended period of time (Courtois, 2004). Psychiatrist Judith Herman (1992) formulated the grounds for identifying the distinction between PTSD and complex post-traumatic stress disorder (CPTSD). When a patient has endured reoccurring traumatic experiences for a recurring and extended period of time, PTSD symptoms experienced and expressed can be different from other patients with PTSD (Judith Herman, 1992). When an individual has been chronically traumatized, the victim loses their sense of self where they are in a constant state of arousal and hypervigilance, perceiving threatening and triggering stimulus with an extreme reaction due to being in a constant state of fearing revictimization (Judith Herman, 1992). Complex trauma includes the occurrence of reoccurring and prolonged traumatic experiences that are often interpersonal, invasive, and involve the betrayal of, for example, the primary caregiver or partner (Judith Herman, 1992; Giourou et al., 2018). Those who have either chronic trauma or complex trauma may also report the experience of physical symptoms such as insomnia, or psychosomatic symptoms, dissociative symptoms, difficulties in relationships, changes in personality, and may engage in the reenactment of traumatic experiences (Judith Herman, 1992; Giourou et al., 2018). According to Judith Herman (1992), patients who have experienced chronic trauma have symptoms that present so different from a traditional PTSD diagnosis that they are often diagnosed with personality disorders such as somatization disorder, borderline personality disorder, and dissociative identity disorder.

One of the unique factors when working with a patient who has CPTSD, such as sex trafficking victims, is building a therapeutic alliance and rapport. Many victims of sex trafficking

struggle with being able to trust; their trust has often been violated repeatedly while being sex trafficked. Thus, the development of a therapeutic alliance can be slow (Aron, Zweig, & Newmark, 2006). Often, victims of sex trafficking feel like their trafficker (promised opportunity, love, and protection) violated their trust. Survivors have often also had their trust violated by law enforcement and institutions meant to support them, provide access to resources, and ensure justice (Aron, Zweig, & Newmark, 2006). When initially starting therapy, it is to be expected that not only will the patient be reluctant to trust the clinician but also the institution or agency that they work for as a whole (Aron, Zweig, & Newmark, 2006). Trauma-informed treatment entails having an understanding of how difficult it is for the patient to discuss the content of their traumatic experiences. Discussing trauma can be particularly distressing as it can put the patient in a state where they are essentially reliving their traumatic experiences. According to researchers, even at the very beginning of the therapeutic relationship, around 16 % of patients drop out of treatment before receiving their first treatment session (Wamser-Nanney, & Steinzor, 2017). Furthermore, many patients who are receiving treatment for trauma fail to continue going to their treatment sessions, with around 85 % of patients dropping out before their treatment ends, at around their fifth session of treatment (Wamser-Nanney, & Steinzor, 2017). In general, a therapeutic alliance can make a significant difference in attendance and engagement for patients who have experienced trauma (Wamser-Nanney, & Steinzor, 2017).

Trauma-Focused Cognitive Behavioral Therapy

Cognitive-behavioral therapy (CBT) is a treatment model that is oriented towards examining how the beliefs that influence the mood of the individual impact their behavior and

lead to patterns and characteristics of what can manifest into symptoms of a particular mental disorder (Beck, 2020). According to the CBT therapeutic approach, without treatment, the pattern of thinking and behavior encourages a cycle of maladaptive thoughts and behavior, which can cause the patient distress (Beck, 2020). In CBT, the clinician can address the automatic thoughts of the patient that are impacting their mood and behaviors to provide a different perspective for the patient (Beck, 2020). The clinician equips the patient with skills to evaluate the validity of these automatic thoughts and how they are a reflection of a maladaptive thinking and perception of the world (Beck, 2020). The core beliefs and intermediate beliefs that the patient carries are also confronted, such as when the patient maintains beliefs that if they carry out particular rules or assumptions about themselves and what they do, then they would not experience distress such as embarrassment, shame, anxiety, sadness or other unpleasant experiences the patient may be trying to avoid (Beck, 2020). Research about the PTSD symptoms that sex trafficking survivors experience found that common symptoms included: repeated nightmares, a hyperactive startle response, feelings of detachment, fears of their traumatic experience of being trafficked happening again to them, intrusive and repetitive thoughts of their traumatic experiences, and memories, and hypervigilance (Williamson, Dutch, & Clawson, 2010). Through addressing the automatic thoughts that are distressing a patient, the cognitions of automatic thoughts that may be triggered by stimuli in their environment causing unpleasant thoughts, flashbacks, reliving disturbing scenes, and memories can be treated (Beck, 2020).

When working with victims of sex trafficking, researchers O'Callaghan, McMullen, Shannon, Rafferty, and Black (2013) suggest that trauma-focused cognitive behavioral therapy is effective in reducing their symptoms of trauma. When investigating the effectiveness of trauma-focused cognitive behavioral therapy (TF-CBT), the researchers provided 15 sessions of group TF-CBT organized in modules. The modules focused on the following topics: rules, psychoeducation surrounding sexual violence and trauma, addressing their sense of safety, coping skills for relaxation such as breathing techniques, muscle relaxation, how to stop the flow of distressing thoughts, the expression and regulation of feelings, how thoughts play a role in mood and behaviors, narratives of trauma, and confronting cognitive distortions (O'Callaghan et al., 2013). The researchers also made the treatment culturally modified for the patients that participated in this study to increase receptiveness to treatment by, for example, making psychoeducation examples reflective of their culture (O'Callaghan et al., 2013). The results of this study found that the participants who received TF-CBT had a significant decrease of symptoms of PTSD, depression, anxiety, and conduct problems, as well as a significant increase in prosocial behaviors when compared to the control group that was on a waitlist (O'Callaghan et al., 2013). Amongst the participants who received TF-CBT there was a 55% decrease in symptoms of post-traumatic stress disorder, a 63% decrease in symptoms of depression/anxiety, a 77% decrease in symptoms of conduct problems, and a 31% increase in prosocial behaviors (O'Callaghan et al., 2013). TF-CBT also shows a positive lasting impact in a three-month follow-up of participants who received treatment with symptoms of depression and anxiety continuing the decrease and there being an increase in prosocial behaviors (O'Callaghan et al., 2013).

Researchers Kenny, Helpingstine, and Weber (2019) carried out a TF-CBT case study with a victim of sex trafficking by implementing a tailored approach of TF-CBT due to the sensitive state of the patient and the severity of their symptoms. Specifically, they triaged what would be covered in sessions and prioritized coping skills and psychoeducation (Kenny, Helpingstine, & Webber, 2019). Moreover, the clinician continued to use an approach where they would meet the patient where they were at such that they delayed challenging cognitive distortions and opted to implement Socratic questioning to open them up to engage in reflection of their cognitive distortions through open-ended questions. This less confrontational approach also helped in letting the patient feel safer to express themselves (Kenny, Helpingstine, & Webber, 2019). TF-CBT usually lasts for around 15 sessions or so, depending upon the particular issues that the treatment is being implemented to address; however, the patient in the researcher's study participated in a total of 47 sessions (Jensen et al., 2014; Kenny, Helpingstine, & Webber, 2019). Moreover; the patient in the case study was able to experience a reduction in the severity of their symptoms, no longer engaging in substance use, as well as pursue their education and maintain a stable relationship with their family. These results support that TF-CBT can be effective for patients who \were victims of sex trafficking (Kenny, Helpingstine, & Webber, 2019).

Psychoeducation

Psychoeducational group therapy has also been found to be effective in treating victims of sex trafficking (Countryman-Roswurm, & Bolin, 2014). Psychoeducation is valuable in

informing the patient about their diagnosis, the psychological impacts of trauma, understanding triggers, communication skills, and problem-solving skills (Sarkhel et al., 2020).

A study conducted on a group of youth who were vulnerable to domestic sex trafficking who participated in cognitive-behavioral psychoeducational groups showed promising results (Countryman-Roswurm, & Bolin, 2014). Participants experienced an improvement in refining their resilience through learning how to build and maintain appropriate boundaries, have how to have healthy relationships with others, education on what makes a healthy intimate relationship, and how to build healthy relationships with their peers (Countryman-Roswurm, & Bolin, 2014). Psychoeducation is particularly significant when working with a patient population that is a victim of sex trafficking due to its strength in providing patients with greater insight into how traffickers implement coercive control and what particular vulnerabilities they exploit, and how they engage in recruitment (Litam, 2017). Therapeutic techniques such as this not only can provide an opportunity to implement psychoeducation but also allow the patient to achieve greater insight concerning their trauma-specific experiences, such as how they may have entered into being sex trafficked (Litam, 2017).

Many victims of sexual abuse as well as sex trafficking have struggled with the sense of shame and guilt associated with their traumatic experiences. Psychoeducation is valuable in addressing the particular aspects of being trafficked that may be impacting their shame, such as feeling shame about their boyfriend or family members trafficking them, developing a “trauma bond,” and/or experiencing grooming (Márquez, Deblinger, & Dovi, 2020). Moreover, psychoeducation provides the opportunity for the clinician to challenge victim-blaming

narratives that the patient may have adopted when interpreting their traumatic experiences through exploring how they were trafficked (Márquez, Deblinger, & Dovi, 2020). By challenging those narratives that the victim provides, the clinician can equip them with knowledge of how abusers implement grooming and coercive control to confine them and highlight the difference between sex and sexual abuse (Márquez, Deblinger, & Dovi, 2020). Teaching the difference between sex and sexual abuse is significant in addressing the sense of shame and guilt that many victims of sex trafficking struggle with, as many may describe themselves as feeling "dirty," and it is important for the clinician to dissect this matter in a non-judgmental way where the victim can come to terms with how every time they were sexually exploited and abused, they were not having consensual "sex" (Márquez, Deblinger, & Dovi, 2020).

In a study that examined the effectiveness of trauma-focused psychoeducation group therapy, results supported that the treatment was effective in helping the participants realize that other women had experienced similar abuse as they have (Roe-Sepowitz, Bedard, Pate, & Hedberg, 2014). What is significant in this is that there were some participants in the treatment group who had not identified as having experienced abuse who, through the treatment program was able to recognize from the group therapy were able to recognize the abuse they experienced, their trauma, and how their emotions impact their behavior and reactions to the environment around them (Roe-Sepowitz, Bedard, Pate, & Hedberg, 2014).

Prolonged Exposure Therapy

In cognitive behavioral therapy, exposure therapy can be implemented in a number of different ways such as through imaginal exposure and in-vivo exposure (Castillo, 2011). Literature suggests that exposure therapy can be an effective treatment approach for victims of sex trafficking (Castillo, 2011). For example, Prolonged Exposure therapy can be effective in treating a sex trafficking victims engagement in the avoidance of reminders of trauma, such as avoiding talking about their experiences, as well as physical reminders of their trauma, consequently preventing them from fully processing the traumatic experiences and correcting unhealthy cognitions that may contribute a self-blame, guilt, perceptions that they have about themselves, and perceptions they have about the world (Castillo, 2011; Foa, & Rauch, 2004).

Research indicates that Prolonged Exposure has shown to be beneficial in the treatment of victims of sexual assault (Foa, & Rauch, 2004). In a study investigating the effectiveness of prolonged exposure therapy in women who were victims of sexual and non-sexual assault, of the 27 participants who completed participation were randomly assigned to receive prolonged exposure therapy and given imaginal exposure therapy where they had to retell their traumatic experiences in weekly sessions in the present tense (Foa, & Rauch, 2004). With the implementation of imaginal exposure therapy, the participants confront their avoidance of the memories and thoughts that they have regarding their traumatic experiences (Castillo, 2011). A total of 27 participants were either randomly assigned to receive prolonged exposure therapy imaginary exposure therapy with cognitive restructuring, while the other participants were randomly assigned to be on a wait list (Foa, & Rauch, 2004). According to the findings of the

researchers, it was found that the participants who received imaginal exposure therapy experienced a significant decrease in cognitions that resulted in negative perceptions of themselves, the world, and cognitions of self-blame (Foa, & Rauch, 2004). Those who received imaginal exposure therapy and cognitive restructuring did not experience a greater decrease in symptoms when compared to those who received imaginal exposure therapy alone. These results indicate how the process of retelling one's traumatic experiences through prolonged exposure therapy can be an effective treatment approach for victims of sexual violence and the decrease in the symptoms of PTSD (Foa, & Rauch, 2004).

In vivo exposure therapy confronts the patient's avoidance of places, people, and other stimuli that may remind them of their traumatic experiences (Castillo, 2011). In vivo exposure therapy can be helpful when treating patients who may engage in generalization with their trauma, such as associating hotels with their sexual exploitation and sexual assaults, so much so that they avoid those places as an act of self-preservation against the anxiety and other distressing symptoms (Castillo, 2011). According to a case study by researchers Kenny, Helpingstine, and Webber (2019), in the case with a patient who could not look at mirrors due to how the object would remind them of a specific sexual assault that took place in front of a mirror the clinician would gradually expose the patient to mirrors in order to desensitize them from the anxiety associated with this object. Through the utilization of in vivo exposure therapy with TF-CBT, the patient no longer experienced distress when exposed to mirrors and showed an overall improvement in symptoms (Kenny, Helpingstine, & Webber, 2019).

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing therapy (EMDR) has been utilized in the mental health field to treat PTSD, and guide a patient through a traumatic experience and their symptoms of PTSD (Bryant-Davis, 2011). According to adaptive information processing theory, when an individual is experiencing a traumatic event, the experience is warehoused in the individual's mind in an unprocessed state; which is why traumatic memories are experienced similarly to how they were lived, resulting in anxiety-inducing symptoms (Hase et al., 2017). The course of treatment for EMDR has been considered in comparison to other courses of treatment to be relatively short, with many patients usually requiring a range of 3 to 5 treatment sessions to guide them through the traumatic event for the symptoms of the PTSD associated with that memory subsides (Clayton, 2011). However, when working with patients that have CPTSD, it can be much more complicated such as when providing treatment for patients who have trauma from their experience being sex trafficked as EMDR is traditionally used to address one traumatic event in contrast to a multitude of traumatic experiences at once (Hepburn, 2017).

Researchers who have implemented EMDR with a population of patients who were victims of sex trafficking described how the approach of EMDR can be very difficult and more distressing for those who have CPTSD (Hepburn, 2017). In contrast to having the patient focus on their worst traumatic experiences and guide them through that narration, for those with CPTSD, it can become so uncomfortable that the patient will express the desire for treatment to go back towards a CBT approach (Hepburn, 2017). While research is limited concerning the implementation of EMDR of sex trafficking victims who have CPTSD, according to researchers,

the incorporation of CBT along with EMDR and validation from the clinician has been found to be effective (Hepburn, 2017). Additionally, scholars recommend equipping patients with effective self-soothing skills to regulate their emotions as well as feel comfortable discussing their experiences endured from sex trafficking prior to engaging in EMDR (Hepburn, 2017). As a result, when working with a population with CPTSD, such as those who were sex trafficked, the clinician should appreciate the uniqueness of the victims' trauma and make sure that they are comfortable with EMDR as a treatment approach.

Dialectical Behavioral Therapy

Dialectical behavioral therapy (DBT) has been found to be effective when treating persons who have borderline personality disorder and engage in parasuicidal behaviors and emotional dysregulation (Bohus, et al., 2004). A study was conducted where researchers recruited individuals who met the diagnostic criteria for Borderline Personality Disorder who had a history of engaging in a previous suicide attempt or two incidents of self-harming acts in the past two years (Bohus, et al., 2004). It was found that of the participants who received DBT, when compared to the control group that was on a Wait List, showed a significant decrease in the engagement in self-harming behaviors and improvement in their symptoms of depression, anxiety, disassociation, socialization, and relating to others (Bohus, et al., 2004). Those who received DBT had a significant decrease in symptoms of anxiety, as well as a significant improvement on their Global Assessment Functioning scale, indicating an overall improvement in the patient's psychopathology (Bohus, et al., 2004). According to researchers Harned, Jackson, Comtois, and Linehan (2010), DBT, when treating patients who struggle with

suicidality or engage in self-harming behaviors with borderline personality disorder and PTSD, had been found to be effective in reducing the severity of distressing symptoms (Harned et al., 2010). The participants' imminent risk of committing suicide decreased from 28 % to 0 %, their dependence on a substance decreased from 19 % to 0 %, self-harming behaviors decreased from 96 % to 29 %, and symptoms of disassociation decreased from 44 % to around 23 % (Harned et al., 2010).

According to researchers Steil, Dyer, Priebe, Kleindienst, and Bohus (2011), DBT has also been found to be effective when treating patients with PTSD due to childhood sexual abuse. The participants in this study participated in weekly individual and groups sessions covering coping skills, self-esteem, mindfulness, psychoeducation, as well as additional group treatment that taught the participants creative expression through approaches such as art therapy (Steil et al., 2011). When comparing the severity of the participant's symptoms before and after treatment, it was found that there were significant decreases of symptoms of PTSD, depression, anxiety, and their score on the Symptom Checklist-90 R – that was maintained at six weeks follow-up (Steil et al., 2011).

DBT has been noted to be particularly good at addressing maladaptive behaviors that the patient may engage in order to regulate their emotions or, as a consequence, failing to regulate their emotions (Linehan, & Schmidt, 1995). DBT has been noted to be effective in decreasing behaviors such as self-harming, substance use, or engaging in suicide attempts, as well as confronting behaviors that the patient may engage in to interfere with the therapeutic process, such as missing sessions or not participating (Linehan, & Schmidt, 1995; Wagner, Rizvi, &

Harned, 2007). Furthermore; there is a particularly helpful aspect of DBT that can be valuable when treating patients that engage in parasuicidal behaviors through the employment of behaviors chain analysis enabling the clinician and the patient to explore episodes where they may have engaged in self-harm and look into what behaviors, thoughts, and feelings may have contributed to the episode and how they could implement healthy coping mechanisms in the future to have a healthy response to distress (Wagner, Rizvi, & Harned, 2007). DBT does not have to exclusively be implemented for parasuicidal behaviors and can also be implemented when the patient may engage in other maladaptive behaviors such as lashing out in anger with a significant other; this essentially guides the patient through the day and develop an understanding of themselves and what experiences, thoughts, and feelings lead them to engage in certain behaviors, so in the future, they can address similar situations in a more healthy manner.

Liberation Psychology

Recognizing the significant impact that racism and discrimination have on those who are sex trafficked is significant as survivors are disproportionately people of color. It is necessary for mental health professionals to understand and appreciate the implications of the structural inequality of racism as well as their patient's individual experiences (Carter, 2007). According to researchers, those who experience racism are likely to have symptoms of anxiety as well as somatic symptoms attributed to the psychological distress of experiencing racism (Carter, 2007). The experience of racial trauma can be similar to chronic trauma as it is a kind of trauma that has been endured for, in many cases, an extended period of time, starting from a young age (Courtois, 2004). The experience of racism throughout the individual's life can result in the

development of cultural paranoia in racial, ethnic, and cultural minority communities, which consists of symptoms similar to PTSD symptoms, such as hypervigilance, and /or avoidance, due to the unpredictability of when people of color will have experience racism (Carter, 2007, p. 36). Individuals with racial trauma may also experience recurring memories of their experiences of racism, which can be anxiety-inducing (Carter, 2007, p. 36). Individuals may also experience feelings of internalized racism, which, similarly to PTSD symptoms, results in the individual feeling guilt, shame, and self-blame around their experience of racial trauma (Carter, 2007, p. 36).

Liberation Psychology has been identified by scholars as a particularly empowering approach towards providing psychotherapy to patients who are racial and ethnic minorities who are pursuing mental health treatment (Duran, Firehammer, & Gonzalez, 2008). Through the implementation of Liberation Psychology, a therapeutic approach that was established by scholars Ingacio Martin-Baro and Paulo Freire, write about the significance of a therapeutic approach that recognizes and explores the social and historical oppressions of the patient's background helps the patient learn to understand how their trauma is not only experienced by them as an individual but also by others who are disproportionately oppressed as well (Martín-Baró, 2019). When counselors do not acknowledge the historical oppression of their patients who have endured trauma that disproportionately impacts people of color, women, and other oppressed groups, they are also carrying out a form of oppression against the patient (Duran, Firehammer, & Gonzalez, 2008). Through addressing the historical oppression of people of color, the patient can also be given the opportunity to discuss generational trauma that has

impacted their family and their community (Duran, Firehammer, & Gonzalez, 2008). By addressing the proponents of social, historical, and generational trauma that patients' communities have experienced in a therapeutic setting also provides the patient the opportunity to feel validated in their cultural interpretation of their traumatic experiences (Duran, Firehammer, & Gonzalez, 2008).

A treatment approach that has been based on the theory of Liberation Psychology is called the Healing Ethno and Racial Trauma Framework, also known as the HEART framework (Chavez-Dueñas et al., 2019). The HEART framework is implemented in four phases throughout treatment and includes components of cognitive-behavioral therapy (Chavez-Dueñas et al., 2019). For instance, HEART involves confronting cognitive distortions such as self-blame for patients' experiences of racism, as well as equipping them with coping skills such as mindfulness and meditation (Chavez-Dueñas et al., 2019). The clinician can also provide encouragement for the patient to express themselves in healthy ways, including becoming involved in the arts, getting involved in their community, building a social support system, and/or engaging in activism for their community (Chavez-Dueñas et al., 2019). This kind of treatment approach is geared towards getting the patient in touch with their ethnic and racial background and guiding the patient to forge a place in their life where they can feel at peace (Chavez-Dueñas et al., 2019). The clinician can guide the patient to recognize and learn how to manage their experience of racial trauma, build and foster greater relationships with their community as well as a cultural community, and motivate the patient to become passionate about their goals, future, and advocate for themselves and their community (Chavez-Dueñas et al., 2019). Forsyth and Carter

(2014) suggest that when an individual is encountering racism, it can be empowering to respond to the experience through asserting their rights, engaging with empowering resources and communities, and/or becoming more engaged in cultural spirituality, traditions, religion, and beliefs. Through having patients interpret their experience through a social justice perspective, they can become empowered to not feel defeated by their trauma but to find a sense of purpose in having a future of combating those inequalities and oppressions (Chavez-Dueñas et al., 2019).

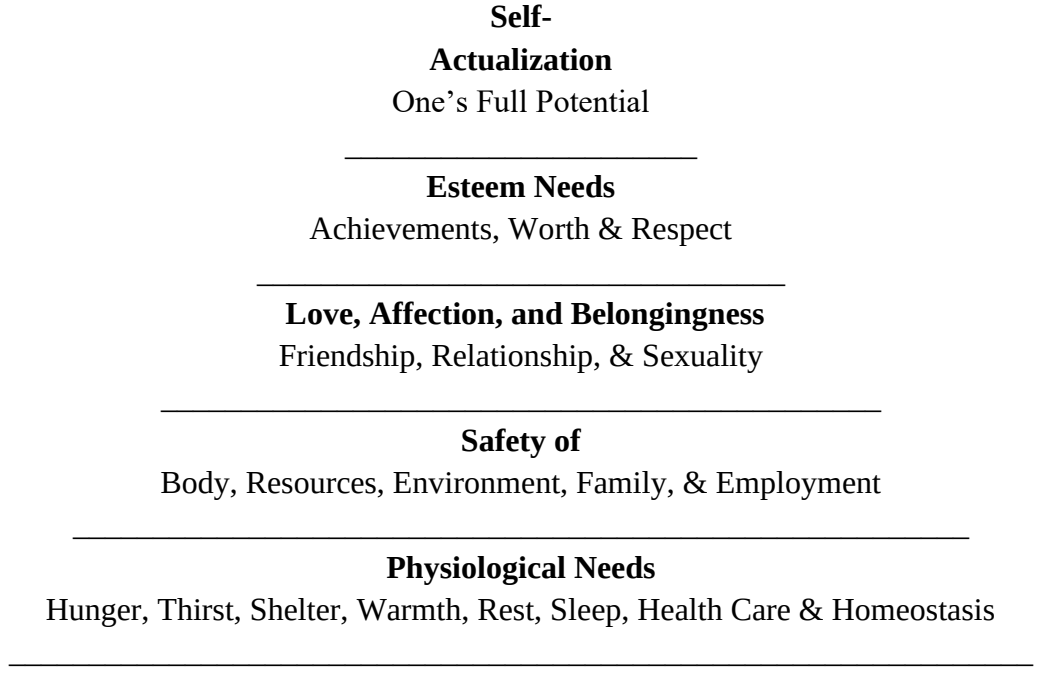
Addressing the Needs of Patients

The treatment needs of victims and survivors of sex trafficking are unique depending upon what stage they are in with concerns to their trafficking situation. The needs of a particular patient depend upon if they are currently in their trafficking situation, in the process of escaping trafficking, just recently escaped trafficking, are no longer being trafficked, and/or are looking for services and treatment that may address more of the mental escape of trafficking (Macy, & Johns, 2011). In understanding what needs an individual is motivated to satisfy, Maslow's Hierarchy of Needs provides a framework towards what needs are to be triaged in order to facilitate the growth of an individual (Maslow, 1943).

Maslow's Hierarchy of Needs

According to Abraham Maslow (1943), the motivations of an individual are hierarchical, with the drives of an individual resting upon the satisfaction or lack thereof of another. According to Maslow's Hierarchy of Needs, the needs of an individual reside upon the motivations to satisfy the following: (1) physiological needs, (2) safety needs, (3) love, affection, and belongingness needs, (4) esteem needs, (5) self-actualization (Maslow, 1943).

Figure 1. *Maslow's Hierarchy of Needs (Maslow, 1943).*



The first level in Maslow's hierarchy of needs is physiological needs such as hunger, thirst, shelter, and rest (Maslow, 1943). According to Maslow (1943, p.5), "A person who is lacking food, safety, love, and esteem would most probably hunger for food more strongly than for anything else". Many victims of sex trafficking have expressed that when initially trying to escape their trafficker, they were eager to be referred to resources and agencies that could provide them with their necessities such as food, whether appropriate clothing, feminine products, and shelter (Aron, Zweig, & Newmark, 2006). Some victims of sex trafficking may be looking for immediate assistance, such as needing prompt access to resources that can provide them with substance abuse services (Macy, & Johns, 2011). Securing the immediate needs of victims of sex trafficking has also been done through working through substance abuse addiction by having the patient go through impatient treatment before addressing other treatment concerns

(Twigg, 2017). This patient population is also likely to have neglected medical needs such as STD/STI testing and treatment, gynecological needs, physical injuries, and nutritional deficiencies (Laser-Maira, Peach, & Mounmenou, 2019).

Patients may seek out the second level of Maslow's hierarchy of needs by securing a safe environment, safety from their trafficker, and safety from themselves engaging in self-harming behaviors (Maslow, 1943; Laser-Maira, Peach, & Mounmenou, 2019). Needs regarding safety also include securing legal resources such as translating services, legal assistance, immigration assistance, and securing financial resources through employment (Macy, & Johns, 2011; Laser-Maira, Peach, & Mounmenou, 2019). While the patient may be physically safe and have resources secured to meet their needs, they may not feel safe. Feeling safe is also a need that the patient must achieve in order to encourage their growth upwards through Maslow's hierarchy. In order to improve the patient's feelings of safety, the clinician must address symptoms of PTSD that may be impacting their perceived safety, such as re-living of traumatic events, hypervigilance, avoidance, flashbacks, nightmares, and dissociation (Laser-Maira, Peach, & Mounmenou, 2019).

Patients may be seeking to fulfill more than the physical need, such as wanting to fulfill their needs for love, affection, and belongingness (Maslow, 1943). Researchers who interviewed victims of sex trafficking found that many of them expressed the need for someone who was not going to judge them based upon their experiences, and a clinician who is culturally sensitive to their background (Aron, Zweig, & Newmark, 2006). The relationship that the patient builds with the clinician can also facilitate a learning experience in how they can foster meaningful and

healthy relationships with others outside of a therapeutic setting (Laser-Maira, Peach, & Mounmenou, 2019). In developing this level of the hierarchy of needs, it may be valuable for the patient to develop an understanding of the kinds of relationships patients have previously had with others, such as their history of child abuse and intimate partner violence (Laser-Maira, Peach, & Mounmenou, 2019). Understanding the abusive dynamics that occurred in these relationships can provide an opportunity for the clinician to guide the patient towards looking forward towards better relationships with others with healthy boundaries, trust, autonomy, and respect (Laser-Maira, Peach, & Mounmenou, 2019). Some patients may consider getting back with their families as a need to be worked towards in treatment (Twigg, 2017). According to researchers, when a victim of sex trafficking is able to get united with their family, service providers have found that they experience enhanced treatment outcomes (Twigg, 2017). The needs for love, affection, and belongingness are not only fulfilled by giving to others and building relationships with others but also building a positive relationship with one's self and loving one's self enough to receive the good life has to offer (Maslow, 1943).

The patient may pursue to fulfill their esteem needs by developing their sense of confidence, respect, and accomplishment (Maslow, 1943). Many victims of sex trafficking express struggling with feelings of guilt, shame, and self-blame surrounding their sexual abuse and exploitation; this is a significant issue that also must be confronted in treatment (Office of Justice Programs, 2011; Nishith, Nixon, & Resick, 2005). Victims of sex trafficking have described that, even when they have escaped their trafficking situation, they have experienced the service providers making the pace of their treatment too fast for them (Aron, Zweig, &

Newmark, 2006). For example, if the very first session, the clinician is having discussions about the goals that they want to address in contrast to focusing on what the patient wants to address (Aron, Zweig, & Newmark, 2006). It is important to consider how the victim may still be in a very traumatized state early in treatment, consequently resulting in the clinician needing to take a slower treatment plan approach (Aron, Zweig, & Newmark, 2006).

Many victims of sex trafficking want to have a sense of agency in treatment and in the establishment of therapeutic goals, as well as be able to have a good idea of what to expect in future sessions (Aron, Zweig, & Newmark, 2006). As a result, is a significant element in making sure that they do not feel discouraged to continue pursuing mental health services (Aron, Zweig, & Newmark, 2006). An additional significant factor is for the patient to achieve their goals as they see it, such as with concerns to pursuing justice (Husseman et al., 2018). Some patients may be in the midst of legal proceedings and may require collaboration from their service providers in order to get their trafficker and abusers convicted (Twigg, 2017). Some clinicians may have goals pre-defined; however, it is important to understand that some victims of sex trafficking may not see justice as getting their trafficker arrested, but by getting past their trauma and moving forward with their life through; for example, pursuing higher education (Husseman et al., 2018). It is important for the patient to feel empowered and that their autonomy in treatment is respected as navigating the therapeutic process can provide them the opportunity to exercise their freedom as a patient to articulate the goals that they would like to achieve, such as achieving educational, professional, personal, cultural, religious, and therapeutic milestones (Maslow, 1943; Laser-Maira, Peach, & Mounmenou, 2019).

Encouraging a patient to achieve their self-esteem needs also requires that the clinician is being non-judgmental of the patients' experiences and diverse cultural backgrounds so they can extinguish lingering senses of inferiority and shame (Maslow, 1943; Laser-Maira, Peach, & Mounmenou, 2019). Research indicates that culturally competent trauma-informed treatment such as meditation, acupuncture, religion, and/or spirituality the patients showed a more rapid recovery process (Clawson, Dutch, Salomon, & Grace, 2009b).

According to Maslow (1943), the pursuit of self-actualization is something that an individual can constantly get closer to achieving in order to reach their full potential. Self-actualization may be demonstrated by a patient advocating for themselves and others, being their authentic selves, pursuing one's dream to be a musician, a doctor, or a journalist that uplifts the stories of other survivors of sexual violence, or in many other self-consistent actions (Laser-Maira, Peach, & Mounmenou, 2019). Self-actualization for a victim of sex trafficking therapeutically could be understood as having fulfilled all of the needs in the lower levels of Maslow's hierarchy of needs and is able to implement healthy coping skills, is able to maintain trust with mental health professionals/in their relationships, maintain a sense of safety in their life, recognizes their worthiness as a person and healthy self-esteem, maintain the necessities of housing, employment, health, a sense of community, and independence (Clawson, Dutch, Salomon, & Grace, 2009b).

Clinician's Experiences When Working With Sex Trafficking Victims

When clinicians are confronted with the opportunity to provide mental health treatment for patients who are victims of sex trafficking, it is important that they are not only skillful in

treating chronic trauma and are aware of how working with this patient population can also require security for the patient's and the clinician themselves. Clinicians should also be sure to provide healthy opportunities to challenge the patient when treating their trauma and make sure that they do not re-traumatize them throughout the course of treatment. In making sure that the patient is not pushed so hard that they prematurely withdraw from treatment, the clinician must make sure to let the patient still maintain their sense of autonomy and be able to express what they are comfortable in engaging and what they are not comfortable in engaging in such as treatment approaches and how due to the complexity and severity of their traumatic experiences that a slower-paced approach to treatment may be beneficial.

Treating a patient population that has endured traumatic experiences can also put the clinician that is providing mental health services for the patient at risk of developing symptoms of vicarious trauma. When working with patients who are victims of sex trafficking, it is important for the clinician to make sure that they are maintaining professionalism when they may be experiencing distress from working with this patient population. Experiencing vicarious trauma may require the clinician to engage in self-evaluation and consider how compassion fatigue, hypervigilance, and overly emotional concerns for their patient may impact the quality of mental health care that they may be providing.

Challenges That Clinicians May Face

Servicing victims of sex trafficking have been shown, according to researchers, to be a challenging endeavor through facing the difficulties of identifying victims of sex trafficking, the risk of developing vicarious trauma. Scholars have noted that a substantial challenge surrounding

the treatment of sex trafficking victims is the lack of mental health professionals' ability to consistently and accurately identify them (Clawson, & Goldblatt, 2007). Researchers have found that mental health professionals also have their own biases and assumptions about those who are prostituted persons, and many may have the belief that those who are engaging in prostitution are doing so of their own free will (Clawson, & Goldblatt, 2007). Additional challenges may be if the patient is connected to the trafficker due to the trafficker being a parent to their child, the hope of being in a relationship with the trafficker, access to financial resources the trafficker provides, as well as the physical location of the shelter or housing that they are receiving treatment which may place the individual in an increased risk of returning to their trafficker if they were trafficked in the same location (Schmidt, 2014). Furthermore, there are some stereotypes about human trafficking that can give the mental health professional a misconception that only particular groups of people can be sex trafficked, such as reserving this crime to individuals who are immigrants; however, a substantial amount of those who are sex trafficked in the United States of America are victims of domestic sex trafficking (Clawson, & Goldblatt, 2007). Furthermore, providers should be educated on the vulnerabilities of the population of people that they provide their expertise; for example, many shelters for women as well as other facilities that provide services to vulnerable women, such as group homes and are often pursued by traffickers as they engage in recruiting young girls and women, as well as traffickers sending other women and girls go inside the facility to engage in recruitment of their patients to be sex trafficked (Clawson, & Goldblatt, 2007).

Mental health professionals who are working with patient populations who have endured traumatic experiences are at an increased risk of developing vicarious trauma (Molnar et al., 2017). Vicarious trauma refers to an individual who develops a changed perception of their life and the world around them after being exposed indirectly to the trauma of another individual (Molnar et al., 2017). Vicarious trauma is particularly common amongst those who work in the mental health field as they are repeatedly being exposed to detailed accounts of traumatic experiences; furthermore, the therapeutic role that the clinician provides in the disclosure of their patient's traumatic experiences can also contribute to compassion fatigue (Ramirez et al., 2020).

Research indicates that the symptoms of vicarious trauma can be similar to the symptoms seen in those who have PTSD, such as re-experiencing the event through experiencing recurrent thoughts and mental images of the detailed accounts of trauma that their patients have experienced (Lerias, & Byrne, 2003). Clinicians may even find themselves engaging in avoidance similar to those who have PTSD as they may engage in behaviors such as avoidance of intimacy, as well as avoiding situations or locations that they may interpret as implicating their safety due to the account of their patient's traumatic experiences (Lerias, & Byrne, 2003). This can be reflective of how the clinician can have a greater acknowledgment of their vulnerability in the world through providing treatment to patients who have experienced traumatic events (Lerias, & Byrne, 2003). Clinicians with vicarious trauma may also have a greater sense of arousals, such as experiencing an increase in irritability, anxiety, as well as difficulty sleeping, as well as anger, and shame (Lerias, & Byrne, 2003). According to research, some clinicians who work with patients who are victims of sex trafficking may be concerned for

the safety of their patients, as well as even experience anger and frustration when the patient may go back to their trafficker (Ramirez et al., 2020).

Barriers to Effective Treatment

When providing treatment for patients who have trauma, particularly from sex trafficking, it is important to be cautious not to retraumatize the patient. By being educated upon the experiences and making sure to build rapport with the patient and form a therapeutic alliance, the clinician can become more sensitive to the needs of the patient and aware of what may be distressing to the patient and could cause them to become distressed (Hopper, & Hidalgo, 2006). For example, taking into consideration the way in which the patient may have been sexually exploited, such as being locked in an enclosed space and held captive throughout their sex trafficking experience, can cause them to be distressed when in psychiatric units where they may have to be held in a small room, moreover, the illusion of feeling trapped can cause them to become distressed as well (Hopper, & Hidalgo, 2006). By making sure that the concerns of the patient's need to feel safe are triaged and prioritized, the therapeutic alliance can begin to be fostered. If the clinician fails to address their concerns of needing to feel safe in the therapeutic environment, then it is likely that the patient will no longer pursue treatment at their particular organization, agency, or facility, and may even no longer pursue treatment at all (Hopper, & Hidalgo, 2006).

While research surrounding treatment models for those with PTSD had found exposure therapy to be effective, according to the accounts of victims of sex trafficking, many of them had found exposure therapy to be ineffective, exacerbate their symptoms, and retraumatizing to the

point where they wanted to stop going to therapy (Hopper, & Hidalgo, 2006). While exposure therapy is geared to desensitizing the patient from their trauma through learning healthy self-soothing coping skills to develop a tolerance and decreased severity of anxiety (Márquez, Deblinger, & Dovi, 2020). However, the process of trauma-focused therapy implementing exposure therapy should be gradual over time throughout treatment; additionally, psychoeducation should be accompanied with treatment so that patient understands the reason for the treatment plan as well as understanding what to expect when going forward with exposure therapy (Márquez, Deblinger, & Dovi, 2020). This can be a challenge for the clinicians as they must consider the significance of the pace of the sessions and treatment approach that they are implementing so that the patient can experience the benefits of treatment.

Vicarious trauma may place the clinician in a state where their professional judgment may be clouded by their want to protect the patient; according to researchers, some clinicians may become more coercive in telling the patient what to do in order to prevent them from going back to a trafficking situation as well as boundary slipping where they no longer are focusing treatment on what the patient wants to address (Ramirez et al., 2020).

Current Study

This study is geared towards expanding the research literature on how mental health professionals provide mental health treatment to victims and survivors of sex trafficking. Furthermore, this study aims to examine the unique experiences that clinicians have experienced when working with this patient population and how they have been able to therapeutically address the complexities of survivors' traumatic experiences and difficulties that they have

endured. Researching how mental health professionals experience providing treatment for sex trafficking victims and survivors can provide greater insight into what approaches they find to be most effective in improving the patient's understanding of their trauma, decreasing the severity of their symptoms, and equipping them with healthy coping skills. Furthermore, this study seeks to understand what clinicians have found to be ineffective when working with this patient population. This study also will assess what providers have learned from their previous treatment of sex trafficking victims that has influenced a therapeutic approach for their patients.

This study looks into (1) the challenges that mental health professionals are confronted with when working with patients who are victims of sex trafficking and (2) what they have found based upon their professional experience to be effective in their field of work. This study will investigate the accounts of mental health professionals working in the United States who have experience treating a patient population of sex trafficking victims. Based upon research on the trauma of those who are victims of sex trafficking and mental health treatment for this particular patient population, the challenges that mental health professionals are confronted with are quite robust. Many victims of sex trafficking experience symptoms of depression, anxiety, PTSD, and substance use disorder. Research indicates that victims of sex trafficking may also struggle with mistrust in institutions as a consequence of the structural inequalities, ethno-racial trauma, sexism, and previous negative experiences with mental health services that they have endured.

Methodology

Introduction

This study investigates how mental health professionals have been able to confront the challenges of therapeutically approaching the unique needs of sex trafficking victims. Through open-ended qualitative interviews, clinicians will provide researchers with a greater understanding of (1) how professionals are approaching treatment for victims and survivors of sex trafficking and what they have found effective (2) how they address the unique vulnerabilities of the patient therapeutically, such as race, sex, and other forms of oppression. The goal of the study is to gain a greater understanding of what approaches clinicians have found to be most effective in treatment of sex trafficking victims and survivors.

Research Design

The design of this study is channeled through a grounded theory approach, a method for qualitative research developed by Barney Glaser and Anselm Strauss (Babchuk, 1996). Grounded theory research is a research design that is directed towards developing theory that gives the opportunity for researchers to discover theory through the data that is collected from the research study (Egan, 2002). Grounded theory research will be used as an inductive approach to understanding an effective treatment approach for clinicians to implement when working with victims of sex trafficking based upon the data collected from the interviews with mental health professionals. Through collecting data from interviews with mental health professionals who have experience working with patients who were victims of sex trafficking, a comparison of their professional experiences and a collection of commonalities can be made. The data collected from

this study will be grounded in the therapeutic approaches that the mental health professionals have found to be effective.

Sampling and Setting

The population of interest for this study was mental health professionals such as psychologists, therapists, social workers, licensed mental health counselors, and other professionals in the United States who have worked with patients who are victims of sex trafficking. This study had the goal of using a sample of 10 to 15 mental health professionals in the United States. Efforts were made to make sure that the sample consisted of a diverse sum of mental health professionals as well as diverse in racial and ethnic backgrounds of those participating in the study. Recruitment for participants of mental health professionals throughout the United States took place online through emailing organizations that provide mental health services for patients such as sex trafficking victims.

Research Participants

A total of 13 individuals participated in Part 1 of the study. Of those that participated in Part 1 of the study 62 % (n = 8) out of the 13 participants met the eligibility criteria for Part 2 of the study. Of the participants that met the eligibility criteria for Part 2 of the study, a total of 6 individuals participated in the qualitative semi-structured interviews.

All of the participants for Part 2 of the study were female. The sample of the participants for the study was diverse. The racial/ethnic composition of the participants included (n = 3) white, (n = 1) Latina, (n = 1) Asian, and (n = 1) African American professionals. The credentials of the participants included 50 % (n = 3) Licensed Clinical Social Workers, 17 % (n=1) Clinical

Psychology Doctorate candidate, 17 % (n=1) Licensed Master Social Worker, and 17 % (n=1) Peer Care Navigator. The educational background of the sample comprised of 17 % (n=1) Clinical Psychology Doctorate degree candidate, 83 % (n=5) Master's degrees, and 17 % (n=1) completed Bachelor's degree with Master's degree in progress. All 100 % (n=6) participants provided services in New York City; 67 % (n=4) of the participants provided services in all 5 Burroughs, while 33 % (n=2) only provided in the Burrough of Manhattan. Seventeen % (n=1) of participants also provided services in New Jersey and the Northern Mariana Island US Territory Saipan.

The experience of the professionals was an average of 7 years ranging from 4 years to 12 years working with patients. The participants in the study worked with a range of 45 to 200 clients or patients who were sex trafficked. Thirty-three % (n=2) of participants had experience working with more than 100 patients who were sex trafficked, while 67 % (n=4) had experience working with less than 100 patients who were sex trafficked.

All 100 % (n=6) of the participants received training specifically on working with sex trafficking victims provided by their employers. Participants received training that has guided the way that they service victims of sex trafficking on trauma, interpersonal violence, advocacy, psychotherapeutic approaches, trafficking, and engaging in peer collaboration.

Table 1. *Relevant Training Received by Participants*

Trauma	Interpersonal Violence	Advocacy	Psychotherapeutic Approaches	Trafficking	Peer Collaboration
General Trauma Training	General Interpersonal Violence Training	General Advocacy Training	Acceptance and Commitment Therapy (ACT)	General Training on Trafficking	Meeting with other service providers to learn
Trauma-informed care	Gender-Based Violence (Domestic Violence and Sexual Assault)	Victim Survivor Leadership	Dialectical Behavioral Therapy (DBT)	Laws on Human Trafficking	Receiving training from other providers
Stages of Change	Abuse Dynamics		Internal Family Systems		
Judith Herman's Theories of Trauma and Recovery	Survivors of Torture		Eye Movement Desensitization and Reprocessing Therapy (EMDR)		
			Motivational Interviewing (MI)		
			Psychodynamic Methods		
			Somatic Experiencing		

Additional external training was pursued by 67 % (n=4) of participants. None of the participants received academic training specifically on working with sex trafficking; however, 17 % (n=1) of participants completed a domestic violence internship while completing their educational program, which included a training on working with victims of sex trafficking.

Data Collection

The study was divided into two parts. The first part of the study determined participant eligibility. If the participant selected no to any of the questions of the prescreening survey, then they were determined to be ineligible to go forward with the second part of the study.

Eligibility and Exclusion Criteria

If the participants answered yes or maybe to all of the content on the study, then they were found to be eligible for the second part where they could participate in an interview about their experience treating patients who have been sex trafficked.

Part 1:

In the first part of the study, mental health professionals completed an online prescreening survey that determined their eligibility to participate in the interview portion of the study. The brief online prescreening survey was comprised of 9 questions concerning their experience as mental health professionals, if they have worked with patients who were sex trafficked, and their professional background. For the first question of the pre-screening survey, the participant could select one of five options for their professional title or role such as Licensed Social Worker (LMSW), Psychologist (PHD) (PSYD), Licensed Mental Health Counselor (LMHC), Therapist, or Other. For question two, the participant could select one of four options for length of time practicing in mental health care such as Less than 1 year, 2-5 years, 6-10 years, and more than 10 years. For the rest of the questions on the pre-screening survey, the participant could select one of the three following options either “Yes”, “No”, or “Maybe”.

In order to be eligible to participate in the second part of the study, participants must have selected either “Yes” or “Maybe” to each of the items. If they selected “No” to any of the items on the survey, they were considered ineligible for further participation. Mental health professionals who did not have experience working with patients who have been sex trafficked were not eligible to participate in the second part of the study.

Mental health professionals who selected responses on the pre-screening survey that indicated that they have experience working with patients who were victims or survivors of sex trafficking were included in the study and provided their email to be contacted with information for the second part of the study. Mental health professionals who were eligible to participate in the second part of the study scheduled a date and time through emailing or calling the researcher to make an appointment for an individual interview.

Part 2:

In the second part of the study, the mental health professionals who were scheduled to participate in the interviews were given a password-protected Zoom link. Each interview lasted approximately 45 minutes. The interviews contained 31 questions consisting of 1 question on their credentials, 2 questions on where they see their patients, 6 questions on their demographics and background, and 22 questions about their professional experiences.

I conducted the interviews and audio recorded them for coding through the Zoom recording feature. After the completion of the interview, the participants were compensated a total of $50 for their participation.

Procedures

All of the participants were given a unique identification number with the researchers' initials who conducted the virtual interview. The audio recordings were saved until transcription with a unique set of numbers generated by Zoom. I transcribed the audio recordings of the interviews. All identifiable language was removed and replaced with non-identifiable language throughout the transcription process. Upon transcription of the audio recording, files of the interviews with mental health professionals were deleted.

Data Analysis

This Qualitative study was guided by a grounded theoretical approach to hand-code the content of the interviews of the mental health professionals into themes. Once all of the interviews are transcribed and undergo data cleaning, they are reviewed at a minimum of 2 times for the researcher to become familiar with the data. The phases of coding are on a three-step basis (1) open coding, also known as initial line by line coding, (2) axial coding, also known as focused coding; and (3) selective coding (Creswell, 2013).

Open coding is a process where the researcher navigates the transcripts and starts to pull themes from the data (Creswell, 2013). The researcher, after identifying these themes, returns to the data to create categories around the identified phenomena (Creswell, 2013). Themes are then developed surrounding the identified phenomena surrounding *casual conditions* or proponents that motivate the occurrence of the phenomena, then identifying *strategies* engaged in response to the phenomena, the identification of *intervening conditions* that may influence the implementation of strategies, and then the *consequences* or result of the utilization of such

strategies (Creswell, 2013). With the themes identified and surrounding the identified phenomena, a theoretical web can be demonstrated with axial coding, this leading to selective coding for the story of the mental health professionals to be told as a theory for treatment for victims of sex trafficking (Creswell, 2013).

Interrater Reliability

In order to ensure the reliability of the codes that were developed throughout the data analysis process of reviewing the content of the qualitative interview transcripts, interrater reliability checks were put in place. Through the implementation of intercoder agreement, a researcher and a Clinical Psychology Ph.D. candidate had to agree upon the emerging themes and identified phenomena throughout the interpretation of the data.

Validity

In order to ensure the validity of the interpretation of the results of the data collected the following techniques were implemented: (1) Peer debriefing, (2) triangulation, (3) negative case analysis, and (4) thick description (Creswell, 2013). Peer debriefing served as a way to keep the research process held accountable by challenging the researcher by providing questions and a different perspective on the methodology, the screening and interview instruments, and data interpretation (Lincoln & Guba, 1985). Triangulation served as an approach to use multiple and varying sources to support the interpretation of the results from the qualitative data (Lincoln & Guba, 1985). This study utilized triangulation through member checking the researcher's interpretation of the collected data (Lincoln & Guba, 1985). Negative case analysis was implemented through the continuous revision of the hypothesis throughout the data collection to

facilitate the development of a theory based in the data (Lincoln & Guba, 1985). Thick description is another proponent implemented in the recording and interpretation of the data to provide detailed descriptions of the context, emotion, and behavior of the participants of the study (Lincoln & Guba, 1985).

Results

Victim Identification

Fifty % (n = 3) of the participants worked directly with victims of sex trafficking and therefore did not have to screen for elements of trafficking. The other 50% (n = 3) were able to identify victims of sex trafficking in their professional experience. Of the 50% (n = 3) that identified victims of sex trafficking, 67% (n = 2) identified sex trafficking in a situation that initially looked like domestic violence. Examples of elements to look for that can be effective in identifying a potential victim of sex trafficking were provided by (n = 6) all of the participants.

Of the participants that were able to identify victims of sex trafficking, each were able to illustrate the incidents in which an identification of a potential victim was made. One of the participants that was able to identify a victim of sex trafficking stated that, when investigating the possibility of a patient being a victim of sex trafficking, “I usually apply the idea of force, fraud, or coercion and how that enters into work, and also childhood, and as it relates to sex.” The participant described how they would screen for the possibility of sex trafficking by asking the following questions: “Have you ever experienced having your documents withheld, or being surveilled, or being forced to do work that you didn’t want to do?” When asked to elaborate regarding the intake process, the participant expanded on the questions, they would ask stating that they would ask, “What force have you ever experienced [such as] physical, sexual, [or]

psychological abuse?". When investigating the potential fraud, a patient may be experiencing, the participant would ask "Have you ever been made a false promise, and the client might say… A promise of love or marriage, of a partnership, of documentation in terms of like immigration status". When investigating the potential coercion experienced by a patient the participant would ask if they were "threatened with harm to yourself, to your family, to your reputation".

Another participant who was able to identify potential victims of sex trafficking provided an example by stating the following: "There was a domestic violence case that came in. Concerns were that it was a very recent relationship that had met online… and there was a violence incident that arose around an argument about sex."

An additional participant who was able to identify a victim of sex trafficking stated the following:

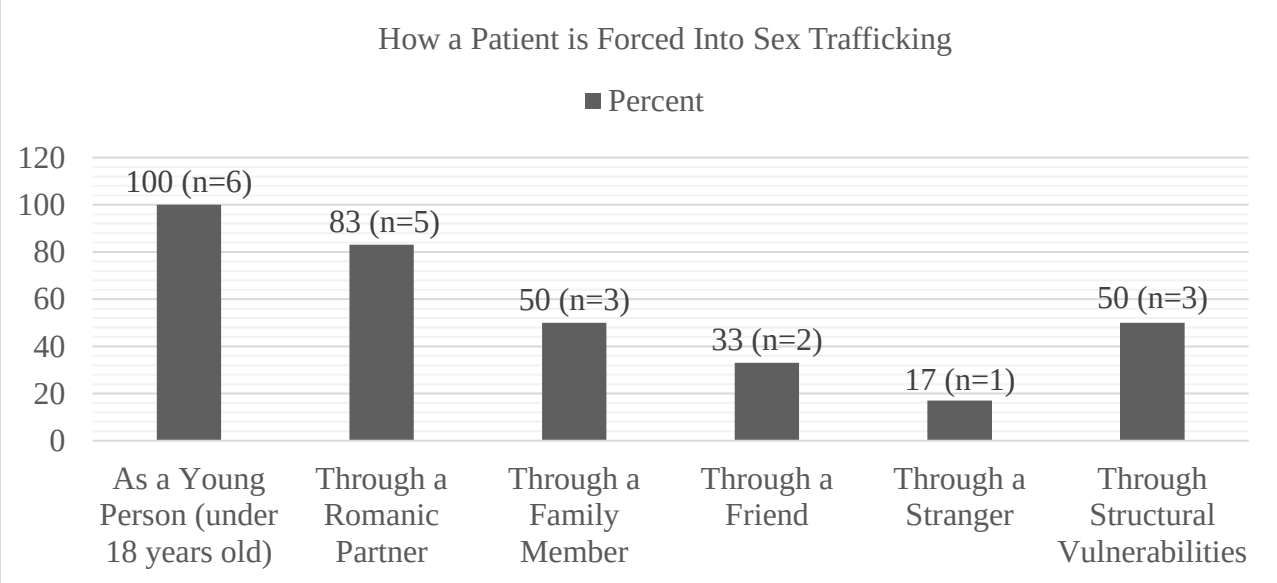
> *"A woman had called and she was reporting a lot of violence between her and her partner, she was also seemingly very paranoid, and this paranoia was about like people watching her, about her being followed." The participant described how they wondered if this person may have had what they described as "potentially more severe symptomology" and continued by stating, "I don't think that I would have been able to ask the questions that I ended up asking [and inquire more] about you know, some sort of reality testing sort of questions about some of this paranoia and [had I] not had exposure to the abuse dynamics involved in [trafficking] or trafficking dyads. But I ended up asking a lot of those [questions], and it turns out that she was involved in, as is often the case, both a romantic relationship and also being exploited for commercial sex."*

Examples of indicators of vulnerabilities and victimization that are commonly seen amongst victims of sex trafficking that can help in identifying a potential victim were provided

by all (n = 6) participants. For example, one of the participants stated, “The way that we found out is by the client telling us, and they were usually [needing] money and were pretty honest about needing money, being willing to do anything to get it.” Another participant stated the signs of a young person experiencing sex trafficking may include: “Missing school al lot. Sometimes if they have like really expensive things, that kind of can’t be explained, where it came from.” The participant added that they also do work at a women’s reproductive health organization and described signs of a victim of sex trafficking, stating, “If a young girl is there and then like a much older man is kind of accompanying them to their like statement… being forced into the decision” they may suspect sex trafficking. The participant continued that there is not one indicator of sex trafficking and identified other indicators such as other signs of trauma, fear, increased outbursts, being really withdrawn, not trusting people, not trusting adults, and multiple STIs. An additional participant also summarized indicators with “common themes; [like] child abuse, domestic violence, intimate partner trafficking.”

How A Patient is Forced into Sex Trafficking Impacts the Course of Treatment

Figure 2. *How A Patient is Forced into Sex Trafficking*



When participants were asked how the way that the sex trafficked victim was forced into their trafficking situation impacted the course of treatment all (n = 6) participants addressed the victims' forceful entry into sex trafficking through therapeutically examining traumatic relationships. A participant stated, "It goes on with this theme of betrayal… in a lot of these relationships, it's come to some similar points of intervention and being able to talk about how betrayal manifests in particular relationships and untangling those, understanding those, exploring those." All participants (n = 6) reported that being sex trafficked at a young age under the age of 18 was an impactful factor for the course of treatment. Being trafficked by a romantic partner was reported by 83% (n = 5) of participants, a family member was reported by 50 % (n = 3) of participants, a friend was reported by 33 % (n = 2) of participants, and a stranger was reported by 17 % (n = 1) of participants to be an impactful factor for the course of treatment. Being coerced and forced into sex trafficking through structural vulnerabilities were also identified as an impactful factor for the course of treatment by 50 % (n = 3) participants.

Being sex trafficked as a young person under the age of 18 was described by all (n = 6) of the participants as an impactful factor in treatment. All of the participants worked with victims of sex trafficking, most of whom were forced into sex trafficking as a minor. A participant stated, "it's a process that normally starts from childhood" An additional participant stated, "Depending on the time or the age they were trafficked, a lot of the young women that I worked with… were poached very early on in their adolescence or childhood, and it was very intentionally. They had pimps right, and they would go to the park, go to the schoolyard and court them. This is something that could be more of a traumatic experience, like starting it that way could severely impact how they trust people, what they think about people." Another participant stated, "I worked with a lot of younger individuals" They continued with, "A lot of the individuals I

worked with had sort of learned about relationships with others around their experience with sex trafficking. So, their experience of forming a trusting relationship with an adult was heavily influenced by the fact they are some of their earlier relationships with adults were traumatic." The participant also added, "Helping them understand healthier boundaries was more challenging on me."

Being trafficked by a romantic partner, such as their trafficker courting and manipulating them into a relationship was described by 83 % (n=5) of the participants as impactful. One participant stated, "As the person becomes a teenager, everyone is looking for love and acceptance, so you come across these [abusers], these manipulators, these predators, who have glamorized how they love you and they know [their] your partner, but at the end of the day they want you to perform a service to take care of their needs." The participant continued, "I feel like helping them identify that," and described how differentiating the "Lifestyle versus the fairytale" can be hard for the victim. The participant provided an example of a patient's thought processes, stating, "No, but he really loved me, no one else loves me, but he loved me." The therapist explained that they would challenge the patient by presenting them the following question: "Then why is he not on the corner with you?" A participant described how for one of their patients, "it was her first love that trafficked her." Another participant stated "When a young person leaves the life…their first romantic connection after that tends to be an intimate partner violence situation because you know oftentimes that's what they kind of know and feels familiar." An additional participant reiterated the romantic partner trope seen in the dynamics of sex trafficking and stated, "In my treatment, it's very similar like partner becomes pimp becomes trafficker."

Being trafficked by a family member was identified as an additional factor to impact the course of treatment by 50% (n=3) of the participants. A participant stated, “Betrayal for some clients may have occurred through an early parental figure who introduced them to like one client incest.” Another participant stated the following: *“*

> *[What] we will most see, to be honest, is that most of our young people entered the life through either their family, like their family was the one who was pimping them out or kind of what we call seduction coercion where right like they didn’t really have a strong family unit or they were abused at home right like where it was like sexual abuse or physical abuse or things like that.”*

The participant continued by stating that traffickers may “take the role of being like their dad” and noted that “there can be women exploiters to be like their mom” as well.

Being sex trafficked through a friend was also identified as a factor that impacts the course of treatment by 33% (n = 2) of the participants. According to one participant, “Entering trafficking can be coercive, it can be forceful, but it can also not be. It could be a friend like ‘hey, you wanna get some money with me? Let’s do this.’ And that probably may not be as traumatic.” However, another clinician stated entering sex trafficking through a friend “goes on with this theme of betrayal.”

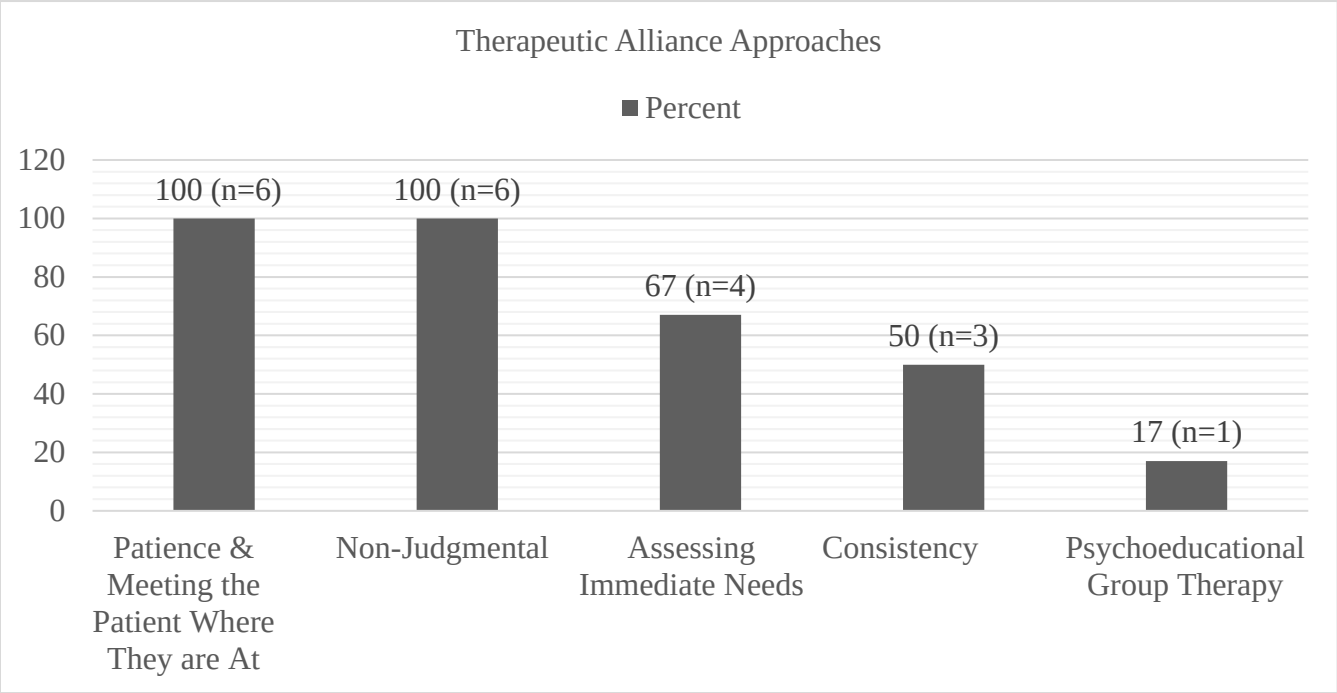
Being sex trafficked through a stranger was described as an impactful factor through the course of treatment by 17% (n=1) of the participants. A participant stated, “I do really tailor my therapy. I think sometimes what can look really different is like, you know so we have a couple of girls who literally were like, okay, they were straight-up kidnapped… And they had like a really supportive family who was looking for them, and things like that.” They continued by stating that treatment “might look a little different because they have a supportive family at home

or they have a good support system right so. Sometimes you can bring in like their support system… into like a little bit of the treatment." Being trafficked by a stranger, unlike in the other ways in which an individual can end up being sex trafficked, is unique in how the victim may still have a supportive family, romantic partner, and community that can facilitate their recovery from the traumatic experience.

Structural vulnerabilities that played a role in how someone is coerced and forced into sex trafficking were identified by 50% (n = 3) of the participants as impacting the course of treatment. One participant stated, "If you are taken out of the home, and you go into the systems, the oppressive systems, whether its juvie, foster homes, there's abuse there as well." Another participant stated, "Being in the foster care system is a huge risk of ending up in the life, and so you know [the] kind of exploiters are really good at what they do right. So, they can kind of tell when a young person doesn't really have those safety nets, doesn't have that support system, that community around them, and so they kind of start out by being that for them right like being like "oh you're so pretty you're so smart, what are your dreams?"

Therapeutic Alliance and Trust

Figure 3. *Therapeutic Alliance Approaches*



Effective approaches to building therapeutic alliance and trust with victims of sex trafficking were provided by all (n = 6) of the participants. Having patience and meeting the patient where they are at was reported by all (n = 6) of the participants as an effective approach. Being non-judgmental was reported by all (n = 6) of the participants as an effective approach. Assessing for immediate needs was reported by 67% (n = 4) of the participants. Consistency was reported by 50% (n = 3) of the participants as an effective approach for building therapeutic alliance and trust.

Having patience and meeting the patient where they are at was described as important when building a therapeutic alliance with victims of sex trafficking by all (n = 6) of the participants. A participant stated, “I think patience is really important, trying your best to build trust.” The participant continued stating, “It’s really also a waiting game, wait till they’re ready, and when they are ready, they will talk to you, in my experience.” An additional participant

described building trust as "allow that trust to build slowly over time." A participant stated, "each individual is unique" they continued stating, "I like to do 90 days of building rapport with them so that they can feel safe and secure; this allows them to, to learn to use their voice, this allows them to feel like they have self-agency and empowerment." Another participant stated, "I will never push a client to tell me more than they feel comfortable in the moment." An additional participant described the significance of patience with the following example: "Meet them where they're at right so. Some survivors will come, and they want to tell you that everything and then want to tell you every single like part of the trauma" The participant noted this behavior was "like flooding" and continued with "Trying to get them to take a step back because, right, sometimes they might be talking; telling, telling, telling, and then later they're like 'oh [expletive]… I just told this like woman, I don't really know, like all my stuff and now like I don't want to talk.'" The participant added with the following:

> *"The opposite end of the spectrum, right, you might have a young person that's just like really not wanting to talk… I'm not here to make you do anything… You don't have to talk to me but, I'm here if you want to… I find like talking to them about things like that have nothing to do with their experience as a survivor, like what are you binging on Netflix, what's your favorite show, what music are you listening to… Just talking to them about things that don't have to do with… Being a survivor, because there is more to them than just being a survivor, right, and I think that can help gain the trust as well."*

A participant stated that giving the patient, "time" and "not rushing any sort of trauma work, not rushing any sort of processing before that safety is established."

Nonjudgmental therapeutic approaches were described by all (n=6) of the participants. A participant stated, "Definitely being nonjudgmental, right they've had a lot of people be really

judgmental of the things that they've done… Being like… You know we're not here to judge at all. Like we're just here for them and for their goals and what they want, so I think conveying that is really important, as well." An additional participant stated, "Sometimes there's a lot of shame and embarrassment around this participation in sex work, um, so you really just want to build as strong as a relationship as possible so that this person trusts you enough to be able to share with you what they are going through." The shame associated with being sex trafficked was reiterated by a participant who stated, "The fact of doing crimes and the sex act really, places the three A's on them…I start off with them [by] identifying the three A's, which is Alone, Afraid, and Ashamed". Another participant stated, "From a longer-term perspective, I tend to base my therapeutic alliance and relationship on Carl Rogers' Unconditional Positive Regard… To view them positively, approach without any anger or judgment and share some of myself in sort of a positive and encouraging way to sort of help rebuild trust in individuals." Additionally, a participant described how "A lot of the principles of trauma-informed care in terms of respect, collaboration, and allowing the client to make choices like answer to the extent that you feel comfortable" were valuable in building trust and a therapeutic alliance with victims of sex trafficking with a non-judgmental approach. Another participant reiterated the importance of a nonjudgmental approach by stating therapeutically incorporating, "a lot of validation, a lot of I think warmth."

Assessing for immediate needs according to 67% (n = 4) of the participants were described as effective in building a therapeutic alliance with victims of sex trafficking. One participant stated, "I think I use a very basic approach to start around, like Maslow's hierarchy of needs, just really serving making sure the basic needs are met right off the bat. Are they hungry, are they, do they have a place to stay, assessing for active safety?" Another participant stated,

"Knowing that the client is in the life, or just came out of the life, they are being exposed to all these service providers, and they're trying to do multiple things. They're trying to deal with their substance abuse, their mental abuse, their financial hardships, education, [and] employment. So, therefore we do action plans, where we're like, what's the most immediate need right now?" An additional participant provided an example where a medical need was identified and addressed "There was a client who had avoided going to a gynecologist for a very, very long time, and she was experiencing a great deal of pain in her genitals, and so she told me about that, and I said, well I can, I think to offer a form of accompaniment. Whether virtual over the phone or in-person. That went a really long way of; maybe I can't provide all the words to fix anything because some things cannot be fixed, but presence and solidarity, that can go a long way." Another participant stated that they would "create physical safety [and] emotional safety" in the therapeutic space. The participant added that they try to "leave a sense of choice for agency in the clients' or patients' hands. So, asking a lot of questions, 'is that okay?', 'yes?', 'are you ready?' too… 'are you comfortable sitting in the seat?' like getting back to that kind of safety."

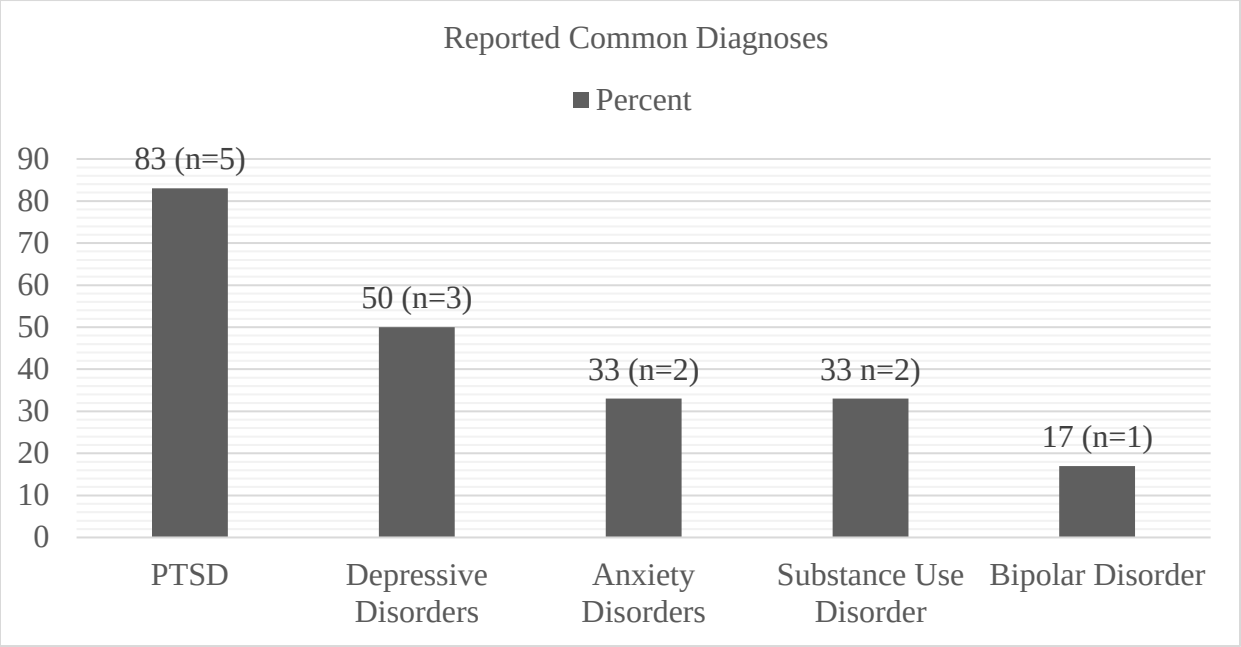
Consistency was described as effective in building a therapeutic alliance and trust by 50% (n = 3) of the participants. A participant stated that, "We really tried to build some consistency in our engagement with her, and I think that consistency allowed her to know that we were always gonna be there. Right, so whether you need something or not, we are gonna be here. And in the event that you do need something, it's perfect because we've been here anyways." Another participant stated, "I think consistency, predictability in terms of having this set up time. If I make a commitment to call them at a certain time, I will definitely do that and follow through." An additional participant stated, "Consistency and patience are the two most

effective tools for me just continuing to be available. Continuing to follow through on my word if I said I would do something, doing that, and not expecting anything to happen quickly."

A less common approach reported to be effective in building a therapeutic alliance and trust with victims of sex trafficking was psychoeducational group therapy. Psychoeducational group therapy was reported by 17 % (n=1) of participants as an effective way to build trust in mental health professionals and getting victims of sex trafficking to pursue therapy. The participant stated that they led a "psychoeducational group, and so I found sometimes like in a [group] setting when I'm doing like some education on what trauma looks like" the participant added, "I do find that sometimes in those groups… It let them get to know me without me specifically being like, your trauma, let's talk about it. And then they'd hear me say something or … hear about trauma and be like oh wow I actually have these symptoms and like sometimes they reach out to me." The participant continued stating "I can tell them a little bit about like what counseling and therapy looks like."

Common Diagnosis from Trauma of Experiencing Sex Trafficking

Figure 4. *Reported Common Diagnoses*



When the participants were asked to describe the most common diagnoses that they would see amongst those who were sex trafficking victims. PTSD was identified as one of the most common diagnosis for victims of sex trafficking by 83 % (n=5) of participants. Complex PTSD as a common diagnosis for victims of sex trafficking by 33 % (n=2) of participants. Depressive disorders were identified as one of the most common diagnoses for victims of sex trafficking by 50 % (n=3) of participants. Anxiety disorders were identified as one of the most common diagnoses for victims of sex trafficking by 33 % (n=2) of participants. Substance use disorders were identified as a common diagnosis for victims of sex trafficking by 33 % (n=2) participants. Bipolar disorder was identified as a common diagnosis for victims of sex trafficking by 17 % (n=1) participants.

Fifty % (n=3) participants stated that they have found that the mental health community does not fully understand what trauma may look like amongst victims of sex trafficking. A participant stated that many of their patients have their PTSD misdiagnosed as bipolar disorder

that was received from previous mental health professionals their patients had encountered. This participant stated the following regarding bipolar disorder "A lot of them come in with a bipolar diagnosis, but I've actually found that I think most of those diagnoses [are] actually not true, and it's actually PTSD, because in some ways they can present very similarly."

Complex PTSD was reported as a common diagnosis for victims of sex trafficking by 33 % (n=2) of participants. A participant stated PTSD was described as an uncomprehensive diagnosis. The participant stated, "I think the diagnosis is really limiting, especially when it comes to chronic interpersonal violence, exposure to violence or trauma." The participant described how the PTSD diagnosis "maybe oversimplifying a lot of the difficulties that result from that kind of trauma" The participant stated that they prefer the complex PTSD diagnosis by stating the following:

> *"I think there have been some improvements to the PTSD diagnosis from the last version of the DSM but, you know, I think complex trauma takes into account…a lot of the affective and the interpersonal sort of consequences of chronic trauma, and PTSD I don't think does [a] good enough of a job at capturing those and maybe relies a little too heavily on sort of like the flashback, intrusive sort of symptoms."*

Another participant expressed the dissatisfaction that many of their patients have with psychiatrists overmedicating their symptoms when the patients who prefer an alternative to medication. The participant stated the following "there [are] not enough mental health professionals who have an expertise in sex trafficking, we need more of this, and we need more with psychiatry because the clients want more of a holistic effect." The participant added, "When the psychiatry is like, well you're not sleeping, so we have to prescribe this and that, they don't want to get more codependent."

Challenging symptoms to work through therapeutically were described by one participant. Dissociation was identified as a common symptom for victims of sex trafficking that by 17 % (n=1) participants. One participant stated the following “The ones that suffer from drug abuse is the dissociation, the ones that have gone through extreme violence, those are the ones that are really, really hard to get them to participate…”

Treatment Approaches

All 100 % of participants (n=6) provided examples on therapeutic approaches that they utilized to treat victims of sex trafficking.

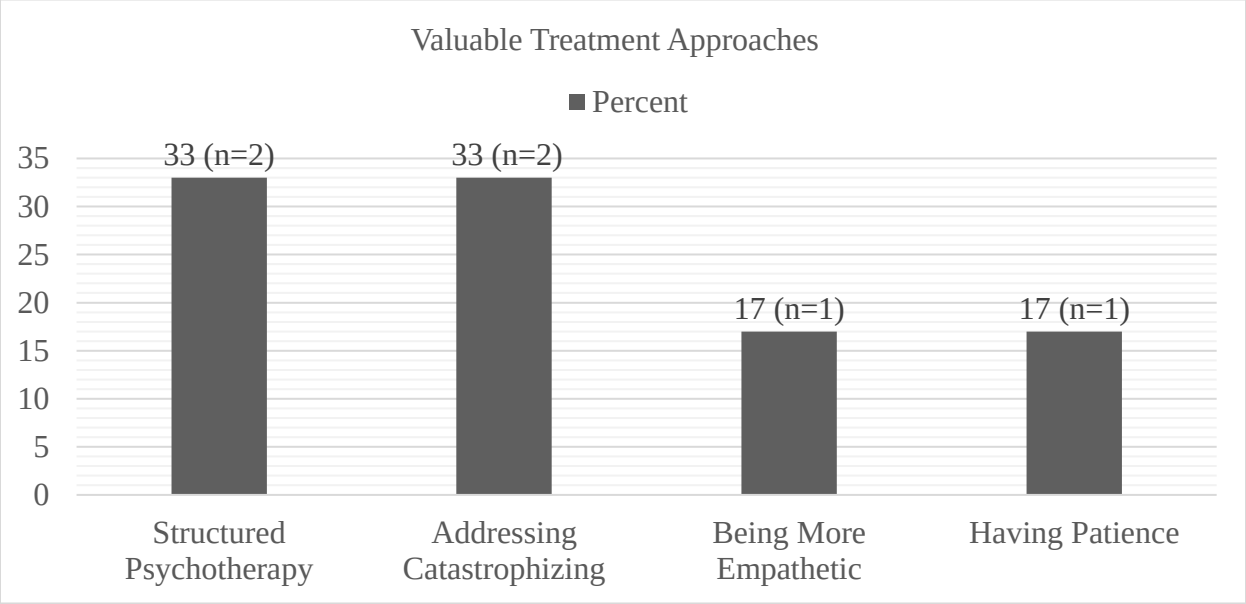
Table 2. *Treatment Approaches Utilized with Sex Trafficking Victims*

Treatment Approach	Number of Participants
Psychodynamic theories	67 % (n=4)
Meeting the patient where they are at	50 % (n=3)
Motivational Interviewing (MI)	33 % (n=2)
Cognitive Behavioral Therapy (CBT)	33 % (n=2)
Dialectical Behavioral Therapy (DBT)	33 % (n=2)
Safety planning methods	33 % (n=2)
Psychoanalytic theories	33 % (n=2)
Empowerment	33 % (n=2)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	17 % (n=1)
Solution-Focused therapy	17 % (n=1)
Narrative therapy	17 % (n=1)
Internal Family Systems	17 % (n=1)
Stages of Change	17 % (n=1)
Crisis Counseling	17 % (n=1)
Psychoeducation	17 % (n=1)
Psychoeducational Group	17 % (n=1)

All 100 % (n=6) of participants reported learning approaches they found valuable over time from treating victims of sex trafficking that have been helpful in treating other victims of sex trafficking. Utilizing structured psychotherapeutic approaches was learned to be valuable when working with victims of sex trafficking by 33 % (n=2) of participants. Addressing

catastrophizing was learned to be valuable when working with victims of sex trafficking by 33 % (n=2) of participants.

Figure 6. *Valuable Treatment Approaches*



Utilizing structured psychotherapeutic approaches were learned from treating previous victims of sex trafficking to be valuable and effective when treating other victims of sex trafficking, according to 33 % (n=2) of participants. A participant stated, "I was surprised how applicable Judith Herman's like stages of recovery would be throughout my professional career… and with so many populations, [from] survivors of torture to trafficking." Another participant stated, "Traditional psychotherapy I found doesn't tend to work well for most of them and so I do feel like I kind of learned that really sometimes like when I would try to do it in that manner, they'd be really quiet. Or I actually have a young woman…that is doing so well, like, I found when I was…like "well, what do you want to talk about, what's going on?" she [would] kind of be like "I'm cool, I'm fine"…Doing like that more CBT more DBT like that was much more effective, right, where [there] was structure to it like your kind of learning a skill, you're kind of doing [a] worksheet and like challenging your thoughts and things…But like I said, right,

every young person is different, but I found [for] the majority of them a more structured therapy seems to work better."

Therapeutically addressing catastrophizing was learned from treating previous victims of sex trafficking to be valuable and effective when treating other victims of sex trafficking, according to 33 % (n=2) of participants. A patient stated that "maintaining a level of calm in response to a trauma response" was valuable and effective in their experience. The participant continued with stating, "if the patient comes in extremely heightened, learning to sort of take things slow, helping them to understand what is a crisis and isn't; so you know, for example, someone coming in and panicking telling me, I have to sign this form right away because [its] the only way they're going to get, you know, this thing at school." The participant elaborated by stating the following:

> *"Stay calm in those situations and think critically sort of to help model to them that this is how we respond to a, to a crisis and, and by crisis, I mean something that's not life or death. Sort of helping them understand what is life or death because they had been through situations like that, and what isn't and learning how to tell the difference and modeling that to them that it's not the end of the world…. helping with the catastrophizing was a big element that I learned was critical in the work and, and really helped me because I think that many advocates in the trauma field tend to freak out when the patient is freaking out, and I think that the key is to learn to stay calm and, and that's modeling for the patient to be able to understand that not everything's a crisis and, and that's an important lesson for life."*
>
> An additional patient similarly stated the following:

"The reality of the world for us today is we're going through a lot of wars, right, went to a medical war, a financial war, or [a] racial war. Covid has really changed our lives, and with social media and Hollywood…people are paranoid. So, I explained to the survivor like 'hello, the person with a degree and the good job is suffering, just as much, we're all suffering, we're not having human engagement, we're isolated, we're running out of things to do, we're eating.' So, if a normal person is struggling through these things, don't allow your past and your trauma to be the frontline of 'I am the victim', you see me, I have victim on my head, please predator, come after me… So, you know [what] stand up, stand proud, gear up."

Less reported therapeutic approaches learned from the participants' experiences in treating patients of sex trafficking were reported by 33 % (n=2) of participants. Being more empathetic was learned to be valuable when working with victims of sex trafficking by 17 % (n=1) of participants. Having patience in the pacing of the treatment was also learned to be valuable when working with victims of sex trafficking by 17 % (n=1) of participants.

Being more empathetic was learned from treating previous victims of sex trafficking to be valuable and effective when treating other victims of sex trafficking, according to 17 % (n=1) of participants. The participant stated the following:

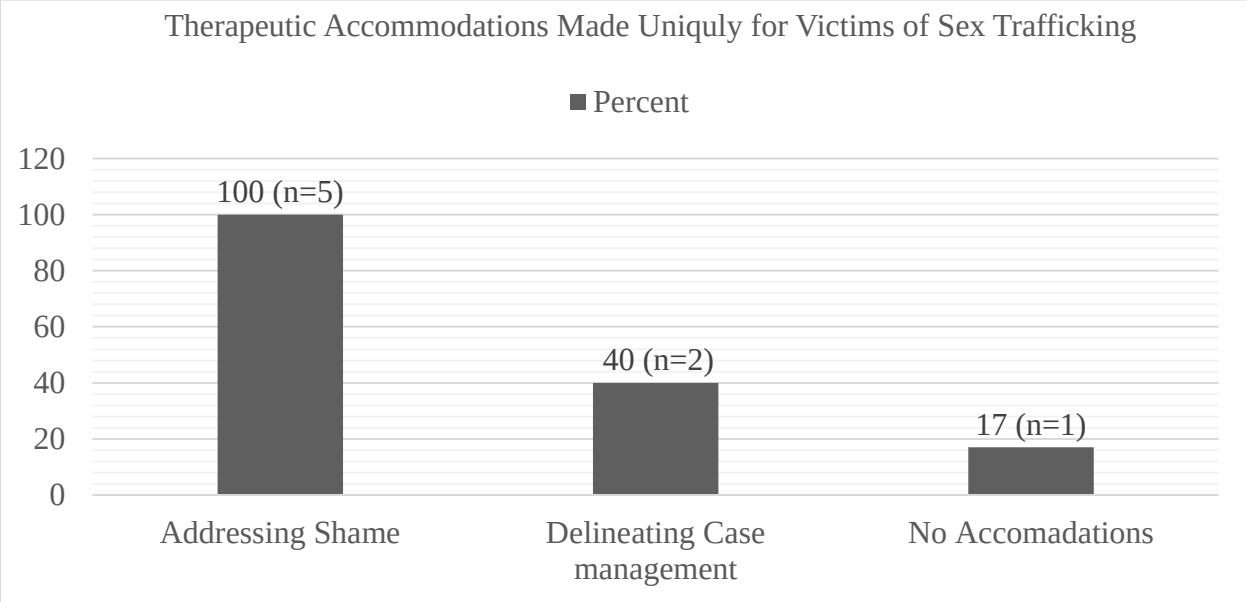
"They have gotten very good at defense mechanisms. So maybe there is a lot of projection, or maybe there's a lot of displacement and things like that. But I have learned that maybe that is the way that they have learned to navigate the world, and I've learned to kind of be patient with those defenses and try your best to navigate them because a lot of times underneath those defenses is fear and scaredness, being scared…I've just learned to look at a lot of people that I've observed and their behavior through the lens

of fear. So, if this person is screaming in my face to 'Get out.', what would it look like if this person wasn't angry? If I didn't interpret this person as angry versus, I interpret this person as scared. I interpreted their behavior as someone who is scared versus this [is] someone who is angry. [And] that allowed me to be a lot more empathetic and a lot more patient, and just a lot more understanding for what they are going through."

Being patient was learned from treating previous victims of sex trafficking to be valuable and effective when treating other victims of sex trafficking, according to 17 % (n=1) of participants. The participant stated, "I sort of learned over time, just like the pacing of treatments… When I first started out as a therapist, I was more sort of eager or quick to move to like trauma processing, more inquiring about these really painful events, and it was something that I learned over time…let the patient or let the client [come] to you with those things, because they will."

Making accommodations to treat victims of sex trafficking in comparison to how they would treat other victims of sexual violence was reported by 83 % (n=5) of participants. Of the patients who made accommodations in treatment approach for victims of sex trafficking, 100 % (n=5) made accommodations surrounding shame that the patient experiences by being more empathetic. Delineating case management from psychotherapy was reported by 40 % (n=2) as a therapeutic accommodation made uniquely for victims of sex trafficking. Seventeen % (n=1) of participants reported that they do not make therapeutic accommodations to treat victims of sex trafficking.

Figure 7. *Therapeutic Accommodations*



Of the 100 % (n=5) of the participants who would make accommodations therapeutically to address **s**hame, the following approaches were utilized to bring greater empathy into the therapeutic space: understanding the unique experiences of sex trafficking victims, utilizing psychoeducation, and reminding the patient of how much progress they have made.

Understanding the unique experiences of sex trafficking victims to bring empathy into the therapeutic space was described as a therapeutic accommodation made by 40 % (n=2) of participants. A participant stated, “I think it’s really being like educated on it… bringing that understanding, that empathy, that education into the therapeutic space” The participant added, “Listen, like CBT can be done on like anyone, right, or DBT, or trauma-focused CBT, EMDR like all those approaches can be used on anyone, not just sex trafficking survivors.” The participant continued by stating the following:

> *“You adapt because you, yeah, you need to have that education and understanding of what like they’ve been through… a lot of people like don’t understand like a lot of people in their life don’t understand right like ‘Why would you still do this,*

why would you sell yourself like that's terrible, like why would you do this, why would you do that?' You know, a lot of times, their parents have been like, 'No one's ever gonna understand you like you're never going to be able to go back into the straight world of the square well because everyone's going to see you as a whore.'"

The participant elaborated by stating, "Coming from that approach and understanding, like the shame and the complicated feelings that really come with it, right, how the life has sometimes served them in certain ways right like and also understanding that" was described as important therapeutically. Another participant stated "I do think that, like, shame has come up uniquely with sex trafficking survivors and victims. And that's not to say that shame doesn't exist in domestic violence or sexual assault." They elaborated by stating that when working with this patient population "I'm certainly thinking about it more in my conceptualization and sort of listening for it in a more overt way…"

Psychoeducation was described as a therapeutic accommodation by 20 % (n=1) of participants to guide the patient in understanding their trauma from their experience being sex trafficked. A participant stated the following

"I find it really helpful… to do like a lot of psychoeducation on like the brain and trauma and like I'm like you know "actually like your brain is super cool and smart because you adapted to this really scary dangerous situation and you survived it and you also, right, listen you were homeless, but you had no one that was feeding you. You had no family, and you knew your needs right, and you did the best you could to get some of those needs met, and your brain adapted, and it was doing all these things to keep you alive, so you know that's like that's amazing. But right now, that you are out of that and you're out of that dangerous situation, but now your brain needs to write relearn, and we

need to retrain it that you're not in that dangerous situation or some situations that remind you of it doesn't mean they're dangerous situations."

The participant provided the following example they would present to their patients "I use like a teddy bear and like our grizzly bear example a lot like you know if a grizzly bear is constantly coming in and scaring you, and then you see a teddy bear, and it's going to remind you [of the] grizzly bears. The teddy bear can't hurt you, but you're going to freak out on the teddy bear."

Reminding the patient of how much progress they have made was described as a therapeutic accommodation that they made when working with victims of sex trafficking 20 % (n=1) of participants. A participant provided the following example of how they would put the progress that the patient is making into perspective:

"For example, a [survivor] every March; her body goes through all this pain, and she can't sleep [well] for 30 to 60 days. But she just got a new position of employment, and she's trying to prove herself…I picked up my notes, and I was like, 'do you know it's been a year since you escaped, you've only been out? After 19 years of service, you only have 12 months out, and in 12 months, you opened up a business, you got an education, you have a new job, you're going to get an apartment. So don't allow the progress that you made, don't allow anything to take that away from you.'"

Delineating case management from psychotherapy was reported by 40 % (n=2) of participants as an accommodation when treating victims of sex trafficking in comparison to other sexual violence victims. A participant stated the following "I think the biggest difference I see between these, say sex trafficked individuals and sexual violence, is the profit piece, that might

not be involved in the [other] sexual violence category." The participant added with the following statement:

> *"Being able to with clients who are sex trafficking survivors clearly delineate case management from psychotherapy because throughout organization, we're able to provide financial assistance to clients and, in some ways, that could be a reenactment of 'hey, you come to therapy, I provide you assistance' and I don't want that connection to exist because it's a reenactment. And so being extremely careful from the start of being able to talk about what does it mean to receive this money from us or these gift cards and I think I would end up being more intentional about those kinds of interactions because trafficking in itself is also an economic violation… time that hasn't been compensated, labor that hasn't been compensated, dignity that can never be compensated, and so, in some ways, providing assistance financial assistance [is] essential, [but] how can [it] be not tainted."*

An additional participant reiterated similar challenges by stating the following:

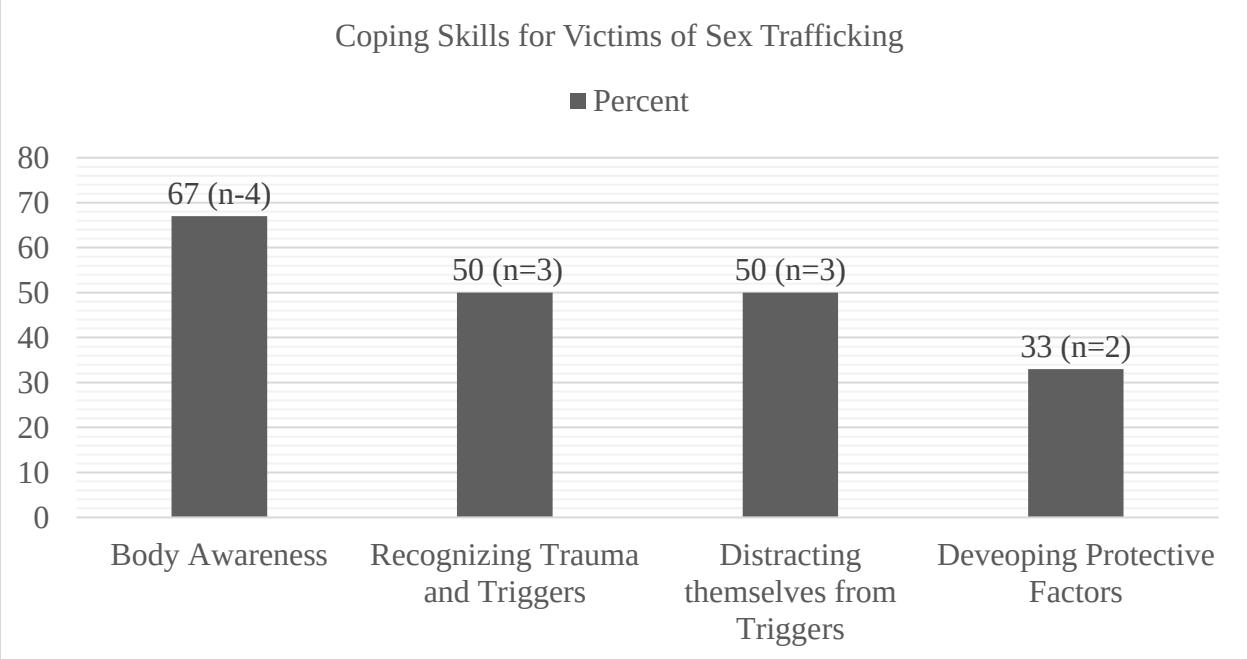
> *"I have to constantly adjust. I'm not very comfortable with a borderline personality disorder diagnosis; I think it's much more trauma-based, I think that the symptoms do present, though… but there were symptom patterns that would emerge with a lot of people that I worked with it made things much more challenging a lot of splitting, a lot of feeling like [there] was a lot of using me as the therapist, as using me to get what they needed sort of survival-based mentality which can be challenging sort of showing up when they feel that I could do something to benefit them, not showing up when they feel like something else is more important. Much more so than [individuals] who had been through domestic violence, which was the other population that I work with at the time.*

So, much more fear, and unpredictability in their lives outside of therapy, which made therapy much more challenging."

Not making therapeutic accommodations was the least commonly reported response by 17 % (n=1) of participants when asked if accommodations to treat victims of sex trafficking are made in comparison to how they would treat other victim of sexual violence. The one participant that reported not making therapeutic accommodations stated that "The approaches were not necessarily different. Like they all start with the same foundation to me, which is ensuring that there is a safe space and ensuring that you are doing your best to build trust no matter what they have experienced."

Effective Coping Skills

Figure 8. *Coping Skills for Victims of Sex Trafficking*



The participants reported the following copings skills for victims of sex trafficking: Body awareness, recognizing their traumas and triggers, distracting themselves from triggers, developing protective factors in the patient's life. Body Awareness was described as effective

when working with victims of sex trafficking by 67 % (n=4) participants. Guiding the patient in recognizing their trauma and triggers was described as effective when working with sex trafficking victims by 50 % (n=3) participants. Distracting themselves from triggers was described as effective coping skill by 50 % (n=3) of participants. Developing protective factors for the patient was described as effective by 33 % (n=2) of participants.

Body Awareness was described as effective when working with victims of sex trafficking by 67 % (n=4) participants. A participant described how body awareness can be effective when the patient is feeling angry or triggered and stated the following "I also talked to them a lot about what is their physical body feeling right, so if they can, if they feel like they're going to start to get upset early; triggered." The participant stated that they guide the patient to ask, "Are their palms sweating? … Is their heart beating, are they getting really hot?" Essentially, they are "helping them really like tap into like their body, and so, if that's happening right before they go to the top of anger mountain, as I call it; like what can they do?" Another participant stated the following "I needed to use some body awareness and coping mechanisms first, like a body scan, but I need to adjust usually to allow for some of their trauma responses, leaving your eyes open, for example, having them seated in a place that felt safe with their back against a wall, for example. So, I guess I would say trauma-focused body awareness coping mechanisms for the most effective" An additional participant stated, "I really find that the body scan with my clients is very helpful to identify what parts are in pain, what parts they haven't really looked at or held in a while." Additionally, a participant stated the following:

> *"I found grounding exercises like in the end of a session [is] really helpful, just like returning to the present moment. I also think like so much of it is stored in the body and so… movement (participant waves arms in the air) at the end [of] the session,*

whether it's like getting up and kind of like jumping a bit, which sounds kind of silly but just kind of like shaking it out which I think restores sort of presence…"

Guiding the patient in recognizing their trauma and triggers was described as effective when working with sex trafficking victims by 50 % (n=3) participants. A participant stated that victims should come to say the following "Yeah, I can do this, I just have to realize that I have trauma and triggers, and if I smell this or I hear this song, how am I going to sustain myself." Another participant stated,

"In the CBT vein… We sometimes talk about, you know, that cognitive-behavioral triangle, the thoughts, the feelings, [the] behavior. So, kind of trying to get them to recognize their thoughts more like slow down a little bit. Because a lot of them will describe it is like they black out, or you know they often call it [they] 'blacked on someone' where… they get triggered and then it… feels like they're from zero to 100… But they actually don't go zero to 100 right like there's like a mountain."

An additional participant described using "coping skills related to like finding safety in line with Judith Herman's ideas like being able to notice the present moment, being touched with this tenses, and draw those somatic, psychological connections that may have been ruptured." The participant added that "we also have talked about like the idea of avoidance and avoiding avoidance as being a way to, to unearth better coping skills."

Distracting themselves from triggers was described as effective coping skill by 50 % (n=3) of participants. A participant stated when the participant could feel themselves getting angry, *"*

sometimes a mindfulness can come in, some deep breathing, sometimes like DBT skills of like distracting yourself, right, so doing something else. You know, to kind of stop

the thoughts and feelings, so I teach them a lot of like DBT and CBT kind of coping skills around that, um, but yeah. A lot of it, a lot of it to get them to cope, right, is to just start to also like recognize when it's happening. Because you know some, if you're already at 100 might be too late, so I think that's a huge part of it."

Another participant stated that they also found it effective to implement "tactile coping mechanisms as well" and continued by stating that they give their patients "something that they could fidget with, playing with play dough something to manipulate and that they could sort of mess with." An additional participant stated encouraging the patient to engage in "anything that brings joy or brings fulfillment can be helpful. So, there is really a large spectrum of coping mechanisms that could be encouraged. It really depends on the person." Writing was also provided as an example "writing anything that can help get in tune with you can be helpful."

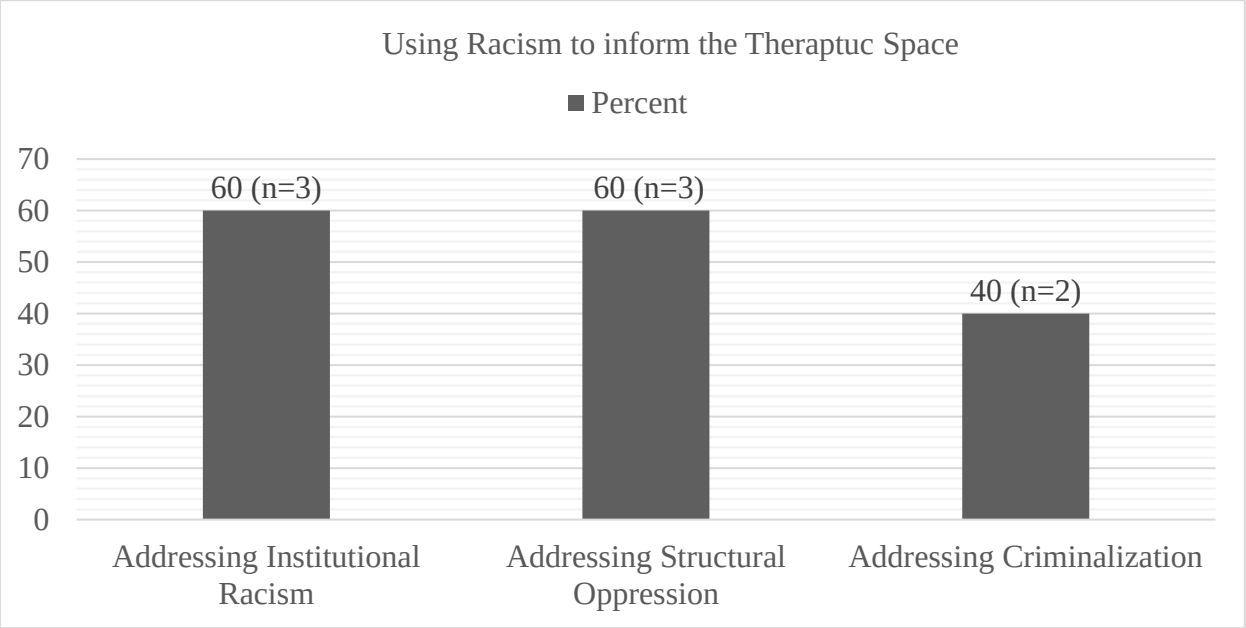
Developing protective factors for the patient was described as effective by 33 % (n=2) of participants. A participant stated the following:

"Let's just say 24 months is needed for them to relax and feel like they're not, somebody's not going to kick them back, or they're going to fall back into it. Let's say let's give them another year to two years for them to get an education because their childhood was robbed. And then lastly, let's find a career that they actually want to do as opposed to minimum wage. And then lastly, what about housing?"

Another participant stated, "protective factors like: do you wanna get back to school, do you wanna work, like what do you wanna do with your life, do you wanna be a caretaker?" were described by the participant as important for victims "to have those measures to also keep them safe."

Using Racism to Inform the Therapeutic Space

Figure 9. *Using Racism to inform the Therapeutic Space*



When participants were asked how they therapeutically address racism 83 % (n=5) of participants reported that they utilize racism to inform the therapeutic space to develop a deeper understanding of the patient's experiences. Of the participants that therapeutically addressed racism, institutional racism was therapeutically addressed by 60 % (n=3) of participants. Structural oppression and the intersections of racism was therapeutically addressed by 60 % (n=3) of participants. The criminalization of their patients who were sex trafficked was therapeutically addressed by 40 % (n=2) of participants. One participant generally stated that they therapeutically are "looking for the patients' or the clients like own perceptions of their experiences and sort of validating those perceptions" as a way to therapeutically address racism by using racism to inform the therapeutic space and understand how all of these factors impacted the patients' experience being sex trafficked.

Validating and exploring institutional racism was reported by 60 % (n=3) participants as a way to use racism the patient experienced to inform the therapeutic space. A participant stated,

"They were sitting in a location and interacting with the police and attorneys and acknowledging that there may have been well usually was, you know, racism present in the decision to prosecute in who they prosecuted and thinks like that sort of acknowledging that it was a part of that process, and especially if brought up by the victim." Another participant stated the following regarding the media "Community stuff… Like little while girl with blond hair and blue eyes goes missing, and the media is like 'oh my God' and like you know she's like the story, and then it's like you know, a young Black girl goes missing, and you don't hear anything about it."

Validating and exploring structural oppressions and the intersections of racism was used to inform the therapeutic space by 60 % (n=3). A participant stated, "There's tons of racism in the sex trafficking world because, you know. I mean, there's so many levels to it right about how you know disenfranchised communities have been left out of resources and poverty and communities that are not safe that are policed no in a supportive way, but are policed in very dangerous and scary way." Another participant stated that they "use racism, discrimination, poverty, and oppression as tools to greater understand why this person may be engaging in this behavior. If this person was more likely to be engaged in sex trafficking and to be encouraged to do something like this." The participant continued with stating, that they may explore how oppression impacts "why this person might not have any money and may be considering doing this for money. So, we kind of use racism to inform the work but not necessarily engage about the work to the client." The participant elaborated their response stating the following:

> *"I've learned to look at the client is as a person in an environment or look at the intersection of their identity, and those include their race, their socioeconomic status, the community they grew up in, the socioeconomic status of that community and all of that will help us better understand the client and where they are coming from and what got*

them to today… So a client who may be from Oregon who identifies as white who is now traveling from the west coast to New York may have a different experience of sex trafficking than, let's say, an older Black woman who's been in New York her whole life and has experienced homelessness. Those two people, all be it engaged in the same things, have completely different backgrounds and intersections that brought them to today."

Validating and exploring the criminalization of sex trafficking victims of color was described as effective by 40 % (n=2) of participants. A participant provided the following example of how they may address racism to inform the therapeutic space:

"An example, might be working with an individual who felt that the police had targeted her because of her race, and while I may not have been able to be there or witness that or say that, you know, I could validate that that's something that does happen and, and hear her out and sort of speak to the fact that in that particular case, she was a Black woman working with all white criminal justice staff and just kind of acknowledging the inherent issues at face that I could even see from that situation."

Another participant provided a similar response by stating, "A lot of our girls had really bad run-ins with law enforcement."

Less commonly utilized approaches towards addressing racism therapeutically were reported. Clinicians acknowledging their own privilege was reported by 20 % (n=1) of participants as a way to therapeutically address racism. Utilizing an approach of injustice tolerance therapeutically was reported by 20 % (n=1) of participants as a way to therapeutically address racism. Examining the history of racism was reported by 20 % (n=1) of participants as a way to therapeutically address racism. Examining the over-sexualization of people of color was

reported by 20 % (n=1) of participants as a way to therapeutically address racism. Referring patients who would rather work with a professional of color was reported by 20 % (n=1) of participants as a way to therapeutically address racism. Encouraging patients to engage in activism was reported by 20 % (n=1) of participants as a way to therapeutically address racism as well.

Clinicians being self-aware of their own privilege when working with victims of sex trafficking was described as effective by 20 % (n=1) of participants. One participant stated the following "I understand that I have privilege… I myself have never experienced racism, right, but that doesn't mean that we can't meaningfully talk about it in therapy." The participant continued by stating:

> *"I've heard some like girls in the past when they tried to talk to a therapist... they sort of shut them down or become uncomfortable… So, I just try to make them feel really comfortable and be like… You can [smack] talk white people all you want, because sometimes they'll say something about white people and then they're like 'oh sorry, and I'm like… 'as a people we're not great, it's totally cool.'"*

By providing a safe space for sex trafficking victims of color by a clinician demonstrating self-awareness of their privilege also provides the opportunity for the patient to feel safe enough to discuss racial trauma and the discrimination that they have experiences.

Injustice tolerance was described as an effective approach by 20 % (n=1) of participants. The participant stated the following:

> *"I would refer again to DBT in terms of distress tolerance and reframing as injustice tolerance. For so many of the clients who deal with grief, whether in the loss of people in their lives, are also in terms of ambiguous loss like clients have talked about*

the loss of self-respect, loss of opportunity, loss of innocence. That being able to hold all of that, I then bring in Judith Herman again to mourn it, to remember, to celebrate those parts of the self that allowed survival to occur."

The participant continued, "For certain clients like that, reconnection portion is also extremely important to not really moving on necessarily but integrating the past with the future."

Examining the history of racism and how that impacts the patient was described by 20 % (n=1) of participants. One participant stated, "I was working in a system, the criminal justice system that does have a heavy history of racism, and so I would say the most common way that I addressed racism was acknowledging that."

Over-sexualization of people of color was described as effective to understanding the experience of sex trafficking victims of color by 20 % (n=1) of participants. One participant stated the following:

"Racism plays into… who do we actually see as a victim… (according to research) When people look at you know, Black girls and white girls, they saw the white girls [as] younger, and they saw the Black girls [as] older than they were, and so I think there's also this over-sexualization, right, of young Black girls and thinking they're more mature, older than they are."

Providing the kind of mental health professionals that the patient prefers was described as effective by 20 % (n=1) of participants. According to the participant they stated, "if they want like a Black or Latina therapist like that's also really cool, and I will refer them to someone."

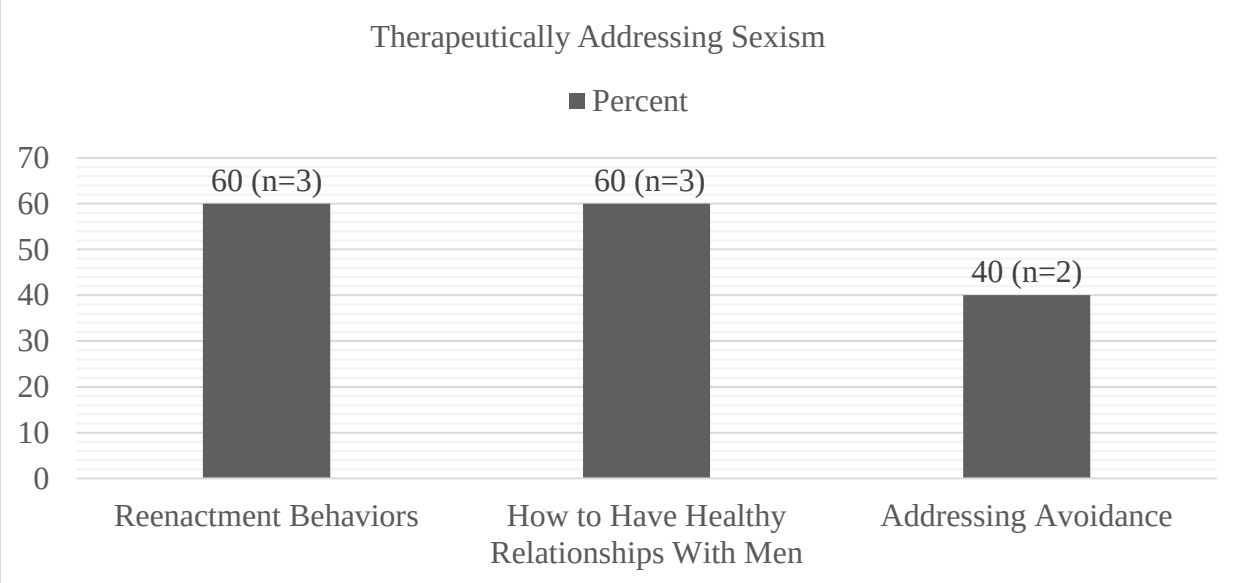
Activism was described as effective by 20 % (n=1) of participants. One participant provided the following example*:*

> *"I think of one young person I have in particular. You know when the George Floyd stuff was going on, and you know she was getting very like triggered and stuff like that, and so we talked about it… She decided she wanted to go to some protests, so we looked up… Some protests and like what did she want her sign to say and what was she going to do with the protest if she got too [triggered] like how could she take care of herself."*

The participant continued, "When [patients are] upset or angry about it, right, like have helping them channel that also or like do they want to register to vote, and they want to know, like what candidates are… supporting what."

Therapeutically Addressing Sexism

Figure 10. *Therapeutically Addressing Sexism*



Addressing sexism therapeutically was addressed by 83 % (n=5) of participants. Addressing reenactment behaviors when interacting with men was a way that sexism was therapeutically addressed by 60 % (n=3) of respondents. Examining how to have a healthy relationship with men was a way that sexism was therapeutically addressed by 60 % (n=3) of

respondents. Addressing avoidance of relationships and interaction with men was a way that sexism was therapeutically addressed by 40 % (n=2) of respondents.

Addressing reenactment behaviors and when interacting with men was described as effective by 60 % (n=3) of participants. A participant stated that "sometimes they want the approval of men, right, and they want that approval, and will put up with any [expletive] like [to] feel that approval." The participant continued with stating that they are "working around this kind of right the sexism, or the abuse they've had at the hands of [men]. Because listen, the majority of it is men that have abused them, the johns, the pimps, like their uncle when they were younger". Another participant stated that victims "might reenact those experiences of being violated, and they might pursue relationships that are violating." An additional participant stated the following:

> *"I wouldn't say that it was something that I overtly spoke about with the patients, but, something that I was always very conscious of was how the male NYPD officers would interact with the people that I worked with and how they tended to use flirting as a way to sort of build trust, which for the patients that I worked with that was something very familiar, and so it wasn't that scary they knew how that game worked, even though it had it's flaws. And that led to them sort of conflating the cops with their customers or Johns… I think at times, I felt that it was not comfortable for some of the patients who worked with me to be alone in a room with me, because that was relating to another woman without the presence of a man there, you know, these cops had this very flirty attitude I think sometimes that was a little bit alarming at times because it wasn't as familiar to be able to take about these things without this defense mechanism… without the familiarity of 'oh I know what's going on here, I know how to play this kind of*

survival skill.' It was a dynamic that I felt was always very present in our interactions, and when that left the room, when the cops left the room, and it was just me, and the person I was working with, it was always… The energy shifted and sort of addressing that energy shift and helping them understand who I was and how [to] understand the fact that we weren't going to interact on that level. So that… wasn't gonna be a part of our relationship, which was sometimes difficult [for the victim]."

Examining how to have a healthy relationship with men was described as effective 60 % (n=3) of participants. A participant stated, "They deserve healthy relationships, they deserve respect" the participant provided an example of how to illustrate that by stating, "I have them make like a little fantasy list of like what is their fantasy of like what they would have in a partner." The participant would then ask the patient the following "Are you getting any of these things in this relationship? What things are not acceptable?" the participant continued by stating that they guide the patient to "find that worth" so that they are "standing up for themselves." Another participant stated, "The tendency is either the extreme of avoidance or reenactment and recreation of certain dynamics, and I think grounding it in safety, a lot of relational healing happens." The patient continued with stating questions they would ask the patient, such as "What [does] trust look like? What can a healthy relationship look like? Can we model it here? Can you test it out in other areas of your life?" The participant added, "Does it feel right? If it doesn't feel right, if your intuition is saying otherwise, like what does it mean if you avoid it?" An additional participant stated the following "Working with people who have been sex trafficked is there is a lot of focus on the role of the pimp and his ability to control, his ability to manipulate, um and the fact that the majority of the pimps were men." The participant continued by stating that they "didn't directly address sexism with the clients, but we used it as something to inform the space."

The participant provided the following example of questions they would ask a patient by stating, “What have the relationships with men looked like before you met your pimp at 14, and now what do your relationships with men look like now that you are in the game, now that you are being exploited and have a pimp? Also, how has having Johns (buyers) that are primarily men impacted your idea of intimacy, love, connection, trust?”

Examining avoidance of relationships and interaction with men was described as effective by 40 % (n=2) of participants. A participant stated, “In CBT sometimes… they have a core belief that… all men are dangerous, all men are scary, all men are going to abuse you, and so, then they’re kind of walking around really scared.” The participant also provided an example stating, “One young person I’m working with like they actually came to me because they’re like so triggered by men like all men, like they feel like every man is an abuser and is a misogynist, and it hurt them, and that’s a hard way you know, to go in the world, when you know 50 % of the people, right, are men.” The participant continued by stating “so [its] kind of trying to get them in the middle” The participant added, “not all men are dangerous and abusers so they can go and they can live their lives, and they can get on the bus without being scared of every man that’s on there.” An additional participant stated, “I think a lot of the clients who’ve experienced being [assaulted and] victimized by men, they have a fear of it sometimes, it’s on an extreme. It might be that they completely avoid any kind of sexual romantic attachment to a man.”

Less commonly utilized approaches were described by participants in order to therapeutically address sexism by 40 % (n=2) of participants. The less commonly utilized approaches included examining internalized sexism that the patient may have as well as engaging in validating the patients’ experiences of sexism.

Examining internalized sexism was described as effective by 20 % (n=1) of participants. One participant stated the following:

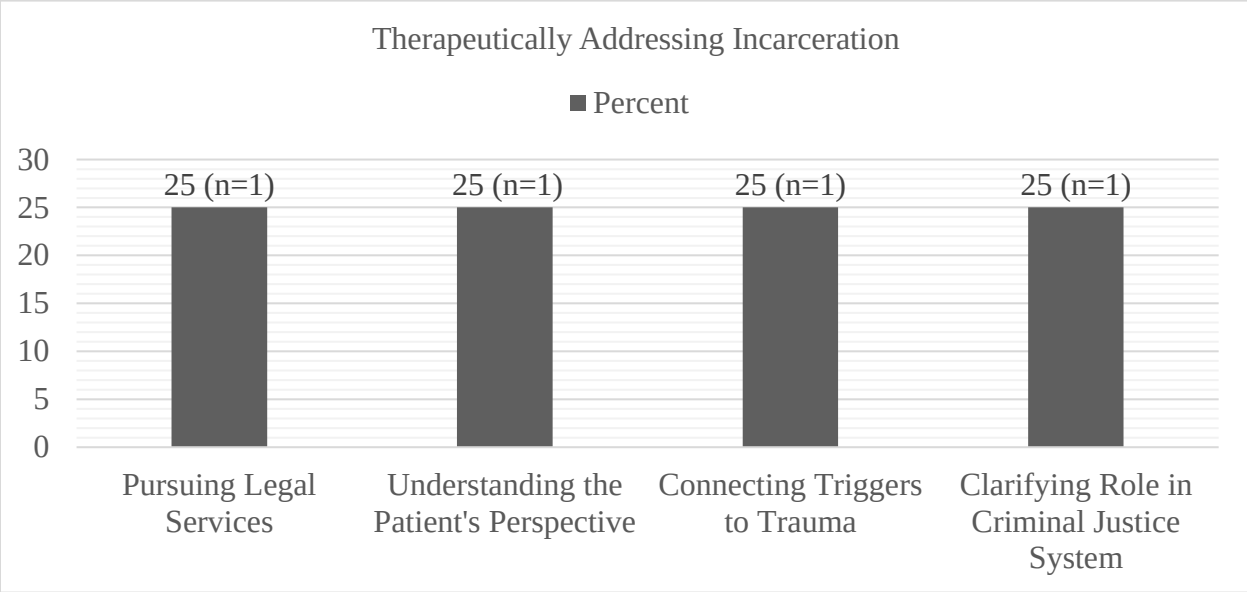
> *"Sometimes they also say really sexist things themselves about like other girls because oftentimes as well, like a pimp might not just have one girl, right, like he might have multiple girls and he's sleeping with all of them, and you know the girl who brings home the most money is like his favorite girl, and all the other girls are 'Bit****' and sometimes, like you know they might make you know their best girl like abuse the other girls… Sometimes there's a lot of like internalized sexism and misogyny, and like [think], women are like this, women do this…"*

The participant continued by stating that they guide the patient to learn more about themselves through examining the internalized messages that they hold and how that impacts their perception of women and themselves as a woman.

Validation of the experiences of sexism was described as an effective approach by 20 % (n=1) of participants. The participant stated that they would engage in "heightening her, her perception which felt like reality and wondering about the feelings associated with it 'does that make you angry? Does that make you sad?' exploring that and then really sort of validating the feelings that came up around it."

Therapeutically Addressing Incarceration

Figure 11. *Therapeutically Addressing Incarceration*



Sixty-seven percent (n=4) of participants who were in the study had experience providing therapy to victims of sex trafficking who were incarcerated. In one of the interviews for this study, an error was made where the question on incarceration was not presented to one of the 6 participants. Of those the participants who provided treatment to patients who were incarcerated, 100 % (n=4) would address the matter with the following approaches: Pursuing legal services to expunge charges from their record, understanding the perspective of incarceration as the patient sees it, guiding the patient to connect their triggers to their trauma, making one's role in the criminal justice system clear and how that impacted the therapeutic relationship.

Pursuing legal services to expunge charges from their record has been incorporated as a way to therapeutically address incarceration by 25 % (n=1) of participants. One participant stated the following:

> *"There has been a lot of criminalization of our clients who are victims and survivors of trafficking. I think it's sometimes two-prong, in that, clients would be*

engaging in legal services to expunge those charges from their record, and if they haven't already, I would open up the idea of pursuing that as a way of also healing those imbalances and injustices [that] are born from the trafficking… With our sex trafficking survivors, that process of uncertainty of whether or not like a prosecutor would expunge it, whether or not their trafficking was severe enough; that constant battle to prove worthiness, deservingness of forgiveness, so to speak, is extremely painful and being able to just sit with uncertainty and also advocate on the side or write letters of support that's been part of the therapy. In a way, case management has been a part of the therapy."

Understanding the perspective of incarceration as the patient sees it was incorporated as a way to therapeutically address incarceration by 25 % (n=1) participants. One participant stated the following:

"There is a safe harbor law which says that now, now one under that age of 17 can be arrested for prostitution. But, like some of our girls when they were coming up in the life… they were arrested when they're like 14 years old for prostitution like thrown in Rikers… You have to kind of be where they're at and see how they see it because [here] some girls, they were actually like, 'oh, that's actually what allowed me to get out.' Some of them are like, 'oh, I actually look at it as the thing that finally got me away from my pimp and connected me to services, he will let me actually go to the services because he knew I had to, or it gets thrown in jail, he [doesn't] want you in jail he just [wants] to make money.'"

The participant elaborated and expanded with how other patients may view incarceration as a traumatic experience with the following:

> *"For them, sometimes the cops… sexually abused them [they] would [say] 'oh, if you have sex with me then I won't arrest you, or we won't throw you in jail', so I also kind of look at it, as like when we're looking at the complex trauma that these young people experience. Like, is that a trauma?... It varies like for some girls like yeah… they got thrown in jail for the night, but in the… context of everything there they've gone through that doesn't feel like a big deal to them right, like that's not a trauma that like comes up for them all the time, or they think about, but for other girls, it is. And so, you kind of got to be where they are."*

Guiding the patient to connect their triggers to their trauma was incorporated as a way to therapeutically address incarceration by 25 % (n=1) of participants. One participant stated that if the experience of incarceration was identified as a trauma, they described how it would be addressed by saying the following "I think you treat all the traumas borderline in the same way and then… get them to like, you know, make connections about why certain things trigger them or why they get upset, [and get them to] kind of process what happened, [and] make connections."

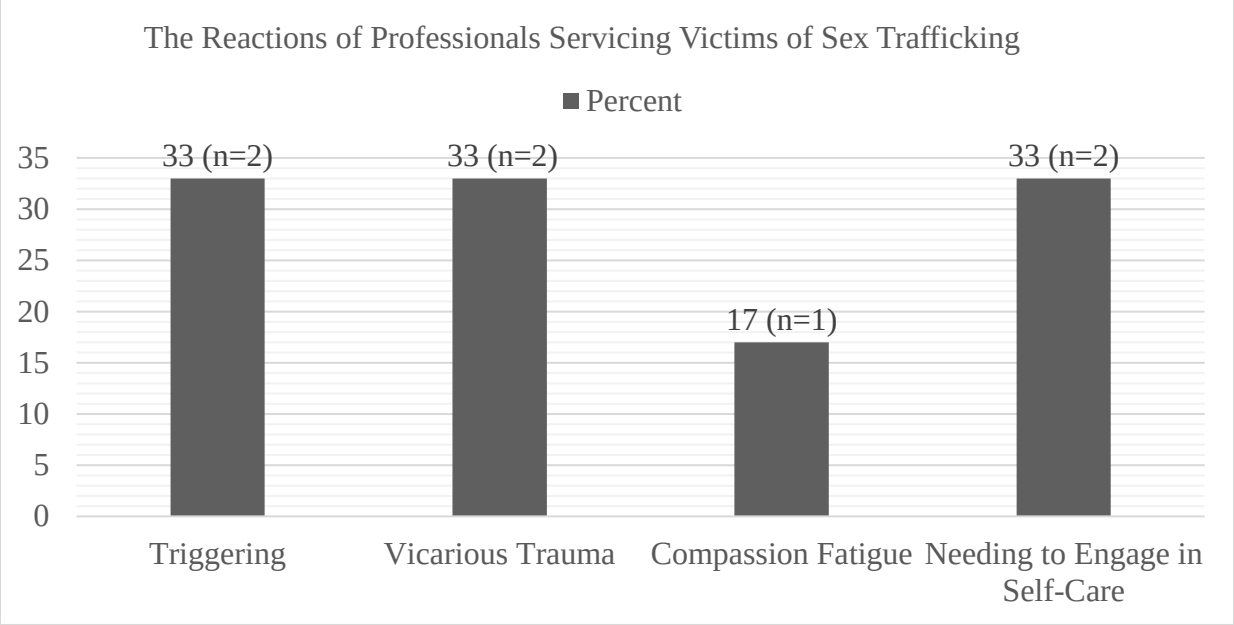
Making one's role in the criminal justice system clear and how that impacted the therapeutic relationship was incorporated as a way to therapeutically address incarceration by 25 % (n=1) of participants. Due to the nature of the work this participant engages in, the participant stated the following:

> *"I think that the challenge for me was that because I worked in the criminal justice system [it] shifted my role. I wasn't able to work with them after that (incarceration). If there was any suspicion that this person had participated in the sex trafficking of another person, I could no longer work with them in the same way. And I*

guess how I would address that was to always be extremely clear about my role and who I worked for and to help set up resources that did not have the lack of confidentiality that [is] added [in] my position."

How Are Professionals Reacting to Treating Victims of Sex Trafficking?

Figure 12. *The Reactions of Professionals Servicing Victims of Sex Trafficking*



Of the participants asked how they would feel listening to the experiences of patients who are sex trafficking survivors, and the emotional challenges they would experience as a provider, all (n=6) of participants reported feeling emotions of sadness when listening to the patients' experiences. Thirty-three % (n=2) of participants described working with victims of sex trafficking as triggering. Thirty-three % (n=2) of participants reported experiencing symptoms of vicarious trauma. Seventeen % (n=1) of participants reported experiencing compassion fatigue.

Needing to engage in self-care was described as important by 33 % (n=2) of participants. One participant provided some examples of self-care by listing that they "made sure to take walks after difficult interviews, I use supervision very frequently in my work and try to shut off

during the weekends and work at a feasible time, reasonable time." A second participant stated, "You know you work in supervision with your supervisor around those feelings, any countertransference you may have. If you have a good supervision space, I find that it's ok that you feel sad because you will work on that in a professional space, and you'll work on how that impacts you doing the work, how that impacts you overall."

Less commonly expressed feelings were described by 67 % (n=4) participants when providing treatment for victims of sex trafficking. These feelings included expressed frustrations with the lack of support systems available for victims of sex trafficking, noting that it can be therapeutically valuable to communicate the emotions the clinician feels to the patient, finding the experience of servicing victims of sex trafficking as rewarding, as well as grappling with the cognitive dissonance of informed consent with patients.

Frustrations with the lack of adequate support systems for victims of sex trafficking was expressed by 17 % (n=1) of participants. One participant stated the following:

> *"I have a lot of frustrations with… the systems of society that I'm working within right because it's like, housing organizations are not a very helpful system… a lot of our girls are very housing insecure, and housing in New York City is a disaster, and… getting them… jobs…I'm doing the therapy, and I'm… hopefully a supportive person who's helping to teach them… some skills to feel better, but it's also like they have every right to be pissed off… and you know it's really hard to get them in a like a good, safe, stable place where you know they can heal. And so, I think a lot of colleagues would agree with this… as a community, our systems are not… really set up to support these young women, and that's extremely angering and frustrating."*

Communicating the emotions, the clinician feels to a patient was described as therapeutically valuable by 17 % (n=1) of participants. One patient stated the following:

> *"It's hard to hold back the emotion that erupts from within, and yet, we, still must have to, to center the client. Sometimes I think that displaying that and really being honest about like the pain that the client triggered is a way to support them to heal like 'hey, what you experience is real; just hearing it hurts me' So yeah."*

Providing for victims of sex trafficking was described as a rewarding experience by 17 % (n=1) of participants. One participant stated the following "When I hear what they're experiencing or what they're going through, it always pulls me back into time into that moment, when I was in that situation, and then I recognize like wow, not only did I get myself out, but I was able to get my fellow human being out as well."

Grappling with cognitive dissonance of consent was described as an important by 17 % (n=1) of participants. The participants stated the following:

> *"I would say some cognitive dissonance around the persons' ability to choose and consensually participate in sex work, right, like, because there are some people that do that. So how much of these decisions are informed decisions? That is something that I always try to work on with the client like no matter what you do, is this consensual, are you protecting yourself, everything like that, is this an informed decision, or are you being forced?"*

Therapeutic Approaches That Were Found to Cause More Harm Than Good.

Therapeutic approaches or treatment models that were described to cause more harm than good or ineffective for implementation when working with victims of sex trafficking were

described by 50 % (n=3) participants. Failing to meet the patient where they are at was reported by 100 % (n=3) of respondents as harmful or ineffective.

Failing to meet the patient where they are at was described as an more harmful treatment approach when working with victims of sex trafficking by 100 % (n=3) of respondents. A participant stated the following:

> *"This is more unique to my setting, but I found that while I think CBT is a very effective therapeutic technique, I didn't feel that it was useful when the person was still in a crisis, and I found that I had to adjust the technique quite a bit. And given the unpredictability of the person showing up or not their sort of fear response to beginning to go into some of what had happened to them, I found that that wasn't as effective and that mindfulness-based, present-focused approaches were more effective, but that was also more due to my position, I think, because usually, it was where there was an active criminal case going on."*

Another participant stated similarly:

> *"Sometimes elements of acceptance and commitment therapy, when not used at the right time, can be painful for a client. So, if I were to say to a client who's experienced a great deal of trauma reactions, 'I want to want you to observe yourself like you're a cloud in the sky. [And] you notice that this trauma reaction is occurring again and now choose and commit to another way of dealing with it.' It could also be very invalidating of their [experiences]; I think it depends. Like where they are in their heading if this is the beginning… If this is a point of like months and months or even years into therapy where we're saying 'Hey there are all these things that we've identified in our time of working together, and they seem to help to soothe the trauma*

> *reaction. And…we have a strong… toolbox of ideas to use' …I might suggest that idea like 'remember this, remember that, okay observe yourself as a cloud in the sky' and when you're [going] in let's say a spiral, can we apply these to that moment to change the trajectory of that feeling or that thought' yeah."*

Similar points were described by an additional participant who stated, "I don't think it's so much like all this treatment would be like harmful or helpful, but it's more you really got to think about where the young person you're serving is [at]." The participant provided the following example:

> *"If I'm working with a young person and they're in a kind of unstable situation, or they don't have a lot of support, and I'm doing TF CBT with them where I'm like literally, making them make a narrative about their trauma and what's happened like that could be in some instances [harmful] or EMDR right if they're not in a safe place and someone does EMDR with them like that can be very harmful. On the other hand, right if they're kind of separate if they're in a more like safe, supportive space, you know, or they have some separation from the "life" things like [those] can be extremely helpful techniques."*

Less commonly reported ineffective or harmful approaches or treatment models included by 67 % (n=2) of respondents. The less commonly reported harmful or ineffective approaches or treatment models include being judgmental and implementing an abstinence from prostitution approach.

Being judgmental was described as harmful by 33 % (n=1) of participants. One participant stated the following "I would say, like the old school kind of like being hard on them or kind of telling them what to do is very harmful. I don't think that's helpful at all." The

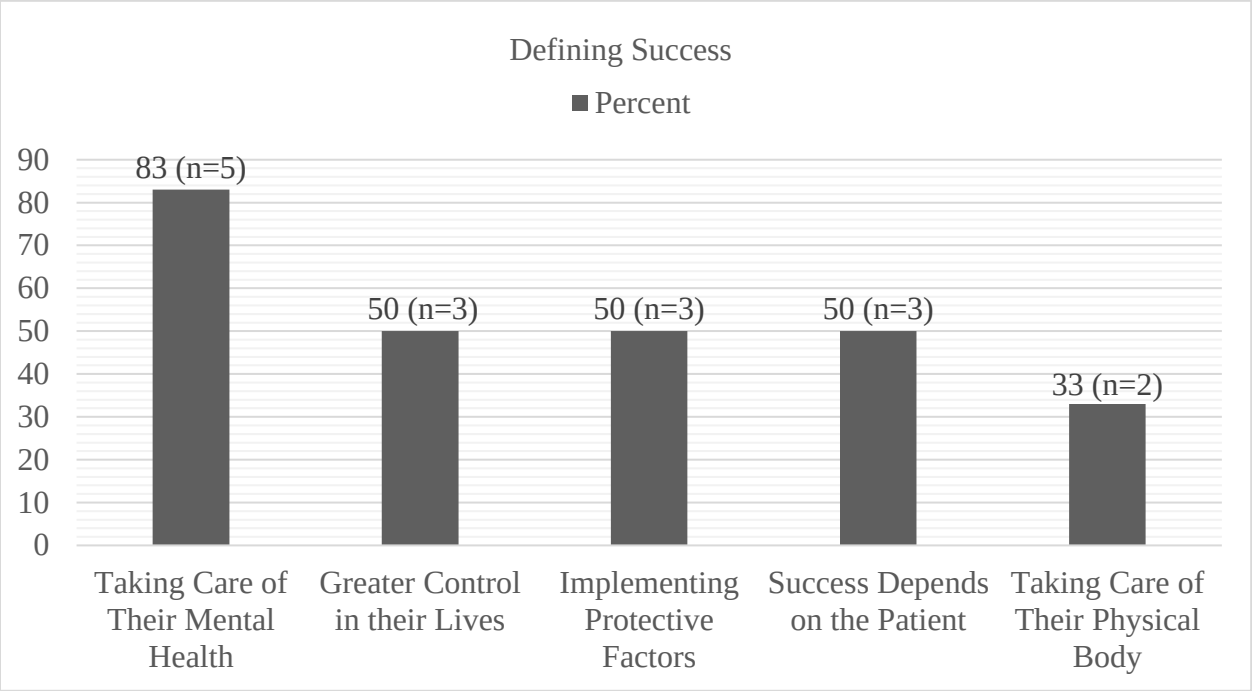
participant continued by stating, “I work [with] some girls who are still in the life, and you know I’m not like ‘What are you doing to yourself? Terrible look what’s happening?’ right, that’s really [harmful] um you know that’s when kind of motivational interviewing comes in right like what do you want, what are your goals like what’s important to you?”

Implementing an abstinence from prostitution approach by 33 % (n=1) of participants. One participant stated that some individuals have reasons that prevent them from more rapidly escaping their sex trafficking situation with the following:

> *“[Some victims] have good reasons, sometimes for wanting to be in ‘the life’ right it’s their shelter, it’s how they’re making money. They feel it may be ambivalent about their pimp right because, like sometimes they hate their pimping [they] know he’s abusing them, but sometimes he’s really nice to them, and he’s like kind of their emotional support, the one that got them off the streets. So, I would say I think therapists who want to, I don’t know, try to convince or take an abstinence only model or things like that I think would be extremely harmful.”*

Successfully Treating Victims of Sex Trafficking

Figure 13. *Defining Success*



All 100 % (n=6) of the participants believed that the therapeutic approaches that they utilized to provide treatment to victims of sex trafficking were successful in treating the patient's needs. When participants were asked to define a successful treatment outcome, 83 % (n=5) of participants described that they would define a successful treatment outcome as the patient taking care of their mental health. Having a greater sense of control in their lives was described as a successful treatment outcome by 50 % (n=3) of participants. Implementing protective factors was described as a successful treatment outcome by 50 % (n=3) of participants. Defining success was also reported to vary depending on the patient by 50 % (n=3) of participants. The patient taking care of their physical body was also described as a successful treatment outcome by 33 % (n=2) of participants.

Taking care of their mental health was reported by 83 % (n=5) of participants as a successfully treatment outcome. A participant stated that a successful treatment outcome would

be the following “They learn to cope with some of their triggers.” The participant added “they understand themselves better, they’ve been able to let go of the shame.” The participant continued by stating, “I do like a PTSD scale, you know, which is about their symptoms, that their symptoms relieve a bit…if they started at like, like [at] high scores kind of like a 46 or 47 and then they’re down to like a 20, like, that’s not nothing right, like that’s their symptoms… I think sometimes you have to get small victories too.” Another participant stated that enrollment in mental health care is a successful treatment outcome. An additional participant provided the examples of engaging in meditating and yoga as a successful treatment outcome.

Having a greater sense of control in their lives was reported by 50 % (n=3) of participants as a successfully treatment outcome. A participant stated the following:

> *“One of my clients [once] said, ‘the greatest gift that I gave to myself, was that of studying myself”, and that in studying herself, she was able to lead a life with true, like, self-determination…Knowing yourself, you can make better choices for yourself, ones that align more with your values and [that] [are] actually a part of the acts that [you] really love. With a lot of clients, I’ll say, ‘let’s center your values right now and not your fears.’”*

Another participant similarly stated that a successful treatment outcome could be “feeling a little bit closer to oneself, and that could mean a million different things. That could mean less dissociation, that could mean knowing your internal world in a deeper, fuller way.” The participant continued by stating, “feeling closer to oneself leads to a whole bunch of other things like improved relationships, improved ability to trust.” The participant also stated the following:

> *“I think a lot of the abuse dynamics that the trafficker utilized or abuse tactics… attacks the essence of the victim or survivor. Her reality is a little off, she convinces*

herself by way of the traffickers' coercion that you know this is okay, or that it will end or you know, they'll be married one day, or they'll have a family… so providing a treatment that allows the person to get in touch with their essence again, right, whether that's rebuilding, or finding that core essence they think is really meaningful."

An additional patient similarly stated:

"I think at a very basic level that they have a better power balance in their own lives, that they were able to feel… a stronger sense of their internal, internal sense of control. That they could control a situation, that they had power over their decision-making more so than they entered treatment, and not a false sense. That they really genuinely could influence their environment."

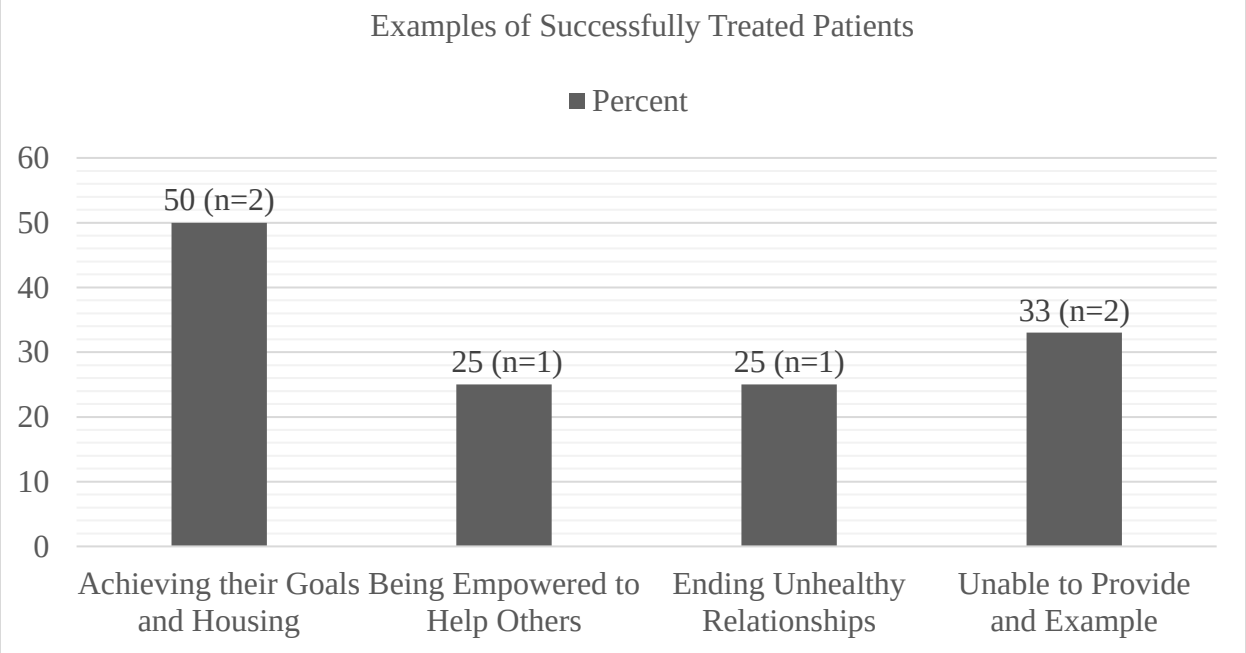
Implementing protective factors was reported by 50 % (n=3) of participants as a successful treatment outcome. A participant provided the examples of having a job, stable housing, and a social support system and friends. Another participant stated a "successful outcome would be implementing protective factors like schoolwork, a day program, participating in things that would move them away from that behavior and that activity…making sure they are structuring a system of support around them despite what they are engaging in that's what I would say." An additional participant also reiterated a stronger social support system with the example of "improved relationships".

A successful treatment outcome was reported to vary depending on the patient by 50 % (n=3) of participants. A patient stated, "it depends; it's definitely case by case." Another participant responded similarly, stating, "It depends on the patient." An additional participant stated that it could mean "different things".

A patient taking care of their physical body was reported by 33 % (n=2) of participants as a successful treatment outcome. A participant stated that enrollment in medical care could be a successful treatment outcome. Another participant provided the example of not being codependent on drugs, eating healthy, and positively engaging their physical senses (e.g., sense of smell) as a successful treatment outcome.

A less commonly reported successful treatment outcome was expressed by 17 % (n=1) of participants. Implementing harm reduction was reported as an additional successful treatment outcome. A participant stated the following "A successful outcome would be implementing harm reduction. Because I don't want to say that the only successful outcome is to stop, like, I think that…I don't feel comfortable that being a successful outcome because that is often not the outcome for many of these people."

Figure 14. *Examples of Successfully Treated Patients*



When participants were asked if they could provide an example of a successfully treated patient, 67 % (n=4) of participants were able to provide an example. Of the 67 % (n=4) participants who could provide an example of a successfully treated patient, 50 % (n=2) provided

the example of the patient achieving their goals and obtaining housing for themselves and their children, 25 % (n=1) provided the example of being empowered to help others, and 25 % (n=1) participants provided the example of ending an unhealthy relationship. Thirty-three % (n=2) of participants stated they could not to the extent in which they would like to see provide an example of a successfully treated patient in their professional experience.

Of the 67 % (n=4) participants that could provide an example of a successfully treated patient, they described a successful patient as someone who was able to achieve their goals and housing, become empowered to help others, and end unhealthy relationships. A participant provided the example of a patient achieving their goals and obtaining housing for themselves and children with *the following response:*

> *"So we had a young woman who first came to us; her child had been taken from her…because she was living in a shelter, and she stole from someone in the shelter… then she like became like housing insecure, and she moved back, she moved in with mom, and her mom was just so abusive… This organization [was] really putting her through the wringer to get her daughter back… and she was so motivated to get her daughter back like [and] so motivated to get her own place… in the last year and a half, I've literally just [watched] her like this really just shy, not sure what to do, young lady to like really working you know, doing everything all the ridiculous things this organization asked of her, she did it, and she worked out program she came to all our groups. You know she did the therapy, she made friends with other girls in the program… and she now has full custody back to her daughter, she has her own apartment… she went from this completely unstable situation where she felt like she had nothing to now having, right, the things that she wanted, and achieving the things that she wanted, despite all the*

challenges, despite having everything against her, right, she was able to use the program and the therapy and the counseling to get there."

Another participant stated that they had many examples of successfully treated patients and provided a similar example of a patient achieving their goals of housing for themselves and children with the following response:

"I would say in my first experience, we had a young woman who was engaged in the life… She ended up having two children; she transitioned from the transitional home to the permanent housing we had, and then she moved into her own place with her children. And I think that was a successful interaction because it proved that she could have attained her goals without having to get money without doing that kind of work. You know, she was able to get entitlement, she was able to get assistance so that she could get housing for herself and kids."

An additional participant provided an example of a successfully treated patient who was able to become empowered by their trauma to help others by stating the following:

"Maybe, that same client who said, 'the greatest gift I gave myself is to study myself" and that she really was able to walk through so much of her trauma, like to find safety to mourn it, and then to connect to this day in another city where I worked. She, she feeds the homeless and she, works at a shelter, and was able to revive her faith and to heal some of that moral trauma that existed. [As it was] her religious community that shunned her, and now she's able to find another path forward with connecting with people who share a similar faith. And she sometimes does speaker events, and I think she was able to bring her trauma from a private realm to a public realm and for it not to be painful, but for it to be regenerative."

Another participant provided the following example of a successfully treated patient through ending an unhealthy relationship and stated:

> *"I worked with a patient for probably almost a year who had a history of sex trafficking and, at the end of our treatment, she ended a five year relationship…and that felt like a success because it felt like she had decided she was worth more by way of the work she did in therapy, and decided that the 'crumbs'… in her words, that she was getting from this person were not enough anymore, and so that felt, felt very powerful for her to, yeah, to reestablish some sense of being worth more."*

33 % (n=2) of the participants stated that they could not provide an example of a successfully treated patient. One of the participants who works in the criminal justice system stated the following:

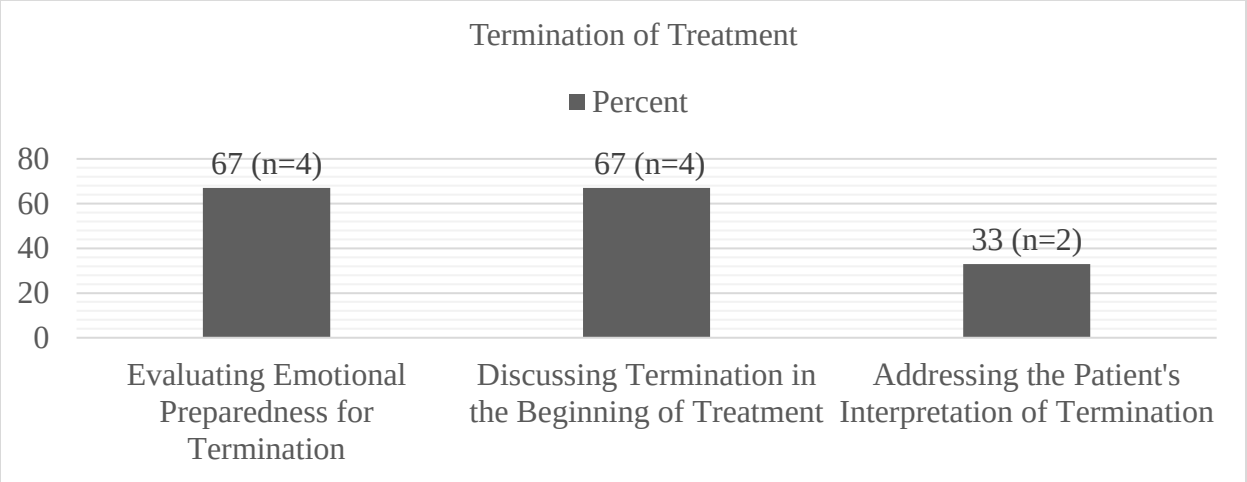
> *"I don't think so; that's the sad part… I worked a lot with some more crisis-oriented situations… I guess the better outcomes had to do with cases that were older, so people that were testifying on a case that was five or so years older. I didn't do a lot of long-term work; it was more intense. I mean, there were successful cases, there were cases that were successfully prosecuted, but I don't think that always related to what the individual wanted. So, I mean, a big factor was time I was working with people that were maybe four or five months removed from a traumatic situation; it's not even at a point where I can diagnose PTSD so, according to the DSM. So it was really challenging to sort of assess success in that way therapeutically from a criminal justice perspective. I could, but I don't think that always related to what the patient wanted."*

The second participant that could not provide an example of a successfully treated patient stated the following:

"I kind of struggle with this one, a bit… I've noticed that even survivor leaders that have years of being with a mental health professional; until they unmask completely and face the three A's of being alone ashamed and afraid, they still have habits associated to their trauma… I can watch them [do] public [speaking] at all these panels, be with the Senators, be in the White House advocating, but yet, they're still at the strip club, or they're still in that domestic violence relationship." The participant added, "That's because they have on a mask."

Termination of Treatment

Figure 15. *Termination of Treatment*



When participants were asked how they would prepare participants for termination of treatment 67 % (n=4) of participants would address termination of treatment from the very beginning of the therapeutic process. Evaluating emotional preparedness for termination of treatment was addressed by 67 % (n=4) of participants. Addressing the patient's interpretation of termination of treatment was engaged in by 33 % (n=2) of participants.

Termination of treatment was discussed from the very beginning by 67 % (n=4) of participants. A participant stated, "from minute one, I would talk to them about how long I

would be around, what circumstances they could contact me, and what the situation would look like once the case was over, and how they could interact with me after that point." Another participant similarly stated, "In the first session that I have with a client, I'll talk about the idea of one day in the future, when we don't work together and so it kind of sets up that idea when, when that point comes." An additional participant stated "the preparation for termination really starts as soon as you start treatment… I worked [at] an 18-month transitional program, so first day we are talking about what 18-months out looks like and what that means for the work that we are doing likely you are gonna go to another housing setting your gonna have different staff you are gonna be in a different environment." Another stated, "I've started talking about [termination] really early on."

Evaluating emotional preparedness for termination of treatment was addressed by 67 % (n=4) of participants through evaluating if the participant is able to demonstrate emotional regulation, therapeutically addressed their trauma, or have an emotional support system if they no longer will be receiving treatment. A patient stated, "With some clients, it may get to a point where they don't have much to bring to there anymore." The participant provided an example of how they may address that with the patient by stating, "I noticed that you've been prep skipping sessions or not as engaged, and maybe, maybe you're ready in a lot of ways to move on, and that's a good thing." Another participant provided an example in how they prepare participants for termination by stating the following "let's say one of their triggers is like feeling shame, then they have their little coping card to remember okay, I'm feeling shameful pull it out, how do I cope with it." An additional participant stated that evaluating preparedness for termination also includes extending treatment with the following "If let's say right before the 90 days or 120 days is about to come, and something traumatic happens, then we say, okay, we're going to give you

an additional 90 days and work on that. But we can make referrals, let's get you a mentorship at this service provider, lets provide you an internship at an academy for sex trafficking victims where they have more resources, just for them to feel like they didn't put [in] all that working and at any moment it can be pulled out from them." Another participant noted that when a patient is being evaluated for termination of treatment, "You want to make sure that ideally, they have that system of support there upon termination so that they can help them continue."

Addressing the patients' interpretation of termination of treatment was addressed by 33 % (n=2) of participants. A participant stated, "Talking to them about what terminations means for them, exploring their fears of abandonment if any. So yeah, you definitely want to start preparing sooner than later." A second participant similarly stated, "Just making a lot of space for that, a lot of feelings that come up with trauma, there's you know, often like fears of abandonment, and that gets reenacted through termination. So really just making a lot of space and welcoming the emotions that come up around termination, anger, you know, sadness."

A less commonly reported way of preparing the patient for termination of treatment was evaluating resource security for preparedness. Evaluating resource security for termination of treatment was addressed by 17 % (n=1) of participants. The participant stated the following "To terminate with us, right they've been able to find a job, and they've been able to use their coping mechanisms; they're still working at a job, and they [became] housing secure."

Closing Thoughts on Anything Else Important when Servicing Victims of Sex Trafficking

When participants were asked if there was anything else that they would like to share that hasn't been asked or anything else that they felt was important to say when providing treatment and working with sex trafficking victims, 67 % (n=4) of participants provided responses. A need for greater funding for long term care was described as an important factor to keep in mind when

working with sex trafficking victims by 25 % (n=1) of participants. The participant stated, "There needs to be a large part of funding for, for the clients, because their mental health needs is a priority, and so is housing. You know, and we need realistic plans; you can't do a one-year plan."

An empathetic and empowering therapeutic approach was described as an important factor to keep in mind when working with sex trafficking victims by 25 % (n=1) of participants. The participant stated the following:

> *"You just really got to come from a place of compassion, a place of non-judgment, [a] place of empowerment, a place of recognizing their strengths…I think that's the biggest thing because these young women feel so much shame. They feel so broken down. You know their pimps break them down, right, that's how part of how they get them to stay…You just really, really got to come from that position that you are going to help build them up because they deserve that because they're incredible young women."*

The need for there to be a greater understanding in the field on how they can best service victims of sex trafficking was reported by 50 % (n=2) of participants. The participant stated the following:

> *"I think that one of the [challenges] in the field that made therapy difficult and made evidence-based approaches difficult was that every advocate, therapist, lobbyist, whatever, was seeing a different side of sex trafficking. So [I] kind of felt like what I always used to say to people was it felt like the fable of like the blind men and the elephant where you [have] five blind men standing around an elephant they're all feeling a different part of the elephant [and] they're all feeling a different part of the elephant.*

And someone thinks he's feeling the tail, and he says, this is a paintbrush, and someone's feeling the leg and says this is a tree. No one's able to put together the whole picture, and by no fault of their own, and I think that's something that made the field especially difficult… It's a very disjointed field, and as a professional, so that was something that made it extremely challenging, and added to the vicarious trauma piece."

Another participant expressed the desire for more future research to be done on sex trafficking and mental health treatments for the field to have a better understanding on how to treat this patient population. The participant stated, "I wish that there were a lot more studies like this. A lot more space for people who do not necessarily know each other or have worked together to have a meeting of the minds about how they have experienced work with certain populations."

Discussion

While there have been a number of studies regarding mental health treatments for victims of sexual violence and domestic violence, seldom has there been research geared towards conceptualizing and treating the unique mental health needs of victims of sex trafficking. As a result, this study examines professionals with experience providing mental health services to victims of sex trafficking. Through open-ended qualitative interviews, 6 professionals were able to provide researchers with a greater understanding of (1) how professionals are approaching treatment for victims and survivors of sex trafficking and what they have found effective (2) how they address the unique vulnerabilities of the patient therapeutically, such as race, sex, and other forms of oppression. In order to conceptualize a theoretical framework for a comprehensive treatment approach to meet the unique needs of victims of sex trafficking this study examined how experienced professionals approach the following proponents of treatment: victim

identification and how the patient entered trafficking impacts the course of treatment, how to build therapeutic alliance and trust with a victim of sex trafficking, the common diagnoses from the trauma of sex trafficking, the implementation of treatment approaches that meet the unique needs of victims of sex trafficking, an understanding of what approaches could be harmful for this patient population, effective coping skills, racism, sexism, incarceration, conceptualizing what successful mental health treatment means when working with a victim of sex trafficking, termination of treatment, how professionals may react when working with victims of sex trafficking, and any closing thoughts that professionals may find important to highlight when working with victims of sex trafficking.

Victim Identification and Entering Trafficking

Half of the participants in this study either worked directly with victims of sex trafficking or were able to identify a patient that was being sex trafficked in their professional experience. This indicates that the sample that participated in the study had comprehensive experience servicing victims of sex trafficking and had a thorough enough understanding of sex trafficking to be able to identify victims. Of the 50 % (n=3) participants that identified a victim of sex trafficking in their professional experience, 67 % (n=2) participants identified sex trafficking in what initially looked like domestic violence. One participant reported how being informed on abuse dynamics involved in trafficking guided the questions that they posed to the patient in order to understand why they were presenting with symptoms of fear and paranoia; in the words of the participant, “A woman had called and she was reporting a lot of violence between her and her partner, she was also seemingly very paranoid, and this paranoia was about like people watching her, about her being followed” however after further questioning this dynamic turned out to be something more than domestic violence and the patient stated the victim was “as is

often the case, both [in] a romantic relationship and also being exploited for commercial sex" . The abuse dynamics often seen with victims of sex trafficking are different can make a patient appear to be paranoid as a consequence of the traffickers' utilization of Biderman's framework of coercion. One of the coercion techniques of Bierman's framework of coercion that is utilized by sex traffickers is omnipotent control (Baldwin, Fehrenbacher, & Eisenman, 2014). According to scholars' traffickers may convince the victims that if they try to escape their trafficking situation, they have people ready to go after their children or family if they do (Baldwin, Fehrenbacher, & Eisenman, 2014). Traffickers often also convince their victims that they always have someone watching their every move even when they themselves are not around and would know if they tried to do anything to expose that they are being sex trafficked by contacting authorities or escaping (Baldwin, Fehrenbacher, & Eisenman, 2014).

Being sex trafficked through a romantic partner was reported by 83 % (n=5) of the participants as an impactful factor in the course of treatment. According to participants, when working with victims of sex trafficking that are trafficked by a romantic partner, providers are tasked with therapeutically addressing the "lifestyle versus the fairytale" and how traffickers "glamorized" the kind of abusive relationship they entrap their victims in. These responses echo what has been described throughout literature regarding the abuse dynamics of sex trafficking through the lens of Evan Stark's theory of coercive control (2006). Moreover, many traffickers utilize a tactic of "Love bombing," where they lure their victims into an essentially fraudulent relationship of love, provision, and protection to becoming entrapped with manipulation, debts, and physical, sexual, and psychological abuse (Dorias, & Corriveau, 2009). These findings also support how victims of sex trafficking, according to researchers Doychak and Raghavan (2020)

can develop trauma-coerced attachments with their traffickers where the victims' need for love becomes exploited.

Being trafficked as a young person was reported by 100 % (n=6) as an impactful factor in the course of treatment. According to participants, when working with victims of sex trafficking that are trafficked as a young person, providers are tasked with “helping them understand healthier boundaries” this is a significant factor as being trafficked as a young person meant that they “learned about relationships with others around their experience with trafficking”. Moreover, another participant reported how the poaching of potential victims of sex trafficking was something very intentional in how they would “go to the park, go to the schoolyard and court them”. This is another matter that professionals are tasked with having to address how this intentional preying perpetrated by traffickers impacts how the patient trusts others. According to literature on Life Course Theory, timing of life events can increase the risk of an individual being sex trafficked, such as having a strong desire to be loved and belong (Reid, 2012). If a trafficker senses that an individual is going through a time in their life where they have these emotional vulnerabilities, they are likely to exploit those emotional needs. Social factors such as being exposed to violence in their home, experiencing rejection from peers, and being a runaway youth increase one’s risk of being sex trafficked. Furthermore, these findings also similarly reflect how 75 % of youth run away from their homes because they are experiencing some form of physical abuse at home (Welsh et al., 1995). Furthermore, amongst runaway youth, the rates of sexual abuse are 5 times greater than the general public (McCormack et al., 1986). According to the results of the study, being young is a notable factor when identifying victims of sex trafficking as well as how their past experiences of abuse can result in them seeking love,

acceptance, and a sense of belonging elsewhere and consequently have those vulnerabilities exploited by a trafficker.

Being trafficked by a family member was reported by 50 % (n=3) of the participants as an impactful factor in the course of treatment. According to participants, when working with victims of sex trafficking that are trafficked by a family member, providers are tasked with addressing the patients' feelings of betrayal and the trauma of experiencing sexual and physical abuse at home and exploring how traffickers may "take the role of being… their dad" or how "there can be women exploiters to be... their mom." According to Life Course Theory, social factors can increase the risk of being sex trafficked when a family member is also engaging in trafficking (Estes, & Weiner, 2001). Many of the individuals who have experienced sex trafficking have had a history of experiencing familial sexual abuse; according to a study that gathered data from 126 prostituted persons, Black women, in particular, were more likely to be trafficked as a minor and report a history of childhood sexual abuse (Hankel, Dewey, & Martinez, 2016).

Being trafficked as a consequence of structural vulnerabilities was reported by 50 % (n=3) of the participants as an impactful factor in the course of treatment. According to participants, when working with victims of sex trafficking that are trafficked as a consequence of structural vulnerabilities, providers are tasked with addressing how systems such as the foster care system, the juvenile justice system, and the ack of support systems in the individual life increase the likelihood of exploitation. These findings are also supported by literature on sex trafficking. According to literature, not only to victims of sex trafficking have interpersonal barriers of oppression due to histories of abuse and the experience of physical, sexual, and psychological trauma but also other forms of oppression such as structural inequalities, housing

insecurity, poverty, and a lack of resources which traffickers exploit (Domoney et al., 2015). These findings also are supported by literature in understanding sex trafficking through the theoretical framework of Life Course Theory, where a number of environmental factors such as coming from a low socioeconomic background, and living in an impoverished community where there are a lack of community resources and safety nets can increase the risk of the individual being sex trafficked (Clawson et al., 2009a).

Therapeutic Alliance and Trust

A therapeutic alliance is the partnership between the professional and the patient in achieving the goals of the patient throughout their journey pursing treatment. Having patience and meeting the patient where they are at was reported by 100 % (n=6) as a successful approach towards building a therapeutic alliance with victims of sex trafficking. Being non-judgmental was reported by 100 % (n=6) as a successful approach towards building a therapeutic alliance with victims of sex trafficking. Having patience and meeting the patient where they are at is supported by literature surrounding trauma-informed treatment (Elliott et al., 2005). According to researchers, trauma-informed treatment is employed through the clinician having an understanding of the trauma of the patient and shaping their therapeutic experience around what they have endured, and catering to their unique needs (Elliott et al., 2005). Part of trauma-informed treatment includes pacing the treatment according to the patient's needs (Elliot et al., 2005). Having patience with the patient is also highlighted by researchers Aron, Zweig, and Newmark (2006) where many victims of sex trafficking have reported that clinicians may be pushing them to engage in sessions in a faster pace than they are comfortable with. As a part of being trauma-informed it is also significant in empowering the patient who has endured so much of their autonomy being taken away from them by nature of being a victim of sex trafficking to

have autonomy throughout the therapeutic process (Aron, Zweig, & Newmark, 2006). Having patience to build a therapeutic alliance can facilitate the development of the patients' esteem needs. According to Maslow's hierarchy of needs in, practicing one's sense of autonomy in a safe therapeutic space in expressing what they are comfortable and uncomfortable with can establish their therapeutic goals within those parameters (Maslow, 1943; Aron, Zweig, & Newmark, 2006).

Assessing for immediate needs was reported by 67 % (n=4) of participants as a successful approach towards building a therapeutic alliance with victims of sex trafficking. Assessing for immediate needs when working with victims of sex trafficking and building therapeutic alliance is an approach that is supported by literature as it is important to address the most pressing needs of the patient in order to ensure that they will be receptive to treatment. Moreover, assessing for the patient's unique immediate needs is an approach that also recognizes that not every patient is going to have the same needs and may also be in a different stage of their trafficking situation (Macy, & Johns, 2011). A participant understood this by stating that there are different needs that they are evaluating for their patients, such as addressing "substance abuse, their mental abuse, their financial hardships, education, employment," and by evaluating these various needs, they can cater their the patient uniquely, and by doing so, this can effectively contribute to forging a strong therapeutic alliance. These findings are supported by the theoretical framework of Maslow's hierarchy of needs (Maslow, 1943). According to Maslow's hierarchy of needs, individuals are to strive to satisfy their physiological needs, safety needs, needs for love, affection, and belonging, and esteem needs, in order to achieve one's full potential and become self-actualized (Maslow, 1943).

The findings of this study similarly reflect that of literature; according to a participant, they stated that when they encounter a patient, they make sure to start off addressing "Maslow's hierarchy of needs" and evaluate their physiological needs and safety needs so they are addressed as soon as possible. Maslow's hierarchy of needs is particularly relevant when working with victim of sex trafficking as it is essential to address their physiological needs, such as needing shelter, food, substance use services, as well as healthcare services (Aron, Zweig, & Newmark ,2006; Macy, & Johns, 2011; Laser-Maira, Peach, & Mounmenou, 2019). One participant provided the example of how physiological needs were addressed by providing solidarity to the patient and encouraging to address a medical need with a patient who was avoiding their gynecological needs and experiencing pain in their genitals. Addressing the gynecological needs of patients who are victims of sex trafficking is also supported by literature, particularly given the nature of the kind of sexual abuse and assault ensured by victims of sex trafficking.

Safety needs are another proponent of Maslow's hierarchy of needs; this factor is essential in building a therapeutic alliance with a patient, especially a victim of sex trafficking. According to literature addressing safety needs not only pertains to the patient's physical safety from their trafficker and other threats, but also emotional safety and perceived safety so that they can feel comfortable enough to participate in the therapeutic process (Laser-Maira, Peach, & Mounmenou, 2019). The findings of this study similarly reflect the evaluation of safety needs as effective in building a therapeutic alliance; for example, a participant stated that they would "create physical safety [and] emotional safety" in the therapeutic space for their patient and being consistent with empowering the patient to have a sense of agency by asking the patient questions such as "is that okay?" before doing something.

Taking a non-judgmental approach in building a therapeutic alliance was reported by 100 % (n=6) of participants. Building the therapeutic alliance by addressing the patients' needs for love, affection, and belongingness through a non-judgmental approach is supported by the theoretical framework of Maslow's hierarchy of needs (Maslow, 1943). The findings of this study reflect similarly to literature in how building a therapeutic alliance one participant stated that the utilize Carl Rogers' Unconditional Positive Regard to be non-judgmental and to be encouraging to them. According to the results of the study, many participants described how their patients have a substantial amount of shame surrounding the trauma of being sex trafficked. One participant stated, "there's a lot of shame and embarrassment around this participation in sex work" an additional participant stated that it is not solely the engagement in sex acts but also other non-sexual crimes that may stir the emotions of shame. Another participant stated that being non-judgmental is significant as it is very likely that patients who are victims of sex trafficking have already encountered many other persons who have been extremely judgmental to them, this only makes it even more important to be a non-judgmental presence in the patients' life.

As a result, it is essential for the clinicians to take a non-judgmental approach to ensure a strong therapeutic alliance where the patient can develop enough of a trusting relationship with the clinician to be able to safely share their experiences and yield the benefits of mental health treatment. An additional participant described how utilizing a trauma-informed approach has also been effective in building a therapeutic alliance with the patient so that they can develop a trusting therapeutic relationship so that they may feel comfortable to engage in working through their trauma with the professional. A part of being trauma-informed in the treatment that is being provided to victims of sex trafficking is being mindful of the kind of abuse that they have

endured and how that may impact the therapeutic space. According to researchers, many victims of sex trafficking have endured dynamics similar to Biderman's Framework of Coercion which includes abusive forms of humiliation and degradation as a weapon to confine the victims into sex trafficking (Baldwin et al., 2015; Amnesty International, 1973). By making sure that one is building a therapeutic alliance by through a non-judgmental approach also ensures that the therapeutic space that the patient is stepping into does not repeat abusive dynamics that the patient has experienced before.

Consistency was reported by 50 % (n=3) participants as a successful approach towards building a therapeutic alliance with victims of sex trafficking. This study found a particular therapeutic approach that was not explicitly described in the literature regarding treating victims of sexual violence and sex trafficking. However, given the responses provided by the participants, the utilization of consistency as a means of building a therapeutic alliance with the patient this may also be reflective of having a trauma-informed therapeutic approach in having an understanding of the kind of chaos an inconsistency that the patient may have endured during their trafficking experience (Aron, Zweig, & Newmark, 2006). According to the responses provided by participants, consistency had been expressed in a way that they as a clinician would be consistent in regards to their availability, for example one participant stated "whether you need something or not, we are gonna be here. And in the event that you do need something, it's perfect because we've been here anyways." This kind of consistency can serve as a foundation in the lives of that patient in knowing that they have someone reliable in their life. Literature regarding the kind of abuse and trauma experienced by victims of sex trafficking reflect the need for consistency to be part of the therapeutic space so they can have a sense of stability. According to Biderman's framework of coercion, isolation, occasional indulgences, and the

enforcement of trivial demands were utilized by sex traffickers as a part of entrapping their victims (Amnesty International, 1973). Through the utilization of consistency as a way to foster a therapeutic alliance, the patient can have a decreased sense of isolation since they will know that they can turn to the clinician and that they will be able to consistently operate within their parameters of their profession to be a resource for them. Consistency can serve as a stabilizer for the patient especially for those who have endured the coercion tactic of occasional indulgences where there is essential the complete opposite of consistency in their life. Occasional indulgences often leave the victim following the demands of the trafficker hoping that they may receive an indulgence which often times is not an indulgence at all but the trafficker engaging with the victim in a non-abusive manner such as giving them a necessity such as extra rest or a more filling meal (Baldwin, Fehrenbacher, & Eisenman, 2014). Many victims of sex trafficking have also endured abuse through their trafficker enforcing trivial demands and making them do everything they tell them to do no matter how minor the demands, these demands can also be ever changing as a way to manipulate the victim and keep them in a state of confusion (Logan, 2007). By providing a sense of stability through being consistent with the patient in availability and service the providers can give their patient a sense of normalcy when they enter the therapeutic space separate from the inconsistent and overwhelming dynamics in their experience of being sex trafficked.

Common Diagnoses From Sex Trafficking Trauma

PTSD was reported by 83 % (n=5) as a common diagnosis from the trauma of experiencing sex trafficking. Depressive disorders were reported by 50 % (n=3) as a common diagnosis from the trauma of experiencing sex trafficking. The findings of this study are consistent with literature on sex trafficking as it was expected the as a result of the substantial

amount of physical, sexual, emotional, and psychological abuse endured by this patient population that PTSD and depressive disorders would be the most commonly reported (Hossain et al., 2010). An interesting finding in this study was the responses regarding Complex PTSD which was reported by 33 % (n=2) of participants. Of those who reported Complex PTSD as commonly seen amongst patients who have been sex trafficked, the participant described that they believe that CPTSD is a better way of conceptualizing the way that their trauma is expressed in symptoms. A number of criticisms were expressed regarding the mental health communities lack of understanding how trauma looks like amongst victims of sex trafficking by 50 % (n=3) participants. These criticisms highlighted the misunderstanding of affective and interpersonal consequences of "chronic trauma, and PTSD". Another participant, described further criticism regarding the overdiagnosis of bipolar disorder as a consequence of other mental health professionals misunderstanding the affective dysregulation associated with severe PTSD. Notably, these responses are reflective on literature regarding complex trauma according to Judith Herman's (1992) proposal of CPTSD. According to Judith Herman's proposal of CPTSD, the symptoms of CPTSD can result in misdiagnosis due to symptoms expressing differently from the traditional PTSD diagnosis such as changes in their personality, dissociative symptoms, having difficulties with relationships, or engaging in reenactments of traumatic experiences (Herman, 1992).

Treatment Approaches

Psychodynamic theoretical approaches were reported by 67 % (n=4). Meeting the patient where they are at was reported by 50 % (n=3). Motivational Interviewing was reported by 33 % (n=2). CBT was reported by 33 % (n=2). DBT was reported by 33 % (n=2). Safety planning methods was reported by 33 % (n=2). Psychoanalytic theoretical approaches were reported by 33

% (n=2). Empowerment approaches were reported by 33 % (n=2). Some of the findings in this study were contrary to what is described in literature. An unexpected result from the study was the utilization of Psychoanalytic and Psychodynamic theoretical approaches, with Psychodynamic approaches being the most reported by participants. While this result is unexpected, given that many of those who are victims of sex trafficking often times enter into commercial sexual exploitation at a young age, Psychodynamic theoretical approach may likely serve as an effective means for professionals to use as a tool for guiding the patient through navigating their traumatic experiences, childhood, and how those traumatic experiences may impact their behavior and implementation of defense mechanisms.

Meeting the patient where they are at was the second most reported treatment approach by participants. While this is not a formal treatment model, it is an approach that echoes the significance of patience and honoring the boundaries of the patient given all that they have endured. These findings are supported by literature on mental health treatments for victims of sex trafficking. According to literature meeting the patient where they are at is a common theme in trauma informed treatment models (Wamser-Nanney, & Steinzor, 2017). According to scholars Aron, Zweig, & Newmark (2006) when working with patients who have had traumatic experiences it is important to have a trauma-informed pacing to treatment which requires the clinician to have an understanding that some of the patients that they work with are not going to be ready to jump into discussing their trauma. Meeting the patient where they are at can come in the form of also moderating the pace of treatment in order to prevent the re-traumatization of the patient (Elliott et al., 2005).

Motivational Interviewing was another commonly utilized treatment model to use when working with victims of sex trafficking. While Motivational Interviewing was not an approach

that was included in the literature review it is evident that a notable number of participants have reported that this approach has been useful in getting the patient to engage in the treatment process. Motivational Interviewing may be especially effective when working with victims of sex trafficking due to many patients having a reluctance to share their experiences being sex trafficked with others (Aron, Zweig, & Newmark, 2006). Motivational Interviewing can be effective in facilitating the participation of the patient as they come into the therapeutic space in order to ensure that they feel heard and validated.

CBT was another therapeutic approach commonly reported by participants who work with victims of sex trafficking, these findings are consistent with literature on mental health treatment for victims of sex trafficking. CBT has been noted by researchers to be effective in addressing the symptoms that may be particularly distressing amongst those who have endured traumatic experiences. Through CBT, the patient can have their thoughts, feelings, and behaviors examined in order to break maladaptive cycles of patterns that may be resulting in a, for example, depressed mood (Beck, 2020). CBT is found to be and effective treatment model for equipping the patient with skills for evaluating the validity of the automatic the patients may have associated with distressing traumatic experiences and how challenging those thoughts can decrease the bleak expectations that they may have about their environment and people they may encounter in their life (Beck, 2020). CBT has also shown to be effective in addressing the core beliefs that may have been developed as a consequence of the trauma that they endured and may be engaging in the maladaptive defense mechanisms of avoidance to prevent a future traumatic experience (Beck, 2020). DBT is a treatment approach that is supported by literature to be effective for victims of sex trafficking and was reported to have been utilized by the participants of the study. According to literature DBT has been particularly effective when providing

treatment to individuals with a diagnosis of borderline personality disorder, and while this diagnosis was not reported as a common diagnosis by the participants of this study there was a report in how due to the extreme trauma endured by this patient population their symptoms of trauma may display differently from the traditional PTSD diagnosis (Bohus et al., 2004). Due to unique difference in the way that trauma may present amongst this patient population, DBT has been known to be effective in treating symptoms of depression, self-harming behaviors, dissociation, and increasing the patient's ability to engage with others positively (Bohus et al., 2004). Furthermore, DBT has been noted to be effective in treating those who struggle with affective dysregulation and angry outbursts (Wagner, Rizvi, & Harned, 2007).

Safety planning was reported as a treatment approach utilized when working with victims of sex trafficking. Incorporating safety planning in treatment when working with victims of sex trafficking is supported by literature. Given the nature of sex trafficking, there are a number of elements that clinicians should keep in mind when working with this patient population such as if the patient is currently in a trafficking situation, or if the patient is currently living with their trafficker. Even in instances where the patient is not currently in their trafficking situation, that does not necessarily mean that that there are no concerns that should be taken with regards to the patient's safety. According to literature the safety of the patient should also be considered when they are living or receiving care at a shelter or other facility where they were trafficked (Schmidt, 2014). Safety planning also entails, different mediums of safety including safety with themselves as well as addressing any legal safety concerns that the patient may have (Macy, & Johns, 2011).

Implementing an empowerment approach in treatment was an additional treatment approach reported by participants. Empowerment has been noted by scholars as an effective treatment approach for victims of sex trafficking, especially considering the nature of the kind of

abuse that they have endured. Empowerment has been noted as effective in addressing the different domains in which the patient has experienced trauma. Empowerment has been noted as particularly effective when addressing the inequalities and oppressions that impacted the lives to patients who are victims of sex trafficking. Trauma-informed treatment approaches can facilitate in the empowerment of sex trafficking victims to find their voice, and to claim their autonomy back from the therapeutic space and into their lives (Elliott t al., 2005). Liberation psychology has been noted to be an additional treatment modality that is geared towards empowering racial and ethnic minorities with a therapeutic model that acknowledges the historical oppressions endured by the individual and their people to guide them in understanding the oppressions experienced by the patient (Martín-Baró, 2019). The empowerment of historically oppressed groups of people is not exclusively practices for those who are racial and ethnic minorities but also women, and other groups of persons such as those who may come from a low-income background or may be a part of an immigrant community (Duran, Firehammer, & Gonzalez, 2008). A liberation psychology approach can be effective when also empowering the patient to utilize what is learned in treatment and be able to implement the skills outside of sessions, empowerment can also be facilitated through guiding the patient to become more independent whether that be financially, emotionally, and becoming more engaged with a positive community (Forsyth, & Carter, 2014).

Structured psychotherapy was reported by 33 % (n=2) to be a valuable treatment approach that they have learned to be helpful when treating victims of sex trafficking. Addressing catastrophizing was reported by 33 % (n=2) to be a valuable treatment approach that they have learned to be helpful when treating victims of sex trafficking. These findings were interesting and while the utilization of structured psychotherapy is not explicitly described as

uniquely effective when working with victims of sex trafficking, literature points towards structured psychotherapy, such as CBT and DBT, as effective when working with this patient population. Moreover, the utilization of structured psychotherapy can be effective for victims of sex trafficking with not having to worry about the therapeutic space that they are stepping into being confusing and unpredictable. Utilizing structured psychotherapy was reported to be a good way to ensure the engagement of the participant during sessions and a sense of order in learning skills. The implementation of structured psychotherapy may be particularly useful when working with victims of sex trafficking as the predictability of the structure in the nature of the sessions can reduce potential anxieties of pursuing or continuing to go to treatment sessions (Baldwin, Fehrenbacher, & Eisenman, 2014). Literature also notes that having the therapeutic space that the patient will be stepping into set up in such a way that the patient will be able to know what to expect for future sessions (Aron, Zweig, & Newmark, 2006).

Addressing catastrophizing was also reported to be a valuable treatment approach that they have learned to be helpful when treating victims of sex trafficking. These findings while are not explicitly noted to be a unique factor to address with victims of sex trafficking, are evidently important to therapeutically confront especially when working with populations who have endured a substantial amount of trauma. According to the responses provided by the participants, when a patient is in a heightened state of anxiety and stress, as stated by one participant “the key is to learn to stay calm and, and that’s an important lesson for the life.” The responses highlighted the significance of modeling how one would respond to a non-life or death situation that while it may still be distressing does not necessarily mean that everything is a crisis. The significance of addressing catastrophizing with victims of sex trafficking is reflective of literature on CPTSD as patients who have experienced chronic trauma they are often in a

constant state of arousal and fear revictimization (Herman, 1992). With this kind of constant state of arousal and fear of revictimization many victims of sex trafficking were in situations where they had to be in a state of constantly looking out for threats and if one thing did go wrong that would mean severe consequences. Psychoeducation has also been noted as an effective way to address catastrophizing so that the patient has a greater understanding of their diagnosis, trauma, and the behaviors that may be unconsciously engaging in (Sarkhel et al., 2020).

Making accommodations to treat victim of sex trafficking in comparison to how one would treat other victims of sexual violence was reported by 83 % (n=5) of participants. Of the participants who make therapeutic accommodations to treat victims of sex trafficking 100 % (n=5) make therapeutic accommodations surrounding shame and 40 % (n=2) make therapeutic accommodations delineating case management from psychotherapy. The findings of this have highlighted the significance of making unique therapeutic accommodations surrounding shame when working with victims of sex trafficking that have been noted to be done so differently in comparison to when working with other patients who were victims of sexual violence. According to the responses provide, addressing the unique feelings of shame associated with being a victim of sex trafficking required the implementation of a number of approaches such as being empathetic, utilizing psychoeducation, and reminding the patients of how much progress they are making. According to the response of one participant they stated that they have to adapt to working with victims of sex trafficking in comparison to working with other victims of sexual assault and domestic violence. Another participant described how bringing empathy into the therapeutic space is vital as many victims of sex trafficking have been told “everyone’s going to see you as a whore”. With victims of sex trafficking constantly being blamed for the trauma that they have endured being more empathetic when servicing victims of sex trafficking provides

there to be a greater understanding of how the patients may be utilizing their defense mechanisms to bury the shame associated with the traumatic experiences that they have endured.

Psychoeducation was described as an approach that can be used to address the shame as a therapeutic accommodation that they make to uniquely address patients who are victims of sex trafficking. According to the participant's response there can be empowerment put in the place of where there may be shame for having endured so much as they stated that when they speak to their patients, they describe how trauma impacts the brain. In contrast to pointing out the way in which trauma impacts their behavior in a negative way, psychoeducation can be utilized as a way to understand how their brain adapted to the hostile satiations and environments that they were in. One participant stated "you know your needs right, and you did the best you could to get some of those needs met, and your brain adapted, and it was doing all these things to keep you alive." These findings in the study are reflective to what is described as an effective way to address shame when working with victims of sex trafficking. According to literature, psychoeducation has showed promising results as a way to guide a patient to gain a greater understanding of how their traumatic experiences impacted their brain and behavior (Litam, 2017). The participant state that they would pose the following example to patients in order to develop a greater understanding of how trauma impacts the brain by using an example of a teddy bear. By basing the trauma reactions that the patient has as a way to highlight their strengths and resilience the participant can combat some of the shame that they may be feeling and point towards how they have learned to stay hypervigilant in avoiding threats. The participant utilized the example of how the brain would react if someone was repeatedly having a grizzly bear scaring them, as a result the brain will associate the grizzly bear with fear. After having many fearful encounters with a grizzly bear the brain will then keep an eye out for potential threats

associated with those past experiences so the a person may also get scared when they see a teddy bear because it reminds them of the grizzly bear.

This example is something that can allow the patient to understand that their symptoms of PTSD is not a weakness but a strength that aided them in surviving the dangerous experiences that they endured being sex trafficked. The participant also stated that they use psychoeducation to address shame by putting their traumatic experiences into context by addressing the vulnerabilities that were exploited by traffickers and describing how homelessness, hunger, poverty, lack of familial support, and exposure to violence were factors that were out of the control of the patient. These findings are also supported by literature on psychoeducation, as a great way of confronting the impacts of how the vulnerabilities in their life and how traffickers utilize coercive control to exploit those vulnerabilities and their experience being sex trafficked (Litam, 2017). The utilization of psychoeducation can also play a role in dispelling the internalization of victim blaming narratives that the patient may be carrying regarding their trauma and counter the shame (Márquez, Deblinger, & Dovi, 2020).

Reminding the patient of how much progress they have made through the therapeutic process is noted as an essential proponent in countering the shame of patients who were sex trafficked. According to one participant they were been working with a patient who got out of their sex trafficking situation for a year but constantly were trying to prove themselves even after pursuing education, having employment, getting a new apartment, and opening up their own business. These findings of the study while are not explicitly described in literature. However, according to Maslow's hierarchy of needs, when a patient is pursuing their esteem needs, they can develop a greater sense of confidence, accomplishment, and respect (Maslow, 1943). As a result, by periodically reminding the patient of how far they have come and how much of their

goals they have achieved the patient can celebrate those achievements, and the clinician can also point out that those achievements are worth celebrating.

Delineating case management from psychotherapy was described as a therapeutic accommodation that is made when working with victims of sex trafficking in contrast to other victims of sexual violence. According to the responses that were provided by the participants, when working with victims of sex trafficking it is important to not repeat dynamics that occurred in their trafficking experience. As a result, it is important to keep in mind the nature of the commercial sexual exploitation that was a reoccurring theme in their trauma. According to the responses of one of the participants in recognizing the uniqueness of the trauma of being sex trafficked there is not only a physical, sexual, and emotional violation but also an "economic violation" as stated by one participant. An additional participant stated that when working with victims of sex trafficking they experienced "a lot of using me as the therapist, as using me to get what they needed." and that many of the victims have a "survival-based mentality which can be challenging sort of showing up when they feel that I could do something to benefit them, not showing up when they feel like something else is more important." This is a significant aspect of the unique kind of exploitation in which sex trafficking entails as many of the individuals who are disproportionately sex trafficked are those who come from poverty (Domoney et al., 2015). Moreover, there is a trauma that is also associated with the financial aspect of sex trafficking as a form a abuse that many victims of sex trafficking endured may be associated with the fraud of being promised employment and debt bondage (Logan, 2007). By preventing the financial services that may come with receiving services from a particular organization and explaining clearly what it means to receive the financial resources the patient can still experience the

benefits of the resources while also having an understanding that it is not for those resources for which mental health treatment is what they are going to those sessions for.

Therapeutic Approaches That Were Found to Cause More Harm Than Good

Therapeutic approaches that were found to cause more harm than good were reported by 50 % (n=3) participants. Of the participants that provided a response 100 % (n=3) of the participants stated that failing to meet the patient where they are at was the most harmful approach that a clinician could take when working with victims of sex trafficking. According to the responses of the participants meeting the patient where they are at can mean a lot of things such as changing the kind of approaches that are being utilized in order to be most effective. For example, one participant stated that while CBT is often times an effective treatment model, there comes a point where a patient may be in such a crisis that a patient would likely not be as receptive to CBT in comparison to "mindfulness-based, present-focused approaches". Furthermore, an additional participant stated while acceptance and commitment therapy can be effective for many patients if a patient has recently escaped sex trafficking it is likely to be "very invalidating". These results are similar to what is expressed in literature on engaging in trauma-informed treatment methods to ensure that the patient is being serviced in such a way that facilitates their recovery (Elliott et al., 2005). There are times where implementing a particular treatment approach may be too extensive for the patient as described by these participants and patients may not be ready to dive into working through their trauma and may just need to have the clinician be present to ground them in the midst of a crisis.

Recognizing that failing to meet the patient where they are as harmful in treatment is also supported by literature and highlights the importance of having a trauma-informed treatment approach (Aron, Zweig, & Newmark, 2006). By meeting the patient where they are at also can

help the therapeutic space be inviting and increase the chance that they will continue participation in mental health treatment (Wamser-Nanney, & Steinzor, 2017). Being conscious in pacing and shaping the sessions in such a way that cannot be invalidating to the patient and their traumatic experiences is also noted as a significant proponent of healing and is supported by literature as a fundamental way of meeting the patient where they are in how they interpret their experiences (Duran, Firehammer, & Gonzalez, 2018). One participant explained how failing to meet the patient where they are at can be invalidation when asking them to move forward through trauma work without equipping them the appropriate tools by stating that after months or even years into therapy, they could approach the patient with "Hey there are all these things that we've identified in our time of working together, and they seem to be helpful to soothe the trauma reaction, and… we have a strong. Toolbox of ideas to use" it is then that the clinician would be able to guide the patient into how they could differently react to when they are in emotional turmoil and experiencing a trauma reaction. A third participant described that failing to meet the patient where they are can also be harmful by having the patient who may still be in an unstable situation with little support do a trauma narrative as part of TF CBT or engage in EMDR without having equipped them with support, facilitate healing and get the patient to have "some separation from the 'life'". This response is also similar described in literature on trauma-informed treatment approaches as it is important for the clinician to establish safety in the therapeutic space and pace the treatment to ensure that they are not re-traumatizing the patient by having them dive into working through their trauma (Hopper, & Hidalgo, 2006).

Effective Coping Skills

Coping skills are an essential aspect of preparing the patient to become empowered in regulating their emotions and reactions to triggers. According to the results of this study body

awareness coping skills was reported as effective by 67 % (n=4) participants, distracting one's self from triggers was reported as effective by 50 % (n=3) participants, and recognizing one's trauma and triggers was reported as effective by 50 % (n=3) participants. The reported effectiveness of trauma-informed body awareness coping skills as described by one participant who stated "I need to adjust usually to allow for some of their trauma responses, leaving your eyes open, for example, having them seated in a place that felt safe with their back against a wall." Additionally, another participant described that body awareness also assists the patient with becoming more aware with how they are physically reacting to trauma reactions and when they are getting triggered by keeping in mind the psychosomatic symptoms of their body temperature increasing or their palms sweating as a way to regulate their emotions prior to getting to a point where they may be too distressed to calm down. While it was not expected that body awareness coping techniques would be the most reported by participants for this study, given the nature of sex trafficking and the physical and sexual exploitation that the patient endured was the commoditization of their body. These kinds of abuses can result in the patients having a very difficult relationship with their bodies as the exploitation of their bodies also stemmed from the sexualization and objectification of their bodies (Dempsey, 2009). Through the utilization of body awareness in a trauma-informed way the patient in a sense is being encouraged to reclaim power over their body in becoming more in tune with themselves. By utilizing CBT body awareness and psychoeducation as a part of recognizing how their bodies react to anger and emotional distress the patient can gain become more knowledgeable in understanding the relationship that the mind has with the body and the body with the mind (Judith Herman, 1992). This can also provide a way for the patient to develop a healthier

relationship with their body and if they are feeling any discomfort a discussion can be had on what can be done.

An additional coping skill was to equip the patient with ways that they can distract themselves from their triggers to stop the flow of negative thoughts associated with their trauma. According to the responses provided by the participants when the patient is able to sense that they are getting angry or emotional distress such as anxiety DBT and CBT skills were reported by one participant as effective in getting the patient's mind off of what may be triggering to them. According to the participants anything else that is positive that the patient can move their attention towards can be effective in coping with negative emotions and feelings, such as utilizing mindfulness skills, writing, tactile items that they can "fidget with" were reported as helpful. These responses are similar to what is reported by literature in guiding the patient towards investing their attention towards positive activities in place of where they may become distressed and emotionally dysregulated. DBT and CBT skills have been noted by literature to be effective in treatment for victims of sex trafficking through practicing mindfulness, meditation, and engagement in positive expressions of emotions through for example, the arts (Chavez-Dueñas et al., 2019).

Recognizing one's trauma and triggers was reported to be an effective coping skill according to the results of the study. Recognizing one's trauma and triggers provides the patient to become more aware of tying their traumatic experiences with what internally and externally may be causing distressing symptoms and reactions. According the response of one participant they stated that victims of sex trafficking should get to the point in treatment where they can connect the dots of their experiences by stating "I just have to realize that I have trauma and triggers, and if I smell this or I hear this song, how am I going to sustain myself." This stated

perfectly gives the opportunity for the patient to utilize the coping skills that are learned if that be body awareness techniques or skills that they can implement in their life as a way to draw their attention and energy towards things that give them joy so that they can sustain themselves at times of distress. Similarly, to what is described in literature CBT and psychoeducation have been noted to get patients to have insight into the way that their thoughts, feelings, and behavior are all tied together in the way that they are navigating their life (Beck, 2020). Moreover, by drawing upon the connections of their trauma and understanding how those experiences have brought them to where they are at they can become more mindful on how to regulate their emotions when they are experiencing distressing affective or somatic symptoms of trauma (Herman, 1992).

Using Racism to Inform the Therapeutic Space

Therapeutically addressing racism was reported by 83 % (n=5) of participants as a way to use the experiences of racism that the patient expresses as a way to greater inform the therapeutic space of the various forms of oppression that they endured. Of those who therapeutically addressed racism used 60 % (n=3) institutional racism, and 60 % addressed structural oppression as a way to inform the therapeutic space**.** According to the responses that would inform the therapeutic space by examining the proponents of institutional racism that the patient has experienced the primary approach that clinicians would take is to explore those experiences and validate their expression of their experiences of this form of oppression. According to one participant who worked in the criminal justice system they stated that when working with a patient who was a woman of color, they would engage in acknowledging that racism played a role in the decisions of who would be prosecuted, and the decision to prosecute. Intuitional racism was also described to be an implicate who is seen as a victim according to another

participant who stated that communities often fixated in coming to the aid of a “little white girl with blond hair and blue eyes” who goes missing but when a young Black girl goes missing “you don’t hear anything about it.”. According to literature engaging in the validation of the institutional racism that victims of sex trafficking experience is a part of confronting racial trauma. These findings are also supportive of the examination of sex trafficking through the theoretical lens of critical race theory which takes into account the role in which the historical oppression of people of color and the oppressive institutions that have played a role in entrapping women of color in sex trafficking and coerce and force them into exploitation (Butler, 2015a). Moreover, one of the participants described how when a white girl goes missing often times there is a notable amount of media attention and resources dedicated for their safe return but when a Black girl goes missing there is little to no media coverage or mass concern for their wellbeing. Research has noted that white women who are victims of sex trafficking and sexual exploitation are recognized more as victims, while many women of color are not seen as victims but are often criminalized for prostitution (Brooks, 2021).

Engaging in the validation of the structural oppressions that played a role in the traumatic experiences of victims of sex trafficking is also supported by literature. According to one participant they stated that they “use racism, discrimination, poverty, and oppression as tools to greater understand” the patient and their experiences being sex trafficked. The participant continued by stating that they examine the “intersection of their identity, and those include their race, their socioeconomic status, the community they grew up in.” as a way to facilitate a deeper understanding of the various factors that may have played a role in how they ended up where they currently are. Through the examination of sex trafficking through the lens of critical race theory women of color have historically been disproportionately fetishized as a consequence of

colonialization, and imperialism (Butler, 2015b). The historical oppression of people of color has also resulted in disproportionate inequalities such as inadequate housing, and barriers for obtaining education and employment opportunities (Brooks, 2021). According to literature on Liberation psychology through validating the different forms of oppression that the patient has experienced in their life they can become empowered by gaining an understanding that the battle that they have been fighting their whole life was not a battle that they have been fighting alone (Chavez-Dueñas et al., 2019). In understanding the role in which racism has place in their sex trafficking experience patients of color can also examine any self-blame, guilt, or shame that they may have regarding the various forms of oppressions that have coerced and/or forced them into sex trafficking (Carter, 2007).

Therapeutically Addressing Sexism

The two most reported approaches for addressing sexism were to therapeutically address reenactment behaviors which was reported by 60 % (n=3) of participants and how to have healthy relationships with men which was reported by 60 % (n=3) of participants. According to participants that reported that they addressed sexism by addressing reenactment behaviors, they discussed how much of the abusive dynamics that the patients have experienced at the hands of man has been normalized. Many patients who are victims of sex trafficking that the participants have worked with may be drawn to abusive relationships with men because it is what is familiar to them or perhaps all they know. For example, one participant stated “something that I was always very conscious of was how the male NYPD officers would interact with the people that I worked with and how they tended to use flirting as a way to sort of build trust, which for the patients that I worked with that was something very familiar, and so it wasn’t that scary they knew how that game worked, even though it had its flaws. And that led to them sort of conflating

the cops with their customers or Johns." According to this participant, they described this behavior as essentially a "survival skill" and "defense mechanisms". According to literature on chronic trauma, individuals who have chronic trauma are more likely to have symptoms be presented differently than what is most commonly seen amongst patients with a traditional PTSD diagnosis and may engage in reenactment of traumatic experiences (Herman, 1992). These kinds of behaviors are likely as a result of the past negative experiences that the patients have had with those who have purchased sex or "Johns" as referred to by this participant and became violent. According to literature, many victims of sex trafficking not only experience a substantial amount of violence from their traffickers but also the "Johns" who perpetrate repeated sexual assaults, physical violence, racial trauma, and harassment (Territo, & Kirkham, 2010; Butler, 2015b).

These findings are reflective of a study that carried out interviews with individuals who purchase commercial sex where a buyer stated that when they pay for the sex the prostituted person forfeits their "right to say no" as a result it is likely that these patients are indeed engaging in a survival skill and behaving in a "flirty" way and conflate the way that they engage with men with "Johns" in order to prevent conflict in the traumatic dynamic of sex trafficking that they have been in (Farley, 2006, p. 131). However, it is important for the clinician to explore with the patient how just because a particular dynamic may be familiar does not mean that it is healthy or safe and that there are men that they can have in their lives where they do not need to or should feel that they have to interact with them in a sexual way.

An additional way of therapeutically addressing sexism with the patient is to develop an understanding of what a healthy relationship with men are. According to the responses provided by participants when exploring what a healthy relationship with a man would look like one clinician would ask their patient to make a fantasy list of all of the things they would like to have

in a partner. When exploring what a health relationship with a man looks like they would then challenge the patient by asking them questions such as if they are getting any of those much-wanted qualities in a man from the relationship that they are currently in. The approach of the utilization of Socratic questioning to open the patient regarding any matters where there may be cognitive distortions is supported by literature and may be effective in having the patient reflect any gaps between the ideal relationship that they would like to have with men in their lives and the previous or even current unhealthy relationships that they have had or have with men (Kenny, Helpingstine, & Webber, 2019).

Another participant stated that they would try to get the patient to provide develop an understanding of what a healthy relationship could look like and how it can be modeled in the therapeutic space so that they can test out the dynamics in their life outside of the sessions. According to literature educating patients on what a health relationship with men are like and healthy intimate partner relationships is an essential aspect of guiding the patient to develop healthy boundaries (Countryman-Roswurm, & Bolin, 2014). A participant expanded regarding the significance of understanding the difference between an unhealthy relationship and a healthy relationship in providing insight of the abusive dynamic in which many of the men that the patient came across when they were being sex trafficked were perpetrating against them. The patient stated that essentially relationships should be grounded in safety. Psychoeducation regarding the abusive dynamics that traffickers perpetrate and how they can avoid relationships that have similar dynamics has shown to be effective when working with victims of sex trafficking so that they can become more empowered in appreciating their worthiness for a relationship of mutual respect, love, and physical and emotional safety (Litam, 2017).

Therapeutically Addressing Incarceration

When participants were asked about how they therapeutically address incarceration all of the participants that provided a response to the question provided different answers. As a result, it is difficult to draw conclusions given the lack of agreement amongst the participants on a particular approach that have been found to be uniquely effective when working with victims of sex trafficking. However, some of the responses that were provided are reflective of what is described a therapeutically effective approaches to implement when working with victims of sex trafficking particularly with 25 % (n=1) of participants supporting the patient with pursing legal services and with 25 percent (n=1) of participants understanding the patient's perspective of incarceration. When examining sex trafficking through theoretical framework of Maslow's hierarchy of needs, when looking within the parameters of safety needs, securing legal resources such as representation, immigration assistance, and translation resources (Macy, & Johns, 2011; Laser-Maira, Peach, & Mounmenou, 2019). According to the participant in many ways being able to successfully navigate the legal system with the support of their provider can play a role in healing especially if the patient is able to get their criminal record expunged. The impact of having a criminal record as a victim of sex trafficking had been noted to be a great source of shame as many victims of sex trafficking are not only arrested on prostitution charges but also drug offenses, resisting arrest, assaulting an officer and more (Barnard, 2014). The participant noted that they would open up the idea of healing the injustice of being criminalized.

It is important however for the clinician to also get the perspective of how the patient understands their experience of being incarcerated as not all victims of sex trafficking may view it the same. While literature notes that many victims of sex trafficking have reported the experience of being arrested as a source of substantial trauma such as enduring police brutality in raids, as well as being periodically arrested and re-arrested by police even though they were a

victim of sex trafficking (Ditmore, 2009; Bejinariu, Kennedy, & Cimino, 2020). Moreover, many victims of sex trafficking, particularly women of color have reported experiencing a notable amount of racial trauma throughout their encounters with police, as Black women are disproportionately arrested on prostitution charges in comparison to their white counterparts (Brooks, 2021). Other victims of sex trafficking according to the response of one participant some of their patients have viewed being arrested as what allowed them to get away from their sex trafficker and be eventually connected to services. Moreover, the patient also stated that the patient may not view being arrested and incarcerated within the context of all of the other traumatic things that they have endured as traumatic by stating that in the "context of everything there they've gone through that doesn't feel like a big deal to them…" the also stated that "you kind of got to be where they are." This kind of therapeutic approach repeatedly is highlighted throughout the responses of the study and is also highlighted by trauma informed literature where it is important for the goals of treatment to be pre-established by the clinician but for the patient to feel empowered to establish the goals that are important for their healing (Aron, Zweig, Newmark, 2006).

Successfully Treating Victims of Sex Trafficking

All of the participants for this study believed that the treatment approaches that they implemented were successful in treating the needs of sex trafficking victims. Being able to the patient to take care of their mental health was the most reported definition of a successful treatment outcome by 83 % (n=3) of participants, having greater control in their lives was reported by 50 % (n=3) participants, implementing protective factors was reported by 50 % (n=3) participants, however 50 % (n=3) of participants also recognized that defining a successful treatment outcome also depends on the patient. Taking care of one's mental health was the

overwhelming response in defining a successful treatment outcome according to the responses provided by the participants. This was an expected result of the study due to the nature of getting a patient to engage in treatment as the goal often times is to get the patient to be able to implement what is learned in the sessions into their lives once they leave the clinician. According to the response of one participant the stated that success can be defined as the patient learning to "cope with some of their triggers" while also "understanding themselves better" and being able to "let go of the shame". These results of the study are also reflective of literature on the role that psychoeducation has on tackling the self-blame that many victims of sex trafficking have regarding their exploitation, however by highlighting the things that were out of their control allows that weight to be taken off of their shoulders (Ditmore, 2009). These factors are a number of elements that have been touched upon in the previous questions that were discussed as topics to address throughout the therapeutic process. Being able to come to a point in treatment where one is able to successfully implement coping skills when experiencing a trigger and emotional distress requires one to be in tune with one's self so that they can understand where the feelings are coming from in a non-judgmental way towards themselves. These findings are consistent with literature on trauma-informed treatment as the goals of treatment t should be framed around the patients' recovery from trauma (Elliott et al., 2005).

Patients having greater control in their lives was an additional way in which respondents defined a successful treatment outcome for victims of sex trafficking. This kind of response is additionally reflective of literature and echoes some of the previous therapeutic approaches in which the participants provided regarding providing consistency for the patient and a sense of stability given how unpredictable and unstable the life of being sex trafficked can be. According to the responses provided by participants having greater control in their life can look like the

patient having a greater understanding of one's self as put by one of their patients "The greatest gift that I gave to myself, was that of studying myself" which is essentially what occurs throughout the therapeutic process. To study one's self is to engage in self-examination which can be a grueling process of engaging in psychotherapy confronting one's thoughts, feelings, and behaviors, and walking through one's trauma with the clinician beside them. Similarly, another participant stated that success could be defined as "feeling closer to oneself". Feeling closer to oneself not only includes having healthy relationships in their life, having a greater ability to trust others, and have a more grounded understanding of the abuse of coercion and control the trafficker perpetrated against them and build or rebuild their internal sense of self. Having the patient come to understand themselves and their trauma as a means of them gaining a greater sense of control in their lives facilitates the patient to reclaim their autonomy. With the abusive tactics of coercive control, and Biderman's framework of coercion the victims were unable to exercise freedom to socialize with others, and were made to be dependent upon the trafficker for some of the most basic of necessities even for going to the bathroom or having to make a phone call, as well as even controlling the victim's thoughts in convincing them that they could never escape and if they tried, they would get caught (Amnesty International, 1973).

The results of this study also included the definition of successful treatment as having implemented protective factors in the patient's life. The protective factors described by the participants included having employment, adequate housing, a positive social support system, pursuing education, having healthy interpersonal relationships with others, or even attending a day program. According to one participant including the implementation of protective factors for a victim of sex trafficking is significant for defining success because it can facilitate them to "move them away from that behavior and that activity" of engagement in commercial sex. These

findings are similar to what is expressed in literature in what a successful treatment outcome can look like. According to Maslow's hierarchy of needs the stability of the foundational necessities of the patient such as having adequate and stable housing to the safety needs of having steady employment, their needs for belongingness by establishing a positive social support system and healthy interpersonal relationships, and establishing their esteem needs by establishing their sense of achievement through obtaining an education for themselves gets the patient closer to achieving self-actualization where they can focus their efforts upon reaching their full potential (Maslow, 1943). According to this theoretical framework when a victim of sex trafficking gets to the final stage of the hierarchy of needs, they will have stabilized their other needs.

When participants were asked to if they could provide an example of a successfully treated patient only 67 % (n=4) of participants could provide an example; of the participants who could provide an example, 50 % (n=2) described the patient achieving their goals and obtaining secure housing as success. These examples similarly reflect the literature on the theoretical framework of Maslow's hierarchy of needs where success entails the necessities that the patient needs in their lives such as housing while the biggest driver for both of the patients to push through the treatment plans was not for themselves but for their children. According to one example provided by a participant, there was a victim of sex trafficking that had fought to engage in therapy and obtain housing so that she could get custody of her daughter. This finding is also reflective of a study that found that when the family is positively regarded by the patient, when the patient is able to get united with their family it has found to result in an enhanced treatment outcome (Twigg, 2017). For this patient not only does getting custody of her child fulfil her needs for love, affection, and belongingness, or their sense of accomplishment in achieving their goals, but also proponents of self-actualization as the mother had been engaging

throughout the entire process for her daughter and also being regarded as a peer leader at the organization when in groups not only advocating for herself but also for other victims of sex trafficking (Laser-Maira, Peach, & Mounmenou, 2019).

Termination of Treatment

When the clinician believes that the patient has gotten to the point in treatment when they have achieved a successful outcome 67 % (n=4) reported that they evaluate the patient's emotional preparedness for termination. As a means of emotionally preparing patients for termination of treatment it was reported by 67 % (n=4) of participants that right from the beginning of the therapeutic relationship as a means of preparing them for understanding that the clinician that there is going to come a time where they will have to part ways. This first step at the very beginning of the therapeutic relationships serves as a mental preparation for the patient that they will be working before that eventual time comes. Evaluating the emotional preparedness of patients for termination of treatment serves as a way of making sure that they are able to implement everything that they have been covering throughout the session so that they will be able to sustain themselves when navigating their life. One participant stated that when termination of treatment occurs, they also equip the patient with reminder materials of skills that they can implement when they are feeling distressing symptoms to a trauma reaction by stating "lets say one of their triggers is like feeling shame, then they have their little coping card to remember, okay, I'm feeling shameful, pull it out, how do I cope with it." Moreover terminating treatment once reevaluated does not have to be set at a firm date once agreed upon, for example another participant stated "let's say right before the 90 days or 120 days is about to come, and something traumatic happens, then we say, okay, we're going to give you an additional 90 days and work on this" so the patient does not feel like all of the work that they have spent in

treatment has been undone and that when they are stepping to the phase of termination of treatment that they can do so feeling emotionally prepared to venture onward with their lives.

Termination of treatment may also be approached if the clinician notices that when they are coming to session that they are not really having anything much more to discuss or examine, and has been able to address their trauma and implement the tools they have been equipped with throughout the therapeutic process to "demonstrate emotional regulation". The findings of this study are supported by literature when working with victims of sex trafficking in a trauma-informed manner (Aron, Zweig, & Newmark, 2006). As a result of the kind of interpersonal abuse that had been endured by the traumatic dynamics that victims of sex trafficking often experience, by emotionally preparing the patient to stand on their own after termination of treatment is also upholding the difficult process of building trust with this patient population. Often times many victims of sex trafficking have had their trust violated by those whom they loved whether that be as a consequence of familial sex trafficking, being sex trafficked by their romantic partner, or trafficked from someone who promised to provide them with opportunity, love, and protection (Estes, & Weiner, 2001; Aron, Zweig, & Newmark, 2006).

How Are Professionals Reacting to Servicing Victims of Sex Trafficking?

When the participants were asked how servicing victims of sex trafficking felt and if there were any emotional challenges that would arise, 100 % (n=6) of the participants reported feeling emotions of sadness when listening to their patients' traumatic experiences. While much of the specifics regarding those difficult emotions varied amongst participants 33 % (n=2) reported experiencing vicarious trauma, and that it could be triggering at times to be working with this patient population and needed to engage in self-care. One participant stated that working with one's supervisor, and well as sort through any countertransference to ensure that

the difficult emotions that they are feeling does not negatively impact the patient they are working with. A second participant stated that they may also take walks and try to disconnect from their work when they are off duty to ensure that they able to provide adequate care for their patients. These responses are similarly reflected on literature regarding the challenges of working with patients with severe trauma such as victims of sex trafficking. According to literature many mental health professionals experience compassion fatigue, and may even develop vicarious trauma which can result in the clinician experiencing symptoms similar to PTSD such as hypervigilance, irritability, anxiety, as well as sleep disturbances (Lerias, & Byrne, 2003). Emotions of anger and frustration when working with patients who are victims of sex trafficking who are pulled back into the abusive dynamic of going back with their trafficker after leaving them (Ramirex et al., 2020). It is as a result of the difficult emotions that arise when working with victims of sex trafficking that the professionals working with them make sure to manage those emotions in a healthy way if that be as described by one patient as simple as taking walks to clear one's mind or even discussing how those emotions can be sorted out with supervision to ensure that the patient is getting the quality of care that they should be getting.

Closing Thoughts on Anything Else Important when Servicing Victims of Sex Trafficking

When participants were asked for their closing thoughts on anything else they wanted to highlight as important when servicing victims of sex trafficking 64 % (n=4) of the participants each added a closing statement. Of the participants who provided closing statements 50 % (n=2) of participants discussed the need for there to be a greater understanding in the field on how to best services victims of sex trafficking. One participant stated that there needs to be greater resources such as funding, housing, and time for victims of sex trafficking because the treatment plans and resources currently available are limited in adequately meeting their unique needs. The

response provided by this participant is reflective of what is articulated regarding the uniqueness of working with victims of sex trafficking, particularly regarding the plethora of resources that are required to meet their needs. According to research on mental health treatment for victims of sex trafficking often times the treatment plans are much longer than other victims of sexual violence due to the need for a slower paced development of a therapeutic alliance as wells as the nature of working with patients who have CPTSD (Aron, Zweig, & Newmark, 2006; Jensen et al,. 2014; Kenny, Helpingstine, & Webber, 2019).

A second participant stated that the treatment approaches clinicians should be utilizing when servicing victims of sex trafficking needs to be empathetic and empowering and coming from a place of "recognizing their strengths". According to literature on having an empowerment approach towards treatment much of what is described in this response is reflective of a Liberation psychological treatment approach which is geared towards empowering patients through examining the oppressions that have played a role in their trauma and focus on health through empowerment. Empowering the patient can look a lot like getting the patient to observe their resilience as their strength in overcoming their trauma and all of the institutional and structural oppressions that played a role in their experience being sex trafficked.

The third and fourth participant who provided closing thoughts both described the significance of there needing to be a greater understanding in the field on how to best services victims of sex trafficking. The third participant discussed that the field of anti-sex trafficking is a "very disjointed field" which makes servicing victims of sex trafficking very difficult. The third participant also stated that many people are only seeing a particular side of sex trafficking depending upon the role that they have in servicing this population, consequently this results in the fable of the blind men and the elephant. They stated "five blind men standing around an

elephant they're all feeling a different part of the elephant [and] they're all feeling a different part of the elephant. And someone thinks he's feeling the tail, and he says, this is a paintbrush, and someone's feeling the leg and says this is a tree. No one's able to put together the whole picture." The fourth participant also highlighted that there needs to be more research on sex trafficking and expressed the significance of having professionals sharing their experiences working with specific patient populations such as sex trafficking victims. These final thoughts regarding servicing victims reiterates the purpose of the study as the current literature regarding mental health treatment for victims of sex trafficking I quite limited in providing a comprehensive understanding of how mental health professionals can more effectively address the unique needs of this patient population.

Limitations and Future Research

There are a number of limitations that have implicated the findings of this study. This was a sample of 6 people mostly based in NYC so there are limitations to generalizability when interpreting the results of the study as the treatment approaches are likely to be biased to particular psychotherapeutic approaches that may be particularly popular in the North-Eastern region of the United States. This was particularly reflected in how the most common response for treatment approaches was Psychodynamic theoretical methods. Additionally, all of the participants for this study identified as female, which is a limitation concerning the diversity of the sample of the study. There was also an error made by the researcher when collecting data from one of the participants in the study, which resulted in the one participant not being asked about how they therapeutically address incarceration, which made interpreting the results for that question difficult to draw conclusions from with every participant that was asked this question

providing a different answer. It is believed that if a similar study such as this were to be completed that the sample should be much larger such as the sample goal for this study which was 10 to 15 mental health professionals or more. For future research like this study, it is also recommended that participants be compensated more than $50 dollars as it is evident that service providers who work with this patient population have very limited time to participate in studies such as this, especially 2-part studies that require 45 minutes to an hour interview.

Conclusion

The core questions of interest for this study consisted of investigating (1) how professionals are approaching treatment for victims and survivors of sex trafficking and what they have found effective (2) how they address the unique vulnerabilities of the patient therapeutically, such as race, sex, and other forms of oppression. According to the findings of the study, it is believed that the research questions were answered in developing a theoretical understanding of how mental health professionals with experience treating victims of sex trafficking are servicing this patient population.

When engaging in victim identification, the majority of the time, sex trafficking situations can be identified in dynamics that may initially look like domestic violence. Similarly, it was reported that victims of sex trafficking are the most likely to be trafficked by a romantic partner. Those who enter into sex trafficking are usually trafficked at a young age, according to the respondents. However, it may also be common to see patients who also entered into sex trafficking through a family member as well as a consequence of structural vulnerabilities.

When developing a therapeutic alliance and trust with victims of sex trafficking, the findings of this study highlight the significance of having patience and meeting the patient where

they are, and being non-judgmental, assessing the patients' immediate needs was also noted as a successful approach for building a therapeutic alliance in addressing their physiological needs and safety needs so that they can be more receptive to treatment. Engaging in consistency with the patient throughout the therapeutic process is an additional proponent of building a therapeutic alliance in providing a sense of stability for the patient.

Common diagnoses from the trauma of experiencing sex trafficking included PTSD and Depressive disorders. However, some of the participants of this study also recognized the nuances in the way that CPTSD presents differently than the traditional PTSD diagnosis and how that related to providing treatment to victims of sex trafficking and how that may commonly result in incorrect diagnosis amongst this patient population.

The most-reported treatment approaches implemented by professionals when working with victims of sex trafficking include the implementation of psychodynamic theoretical approaches, meeting the patient where they are, motivational interviewing, cognitive behavioral therapy, dialectical behavioral therapy, safety planning, psychoanalytic theoretical approaches, and having an empowerment approach. It is evident that when working with victims of sex trafficking, mental health professionals are implementing a multidisciplinary approach in order to best meet the needs of patients. Furthermore, the findings of the study also highlighted the significance of utilizing a structured psychotherapeutic approach in order to provide a therapeutic space that is more concrete for the patients, this again bringing a sense of stability into the lives of the patient when entering and participating in the therapeutic space. Addressing catastrophizing was noted as a significant treatment approach to address the patient's fears of experiencing revictimization and how they can utilize different skills to implement when in a heightened state. When servicing victims of sex trafficking, the findings of this study show that

this patient population requires professionals to accommodate their treatment approach differently in comparison to how they would work with other patients of sexual violence. The therapeutic accommodations are made surrounding addressing the patient's feelings of shame associated with their trauma as well as delineating case management to prevent reenactment of dynamics of economic violations they endured when being sex trafficked.

When participants were asked what treatment approach could be harmful to patients who were victims of sex trafficking, respondents stated that failing to meet the patient where they are at was the most harmful. When a clinician fails to meet the patient where they are at, a number of consequences can occur, such as failing to make accommodations to meet the moment in which a patient may be in the midst of a crisis, failing to utilize a treatment approach that can be validating in contrast to facilitating their healing, or even pressuring a patient engage in working through their traumatic experiences without the appropriate coping skills to regulate their emotions. The consequences of a failure to meet the patient where they are at can lead some patients to become re-traumatized. As a result, these responses highlight the significance of meeting the patient where they are at; working with victims of sex trafficking may require a treatment plan to be longer in comparison to other patient populations.

Effective coping skills for victims of sex trafficking include engaging in body awareness techniques, distracting the patient from their triggers, and guiding the patient to better understand one's trauma and triggers in order for the patient to better regulate trauma reactions. Body awareness and distracting one's self from their triggers have been noted as effective for victims of sex trafficking, getting the patient to become more present when experiencing a trauma reaction. Moreover, these approaches may be particularly effective given the extensive abuse they have endured in also encouraging them to find safety in their bodies as a way to ground

themselves. These findings highlight the significance of the utilization of DBT and CBT skills, as well as the utilization of psychoeducation to provide the patient with greater insight into understanding why they may be reacting to a particular stimulus and how that relates to their trauma.

Therapeutically addressing racism as a way to inform the therapeutic space was an approach implemented by the majority of participants. According to the responses of the participants, it was important for the clinician to engage in the validation and exploration of their experiences of racism institutionally and structurally. Many of the clinicians would explore the patients' experiences of racism institutionally and structurally in how that relates to their traumatic experiences of being sex trafficked. However, addressing racism does not have to be in the overt sense as, according to the findings of this study, much of the way in which racism can be addressed involves the intersections of oppression given the identities and experiences of the patient. It is in considering these proponents that the clinician can obtain a greater understanding in how these factors impacted the patient’s experience of being sex trafficked.

Therapeutically addressing sexism was addressed by the majority of participants when working with victims of sex trafficking. According to the responses of the participants, it was important for professionals to therapeutically address reenactment behaviors as well as how to have healthy relationships with men. Addressing reenactment behaviors was noted as significant when working with victims of sex trafficking, as often times many victims of sex trafficking may have normalized abusive dynamics, especially with men. It was reported as significant for the clinician to guide the patient in developing an understanding of what a healthy relationship with men can look like in order to challenge the normalization of unhealthy abusive dynamics, which may have been normalized as a consequence of their experience being sex trafficked.

Therapeutically addressing incarceration was a part of the study where there was not much mutual agreement regarding a particular approach that could be most effective in addressing the patients' experiences; however, every participant that was asked this question noted its significance. The responses that were provided where literature supports the responses included supporting the patient to pursue legal services, as well as demonstrating understanding of the patient's perspective of being incarcerated. Pursuing legal services can be encouraged or supported by the clinician as a way to facilitate the patients' healing by getting their records expunged. However, it is significant to develop an understanding of the patient's perspective of being incarcerated in the context of what they understand to be a traumatic experience.

According to the results of the study, all of the participants reported that the treatment approaches that they utilized were successful in treating the needs of victims of sex trafficking according to their experience. When participants were asked to specify what a successful treatment outcome for a victim of sex trafficking would look like, the most reported response was for victims to demonstrate taking care of their mental health, such as being able to show that they could implement the skills that were learned in treatment to regulate their trauma reactions, as well as therapeutically work through their traumatic experiences. Additionally, having greater control in their lives was reported as a successful treatment outcome; control was described as an internal control in the patient gaining a greater understanding of themselves, their trauma, and how that impacts them, as well as developing greater control in feeling that they can positively impact and influence their life and environment. Implementing protective factors in the patients' life that can serve as a way to keep the patient in a support system of having employment, adequate housing, engagement in a day program, and other positive systems in their life in order to keep them out of slipping back into a sex trafficking situation. When participants were asked

to provide an example of a successfully treated patient, participants described a patient who was able to achieve their goals and obtain secure housing. These responses indicate that success often entails the necessities but also a non-tangible sense of accomplishment for the patient.

When considering termination of treatment for a patient who was a victim of sex trafficking, the respondents reported that the first step is to start the therapeutic relationship in the very beginning by informing the patient of termination of treatment that there will be a time when they will part ways. When the time does come for termination of treatment, evaluating the emotional preparedness of a patient for termination of treatment was noted as significant in making sure the patient is truly equipped with the skills and has yielded the benefits of treatment so that they will be able to manage their trauma reactions and have experienced a decrease in distressing symptoms.

When looking into how service providers for victims of sex trafficking feel when working with this patient population and if they would experience any emotional challenges, all participants reported experiencing emotions of sadness. Additionally, some participants reported experiencing vicarious trauma; it was reported that when working with victims of sex trafficking, listening to their experiences could also be triggering for professionals. Moreover, as a result of the emotional challenges that professionals can experience when servicing victims of sex trafficking, some participants reported that they needed to make sure that they carried out self-care activities in order to ensure that they could take care of themselves so that they can provide adequate services for the patients.

When participants were asked for their final thoughts, multiple participants reported that there needs to be further research done to understand the unique needs of victims of sex trafficking. These responses highlighted the significance of research such as this study.

Moreover, additional participants also noted that there is a lack of resources dedicated to servicing victims of sex trafficking to meet their unique needs for housing and longer treatment plans. A need for empowerment and a strengths-based treatment approach was also described as significant when working with victims of sex trafficking, pointing toward the importance of clinicians recognizing how resilient this patient population is.

Appendices

Appendix 1: Prescreening Survey Questions

1. What is your professional title or role?

2. How long have you been practicing Mental Health Care or providing these services?

3. Have you ever directly worked with or are working with clients that had a history of trauma due to sexual abuse or assaults?

4. Have you ever worked with or are working with clients that expressed an incident of being forced or coerced to engage in a sexual act?

5. Have you ever worked with or are working with clients who expressed unpleasant sexual experiences?

6. Have you ever worked with or are working with clients who expressed experiencing prior physical abuse or fear of physical harm?

7. Have you ever worked with or are working with clients who expressed being in a relationship where they are afraid to say no to their partner or other persons in close relation to the client?

8. Have you ever worked or are working with individuals who identify as sex workers or are engaged in prostitution?

9. Have you ever worked with or are working with individuals who identified as a survivor or victim of sex trafficking?

Appendix 2: Semi-Structured Qualitative Interview Questions

1. What is your gender identity?
2. What is your racial-ethnic background?
3. What is your educational background?

4. Tell me a little bit about yourself? What influenced you to go into the mental health profession?
5. How long have you been a mental health professional?
6. How long have you been in your present position?
7. Approximately how many clients or patients have you worked with that identified as sex workers or sex trafficking survivors?
8. Can you please describe any training you may have received to work with survivors of sex trafficking?
9. Was the training you described above provided through your academic programs, or did you have to pursue additional training? If yes, could you please describe that training in more detail?
10. Have there been times where you were able to identify a patient as a sex trafficking victim, and if you have, how so? Can you provide an example?
11. What have you found to be effective in building a therapeutic alliance with the patient?
12. What approach did you find most effective in getting the patients to build enough trust to build rapport to discuss their trauma and experience being sex trafficked? Could you please provide an example?
13. What diagnosis did you see as most common for the clients who had been sex trafficked?
14. When you were treating survivors of sex trafficking, what mental health approach or therapy did you utilize?
15. How has the way that the sex trafficking victim entered their trafficking situation impacted the course of treatment?

16. What coping skills have you found, in your experience, effective to implement in treatment when working with a survivor of sex trafficking?
17. When working with survivors of sex trafficking, what was the most effective way to therapeutically address racism that the patient experienced according to your professional experience? Could you please provide some examples?
18. When working with survivors of sex trafficking, what was the most effective way to therapeutically address sexism that the patient experienced according to your professional experience? Could you please provide some examples?
19. Were some of the patients who were survivors of sex trafficking ever arrested on prostitution charges or even incarcerated? How was this experience addressed therapeutically in treatment?
20. How would you feel when listening to the experiences of patients who are survivors of sex trafficking? Were there some emotional challenges that you would experience when providing treatment for this patient population?
21. Were there any therapeutic approaches and/or treatment models that you thought would be helpful for survivors of sex trafficking, but when you started using that particular approach, found that it was causing them more harm than good? Are there any examples you can provide?
22. Have you had to accommodate your treatment approach to be more effective for survivors of sex trafficking in contrast to other populations of sexual violence survivors? If yes, what were the approaches that you used?
23. What do you consider a successful treatment outcome for a patient?
24. Can you provide an example of a successfully treated patient?

25. In your professional opinion, was the therapy treatment approach you utilized successful in treating the clients' needs?
26. If the therapeutic goals were achieved, how did you prepare the patient for termination of treatment?
27. Is there anything that you have learned from treating previous survivors of sex trafficking that you have found valuable and effective in treating other survivors of sex trafficking?
28. Is there anything else you would like to share with me that I haven't asked or anything else you feel is important when providing treatment and working with this population?

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