

IMPACT OF WORKING WITH HUMAN SEX TRAFFICKING SURVIVORS

The Impact of Working with Human Sex Trafficking Survivors on Clinicians' Personal and Professional Lives

An Thai

Thesis submitted to the faculty of the Virginia Polytechnic Institute and State University in partial fulfillment of the requirements for the degree of

Master of Science
In
Human Development

Mariana K. Falconier, Chair
Marjorie Strachman-Miller
Bertranna Muruthi

August 7, 2017
Falls Church, Virginia

Keywords: human sex trafficking, clinicians, survivors, secondary trauma, self-care, resources

IMPACT OF WORKING WITH HUMAN SEX TRAFFICKING SURVIVORS

The Impact of Working with Human Sex Trafficking Survivors on Clinicians' Personal and Professional Lives

An Thai

ABSTRACT

This qualitative phenomenological study considered the experience of a clinician working with victims and survivors of human sex trafficking and their families. In the overwhelming majority of cases, family members were not involved in the clinical treatment of human sex trafficking survivors. The clinicians primarily worked with the individual client. The data from phone interviews was analyzed using thematic analysis, which resulted in the following themes emerging: vulnerability to secondary trauma, impact on the clinician's life, and self-care strategies and resources. The work with human sex trafficking survivors impacted the clinicians' personal, family, and professional lives. Limitations, clinical implications, and suggestions for future research are discussed.

Keywords: human sex trafficking, clinicians, survivors, secondary trauma, self-care, resources

IMPACT OF WORKING WITH HUMAN SEX TRAFFICKING SURVIVORS

The Impact of Working with Human Sex Trafficking Survivors on Clinicians' Personal and
Professional Lives

An Thai

GENERAL AUDIENCE ABSTRACT

This research study aimed to explore and understand how working with human sex trafficking victims and survivors impacted a clinician's life in a personal and professional way. The results showed that clinicians did experience change or influence from this work on their personal and professional lives. This study could be used to train future clinicians who would work with human sex trafficking victims and survivors.

Acknowledgements

The first and most important thanks I have to give is to my parents. Thank you for always being there and supporting me no matter what choices I made for my life and for my future. Thank you for the lessons you taught me about hard work, the pursuit of happiness, and the importance of healthy relationships. I would not be the person I am today or have the life I live today without your resiliency and determination to have a good life for yourself and your children. Thank you for everything you have done for our family.

I would like to specially thank my thesis committee for believing in me and sticking with me through the end of my thesis.

Dr. Mariana Falconier supplied me with endless encouragement, and I could not have asked for more support from such a caring person. Thank you so much, Mariana, for giving me the opportunity to learn from you and continue working with you in so many capacities. It is truly inspiring to see an example of how one person is capable of doing so much; the lessons about resiliency I have learned from you will never be forgotten.

Dr. Marjorie Strachman-Miller was incredibly generous with her time and support for me throughout my thesis process. From my earliest stages of formulating this research idea in Research Methods during my first year in the MFT program, Dr. Strachman-Miller has been guiding me and teaching me how to be a researcher in this field. It was due to her research experience and expertise in the field that I was able to lean on her in my most frustrating moments. The patience, humor, and kindness made me this whole process much more enjoyable and seemingly possible. Thank you, Marjorie, for not giving up on me and staying so interested through the past few years. You helped me see and reach the light at the end of the tunnel!

Dr. Bertranna Muruthi brought vast amounts of optimism and positivity during all our interactions from the moment we met. Thank you so much, Bertranna, for encouraging me and finding ways to show your support for my study even before you were on my thesis committee. I can't thank you enough for your uplifting chats when I felt stressed. Your experience and guidance is and always will be very appreciated.

I would like to thank Dr. Eric McCollum for his support throughout this process. Thank you so much, Eric, for providing the time and space for my ideas to grow and for this thesis to develop. Thank you for pushing me to go outside my comfort zone and for keeping me grounded. Thank you for seeing and understanding my vision for this study even when I couldn't put it into words.

Thank you to all the clinicians, professors, service providers, and contacts I made throughout my research process. Whether it was words of encouragement, a meaningful conversation, a potential participant referral, or any kind gesture, you all helped me to complete this study. I cannot thank everyone enough for the support and encouragement.

Thank you to my wonderful boyfriend, Jimmy Twomey. Thank you for being so patient and kind with me throughout this process. Thank you for the many meals made with love, and thank you for helping me find ways to laugh when I needed to most.

Thank you to my amazing friends and family who would check in on me and ask how thesis was going even though they hadn't heard from me in weeks. Thank you to my brother, sister-in-law, niece, and nephew, who provided me with many heartwarming meals and plenty of love. Thank you to my hilarious cousins, who were always willing to find ways to help me release stress after long work days. Thank you to all my best friends – your love and support was felt despite my absences. Thanks for still being there when I was ready to be social again!

Last but absolutely not least, thank you to my classmates, coworkers, and peers. The hours we've spent together had a lasting impact on me, and I drew motivation and inspiration from working with all of you. Thank you for constantly encouraging me. I'm thrilled to have shared this part of my life with you, and I send you all my best wishes for your future endeavors.

Table of Contents

CHAPTER 1: Introduction 1

 The Problem and its Setting 1

 Significance..... 3

 Rationale..... 4

 Theoretical Framework 5

 Purpose of the Study 6

 Research Question..... 6

CHAPTER 2: Literature Review 7

 Prevalence 7

 Trafficker’s Role 7

 Luring and Enticement of Victims 8

 Trauma Bond between Survivor and Trafficker 9

 Survivor’s Experience 9

 Identification/Comorbidity 11

 Society’s Role..... 12

 Approaches to Working with This Population 13

 Vicarious Trauma for Clinicians 13

CHAPTER 3: Methods 16

 Design of Study 16

 Participants 16

 Procedures..... 17

 Instruments..... 18

 Interview Outline..... 18

 Validity and Reliability 20

 Analysis..... 20

Reflexivity	21
Chapter 4: Results	22
Vulnerability to secondary trauma	23
Difference between human sex trafficking survivors and other trauma clients	25
Impact on the clinician’s life.....	27
Self-Care Strategies and Resources	31
Chapter 5: Discussion	37
Limitations.....	40
Clinical Implications	41
Future Studies	42
Conclusion	43
References.....	45
Appendix A.....	49
Appendix B.....	50
Appendix C.....	53

CHAPTER 1: Introduction

The Problem and its Setting

Research suggested that within the next ten years, human trafficking would surpass drug and arms trafficking in terms of profits and incidences. As an illegal activity, human trafficking has one of the lowest risks and highest profit margins due to the ability to house victims in substandard living conditions where they can be sold and resold (Jordan, Patel, & Rapp, 2013). Human trafficking has been gaining more and more attention from multidisciplinary perspectives. The United Nations' (UN) definition of human trafficking, as quoted by Yakushko (2009), is

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

Victims of human trafficking were easy to misidentify or overlook because these terrorized individuals have been forced to appear compliant and submissive, which was mistaken for consent; the fraud and coercion tactics traffickers use on their victims were difficult to prove (Reid, 2012). Approximately 500,000 to 2,000,000 individuals were annually trafficked worldwide, and researchers estimated that 27 million victims of human trafficking exist today (Jordan, Patel, & Rapp, 2013). Yakushko (2009) reported that 80% of trafficking victims were women, and 75% of victims were 25-years-old or younger. Accurate statistics on human sex trafficking were difficult to measure due to the secretive nature of the activity and the victims

being a well-hidden population (Perdue, Prior, Williamson, & Sherman, 2012). The prevalence of human trafficking was shocking to most people, which was why awareness was imperative.

Although there were two types of human trafficking: sex trafficking and labor trafficking, this study focused only on human sex trafficking. The United States Congress passed the Trafficking Victims Protection Act (TVPA) in 2000, which defined sex trafficking as “when a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age” (Hardy, Compton, & McPhatter, 2013, p. 8). The TVPA identified those who were under the age of 18 as victims, no matter if force, fraud, or coercion was used in their recruitment. Despite the distinction of labeling the youths as victims, there were still people who viewed those who were enslaved in the commercial sex industry as offenders and delinquents (Kotrla, 2010). In the United States, sex trafficking of minors was occurring with annual exploitation ranging between 200,000 and 300,000 individuals (Hardy et al., 2013). With such a huge portion of domestic trafficking victims including the children of our country, it was no wonder that most of the research focuses on the sex trafficking of minors.

Domestic minor sex trafficking (DMST) was the “modern-day slavery of children” (Kotrla, 2010, p. 181). Prostitution, pornography, stripping, escort services, and other sexual services were all forms of DMST. The average age of recruitment was between 10-14 (Hardy et al., 2013). There were at least 100,000 DMST victims, with up to 325,000 more possible victims at risk. DMST victims were most often children who were known as or misidentified as runaway or abandoned children who had left or were kicked out of their homes and families; at least 70% of women involved with prostitution were first introduced to the commercial sex industry as minors (Kotrla, 2010).

Significance

Research in this field has identified major risk factors for young victims of DMST. Hardy et al. (2013) reported that 70-90% of female trafficking victims experienced sexual abuse prior to their recruitment. The victims also usually displayed the following risk factors: deficiencies in social skills, criminal behavior, involvement in gangs, family dysfunction with domestic violence and substance abuse, and mental illness of caregivers. Along with troubled family backgrounds, these victims also came from backgrounds of especially low socioeconomic status and low education (Jordan et al., 2013). Under any usual circumstances, this would be the profile of many troubled adolescents.

According to Jordan et al. (2013), oftentimes these children left their homes due to physical, sexual, and psychological abuse, which made them extremely vulnerable with low self-esteem. Reports said that it was within 48 hours that the child was approached by sex offenders, pornographers, and pimps to participate in prostitution or other forms of sexual exploitation (Jordan et al., 2013). Victims were approached at malls or public places where children wander unaccompanied. There was a grooming period during which the pimp plays the role of the victim's boyfriend, showering her with gifts to gain her loyalty and trust (Kotrla, 2010). "Traffickers also recognize the victim's natural desire for love, protection, and family, thus using this desire as a source of manipulation" (Hardy et al., 2013, p. 11). Once entered into DMST, victims became unable to leave due to the continuation of manipulation, coercion, and abuse from their perpetrators (Hardy et al., 2013). It took a great deal of effort for these victims to leave their trafficking conditions, and that effort can include help from law enforcement, social workers, and medical professionals (Hardy et al., 2013). Once they escaped or were rescued, the survivors faced the difficulties of returning home to make a life independent of sex trafficking.

Research involving treatment for the victims once they had escaped sex trafficking is lacking, but that meant that there was plenty of room for growth and further development. Current research focused on different mental health professionals who worked from many different backgrounds such as social work and child psychiatry. Mental Health Professionals are encouraged to work from a client-centered, trauma-focused approach (Countryman-Roswurm, 2014).

Jordan et al. (2013) referred to models that show potential to effectively treat sex trafficking survivors after they had escaped captivity. One major domain to address with sex trafficking survivors was “reintegration into society—whether that is back to their home of origin or in their new surroundings” (Jordan et al., 2013, p. 363). Since reintegration was such an important process, it would be beneficial to understand properly how reunification works and the clinician’s role in the family’s reunification. Studying the experiences of clinicians who have worked with families going through the reunification process after a child has been trafficked would benefit all mental health professional fields in which a clinician might encounter such a clientele. In particular, marriage and family therapists should have more of an understanding of how their systemic work might influence these families in a beneficial way. This study aims to provide more information on future training topics for clinicians wishing to learn more about how to work with the human sex trafficking victims and survivors population.

Rationale

A qualitative methodology was used in an effort to expand the group of helping professionals working with this population to include marriage and family therapists. Creswell (2013) suggested using a qualitative study design when researching a topic where there is little known. It was important to learn more about clinicians’ experiences in other fields in order to

understand where the clinical field stood in terms of how to work with this population and what it was like for the clinician to work with this population. There have been various trainings and concentrated human sex trafficking task forces that have experienced varying degrees of success in treating these families. Individual interviews with the participants allowed for each participant to share their personal experiences of working clinically with the human sex trafficked population without fear of judgment from others who might have had differing viewpoints or who were in different stages of their lives or careers. The phone interview was the chosen interview method because participants were in varying locations around the United States, and the telephone communication removed the barrier of geographic location from the study eligibility criteria for participants. The information shared during the interview could have been sensitive information, and the participants had not always met the researcher in person prior to the interview. Not holding the interview in-person made the lack of familiarity with the interviewer less uncomfortable for both the participants and the interviewer. Any bias toward physical features was removed by not having the interview face-to-face.

Theoretical Framework

The theoretical framework that guided this study was phenomenology. Since each participant's experience of working with families in which a child has been sex trafficked might have been different from the others, it was important to keep in mind that every clinician has accepted and given meaning to the experiences based on his or her unique circumstances. "They develop subjective meanings of their experiences...These meanings are varied and multiple, leading the researcher to look for the complexity of views rather than narrow the meanings into a few categories or ideas" (Creswell, 2013, p. 24). The researcher learned about each participant's experience and the impact that this work had on the participant's lives in different capacities.

The researcher learned about the emerging phenomenon of clinicians working with this population by understanding how each participant developed the meaning of their experiences of working with human sex trafficking victims, survivors, and/or their families. The meanings made from their experiences may have come about through unique circumstances, but the described meanings behind the experiences was similar throughout the study sample.

Purpose of the Study

The purpose of this study was to understand the experience of clinicians working with families of human sex trafficking survivors during the reunification process. Reunification was understood to be the survivor reintegrating back into society as well as back home with their families. At this stage of the research, the families of human sex trafficking survivors in the reunification process are generally defined as families who have had a child sex trafficked and returned home and are seeking family therapy with a clinician (counselor, therapist, social worker, psychologist, psychiatrist, etc.). During interviews, it was found that most survivors did not reunify with their families, and the clinical work was focused more on reintegrating the survivor back into society. Working with the human sex trafficking population impacted clinicians in a way that was worth exploring; the vicarious trauma that this work can cause was shown in the interviews.

Research Question

1. What is the experience of a therapist working with sex-trafficking victims?
 - a. How does this work impact a clinician on an individual level?
 - b. How does this work impact a clinician on a family level?
 - c. How does this work impact a clinician on a professional level?

CHAPTER 2: Literature Review

Prevalence

Human sex trafficking research has been lacking accurate statistics on the prevalence of victims. In a study done by Brennan in 2008, it was claimed that misinformation from focused trafficking research led to little empirical scholarship and particularly lacked writing done by survivors. Perdue, Prior, Williamson, and Sherman (2012) and Todres and Clayton (2014) stated that the lack of estimates of numbers of youth victims is due to the secretive nature of trafficking and the difficulty of measuring populations that remain hidden. Since the data cannot be reliably collected, the current statistics were controversial (De Chesnay, 2013). This posed complications for researchers who would like to assess the severity of this issue in the United States. This lack of accurate information about the magnitude of human sex trafficking presented as an opportunity for researchers to continue proper research on this issue, while employing better ways of obtaining those accurate numbers.

Trafficker's Role

Traffickers utilized various types of power and control methods in order to retain their victims. Marcus, Horning, Curtis, Sanson, & Thompson (2014) found that for young victims, there was a clear pattern of traffickers increasing the levels of control over working conditions over time; physical means of ongoing control were less common but more enduring and more abusive. While being trafficked, a trafficking victim typically experienced beatings, gang rapes, and threats of harm to the victim or family members of victims (De Chesnay, 2013). Traffickers maintained power and control over a victim through coercion and force, and it was clear how dangerous traffickers can be to a victim's well being. In some cases, the adult in charge of the victim's well being was the one endangering it. Kotrla (2010) stated that "familial prostitution"

(p. 184) forced victims to perform sexual acts in exchange for monetary and other goods for parents or relatives of the victims, whom the victims generally viewed as safe people. The impact of familial prostitution seemed to further complicate the process of reunification with the family after the survivor has been able to leave the trafficking situation.

Luring and Enticement of Victims

There was a misconception that DMST victims were particularly vulnerable due to their backgrounds or their families' circumstances. Traffickers could prey on adolescents with addictions or needs for food and shelter by using those vulnerabilities as motivation for participating in sex work due to the possible monetary gains (Hickle & Roe-Sepowitz, 2014). While certain risk factors can expose women to sex trafficking, the literature showed that DMST was a nondiscriminatory crime. De Chesnay (2013) stated that children from all family backgrounds, dysfunctional and healthy, are at risk for sex trafficking. Traffickers knew how to target adolescents and convinced them to follow along with what the trafficker has in mind. Traffickers often did not kidnap their victims; they could meet when victims willingly going out with friends to a place where the trafficker used charm and flattery as an introduction (De Chesnay, 2013). Kotrla (2010) found that traffickers searched the Internet via Facebook and MySpace for potential victims, and they posted advertisements of children for sexual purposes through hundreds of websites. The grooming period was the beginning of the relationship between a trafficker and victim when the trafficker usually posed as a potential victim's admirer and then boyfriend, showering the victim with gifts to gain trust and loyalty (Kotrla, 2010). As frightening as the traffickers' tactics were for keeping their victims under their control, traffickers could use placid strategies for introducing themselves into victims' lives.

Trauma Bond between Survivor and Trafficker

While they were trafficked, survivors usually had a strong relationship with their traffickers due to the purposeful acts of control that the traffickers practiced. Those acts of control served the purpose of creating a trauma bond. Jordan, Patel, & Rapp (2013) defined trauma bond as “a form of coercive control in which the perpetrator instills in the victim fear as well as gratitude for being allowed to live” (p. 361); traffickers used reward and punishment as well as acceptance and degradation to produce this loyalty in their victims. The trauma bond created a false sense of safety and connection for the victim to the trafficker, which could be difficult to break even after reunification with the family. When reintegration and reunification became overwhelming or too challenging, survivors might have returned to their traffickers because their traffickers deeply instilled a sense of trust between them (De Chesnay, 2013). Survivors might not be ready to accept that the person they thought they had a genuinely compassionate relationship with was taking advantage of them through coercion and shame (Marcus, Horning, Curtis, Sanson, & Thompson, 2014). The trauma bond between a trafficker and victim could be strong enough to withstand the survivor returning home, and the survivor could return to being a victim if the trafficker was still perceived as a safer person than the family members.

Survivor’s Experience

While a survivor was trying to make sense of the experience of being trafficked, it was imperative for those in charge of support during reunification to understand the difficulties a survivor must face upon returning home. De Chesnay (2013) stated that many victims resent the label of victim because they did not view themselves as such. The study went on to describe this as an autonomous response to the rejection survivors feel from the term “victim”. McIntyre

(2014) found that survivors reported feeling a loss of identity when “‘what’ happened to her becomes seen as ‘who’ she is” (p. 45). The survivor’s identity could be compromised as a result of the trauma endured while being trafficked, and reunifying with a family and community that mislabels the survivor could exasperate the loss of identity. As helpful as family members, community members, and other service providers would like to be, sometimes the survivor needed time to come to their own understanding before being able to accept others’ support.

Martin (2013) found that there was a profound disconnection between the survivor and systems of care by families, communities, and other basic human supports. Resentment could build up over time after the survivor returns to a family that struggles to understand the difficulties that the survivor faced while still a victim (Brunovskis & Surtees, 2012). A study done by Brunovskis & Surtees (2012) found that survivors exhibited behaviors indicative of stress, anxiety, fear, shock, confusion, suspicion, shame, anger, irritability, and depression. These feelings and behaviors could easily overwhelm the survivor upon returning home, where unhelpful coping skills could lead to further struggles during reunification. McIntyre (2014) found that survivors had destructive coping abilities due to their dissociative survival mechanisms; these included self-harm, suicidal ideation, homicidal behaviors, and substance abuse. Survivors often learned those skills to dissociate from the trauma they were experiencing during trafficking, however, those behaviors can be damaging to the reunification process.

Survivors instinctually protected themselves using ways they have learned after experiencing trauma. While they were trafficked, survivors had tapped into their own strengths to find their way to safety. In the reunification process, survivors’ inner strengths and resources must be maintained and continually developed to adapt to the newer, safer environment, all while protecting them from future threats (McIntyre, 2014). When the survivor and family were in

treatment during the reunification process, clinicians must have kept in mind the resiliency that the survivor has displayed. By remaining open and non-judgmental, clinicians could provide a safe space where survivors can share their stories without the daily danger, chaos, and stigma that they face from others (Martin, 2013).

Identification/Comorbidity

The secretive nature of DMST not only made researching this population difficult, but it also made it difficult to identify victims and survivors. Because victims did not usually self-identify as such, clinicians could be left wondering how to properly approach a potential victim of DMST. An added layer was that there were currently no validated protocols to guide service providers through identifying DMST (Todres & Clayton, 2014). Identification of DMST pulls from assessment of other complex trauma symptoms, usually resulting from maltreatment of children and interpersonal violence (Todres & Clayton, 2014). DMST could affect children of any age and any background. Macy & Graham (2012) and Jordan, Patel, & Rapp (2013) found that service providers could expect to encounter trafficking victims as clients in agencies related to child advocacy, child protection and welfare, criminal justice, domestic violence, health care, homelessness outreach and shelter, juvenile justice, and victim advocacy. Most outreach programs were meant for female youth, which left gay, bisexual, transgender, and queer male youth at higher risk for misidentification (Ijadi-Maghsoodi, Tood, & Bath, 2014). Clinicians and all other service providers should be prepared to meet this population in a number of different settings, however, the lack of specific guidelines left clinicians vulnerable to misidentifying and mistreating these victims and survivors.

The symptoms of the complex trauma that DMST victims and survivors have experienced were similar to symptoms exhibited by victims and survivors of other traumas.

Johnson (2012) found that typical symptoms included attachment issues, affect or emotional regulation, dissociation, behavioral control, cognition, and self-concept. The aftermath of DMST was often diagnosed as post-traumatic stress disorder, dissociation, and anxiety; depression, lack of self-esteem, shame, and guilt is often prominent with these clients (Hom & Woods, 2013).

Jordan et al. (2013) found that there was comorbidity with dissociative disorders, substance abuse disorders, conduct disorders, attention-deficit/hyperactivity disorder, obsessive compulsive disorder, post-traumatic stress disorder, depression, and anxiety. These major diagnoses could be difficult for clients to manage and for clinicians to help clients manage.

Society's Role

The social stigma of human sex trafficking can be tough for adolescent survivors to face upon leaving the trafficking situation. Brennan (2008) identified two connotations: sex trafficking has come to include all forms of labor trafficking, and linking voluntary prostitution with sex trafficking by including voluntary adult sexual exchanges in sex trafficking. Though sex trafficking and labor trafficking share similarities in the forced nature of the victim's participation, the two subjects were separate issues. The seemingly bigger social morality debate (Brennan, 2008) was whether or not to include voluntary prostitution participants with involuntary sex trafficking victims under the sex trafficking umbrella. Prostitution was considered socially unacceptable and stigmatized, which challenged domestic minor sex trafficking (DMST) victims to shift their own self-perceptions from "criminal to victim" (Kotrla, 2010, p. 182). The treatment required in order to help DMST survivors make that shift within themselves also requires societal and familial support. McIntyre (2014) found that when communities failed to provide social protection resources for their members, children and their families experienced struggles in the subsystems' abilities to care for themselves and one

another. When a DMST survivor returned home or reintegrates into society, that adolescent would need support from the family as well as the community in order to reintegrate back into society.

Approaches to Working with This Population

Clinicians did not have complete resources for working with this population in terms of a step-by-step guide on how to treat these survivors. There were some principles that have been adopted from various models of therapy and treatment models for other complex traumas that seemed to apply well to these clients. Countryman-Roswurm & Bolin (2014) stated that the primary principle was that services are survivor-centered, meaning that the survivors of DMST remained experts of their own lives and were leaders in their path of recovery throughout treatment. Treatment seemed to work best with a collaborative approach among a team of multidisciplinary practitioners. Recommended therapy models included Trauma Focused Cognitive Behavioral Therapy, Dialectical Trauma Focused Cognitive Behavioral Therapy, Expressive Therapies such as Art and Music Therapy (De Chesnay, 2013), Eye Movement Desensitization and Reprocessing (Kotrla, 2010), and Group Therapy (Hickle & Roe-Sepowitz, 2014). Using a holistic approach allowed for exploration of DMST survivors' experiences, vulnerabilities, and needs after having gone through so much intense trauma (Marcus, Horning, Curtis, Sanson, & Thompson, 2014). Clinicians could practice flexibility when working with these clients in order to tailor services directly toward helping the clients reach goals they had set for themselves.

Vicarious Trauma for Clinicians

Clinicians had the role of helping clients process the tough experiences they have throughout their lives. When it came to cases with high levels of trauma, it was worth

considering how the clients' trauma may have affected the clinicians. When clinicians heard their clients' stories of traumatic experiences, they sometimes developed symptoms similar to that of post-traumatic stress disorder even though they had not been directly exposed to the trauma (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015). This was called vicarious traumatization by McCann & Pearlman (1990). Finklestein et al. (2015) found that clinicians could be more susceptible to vicarious traumatization when they had higher professional caseloads, lower numbers of coping resources, conflicting feelings about professional and family responsibilities, and higher senses of uselessness, insecurity, and helplessness in regards to professional self-efficacy. When working with the human sex trafficked population, clinicians should be aware of the risk for experiencing vicarious trauma especially considering the complex trauma that human sex trafficking victims and survivors describe.

A study done by Way, VanDeusen, Martin, Applegate, & Jandle (2004) found that a shorter time working with survivors of sexual abuse or sexual offenders resulted in higher levels of vicarious trauma for clinicians. The study hypothesized that this finding was due to newly trained, inexperienced clinicians leaving the field soon after starting to work with this specific population (Way et al., 2004). Vicarious trauma levels were lower for clinicians who practiced self-care and had longer exposure in the field (Way et al., 2004), which suggested that clinicians should adapt their self-care as they continue to work in this field. Clinicians who started out working with a highly traumatized early in their careers should structure their self-care strategies to prevent as much vicarious traumatization as possible; clinicians with more experience working with highly traumatized populations should continue building and reinforcing their self-care strategies.

Clinicians assessed their clients' protective factors during treatment, and they should have done the same for themselves when working with this population. Harrison & Westwood suggested that clinicians put clear boundaries, active optimism, holistic self-care, and regular supervision into place as protective factors against vicarious trauma (2009). It was also suggested that clinicians embrace the trauma that their clients may expose the clinicians to because both the client and clinician learned to heal through that connection (Harrison & Westwood, 2009). Clinicians were strongly urged to seek regular supervision and have extra time dedicated to self-reflection and self-care when working with highly traumatized populations (Harrison & Westwood, 2009), which would include the human sex trafficking population.

CHAPTER 3: Methods

Design of Study

A qualitative study design was used to learn more about the experience of a clinician working with families during the reunification process after a child has returned from being sex trafficked. This study employed a phenomenological design to learn more about this phenomenon. The study of the clinician's experience included the clinician's roles, strategies, strengths, and challenges when working with this population. Participants first completed a brief demographic survey. The phenomenon was studied through individual phone interviews with clinicians who have worked with families during the reunification process after a child has been trafficked and has returned home.

Participants

Participants in this study were clinicians who have worked with families during the reunification process after a child, who has been sex trafficked, returns home. In order to meet the criteria for participation in this study, clinicians must have worked with more than one family in this population and have followed at least one family through the reunification process in order to ensure crisis assessment and continuation of therapy. Any mental health professional with a therapy or counseling practice was eligible for participation; clinicians were not restricted by their specific licenses. Ideally, at least eight participants would have been recruited for this study. The clinicians participating in this study could have been, and most likely were, scattered around the country. Participants were recruited through email flyers sent to the Marriage and Family Therapy listserv in the Northern Virginia area as well as the National Center for Missing and Exploited Children's list of associated clinician referrals. Participants were not compensated for participation in this research.

Procedures

Approval from the Institutional Review Board was obtained before research can begin. Once approval was obtained, the researcher sent out recruitment emails containing the recruitment flyer, which contained information about the study as well as participant criteria. When potential participants contacted the researcher, the researcher conducted a brief screening phone interview to assess participants' qualifications for this study. After participants qualified to participate in the study, the researcher sent the consent form for participation in this study to the participants via email. After consent was obtained, the researcher scheduled a time to conduct a phone interview with the participant.

When the scheduled phone interview time arrived, the researcher began conducting the interview. The researcher started with a demographic questionnaire that asked for information about participant's age, gender, cultural background, field of work, and how long the participant has been working with this population. Phone interviews ended with the researcher debriefing with the participant.

The semi-structured individual phone interview was recorded for transcription as well as for the purpose of verifying information later on when analysis was conducted. The researcher also kept field notes for verification purposes throughout the interview. After the interviews were finished, the researcher transcribed the interviews for further analysis. All materials, including audio recordings, documents, and data, were kept in a secure location and remained confidential. All materials containing identifying information about participants was kept locked in a secure location where the researcher was the only person with access to that information. After completing analysis of the data, all data was securely destroyed.

Instruments

The demographic questionnaire was used to obtain information about participants regarding their age, gender, cultural background, field of work, and length of time working with this population. A semi-structured interview with open-ended questions was conducted to explore the following research question: What is the personal, professional, and family life impact of working with human sex trafficking survivors and their families on clinicians?

Interview Outline

1. Introductions and Permission/Informed Consent

Thank you for agreeing to participate in this research. The purpose of this interview is to understand and describe the impact that working with families who are reuniting with a sex trafficked family member has on a clinician's personal and professional life. This study aims to help educate clinicians on the potential impact of working with this population as well as the importance of self-care. The interview should take between 30-45 minutes to complete. Our conversation will be recorded for accuracy. Do I have your permission to record?

2. Demographic Questions:

- a. Age _____ ?
- b. Gender _____?
- c. Cultural Background _____ ?
- d. Field of work _____?
- e. How long have you been working with this population? _____

3. Interview Questions:

A. What has been your experience working with families of human sex trafficking survivors during the reunification process?

- a. How did you become involved with treating families who have been reunified with a sex trafficked family member?
- b. What are rewards of working with this population?
- c. What are the struggles of working with this population?
- d. What has been your emotional experience while helping these families to navigate the reunification process?
- e. What impacts have you noticed in your professional life, if any?
- f. What impacts have you noticed in your personal life, if any?
- g. How has this work impacted your own family life, if at all?
- h. Have you noticed within yourself any symptoms of trauma associated with working with these families?
- i. How might working with this population feel different than working with other types of trauma cases?
- j. What self-care do you engage in to take care of yourself in order to work with this population?
- k. What are other approaches to self-care that you might recommend to newly starting clinicians, who are working with this population, that you may or may not utilize yourself?
- l. What support or resources have been helpful?
- m. What support or resources have not been helpful?

Those are all the questions I have for you today. Thank you so much for your participation. The interview is done, and you may leave now if you do not have any other questions or concerns that I could address at the moment. If you have any questions please feel free to contact me.

Validity and Reliability

A second coder reviewed and coded all transcripts to ensure inter-coder reliability. Validity was established by peer review and triangulation using field notes.

Analysis

The researcher used Braun & Clarke's (2006) thematic analysis, a six-step process, to analyze the data from this study. The first step included familiarizing the researcher and second coder with the data through transcribing the interviews, reading and rereading the transcripts, and taking notes on initial ideas. The researcher then generated initial codes by systemically marking data throughout the transcripts that related to each code; the second coder also generated initial codes. The researcher and second coder discussed the initial codes that were generated, and a list of codes was generated to give to the co-chair for review. The co-chair reviewed the list of codes and discussed the emerging themes with the researcher. The researcher edited the code list to reflect the emerging themes in the data. The researcher then reviewed the themes to check how they related to one another to create a map of the analysis. Then, the researcher defined and named the themes to clearly define each one. The co-chair reviewed the codes and themes and gave final approval. The final step was to produce the report, which included finding directly relevant examples as part of the final analysis. These examples were direct quotes from the participants during the interviews.

Reflexivity

The researcher had experience with the human sex trafficking field through trainings on how to work with this population as a clinician. The researcher also had volunteered with organizations that supported victims and survivors of human sex trafficking for the past four years. This experience served to inform the researcher about some common practices when working with this population, but this could also present an opportunity for bias while coding the data. The second coder had no previous experience with the human sex trafficking population, which allowed her to remain more objective than the researcher when reading through the transcripts. Despite this potential bias on the researcher's part, both the researcher and second coder reviewed the same data and ended up generating similar codes and themes.

Chapter 4: Results

Participant #	Gender	Age	Cultural Background	Field of Work	Length of Time Working with This Population
1	Female	25	Asian	Public Policy	2 years
2	Female	39	Asian	Social Work	10 years
3	Female	42	Asian	Counseling	3 years
4	Female	72	Asian	Case Management	9 years
5	Female	36	Caucasian	Social Work	7 months
6	Female	34	Latino	Social Work	10 years

A total of six participants participated in this study. All six participants were female; their ages ranged from mid-20s to early-70s. Two participants were single women with no children, and four participants were married with children. The length of time working with the human sex trafficking population ranged from 2 years to 10 years. The clinicians all had experiencing working with human sex trafficking victims and survivors in a clinical capacity, but only three of the participants had experience working with the survivors’ families during the reunification process. The participants reported that oftentimes, clients’ families were involved in the trafficking itself or in general did not provide a healthy environment to which the client could return. Due to the lack of healthy family support, clinicians did not work with reunifying the clients with their families; instead, clients worked on reintegrating back into society.

The findings from the participants’ interviews and data analysis show that each participant was impacted by their work with the human sex trafficking victims and survivors population. The participants shared their experiences and ways that this work has impacted their

lives on individual, relational, and professional levels. Each participant had unique meanings for their experiences that they spoke about, and there were several similarities among the participants' experiences and meanings made from those experiences. The participants made meaning of how their experiences were similar if not parallel to their clients' experiences of trauma, whether they explicitly labeled the secondary trauma or not. Along with experiencing similar trauma to that of their clients', participants also spoke about sharing similar self-care activities and resources as their clients' used. The themes that emerged from the interviews that described the clinician's experience of working with human sex trafficking survivors were vulnerability to secondary trauma, the difference between working with this population and other trauma populations, impact on the clinician's life, and self-care strategies and resources.

Vulnerability to secondary trauma

When asked about their own secondary trauma symptoms, all participants responded that they could recognize secondary trauma symptoms within themselves during their time working with this population. The themes that emerged were different secondary trauma symptoms and what it was like to experience the symptoms.

Secondary trauma symptoms. All six participants reported having experienced secondary trauma symptoms within themselves while working with the human sex trafficking population. Participant 2 (P2) described her experience as a struggle between hearing the horrible things clients would report at work and having to come home to live life normally with her family while experiencing secondary trauma symptoms. Participant 5 (P5) summarized the experience by saying,

I mean, sometimes if I have a really bad one, I will go home and feel like shitty about it or just like what could I have done better or what could I have done differently or just

like, you know, but I think that's normal, I'm not like – I think it's the normal sort of vicarious trauma thing.

Hypervigilance. Four participants reported experiencing hypervigilance after having worked with the human sex trafficking population. They reported that when they were going about their daily lives, they noticed hyperawareness of their surroundings and how others might be perceived as partaking in human sex trafficking. Participant 3 (P3) stated,

...I always try to think, 'Is this trafficking? Oh, is this domestic violence? Oh, is this trafficking?' Being more ...cautious when seeing things in the community, or seeing things, or hearing things. Stories similar like that around me or in the community.

Uncontrollable crying. Two participants reported that they experienced uncontrollable crying during and after listening to clients' stories about being human sex trafficked.

Participants reported that they were not supposed to show emotional breakdown while with the clients, but sometimes it would be too difficult to hold back tears. Participant 4 (P4) stated,

Sometimes the supervisor tells me, "[P4]! Don't cry, okay! I saw tears in your eyes okay! Control yourself! You are second-degree traumatized." When I say something to them, not with the clients. When the clients left and the supervisor talk to me, and I cry...

"Calm down, calm down! You are secondary traumatized!" Sometimes in the meetings, I spoke to other agencies. Because I love them, I cannot control my tears or my eyes. My tears in my eyes. Because I love them and I can't help them.

Even after they had left their meetings with clients, the participants found themselves crying at inappropriate times or always tense and felt as though they were about to cry. P3 stated, "And getting, getting emotional. Very upset easily. I remember that time, yeah. Oh, very tense. I was very tense and always like I'm ready to fight. Or I'm ready to break down any time."

Difficulty sleeping. Two participants reported experiencing issues with sleeping. Both participants stated that they lacked sleep early on in their careers working with the human sex trafficking population due to nightmares. Participant 6 (P6) stated, “Besides early on, the nightmares that I experienced and the hypervigilance, I can't think of any others,” when asked if she could think of any other trauma symptoms she may have experienced while working with this population. P3 reported that her “lack of sleep” was really memorable for her when asked about trauma symptoms she recognized within herself.

Difference between human sex trafficking survivors and other trauma clients.

Participants shared their perspectives on why or how clients who had been human sex trafficked were different from other clients who had experienced trauma. When asked how this population differs from other traumatized populations, participants stated that this population had more severity in trauma and therefore needed more than other types of trauma clients. The participants' time working with these clients had different rules than when working with other trauma populations. The themes that emerged were severity of trauma and unknowingly working with the human sex trafficking population.

Severity of trauma. Five participants reported that they believed clients who had been sex trafficked were more severely traumatized than other trauma clients who may have experienced sexual trauma. P4 explained her rationale by saying,

I think that the victims of sex trafficking are the worst. Yes, they need help a lot.

Sometimes they were sex trafficked, labor trafficked, and sometimes domestic violence as well. Some victims were both sex trafficked, human trafficking, and then domestic violence. They are victims of all kinds of suffering. But domestic violence, because they were afraid, but by their husband. That's less terrible than by anybody in the world.

P6 described it by stating,

The difference is severity. Even though I tell my clients at the end of the day, the severity doesn't matter, it's still that emotional pain that we all feel, it's still the severity of the experiences when you hear what has happened to them, and also the treatment is longer. You know, with my sexual assault survivors, usually a year – we're at a good point, a year to 18 months. But with my trafficking survivors, we're really building on that trust, I'm seeing that the first like few months, I'm just trying to build their trust and have them just slowly open up to me because they've had people who have hurt them and now they don't know what to do in regard to meeting new people. It's definitely been the difference, the severity, obviously, the experience, losing that trust.

When asked how long her average human sex trafficking cases were in treatment, P6 stated that they often ran away, which extended their time in treatment. P6 reported that her average human sex trafficking survivor was in treatment on-and-off for about two years.

Unknowingly working with human sex trafficking population. The participants were clinicians who had been working in the field with survivors of human sex trafficking for at least seven months. The participants stated that they came to this field unknowingly. Four participants stated that they had started out working with victims of domestic violence at the beginning of their clinical careers. They realized that there was more than just domestic violence going on in their clients' stories of trauma. As they learned more about the human sex trafficking field and what signs to look for, the participants became the experts in their organizations or geographic areas. The participants began receiving more and more referrals for clients with human sex trafficking issues until some of them exclusively saw human sex trafficking clients. P3 described,

...the majority of my human trafficking victims were in the intersection of domestic violence and human trafficking...it's really hard for us to work with them and try to educate them on pretty much everything...they called us to get help with domestic violence but when the attorneys in the office screened them we just, we realized that they're not only victims of domestic violence but also human trafficking.

Impact on the clinician's life

The participants were asked about the impact of working with the human sex trafficking population on their personal, family, and professional lives. Participants gave insight into how they viewed their personal, family, and professional lives affected or changed due to their work with this specific population. Working with this population changed participants' worldviews and the way that they related to other people in their lives. Participants were able to give examples of these impacts.

Personal impact on the clinician's life. Participants described how they were impacted on an individual level by this work. Three participants reported that their individual reactions and emotions changed after working clinically with the human sex trafficking population. Participant 1 (P1) stated,

I'm a lot more...cynical than when I first started. I wouldn't say that I have the most patience in the world, but I would say I have way less patience and tolerance for BS...Meaning, things that I don't see as problems like before working there I'd be like "Oh, yeah, okay, yeah, that's really hard." You know, whoever I'm talking to like, "I'm really sorry you're experiencing that blah blah blah I can see why that's a struggle," but now it's kind of like, "I don't think that you should be freaking out about that. That's not

really like a big deal,” and ”Let's move on type of thing.” I think I've become less patient and more cynical in terms of what I give my attention and my emotional capacity to.

Three participants reported feeling emotional burnout or numbness due to the difficulty of their clinical work with the human sex trafficking population. P2 stated, “I've experienced a certain level of burnout. So I've had, you know, months where I think it's been really hard to go to work because you experience a certain kind of numbing because the work itself can be so, so challenging.” P2 further discussed her emotional burnout:

I definitely think that as stress of the work because this work requires so much of yourself. And it requires so much emotional availability. And that, that's the very thing that's gonna get you in the end and I think that's the problem. Because when you become emotionally available to the work, that means that you're gonna be hurt by the work.

You're gonna be pained when you hear the kind of things that you hear and see the kind of things that you see. I never imagined in my entire life that people could do these kinds of things to other people.

Family impact on the clinician's life. When asked about how this work impacted their family lives, participants responded with how their relationships have changed with family and friends. The way that they relate to other people in their lives changed due to their work in this field with this population.

Three participants reported that their work impacted the way they viewed themselves as parents. One of these participants stated that she has decided not to have children at all. Two participants discussed how having their own children affected their work by making them more aware of human sex trafficking around them and their families. P2 stated

Part of it is having children, and you know, you just see things differently when you have children of your own. So I would say that I am probably more protective than the average parent. I don't know if that's a good thing for my kids or not, but I've seen some really horrible things happen to kids and young people so I am extremely careful with my kids, probably too careful. So I think that that has had, has taken its toll in some ways...I think that the catch-22, is that you open your heart to feeling pain for these young people and then you carry that home and then try to figure out how to put that aside and still live a regular life, right? So you know, nobody outside of this system could even imagine the kind of trauma these kids go through. So I might have a work day where I've heard of a lot of really horrible things, but I still have to come home and I have to make dinner and I have to play my 5-year-old and my 7-year-old, and their lives are perfectly normal and wonderful and happy. There's no space in our family life, you know certainly I'm not going to be telling my kids what I did for the day.

Two participants reported that this work impacted their sex lives. The participants discussed how working with human sex trafficking populations and other sexual assault victims and survivors turned them off from sex due to the traumatic experiences their clients described. P6 explained,

It actually had an impact on my sex life because you would hear stories, you'd hear details about what other people have done, and it really turns you off...It really does, it just makes you want to have – not to enjoy sex. But sex is natural, sex feels good and it is – it was a struggle to finally get to the point where you're not thinking about what you've heard, or it's not making you want to cry afterwards. So, finally passed that. But at the beginning, when you work with survivors of sexual crimes, that happens.

There were four participant who reported experiencing hypervigilance as a secondary trauma symptom. The hypervigilance changed how participants related to their friends, family, and even strangers they encounter. P6 described how the hypervigilance was disruptive to her everyday life:

Even yesterday actually, my co-worker and I went to lunch...and we were sitting on the patio, and then these two little boys are asking us to buy something – and we're looking around – are there any adults...we're just like, okay, well, what's – and then we had to kind of both stop and say, we need to enjoy our lunch...Because it's like you're constantly on.

Professional impacts on the clinician's life. The participants were asked how this work affects them professionally. They reported about how this work has shaped their career development. Four participants stated that they experienced boundary issues and had to learn to be more flexible with human sex trafficking survivors than they normally would be with their other clients. They reported that human sex trafficking clients required more of their time, energy, and attention than other clients required. P5 stated that she felt she had a responsibility to be constantly available for her clients. “They're [human sex trafficking victims and survivors] much needier, and they need much more support because of the significant trauma. So that does like weigh on me because I feel like I'm responsible for running their life.” P6 described her struggle with boundaries with her clients due to communication tools:

In my professional life, I think – actually, with this role it's different from my other roles because our clients like to text for communication, so we have a Google Voice number that we use. So that has been really hard to navigate because in my previous roles, my clients didn't have that much access to me. So, I'm working on my boundaries with texts

because it's easy just to like respond. But I'm like, wait, no, it's 7:00 at night. I'm out of the office. I can't do that. So, with me right now it's been trying to figure out those boundaries.

P5 also reported that this work has made a professional impact on her because she was the only one in her entire agency working with human sex trafficking survivors. P5 stated, But it does feel sometimes isolating because of the confidentiality and because of the trauma and because of all these little weird things that happen to fall into this category, especially like all this federal money...so, you know, we're like, you know, looked at as like special and different, but we just want to help our people like everybody else but it becomes like a weird dynamic sometimes.

P5 explained that her coworkers did not always understand how or why her clinical relationship with her clients was different from the other victims and survivors of sexual assault. She was given more resources and support for her clients than they were given for their clients, and that created a strange dynamic between herself and her coworkers.

Self-Care Strategies and Resources

The participants described why they stayed in this field after having experienced secondary trauma. The participants reported combatting their secondary trauma symptoms with self-care and coping skills. They were asked to discuss their most helpful resources and recommended strategies for new clinicians working with the human sex trafficking population. The themes that emerged were motivation to stay in the field, self-care strategies, and resources needed to support clinicians.

Motivation to stay in the field. All six participants reported having job satisfaction and staying in the field of working with human sex trafficking survivors because of their passion for this field. P3 described her motivation for staying in the field as:

I think this is the rewarding part that keeps me working on this field for a long time because I guess I'm so selfish because I'm seeing all of the rewards makes me so happy, and oh, yeah, I love this piece of helping...It's just like I'm sure we're doing good things for people, and [making] them happy, and this is what I believe human rights – this is what I believe [how] people should be treated, and this means that right now they're happy...They have happy lives, and they have happy families right now. And that's just all for me.

Four participants described their biggest rewards from this work as being positive cognitive changes for the clients. P6 explains,

The rewards are definitely the resiliency. It's incredible, like when you're – when clients are in treatment and everyone is working towards the same goal and on the same page on those goals, you really get to see the changes, you know? When you get to see the pattern and the change of critical thinking and really...critical thinking. To be able to work with clients, for them to stop for a moment and actually think about, okay, if I were to make this decision, would it make my life better or worse? And, when clients get to that point, it's just breathtaking, it's just – it's why I do the work. And when they're able to apply those critical thinking skills, it's great.

Self-care strategies. All six participants described exercise and mindfulness in some

form or capacity as their top self-care strategies they utilize themselves and recommend for newly starting clinicians who want to work with this population. P2 describes her most effective workouts by saying,

You actually break a real sweat and your heartbeat is up, I think also makes a difference in the day. I think those are all things you've heard over the years or good things for you to do, but you know, until you actually do it, you realize that the experts were right in those particular research pieces.

When describing mindfulness techniques, P6 stated that she did not always “have the attention span to sit there for 10 minutes.” P6 explained that instead of meditation, “I'm trying to build my five senses – my five senses self-care tool box.” P6 described mindfulness activities other than meditation that engage the five senses for clinicians and clients alike. P6 reported that she found her other mindfulness techniques and activities from Pinterest.

Four participants named therapy as one of their top recommendations for self-care strategies. Three participants have been to therapy since starting their careers working with human sex trafficking survivors, and one stated that she regretted not going to therapy but would highly recommend it. P3 stated,

Like I said, they should see a counselor or therapist as soon as you realize there's a problem because I really thought about it and said I should have gone. Now one of the things that I regret that I did not do for self-care was not seeing a counselor because I thought even though I did a lot of things like talking to people or other things...the problem is still there because it did not really help me completely...So I think in just my opinion, seeing the counselor will be a lot more helpful and if I did, I may, I may not quit my job at that time.

All six participants mentioned de-stressing by talking with their coworkers, friends, or families. P1 described how talking to her coworkers, who were also her friends, was helpful:

I think a way that I also processed was talking to my friends and coworkers. Like, “This was really difficult for me this week, and I can't figure out why.” Talking it out and processing it with them, and then like them sometimes being a third party, but also understanding all the dynamics of the place where we worked and the kids that we worked with, and being able to really offer some insight like, “Maybe do you think this is why that you reacted that way?” or like, “Well, you know so-and-so was going through this at that time, and like did you know that?” That really helped as well.

Other self-care strategies that were reported mainly revolved around the idea of engaging other passions, which included cooking, watching TV, watching movies, crafting, praying, and reading.

Resources needed to support clinicians. All six participants stated that supervision or group support was a helpful resource. P5 stated that she was motivated to start a work group to support others in her area who might be working with the same population of clients. She described it by saying,

We have our six partner agencies that work with us...not all of them have a designated human trafficking person – it's sort of managed by their DV staff or SA staff – but we've talked about like all getting together, and while we can't share everything, we can sort of share some things and like what works and what doesn't, because I think our experience is unique and just because it's like really exploding around this area lately, about having like – oh, not a support group, but like a work group, something where we can get

together and just talk about ideas and what works and what doesn't and share resources type of thing.

Two participants reported that trainings done by other professionals in the field of working with human sex trafficking victims and survivors were helpful as they were learning how to best help their clients. P4 described her cases as involving a team of other professionals in the field, which was helpful to learn about how other fields' best practices could be helpful to her clinical practice.

They sent us all the forms that we need to fill out to do intake of the case. Through many sessions we met with each other, we learned how to interview, how to ask questions to victims and what to do, what program we need to contact, and something like that. They gave us documentation. A textbook to follow. And then every month they have a meeting on the training Webinar for training to ask questions. Yes, very good, very helpful. If we have any difficulty in the webinar, we may raise our questions and we share our skills, experience online to help each other, and if we have any questions, we share our experience and skills to help each other. Very helpful.

One participant reported that the trainings on trauma-informed care were not helpful to her. P6 stated,

I went to the two-day trauma informed care and that just was – I didn't find it very beneficial probably because of working in trauma for so long, it...you want tools and sometimes you're not getting those in the professional world, like a fresh perspective of how – what is best case practices now and just, you know, those tools, and I don't feel like I've been getting that at some of the trainings I'm going to. It's just there's more people that working with trauma now that – obviously they wanted to get that

information out, because I know it's been beneficial for some of the other participants, but I guess for the ones who have been working in the field for a while, we just – we want more. But it's nice – it's kind of reassuring when you do go to those trainings, you're like, okay, I know what I'm doing.

Chapter 5: Discussion

The findings from this study were congruent with the literature reviewed on the subject of clinical work with human sex trafficking victims and survivors. The clinicians who participated in the study reported that they had experienced secondary trauma due to their work with clients who had been human sex trafficked. Literature showed that female counselors working with sexual violence survivors with greater number of caseloads were highly likely to experience post-traumatic stress disorder symptoms and disruption of the belief in the goodness of people (Schauben & Frazier, 1995). The participants described symptoms of hypervigilance, lack of emotional control, and difficulty sleeping as their main secondary trauma symptoms. One participant normalized her trauma symptoms, saying that it was to be expected of anyone working in a related field that dealt with trauma.

Working with this population and experiencing secondary trauma impacted the participants on individual, relational, and professional levels. Though there was previous research done on approaches and how to work with human sex trafficking populations, there was little information about what it was like to work as a clinician with this population. The participants shared their experiences and gave meaning to their experiences of working with this highly traumatized population, experiencing their own secondary trauma, and overcoming the struggles. The participants had similar experiences of trauma as their clients', and their self-care methods were similar to those they would teach their clients.

The parallel between the clinicians' experiences and their clients' experiences was undeniable. The participants described how they were unable to share their experiences with their family and friends due to confidentiality issues as well as for maintaining the normality of their relationships. The same could be said for the participants' clients. While a child had been

trafficked, the family was left wondering what has happened or what may happen if or when the child returned home. The survivor often still needed time to make sense of the experience, and the family does not know what the experience was like. Brunovskis & Surtees (2012) found that the major obstacle in post-trafficking relationships between survivors and their families was that the families did not know what the survivor has been through. Not only did the families not know or understand the survivor's experience, but the survivor was usually reluctant to share information and details about the trafficking experience. Johnson (2010) found that the most common question from mothers of survivors was, "Why didn't my child speak up?" (p. 366). Families were left in confusion and desperation to help the survivors, but the survivors were often not ready to open up to their families. Clinicians' families could also be left wondering how to better help the clinicians deal with secondary trauma symptoms that may appear, but helping the clinicians might be difficult when the clinician is unwilling to share information about their experiences in this field of work.

Due to their previous experiences with domestic violence victims and survivors, these participants were able to share their perspective on why human sex trafficking survivors' trauma experiences were more complicated than other trauma clients' were. A study by O'Connor in 2017 reported on the human sex trafficking survivor's experience of choosing to engage in sex work, sometimes due to wanting to please the trafficker, but the survivor had not anticipated or known the extent of the trauma implications they would be facing (e.g., coercion, direct force, exploitation, etc.). A parallel was drawn between the clinician's initial expectation of the magnitude of trauma their clients would be bringing to clinical work together and the client not knowing the level of trauma they would be subjected to when they were pressured into trafficking. That was not to say that the clinician's secondary trauma was comparable to the

client's trauma from being sex trafficked; clients' experiences of human sex trafficking had a deeply profound effect on the clinician's experience of clinical work together.

Participants were also able to describe how frustrated they became when their clients would lash out at them, which was their clients' way of showing how frustrated and emotionally unregulated they were. Participants reported feeling emotionally unregulated and having to process those emotions in a healthy way, which was what they were trying to teach and exemplify for their clients. When participants described how gratifying it was to witness their clients' cognitive breakthroughs in developing healthy patterns, they also talked about their own breakthroughs with discovering how to take care of their own health.

The participants' methods of self-care and coping with the secondary trauma were similar across all six participants. Each participant seemed to have her own personal passion or interest to engage in outside of the field of human sex trafficking. The participants who had been working with high trauma populations for longer amounts of time, usually at least 10 years, were the ones who gave the most examples of self-care strategies. None of the participants had not experienced those trauma symptoms recently, which gave them insight into which strategies were best to utilize. In retrospect, participants were able to give better advice knowing which self-care strategies had worked and which had not worked for them.

The resources and self-care strategies that participants identified as helpful were highly focused on social support. Whether support through friends, coworkers, or supervisor, it was clear through the findings that participants recommended seeking someone with whom to share the experience. The trauma and stress caused by their work seemed to push the participants to look into different trainings and self-care strategies. Finklestein et al. (2015) suggests that postgraduate training specialized in working with trauma survivors would be helpful in preparing

clinicians for the potential exposure to vicarious trauma. Hernandez-Wolfe, Killian, Engstrom, & Gangsei (2015) state that “explicit attention to [vicarious trauma] in training and supervision has the potential to prevent burnout and foster a sense of reasonable hope.” Supervision, particularly with a trauma-informed supervisor, is also highly recommended by Finklestein et al. (2015). Having these support structures in place will not only benefit the clients, but the clinicians themselves will also experience more overall wellbeing (Finklestein et al., 2015). The participants who had been regularly practicing their self-care seemed to have a more positive outlook on their work with their highly traumatized clients.

Limitations

The primary limitation in this study was the availability of eligible participants. Out of the thirteen interested clinicians who responded to email recruitment of participants, only six ended up scheduling and following through with the phone interview. Three of the interested clinicians who responded to the researcher and scheduled their phone interviews ended up having scheduling conflicts and were ultimately unable to hold the interview. There did not seem to be many clinicians who were able and willing to work with this population, and the clinicians’ caseloads seemed overwhelming at times. This could be another contributing factor to the low participant sample.

Another limitation of this study was that it was only asking the clinicians about their experience of working with the human sex trafficking survivor population. A perspective that would have enriched this data would have been that of the clinician’s friends and family members. The impacts of this work on the clinician affected their relationships as well, which would have been interesting to explore. The clinicians worked with their clients for a lengthy amount of time, and their clients’ perspectives on the clinical work would have been interesting

as well. Due to confidentiality and safety issues, it would have been difficult to find and interview the survivors directly about their experiences.

Clinical Implications

The findings from this study could be used to provide more information for future trainings for clinicians who would like to work with the human sex trafficking population. The participants who have attended trainings and did not gain much from those trainings seemed to have a desire for more, newer information about this field. Incorporating the self-care aspect of working with this population into the trauma-informed trainings would enhance the existing trainings. Clinicians could learn different models and approaches to clinical work with these clients, and they can learn how to take care of themselves while they are doing this work. Based on what the participants stated, clinicians working with this population should consider finding their own therapist, focusing on their own self-care techniques, attend the trainings with the most up-to-date information, and work with a team with experienced supervision.

Clinicians could learn more about how to identify human sex trafficking among their clients. Many of the participants in this study did not know or realize that their clients were going through human sex trafficking at first when they were working with domestic violence victims. Human sex trafficking victims have been trained to hide their traumatic experiences (Brunovskis & Surtees, 2012), which makes it very difficult for untrained clinicians to recognize the signs and get their clients the help they need. Though the awareness about human sex trafficking has increased, more clinicians could learn more about this population and how to best work with them.

There was some existing research on how to work with this population, but this study was able to provide insight and understanding about what the experience of working with this

population was like for a clinician. It was learned that the human sex trafficking experience was not only highly traumatizing for the clients, but it was also highly traumatizing for the clinician working with the clients. Clinicians working with this population would have different boundaries than when working with other clients, which makes clinicians more susceptible to experiencing secondary trauma. Working with a higher severity of trauma increased the chance that the clinician would experience secondary trauma. The amount of self-awareness and self-care a clinician must have to persevere through working with human sex trafficking victims and survivors takes time to build, and clinicians should be mindful of that.

The participants reported experiencing secondary trauma symptoms such as hypervigilance, loss of sleep, and change in worldview. Those symptoms changed the way that they related to the world around them and the people around them. When the clinicians experienced those trauma symptoms, that showed that this work with human sex trafficking victims and survivors did not just have an impact on the clinician as an individual. The work with human sex trafficking survivors affected the clinician's entire system: the client, the client's system, the clinician, the clinician's friends and family, and the clinician's professional life. Oftentimes, it was easier to focus on the client and what the client's system must be experiencing, but this study showed that considering how a clinician and the clinician's system could be impacted improved the work between a clinician and their clients. Taking care of the clinician will help the clinician to take care of the clients.

Future Studies

Future studies could explore more about the clinician's experience of working with families of human sex trafficking survivors. Future studies could explore what the family's experience is when their family member is sex trafficked. Many of the human sex trafficking

survivors do not return to their families according to the participants' experiences, and it would be fascinating to explore why or how that is.

Given the high occurrence of families trafficking their own family members, future studies could learn how to work with those families who were the perpetrators of human sex trafficking. The studies could further explore how to work with those families clinically from a systemic model, given that the perpetrator of the crime and the victim of the crime are so closely tied. The systemic impacts of familial human sex trafficking could inform the clinical field working on how to better navigate working with highly severe trauma cases.

Future studies could explore the currently available trainings and their training methods. Those studies could better inform trainers and curriculum developers on which areas need to be focused on and how to improve current methods. The efficacy of the trainings could be studied to pinpoint what works and what does not work. These future studies could result in more trainings for clinicians, which will expand the network of available resources for human sex trafficking victims and survivors.

Another future study could be one that looks into the multidisciplinary approach to treating a human sex trafficking survivor case. Law enforcement, legal teams, and clinical teams are typically involved, which would lend itself to incorporating many mixed methods of help and treatment. The future study could explore how each field approaches the survivor, which methods work best, and how can these fields work together to prevent the survivor from self-sabotaging or returning to the trafficker.

Conclusion

Working with survivors and families of survivors of human sex trafficking had a deep impact on the clinician's personal, family, and professional life. This work caused clinicians to

experience secondary trauma, which could be prevented and processed with a variety of self-care techniques. There was a need for increasing awareness about this work as well as a need for creating better trainings for future clinicians wanting to work with this population. Learning about each participant's experience was meaningful and powerful. The level of passion that went into each participant's willingness to persevere even through the toughest experiences of working with this population was moving. Each clinician seemed to put their heart and souls into this work, and the researcher was inspired to continue exploring this area to further the future of complex trauma clinical work. As the prevalence of such crimes and trauma increases, clinicians will undoubtedly encounter more of these cases. It will be imperative for clinicians to be prepared to identify such issues and handle these clients properly in order to do their part in preventing future victimization.

References

- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.
- Brennan, D. (2008). Competing claims of victimhood? Foreign and domestic victims of trafficking in the United States. *Sexuality Research & Social Policy*, 5, 45-61.
- Brunovskis, A. & Surtees, R. (2012). Coming home: Challenges in family reintegration for trafficked women. *Qualitative Social Work*, 0, 1-19.
- Countryman-Roswurm, K. & Bolin, B. L. (2014). Domestic minor sex trafficking: Assessing and reducing risk. *Child and Adolescent Social Work Journal*, 1-19.
- Creswell, J. W. (2013). *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*. Washington, D.C.: SAGE Publications.
- De Chesnay, M. (2013). Psychiatric-mental health nurses and the sex trafficking pandemic. *Issues in Mental Health Nursing*, 34, 901-907.
- Finch, H., Lewis, J., & Turley, C. (2014). Focus groups. In J. Ritchie, J. Lewis, C. M. Nicholls, & R. Ormston (Eds.), *Qualitative Research Practice: A Guide for Social Science Students & Researchers* (211-242). Washington, D. C.: SAGE.
- Finklestein, M., Stein, E., Greene, T., Bronstein, I., & Solomon, Z. (2015). Posttraumatic stress disorder and vicarious trauma in mental health professionals. *Health & Social Work*, 40(2), 25-31.
- Hardy, V. L., Compton, K. D., & McPhatter, V. S. (2013). Domestic minor sex trafficking: practice implications for mental health professionals. *Journal of Women and Social Work*, 28(1), 8-18.
- Harrison, R. L. & Westwood, M. J. (2009). Preventing vicarious traumatization of mental

- health therapists: identifying protective practices. *Psychotherapy Theory, Research, Practice, Training*, 46(2), 203-219.
- Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gansei, D. (2015). Vicarious resilience, vicarious trauma, and awareness of equity in trauma work. *Journal of Humanistic Psychology*, 55(2), 153-172.
- Hickle, K. E. & Roe-Sepowitz, D. E. (2014). Putting the pieces back together: A group intervention for sexually exploited adolescent girls. *Social Work with Groups*, 37, 99-113.
- Hom, K. A. & Woods, S. J. (2013). Trauma and its aftermath for commercially sexually exploited women as told by front-line service providers. *Issues in Mental Health Nursing*, 34, 75-81.
- Ijadi-Maghsoudi, R., Todd, E. J., & Bath, E. P. J. (2014). Commercial sexual exploitation of children and the role of the child psychiatrist. *Journal of the American Academy of Child & Adolescent Psychiatry*, 53, 825-829.
- Johnson, B. C. (2012). Aftercare for survivors of human trafficking. *Social Work & Christianity*, 39, 370-389.
- Jordan, J., Patel, B., & Rapp, L. (2013). Domestic minor sex trafficking: a social work perspective on misidentification, victims, buyers, traffickers, treatment, and reform of current practice. *Journal of Human Behavior in the Social Environment*, 23, 356-369.
- Kotrla, K. (2010). Domestic Minor Sex Trafficking in the United States. *Social Work*, 55, 181-187.
- Macy, R. J. & Graham, L. M. (2012). Identifying domestic and international sex-

- trafficking victims during human service provision. *Trauma, Violence, & Abuse, 13*, 59-76.
- Marcus, A., Horning, A., Curtis, R., Sanson, J., & Thompson, E. (2014). Conflict and agency among sex workers and pimps: a closer look at domestic minor sex trafficking. *The ANNALS of the American Academy of Political and Social Science, 653*, 225-246.
- Martin, L. (2013). Sampling and sex trading: Lessons on research design from the street. *Action Research, 11*, 220-235.
- McCann, L. & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131-150.
- McIntyre, B. L. (2014). More than just rescue: Thinking beyond exploitation to creating assessment strategies for child survivors of commercial sexual exploitation. *International Social Work, 57*, 39-63.
- O'Connor, M. (2017). Choice, agency consent and coercion: Complex issues in the lives of prostituted and trafficked women. *Women's Studies International Forum, 62*, 8-16.
- Perdue, T., Prior, M., Williamson, C., & Sherman, S. (2012). Social justice and spiritual healing: Using micro and macro social work practice to reduce domestic minor sex trafficking. *Social Work & Christianity, 39*, 449-465.
- Reid, J. A. (2012). Exploratory review of route-specific, gendered, and age-graded dynamics of exploitation: applying life course theory to victimization in sex trafficking in North America. *Aggression and Violent Behavior, 17*, 257-271.
- Schauben, L. J. & Frazier, P. A. (1995). Vicarious Trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19*(1), 49-64.

Todres, J. & Clayton, E. W. (2014). Responding to the sexual exploitation of minors. *New England Journal of Medicine*, 370, 1282-1283.

Way, I., VanDeusen, K. M., Martin, G., Applegate, B., & Jandle, D. (2004). Vicarious trauma: a comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence*, 19(1), 49-71.

Yakushko, O. (2009). Human trafficking: a review for mental health professionals. *Int J Ad Counselling*, 31, 158-167.

Appendix A

Recruitment Electronic Mail

Hello!

I am now recruiting for a study exploring the professional, personal, and family life impact on a clinician of working with families during the reunification process after a family member has been sex trafficked. The purpose of this research study is to understand the impact of working with this population on a clinician's professional and personal life. This study aims to educate other mental health professionals about the potential impact of working with this population as well as the importance of self-care. The results of this study will be published in my masters thesis.

I am looking for:

- Clinicians who work with survivors of human sex trafficking and help families reunify
- Any mental health professional with a therapeutic practice
- Clinicians who have worked with more than one family in this population and have followed at least one family through the reunification process
- Are available for a phone interview (has access to a telephone)

What is involved in the study?

A phone interview lasting approximately 45 to 60 minutes. The researcher will ask questions about your experience with helping families reunify after a member has returned after being sex trafficked.

Potential benefits of the study include: Helping to bring more awareness to the mental health field about working with families during the reunification process after a family member has been sex trafficked. Participants will also be helping to potentially create a training for future clinicians who will work with this population.

Potential risks of the study include: The interview requires the participant to discuss his or her life while working with families during the reunification process after a family member has been sex trafficked. This could potentially be difficult for the participants because of the emotional pain that can be associated with working with a difficult population. There is also a potential of breach in confidentiality. However, every effort will be made to ensure privacy. The participant will be given the opportunity to stop the interview if at any point he or she finds it too emotionally difficult.

I invite you to participate in this study. If you are interested in this study, please contact me at anxt307@vt.edu or (703) 944-2119. I am happy to discuss the study and answer any questions.

Thank you!

Appendix B

Informed Consent Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: The Impact of Working with Human Sex Trafficking Survivors' Families During the Reunification Process on Clinicians' Personal and Professional Life

Investigators: Eric E. McCollum, Ph.D. (Principal Investigator and Virginia Tech faculty member) ericmccollum@vt.edu; 703-538-8460

An Thai (Co-investigator and graduate student in the Marriage and Family Therapy Program) anxt307@vt.edu (703) 944-2119

I. Purpose of this Research Project

I am conducting a qualitative study of the lived experience of clinicians working with families of human sex trafficking survivors during the family reunification process after the family member has survived and returned from being sex trafficked. I will be gathering data through semi-structured interviews. The purpose of conducting this study is to understand and describe the impact that working with this population has on a clinician's personal and professional life. This study aims to help educate clinicians on the potential impact of working with this population as well as the importance of self-care. The results of this study will be used in a masters thesis and published.

II. Procedures

Should you agree to participate in this study you will be asked to participate in one telephone interview that will be audio recorded. The interview will take between 45-60 minutes. Participants may choose to have the conversation wherever they feel comfortable. Participants will be expected to provide their own telephones.

III. Risks

The interview requires you to discuss your experiences during the time that you worked with the families of human sex trafficking survivors. This could potentially be difficult because of emotional pain you may have experienced throughout your time working with these families. If at any point in this process you find it too emotionally difficult to continue, you may request to take a break or stop the interview without penalty.

Any expenses accrued for seeking or receiving medical or mental health treatment will be the responsibility of the subject and not that of the research project, research team, or Virginia Tech.

IV. Benefits

One of the benefits of participating in this study is that it will help us know more about how clinicians' experiences of working with families in which a family member has been sex trafficked has affected the clinicians' personal and professional life. This perspective could be particularly beneficial to other mental health professionals, who are likely to come into contact with clients from this population. The clinicians participating in this study will be helping other mental health professionals learn about proper self-care and preparation in order to work with this unique population. Another potential benefit is the community of treatment practitioners learning from the participants' stories and making appropriate changes where needed.

No promise or guarantee of benefits has been made to encourage you to participate.

V. Extent of Anonymity and Confidentiality

Data from the interview will be audio recorded and stored on my password protected personal computer. No identifying information besides first names will be used in the interview. At no time will the researcher release identifiable results of the study to anyone other than individuals working on the project without your written consent. The audio recording and the transcriptions will be destroyed upon completion of this study after the thesis defense.

The Virginia Tech (VT) Institutional Review Board (IRB) may view the data for auditing purposes. The IRB is responsible for the protection of human subjects involved in research.

In some situations, it may be necessary for the researcher to break confidentiality. If the researcher has reason to suspect that a child or an elderly or vulnerable adult is/was abused or neglected or that a person poses a threat of harm to others or themselves, the researcher is required by Virginia State law to notify the appropriate authorities.

VI. Compensation

There is no compensation for participating in this study.

VII. Freedom to Withdraw

It is important for you to know that you are free to withdraw from this study at any time without penalty. You are free not to answer any questions that you do not wish to answer or not respond to anything that is being asked of you without penalty.

Please note that there may be circumstances under which the investigator may determine that a subject should not continue in the study. These circumstances include, but are not limited to, the subject not meeting eligibility criteria for participation, the subject becoming overwhelmed by the interview, and/or the subject asking to be removed as a participant.

Should you withdraw or otherwise discontinue participation, you will be compensated for the portion of the project completed in accordance with the Compensation section of this document.

VIII. Questions or Concerns

Should you have any questions about this study, you may contact one of the research investigators whose contact information is included at the beginning of this document.

Should you have any questions or concerns about the study’s conduct, or your rights as a research subject, or need to report a research-related injury or event, you may contact the VT IRB Chair, Dr. David M. Moore at moored@vt.edu or (540) 231-4991.

IX. Subject's Consent

I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:

_____ Date _____
Subject signature

Subject printed name

(Note: each subject must be provided a copy of this form. In addition, the IRB office may stamp its approval on the consent document(s) you submit and return the stamped version to you for use in consenting subjects; therefore, ensure each consent document you submit is ready to be read and signed by subjects.)

Appendix C

Telephone Interview Guide

1. Introductions and Permission/Informed Consent

Thank you for agreeing to participate in this research. The purpose of this interview is to understand and describe the impact that working with families who are reuniting with a sex trafficked family member has on a clinician's personal and professional life. This study aims to help educate clinicians on the potential impact of working with this population as well as the importance of self-care. The interview should take between 30-45 minutes to complete. Our conversation will be recorded for accuracy. Do I have your permission to record?

2. Demographic Questions:

- a. Age _____ ?
- b. Gender _____?
- c. Cultural Background _____ ?
- d. Field of work _____?
- e. How long have you been working with this population? _____

3. Interview Questions:

- A. What has been your experience working with families of human sex trafficking survivors during the reunification process?
 - a. How did you become involved with treating families who have been reunified with a sex trafficked family member?
 - b. What are rewards of working with this population?
 - c. What are the struggles of working with this population?

- d. What has been your emotional experience while helping these families to navigate the reunification process?
- e. What impacts have you noticed in your professional life, if any?
- f. What impacts have you noticed in your personal life, if any?
- g. How has this work impacted your own family life, if at all?
- h. Have you noticed within yourself any symptoms of trauma associated with working with these families?
- i. How might working with this population feel different than working with other types of trauma cases?
- j. What self-care do you engage in to take care of yourself in order to work with this population?
- k. What are other approaches to self-care that you might recommend to newly starting clinicians, who are working with this population, that you may or may not utilize yourself?
- l. What support or resources have been helpful?
- m. What support or resources have not been helpful?

Those are all the questions I have for you today. Thank you so much for your participation. The interview is done, and you may leave now if you do not have any other questions or concerns that I could address at the moment. If you have any questions please feel free to contact me.