

DOMESTIC MINOR SEX TRAFFICKING: RESCUE, RESTORATION, AND
REINTEGRATION

by

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DEDICATION

For front line service providers; giving a voice to the victims.

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TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	v
CHAPTER	
I. INTRODUCTION	1
Purpose Statement.....	4
Research Questions.....	5
II. REVIEW OF LITERATURE.....	7
Domestic Sex Trafficking: Definitions and Descriptions	7
Domestic minor sex trafficking	8
Domestic Sex Trafficking: Physical and Mental Health Consequences.....	9
Physical health consequences	10
Mental health consequences	12
Trauma and Complex PTSD.....	14
Posttraumatic stress disorder.....	15
Stockholm syndrome and trauma bond.....	17
Attachment Theory as a Mechanism for the need for Long-Term Treatment.....	19
Attachment theory.....	20
Attachment and complex PTSD/trauma	22
Treatment Services and Reintegration	26
Rescue	26
Short-term transitional care.....	28
Long-term transformational care	28
Reintegration.....	30
Summary	31
III. METHODOLOGY	33
Participants.....	33
Procedures	34
Data Analysis	36

IV. RESULTS	38
Attachment Framework	38
Comprehensive Services	41
Basic needs/shelter.....	42
Mental/emotional services	45
Educational services.....	50
Legal services.....	51
Medical services.....	54
Substance abuse treatment services	55
Job skills services.....	56
Barriers to Services	57
Lack of available services	57
Criminalization of victims	58
Victims failure to identify as victims.....	59
Factors to Strengthen Services	60
Trust and rapport with service providers	60
Comprehensive approach.....	61
Empowerment	61
V. DISCUSSION	63
Attachment Framework	63
Comprehensive Services	65
Barriers to Services	70
Factors to Strengthen Services.....	72
Limitations and Implications for Future Research and Practice.....	73
APPENDIX SECTION.....	76
REFERENCES	84

I. INTRODUCTION

Human trafficking is an international problem recognized today as a form of modern-day slavery plaguing the global community. The United States State Department (2012) estimates there are 600,000 to 800,000 individuals trafficked across international borders annually and between 100,000 and 300,000 American youth at risk for trafficking (Polaris Project, 2013). Currently, 27 million trafficked individuals are being exploited (United States State Department, 2012), 80% of those are women and 50% are minors (U.S. State Department, 2012), creating a criminal enterprise worth \$44.3 billion globally (Belsar, 2005). In the United States alone, reports have estimated that as many as 50,000 people are trafficked across U.S. borders each year (Jordan, Patel, & Rapp, 2013).

Though human trafficking is commonly confused with human smuggling (i.e., the movement of people from one location to another), according to the United Nations 2000 Convention Against Organized Crime, the legal definition of human trafficking is:

the recruitment, transportation, 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 of payments or benefits to achieve consent of a person having control over another person, for the purpose of exploitation (Trafficking Protocol, Article 3a).

There are two identified forms of human trafficking, sex trafficking and labor trafficking, that are prevalent in most countries in the world (United States State Department, 2012; United Nations, 2000); sex trafficking being the most predominant (United States State Department, 2012) and the focus of this study.

Sex trafficking has developed into a large criminal economic enterprise throughout the world, with monetary estimates at \$9.5 million in the United States alone (United Nations, 2000). The United Nations has estimated that approximately 2,000,000 children worldwide become victims of sexual exploitation each year (United Nations, 2000). In the United States, legislation has recently begun to change at the federal and state level to reflect the realization that many sex workers and all minor sex workers are victims and not criminals (Trafficking Victims Protection Act, 2000). Federal legislation passed to address the trafficking of victims in the U.S. is known as the Trafficking Victims Protection Act (TVPA) of 2000. This legislation has been amended four times and continues to be amended and ratified at different levels of the government to best combat trafficking and provide services for victims. The Victims of Trafficking and Violence Act of 2000, defines sex trafficking as the “recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act” (p. 7). Domestically, trafficking victims are enslaved and brought across U.S. borders or recruited within our own cities through the use of force, fraud, and coercion (Smith, Vardaman, & Snow, 2009). It is estimated that over 100,000-300,000 U.S. minors are at risk of being sex trafficked within the United States each year by being kidnapped, manipulated, coerced, or deceived through false relationships (Estes & Weiner, 2008; Smith et al., 2009). This type of sex trafficking is also referred to as “domestic minor sex trafficking” (Clawson & Goldblatt Grace, 2007; Hardy, Compton, & McPhatter, 2013) and is a significant risk to American youth.

Victims of sex trafficking are at risk for dire physical and mental health consequences due to the traumatic nature and abusive elements of trafficking (Abu-Ali

&Al-Bahar, 2011; Banovic & Bjelajac, 2012; Hardy et al., 2013; McClain & Garrity, 2011; Tsutsumi, Izutsu, Poudyal, Kato, & Marui, 2008; Zimmerman, Hossain, & Watts, 2011). The potential physical health consequences are HIV and sexually transmitted diseases, fertility issues, physical abuse and trauma, substance abuse, and untreated diseases (McClain & Garrity, 2011; U.S. Department of Health and Human Services, 2009). In addition, sex trafficking victims are likely to display symptoms of depression, anxiety, complex PTSD, and dissociative behaviors (Clawson & Grace, 2007; McClain & Garrity, 2011). Similar to the research on complex trauma and child abuse victims, it has been suggested that sex trafficking victims may be especially vulnerable to attachment disorders and behaviors associated with insecure attachment (Abu-Ali & Al Bahar, 2011; Pearlman & Courtois, 2005). A lack of consistent care, treatment services that are disjointed, as well as the possibility of many victims being incarcerated would not allow victims to be treated properly (Clawson & Goldblatt Grace, 2007; Pearlman & Courtois, 2005). In addition, victims of trafficking more commonly come from lower socioeconomic backgrounds and are considered to be in at-risk situations prior to their trafficking experience, further complicating their identifiable symptoms and necessary treatment (Clawson & Goldblatt Grace, 2007). All of the health issues combined make treatment for sex trafficking victims complex and expensive (Clawson & Goldblatt Grace, 2007).

Further obscuring a direct path to restoration is that rescue and treatment of these victims require a multi-disciplinary response by many different service providers (Children at Risk, 2010). Examples of agency involvement resulting in a multi-disciplinary response could include the following: government officials (city, county,

state, and federal), law enforcement officials, social workers, mental health professionals, health providers, educational services, spiritual services, temporary and long-term shelters and safe house care staff, and others (Children at Risk, 2010). In 2010, Children at Risk, based in Houston, Texas partnered with Shared Hope International, a large non-profit in Washington to create a survey to examine the core components of care being offered by available safe houses in the United States. In addition, the Department of Health and Human Services has compiled recommendations for shelters and safe houses based on the recommendations of social workers and law enforcement officials (Clawson & Dutch, 2008; Clawson & Golblatt Grace, 2007). They reported similarities in the recommended services that are needed for trafficking victims, but they fail to give specific guidelines on the process of moving a victim from rescue to reintegration into society. In addition, it is commonly reported that building a trusting relationship is the foundation for victims willingness to accept services and begin the healing process (Clawson & Dutch, 2008; Clawson & Golblatt Grace, 2007; Clawson, Salomon, & Goldblatt Grace, 2008) and that attachment disorders are commonplace (Abu-Ali & Al Bahar, 2011; Pearlman & Courtois, 2005); however, current research fails to determine the role attachment plays in the healing process of the victim and how that relates to the services that are offered by service providers.

Purpose Statement

The purpose of this descriptive, qualitative study was to determine the recommended steps for immediate treatment of a trafficking victim upon rescue through the use of a multiple disciplinary response by multiple service providers (0-90-day immediate transitional care). In addition, transformational care (i.e., long-term treatment)

for survivors was explored utilizing attachment theory as an underlying mechanism to determine if there is a need for long-term care. It was also the purpose of this study to discover what components of treatment need to be present for survivors of trafficking in order to reintegrate into society. In the study, interviews were used to collect data from multiple disciplines (i.e., law enforcement, social workers, prosecuting attorneys, youth shelters, juvenile justice, and mental health professionals) regarding transitional and transformational care. Services for victims were explored through interviews with select service providers working in current rehabilitation services for victims with an emphasis on examining the role of attachment in the restoration of victims. Utilizing qualitative measures addressed the paucity of current research on victim services as well as shed light on why the current recommendations for treatment were not in line with the treatment actually being received by victims.

Qualitative methods were chosen to discover the meaning behind the current direction of services or lack of services for human trafficking victims. Empirical literature is very limited; thus, it was important to explore the complexity of needs for victims prior to building best practice approaches for services. This included exploring services upon rescue, restorative care, and a process for reintegration.

Research Questions

Research Question 1: What are the recommended multi-disciplinary services required for victims of human trafficking for physical, emotional, mental, cognitive, legal, and spiritual restoration and reintegration into society?

Research Question 2: How is a documented victim of human trafficking currently processed through legal and human services?

Research Question 3: How adequate are services in addressing the complex needs of victims identified in previous studies?

Research Question 4: What type of services and who will be responsible for administering these services throughout the course of treatment (immediate, long-term, reintegration)?

Research Question 5: How does the diagnosis of an attachment disorder in a victim change the recommended model for treatment in the restoration of victims?

Research Question 6: What interplay exists between attachment and the overall healing process for each component of care (rescue, restoration, and reintegration)?

II. REVIEW OF LITERATURE

The following review of literature was conducted to explore the current state of research regarding domestic minor human trafficking. Empirical literature on this topic is scarce; therefore, literature on trafficking victims studied in other countries and literature from similar topics was included to examine the physical and mental health consequences and the role of attachment for trafficking victims. The following literature review 1) defines and describes legal definitions and demographics of domestic sex trafficking victims, 2) reviews the complexity of general health and mental health needs plaguing victims, 3) discusses attachment theory as an underlying mechanism for resistance of victims to treatment, and 4) summarizes current recommended processes for treatment and the adequacy of the current processes to address complex general and mental health needs.

Domestic Sex Trafficking: Definitions and Descriptions

Domestic sex trafficking is divided into two categories, domestically recruited victims and victims who are brought across international borders into the U.S. and sold to traffickers (Fong & Cardoso, 2009; Hardy et al., 2013; Kotrla, 2010; McClain & Garrity, 2011; Reid, 2012; Zimmerman, Hossain, & Watts, 2011). The focus of this review of literature is on domestically recruited sex trafficking victims. As previously mentioned, the TVPA (2000), defines sex trafficking as the “recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act” (p.7); this includes both minors and adults who are forced, coerced, or fraudulently misled into offering services in the commercial sex industry (Fong & Cardoso, 2009; Hardy et al., 2013; Kotrla, 2010; McClain & Garrity, 2011). Force, fraud, and coercion include the use

of physical harm, restraint, and kidnapping; deceptive or misleading employment practices; false marriages; and the use of threats of physical or psychological harm to the individual or his/her family for a lack of compliance (Hardy et al., 2013). The commercial sex industry can include prostitution, stripping, pornography production, sex tourism, nude dancing, and sex shows (Kotrla, 2010; Reid, 2012). These can take place on the streets of cities and towns, brothels, false businesses (e.g., nail salons, massage parlors, etc.), and through online services (Kotrla, 2010; McClain & Garrity, 2010).

Domestic minor sex trafficking. The recruitment population for traffickers is at-risk women and high risk minors recruited, abducted, or coerced from their current city and sold into a trafficking ring in another destination city (McClain & Garrity, 2011). It is estimated that 70% of these individuals are trafficked as minors (i.e., domestic minor sex trafficking) and many were already considered at-risk youth prior to being trafficked (Kotrla, 2010; McClain & Garrity, 2011; Williamson & Prior, 2009). Risk factors for domestically recruited sex trafficking victims include runaway or homeless youth with low socioeconomic status, school failure, a history of abuse, and poor or no familial connection (McClain & Garrity, 2011; Macy & Graham, 2012; Williamson & Prior, 2009); most of these young people are recruited between the ages of 12-14 (Macy & Graham, 2012; Smith et al., 2009).

The recruitment of minors for domestic sex trafficking occurs in both large, urban cities and smaller, rural communities; however, high risk cities tend to have lower literacy rates, higher levels of poverty, more runaways, and larger homeless populations (Davis, 2006). Leading cities for the sexual exploitation of minors are typically destination cities with some of the following characteristics: multiple military bases; high

tourist volume; frequent conventions, cultural events, recreational or sporting events; a well-known reputation for escort services and strip clubs; or being thoroughfares for truck drivers (Davis, 2006; Kotrla, 2010; Prior, 2009; Smith et al., 2009). Traffickers and pimps tend to prey on young females in popular areas for youth to congregate such as movie theaters, shopping malls, and social networking sites (Kotrla, 2010).

Human service providers and legislators are very concerned about the rise of domestic sex trafficked minors occurring within U.S. cities and the lack of services and treatment centers available for this population of victims (Clawson & Grace, 2007; Jordon et al., 2013; Kotrla, 2010; McClain & Garrity, 2011). At-risk youth (e.g., homeless or runaway teenagers) will likely be approached by a trafficker within 48 hours after leaving home (Polaris Project, 2011). According to the Innocence Lost Initiative, it is estimated that over 56,000 runaway American youth are in danger of being trafficked, and since the inception of the initiative, only 2,000 minors have been rescued from sex trafficking operations (Jordan et al., 2013).

Currently, research and services for recognizing and treating these victims are lacking (Clawson & Grace, 2007; Jordan et al., 2013). Clawson and Grace (2007) found that many human service providers and social workers were not even clear on the definition of a domestically trafficked individual and lacked the skills to identify or assess a trafficked victim. In addition, they found that services provided for this population were inadequate and ineffective in treating the complex issues of a trafficked victim (Clawson & Grace, 2007).

Domestic Sex Trafficking: Physical Health and Mental Health Consequences

The physical and mental health consequences of an individual being trafficked for sexual exploitation are complex and intense. Research has shown that victims of this

form of sexual exploitation are at high-risk for a myriad of short-term and long-term health problems; some will even be at risk for chronic illnesses such as HIV and certain types of cancer resulting from sexually transmitted diseases (STDs; Banovic & Bjelajac, 2012; Clawson & Goldbatt Grace, 2007; Dovydaitis, 2010; Hardy et al., 2013; Huda, 2006; McClain & Garrity, 2011; Muftic & Finn, 2013). Most of these victims will also exhibit symptoms of mental illness consistent with sexual exploitation, with most of them displaying symptoms of complex PTSD and trauma (Abu-Ali, 2011; Banovic & Bjelajac, 2012; Clawson & Goldblatt Grace, 2007; Hardy et al., 2013; Hossain et al., 2010; Huda, 2006; Muftic & Finn, 2013; Tsutsumi et al., 2008; Zimmerman, Hossain, & Watts, 2011). The next sections will review current research relating to physical and general mental health issues (e.g., anxiety and depression), as well as complex PTSD. Because literature on the topic of sex trafficking in the United States is limited, international research on sex trafficking victims will also be examined as a starting point for understanding domestic victims.

Physical health consequences. Previous studies on the health consequences of victims of sex trafficking have identified a considerable number of diseases and illnesses that victims are at high risk for developing (Bozidar & Bjelajac, 2012; Clawson & Goldbatt Grace, 2007; Dovydaitis, 2010; Hardy et al., 2013; Huda, 2006; McClain & Garrity, 2011, Muftic & Finn, 2013). These health issues are a result of harsh living conditions, the nature of sex work, repeated beatings and physical abuse by a trafficker or client, and a lack of necessary health care (Clawson & Goldbatt Grace, 2007; Dovydaitis, 2010; Hardy et al., 2013; McClain & Garrity, 2011, Muftic & Finn, 2013). Muftic and Finn (2013) found that health consequences for sex trafficking victims being exploited on

the streets versus an establishment (i.e., brothel) did not differ much. Most, if not all, victims exhibited at least some health issues (Clawson & Goldbatt Grace, 2007; Dovydaitis, 2010; Hardy et al., 2013; McClain & Garrity, 2011, Muftic & Finn, 2013). These issues included somatic complaints (e.g., headaches, stomach pain, chronic pain), malnutrition, weight loss, fatigue, addiction (which is often forced upon the victims as a method of control), injuries (e.g., knife wounds, severe bruising, cigarette burns, fractures, complications from rape), and issues related to sex work (e.g., HIV, STDs, pelvic inflammatory disease, unwanted pregnancy, unsafe abortions, etc.: Bozidar & Bjelajac, 2012; Clawson & Goldbatt Grace, 2007; Dovydaitis, 2010; Hardy et al., 2013; Huda, 2006; McClain & Garrity, 2011, Muftic & Finn, 2013). This long list of identified health issues shows that victims of sex trafficking are almost always in need of medical attention.

As noted above, the research on domestically trafficked victims is limited, but, according to a study by Muftic and Finn (2013), domestically trafficked sex workers were more likely than internationally trafficked sex workers to have poorer health outcomes and were more likely to suffer from addiction, thoughts of suicide, and chronic illness. The lack of safe medical care only complicates many of these health issues, making later treatment more difficult, lengthy, and expensive (Clawson & Goldbatt Grace, 2007; McClain & Garrity, 2011).

Similar to human service providers, many health care providers are not adequately trained to recognize signs of sex trafficking victimization in their patients (McClain & Garrity, 2011). McClain and Garrity (2011) postulate that nurses and doctors, specifically those working in trauma centers and emergency rooms, are in a distinct position to

identify victims of sex trafficking, especially trafficked minors. It is quite possible that health care workers will come in contact with a trafficking victim while they are still being trafficked (Dovydaitis, 2010). Health care providers' awareness of the common health concerns of trafficked individuals and other identifiable factors (e.g., runaway, older boyfriend, signs of violence and psychological trauma) may help to rescue victims of sex trafficking (McClain & Garrity, 2011).

Mental health consequences. Internationally, victims of sex trafficking have displayed symptoms of a variety of mental health consequences, most believed to be a result of the trafficking experience, although many victims also reported abuse prior to recruitment which may complicate their mental health upon rescue (Abu-Ali, 2011; Banovic & Bjelajac, 2012; Clawson & Goldblatt Grace, 2007; Hardy et al., 2013; Hossain et al., 2010; Huda, 2006; Muftic & Finn, 2013; Tsutsumi et al., 2008; Zimmerman, Hossain, & Watts, 2011). Multiple studies examining mental health of trafficked women found that 59-90% had a history of sexual abuse prior to their trafficking experience (Hardy et al., 2013; Lloyd, 2011; Zimmerman et al., 2008). However, experiences such as kidnapping, confinement, physical assault, psychological degradation, and sexual torture are all commonly reported experiences among trafficking survivors that have been documented by professional counselors working with victims in recovery centers (Banovic & Bjelajac, 2012). These experiences lead to complex psychological and emotional problems making recovery and reintegration programs difficult to formulate (Clawson & Goldbatt Grace, 2007).

The most commonly reported mental health consequences of sex trafficking are anxiety and depression (Banovic & Bjelajac, 2012; Chudakov, Ilan, Belmaker, & Cwikel,

2002; Hossain et al., 2010). In two separate studies, one in Nepal and the other in Israel, researchers found that victims of sex trafficking scored higher on anxiety and depression measures than sex workers who were not being trafficked (Chudakov et al., 2002; Tsutsumi et al., 2008); however, there were no differences in the rates of anxiety and depression in minors versus adult trafficking victims (Tsutsumi et al., 2008). In a separate study, Hossain and colleagues (2008) interviewed sex trafficking survivors from 12 countries; they found that half of their participants met the criteria for high levels of anxiety (48%) and depression (55%).

In addition to anxiety and depression, Muftic and Finn (2013), found that domestically recruited sex trafficking victims had very high rates of substance abuse and suicidal thoughts, and that these rates were higher for domestically recruited victims than internationally recruited victims. Furthermore, trafficked sex workers who were enslaved for a longer period of time and reported regular physical assault from their trafficker, also displayed more mental health problems (Muftic & Finn, 2013). It is possible that the repetitive nature, multiple episodes of victimization, and the length of trafficking experience (e.g., rape, sexual exploitation, torture, beatings, kidnapping, relocations, etc.) make the mental health problems of victims more intense than victims who were trafficked for a shorter period (Hossain et al., 2008). This research would indicate that though factors outside of the trafficking experience may play a role in mental health, the experience of being trafficked for sexual exploitation alone has extreme psychological consequences (Banovic & Bjelajac, 2012; Chudakov, Ilan, Belmaker, & Cwikel, 2002; Hossain et al., 2010; Stotts & Ramey, 2009; Tsutsumi et al., 2008).

Currently, there is no research on the mental health of victims of sex trafficking who have not been rescued and are still being trafficked; however, researchers believe mental health symptoms may be even more severe during the trafficking experience (Muftic & Finn, 2013; Tsutsumi et al., 2008). At this time, the available research does not allow us to have a complete picture of what many of these victims may be experiencing in regard to their general health and mental health during the trafficking experience, but so far, research does support a high prevalence of physical and mental health issues upon rescue (Banovic & Bjelajac, 2012; Clawson & Goldbatt Grace, 2007; Dovydaitis, 2010; Hardy et al., 2013; Hossain et al., 2008; Huda, 2006; McClain & Garrity, 2011; Muftic & Finn, 2013; Tsutsumi et al., 2008). Other subsequent forms of mental health problems are related to PTSD in survivors of sex trafficking.

Trauma and Complex PTSD

Mental health consequences among trafficking victims are prevalent, and researchers and human service providers suggest that the most difficult mental health problems to treat are a complex form of PTSD and complications from acute trauma (Abu-Ali & Al Bahar, 2011; Banovic & Bjelajac, 2012; Courtois, 2004; Hardy et al., 2013; Hossain et al., 2010; Tsutsumi et al., 2008). Research has shown that many victims of sex trafficking develop a form of PTSD and, for most victims, it is even more complex than war-related PTSD because of the repeated nature and the lengthy period of time in slavery (Courtois, 2004). Furthermore, these victims are also at risk for developing a “trauma bond,” also called Stockholm syndrome, with their trafficker, making recovery and reintegration lengthy processes (Hardy et al., 2013).

Posttraumatic stress disorder. Posttraumatic stress disorder is defined as a mental health condition that is the result of a traumatic event (Courtois, 2004). Symptoms of this disorder include extreme moments of anxiety, nightmares, social withdrawal, flashbacks, and inability to connect with others and one's environment (Banovic & Bjelajac, 2012). Because of the repeated nature of trafficking and the complexity of the trafficking experience for victims in a holistic (physical, emotionally, socially, psychologically, & spiritually) sense, researchers have suggested that a more accurate diagnosis for victims is Complex PTSD (Courtois, 2004; Abu-Ali & Al-Bahar, 2011). In addition to the aforementioned symptoms, Complex PTSD also includes alterations to one's sense of self and interpersonal skills (e.g., poor emotion regulation, difficulty with affective behaviors), attention and problems with consciousness, difficulty with attachment, and beliefs about the trafficker that result in giving false meaning to the trafficking experience (Abu-Ali & Al-Bahar, 2011, Courtois, 2004). Furthermore, when trauma occurs during childhood, there is potential for developmental disruptions and mental health symptoms may be more severe (Abu-Ali & Al-Bahar, 2011, Courtois, 2004).

The prevalence of PTSD in trafficking victims has been documented in international studies, but no empirical studies on domestically trafficked victims and PTSD were found. In an international study on sex trafficked survivors in twelve countries, Tsutsumi and colleagues (2008) found that 77% of women met the criteria for a PTSD diagnosis, with those reporting sexual violence (e.g., rape) during the trafficking experience being strongly associated with PTSD. Another study of sex trafficking victims in Nepal, found that approximately 30% of victims scored above the cutoff point

for PTSD; indicating that the incidence of PTSD in trafficking victims was higher than that found in the general population. Hossain and colleagues (2010) also found that victims who had been rescued from trafficking for longer periods of time had lower levels of depression and anxiety than newly rescued victims, but did not have lower levels of PTSD. This might suggest that PTSD continues to be a mental health complication beyond other mental health consequences. Two other Israeli studies that examined mental health of sex workers in brothels and those awaiting deportation found the existence of PTSD in approximately 20% of these women. This was not as prevalent as in the other studies; however, in the Israeli studies, not all of the sex workers met the criteria of a trafficking victim (Chudakov et al., 2002; Cwikel, Chudakov, Paikin, Agmon, & Belmaker, 2004).

According to Abu-Ali and Al-Bahar (2011) and Courtois (2004), further psychological consequences related to the complex trauma of trafficking include splitting (dissociation), self-harm, suicide, and hostility. Similar to studies on child abuse and domestic violence, it is theorized that the abused victim develops a good “self” and a bad “self” (i.e., splitting/dissociation) in order to cope with the abuse (Celani, 1994). For many trafficking victims, a pimp’s design to recreate them (psychologically and through giving them false identities), could further exacerbate the development of a separate “bad” self. Even when the abuse has stopped, there is a risk the survivor will revert back to her exploited “bad” self when they are under stress and seeking interpersonal validation (Abu-Ali & Al Bahar, 2011). Additionally, children who have been treated after trafficking abuse have been known to display self-injurious behaviors, hostility, and suicidal thoughts as a result of the trauma (Abu-Ali & Al Bahar, 2011, Courtois, 2004).

According to Hardy and colleagues (2013), though complex PTSD has not been validated empirically for domestic minor sex trafficking victims, many therapists and mental health providers working with this population have found the diagnosis of complex PTSD to be a more accurate diagnosis for the clients. Additional research on this area of mental health could provide clinicians with a clearer direction of the necessary treatments needed and how to provide optimal care for survivors. It is commonly acknowledged by mental health professionals working with this population that treatment for these victims is complex and lengthy (Clawson & Golbatt Grace, 2007, Hardy et al., 2013).

Stockholm syndrome and trauma bond. Stockholm syndrome, though originally developed to describe the positive feelings towards a perpetrator in a hostage situation (Fabrique, Van Hasselt, Vecchi, & Ramona, 2007), has been used to understand the emotional bond that is frequently present between the victim and perpetrator of child sexual abuse and pimp-controlled prostitution (Graham, 1994; Julich, 2010). One review by Graham (1994), examined the possibility of Stockholm syndrome among nine groups of individuals defined as captives, one of which was prostitutes under the control of a pimp. Graham (1994) found that, in all nine groups, Stockholm syndrome could be found in conjunction with the following criteria:

- 1) Perceived threat to survival and the belief that one's captor is willing to carry out that threat,
- 2) The captive's perception of some small kindness from the captor within a context of terror,
- 3) Isolation from perspectives other than those of the captor, and
- 4) Perceived inability to escape (p. 33).

In addition, through the use of structured interviews with adult survivors of childhood sexual abuse, Julich (2005) proposed that some childhood sexual abuse victims were at risk of developing Stockholm syndrome when the victim was under the captor's control for an extended period of time (i.e., similar to a trafficking victim). She suggested that many victims continued to struggle with this traumatic bond long after the abuse had subsided and, as a result, it deterred many victims from reporting the crime (Julich, 2005).

Researchers and leading professionals working with trafficking victims also believe that Stockholm syndrome, or a trauma bond, exists between many victims and their traffickers (Jordan et al., 2013, Smith et al., 2009). The Department of Health and Human Services' trafficking fact sheet defines the 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.1). For many domestically recruited trafficking victims, pimps work through a highly-sophisticated "grooming" process with victims where they may pose as an older boyfriend, friend, or confidant and actively cultivate an emotional bond between themselves and the victim (Albanese, 2007 as cited in Jordan, Patel, & Rapp, 2013). The trafficker then uses this emotional bond to coerce and manipulate the victim to become submissive to the trafficking process, frequently inciting violence at points where the victim pushes back or is hesitant to comply (Smith et al., 2009). The trafficker will also force the victim to refer to him as "daddy" and insist that they develop a "family unit" with other trafficking victims under the control of the same pimp (Smith et al., 2009). To maintain the "trauma bond," traffickers (pimps) will require total dependence by the victims (financially, psychologically, emotionally, physically); this bond is thought to be

one of the main reasons that victims are too fearful to leave captivity, fail to report abuse to law enforcement, and may even return to captivity (Smith et al, 2009). Based on these findings, it is quite possible that many survivors of sex trafficking display symptoms of Stockholm syndrome, an implication important to treatment of survivors of sex trafficking.

It can be presumed that many trafficking victims and survivors will experience some mental health problems in the form of anxiety, depression, PTSD, Stockholm syndrome, and complications from trauma (Abu-Ali & Al Bahar, 2011; Banovic & Bjelajac, 2012; Courtois, 2004; Hardy et al., 2013; Hossain et al., 2010; Tsutsumi et al., 2008). These consequences can have short-term and long-term implications for the victim (Abu-Ali & Al Bahar, 2011). In addition to these mental health consequences, PTSD from sexual trauma has been linked to attachment difficulties. There are currently no empirical studies on trafficking and attachment disorders, but some professionals believe that this may also be an area of mental health that will affect survivors of sex trafficking (Abu-Ali & Al Bahar, 2011; Courtois, 2004).

Attachment Theory as a Mechanism for the need for Long-Term Treatment

Attachment theory has been used as the theoretical framework for many types of research seeking to develop therapeutic models for victims of traumatic experiences due to its empirically validated belief that individuals' attachment styles have ramifications for their cognitive, social, and emotional state (Aideuis, 2007; Courtois, 2004; Joubert, Webster, & Hackett, 2012; Pearlman & Courtois, 2005; Stubenport, Greeno, Mannarino, & Cohen, 2002). Traumatic experiences and disrupted attachment relationships can lead to further mental health consequences and can impede a victim's ability to develop a

secure attachment base on which to begin recovery, develop healthy relationships and create a healthy internal working model that allows for processing social information in a positive manner (Aideuis, 2007; Dykas & Jude, 2011; Pearlman & Cortois, 2005). Courtois (2004) listed attachment disorders as results of PTSD and complex trauma (e.g., sexual abuse) as a possible mental health consequence for trafficking victims. The identified problems with attachment are defined as “alterations in relationships with others” and are characterized by an inability to trust and develop meaningful relationships with others (Courtois, 2004, p. 414). The multiple traumas experienced by a victim (e.g., a child separated from his or her family; repeated physical, psychological, and sexual abuse; inability to trust trafficker; a loss of healthy relationships) can create detachment behaviors in victims in the future when they try to develop relationships for fear of abuse or abandonment (Abu-Ali & Al Bahar, 2011).

Attachment theory. Originally developed by John Bowlby, attachment theory has become a foundational theoretical framework for a multitude of research and therapeutic models addressing issues across the lifespan (Dykas & Cassidy, 2011). Bowlby postulated that humans develop an internal working model that guides their self-perception, social interactions, and the manner in which they view the world around them. It is through this template that they gather and interpret information occurring through social interactions with parents, peers, and significant others (Dykas & Cassidy, 2011). Attachment theory was chosen as a potential theoretical framework for trafficking victims because of the complexity of trauma experienced by trafficking victims and the well documented role of attachment disorders involving victims of complex trauma

(Aideuis, 2007; Courtois, 2004; Joubert, Webster, & Hackett, 2012; Pearlman & Courtois, 2005; Stubenport, Greeno, Mannarino, & Cohen, 2002).

Bowlby theorized that based on the internal working model formed in infancy, the individual begins to process social information in a somewhat subconscious, continual manner throughout the lifespan (Dykas & Cassidy, 2011; Pearlman & Courtois, 2005). Whether this information is interpreted in a positive or negative manner depends heavily on the type of foundational attachment template in existence in their internal working model. For example, in infancy children develop either a secure or insecure attachment to their primary caregiver (i.e., their first social interaction). When infants develop a secure attachment to their primary caregiver, they have developed a sense of trust and safety with the caregiver that allows them to explore their world and process social information with a positive bias (Dykas & Cassidy, 2011). In contrast, insecurely-attached infants will process social information by excluding it, if they perceive it will cause them psychological pain, or they will process with a negative bias (Dykas & Cassidy, 2011), or they will develop a defense mechanism that keeps painful experiences from their consciousness (Joubert et al., 2012). These segregated systems lay the groundwork for the development of an insecure-fearful/avoidant/disorganized attachment style that can lead to dissociation (i.e., splitting into the good and bad self). This form of extreme defensive mechanisms is usually a result of traumatic experiences (during infancy or later in the life course) and is thought to be a biological response for psychological survival (Joubert et al., 2012). Other forms of insecure attachment, insecure-preoccupied and insecure-dismissing, are also seen in infants enduring abuse and neglect, as well as survivors of trauma, though research shows insecure-fearful/avoidant/disorganized

attachment to be the most prevalent in survivors of trauma (Joubert et al., 2012; Pearlman & Courtois, 2005; Stubenbort et al., 2002).

Additional studies conducted with adolescents found similar patterns of processing information with a positive or negative bias based on their attachment style (Dykas & Cassidy, 2011). In addition to social interactions, attachment has contributed to overall healthy development, cognitive functioning, and future romantic relationships (Dykas & Cassidy, 2011; Joubert et al., 2012). Bowlby hypothesized that once this template is set, the internal working model is a foundation in the mind that becomes increasingly difficult to alter over the course of an individual's life (Dykas & Cassidy, 2011). The positive side of that hypothesis is that survivors of trauma with a previously secure-attachment base display more resilience than survivors with a previous insecure-attachment, however, insecurely attached individuals may be more vulnerable to future abuse (Mcehleran et al., 2013; Stubenbort et al., 2002)

Attachment and complex PTSD/trauma. Complex PTSD/trauma is defined as “chronic difficulties in many areas of emotional and interpersonal functioning” (Aideuis, 2007, p. 547). There are seven stated domains of complex trauma and the first deals with attachment:

The child experiences uncertainty about the reliability and predictability of the world; social isolation; distrust and suspicion; interpersonal difficulties such as conflict with parents/caregivers, siblings, peers, and teachers; difficulty attuning to the emotional state of others; and misunderstanding and misinterpreting social cues (Aideuis, 2007, p. 547).

Individuals with a diagnosed form of complex PTSD/trauma frequently feel detached from friends and family, struggle with affective behaviors, and withdraw from social situations (Pearlman & Courtois, 2005). In a study of college-aged women with a history of abuse and sexual victimization, Sandberg (2010) described participants as having a fearful (avoidant/disorganized), pre-occupied, and dismissing attachment, and victims showed classic symptoms of PTSD. It was thought that these women's attachment issues could significantly contribute to the development and continued symptomology of PTSD (Sandberg, 2010). In other words, the interaction between their PTSD/trauma symptoms in relation to their attachment difficulties created a cycle of reinforcement for both attachment and trauma symptoms. Furthermore, individuals with attachment disorders will develop unhealthy relationships with other individuals with poor attachment deepening the inability to trust and develop healthy attachments (Pearlman & Courtois, 2005). Those individuals who are exposed to chronic levels of abuse (e.g., abuse or trafficking) are at a high risk of developing a disorganized and dissociative attachment style (Pearlman & Courtois, 2005). For many, this could be the result of previous attachment difficulties or the traumatic events alone.

In a therapeutic situation with survivors of complex trauma, victims present with one of three classified attachment styles, insecure-preoccupied, insecure-dismissing, or insecure fearful-avoidant (disorganized/dissociative; Pearlman & Courtois, 2005). Insecure-preoccupied survivors present with highly emotional behaviors, without cognitive organization. They are unable to manage their own affect and frequently are dependent on addictive behaviors to control their emotions and impulses. They frequently develop unhealthy attachments as an unconscious impulse due to the fear of isolation

(Pearlman & Courtois, 2005). Insecure-dismissing attachment survivors present with patterns of denial, defensiveness, and discomfort with intimate relationships (Pearlman & Courtois, 2005). These individuals are characterized by minimalizing their feelings and rejecting efforts made by others to offer them assistance or comfort (Pearlman & Courtois, 2005). Finally, the most common style of attachment presented with survivors of chronic trauma is the insecure-fearful/avoidant (disorganized/dissociative) style (Pearlman & Courtois, 2005). These survivors are likely to present a highly disorganized internal working model that can include clinging and rejection, avoidance and splitting, highly unstable emotion and impulse control, and are considered to be dangerous to themselves and others (Pearlman & Courtois, 2005). For survivors in this category their attachment to previous caregivers is described as a “source of comfort and danger,” meaning they may have been dependent on them for survival, but also suffered abuse at the hands of the attachment figure (Pearlman & Courtois, 2005, p. 454).

Based upon this review of existing literature, it is possible that survivors of trafficking diagnosed with complex PTSD/ trauma could also have significant attachment disorder. The empirical evidence presented on attachment difficulties and the vulnerabilities it creates in children, it is plausible to assume that some victims of trafficking are coerced into traumatic relationships with their traffickers due to an existing attachment disorders related to the high prevalence of prior sexual abuse found in victims (Aedieus, 2007; Pearlman & Courtois, 2005, Zimmerman et al., 2008). This type of unhealthy attachment further exacerbates the condition, leading to further issues with trust and interpersonal skills (Pearlman & Cortois, 2005). In addition, some trafficked victims may have been taken or isolated from their families causing them to

struggle to make sense of that loss while enduring further trauma (Abu-Ali & Al Bahar, 2011). It is likely that they will struggle with feelings of abandonment and perhaps hostility toward their family, while developing an unhealthy attachment to their trafficker due to their need for survival (Abu-Ali & Al Bahar, 2011). In turn, the trafficker becomes the victim's primary caregiver and a chaotic, unhealthy attachment develops (e.g., trauma bond); when this relationship dissolves it further complicates the feelings of loss, mistrust, and abandonment (Abu-Ali & Al Bahar, 2011).

Research dealing with recovery for sexually abused children found that a secure attachment between a victim and his/her parents could aid in the recovery process for the victim, especially when the parents were involved in the therapeutic process (Stubenbort et al., 2002). Stubenbort and colleagues (2002) also found that a secure attachment may even act as a buffer for traumatic experiences due to children's ability to process the trauma with a more positive construct due to a secure internal working model. Children with a secure attachment template are more open and trusting of the therapeutic process (Stubenbort et al., 2002). In contrast, children with an insecure attachment relationship with their parents remained in an agitated state, were less trusting of the therapeutic process, and were more likely to engage in unhelpful or even harmful coping strategies (Stubenbort et al., 2002). This is important to the understanding of trafficking victims and the process of victimization and recovery. Trafficking victims come from varied backgrounds, but many may have an internal working model consistent with literature describing attachment for survivors of complex trauma. This viewpoint helps us understand why survivors with past victimization prior to the trafficking experience might have been more vulnerable to the coercion of a trafficker and how the therapeutic

intervention for survivors will require addressing attachment history (Pearlman & Courtois, 2005; Zimmerman et al., 2008).

To illustrate, research has shown interplay between abuse, attachment, and complex PTSD/trauma; thus emphasizing the need for treatment to allow for a safe place where healthy, secure attachment can develop as a foundation for other forms of treatment (Sandberg, 2010). Currently, recovery centers for trafficking victims in the United States are limited and those that do exist are challenged by financial restraints and an unhelpful legal process in many states (Clawson & Goldblatt Grace, 2007). Further research is needed to confirm complex PTSD and attachment disorders as mental health consequences common to trafficking survivors and bolster support for a more refined legal process that allows survivors to receive long-term care where attachment can develop.

Treatment Services and Reintegration

Research on best practice transitional and transformational care is very limited; however, in an effort to provide guidance and a framework for services to trafficking victims, several studies and reports have been written based on what is believed to be the most effective treatment for survivors (Clawson & Dutch, 2008; Clawson & Goldblatt Grace, 2007; Clawson, Salomon, & Goldblatt Grace, 2008; Macy & Johns, 2010). The following section will review the current recommendations and challenges facing services for survivors of trafficking starting from rescue through reintegration.

Rescue. Human trafficking is a difficult crime to track due to the hidden nature of the criminal enterprise and the heavy use of the internet to advertise and sell victims (Clawson & Goldblatt Grace, 2007). Currently, there is a lack of standardized processes

and procedures for the placement and treatment of victims upon rescue. In fact, service providers struggle to develop a cohesive procedure for processing victims and financing the services that are required (Clawson & Goldblatt Grace, 2007; Clawson, Salomon, & Goldblatt Grace, 2008). This is largely because different disciplines have different requirements for the use of services and how funds can be used; this creates logistical issues and leaves law enforcement with a rescued victim with minimal options for placement and services (Clawson & Goldblatt Grace, 2007; Clawson et al., 2008). The lack of available shelters and beds for victims frequently results in victims being placed in detention centers, traumatizing the victims again and creating an immediate barrier to the development of trust for further services and investigation (Clawson & Goldblatt Grace, 2007; Clawson et al., 2008). In addition, law enforcement officials and human service providers frequently report a lack of understanding of human trafficking, how to identify victims, and what services victims need and are entitled to receive (Clawson & Dutch, 2008; Clawson & Goldblatt Grace, 2008; Clawson et al., 2008). A starting point for government agencies and nonprofits working on the issue of human trafficking is to educate law enforcement officials and social workers to recognize the signs of trafficking and how to process victims and assist them in receiving services (Clawson & Dutch, 2008; Clawson & Goldblatt Grace, 2007). Upon rescue, victims would be processed by law enforcement and then referred to a site available for aftercare services where a comprehensive, sensitive needs assessment should be done to determine the immediate, ongoing, and long-term needs of the victim (Macy & Johns, 2010). The next steps for victims would be based on the results of the needs assessment, the legal situation of the victims, and the age of the victim. However, in most states these processes are either non-

existent or still being developed, leaving victims to receive care that is far below the recommended services (Sanborn et al., 2010).

Short-term transitional care. Developing and providing best practice services and treatment to trafficking victims is one of the greatest challenges facing human service providers (Clawson & Dutch, 2008; Clawson et al., 2007; Sanborn, Lew, Kimball, Latiolas, Desai, & Avila, 2010). According to one study that examined directors and staff at current centers where trafficking victims were treated, the common themes for treating the immediate needs of trafficking victims included a multidisciplinary response by multiple service providers (Sanborn et al., 2010). According to Macy and Johns (2010), the immediate needs that are required for a victim are crisis safety and shelter services, basic necessities (e.g., food, clothing, hygiene items), immediate/emergency medical care, legal representation, translation services, and confidentiality. Studies conducted by the Department of Human Services and Children at Risk identified similar reported needs by law enforcement officials and shelter social workers, emphasizing the need for confidentiality and a safe location to house victims away from areas with high crime or trafficking rings (Clawson & Dutch, 2008; Sanborn et al., 2010). Currently, most of these shelters allow victims to stay between 30 and 90 days, but because of a lack of resources, funding, and the current treatment model, extended care is limited (Sanborn et al., 2010).

Long-term transformational care. In 2010, Children at Risk, based in Texas, reported that non-profit organizations offering long-term transformational care to domestic minor sex trafficking (DMST) victims were very limited. In fact, at that time there were fewer than 100 available beds for victims in the United States. Yet, clinicians,

social workers, and experts dealing with human trafficking agree that long-term transformational care is extremely important to the restoration of trafficking victims (Clawson & Goldblatt Grace, 2007; Clawson & Dutch, 2008; Sanborn et al., 2010).

Clawson and Goldblatt Grace (2007), interviewed service providers who felt that the short-term length of care and services provided to victims were making it impossible to offer meaningful treatment. In addition, law enforcement officials believed that youth shelters (a common placement for trafficking victims) did not know how to effectively treat trafficking victims because of the complexity of their needs (Clawson & Goldblatt Grace, 2007). In the case of DMST victims who were being held in detention centers on other charges (e.g., truancy), victims were being treated as criminals and any services they did receive did not address the issues they faced from the exploitation (Clawson & Goldblatt Grace, 2007). Current recommendation for long-term care are based upon reports from direct service providers, due to the lack of solid research or the development of a best practice approach to working with trafficking victims (Clawson & Goldblatt Grace, 2007; Clawson & Dutch, 2008; Sanborn et al., 2010). The recommendations for long-term, holistic care include safety, confidentiality, housing, length of stay (recommended a minimum of 18 months), safe location, basic hygiene and necessities, regular medical and dental care, mental health counseling, education, job skills, life skills, legal services, advocacy, substance abuse treatment, transportation, financial assistance, child care, spiritual care, and repatriation or reunification (Clawson & Goldblatt Grace, 2007; Clawson & Dutch, 2008; Sanborn et al., 2010). Although there are varying opinions about the exact nature of these services, one commonly reported theme is that without long-term transformational care, service providers are not able to build healthy,

trusting relationship with the victims (Clawson, Salomon, & Goldblatt Grace, 2008).

Because research on complex trauma includes attachment disorders as one of the underlying mechanisms of the trauma (Courtois, 2004), this study seeks to explore, from the perspective of service providers, whether trafficking victims with potential attachment disorders are able to accept treatment and build trusting relationships without long-term care. Previous research has identified the lack of trusting relationships as a hindrance to victims accepting treatment, but there has been no research exploring the relation between providing long-term care and the possibility of a healthy attachment through receiving long-term services and the impact on reintegration.

Reintegration. Reunification, repatriation, and reintegration are all components of the healing process for trafficking victims (Clawson & Dutch, 2008). Current recommendations are minimal and non-specific. Most service providers recognize the need for trafficking victims to restore the relationship with their family of origin when it is appropriate (Clawson & Dutch, 2008; Sandberg et al., 2010). In addition, survivors will need to reintegrate into society and may face challenges such as developing healthy relationships, avoiding relapses in substance abuse, returning to their trafficker, or finding and maintaining employment (Sandberg et al., 2010). Service providers recommend that facilities should help survivors develop a life plan (e.g., finish college) and maintain a long-term relationship with them. Some service providers believe that facilities should continue to measure key areas of the survivors' success in order to ensure successful reintegration and that a relationship should be maintained with a survivor's family and community (Sandberg, 2010). However, the limited empirical literature makes it

unknown whether these recommendations are an effective reintegration model or how frequently these recommendations are utilized by service providers.

Summary

The global epidemic of human trafficking is an international problem that will require a multi-faceted approach to ending the sale of human beings. In the United States, there are as many as 350,000 domestically and internationally recruited victims of trafficking, most of which are currently a part of the domestic sex trade (Jordan et. al., 2013; Smith et al., 2009). Yet, research examining the needs of survivors upon rescue is limited, and in many areas of the United States, there is not a clear process for how to support recovery for trafficking victims, resulting in many being imprisoned for minor crimes (e.g., drug possession) or grouped with other survivors of violence and trauma (i.e., domestic violence survivors; Clawson & Goldblatt Grace, 2007; Melton, 2013).

Currently, research on the creation of a best practices approach to rescuing (e.g. immediate care and transitional services), treating victims (long-term restorative care), and reintegrating survivors into society is very limited and in some aspects non-existent. There have been few empirical studies conducted to determine the multi-disciplinary response needed to restore victims (Macy & Johns, 2011). In addition, human services and law enforcement continue to have difficulty identifying victims and a lack of services results in many rescued children being incarcerated for protection where they receive no treatment and are further victimized (Children at Risk, 2010). The lack of empirical evidence makes determining the process from rescue of a victim to reintegration into society a challenge and much of the current recommendations for victims are borrowed from treatments used for victims of other forms of complex trauma (Clawson & Goldblatt Grace, 2007). In order to develop best practice treatment services for trafficking victims,

human service providers must first understand the complexity of the needs of these victims.

Therefore, the purpose of this descriptive, qualitative study was to explore, from the perspective of service providers, the recommended steps for immediate treatment of a trafficking victim upon rescue through the use of a multiple disciplinary response by multiple service providers (transitional care). In addition, transformational care (i.e., long-term treatment) for survivors was explored. It was also the purpose of this study to discover what components of treatment needed to be present for restoration of victims and reintegration into society with an emphasis on understanding the role attachment and the development of trusting relationships play in this process.

III. METHODOLOGY

This study was designed to examine the treatment approach multiple service providers recommend when working with domestic minor trafficking victims upon rescue through transitional, and ultimately transformational care. In addition, transformational care (i.e., long-term treatment) for survivors was explored by looking at the attachment template as a necessary underlying mechanism for treatment. This study also explored what components of treatment need to be present for restoration of victims and reintegration into society. A descriptive, qualitative research design using interviews was chosen as the most informative method of collecting data to answer the research questions.

Participants

Participants for this qualitative study were recruited through personal contact with professionals from multi-disciplinary fields represented at the Alamo Area Coalition against Trafficking (AACAT). AACAT is a federal task force representing Bexar county and the surrounding counties, specifically tasked with addressing the issue of human trafficking from a multi-disciplinary approach. AACAT was chosen as an optimal research sample due to the researcher's current relationship with AACAT and the large number of professionals on the task force who are directly involved with addressing human trafficking.

The researcher made requests for interviews through personal contact or e-mail, beginning with existing contacts through the coalition and by referrals (i.e., purposive snowball sampling) from coalition members. Participants were required to be currently working in a professional discipline relevant to domestic minor sex trafficking and be a

member of the coalition or an employee of an agency represented at the coalition.

Individuals interviewed were all English-speaking and were available to participate in a face-to-face interview with the researcher.

In order to explore the topic through a multi-disciplinary, multi-agency perspective within the coalition, the sampling included fifteen participants from the criminal justice, social work, and mental health fields. There were nine females and six male participants, 11 of the participants had received a Master's degree or higher level of education, and the remaining four had obtained a Bachelor's in their respective fields. There were six participants from the field of criminal justice, six mental health professionals, and three social workers. The median length of time working with victims was 4.2 years (range = 2-10 years) and 13 of the participant had received formal, specific training on working with trafficking victims. The participants provided a description of the professional services they provided to domestic minor sex trafficking victims including identification and assessment of victims, referral services, court services, individual and family therapy/counseling, mentor services, and public awareness/training. All participants who were interviewed for the study were included in the final sampling. After the completion of fifteen interviews, the researcher determined that saturation had been reached.

Procedures

After obtaining approval from the Texas State Institutional Review Board, the researcher informed coalition members about the research study during coalition meetings. Those individuals who expressed an interest in participating in the study received a follow-up e-mail with an official invitation to be part of the study, a synopsis

of the study, and guidelines for setting up an interview date and time. A copy of the invitation e-mail can be found in Appendix A.

The researcher met with each individual to conduct a face-to-face interview at their convenience in a neutral location. Most participants chose to do the interview in their professional office or conference room. Every interview was recorded using an electronic tablet after obtaining permission from the participant for audio recording. Informed consent (Appendix B) was obtained from participants prior to the interview and after informing them of the benefits and risks of participation and ensuring confidentiality. In order to increase reliability of procedures through consistency of data collection, the researcher conducted all interviews personally (Creswell, 2009).

After obtaining consent, the researcher asked each individual to complete a demographic questionnaire (Appendix C) prior to the interview. The questionnaire included sex, professional discipline, level of education, length of direct care to domestic minor sex trafficking victims, trafficking-specific training, and a description of specific services provided. The basic demographic information questionnaire ensured that all data were not collected from one discipline (e.g., social work), but rather from a diverse sampling of multiple disciplines (i.e., source triangulation; Creswell, 2009). A face-to-face semi-structured interview was used to collect data (Appendix D). This allowed the researcher to explore her initial research questions and, at the same time, allowed for follow-up questions to clarify and probe into additional issues that arose during the interview process (Creswell 2009). It also allowed the researcher to gain a greater understanding of the participants' responses.

After the completion of interviews, all participants were coded numerically using the demographic questionnaire so that their names, titles, agencies, or any other identifiable information remained confidential with only the primary researcher having access to identifiable information. All transcribed interviews, notes from interviews, and participant forms were kept in a secure filing cabinet in the researcher's office. Recorded interviews were password protected on the researcher's tablet. Once they were transcribed verbatim and re-checked for errors, the interviews were deleted from the recording device.

Data Analysis

The data collected in the study followed general qualitative data analysis pathway (Braun & Clarke 2006; Creswell, 2009). Data were analyzed from three different disciplines: criminal justice, social work, and mental health in order to increase the validity of the research through triangulation of sources with the intent to gain a broader perspective from service providers (Creswell, 2009; Creswell & Miller, 2000). Specifically, raw data were transcribed verbatim from the recorded interviews, data were thoroughly reviewed, and data were coded numerically according to interview number and alphabetically by professional field (Creswell, 2009). For example, the first interview with a social worker was assigned the code 1S and subsequent interviews 2S, 3S, etc. Once the interviews had been assigned a code, they were organized by discipline. In order to increase the reliability of the data and minimize researcher bias, a team of coders (i.e., analyst triangulation; Creswell & Miller, 2000) were used for thematic analysis and to independently code data using the method outlined by Braun and Clarke (2006). The coders met weekly to compare codes and ensure intercoder agreement was reached

(Creswell, 2009). Using the deductive approach, data were examined for themes that fit into the different recommended services for domestic minor trafficking victims and for the theme of attachment. In addition, data were reviewed using the inductive approach where coders looked for emergent themes that were strongly linked to the data, but did not exist in the initial research questions (Braun & Clarke, 2006; Creswell 2009).

Finally, the organized data were used to interpret and bring meaning to the data in regard to services for domestic minor sex trafficking victims based upon the different components of care.

IV. RESULTS

Thematic analysis of the data collected allowed for the emergence of four main themes: attachment, comprehensive services, potential barriers to treatment, and potential factors to strengthen services. Although attachment emerged as an underlying mechanism for the development of services, the way it was explained by the participants differed from the initial research question. Specifically, rather than a diagnosis of attachment disorders and the development of a subsequent treatment plan, the participants viewed attachment impairment and the recreation of that template as a theme that should be woven through all aspects of treatment. The comprehensive services that emerged as subthemes were basic services, including shelter, legal services, medical services, mental/emotional services, educational/job skills, and substance abuse treatment. In addition, the participants discussed potential barriers to treatment, including lack of services, criminalization of victims, and victims' failure to self-identify, and potential factors to strengthen provided services, including a comprehensive, agreed upon approach, the development of trust between victims and service providers, and empowerment of the victim. Taken together, the results from this study provide important implications for professionals working with victims of domestic minor sex trafficking.

Attachment Framework

The theme of attachment was unanimously discussed by participants ($n = 15$) as a hindrance to victims' for recovery. All but two participants specifically mentioned the ability to develop and maintain healthy, trusting relationships as an obstacle for trafficking victims. In addition, participants ($n = 11$) agreed that most victims struggled

to set boundaries and recognize an unhealthy relationship. One mental health (MH) participant said that victims “trust too little or too much” and “not having those firm boundaries,” they will “just kind of go with anybody and everybody and trust that they are going to be able to survive.” Another MH participant described it this way, “Certainly one of the impacts of the traumatization is the disruption of their basic ability to attach to others and have trusting relationships.” Criminal justice (CJ) participants echoed the high-importance of attachment from the criminal justice perspective with statements such as, “I think that is probably one of the biggest things we have to focus on is attachment” and “I think the majority of kids have to have an attachment with someone.” The theme of attachment was repeatedly emphasized by participants from all disciplines and discussed by various participants in terms of previous and current attachments with the victim’s family, attachment as a dyadic factor in the trafficker-victim relationship, and attachment as an underlying mechanism for the development of services.

All of the participants discussed the history of trauma, abuse, and dysfunctional family backgrounds as a risk factor for youth entering a trafficking situation. The majority ($n = 12$) also attributed impaired attachments to trauma and dysfunction prior to the trafficking experience in the form of a dysfunctional family history and current unstable family environments. As described by participants, victims’ family backgrounds often included teenage pregnancy by their mothers, abandonment, prison, foster care, child abuse and/or neglect, drug use in the home, domestic violence, and almost always a history of sexual abuse. One MH participant said, “I think the child with secure attachment is the least likely to get involved with domestic minor sex trafficking. They are the least likely to be at risk.” CJ participants stated that victims frequently confided

that “they always want their own family, you know, they always say I am ready to have my own family” indicating a sense of loss of attachment with their primary family.

Participants from all disciplines believed that many victims came into the trafficking experience with a previous impaired attachment and the traumatization of trafficking further complicated the attachment deficiency.

Participants also discussed the vulnerability that an impaired attachment and family background created for children making it more likely for them to fall prey to the traffickers’ methods of recruitment. One CJ participant shared that a victim had said, “I am tired of latching on to someone else’s family.” She went on to say, “I think that one of the reasons they are vulnerable to the pimp’s family structure has to do with that.” Other CJ participants stated, “They have very strong bonds with their traffickers” and they believe “he is the only person who has ever loved me.” They described the victims’ connection to the trafficker as a “parasitic relationship.” The CJ professionals also said, “They repeatedly end up with the guys over and over again that are bad news for them.” Social work (SW) and mental health participants validated these statements as consistent with their perspectives. To illustrate, one MH participants said, “They [the traffickers] are deliberately programming the co-dependent relationships. Think about it, the trafficker wants them to become co-dependent on them.” Another MH participant may have summarized the attachment issues the best by saying, “They don’t know how to form healthy relationships even with themselves and because of this they are very vulnerable and that’s why perpetrators, pimps, johns, everybody just takes advantage of them.”

Despite the great consensus of attachment among participants, the diagnosis of a victim with an attachment disorder and subsequent treatment did not emerge in the data.

In fact, contrary to the initial research question regarding how the diagnosis of an attachment disorder changed the recommended treatment model, attachment was not recognized or used as a diagnostic tool. Instead, attachment impairment and the recreation of that template was being articulated as a theme that should be woven through all aspects of treatment and care from rescue through reintegration. In other words, the major theme of attachment could not be isolated to a single component of treatment because of the complexity of attachment difficulties facing victims. Instead, participants articulated the need for services to provide multiple modalities in the approach of recreating attachment throughout the healing process. These specific modalities will be discussed throughout the themes of comprehensive services, barriers to treatment, and factors to strengthen services.

Comprehensive Services

As the coding team reviewed the data to identify recommended services, it was not possible to entirely separate services by a specific phase (i.e., rescue, transitional, transformational, and reintegration) as originally planned. This was due to the manner in which participants advocated for specific services through the interview process. Generally, participants did not tease apart services based upon a specific phase of treatment, but did sometimes discuss a required service at a specific phase of treatment. Therefore, discussion of the different components of required services (i.e., basic needs, medical, mental, etc.) will be discussed and, when possible, will be separated into the different phases of treatment throughout the results section. The subthemes that emerged under the major theme of comprehensive services included the following: basic needs/shelter ($n = 15$), mental/emotional services ($n = 15$), educational services ($n = 14$),

legal services ($n = 12$), medical services ($n = 10$), substance abuse treatment ($n = 10$), and job skill services ($n = 5$).

Basic needs/shelter. Overwhelmingly, one of the most mentioned needed services that emerged from the data was meeting the imperative, basic need of shelter for victims of human trafficking. It also proved to be one of the most articulated challenges mentioned by service providers from all disciplines. One SW participant shared his experiences this way, “I can rescue 50 kids a day, but if I don’t have anywhere to put them then I am going to be rescuing the same 50 kids tomorrow.” The issue of protective shelter was not just an issue for the rescuing of victims, all participants ($n = 15$) spoke to the great lack of available shelters for the placement of victims during the short-term and long-term phases of recovery. Another issue several participants ($n = 5$) spoke of was that many shelters were not willing or able to accept domestic minor sex trafficking victims. One SW participant illustrated the challenge when she said, “The last time I checked for one of our survivors at a place [shelter], they said they’d had domestic minor trafficking victims and it just didn’t work out. They just didn’t have the level of care. The level of care is very high.” In most cases ($n = 9$) participants voiced that the only viable option for sheltering victims of domestic minor sex trafficking was in the juvenile detention center or a court-ordered juvenile residential placement within the juvenile justice system. However, these facilities were minimal as well. One CJ participant said, “If they have a criminal offense, then we have somewhere to put them. They can go to juvenile detention. Um, if they don’t have a criminal offense there is essentially nowhere to put them.”

However, the consensus on the need for additional shelter options by all disciplines was contrasted by the great degree of difference in opinions on the type of shelter. Most ($n = 5$) participants with a criminal justice background advocated for the use of a secure, lock down shelter for victims, whereas participants from the social work or mental health disciplines believed a secure, lock down detention center made the victims feel like criminals. Instead, MH ($n = 5$) and SW participants ($n = 3$) emphasized the need for victims to be in a shelter that “makes *them* feel secure” from their trafficker. CJ participants, on the other hand, differed in their perception of the benefits of a secure facility. Specifically, participants frequently stated that victims would run away and return to the streets if they were not in a secure facility. One CJ participant stated, “If the girl is locked up, quickly and put in wherever, across the nation in a lock-up facility, you are more likely to get what you need out of it with the right person. If she is in the free world, good luck, you ain’t getting nothing.” The SW and MH participants also acknowledged that victims would probably run away from a non-secure facility and a secure facility might be required in the initial stages of recovery. As one MH participant stated, “I know that they have to be detained sometimes, to get detox services at the beginning stage, some of them have high risk behavioral problems, maybe they need to go to a residential treatment facility before they go to another type of facility.”

Participants discussed several plausible solutions for the differences in opinions on shelter type and one SW participant discussed a “revolutionary transitional shelter concept” that allowed for free movement (no handcuffs or chains) by victims within the facility while all entrances and exits were guarded by security. Other participants envisioned facilities with gradual levels of freedom attained through meeting treatment

goals or multiple, collaborating facilities where victims moved from a very secure facility in the initial treatment phase to a free, open facility in the later phases prior to reintegration. Most participants acknowledged that a highly-specialized shelter or a progressive series of shelter options would be needed to house and treat the majority of victims due to the intense nature of needed services, with a focus on keeping victims safe *and* secure. One SW participant summed up the need by restating victims' comments, "The victims have told me if I can't get out, he can't get in and if he can't get in, then I can't get out."

As mentioned previously, most participants believed that a shelter was needed and could benefit most victims of domestic minor sex trafficking during their healing process. They believed the availability of immediate shelter was pivotal to meeting the most basic needs of victims, but whether victims could or should remain in one shelter through the duration of their services was unclear. However, participants from all disciplines believed that a safe shelter would allow victims more opportunity to heal and create healthy attachments away from the environments where they were initially trafficked, especially if returning home was not a healthy choice. As one SW participant voiced, "They need a place where they can establish healthy relationships and get a sense of trust." The final consideration that was raised by participants ($n = 6$) from all disciplines was the need for non-secure housing options upon reintegration, especially for victims that fall in the 18-25 age group. Several participants believed returning to the home environment and community where the trafficking began would only increase the chances of relapse for victims and halt the progress that had been made in helping them develop healthy attachment patterns. One mental health participant said relapse might be minimized if

victims could “start here (long-term care) to work on some of the early attachment and kind of commit to the treatment process and then go live in a group setting in the community.”

Mental/emotional services. All participants emphasized the importance of the presence of mental health services beginning with the initial rescue of a victim. Multiple MH participants ($n = 4$) stated that being removed from their trafficking situation could result in outbursts, escalations, dissociation, and even suicidal ideation; therefore, a trained crisis intervention mental health professional was needed to de-escalate these situations. One MH participant described it this way: “Some of the girls I have seen need immediate crisis intervention when I am there; I mean they are dissociating, they are flashbacking, and so it is a matter of getting them back into the present moment pretty much.” CJ participants ($n = 6$) also discussed the importance of having partner referrals for victims to assess and aid in the creation of a treatment plan from the onset of services. SW and MH participants ($n = 8$) discussed trauma-informed care as being the best practice approach for all service providers who interacted with a victim because, “It can be very intimidating, very scary process for them to even speak to a police officer or a counselor, or a doctor, trying to ensure their safety.” This included approaching the victim with a trauma-informed mindset that involved an understanding of the interaction between the trauma and the manifestation of specific behaviors (e.g., angry outbursts, dissociation, addiction, etc.). One MH participant described it this way, “Children of DMST need more counseling, a different type of counseling, more trauma-informed counseling rather than just, oh, let’s work off your anger over here. Or, oh, let’s just work on the symptoms actually. It’s like, let’s look more into what happened here.” Another

MH participant stated, “A lot of times clinicians who aren’t trauma-informed will diagnose a client with a normal reaction to this abnormal event.” CJ participants ($n = 3$) also recognized that trauma-informed services were becoming a part of their vernacular and approach to interacting with victims. To illustrate, one CJ participant said, “I know that a trauma-informed approach is important in the good sense of that word.” Two MH professionals also furthered the approach of trauma-informed intervention to include an attachment framework when interacting with victims from the onset of services. Because all participants believed the majority of victims began services with an impaired attachment, the relationship between each service provider and victims becomes a pillar for the foundation of continued services. One MH participant described the process this way:

Helping them be less hypervigilant, to be more regulated, and be more open to processing their experience and we really see that coming through the healthy attachment that they are forming with staff and with their therapist and their probation officers. I can’t emphasize enough that consistent, supportive, healthy attachment pattern.

During the long-term services, therapeutic intervention continues to be a significant component of care. It is during this phase that MH and SW participants ($n = 5$) discussed being able to determine the status of both mental and emotional services that are needed for the victim moving forward. Due to the diversity in the services offered and the unique service pathway to each victim, mental health services could not be divided into transitional and transformation care.

There were several therapeutic styles mentioned by MH participants and SW participants that expanded upon the basic premise of trauma-informed care. Individual strength-based therapy, creating a personal narrative, play therapy, animal therapy, and self-care were all mentioned as potentially useful therapeutic approaches with victims. In addition, participants ($n = 6$) discussed the importance of attachment and relationship skills as part of the direct therapeutic process and the therapeutic alliance. One MH discussed it this way:

Healthy attachment should be a consideration in every therapy and/or interaction with victims. Because the foundational part of it is more about caregiver impact and us as caregivers to be able to demonstrate attachment in dealing with our own emotions and modulating, so there is as much modeling as there is teaching to it.

Another SW participant believed the recreation of the attachment template was the core of the recovery process.

Teaching them how to create appropriate emotional bonds with other human beings, non-sexually based. That they have value for who they are and not what they can do. That literally helps recreate their soul in my opinion, because their souls are damaged.

Family re-unification, education and therapy were also discussed by participants as vital to the long-term healing process and foundational for successful reintegration. As mentioned previously, all participants stated the victims had dysfunctional family backgrounds. As a result, participants ($n = 13$) also emphasized the importance of bringing the family into the therapeutic process as part of a comprehensive approach to services. Several MH and CJ participants ($n = 9$) stated that services involving the family

needed to include programs that educated the family on trafficking, healthy relationships and communication skills. To demonstrate one CJ participant said, “When you have a kid who cannot communicate with a parent, I mean, who is she going to talk to.” In addition, all of the MH participants discussed including the parents and/or family system in the therapeutic process with the victim during long-term therapeutic services. MH participants discussed having “the entire family system in the room” and including “the parents in that relationship from the start.” Participants from multiple disciplines also identified the parents as having their own traumatic histories and, thus, stressed the need for potential therapeutic intervention with them. To illustrate one CJ participant said, “If they are not taken care of they are not going to take care of their kid.” Another stated it was important that service providers were “connecting them with someone stable enough to take care of them.” A SW participant also echoed the importance of this service when he said, “You need to have the parent-child therapy together, because you might not just rescue one life, you might rescue two.” MH participants ($n = 3$) also referred to parents of victims as “secondary survivors” in need of services for secondary trauma. One MH participant stated, “sometimes the kids have far less trouble with their experience than the parents do” and believed that including parents in the therapeutic process bolstered the benefits of therapy for the victim by giving tools for parents at home. This was illustrated through comments such as, “If I work with the parents they are going to do most of the healing at home.” Most participants also advocated for working on the attachment in the parent-child dyad during the therapeutic process and through education because they believed that would act as a protective factor for victims upon reintegration. This was illustrated by one MH participant when she said, “Building up those relationships before

they are reintegrated and bringing people on board beforehand. I think that piece is really critical.” Participants also believed that family therapy and reunification would create a support system for the victim within the family and that this could be a crucial piece for successful reintegration. As one MH participant said, “When the caregiver relationships are built up, it can be very much a support in helping the child transition.”

Despite participants overwhelming support of incorporating family services into the healing process for victims, they also unanimously acknowledged that the family unit was not always capable of creating healthy attachments with victims or providing an adequate support system. Due to this, all participants ($n = 15$) believed that trying to establish a support system for victims through alternate services, such as mentorships, could offer the victims the opportunity to develop healthy attachments during the transformational phase of services and act as a buffer to relapse upon reintegration. In regard to the importance of forming healthy attachments, one CJ participant said victims need “someone who can go and have a relationship with them.” Most participants also acknowledged that mentor relationships were beneficial even when it was possible for the family to act as a support system. One MH participant said, “I don’t think there can be enough resources and supports for these girls.” Participants also stated that mentors need to be aware of the importance of their role with a victim through comments such as, “once you have interjected yourself into a youth’s life, you become part of their story” and “that person needs to realize specifically that they want to be a mentor, that the child could possibly always be in your life.” Most participants ($n = 12$) viewed a beneficial mentoring relationship as being one with a trained adult who encompassed certain qualities such as being a healthy, responsible adult. They also believed the mentor could

assist survivors with life tasks (e.g. résumés, job applications, getting to appointments, etc.) and offer emotional support upon reintegration. To illustrate, one CJ participant described mentors this way, “The mentors need to be incredibly stable and put down very firm boundaries.” “Cast a [life] vision for them.” A SW participant also believed that a mentor should be “a positive adult role model” “who is a support to them and who they feel appreciates them.” One MH participant described a mentor in this way: “That person or people they can fall back on if they are having a rough day.” Though mentor relationships were thought to be beneficial to all victims of domestic minor sex trafficking, participants seemed to view the role of mentors for victims without a family support system to be even more important. One CJ participant believed it was the responsibility of the service provider “to ensure someone is there for them once they exit the program. A place where they can go and get support if they need it.” Ultimately, participants believed the mentor relationship became most vital during the reintegration phase. This was illustrated by one MH participant who said, “As we are preparing to reintroduce them into the community that’s probably the more critical time for them to have a mentor.” Several participants noted that relapse diminished with the presence of a support system including a mentor. One SW participant said a victim needed to go “from a supported environment to supported environment, otherwise they are going right back into it [the trafficking situation].” The need for mentor services was probably best described by one SW participant who said, “It takes a village and it takes a mentor and it takes someone standing beside you and encouraging you if you don’t have that support.”

Educational services. Most participants ($n = 14$) mentioned the subtheme of educational services as an essential component of care for victims during the later phases

(i.e., transformational and reintegration) of treatment. They also discussed some of the challenges facing victims and the traditional educational institutions. Participants from all disciplines stated reintegration into public high school was particularly challenging for victims. One CJ participant articulated that “some survivors have a hard time reintegrating to school” because “you have cases where they stop going to school at a very young age so it would be kind of hard to place them at a regular high school.” Several participants recommended offering multiple options for victims in terms of education (e.g., alternative schools, GED programs, homeschool programs) and one MH participant advocated that “trying to find the best fit for them” was the best practice protocol. Participants also advocated for onsite educational services for victims as a part of the comprehensive services offered at a specialized shelter.

Legal services. According to participants, the greatest legal challenge facing victims of domestic minor sex trafficking was their own criminal histories. Currently, most victims of domestic minor sex trafficking are identified through the juvenile criminal justice system. According to all CJ participants, most victims were picked up on charges such as failure to ID, drug possession, assault, truancy, runaway, or violation of probation terms. These victims were then identified as potential domestic minor trafficking victims through the juvenile justice system and non-profit partner organizations who worked in collaboration with juvenile to assess victims. Therefore, the greatest legal need of victims was their criminal histories, which were potentially related to their trafficking experience. As one CJ participant observed, “People have to understand that our kids have two hats, they did something wrong against the law and they are victims as well, so we are very sensitive to that.” Currently, minor victims

cannot be held or prosecuted on charges of prostitution, meaning that if another offense has not been committed, juvenile justice cannot hold the victim.

SW and MH participants also articulated that currently most domestic minor sex trafficking victims had criminal charges and articulated their criminal charges as a hindrance to receiving services. Mental health participants expressed that victims were less likely to cooperate and accept services while being treated as victims and many were angry over being detained when their trafficker was not. In fact, both CJ and MH participants agreed that the girls perceived their arrests and charges as unfair, especially because their traffickers were still out on the streets. One MH participant said, “They’re victims and they are being punished when the pimps should be punished.” MH and CJ participants also discussed the importance of victims’ communication with law enforcement to understand the ongoing investigations involving their traffickers.

Because most domestic minor sex trafficking victims carry criminal histories through their treatment, record closure was another important component of the needed legal services mentioned by participants. According to CJ and SW participants ($n = 5$), the records of all juvenile victims should be sealed when they reach adulthood so their criminal histories will not follow them. However, according to one SW participant, that can be a challenging and difficult process for victims: “We have one case now, when she turned 18 everything was supposed to be expunged off her record, as far as I know, as of today it has not been.” Despite the difficulty of this process, most MH and SW participants agreed that it was a vital factor in the healing process for victims. As one MH participant discussed, “Being able to initiate a new life and not carrying over a lot of

things that they may have done or were forced to do while they were in that situation” as a significant component to the healing process for victims.

Another legal issue facing victims was the need for their participation as a witness for the prosecution in a case involving their trafficker. CJ participants repeatedly mentioned the importance of an immediate forensic interview to collect evidence for law enforcement and the prosecution. One CJ participant described the victim’s body as an “important, potential crime scene;” “we need all the evidence off their body.” Another CJ participant stated:

Even if our victims are a mess and are going through big issues of their own, always trying to get the trafficker or the buyers to that extent, to get them arrested and prosecute them, even if it means we are having to drag our victim a long, you know, because these guys will continue to pimp out the next girl.

In contrast, MH participants discussed how requiring a forensic exam might re-traumatize the victims and remove their freedom of choice. One MH participant stated that part of their role was to “help them [victim] adapt to a possible case being developed and how re-triggering it was for them to go through that initial sexual assault nursing examination or the forensic interview and kind of recalling all of those details and talking about the perpetrator.” It is important to note the different perspectives between disciplines.

Though all participants expressed a desire to heal victims and seek justice for them, CJ participants viewed the victims as evidence and important to the prosecution of the criminal case of the trafficker. On the other hand, MH and SW participants were more concerned about the potential for further traumatization of the victim if they were required to cooperate with the criminal justice system. Participants from all disciplines

discussed legal services as being less crucial to the victim as other needed services, but still a component that cannot be ignored. As one CJ participant said, “The legal is the last thing for us, because we are going to do everything we can to service needs first; the legal aspect is going to be at the end.” However, because many victims had criminal histories, access to legal services could be required over the course of several years.

Medical services. The subtheme of medical services was mentioned as a necessary service by most participants ($n = 10$), and was advocated as a necessary component of care throughout the healing process, including the importance of referrals and continued care through reintegration. The list of potential health consequences identified by participants was extensive and many of them involved continual care with a practitioner. However, the most frequently mentioned medical service required for domestic minor sex trafficking victims was the sexual assault nurse exam (SANE).

In regard to medical services, MH participants advocated for medical practitioners to be included in the service providers who needed to be cognizant of a trauma-informed approach when dealing with victims. When discussing the SANE exam, some participants ($n = 5$) disclosed the use of highly trained, collaborating practitioners to administer the forensic exam and interview that offered specialized care for victims. One MH participant described a collaborating SANE practitioner’s interaction with a victim this way: “We are on your schedule here. If you want me to do it fine...she puts the power where it belongs, with the patient.” Another MH participant also discussed the importance of all practitioners being aware of medical red flags for victims so that they are better able to help identify victims: “We are trying to train more medical providers because they might not receive services without someone identifying the trafficking

survivors.” Many participants listed the SANE exam and a medical evaluation as being the next step upon rescue after ensuring that a victim’s basic needs had been met.

However, according to participants, continuing medical care must also be a consideration through treatment, even after the initial medical evaluation. Some of the ongoing medical concerns mentioned by participants included the following: STDs/HIV testing and treatment, prenatal care, birth control options, fractures, bruising, ongoing psychiatric conditions, and routine medical care (e.g., check-ups, vaccinations, etc.). One CJ participant also suggested that most of the girls needed a “full scale skeletal exam. That’s important, because you get these kids and they’re in a lot of cars and they get thrown out and they get beat up, so they have injuries they don’t even know about.”

The required medical services mentioned by participants for reintegration included ensuring the continuation and access to medical care providers, connecting victims with referrals so that there are no gaps in medications or treatments, and enhancing the chance they will follow-up with medical services. One CJ participant mentioned that many of the victims “have anxiety about finding a new place or a new practitioner” once they are released from placement. In addition, many victims have access to health care through Medicaid, but the long access lines for appointments can cause victims to have lapses in medications (e.g., psychiatric drugs) and create more problems for them. As one CJ participant shared: “You get off your medication and it is kind of this bad spiral. It’s always being on and off your medication and not being stabilized in that way.”

Substance abuse treatment services. The subtheme of substance abuse treatment services was mentioned by 10 participants as part of a comprehensive-approach to

services for victims. Participants from multiple disciplines discussed how substance abuse was common among victims because it was often used as a mechanism of control by their trafficker. To illustrate, one CJ participant said, “A lot of them do it because they were forced to do it.” Similarly, a MH participant described how “some of them get addicted because that is part of what the perpetrators do.” However, participants did state that substance abuse was “by far not their core issue.” They went on to discuss that programs that focused too heavily on substance abuse, instead of the trauma experienced by victims, were not meeting the victims’ core needs. Yet, participants ($n = 7$) believed that if left untreated, it became a catalyst for a victim returning to their trafficker. As one CJ participant said, “What came first the prostitution or the drug habit, but it gets to the point where the prostitution supports the drug habit.”

Job skills services. The last comprehensive service that emerged as a subtheme was the importance of helping victims develop job skills. Several participants ($n = 5$) from different disciplines mentioned that victims needed to learn job skills in a regular workplace setting and stressed the value of helping victims do so while still under the guidance of service providers. One SW participant said, “The girls want to work, they just don’t know how to work.” A CJ participant believed it was empowering to victims to do “what people do in society...that good, hard, clean work.” A few CJ participants ($n = 4$) also discussed a “stable job” as a protective factor for victims against relapse upon reintegration because it enabled them to be free from their trafficker for basic necessities by “allowing them to get a job and do for themselves.”

Barriers to Services

Another main theme to emerge from the data was barriers to services. Within this theme, several subthemes emerged. These included, in order of prevalence, the lack of available service options to victims ($n = 15$), the criminalization of victims ($n = 14$), and victims not identifying as victims ($n = 9$). Participants repeatedly discussed that these three subthemes created difficulties when developing comprehensive service programs for victims. Therefore, they were categorized as potential barriers to services for trafficking victims.

Lack of available services. Funding was one explanation for the lack services. Specifically, although most participants talked about a lack of funding for services, a few ($n = 3$) believed funds were available to offer services, but were being, in their opinions, spent on the wrong types of services (i.e., anger management and substance abuse). As one CJ participant said, “We are already spending the money, we just need to put it in the right place.” Related to this idea, several participants ($n = 4$) mentioned the lack of research and academic resources available to providers as a barrier to services because there were no current recommendations for specific treatment plans for victims. Participants also advocated the need to have different options available for different victims, because each victim brings a unique circumstance and background. One CJ participant summed it up this way, “The more options, the better and we are very limited on options...there needs to be programs for the kind of kid who got trafficked for a week in a non-violent way versus the kids who have been passed off to eight different pimps...that is a totally different kind of kid.”

Criminalization of victims. As a result of the limited shelter options for victims, most domestic minor sex trafficking victims were held in juvenile detention centers and juvenile residential treatment facilities after being charged with a crime. MH and SW participants ($n = 7$) believed the criminalization of victims could create resistant towards service providers and the services being offered. A few participants ($n = 3$) believed that placing a victim in a criminal facility increased the chances of the victim becoming engaged in criminal activity in the future. As one SW participant described, “The reason they are acting like a criminal is that we are treating them like a criminal.” Another SW participant said, “This kid may not be a criminal, but he is going to be a criminal real quick if you put him in juvenile detention.”

Although CJ participants agreed that criminalizing victims was not ideal, they felt it was a far better situation than allowing them to stay on the streets and continuing in a trafficking situation. To illustrate, one CJ participant said, “Usually our best bet is juvenile detention, despite what people would not like to hear, because at least juvenile detention is looking...to get them additional services and provide for their therapeutic needs.” Similarly, another CJ participant stated, “There are a lot of issues with treating the victim like an offender, but at the same time, it removes them from the situation.” Ultimately, CJ participants sought to provide victims with services through their only available option, charging a victim with a crime and placing them in detention or on probation, even for minor charges.

In contrast, MH and SW participants believed this approach would do more harm to victims and make the delivery of services more difficult. This was best articulated by one SW participant who said, “Slavery and chains are synonymous with one another, so

how are we going to repair that youth and make them a functioning member of society if we continue to use chains?” Some participants ($n = 7$) believed that these differing perspectives on criminalizing victims could create barriers for service providers in creating comprehensive services. As one MH participant said, “we need the whole system together on this.” Overwhelmingly, participants from all disciplines ($n = 15$) stated that the lack of available services for victims of domestic minor sex trafficking was a huge barrier to the treatment of victims. Most participants’ perspective echoed what one MH participant said, “I think there is a far greater need than there are services available.”

Victims failure to identify as victims. The final subtheme that emerged under barriers for treatment was the failure of domestic minor sex trafficking victims to identify themselves as victims. A few participants ($n = 9$) emphasized that many of the minors involved in trafficking did not believe they were victims or that their traffickers were perpetrators. To illustrate, one CJ participant said it this way: “A lot of these kids do not view themselves as victims, so they aren’t going to be receptive to treatment or help at the beginning.” Another MH participant shared how victims will often say, “Oh, that wasn’t me, I wasn’t trafficked. I wasn’t exploited. I chose to be part of this.” Most participants ($n = 7$) attributed this to the strong bonds victims had with their traffickers and the impaired attachments that normalized an unhealthy relationship. As one CJ participant explained, “They have strong bonds with their traffickers and they have very mixed feelings about whether they are victims or not.” A MH participant echoed that perspective with this statement: “They think they’re with their boyfriends, what is the problem?” As a result, the participants described how it was unlikely that victims would self-identify, making identification of victims a difficult task, especially minor victims.

Factors to Strengthen Services

In addition to factors that served as barriers to services, participants also discussed various factors that strengthened services for victims. Specifically, the subthemes that were articulated by participants as methods of strengthening services included building trust and rapport between providers and victims ($n = 14$), having an agreed-upon comprehensive approach by service providers ($n = 13$), and developing methodologies to empower the victim ($n = 11$). In addition, the foundational framework of attachment was discussed as being a component of building trust and empowering victims.

Trust and rapport with service providers. Developing trust and rapport was described by most participants ($n = 14$) as a factor that strengthened comprehensive services and created a foundation for ongoing services with providers. In support of this finding, one CJ participant said, “I don’t think you are going to get anywhere...if you don’t have the trust.” Similarly, MH participants said, “We have to truly care and respect these kids before we can do this work” and “it is a critical piece; without that trusting, safe relationship with service providers, there is not going to be any progress.” One MH participant noted that developing trust and rapport had to be present and consistent across all disciplines because “if they don’t trust law enforcement, their SANE nurses, their therapist, that can really influence the work that is being done.” As mentioned previously, some MH participants believed that repairing the attachment template began with the staff-victim relationship and that modeling a healthy attachment was seen as a factor to strengthen services. However, MH and CJ participants also discussed that when this method was used, victims became attached to service providers, which, at times, made reintegration difficult for them. One MH participant described the victims’ perspectives

this way: “They talk about how difficult it is having formed an attachment here and having a trusting relationship with a therapist here, and their frustration that they have to go and begin work with a new provider.” As a result, several participants ($n = 5$) believed that service providers needed to be cognizant of this possibility and discuss various approaches to support victims through this transition to reintegration.

Comprehensive approach. Most participants ($n = 13$) believed that a comprehensive, agreed-upon, multi-disciplinary approach was the most powerful method in helping victims recover from their trafficking experiences. Participants from all disciplines discussed having joint meetings with all service providers to discuss the approach and methodologies used to treat victims. To illustrate, one MH participant said it was vital to “have all the disciplines represented at the table to provide feedback and input to make sure we are covering all of our bases with these kids.” CJ participants frequently discussed “wrap around services” and the importance of “bringing in partnerships and other individuals for services for these kids.”

Empowerment. Finally, the subtheme of empowerment emerged from the data as a potential protective factor for victims when reintegrating into society. Common statements made by participants included allowing victims to “make choices,” “develop a bigger vision for life,” and “set realistic, attainable goals.” Several participants discussed that victims had a very limited vision for their life and did not seem to understand the potential options for them. One CJ participant said, “Sometimes I think I might be the first person to ask them what they want to do or be.” Another CJ participant said that when asking victims about their future goals one said, “Well my goal is to have my own hotel, so that when I am done doing my business [prostitution], I can put up a sign that

says we are closed.” Several participants believed that part of the job of service providers was to help victims “see beyond themselves...broaden their perspective about life in general” and “teach them that they can be and do anything that they want to be and do.” The re-occurring issue of attachment and relationship skills was also discussed in terms of empowerment. One MH participant discussed it this way: “Relationship skills empower people. It teaches people how to ask for help when they need it. It teaches people how to be alone. It teaches people how to have boundaries and how to extend those boundaries.” Overall, empowerment was discussed in terms of making sure victims could continue with a healthy vision and skill set upon reintegration and that it helped ensure service providers met the needs of victims moving forward.

In summary, the findings that emerged from this analysis included a comprehensive description of services (i.e., basic/shelter, legal, medical, mental/emotional, educational, job skills, substance abuse treatment) and the rationale for the development of these specific services by providers. In addition, potential barriers to services were identified and recommendations on how to strengthen services to minimize obstacles and enrich overall treatment were provided. Last, it provides insight for service providers on the role of attachment as an underlying mechanism for delivering services and makes recommendations for re-creating the attachment template in victims.

V. DISCUSSION

Overall, service providers participating in this study described a thorough, comprehensive set of recommendations that should be considered when developing services for domestic minor sex trafficking victims. In addition, the theme of attachment was prevalent throughout the data and emphasized as a crucial component to understanding victims' complex situations and imperative needs moving forward. The themes of barriers to services and factors to strengthen services could potentially play a vital role in ensuring that service providers are aware of potential pitfalls and obstacles faced when striving to offer a best practice approach to delivering services. The themes of recommended, comprehensive services were consistent with previous research; however, the theme of attachment was identified as a potential underlying mechanism in previous research on trafficking victims, but had not been previously researched. The themes of barriers to services and factors to strengthen services were newly identified themes that had been very minimally discussed in the literature. Although there were limitations due to the design of the study, the implications of the study for practitioners and researchers are numerous and provide first steps toward developing a best practice model for the development of services for victims of domestic minor sex trafficking.

Attachment Framework

All participants' opinions supported previous research that attachment and the ability to develop healthy relationships were both lacking in the majority of victims and necessary in order to successfully reintegrate into society. Similar to previous research supporting the interplay between traumatization and attachment, the majority of participants believed that victims struggled to recognize or maintain a healthy

relationship and develop appropriate boundaries within those relationships (Aideuis, 2007; Dykas & Jude, 2011; Pearlman & Courtois, 2005). The findings of this study further confirm the possibility of attachment as a mental health consequence for victims of domestic minor sex trafficking. Furthermore, participants confirmed existing literature that suggest these attachment impairments exist prior to the trafficking experience and that the compounding experience of trafficking creates even more difficulty for victims in recognizing healthy relationships (Pearlman & Courtois, 2005; Zimmerman et al., 2008). Participants attributed attachment issues in existence prior to the trafficking experience to be directly related to the victim's family environment, which they frequently described as dysfunctional. Participants also thought that these dysfunctional environments were the root of many of the attachment difficulties victims faced prior to and after the trafficking experience. This is consistent with previous research that found impaired attachments from previous abuse, neglect, and childhood trauma (especially sexual abuse) were risk factors for children becoming trafficking victims (Aedius, 2007; Pearlman & Courtois, 2005; Zimmerman et al., 2008). The findings also support prior research that found traumatization disrupted the attachment template of individuals (Abu-Ali & Al-Bahar, 2011; Courtois, 2004).

In addition, participants' description of the traffickers' exploitation of victims' attachment vulnerabilities within their family was consistent with previous research on the methods of coercion by traffickers (Albanese, 2007 as cited in Jordan, Patel, & Rapp, 2013, p.17) and the creation of a traumatic bond between traffickers and victims (Smith et al., 2009). For example, traffickers' use of the boyfriend or friend manipulation tactic was described in Albanese's (2007) work and reiterated by participants in this study.

Moreover, the findings of this study supported previous research highlights the likelihood of an emotional bond between the trafficker and the victim (Graham, 1994; Julich 2010). Participants consistently reiterated that it was important for service providers to understand the emotional connection and attachment that exists between victims and their traffickers.

Similar to previous research advocating for services to allow for a safe place where healthy, secure attachment can develop (Sandberg, 2010), participants believed that all providers should be cognizant of the attachment impairments of victims throughout the healing process. However, unlike research on victims of other forms of traumatization and attachment (Aedius, 2007; Courtois, 2004; Courtois & Pearlman, 2005), participants did not discuss diagnosing a victim with an attachment disorder and then providing therapeutic services to address the attachment style of the victim. Instead, service providers believed that the majority of victims suffered from impaired attachments either from the trafficking experience or prior to the trafficking experience. Therefore, all service providers should be cognizant of the existing attachment impairments between the victims and their traffickers, as well as victims and their families.

Comprehensive Services

Consistent with the literature on comprehensive services, this study found there to be a lack of available services or a standardized process for domestic minor trafficking victims (Clawson & Goldblatt Grace, 2007; Clawson et al., 2008). Unlike past recommendations, this study did not find a clear delineation between the different phases of services (i.e., transitional and transformational care; Sanborn et al., 2010), but rather

found that most services were required throughout treatment and into reintegration. Thus, these findings support previous research on comprehensive services (Clawson & Goldblatt Grace, 2007; Clawson et al., 2008; Sanborn et al. 2010), but also allow for a much closer look at the comprehensive needs facing domestic minor trafficking victims and the development of best practice comprehensive services.

Overwhelmingly, the findings of this study support previous research suggesting the lack of appropriate shelters to be one of the greatest challenges to providing comprehensive services. Participants stated that minimal options for protective shelter resulted in victims being placed in the juvenile justice system. This was consistent with previous literature that stated the juvenile justice system as the only shelter option for many victims (Clawson & Goldblatt Grace, 2007; Clawson et al., 2008). In addition, this study highlighted the different perspectives between the criminal justice system and human service providers regarding their view of appropriate shelter. Criminal justice participants supported the notion that victims must be detained in a secure facility before treatment would be possible, but mental health and social workers' perceptions supported previous research that suggested placement in juvenile detention to be inappropriate for victims (Clawson & Goldblatt Grace, 2007; Clawson et al., 2008). Similar to previous research, participants were in agreement that victims needed to be in a safe, protective place from their trafficker and the harsh conditions of the trafficking experience (Sanborn et al., 2010). Highly-specialized shelter options that meet the specific needs of domestic minor sex trafficking victims, while respecting the different perspectives of multiple service providers was best supported by the findings of the study. This could include

shelters that were safe from the trafficker and secured victims inside the facility, but allowed for free movement within the facility (i.e., no locked doors or handcuffs).

Legal representation has been mentioned in previous research as a needed service for victims, but it had only minimally been explored (Macy & Johns, 2010). This study expanded on the legal needs of victims by highlighting that the majority of victims being rescued from human trafficking are also being charged with crimes, immediately labeling them as a criminal. According to participants, most victims are being charged with minor crimes and placed in detention or on probation while their traffickers are free. Though criminal justice participants voiced concern over the victims' criminal charges, it was also advocated by some participants to charge a victim just so they could be detained and receive services. Like previous research (Clawson & Goldblatt Grace, 2007), these findings continue to show that, even though victims cannot be charged with prostitution, they are still being criminalized. In addition, the view of criminal justice participants that the victim is "evidence" and a witness against their trafficker is creating additional challenges for mental health professionals and the therapeutic process. As supported by previous research (Clawson et al., 2008), the current legal process is creating a barrier between victims and providers for further services and investigations. Though all participants believed the legal situation of the victim was the least important aspect of treatment, the current legal process does not reflect an agreed-upon approach from all disciplines and is not the best situation for the victim. The finding of this study suggest that legal services need to reflect a comprehensive perspective from all disciplines, so that victims receive optimal care.

The required medical needs of victims listed by participants supported previous research that found victims have various medical conditions related to the nature of sex work (e.g., STDs/HIV, pregnancy) and the abuse of the traffickers (e.g., broken bones, fractures, severe bruising; Bozidar & Bjelajac, 2012; Clawson & Goldblatt Grace, 2007). Similar to previous findings, medical care was seen by participants as a necessary component of care throughout the healing process (Sandborn et al., 2010). In addition, participants supported research that training for medical professionals to identify victims was important because of their access to high-risk populations (McClain & Garrity, 2011). However, the findings of this study expanded existing research for medical services because mental health participants articulated the importance of medical professionals working with victims to practice a trauma-informed approach for dealing with victims, especially when administering a SANE exam and conducting a forensic interview. Participants stated that re-triggering and re-traumatization of the victim can occur if these considerations are ignored. Another important finding of this study, was the need to for service providers to support victims upon reintegration with finding a suitable medical practitioner who understood and could accurately treat their medical needs. In most cases, the medical services utilized by victims while in a placement setting were not extended upon reintegration. Therefore, participants recommended that service providers ensure the continuity of medical services for victims upon reintegration to minimize the disruption to medications or treatments.

The importance of mental health services was also supported by the findings in this study and consistent with previous research indicating the presence of significant mental health consequences following the trafficking experience (Banovic & Bjelajac,

2012; Chudakov et al., 2002; Clawson & Goldblatt Grace, 2007; Hardy et al., 2013). As mentioned in previous research, participants articulated that victims suffered from complex trauma (PTSD), dissociation, anxiety, and attachment difficulties (Aedius, 2007; Dykas & Jude, 2011; Hardy et al., 2013, Pearlman & Courtois, 2005). Expanding upon existing literature, this study found that attachment impairments and subsequent adjustments to the overall treatment model were necessary for a comprehensive-approach to services. Beginning with a trauma-informed approach from all service providers, interactions between staff and the victim should also include an underlying attachment framework. Participants believed that in order for victims to develop healthy attachments, they had to have healthy relationships and boundaries modeled for them from the onset of services. Also, as mentioned in previous research, the participants in this study echoed the importance of including the family in the therapeutic process, specifically, to repair attachment impairments and communication patterns that may have been present prior to the trafficking experience (Clawson & Dutch, 2008; Sandberg et al., 2010). The inclusion of the family unit was thought to bolster the family through education and therapeutic intervention and minimize relapse through the help of a strong support system. Likewise, a new finding in this study was the strong support for mentor relationships for victims to further strengthen attachment difficulties and provide additional support resources upon reintegration. Mental health services included moving victims from a supported environment in the treatment facility to a supported environment upon reintegration.

Additional components of the comprehensive services articulated by participants included educational services, job skills, and substance abuse treatment. Similar to

previous research noting the importance of including education as one component of care (Clawson & Goldblatt Grace, 2007; Sanborn et al., 2010), the participants in this study also stressed the need for this service to be highly individualized to each victim.

Participants suggested each victim would need an individualized educational plan based on the victim's current educational level (not chronological age) and ability to reintegrate to public school. Some alternative education recommendations included GED programs, charter schools, and homeschool options. Participants also articulated that job skills are needed for victims in order to develop effective work habits prior to reintegration. This matched previous research that found difficulty finding and maintaining employment to be a risk factor for victims returning to a trafficking situation (Clawson & Goldblatt Grace, 2007; Clawson & Dutch, 2008; Sandberg et al., 2010). Participants in this study believed victims wanted to find meaningful work and become self-sufficient, but lacked essential job skills needed for success. Finally, consistent with previous research, participants discussed substance abuse as a method of coercion by traffickers and as a catalyst for victims to return to their trafficker (Muftic & Finn, 2013). These findings confirm previous research that found substance abuse treatment to be necessary for reintegration.

Barriers to Services

The potential barriers to services identified in this study have been explored very little in previous research. These barriers included the lack of services, criminalization of victims, and victims' failure to identify as a victim. As discussed earlier, the lack of available resources, services, and funding has created an obstacle between providers' ability to identify best practice methodology and implement it. Like previous research,

this study found that there are minimal options for shelter or placement of victims, resulting in victims primarily being detained in juvenile detention or probation and charged with a crime (Clawson & Goldblatt Grace, 2007; Clawson et al., 2008). As articulated by most criminal justice participants, currently this is the only means for providing victims with comprehensive services. However, mental health and social work participants in this study shine new light on the challenges it has created for them as service providers because of the similarities between being under the control of the trafficker and being imprisoned by the system. In addition, findings supported previous research that found an attachment is created between the trafficker and victim through the trafficking experience (i.e., trauma bond; Jordan et al., 2013; Smith et. al., 2009). Expanding on this premise, participants in this study stated the attachment between the trafficker and the victim was so strong that most victims do not identify as victims, resist services, and return to their trafficker. The lack of participation on the part of the victim creates a barrier for the therapeutic process and criminal investigations involving the trafficker. The greatest barriers to treatment existed when a victim did not identify, was subsequently arrested and charged with a crime resulting from the trafficking experience, was placed in detention where they resisted services, and, upon release, returned to their trafficker. Like previous research, findings from this study suggest the challenges involved with victim identification, criminalizing victims, and the overall lack of resources must be resolved to create a best practice approach (Clawson & Goldblatt Grace, 2007; Clawson et al., 2008).

Factors to Strengthen Services

In addition to barriers, the participants in this study also identified several factors that strengthened the services provided. Specifically, an agreed-upon, multidisciplinary approach to services, building trust and rapport between service providers and victims, and empowerment were all identified as potential strengthening factors providing best practice services. Consistent with previous research, the importance of a best practice, comprehensive approach that included the perspectives and professional input from all disciplines was considered paramount to a victim's recovery (Clawson & Dutch, 2008; Clawson, Salomon, Goldblatt Grace, 2007; Sandborn et al., 2010). Participants in this study repeatedly discussed "comprehensive services" and "wrap around services" indicating a team approach to creating a model for each victim that truly met their unique needs and situation. In addition, most participants believed that the development of trust and rapport is a foundational component of treatment and must exist between *all* service providers and victims. Expanding on past research of the importance of rapport building with victims (Clawson et al., 2008), the findings of this study also indicate that the development of a trusting relationship with service providers could offer victims the opportunity to develop healthy relationships as a first step toward addressing the overall attachment difficulties. Finally, empowerment was an emergent theme in this study that had not been addressed in previous literature on trafficking victims. Empowering victims was discussed by participants as an opportunity to provide victims with a vision for their life, help them learn to set realistic goals, and make choices for themselves. Participants also articulated that when victims had been empowered through relationships, they reintegrated with the ability to determine a healthy relationship from one that would

enslave them. Consistent with previous research, the participants in this study believed that a team of multidisciplinary service providers committed to a comprehensive approach built on trust between the victim and service providers would strengthen services to victims (Clawson & Dutch, 2008; Clawson et al., 2007; Sandborn et al; 2010) and empower them.

Limitations and Implications for Future Research and Practice

Although this study expands upon the previous dearth of research regarding services for domestic minor sex trafficking victims, there are limitations. First, the use of a purposive, snowball sample through AACAT is a limitation because the sample was limited to one specific, collaborating coalition. Participants' perceptions on required services and methodologies might be influenced by their previous working relationship through AACAT; thus, making the findings less generalizable. Second, the sample size was small, consisting of 15 participants. This was largely due to the design of the study which involved interviewing participants who worked directly with domestic minor trafficking victims. Third, this study collected data from direct service providers rather than victims. Interviews with victims might yield different results regarding the services victims need.

Despite these limitations, there are numerous implications for practice in the development of services for domestic minor sex trafficking victims. First, victims' failure to self-identify creates an immediate and difficult barrier for receiving services. Service providers, especially those who may encounter victims through routine services (e.g., medical exam or arrest at a scene), should be trained to identify potential trafficking victims and be knowledgeable of the next steps required to confirm an individual as a

trafficking victim and provide immediate assistance. In addition, a victim identification tool designed to assess juveniles should be included as part of that training (e.g., M.A.Y.S. I.) In order to strengthen provided services to identified victims, an agreed-upon, multi-disciplinary approach to providing services should be created by a team of service providers including a cohesive process for victims from rescue to reintegration. Utilizing a comprehensive, multi-disciplinary approach will ensure that protocols remain victim-centered while being conscientious of the different procedures of each discipline. Also, all service providers should receive training on trauma-informed care and the attachment difficulties facing victims. Specific guidelines should be created for interactions between service providers and victims to ensure the development of a trusting, supportive relationship between *all* providers and victims. Furthermore, in order to overcome the barrier to services created when victims are criminalized, it is important for service providers and government agencies to address the lack of funding and available services to victims. Until highly-specialized short and long term shelters are available for placement, victims will continue to be criminalized in the juvenile justice system, resulting in a victim with a criminal history who is resistant to therapy. Throughout the treatment process, attachment needs to be a consideration when developing specific services. This includes reuniting the victim with family members in a manner reflective of the trauma experienced prior to and during the trafficking while being cognizant of the attachment difficulties that may exist between a victim and his/her family. In addition, providing therapeutic services for the entire family unit and introducing other healthy relationships to the victim prior to reintegration (e.g., mentors) will allow the victim to move from a supported environment with service providers to a

supported environment in the community. The findings of this study confirm previously recommended services to victims (i.e., basic, legal, medical, mental/emotional, educational, job skills, and substance abuse treatment) and recommend the implementation of specific, strengthening factors that will bolster services to victims and overcome potential barriers faced by service providers.

As voiced by participants, continued research is vital to service providers in the development of an empirically-based best practice model for treating victims of domestic minor sex trafficking. The findings of this study expand existing literature, but future research is needed to confirm findings through more diversified sampling methods and to understand the perceptions of victims. Finally, the role of attachment needs further exploration as both a risk factor for victims of domestic minor sex trafficking and as a framework for creating services.

APPENDIX SECTION

APPENDIX A

PARTICIPANT INVITATION E-MAIL

To:
From:
BCC:
Subject: Research Participation E-mail for AACAT members

Dear Alamo Area Coalition against Trafficking Member,

I am a Master's student studying at Texas State University in the School of Family and Consumer Sciences, Family and Child Development program. I am currently in the process of collecting data for my thesis on the topic of Domestic Minor Sex Trafficking. This e-mail message is an approved request for participation in research that has been approved or declared exempt by the Texas State Institutional Review Board (IRB) [IRB# 2014B5424]

Since January 2014, I have been attending the AACAT meetings while working as an intern with Saul Castellanos at Freedom Youth Project. During this time, I have had the privilege of learning a wealth of information from all of you in regards to human trafficking. I am e-mailing you today to ask for your participation in the collection of data for my thesis. I will be collecting data for the study through interviews with professionals from multiple disciplines who are currently working to address the issue of human trafficking. Below you will find a brief abstract of the purpose of the study.

The purpose of this descriptive, qualitative methods study is to determine the recommended steps for immediate treatment for a trafficking victim upon rescue through the use of a multiple disciplinary response by multiple service providers (transitional care). In addition, transformational care (i.e., long term treatment) for survivors will be explored. It is also the purpose of this study to discover what components of treatment need to be present for restoration of victims and reintegration into society. In the study, interviews will be used to collect data from multiple disciplines (i.e., law enforcement, social workers, prosecuting attorneys, youth shelters, juvenile justice, and mental health professionals) in regards to transitional and transformational care. Services for victims will be explored through interviews with select service providers working in current rehabilitation services for victims with an emphasis on examining the role of attachment in the restoration of victims.

Please know that your participation in this study is entirely voluntary. If you agree to the interview, you are free to refuse to answer any of the interview questions and you may end your participation in the study at any time with no penalty. The interviews are expected to require about one-hour of your time. All information gathered through the study will be kept completely confidential through the use of coding and recorded interviews will be password protected and kept in a secure location (i.e., locked filing cabinet in the researcher's office); there will be no names listed in the study or shared with other study participants. Your decision to participate, or not participate, does not impact your relationship with the researcher, the Department of Family and Child studies, or Texas State University.

This project [IRB# 2014B5424] was approved by the Texas State IRB on 11/14/2014. Pertinent questions or concerns about the research, research participants' rights, and/or research-related injuries to participants should be directed to the IRB chair, Dr. Jon Lasser (512-245-3413; lasser@txstate.edu) and to Becky Northcut, Director, Research Integrity & Compliance (512-245-2314 – bnorthcut@txstate.edu).

If you are willing to participate in the study, please reply to this invitation to katie.miler@freedomyouthproject.org or contact me at 832-978-2537 or feel free to contact my thesis advisor Dr. Morgan Russell at er15@txstate.edu. If you have questions about the study, please feel free to contact me at any time.

Thank you,

Katie Miler

APPENDIX B

CONSENT FORM

You are being asked to volunteer to participate in a research study conducted by Katie Miler (km1761@txstate.edu or katie.miler@freedomyouthproject.org), a graduate student at Texas State University, under the supervision of Dr. Elizabeth Morgan Russell (er15@txstate.edu), my thesis committee, and with the approval of the Texas State Institutional Review Board. I know your time is very valuable and I greatly appreciate your willingness to share your professional expertise for the purposes of this study. I believe the data collected throughout this study will be beneficial to the ongoing development of services for domestic minor sex trafficking victims and the Alamo Area Coalition against Trafficking.

The purpose of this descriptive, qualitative methods study is to determine the recommended steps for immediate treatment for a trafficking victim upon rescue through the use of a multiple disciplinary response by multiple service providers (transitional care). In addition, transformational care (i.e., long term treatment) for survivors will be explored. It is also the purpose of this study to discover what components of treatment need to be present for restoration of victims and reintegration into society. In the study, data will be collected through one-hour interviews with professionals from multiple disciplines (i.e., law enforcement, social workers, prosecuting attorneys, youth shelters, juvenile justice, and mental health professionals) in regards to transitional and transformational care and the reintegration of a victim into society.

Please know that your participation in this study is entirely voluntary. You are free to refuse to answer any of the interview questions and you may end your participation in the study at any time with no penalty. Your decision to participate, or not participate, does not impact your relationship with the researcher, the Department of Family and Child Studies, or Texas State University. This study is exploratory so there is no right or wrong answer to any of the questions and you can stop the interview at any time to review the interview information collected from you. All information gathered through the study will be kept completely confidential; there will be no names listed in the study or shared with other study participants. All interviews will be recorded on the researcher's personal recording device under password protection. Each interview will be coded numerically and the researcher will transcribe the interviews at a later time excluding identifiable information about the individual or agency. Recorded interviews will be deleted after the interview is transcribed and transcribed data will remain under password protection on the researcher's personal computer in the researcher's office. Any printed data collected from interviews data will be kept in a secure, locked filing cabinet in the researcher's office.

The benefits of participation in this study include gaining valuable insight into the expert opinions of the professionals that formally create the Alamo Area Coalition against Trafficking and similar coalitions. The summarized results of the study will be available to all participants and coalition members. The only identifiable risks to participation in the study would be the potential for results that varied from one's own professional opinion.

This project [IRB# 2014B5424] was approved by the Texas State IRB on 11/14/2014. Pertinent questions or concerns about the research, research participants' rights, and/or research-related injuries to participants should be directed to the IRB chair, Dr. Jon Lasser (512-245-3413; lasser@txstate.edu) and to Becky Northcut, Director, Research Integrity & Compliance (512-245-2314 – bnorthcut@txstate.edu).

If you have any questions or concerns during or after the interview, please contact me at katie.miller@freedomyouthproject.org or feel free to contact my thesis advisor Dr. Morgan Russell at er15@txstate.edu. Please indicate your willingness to be interviewed for this study by agreeing to the terms below.

I agree to participate in this research study and have been made aware of the benefits and risks of participation in the study. I am willing to have this interview recorded and transcribed for further analysis.

Participant Signature

Date

APPENDIX C

INSTRUMENTS

Section one: Demographic Information

The following information will be collected by the researcher to describe the professionals and their professional discipline who are interviewed for the study.

1. Sex

- ☐ Male
- ☐ Female

2. Discipline

- ☐ Law Enforcement
- ☐ Social Work
- ☐ Non-profit
- ☐ Government (Federal, State, Local)
- ☐ Mental Health Professional
- ☐ Other, please specify _____

3. State of license or practice: _____

4. Highest Level of Education:

- ☐ Less than high school diploma
- ☐ High school diploma or equivalent (G.E.D.)
- ☐ Some college or training school
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree or higher

In what field did you receive your education?

5. Have you received specific training in working with domestic minor sex trafficking victims?

- ☐ Yes, please specify _____
- ☐ No

6. In your current professional discipline, do you work directly or indirectly with domestic minor trafficking victims?

☐ Yes

☐ No

7. How long have you worked with domestic minor trafficking victims?

8. Please describe the specific services you provide to domestic minor sex trafficking victims.

APPENDIX D

INSTRUMENTS

Section 2: Interview Questions

Ice Breaker

1. How did you first become interested or involved with providing services for domestic minor sex trafficking victims?

Rescue

1. What are the immediate multi-disciplinary services required for victims of human trafficking (i.e., physical, emotional, mental, cognitive, legal, and spiritual) upon rescue? Who ensures a victim receives services? Which agencies or organizations deliver these services?

2. What entity or organization ensures these services are received by the victim? Where is the victim taken upon rescue?

Transitional Care

3. How is a documented victim of human trafficking currently processed through legal and human services?

4. What is the basis for the development of these services (e.g., theoretical, empirical, etc...)? Do these practices address the complex needs of victims identified? Please explain.

Transformational Care

5. What are the long-term multi-disciplinary services required for victims of human trafficking (i.e., physical, emotional, mental, cognitive, legal, and spiritual)?

6. How does the development or lack of development of a trusting relationship with service providers play in the long-term restoration of victims?

7. Are you familiar with the attachment theory as a mechanism for the development of healthy relationships and interpersonal skills? (If no, offer the following brief explanation). A healthy attachment, which begins in infancy, is a framework which an individual use for the development of healthy, trusting relationships and interpersonal skills.

8. Do victims of domestic minor sex trafficking frequently suffer from attachment disorders? What role does the development of a healthy attachment play in the restoration process? How does this look different for a child with a history of secure attachment vs an insecure attachment prior to the trafficking experience?

Reintegration

9. What is the estimated length of time for a victim of domestic minor sex trafficking for recovery and reintegration into society? How is a victim identified as being ready for reintegration?

10. What types of multi-disciplinary services is needed for the victim after reintegration into society?

11. Does the development of a healthy attachment and the ability to develop trusting relationships impact the quality of reintegration and diminish a chance of relapse? Please explain how this would look for a victim.

Closing

11. Are there other comments or important information you would like to share about the process and services needed for domestic minor sex trafficking victims?

12. If you were to create a best practice protocol for domestic minor sex trafficking victims from rescue to reintegration, describe what that look like including all components of care?

13. In your professional opinion, how adequately do current services for trafficking victims match the needed services for a victim to successfully reintegrate into society?

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