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"Where the hope lies."

Therapists' Perspectives on Mental Health Recovery Work with Survivors of Sex Trafficking in the United States: A Qualitative Study

A dissertation
by

Elizabeth A. Gruenfeld

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Dissertation Committee

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Abstract

This qualitative study collected and analyzed original interview data with mental health clinicians and survivor mentors exploring their perspectives on and experiences in aftercare/recovery work with survivors of domestic and international sex trafficking in the United States, through multidisciplinary and multisystemic contexts. This study addresses the significant gap of research on mental health recovery support with survivors of sex trafficking, which exists despite disturbing prevalence rates of sex trafficking, especially amongst girls and women of Color living in the United States. The study examined mental health providers’ perspectives on treatment approaches they employ, the processes they find to be effective, and their views on emancipatory approaches in recovery work. This study collected, transcribed, and analyzed semi-structured interview data with 13 mental health providers (including clinicians and peer/survivor mentors), and employed qualitative conventional content analysis. The study is the first to explore mental health providers’ experiences with service provision/accompaniment with a focus specifically on their work within multidisciplinary and multisystemic environments. It aims to increase understanding about the perspectives and approaches held by multidisciplinary therapists and survivor mentors, who specialize in accompanying survivors of sex trafficking, and may hold important insights into this complex work. The study found that therapists and peer mentors are challenged by barriers, and leverage key opportunities in their work through multidisciplinary and multisystemic contexts, and benefit from partnering with each other in survivor recovery work. It also found that survivor community and peer mentors are central to aftercare/recovery work, and that providers work to employ an intersectional/emancipatory healing lens. Analyses identified fifteen approaches to recovery work, organized into four categories: 1) integrated structural and trauma-sensitive emotional

support; 2) community and emancipatory healing approaches; 3) peer mentor as a critical role; and 4) multiple systems challenge recovery. Implications for future research, clinical practice and policy are discussed.

DEDICATION

To hope.

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Chapter I. Introduction

Background

Human trafficking, as defined by the Trafficking Victims Protection Act (TVPA), is the enslavement of an individual for purposes of sex or labor through force, fraud and/or coercion. Contrary to popular media images, no movement across international borders is necessary, nor is movement of any kind required for a person to be trafficked under the TVPA. Sex trafficking is defined by the TVPA as:

> The recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age (United States, 2000).

The United States Department of State, Trafficking in Persons (TIP) Report (USDOS, 2019) indicates that nearly 25 million people are victimized by traffickers worldwide at any given time, while the International Labour Organization (ILO, 2019) puts the estimate over 40 million. The range suggests the magnitude of the problem and reveals the difficulties with accurate data collection on this under-reported and often invisible crime (Desyllas, 2007; USDOS, 2019).

Prevalence data on human trafficking survivors into and within the United States (U.S.) is similarly variable, prone to undercount, and concerning. Yearly estimates on individuals trafficked internationally into the United States have varied widely, with figures ranging from 14,500 to 50,000 (U.S. Department of Health and Human Services [HHS], Office of the Assistant Secretary for Planning and Evaluation, 2009). The U.S. National Human Trafficking

Hotline, funded by HHS[1] and run by Polaris Project, received reports on over 50,000 victims living in the United States from 2007 to 2019 yet, relying on self-report, victim incidence was presumed to be under-counted (White, 2019). Even so, reports of sex trafficking cases made to the hotline have increased steadily since 2012 (Vollinger, 2021).

Obtaining accurate prevalence estimates has been found to be challenged by multiple factors, including: lack of knowledge and identification by front-line providers (Greenbaum, 2017; Martinho et al., 2020), lack of uniform reporting standards globally (Dell et al., 2019), and access and ethical issues involved in research (Gozdniak & Collett, 2005). In some cases, poor tracking has contributed to unclear prevalence data. For example, scholars have cited a troubling lack of data on the impact of trafficking on Indigenous communities in the United States (Desyllas, 2007; Sweet, 2014), in part because of failure to track Indigenous status for those arrested on prostitution charges (Pierce, 2009). Additionally, shame may prevent survivor self-identification/help seeking (i.e., cultural/community stigma) as well as safety concerns (i.e., criminal networks and risks of re-exploitation) (Martinho et al., 2020), and legality concerns (i.e., related to prostitution or immigration enforcement) (Martinho et al., 2020; Vollinger, 2021).

In recent years, tracking by the United Nations Office on Drugs and Crime (UNODC) has found a global increase in detection and reporting of survivors, owing to increased capacity and/or increased incidence of trafficking (UNODC, 2018). The Department of Justice Office for Victims of Crime (GLOTIP, 2018) reported increased numbers of potential and confirmed trafficking victims between 2014 to 2017; nearly 4000 victims were detected in 2014/2015, as compared to over 8000 victims detected by 2017. In the United States in 2011, out of the 2,515 trafficking incidents reported, 48% were alleged adult sex trafficking and 40% were child sex

[1] U.S. Department of Health and Human Services, Administration for Children and Families

trafficking victimization (Bureau of Justice Statistics [BJS], 2011). There is no available comparison data for adult versus child sex trafficking incidence in 2017 (GLOTIP, 2018), but sexual exploitation as well as combined forced sex and labor accounted for 68% of confirmed victims in 2017 (24% were victims of labor trafficking; 8% were "unknown" forms of trafficking).

In-country trafficking has been found to be the most common form in the U.S. (UNODC, 2018). The Bureau of Justice Statistics (BJS)[2] found in 2011 that 83% of confirmed victims of trafficking in the U.S. were U.S. citizens (BJS, 2011). The United Nations Global TIP Report similarly found in 2018 that most survivors detected in North America were from North America (UNODC, 2018). Specifically, 76% of trafficking victims in North America were from the United States, Mexico or Canada, while 24% were from other regions of the world (UNODC, 2018). For federally identified survivors of human trafficking in 2019, the United States and Mexico were the top two countries of origin, where 58% of victims were U.S. citizens and 11.5% were Mexican nationals (USDOS, 2020). The remaining victims were from Central America, South America and the Caribbean (12%; primarily from Honduras, Guatemala and El Salvador), Southeast Asia (9%; from Philippines and Thailand), East Asia (3%), Africa and the Middle East (3%), South Asia (2%), and Europe and Central Asia (1.5%).

Traffickers mainly target women and girls for sexual exploitation. The BJS found that 94% of survivors in 2011 were female (BJS, 2011). The Department of Justice Office for Victims of Crime (GLOTIP, 2018) similarly found higher incidence of trafficking victimization for girls and women, as compared to men and transgender individuals. In the 2014/2015

[2] The Bureau of Justice Statistics (BJS), part of the U.S. Department of Justice, collects, analyzes, publishes and disseminates information regarding crime (offenders and victims) for the U.S. government.

reporting period, 77% of confirmed victims were female (61% women; 16% girls) and the 2016/2017 reporting period found similar percentiles: 82% were female (62% women; 20% girls). The United Nations confirmed a similar trend globally, where the "vast majority" (p. 10), or 72% of detected trafficking victims for sexual exploitation are female; 49% women and 23% girls globally (UNODC, 2018).

Some authors have argued that risks of sex trafficking are more pronounced for "ethnically marginalized individuals" (Vollinger, 2021, p. 600), who may experience cultural oppression, racism and ethnic bias, and who may be denied access to resources that promote security, including safe housing, employment and economic opportunities, education, and legal protection (Vollinger, 2021). Indeed, despite the difficulties with accurate data collection, available data suggest that women and girls of Color are disproportionately trafficked within and into the U.S. The BJS 2011 special report noted that, of cases that were officially confirmed and investigated in the United States from 2008 to 2010, the majority of domestic and international sex trafficking victims were People of Color (40% Black; 26% white; other races were not known and/or unidentified by the report), while labor trafficking victims were predominantly Latinx (63% Latinx; 17% Asian). Bryant-Davis and Gobin (2019) describe the increased vulnerability to domestic minor sex trafficking that African American girls face, noting that 43% of domestic minor sex trafficking survivors are African American girls.

In the last decade, disturbing data emerged suggesting that Native American[3] women and girls suffer disproportionately high rates of sex trafficking victimization in the United States as well (Deer, 2010; Farley et al., 2011; Johnson, 2012; Minnesota Office of Justice Program, 2012; Pierce, 2009; Pierce, & Koepplinger, 2011). Federal tracking of sex trafficking incidence for

[3] Author uses the words Native American and Indigenous, depending upon the language preference of the report cited.

Indigenous women was uneven or impossible until 2017, when the U.S. Office for Victims of Crime initiated grantee reporting on the race or Indigenous status of victims served (U.S. Government Accountability Office, 2017). Ushering in these changes were community agencies who had found disproportionately high numbers of Native women in Minnesota involved in commercial sexual exploitation (40%) and sex trafficking (27%), and yet who had failed to identify themselves as trafficking survivors in healthcare settings (Pierce, 2009).

Entrapment Factors

Many scholars have suggested that trafficking survivors experience complex adversity and victimization since childhood that increase vulnerability to trafficking. Such entrapment factors may include poverty, discrimination, food insecurity, early school dropout (Contreras et al., 2017), high rates of pre-trafficking childhood abuse (Contreras et al., 2017; Hopper & Gonzalez, 2018), intimate partner violence, gender, mental health, migration (Preble, 2019), sexual orientation, age, race and/or ethnicity (Vollinger, 2021), and community violence and armed conflict (Katona et al., 2015; Martino et al., 2020). Vollinger (2021) describes how the intersection of systemic factors with individual-level factors, such as past history of abuse, poverty, and stigma, cement disproportionate vulnerability for sexual exploitation.

Scholars suggest that vulnerability factors are exploited by traffickers to entrap victims and maintain their exploitation (Preble, 2019). Minors are often recruited into sex trafficking by both those known or unknown in their communities (i.e., in neighborhood stores, malls, or their homes), through coercion by intimate partners (Hardy et al., 2013), or through those posing as potential employers (Bryant-Davis & Gobin, 2019). Families were also found to play a role in trafficking their children (Bryant-Davis & Gobin, 2019; Contreras et al., 2017). Likewise, intricate criminal networks are thought to play a role (Couto, 2012).

Recent scholarship has contributed an historical and structural understanding to conceptualize trafficking victimization. Bryant-Davis and Gobin (2019) link the “historical trauma of the trans-Atlantic slave trade” (p. 386), where African American girls and women were sexually exploited legally and systematically, to the disproportionate “dehumanization and sexual violence” (p. 386) carried out against their descendants through modern day sex trafficking. The Minnesota Indian Women’s Resource Center (MIWRC) comprehensive *Shattered Hearts* report (Pierce, 2009) and the *Garden of Truth* report (Farley et al., 2011) offered a similar historical frame to understanding the problem and impact of trafficking. They detail the traumatic colonial history, and subsequent multi-generational losses and traumas that have put Native peoples at uniquely high risk of trafficking, including U.S. government extermination policies, religious persecution, forced migration, and systematic removal of children to white families and boarding schools. The result has been inter-generational/historical trauma, with widespread impacts including poverty, community and interpersonal violence, poor health outcomes, and disproportionate vulnerability to sex trafficking (Farley et al., 2011; Pierce, 2009).

The processes and mechanisms for trafficking are varied. Polaris Project analyzed the “largest data set on human trafficking in the United States ever compiled” (Polaris Project, 2017, p. 5) to develop a classification system meant to identify the different forms of trafficking exploitation. In collaboration with the National Human Trafficking Hotline and BeFree Textline, they analyzed more than 32,000 reported human trafficking incidences between 2007 and 2016, and identified 25 types of human trafficking in the United States. Some of the 25 typologies related to sex trafficking include: escort services, illicit massage, outdoor solicitation, bars/strip clubs, pornography, personal sexual servitude, and remote interactive sexual acts. Each typology

has its own associated trafficker profile and victim profile, recruitment strategies, business models, and methods of control that cement that particular type (Polaris Project, 2017). Polaris’ work shifted the understanding of exploitation in the U.S. beyond the dualistic categories of sex and labor trafficking, to a more nuanced view of the many ways that traffickers control and exploit for profit. They also identified how traffickers may use multiple business models simultaneously, allowing them to be nimble and avoid disruption efforts.

There remains a lack of scholarship surrounding the means and motives of traffickers. In terms of means, Bryant-Davis and Gobin (2019) noted that traffickers take advantage of victims’ need for love and safety, and exploit using varied methods of force, fraud, or coercion, including shame, humiliation, betrayal, fear, and seduction. Trafficking exploitation may be initiated through paths as varied as intimate partner violence/control; pimp control; forced substance abuse; migration risks including criminal networks and smugglers; child pornography; sale of neonates, infants and children; and more (Martinho et al., 2020). The global scholarship surrounding modern slavery is further elucidating links between and amongst adversities including but not limited to: human trafficking, child soldiering, migration adversity, forced marriage, organ removal/trafficking, and begging (Katona et al., 2015; Martinho et al., 2020; Wright et al., 2021). In terms of motives, Preble (2019) highlighted the dearth of scholarship focused on understanding the characteristics of traffickers and their motivations to traffic. Preble (2019) further underscored the near total lack of research examining how traffickers’ characteristics impact victims’ perceptions of power, which may contribute to keeping victims in exploitative situations and/or returning to trafficked situations. Her work suggests that not only are vulnerability factors exploited by traffickers, but that victims’ perception of traffickers’

control and power may further entrench a victimized state in the "maintenance phase" of being trafficked (Preble, 2019).

Consequences of Trafficking

Survivors of sex trafficking have been found to experience severe physical and sexual violence during trafficking exploitation, including combinations of rape, torture, induced substance abuse, psychological coercion, forced captivity, physical violence and more (Bryant-Davis & Gobin, 2019; Clawson et al., 2003; Contreras et al., 2017). Hardy et al. (2013) described survivors' experiences of domestic violence, political oppression and isolation. Oram et al. (2012) did a systematic review, examining 19 studies about violence and mental health impacts on sex trafficked survivors internationally, and found consistently high prevalence rates of physical and sexual violence experienced by women who were sex trafficked. Hopper and Gonzalez (2018) also found high rates of physical and sexual violence experienced during sex trafficking exploitation in a sample of survivors living in the United States at the time of treatment. Farley et al. (2011) found high rates of racialized violence, where traffickers and sex buyers sometimes leveraged women's Indigenous cultural identities to inflict violent fantasy-based enactments about colonization.

Survivors face a litany of mental health consequences resulting from their trafficked experience. Studies have found that survivors report overwhelming feelings such as fear, shame, mistrust, hopelessness and continuous irritability, as well as sleep disturbances including insomnia and nightmares (Ijadi-Maghsoodi et al., 2016). Hardy and colleagues (2013), in their study of minors who were sex trafficked, found that symptoms of trauma were associated with forced subjugation, separation from family, and sexual acts with multiple perpetrators. Zimmerman and colleagues' 2008 survey of 192 women in recovery services found that 57%

endorsed symptoms suggestive of posttraumatic stress disorder (PTSD) (Zimmerman et al., 2008). Farley et al. (2011) found that 52% of Indigenous women surveyed about sex trafficking met clinical threshold for PTSD.

In one study examining the psychological symptoms reported by 131 survivors of sex and labor trafficking into and within the United States, Hopper and Gonzalez (2018) found prominent rates of PTSD (61%) and depression (71%) amongst trafficking survivors. Most survivors in their sample also met criteria for multiple categories of Complex posttraumatic stress disorder (CPTSD), including affect dysregulation, alterations in consciousness, impacts on interpersonal relationships, revictimization, somatization, and alterations in self-perception (Hopper & Gonzalez, 2018). Likewise, Ottisova et al. (2018) found that trafficked children with PTSD often also had CPTSD symptoms. Sex trafficking survivors (as compared to labor trafficking survivors) reported more severe mental health reactions, including more PTSD and CPTSD symptoms and more frequent comorbid PTSD and depression symptoms (Hopper & Gonzalez, 2018). Likewise, transgender-identified trafficking survivors reported more PTSD and CPTSD symptoms than survivors identifying as male or female (Hopper & Gonzalez, 2018). Hopper (2017) noted that while depression, anxiety and PTSD are often identified amongst survivors of trafficking, depression is most commonly reported, and that chronicity may correlate with safety concerns (suicidality). Ottisova et al. (2018) found that amongst child trafficking survivors, self-harm behaviors and suicide attempts were more common, as were adjustment disorders and affective disorders.

Survivors face wide-ranging challenges after exiting sex trafficking exploitation, including challenges to their physical and sexual health. Zimmerman et al. (2008) found that 63% of women in aftercare services reported suffering ten or more physical health symptoms

concurrently, including headaches, fatigue, dizziness, back pain, and memory issues. Oram et al. (2012) found higher rates of HIV infection amongst sex trafficked individuals globally. In a study with 29 child survivors trafficked into the United Kingdom, Stanley et al. (2016) similarly found multiple physical complaints to be common, including back pain, stomach and headaches, memory issues, and sexually transmitted infections.

Scholars have also found that survivors of sex trafficking experience mental/emotional and structural difficulties with recovery and community re-integration. Survivors often experience social stigmatization post-exit, which complicates community re-integration, perpetuates a sense of ongoing victimization, and makes recovery more difficult (Ijadi-Maghsoodi et al., 2016). Bryant-Davis and Gobin (2019) described "community-wide desensitization to the sexualization of girls" (p. 386) as increasing vulnerability to trafficking, yet it also suggests complications to recovery and community reintegration. Recent scholarship frequently discusses barriers to recovery within the multidisciplinary and multisystemic contexts in which survivors are embedded post-exit (Martinho et al., 2020; Muraya & Fry, 2016). Survivors commonly manage severe and overlapping impacts on their mental, physical and sexual health, social relationships and social stability, legal and/or immigration status post-exit, which lead to psychological and structural vulnerabilities in recovery, including risks for re-exploitation (Contreras et al., 2017; Martinho et al., 2020). The severity and complexity of outcomes post-exit suggest the need for comprehensive recovery and reintegration efforts (Dell et al., 2019; Hardy et al., 2013; Hopper, 2017).

Research Base Under-Developed: Evolving Theoretical Foundation and Care Guidelines

While research on mental health recovery with survivors of human trafficking into and within the United States has increased in recent years (Powell et al., 2018), its status continues to

be characterized as methodologically under-developed as well as lacking a sufficient evidence base and theoretical foundation to guide practice (Dell et al., 2019; Gozdziak & Bump, 2008; Gozdziak & Collett, 2005; Katona et al., 2015; Reid, 2012; Wright et al., 2021). Despite disturbing prevalence trends, the deleterious and wide-ranging impacts of trafficking, the urgency endemic to this form of exploitation, and ever-increasing government and NGO attention on rescue, protection and prevention efforts to support survivors (Polaris Project, 2014), few studies have explored mental health recovery and clinicians’ perspectives on best practices with survivors of sex trafficking (Family Violence Prevention Fund, 2005; Martinho et al., 2020), especially within the multidisciplinary and multisystemic recovery environments in which survivors are often embedded (Martinho et al., 2020). Much of the trafficking research has instead related to individual sex trafficking survivor entrapment experiences and vulnerability factors (Reid, 2012), articles on policy and legal frameworks, and reviews of existing scholarship and NGO reports (Gozdziak & Collett, 2005; Johnson, 2012).

Scholars have cited validity issues with research (Family Violence Prevention Fund, 2005) including poor research design and execution (Dell et al., 2019), and lack of clinical intervention trials examining the efficacy of mental health treatment for sex trafficking survivors (Katona et al., 2021; Levine, 2017; Wright et al., 2021; Zimmerman, Hossain, & Watts, 2011). Martinho et al. (2020) underscored the newness of the field, highlighting that much of the published mental health research is from the second half of the last decade (from approximately 2015 to 2020 as well as from 2021). Much remains unknown about the impact of clinicians (Martinho et al., 2020) and survivor mentors (Rothman, Preis, Bright, Paruk, Bair-Merritt, & Farrell, 2020) on survivor mental health outcomes, and no known scholarship examines the partnerships between clinicians and survivor mentors (Contreras & Kallivayalil, 2019). Even as

research efforts have picked up momentum in very recent years, scholars contend that the mental health recovery and service delivery literature remain underdeveloped (Martinho et al., 2020; Powell et al., 2018). Much remains unknown about the experiences of mental health providers (e.g., counselors, therapists, clinical case managers, peer mentors) who serve sex trafficking survivors.

Nonetheless, based on the research that exists, current guidelines most commonly recommend that aftercare recovery services be trauma-informed (Hopper, 2017; Katona et al., 2015; Macy & Johns, 2011; Wright et al., 2021), victim-centered (Katona et al., 2015), culturally-sensitive/culturally-specific (Hemmings et al., 2016; Martinho et al., 2020; Menon et al., 2020), gender-sensitive (Katona et al., 2015), and include comprehensive multidisciplinary, multi-agency coordination (Martinho et al., 2020; Muraya & Fry, 2016).

Trauma-Informed Approaches

Mental health recovery is a central tenet of anti-trafficking policies globally (Wright et al., 2021) and care guidelines shaping interventions with survivors (Human Trafficking Foundation, 2015). Based on the severity of the crime, research recommendations related to clinical intervention with survivors of sex trafficking largely favor using treatments for complex trauma, designed for and tested on non-trafficked communities, given the lack of evidence base and a presumption of sufficient shared commonalities amongst trauma survivors (Gajic-Veljanoski & Stewart, 2007; Hodge, 2014; Macy & Johns, 2011; Muraya & Fry, 2016; Williamson, Dutch & Clawson, 2010; Zimmerman et al., 2003). The recommendation is to model aftercare provisions on those serving refugees (Shigekane, 2007), torture survivors, and female survivors of sexual abuse, rape, and intimate partner violence (Gajic-Veljanoski & Stewart, 2007; Hodge, 2014; Macy & Johns, 2011; Williamson et al., 2010; Zimmerman et al.,

2003). However, some scholars have suggested that mirroring refugee recovery service guidelines and those designed for survivors of intimate partner violence (IPV) do not adequately address the unique needs of trafficking survivors, because of their complex sequelae of challenges and the longer length of time trafficking survivors need to stabilize as compared with refugees and survivors of IPV (Clawson et al., 2003; Shigekane, 2007). Similarly, while Menon et al. (2020) describe potential in using research with survivors of sexual assault and intimate partner violence to inform intervention work with survivors of human trafficking, they also recommend caution. Survivors of trafficking are a highly diverse, multinational group, and that diversity is not well represented in the sexual assault and IPV literature, and therefore lacks generalizability to trafficked populations (Menon et al., 2020).

Existing studies repeatedly suggest that trafficking recovery service provisions are under-studied, and underscore the lack of evidence-base to guide clinical intervention with survivors (Levine, 2017; Wright et al., 2021). These researchers note that paralleling trafficking survivors’ benefits with presumably similarly impacted populations may be inadequate to support the unique needs and barriers that complicate stabilization and recovery for survivors of trafficking, and that more research is urgently needed (Wright et al., 2021).

Cross-Cultural and Emancipatory Perspectives

Simultaneously, some scholars have called for more research on the development of culturally sensitive clinical interventions for trafficking survivors, and some have further suggested a population-level and historical focus in clinical treatment that contends with histories of racism and colonialism (Bryant-Davis & Gobin, 2019; Carter, 2003; Deer, 2010; Matthews et al., 2010; Minnesota Office of Justice Program, 2012; Pierce & Koepplinger, 2011). With available data indicating that the majority of domestic and international sex trafficking survivors

in the United States are women of Color from culturally varied sub-groups, some scholars have called for combining “trauma-informed, human rights-based, culturally appropriate, and gender-sensitive” approaches in recovery intervention (Nazer & Greenbaum, 2020, p. 211). Combining that call with a social justice agenda, some scholars have called for more research on the development of culturally sensitive clinical interventions for sub-groups of trafficking survivors that contend with intersectionalities of survivors’ social identities (Bryant-Davis & Gobin, 2019; Carter, 2003; Vollinger, 2021).

Some critical scholars point out that identified survivors who are part of post-exit social, legal, and other services are nested within oppressive social structures, including systems that have been designed to support as well as oppress (Vollinger, 2021), and that these act harshly on marginalized groups (Bryant-Davis & Gobin, 2019). Some of this scholarship has advocated a population-level and historical focus within clinical treatment that contends with histories of racism, slavery, and colonialism (Bryant-Davis & Gobin, 2019; Carter, 2003; Deer, 2010; Matthews et al., 2010; Minnesota Office of Justice Program, 2012; Pierce & Koepplinger, 2011). This sparse but important scholarship advocates treatment/recovery models that account for intersectionality of social, cultural and racial identities (Vollinger, 2021) and that combine an individually focused, complex trauma approach with a population-centered, intersectional and emancipatory framework (Farley et al., 2011). Conceptualized together, these lenses aim to contend with survivors’ posttraumatic symptoms, multi-layered needs, and complex social identities as they intersect with social institutions, as well as historical and present-day experiences of racism, colonialism, and gender discrimination, with deep consideration of culture and community as strength-based resources (Carter, 2003; Contreras et al., 2017; Farley et al., 2011; Hossain et al., 2010; Pierce, 2009). These scholars argue the need for a theoretical

framework guiding practice that considers intersectionality, social justice and action in work with survivors of sex trafficking (Vollinger, 2021).

Social Ecological Model: Multisystemic and Multidisciplinary Recovery Context

Lastly, recent studies recommend comprehensive multidisciplinary coordination to support survivor recovery, having found that survivors in the United States interact with a great diversity of systems and disciplinary providers (Martinho et al., 2020). Dell et al. (2019) indicate that the road to recovery is difficult as post-exit challenges interact (i.e., physical, psychological and social problems, substance use, legal and immigration challenges, economic and housing challenges, and societal reintegration challenges), and survivors may come in contact with a broad array of disciplinary providers, agencies, institutions, and systems. These may include social workers, social service and health care staff, police and immigration officers, youth outreach service workers, addiction specialists, and more (Dell et al., 2019). A comprehensive and coordinated service response across multiple system levels may be needed to address the varied domains impacted by trafficking exploitation (i.e., housing, healthcare, mental health and addiction services, vocational support, legal/immigration, and more) (Hammond & McGlone, 2014; Martinho et al., 2020). Thus, current guidelines recommend that aftercare services involve multidisciplinary teams, and a cooperative network of professionals working across agencies, institutions and systems collaboratively (Martinho et al., 2020).

Yet survivors’ complex and multi-faceted needs post-exit may challenge the broad array of disciplinary providers who participate in recovery efforts, including social workers. These multidisciplinary and multisystemic actors and institutions may or may not share a vision for survivors’ post-exit recovery (Menon et al., 2020). While data suggests that survivors are intersecting with multiple systems of recovery, identification and recovery support efforts remain

weak (Hopper, 2017), and barriers exist resulting in uncoordinated care (Clawson & Dutch, 2008; Domoney et al., 2015; Powell et al., 2018). For example, a meaningful number of Native American sex trafficking survivors were found to engage with social service, mental health, and legal services yearly, yet were often not identified as survivors of trafficking (Deer, 2010).

In addition to multidisciplinary work, tailored and multi-pronged clinical response in trafficking recovery support work may be needed across multiple system levels (Hopper, 2017). Some scholars have recently suggested using a social ecological approach to conceptualize and address survivors’ range of psychosocial needs (Hopper, 2017; Salami et al., 2021). A social ecological approach contextualizes survivors of sex trafficking as embedded within and influenced by multiple environments at varied system levels, including the individual, relational and social levels, as well as the dimension of time (Finigan-Carr et al., 2018). It provides a widened intervention framework through which to conceptualize barriers to and resources in recovery.

Existing research suggests the need for a workforce competently prepared in assessment and recovery intervention strategies (Domoney et al., 2015), as well as collaboration and coordination across multiple systems levels. Highlighting the emergent status of scholarship in the field, Martinho et al. (2020) recently concluded the need to assess whether multidisciplinary service providers actually employ “culturally-sensitive, victim-centered, and trauma-informed care intervention” (p. 14) with survivors of trafficking, and if so, how they implement it. Within this landscape, scholars have underscored the dearth of knowledge related specifically to mental health professionals’ experiences providing care (Domoney et al., 2015; Magnan-Tremblay et al., 2019), and the value of accessing insight into trafficked women’s experiences via exploring mental health providers’ firsthand witness accounts (Magnan-Tremblay et al., 2019). Likewise,

scholars have promoted the importance of survivors' perspectives to improve recovery intervention (Wright et al., 2020), found initial evidence of survivor mentors' positive impact on recovery outcomes (Rothman et al., 2020), and argued for the potential value in clinical collaborations between peer mentors and mental health professionals (Contreras & Kallivayalil, 2019).

Some terms that are used throughout this study include multidisciplinary, multisystemic, and wraparound, as well as peer mentor (and survivor mentor). Definitions to these key terms are provided below:

Multidisciplinary: In multidisciplinary collaboration, professionals draw on knowledge and experience from their different disciplines (i.e., doctors, nurses, social workers, lawyers, educators, policy makers, psychologist, psychiatrists, and more) in an approach that has been described as additive (Choi & Pak, 2006). Multidisciplinarity differs from interdisciplinarity, which aims to synthesize links between disciplines into a coherent, coordinated whole (Choi & Pak, 2006). Choi and Pak (2006) describe the aim of multiple disciplinary work in the healthcare sector is to resolve complex problems using distinct perspectives and to provide comprehensive, consensus-based health services.

Multisystemic: Bronfenbrenner's (1979) social ecological model provided a framework for conceptualizing how proximal systems, such as family, peers, and neighborhood, impact the behavior of individuals embedded in multiple intersecting domains, and the reciprocal interplay between and amongst systems (Henggeler & Schaeffler, 2016). Multisystemic therapy was developed to target risk factors for clinical problems within and between multiple domains, and

to conceptualize aspects of a person’s broader ecology that create barriers to the functioning of proximal systems and impede healing (Henggeler & Schaeffler, 2016).

Wraparound: A service planning process and care philosophy emerging out of work with children with serious emotional disturbance and their families, based on a systemic teamwork approach among professionals, grounded in an ecological approach (Mana & Naveh, 2018; Walter & Petr, 2011). This approach promotes client self-determination, relies on natural community supports, is family-centered, offers the least restrictive environment, and addresses the varied contexts in which a child lives and belongs (Mana & Naveh, 2018; Walter & Petr, 2011). While multidisciplinary teamwork is considered essential, it is also understood to be challenging (Mana & Naveh, 2018). Walter and Petr (2011) emphasize the potential of a wraparound ecological approach to promote social justice by working towards systems change.

Peer Mentor: Peer Mentors, also called Survivor Mentors (or survivor-mentors), are terms used in the field of sex trafficking recovery that describe the pairing of a survivor of sex trafficking with someone further along the exit and recovery path. Rothman et al. (2020) refer to a survivor mentor as “a person who has survived sexual exploitation and can function as (a survivor’s) mentor; that is, can help them recover from trauma and re-stabilize” (p. 2). Trafficking recovery organizations also use the terms peer mentor, advertising it as a paid position (RIA House Inc., 2021) and survivor leader (GEMS, 2021). Peer mentors typically receive specialized training from an agency, are one or several years post-exit, and mentor survivors as part of a professional team.

This study makes use of both terms (peer mentor and survivor mentor), and defines the role as a survivor of sex trafficking who works to provide mental health support, accompaniment, advocacy and case management services for other survivors of trafficking. This study also uses the term survivor leader, based on participant preference, to refer to one participants’ additional work founding and running a trafficking recovery non-profit agency. While the participants in this study are primarily credentialed clinicians (and not survivors of trafficking), survivors of trafficking may also be clinicians; that is the case for one participant in this study who is a Doctor of Social Work and a survivor of trafficking. Similarly, the literature review in the next chapter cites an interview with a peer mentor who is also a clinical social worker. Finally it is worth noting that, while all peer mentors are survivors, not all survivors choose to become peer mentors. Survivors of sex trafficking may go on to work in a variety of meaningful careers.

Like the National Alliance on Mental Illness (NAMI), this study employs an inclusive definition of the term mental health provider. NAMI lists multiple roles and training backgrounds under the domain of mental health professional. These include psychologists, counselors, clinicians, therapists, clinical social workers, psychiatrists and psychiatric nurse practitioners, and psychiatric pharmacists (NAMI, 2021). Additionally, NAMI includes peer specialists, B.A. and B.S. level social workers, and pastoral counselors, defining peer specialists as possessing lived experience, training and preparation to support recovery through mentorship. This study employs an inclusive definition of the term mental health provider to include peer mentors, in an attempt to capture the breadth of professionals providing mental health support and therapeutic services to survivors of sex trafficking.

Mental Health Providers’ Perspectives

The exploration of mental health providers’ treatment approaches and perceptions of processes they find effective in recovery work with survivors of sex trafficking is critical to understand the current state of the recovery field (Martinho et al., 2020). With increased state, federal, and international efforts to rescue and protect sex trafficking survivors by promoting their therapeutic recovery and social integration through the TVPA’s “3 Ps” policy of prevention, protection, and prosecution (USDOS, 2011), and as the TVPA policy provides recovery services to foreign nationals (DOJ, 2017) and some domestic survivors [i.e., Native Americans (Johnson, 2012)], the lack of available information about what recovery techniques are being used and their relative effectiveness becomes pressing. Understanding mental health providers’ approaches to treatment and their views of effectiveness with survivors may also contribute to our understanding of what makes particular minoritized groups uniquely vulnerable to (re)trafficking. Importantly, a 4th "P,” partnership, was later added to promote information sharing, allied service provision, and the contributions of survivor networks (USDOS, 2013).

Little is known about the use and effectiveness of the complex trauma framework as a treatment approach with trafficking survivors, about the culturally sensitive adaptations that clinicians make, and if and how emancipatory and decolonizing frameworks are being employed in mental health recovery work. This is of concern since critical multicultural social work scholars assert the importance of taking race, ethnicity, and nationality into account to engage in decolonizing treatment (Goodman, 2015; Gorski, 2015). These outstanding questions, in combination with disturbing prevalence rates for girls and women of Color, establish an urgent need for further research surrounding the clinical treatment of diverse sex trafficking survivors in the United States and the clinical frameworks used.

More attention should be given to clinicians’ voices, in an attempt to explore the current state of practice(s), investigate potentially culturally sensitive interventions, and take a fresh look at whether and how the complex trauma framework, emancipatory or decolonizing models, and ecological/multisystemic/multidisciplinary approaches are drawn on in recovery work with sex trafficked individuals. Examining clinicians’ perspectives including their clinical attitudes and treatment approaches has been found to be useful in contributing to research and practice literature related to gender-based sexual violence. Pierce (2009) and Farley et al. (2011) both recommended more research on the provision of culturally sensitive services for Native women who have been sex trafficked. Pierce (2009) found that service providers were initially unaware their clients had been sex trafficked and that social service agencies under-estimated prevalence rates. Gozdzniak & Collett (2005) highlighted calls for more qualitative research to: bolster complex understandings of survivors’ characteristics to develop culturally appropriate services, explore provider/NGO expertise with different sub-groups of survivors, and clarify “best practices” to develop treatment and recovery programs. Martinho et al. (2020) asserted that “there is still a long way to go” (p. 14) in the establishment of an empirical body of research on child trafficking and call for studies specifically examining the approaches of those who work directly with trafficked people. Martinho et al. (2020) noted a pressing need to assess whether “culturally sensitive, victim-centered, and trauma-informed care intervention” (p. 14) is being implemented, and if so, how.

Researchers from parallel fields have substantiated the value of examining providers’ perspectives, particularly in gender-based sexual violence recovery scholarship. Scholars studying male childhood sexual trauma have highlighted the value of learning from clinicians who are knowledgeable about the needs of their client population and who may have valuable

insights into treatment. These studies with mental health clinicians highlighted needs for improved provider training (Day et al., 2003; Easton et al., 2014; Holmes & Offen, 1996; Holmes et al., 1997), perceptions among therapists of being under-qualified and under-resourced (Lab et al., 2000), lack of available mental health services (Holmes et al., 1997) and barriers to accessing existing mental health services (Gruenfeld et al., 2017). Mental health providers who accompany survivors of human trafficking may shed important light on the treatment landscape that survivors encounter, including treatment choices providers make, processes they find effective, views of emancipatory approaches, and culturally responsive adaptations they do or do not make, and how and why these may differ by client or therapist.

Recent research into recovery from human trafficking also promotes the critical importance of integrating survivor voices into research (USDOS, 2019; Wright et al., 2020). Those providing mental health services to survivors of human trafficking are a multidisciplinary group including: social workers, counselors, psychologists, psychiatrists, case managers and peer/survivor mentors. This study will consider the perspectives of several types of multidisciplinary mental health providers, including peer/survivor mentors. This study follows in the tradition of research that values clinicians’ perspectives to advance knowledge and improve clinical practice, and which centers survivor voices as essential to this endeavor.

Few studies have examined the perspectives of therapists who specialize in treating sex trafficking survivors in the United States about their treatment approaches and their perceptions of treatment effectiveness (Domoney et al., 2015). Likewise, no known studies have examined the clinical collaborations between peer mentors and therapists in trafficking recovery work (Contreras & Kallivayalil, 2019). This clinical wisdom would expand knowledge that could be useful in improving training for mental health providers and for refining aftercare treatment and

recovery guidelines for survivors. Thus, the purpose of this study is to explore mental health providers’ experiences with and perspectives on treatment approaches and processes they find to be effective with diverse sex trafficking survivors in the United States, with attention to their work as embedded in multidisciplinary and multisystemic contexts, and a special interest in their understandings of and perspectives on emancipatory approaches.

Specific Aims

This study aims to explore the perspectives of mental health providers working with culturally diverse sex trafficking survivors in the United States to learn from their experiences in order to close a significant gap in the literature. Given that the field lacks a theoretical foundation to guide practice and research (Gozdziak & Collett, 2005; Reid, 2012; Wright et al., 2021), and scholarship and clinical approaches are actively evolving, this study explored mental health providers’ perspectives on recovery work through the lenses of three contemporary theoretical frameworks: trauma-informed care; cross-cultural and emancipatory approaches stemming from transcultural psychiatry and critical race theory; and social ecological theory. This study recognizes strengths in each approach, and notes critiques, to consider ultimately moving towards an integrated theoretical framework – one that leverages the potential of each frame to support survivor accompaniment and recovery. Exploring the perspectives of the differing types of mental health providers who work in sex trafficking recovery (defined in this study to include clinicians and survivor mentors) has the potential to advance researchers’ understanding of clinical interventions, adaptations being employed, and components of successful peer and professional collaborations. Such exploration may add to understanding of current guidelines and appropriateness of usage within multidisciplinary and multisystemic recovery contexts.

This dissertation is guided by the following research question: What are the perspectives of mental health providers who work with survivors of sex trafficking in the United States, through multisystemic and multidisciplinary recovery work, related to treatment approach, the processes they find to be effective[4], and their views on emancipatory approaches?

[4] “Effectiveness,” a component of the research question, is operationally defined in this study as contributive to healing/recovery (i.e., helpful, supportive). Effectiveness was not quantitatively measured for this study, as it might be in an intervention outcomes study. Instead, effectiveness is operationally defined to be appropriate for an exploratory qualitative study. The semi-structured interview protocol (see Appendix C) included questions inquiring about provider perspectives on the effectiveness and ineffectiveness of mental health recovery guidelines, approaches, and tools to support recovery. It also included questions about providers’ perceptions of their clients’ (or survivor mentees’) perceptions about the same. In response to these interview questions, participants gravitated towards answers that conceptualized effectiveness as contributive to healing, supportive of coping, enhancing of strengths, and helpful to wellbeing.

Chapter II. Review of the Literature

Overview

The research related to mental health recovery for survivors of human trafficking, while developing, is in an early stage of the knowledge base. The status of the research has been frequently characterized as lacking sufficient theoretical foundation and evidence base to guide the work, and as methodologically under-developed (Gozdziak & Collett, 2005; Reid, 2012; Wright et al., 2021). Notwithstanding the prevalence, severity, and impact of this form of exploitation, the research is sparse in many areas, particularly related to mental health treatment and service delivery (Powell et al., 2018), intervention outcomes (Wright et al., 2020), and clinicians’ perspectives on providing care to survivors (Domoney et al., 2015; Family Violence Prevention Fund, 2005; Martinho et al., 2020), especially within multidisciplinary and multisystemic contexts (Martinho et al., 2020; Muraya & Fry, 2016).

Despite the disproportionate sexual exploitation of girls and women of Color, the scholarship related to cross-cultural approaches to recovery work and intersectionality is also under-developed (Vollinger, 2021). Likewise, despite the value of both clinicians’ (Domoney et al., 2015) and survivors’ perspectives on mental health recovery work (Wright et al., 2020), scarce scholarship documents the perceptions and practices of clinicians (Muraya & Fry, 2016) or the clinical collaborations between therapists and peer mentors (Contreras & Kallivayalil, 2019). Even as research efforts have picked up considerable momentum in the last five years, scholars contend that the aftercare literature related to mental health recovery and service delivery with survivors of sex trafficking remains underdeveloped (Powell et al., 2018) and with glaring gaps, emphasizing an urgent need for further research (Martinho et al., 2020; Muraya & Fry, 2016).

This chapter will examine key theoretical and empirical literature in the trafficking recovery field, as well as theoretical insights from related fields, to extend thinking and highlight existing gaps. Given the lack of one cohesive, evidence-based theoretical foundation guiding the field and the complexity of recovery work across intrapsychic, interpsychic, and social/structural domains, this chapter considers the contributions of three theoretical frameworks whose insights undergird, challenge and extend existing research and practice guidelines. The first is the framework of trauma-informed care, more recently conceptualized as complex trauma. The second offers analytic tools to consider cross-cultural, emancipatory and intersectional approaches to recovery work. The third is the social ecological approach, which provides a framework for conceptualizing multidisciplinary and multisystemic relationships. The first and second theoretical frameworks have guided this study since its inception; all three frameworks guided analysis and interpretation of the findings.

This chapter will introduce each theoretical framework, discuss its clinical relevance with survivors of sex trafficking, and review associated key empirical research. It concludes by critically discussing the limitations, gaps, and integrative promise of these bodies of scholarship, and presenting this study’s rationale. That is, this study aims to contribute to the knowledge base in mental health providers’ perspectives on recovery work with survivors of sex trafficking in multidisciplinary, multisystemic environments. This includes the perspectives of clinicians and peer mentors on treatment, processes found to be helpful and unhelpful in recovery, and understandings of emancipatory approaches. In doing so, this study aimed to overcome past limitations and advance integrated thinking.

Since the field is nascent, without an integrated, clearly defined theoretical foundation, this chapter will introduce that which is necessarily evolving. The discussion of theoretical and

empirical research is more expansive in some sections than others, because the knowledge bases are not equivalent. For example, the trauma-informed literature emerges largely out of an epistemological and methodological tradition that privileges empirical studies, so they are available. By contrast, the critical literature inclines towards important theoretical and conceptual contributions, emerging from a distinct epistemological and methodological tradition. As a result, the structure of each sub-sections’ discussion is not identical in structure.

Likewise, some studies and authors will be discussed in more than one section when their insights and recommendations cross over categories. Recovery work, in research and in practice, is multi-faceted and the theoretical divisions imposed here are, to some degree, artificial. The distinctions offered by the sub-sections do not intend to suggest that, for example, trauma scholars fail to consider the impact of poverty, discrimination, or embeddedness in complex multidisciplinary, multisystemic contexts. While unrealistically discrete, this chapter imposes distinctions for the purpose of examining each theoretical domain’s core insights as well as gaps in the theoretical and empirical scholarship. The overlapping nature of key scholarship across multiple domains of this literature review indicates the complexity and multipronged nature of sex trafficking recovery work, the many research gaps that exist, and the lack of one commonly agreed upon theoretical framework to cohere and guide the work. The goal of this study is to offer integrated possibilities for conceptualizing and engaging in sex trafficking recovery work.

Trauma-Informed Care Framework

The trauma-informed care framework is broadly considered to be a useful approach for sex trafficking survivor recovery work and thus is frequently recommended (Macy & Johns, 2011; U.S. Federal Strategic Action Plan for 2013-2017). Indeed, PTSD has been found amongst survivors of sex trafficking across varied cultural settings (Farley et al., 2004; Farley et al., 2011;

Zimmerman et al., 2008). In the absence of an established evidence base or theoretical framework to guide practice, scholars have recommended importing recovery guidelines developed for use with refugees and survivors of intimate partner violence, based on the presumption of sufficient similarities (Zimmerman et al., 2011). This is despite the scant evidence base establishing its effectiveness for survivors of sex trafficking specifically (Wright et al., 2021), and indeed some evidence of its insufficiency (Clawson, 2003; Dell et al., 2019; Menon et al., 2020; Shigekane, 2007). Scholars continue to highlight the serious research gaps related to evidence-based mental health support provision for survivors of trafficking and make urgent calls for more research on effective interventions (Dell et al., 2019; Katona et al., 2015; Wright et al., 2021). The current study aims to explore mental health providers’ perspectives on the practice approaches, frameworks and techniques they use, and the processes they find (un)helpful.

While trauma theory is too vast to review in its entirety, this sub-section first overviews key trauma recovery theoretical literature and then discusses issues related to its clinical relevance with survivors of sex trafficking specifically. It finally presents the empirical literature, emergent from approximately 2000-2011, and recently more robust from approximately 2011-2021. This sub-section will conclude with synthesis and critique of the research gaps; however, a fuller critique of the trauma-informed framework follows in the second sub-section, when critical theory and literature are discussed.

Theory: Trauma Framework

The posttraumatic stress disorder (PTSD) scholarship suggests that trauma is a neurobiological response in the body and brain (van der Kolk, 1994). It is referred to as a biologically-based disorder, which impacts sufferers’ brains with the initiation of biological drives that can lead to entrenched neurological function, with symptoms including avoidance,

hypervigilance, re-experiencing, and dissociation (van der Kolk, 1994). Prior research has suggested that these biological drives are culturally universal for trauma survivors, with differences by culture that influence individual experiences, symptomology/presentation, and treatment preferences (Perilla et al., 2002). PTSD is commonly identified as resulting from extreme adversity, including human trafficking (Oram et al., 2012), across varied cultural contexts (Farley et al., 2004; Farley et al., 2011).

Studies on PTSD symptomology emerged historically out of the need to understand veterans from World War I, World War II (Kleinman et al.,1997; Lykes, 2002) and the Vietnam War, and their significant psychiatric complaints (van der Kolk et al., 2005). The PTSD diagnostic category was developed for inclusion in the 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed,; DSM–III; American Psychiatric Association, 1980) in an attempt to explain and treat such suffering (van der Kolk et al., 2005). It began as a psychiatric, biomedical categorization and treatment tool that was constructed from existing research on war veterans, male burn victims, and ‘battered women’ who were survivors of rape and domestic violence (van der Kolk, 2005).

The PTSD frame innovatively attempted to account for sufferers’ personalities and contexts (van der Kolk & McFarlane, 1996). Van der Kolk and McFarlane (1996) noted that the PTSD diagnosis helpfully dislodged people’s symptoms from their prior place of “genetically based irrationality” (p. 4) to an understanding that adverse experiences could overwhelm an individual’s capacity to cope. They noted that instead of seeing individual’s problems as “diseases without context” (Van der Kolk & McFarlane, 1996, p. 5), which was psychiatry and medicine’s temptation, PTSD corrected this propensity to decontextualize. PTSD was thus an

advance. Van der Kolk and McFarlane (1996) noted that once symptoms were identified and their convergence labeled as PTSD, it turned out to be common.

Today, trauma theorists conceptualize treatment largely through the lens of PTSD as defined by the DSM-V (American Psychiatric Association, 2013), developmental trauma disorder (van der Kolk, 2005), and complex posttraumatic stress disorder (Herman, 1992; van der Kolk et al., 2009). While CPTSD is not a diagnostic category in the DSM-5, it was recognized in the 11th edition of the *International Statistical Classification of Diseases and Related Health Problems* (11th ed.; ICD-11; World Health Organization, 2019), enabling clinicians to use the diagnosis all across the world (Maercker, 2021). These contemporary frameworks contextualize sex trafficked individuals in developmental context with intergenerational linkages, where repeated and chronic traumas are thought to have occurred throughout an individuals' lifespan, making trafficking vulnerability likely and complicating relational/language-based treatment (Hopper, 2017).

The complex trauma construct considers the impact of overlapping traumas on multiple domains of functioning as a constellation of symptoms, presenting in emotional domains (dissociation), as well as via neurobiology, cognition, behavioral response, relationships, sense of self, and future orientation (D'Andrea et al., 2012; Herman, 1997). Treatments privilege attention to body-based symptoms (van der Kolk, 2005). The framework is commonly employed as a phase-based treatment model for individual sufferers, including stages of safety, remembrance and mourning, and reconnection (Herman, 1992). The stabilization phase is often primarily emphasized for trafficked peoples, because structural and emotional needs are often profound, complex, and urgent (Hopper, 2017).

Clinical Relevance for Survivors of Human Trafficking: Trauma-Informed Care

Current guidelines for clinical intervention with survivors of sex trafficking acknowledge the value of psychological intervention (Human Trafficking Foundation, 2015). Because human trafficking has been linked with PTSD (Farley et al., 2004, Farley et al., 2011; Oram et al., 2012) and CPTSD (Hardy et al., 2013), current guidelines widely recommend using trauma-informed treatments in aftercare recovery. The U.S. Federal Strategic Action Plan for 2013-2017 promoted trauma-informed approaches as ones which recognize the broad and deep impacts of trauma, understand healing trajectories, and fully integrate trauma-related knowledge into policies and practices in a culturally and gender appropriate manner. The Action Plan supported the creation of “uniform standards of care” towards programs that are “effective, trauma informed, culturally appropriate, gender appropriate, and protect the safety of staff and clients alike” (p. 14).

Due to the lack of evidence base and a presumption of sufficient shared commonalities amongst varied types of survivors of traumatic adversity, trauma-informed interventions that were designed for and tested on non-trafficked communities have been recommended for survivors of human trafficking (Gajic-Veljanoski & Stewart, 2007; Hodge, 2014; Macy & Johns, 2011; Williamson et al., 2010; Zimmerman et al., 2003). The 2010 Health and Human Services (HHS) report that studied programs serving trafficking survivors recommended that, until an evidence base is established, research done on presumably similar populations can be employed as the foundation for treatment of trafficking survivors (Williamson et al., 2010). Macy and Johns (2011) recommended “trauma-informed services” acknowledging that “although trauma-informed services were not specifically developed for use with sex trafficking survivors, and have not been evaluated with this population, consensus exists in the literature that trauma-informed services have promising potential” (p. 92).

Scholars have specifically recommended relying on trauma-informed aftercare approaches generalized from scholarship with refugees (Shigekane, 2007), survivors of torture, migrant laborers, female survivors of sexual abuse and rape, and survivors of intimate partner violence (Clawson & Dutch, 2008; Gajic-Veljanoski & Stewart, 2007; Hodge, 2014; Macy & Johns, 2011; Menon et al., 2020; Williamson et al., 2010; Zimmerman et al., 2003). Katona et al. (2015) contended that providers trained to work with asylees and refugees are likely trained and prepared to work with trauma, employ cultural sensitivity, and are familiar with immigration issues such as those that may impact international survivors of trafficking. They likewise noted that providers who work with survivors of domestic violence are fluent in safety and threat assessment, legal issues, and emotional and physical abuse, all of which may similarly support complex aftercare recovery work with survivors of trafficking (Katona et al., 2015). Katona et al. (2015) highlighted that, indeed in practice, survivors of trafficking are often referred to refugee service agencies or domestic violence centers, due to the absence of trafficking-specific therapy services. Shigekane (2007) noted that in response, many such agencies have broadened their missions to explicitly include working with survivors of trafficking.

Despite some utility in learning from seemingly similarly impacted groups, there is also an understanding that the unique experiences of trafficking survivors require tailored responses which are distinct from other groups, and that the evidence base guiding these recommendations is limited (Clawson et al., 2003; Gajic-Veljanoski & Stewart, 2007; Zimmerman et al., 2003). This uniqueness is attributed to the severity of trauma overlaps often experienced by sex trafficking survivors, including combinations of rape, torture, induced substance abuse, psychological coercion, forced captivity, and physical violence, requiring providers to contend with a wide variety of issues in care provision (Katona et al., 2020). These are adversities across

multiple fronts, often for extended periods of time, leaving survivors with complex needs across multiple domains (Dell et al., 2019).

Empirical Research/Critiques: Trauma-Informed Care

From Approximately 2000-2011**.** In the first decade of the 2000s, scholars cited validity issues with research and difficulties with data collection as barriers to the knowledge base. The Family Violence Prevention Fund (2005) cited small sample sizes in all research up to 2005 related to trafficking survivors' experiences with early intervention strategies post-exit. They cited three research studies besides their own (discussed below) that made substantial contributions to the field as having sample sizes of 8, 28, and an unknown size (based on in-depth case studies). Gozdziak & Collett (2005) also cited difficulties with data collection that made for limited available information about trafficking survivors' views on treatment.

PTSD found amongst survivors of trafficking. As researchers undertook more studies, they examined symptoms and found evidence of posttraumatic stress disorder amongst trafficking survivors across varied cultural contexts. Trafficking researchers frequently cite research by Farley et al. (2004) and Zimmerman et al. (2008) as justifying the use of trauma treatments with trafficking survivors. Farley et al. (2004) undertook a transcontinental study in the early 2000s and found high rates of PTSD, which suggested the need for trauma-informed services. Researchers interviewed 854 people living in or recently exited from prostitution in nine countries (Canada, Colombia, Germany, Mexico, South Africa, Thailand, Turkey, United States, and Zambia). Participants ranged in age from 12-68 years old (mean age 28); 47% reported being minors when entering prostitution. The majority of participants interviewed (92%) identified as female (3% male; 5% transgender), and the average length of time in prostitution was calculated

as nine years. Using brief structured interviews, the Prostitution Questionnaire and the PTSD Checklist, authors inquired about past histories of sexual and physical violence.

Farley et al. (2004) contended that prostitution was not qualitatively different from sex trafficking, in that most people experienced high rates of violence and did not freely consent to it. For example, authors found that 71% of participants reported having been physically assaulted in prostitution, 63% raped, and 89% desired to escape but reported having no other survival options. Farley et al. (2004) found prostitution to be “multitraumatic” (p. 34), with 68% of participants meeting criteria for PTSD. They specifically found over-representation of First Nations women in prostitution in Canada, increased incidence of child prostitution in Columbia due to political violence, and equivalent rates of PTSD amongst men, women, and transgender survivors of prostitution in the USA, Thailand, and South Africa. The study was designed to examine psychological harm resulting from prostitution. As such, it under-emphasized examination of structural vulnerability associated with prostitution or related remedies (i.e., one participant in Thailand cited lack of good jobs for women as a vulnerability factor for (re)exploitation, but it was not broadly discussed).

Zimmerman et al. (2008) studied health and mental health impacts of trafficking across Europe, and further substantiated the need for trauma treatments with trafficking survivors. Zimmerman et al. (2008) undertook interviews and surveys with 192 women and adolescent girls (ages 15 to 45) who had been trafficked and sexually exploited, and were accessing post-trafficking recovery services in Belgium, Bulgaria, Czech Republic, Italy, Moldova, Ukraine, and United Kingdom between 2004 and 2005. Most participants were from Moldova (38%) and Ukraine (26%). The largest sub-group spent three months or less in the trafficked situation (33%), yet most participants reported protracted trafficking experiences of three months to more

than a year (19% of participants spent 3-6 months trafficked; 20%, 6-12months; and 20%, over 12 months). Researchers measured physical symptoms within two weeks of entry into post-trafficking services using a tool from the Miller Abuse Physical Symptoms & Injury Survey, and assessed mental health symptoms via the Brief Symptom Inventory and the Harvard Trauma Questionnaire.

Zimmerman et al. (2008) found that 57% of participants endorsed symptoms suggestive of PTSD, and found frequent report of depressive symptoms, with 39% of participants endorsing recent suicidal thoughts. They recommended that care address posttraumatic symptoms (i.e., trauma-informed care), and that services build off of best practices used with victims of domestic violence, sexual assault, torture, refugees and migrants. They also recommended trauma-sensitivity amongst providers and law enforcement, including providing adequate time for trafficking survivors to recover and reflect (with access to temporary legal residency and aftercare services) so that they may participate in trafficker prosecution and/or make considered decisions about their safety and their future. Zimmerman et al.'s (2008) findings were constrained by cross-cultural limitations, as authors noted that instruments had not been validated for use with trafficked women. Authors noted, however, that both instruments had been previously used in cross-cultural settings and with other traumatized populations.

*Recommendations made to import aftercare service models from "similar" groups***.** As PTSD was being established as a clinical issue for survivors of trafficking, scholars examined the extent to which services designed for seemingly similarly vulnerable populations were useful in sex trafficking survivor aftercare service provision. The Family Violence Prevention Fund (2005) had developed toolkits in the late 1990s to help healthcare workers identify and screen domestic violence survivors in healthcare settings, and worked to increase awareness about

domestic assault as violence against women. Based on these successes, they undertook a qualitative study to similarly examine the potential of healthcare settings to identify and intervene with survivors of human trafficking. They interviewed twenty-one survivors of international sex and labor trafficking (in the San Francisco Bay Area, Los Angeles & Atlanta) in 2004. Participants were aged 12 to 53 at the time of trafficking; more than half were children or young adults. All but two participants were female, and most participants hailed from Asia, Africa, Latin America, or Europe (from 11 countries of origin, including two U.S. territories).

The Family Violence Prevention Fund (2005) found similarities as well important differences between survivors of human trafficking and domestic violence, and confirmed that healthcare environments were ill-prepared, and therefore potentially missing opportunities for early intervention with trafficked victims. That is, healthcare professionals were found to lack training in trafficking victim identification, and therefore were mistakenly referring trafficking survivors to “battered women’s shelters” (p. 25) and rape crisis centers, as if they were survivors of domestic violence. Authors also found these shelters and centers lacking the expertise to adequately respond to trafficking survivors’ needs (Family Violence Prevention Fund, 2005). Their findings may have been limited by small sample size, although the study noted that theirs was among the largest sample sizes in trafficking research at the time.

Despite the acknowledgment of a scant evidence base related to trafficking treatment, many scholars agreed with importing trauma-sensitive treatment models from research with similarly marginalized and complexly traumatized individuals. Zimmerman et al. (2011) devised a conceptual model that positioned trafficking survivors at the center of what they called similarly “vulnerable and hard-to-reach populations” (p. 333). They suggested that barriers to care and risks experienced by trafficking survivors closely approximate those of refugees,

asylum seekers, survivors of torture, migrant laborers and sex workers, and, therefore, so do their care needs. The conceptual model was based on theory and research from adjoining fields, and suggested that lessons learned from victim needs and response in adjacent fields would improve trafficking recovery response as well, and therefore should be drawn on.

Zimmerman et al. (2011) noted that research moving forward would benefit from an operationalizable conceptual model. Their conceptual model illustrated trafficking as multi-stage process of health risk that accumulates over time, and suggested intervention be tailored to stage of trafficking exploitation (i.e. recruitment, transit, reintegration). They also noted the importance of coordinating with actors from various support sectors transnationally to promote effective recovery interventions. Zimmerman et al. (2011) acknowledged, however, that no intervention trials existed at the time of publication that examined the efficacy of mental health intervention approaches for trafficking survivor treatment post escape.

Limitations of importing aftercare guidelines from “similar” groups. Despite the recommendations to model aftercare services after seemingly similar victim groups, the still emerging field of mental health care for trafficked persons has identified important differences unique to trafficking survivors, as compared to survivors of intimate partner violence and refugees. These relate to supports needed for recovery, length of time to recovery, and extreme nature of trauma suffered, and these differences may render service provisions modeled after similarly traumatized groups to be inadequate (Clawson et al., 2003; Family Violence Prevention Fund, 2005; Shigekane, 2007).

Clawson et al. (2003) examined the needs of trafficking survivors and trafficking victim service providers, as well as barriers to service provision, through a multi-method needs assessment. The needs assessment incorporated a phone survey (n=159 victim service providers)

and sampled nationally across 22 U.S. states and the District of Columbia; authors focused geographically in regions with known concentrations of trafficking survivors. The majority of service providers worked in agencies that served immigrants and refugees (29%), domestic violence survivors (17%), or offered prostitution recovery services (14%), while also offering trafficking recovery services. The phone survey was followed by focus groups (n=20 victim service providers and n=6 survivors of labor trafficking).

Clawson et al. (2003) delineated important differences unique to trafficking survivors, related to recovery timeline, nature of trauma suffered, and reduced supports as compared to survivors of domestic violence, refugees, and sexually exploited persons. For example, a) 49% of service providers surveyed reported working with trafficking survivors for longer periods of time than with the comparison groups (i.e. longer than twelve months); b) providers identified mental health needs/trauma impacts amongst survivors of trafficking as more extreme; c) providers noted increased lack of coordinated services for survivors of trafficking versus survivors of domestic violence; d) they noted trafficked immigrant women had fewer resources available to them for healing; and e) authors found heightened barriers to service provision with trafficking survivors, including lack of funding, provider training and resources, and poorly coordinated inter-agency and inter-governmental action. Clawson et al. (2003), like Zimmerman et al. (2011) and Family Violence Prevention Fund (2005) before them, found that varied professionals including social service providers, healthcare, mental health, housing services, and law enforcement must collaborate to attend comprehensively to the posttraumatic needs of survivors.

Shigekane (2007) examined trafficking survivors’ needs and the services designed to support them and, also finding important differences, called into question the “rapid and eclectic development” (p. 112) and diffusion of aftercare services modeled after non-trafficked groups.

Shigekane (2007) examined three case studies, part of a set of eight case studies from a larger, multi-method research study on forced labor in the U.S., conducted by Human Rights Center at University of California Berkeley and Free the Slaves in 2003-2004. The case studies, which closely followed survivors of sex and labor trafficking from India and Vietnam living in California, examined their rehabilitation and community integration processes once receiving social service assistance from dual or multi-service organizations (Shigekane, 2007). She defined dual or multi-service organizations as those whose services were developed for use with a population other than trafficked people (i.e. refugees and survivors of domestic violence), but who had expanded to serve survivors of trafficking. Shigekane (2007) acknowledged that "intuition" (p. 115) suggested there were common experiences amongst similarly traumatized individuals, but that "solid research is lacking" (p. 115).

Shigekane (2007) found that trafficking survivors' needs and capacities meaningfully differed from refugees. She noted comparatively higher rates of psychological trauma, community integration difficulties, and lack of skills for independent living amongst trafficking survivors. Distinct from many refugees, Shigekane's (2007) research found that survivors of trafficking may be more isolated and disconnected from families and communities, and less ready than refugees to take advantage of benefits, if they seek them out at all. Shigekane (2007) also noted that survivors of trafficking appear to need more time-intensive and lengthy support than refugees. In fact, she showed that trafficking survivors were unable to meaningfully take advantage of stabilization services within the eight-month time period allotted (the eligibility period for refugees), in part due to the complexity of trafficking survivors' complex challenges: related to legal and housing needs, relationship dysfunction, substance abuse, and suicidality.

Additionally, Shigekane (2007) reported differences between survivors of trafficking and intimate partner abuse (IPV) that make dual service provision challenging. For example, the case studies suggested that common shelter space may be challenging. Trafficking survivors required longer-term duration services (i.e., IPV survivors were reported to need three to nine months of shelter support, while survivors of trafficking commonly needed twelve to eighteen months to acquire sufficient independent living skills and/or documentation status). IPV shelters may be unable to accommodate longer stays as it means fewer victims can access services. The case studies also suggested that IPV shelters may be ill-prepared to handle the security needs of trafficking survivors related to criminal networks. Finally, Shigekane (2007) noted that modeling trafficking peer/survivor support groups after those for survivors of domestic violence may detrimentally impact trafficking survivors' recovery, due to differences in mental health symptoms and treatment needs. Shigekane (2007) also noted barriers to culturally-appropriate services for trafficking survivors. Given the rapid evolution in service provision, the documented challenges, and lack of research on best practices, Shigekane (2007) called for more research to evaluate the quickly disseminating psychological treatment programs, case management approaches, and shelter services.

Recommendations for trauma-informed care with survivors of trafficking solidify. Macy and Johns (2011) highlighted the emergent nature of the field of aftercare services for international sex trafficking survivors in the United States. They are still frequently cited in the scholarship for their relatively early work examining aftercare services for international survivors of sex trafficking and for recommending trauma-informed care. Their contributions towards trauma-informed care are discussed here, while their discussions of comprehensive

service delivery and continuum of care are introduced in the final sub-section on social ecological/multidisciplinary approaches.

Macy and Johns (2011) identified trauma-informed services as a new development for the field, but an important one to attend to survivors’ experiences with victimization and polyvictimization, and to foster survivors’ engagement with aftercare services. They undertook a systematic review to examine existing aftercare recovery guidelines for international sex trafficking survivors in the United States. Their inclusion criteria began as peer-reviewed journal articles focused on U.S.-based aftercare services for international sex trafficking survivors, but the available scientific scholarship was sparse (n=3). Macy and Johns (2011) expanded their search to include internet documents, including grant reports and reference guides from U.S. government bodies and think-tanks (n=9), documents from state-level sexual assault coalitions and human rights organizations (n=3), and publications suggested by anti-trafficking researchers (n=5). Authors ultimately synthesized 20 publications, from between 2001 to 2010, related to aftercare services with international survivors of sex trafficking in the United States.

Macy and Johns (2011) found survivors had a continuum of post-trafficking needs that combined the emotional/psychological and the structural, in the immediate-, mid-, and long-term. In the immediate- and mid-term, these included: safety, shelter/housing, health and mental healthcare including help recovering from trauma, basic necessities, immigration and legal services. Authors also described a recovery phase where survivors move towards independence, and require support for long-term needs such as: life skills, education and employment, permanent housing, and possible family reunification and repatriation. Given the complexity, Macy and Johns (2011) recommended several core services, including trauma-informed care, “a relatively new but promising development for the care of violence survivors” (p. 92).

The premise of a trauma-informed care approach holds that systems and practices are adapted to be sensitive to and fostering of survivor involvement, and that they prioritize physical and emotional safety, address co-occurring issues, use an “empowerment philosophy” (p. 92), offer choice and control to survivors, emphasize resilience, and reduce further traumatization (Macy & Johns, 2011). Macy and Johns (2011) noted that providers should work to build trust and rapport with survivors, and offer trauma-informed care as part of a continuum of aftercare services to address survivors’ changing needs across time and domains of functioning.

From approximately 2012-2021**.** Literature predominantly from the 2010s continued to highlight gaps in the still nascent field of mental health support and service provision with survivors of sex trafficking, especially in the area of intervention outcome research, and frequently made calls for further research. This scholarship has accelerated in the last five years (Wright et al., 2021).

Trauma-informed care recommendations persist, but efficacy research lags. Building on Macy and Johns’ (2011) work, Muraya and Fry (2016) examined the limited research base for aftercare services for child survivors of sex trafficking. They acknowledged Macy and Johns’ (2011) important contribution to the field; that is, Macy and Johns (2011) spurred research that began to fill the gap they had identified (Muraya & Fry, 2016). Muraya and Fry (2016), however, specifically highlighted the need for studies on aftercare service provision with child survivors of sex trafficking describing the field as not well documented, with a small evidence base.

Muraya and Fry (2016) undertook a systematic review of research, agency policy, and practice related to aftercare service provision for children who had been sex trafficked globally. They identified their work as the first of its kind to systemically document and analyze that particular evidence base. They considered material between 2000-2013, including grey literature,

and noted that while there had been meaningful growth in the field of aftercare service provision for sex trafficked children in that timeframe, information and research remained scarce. They kept their inclusion criteria broad for that reason, and included research on aftercare services for survivors of domestic and international trafficking, literature from varied countries and regions, and documents related to adult as well as child survivorship.

Muraya and Fry (2016) ultimately examined 15 documents; seven specific to general child survivorship while six were specific to survivors of sex trafficking (Muraya & Fry, 2016). They found that guiding principles for aftercare service provision with child survivors commonly involved trauma-informed service provision and a children’s rights approach. Muraya and Fry (2016) magnified existing calls for ongoing trauma-sensitivity training for providers and partner agencies, finding reduced chances of survivor revictimization when trained social workers and psychiatrists did their initial assessments. Authors also underscored the limited adequacy of PTSD as a diagnostic and treatment frame for survivors, instead recommending complex PTSD, or disorders of extreme stress (DESNOS) as more useful frames to capture the complex and persistent symptomology survivors experience. These include personality impacts, vulnerability to re-victimization and self-harm, and impacts in relational, affective, somatic, behavioral, and cognitive domains (Herman, 1992; Hopper, 2017). Still, Muraya and Fry (2016) highlighted a research gap related to how child survivors experience complex trauma, and the most effective forms of treatment. These authors also acknowledged limitations in their work, noting the difficulty with determining the quality of aftercare services they reviewed. Muraya and Fry (2016) highlighted the need for empirical work to a) identify key components to quality aftercare service provision, especially across diverse contexts and cultures, b) better understand what is

actually happening in practice, and c) determine the impact of aftercare services on survivors, their families and communities.

Scholars have continually identified a lack of scholarship examining the effectiveness of mental health support interventions with survivors of trafficking, and the need for intervention evaluation research. Katona et al. (2015) highlighted a large research gap in evidence-based mental health support globally for survivors of human trafficking, and offered a critical review and research agenda, focused on the mental health recovery needs of survivors of modern slavery. It was written by the Helen Bamber Foundation (HBF), who offers integrated care to survivors of human rights violations through a multidisciplinary team of specialists. Katona et al. (2015) underscored the nascent state of the research on efficacy of mental health recovery interventions, and highlighted a need for evaluation of clinical interventions designed to support the mental health of survivors of modern slavery. They underscored that evidence is limited on the efficacy of treatments and argued for integrated approaches in survivor care. They called for conducting systematic research with common frameworks to enable comparison, documenting survivors’ experiences to mine their crucial insights into treatment challenges and needs, data collection with male and child survivors, and evaluation to determine effectiveness in varied regions and contexts, and whether interventions can be carried out successfully by non-clinicians (Katona et al., 2015).

Katona et al. (2015) also called for more research on integrated treatment approaches, including Narrative Exposure Therapy (NET) and Cognitive Behavior Therapy (CBT). They noted HBF’s intervention research in group cognitive behavioral therapy (GCBT) to treat psychological challenges, including depression and anxiety, either with or without additional PTSD symptoms. Authors highlighted an advantage of not seeking to reduce PTSD symptoms,

and instead attending to other forms of psychological distress. That is, because some survivors with PTSD diagnoses may avoid exposure therapies due to uncomfortable anticipatory symptoms, or barriers such as shame (Katona et al., 2015). In these cases, they focused therapy on establishing a longer-term trusting therapeutic relationship as a model for future relationships. Katona et al. (2015) called for more research into approaches to support those who avoid trauma-focused treatment.

In line with Katona et al. (2015), Levine (2017) identified the total absence of clinical trials identifying efficacious mental health treatments for sex trafficking survivors. In their absence, Levine (2017) noted that trauma-focused cognitive behavioral therapy was commonly used, providing 12-20 structured sessions for survivors to work on coping skills, trauma narrative and processing, and closure. Levine (2017) detailed three principal focus areas in the existing mental health treatment literature: early detection of survivors, identification of efficacious mental health treatment, and organization of multidisciplinary care teams. Like Muraya and Fry (2016), Levine (2017) contended that sex trafficking survivors’ symptoms may fit better under CPTSD conceptualizations, or Disorders of Extreme Stress (DESNOS) than PTSD, and underscored the importance of accurately capturing a diagnosis in order to design effective treatment. Levine (2017) highlighted the work that has been done to advance DESNOS treatment (i.e., van der Kolk, 2001), but noted the knowledge has not yet been adapted for trafficking survivors. He likewise named several interventions with potential promise (i.e., art therapy, music therapy, equine therapy, narrative exposure therapy, EMDR), but underscored that no approach has been tested in clinical trials. Levine (2017) proposed that research efforts are challenged by the multilayered nature of resulting mental health issues, and lack of validated measurement instruments for trafficked populations.

Attempts to understand trauma treatment efficacy with trafficking survivors. Some studies took up Katona et al.'s (2015) and Levine's (2017) calls to examine treatment intervention efficacy. Robjant et al. (2017) examined narrative exposure therapy outcomes with survivors of trafficking, related to PTSD symptomology. Authors conducted a retrospective audit on a narrative exposure therapy (NET) intervention with survivors of sex trafficking in the U.K. (n=10) who had been diagnosed with PTSD. NET was designed to address PTSD symptoms in those who have suffered multiple traumas, and takes a person through her/his life story, identifying positive and traumatic events, to understand them within the broader context of one's life and then to document the account. Robjant et al. (2017) found a reduction in the severity of PTSD symptoms for participants, with sustained reductions at 3-month follow-up. Despite the small sample size, they suggested NET is a feasible treatment course for survivors of sex trafficking, and called for randomized control trial evaluation, although they acknowledged additional adjunctive interventions may be needed.

Hopper et al. (2018) undertook a qualitative analysis of the STARS experiential group intervention, the first structured body-based group intervention designed for youth and adult survivors of sex trafficking designed to address complex trauma symptoms. STARS uses arts-based approaches, including group-based theater games. Employing thematic analysis on self-report and observational data from a pilot program with three groups (n=17), authors found benefits in the realms of interpersonal relationships (i.e., trust development, community building), self-regulation (i.e., managing triggers, accessing positive somatic states), and sense of identity (i.e., exploration of parts of self, personal power). Despite the small sample size, Hopper et al.'s (2018) model highlighted the value of nontraditional, less verbal, and somatically-focused interventions as one element of a comprehensive intervention approach, where survivors can

engage in positive somatic and affective states, within a safe community of trafficking survivors for “’body-up’ re-learning and growth” (p. 237). They called for more research on similar approaches, cross-cultural applications, and as compared to language-based cognitive behavioral approaches.

Dell et al. (2019), like Levine (2017), highlighted the scant research evaluating (post)exit intervention effectiveness with survivors of trafficking. Dell et al. (2019) undertook a systemic review to comprehensively examine the existing evidence base for exit and post-exit interventions, including their effects on (mental) health and psychosocial outcomes, to inform practice and research. Initial inclusion criteria was restricted to experimental or quasi-experimental studies with control groups, but too few studies met these criteria. Inclusion criteria was changed to any empirical study design that quantitatively assessed intervention effects, with either sex and/or labor trafficking survivors, authored in 2005 or later. Six studies met criteria for review; three were peer-reviewed articles, three were unpublished reports, and they spanned North America, Asia and Africa (Dell et al., 2019). The majority of included studies were published later than 2011, and were done with both child and adult survivors of sex trafficking. Most sample sizes were small (n=under 50 participants), and only one used experimental design; both of these facts limit the drawing of conclusions. Half of studies implemented trauma-focused interventions (i.e., trauma-focused cognitive behavioral therapy and treatment for complex trauma) while the other half involved mentoring, family involvement and comprehensive support interventions. Studies measured a wide array of domains, including mental health outcomes, social networks, community reintegration, and employment outcomes.

Dell et al. (2019) discussed the importance of getting providers’ perspectives on Core Outcomes of exit/post-exit interventions (related to mental health & psychosocial impacts) and

getting providers’ perspectives on the social and cultural contexts in which care is provided. Dell et al. (2019) noted that “given the prevalence and complexity of trauma experienced by survivors” (p. 191) trauma treatment should be incorporated into post-exit intervention. Yet they acknowledged that it still remained uncertain whether evidence based trauma treatments imported from non-trafficked populations apply effectively or sufficiently to trafficked populations, given trafficking survivors’ complex needs and complex trauma. Dell et al. (2019) recommended trauma-informed care and culturally appropriate services, but did not identify specific guidelines to carry this out.

Like Katona et al. (2015) and Dell et al. (2019), Wright et al. (2021) recently underscored the ongoing research gap in evidence-based mental health support globally for survivors of trafficking. Wright et al. (2021) also undertook a systematic review to synthesize the evidence-based for mental health interventions to support survivors of modern slavery and/or human trafficking post-exit. Their definition of modern slavery was understood broadly, consistent with the UK’s Modern Slavery Act (2015), and focused on intervention research with survivors of human trafficking, child soldiering, and child survivors of forced labor. They understood this to be the first review of its kind. Beginning with 4540 possible empirical studies focused on mental health intervention with survivors of modern slavery and/or human trafficking, they excluded studies that did not have evaluation components, were theses, or were written in a language inaccessible to the research team. Ultimately, nine studies remained for analysis, only two of which related to survivors of sex trafficking (i.e., Hopper et al., 2018; Robjant et al., 2017, discussed above). Comparisons between and amongst studies were challenged by the heterogeneity of each study’s design, population, and outcomes measured.

Nonetheless, Wright et al. (2021) argued that, despite increased attention, evaluation research remains thin related to the effectiveness of mental health support interventions for survivors of sex trafficking. They highlighted the difficulty of determining the most effective therapeutic approaches from the existing evidence-base as a result, and underscored “the scale of the theory-practice gap in this area” (p. 7) that continues in the year 2021. Wright et al. (2021) also cautioned against an exclusionary focus on trauma, like Katona et al. (2015), as interventions may then fail to address survivors’ non-PTSD mental health concerns. Indeed, Wright et al. (2021) noted that the research base for interventions with survivors of modern slavery which address mental health conditions other than PTSD is even smaller than the nine studies they reviewed.

Wright et al. (2021) also critiqued each studies’ lack of explicit discussion of their “underpinning assumptions” (p. 7) about the problem they sought to intervene upon, and how. They noted that the exclusionary focus on trauma and PTSD reveals assumptions on the part of researchers and practitioners, and should not be assumed to be the same for all survivors. They critiqued the outcomes and measures, therefore, as “pragmatic proxies rather than based upon a specific theoretical underpinning” (p. 7). Wright et al. (2021) importantly questioned the reliance on western conceptualizations of clinical outcomes, and suggested researchers use a wider range of non-clinical outcomes to assess the effectiveness of mental health support interventions with survivors.

Returning to limitations of importing aftercare guidelines from “similar” groups. Finally, Menon et al. (2020) recently re-engaged the question: to what degree can intervention strategies from seemingly similarly impacted populations be imported into work with survivors of trafficking? Menon et al. (2020) found potential as well as limitations in comparing survivors of

intimate partner violence to survivors of sex trafficking. Authors undertook a systemic review examining interventions for survivors of sexual assault and intimate partner violence, in an effort to consider how those interventions might be applied to work with survivors of trafficking. They noted potential in providing a baseline from which to draw on for future studies, given the lack of randomized control trials devoted to examining interventions with survivors of trafficking.

Despite the insights that can be gleaned from work with survivors of sexual assault and intimate partner violence, however, Menon et al. (2020) acknowledged limitations in the comparison, given the large diversity of meaningfully different backgrounds amongst trafficking survivors in the United States. Survivors’ experiences of psychological and physical trauma will vary based on cultural differences, such as by race, ethnicity and nationality, because “how force, fraud, and coercion (are) used to put these victims to work is as variable as the human imagination” (Menon et al., 2020, p. 941). Authors add that distinct pathways to recovery and reintegration are required for survivors of trafficking, yet diversity in nationality is not well accounted for in the sexual assault and intimate partner violence scholarship, and therefore their findings may be more applicable for survivors from Western than non-Western cultures (Menon et al., 2020). Menon et al. (2020) suggest that drawing lessons from work with survivors of sexual assault and intimate partner violence be done with caution.

Sub-Section Conclusion**.** In summary, in the first two decades of the 2000s, scholars found that survivors of sex trafficking suffered from PTSD, even across varied cultural contexts (Farley et al., 2004; Zimmerman et al., 2008). Scholars recommended that trauma-informed care principles guide work with survivors of trafficking (Macy & Johns, 2011; U.S. Federal Strategic Action Plan for 2013-2017). The recommendation was to import these from work with supposedly similar populations; that is, refugees and survivors of intimate partner violence

(Family Violence Prevention Fund, 2005; Macy & Johns, 2011; Menon et al., 2020; Zimmerman et al., 2011). However, in the limited studies available, Clawson et al. (2003) and Shigekane (2007) found that differences exist amongst trafficking survivors, refugees, and survivors of IPV, in terms of length of time to recovery, extreme nature of trauma suffered, uncoordinated services, and complex needs. These differences call into question the value of importing guidelines for treatment with similar groups. Menon et al. (2020) concurred, having found that diversity in nationality is poorly accounted for in the sexual assault and IPV scholarship, limiting its applicability to recovery work with culturally diverse survivors of sex trafficking.

Nonetheless, calls for trauma-informed care solidified (Muraya & Fry, 2016), along with frequent calls for needed intervention efficacy research, given the limited evidence base to draw on related to sex trafficking survivor recovery (Katona et al., 2015; Levine, 2017; Dell et al., 2019). This paucity of research extended to recovery work with child survivors (Muraya & Fry, 2016). Some scholars examined treatment approaches, including narrative therapy (Robjant et al., 2017) and arts-based/embodiment approaches (Hopper et al., 2018), and found promise with survivors of trafficking, Nonetheless, scholars continue the hard work of trying to tailor interventions to survivors’ varied contexts and cultures (Dell et al., 2019; Wright et al, 2021), advocate for widening the recovery frame beyond PTSD to non-clinical, holistic notions of personal recovery (Wright et al., 2021), and continue to find limitations with importing care models from seemingly parallel groups (Menon et al., 2020). Scholars also call for integrating survivor voice into research so that research outcomes of interest will reflect survivor needs and be more useful for practice (Dell et al., 2019; Wright et al., 2020). Scholars continue to highlight the serious research gaps related to evidence-based mental health support provision for survivors of trafficking (Wright et al., 2021).

Taken together, this body of literature reveals that trafficking recovery service provisions and their effectiveness remain under-studied, and that paralleling trafficking survivors' benefits with other similarly impacted populations may be inadequate to support the unique needs and barriers that complicate stabilization and recovery for trafficking survivors, as well as to promote thriving. Likewise, despite the benefits of a trauma-informed approach, these studies suggest that service providers may benefit from conceptualizing survivors not only in terms of PTSD, but in terms of complex PTSD, and via conceptualizations other than mental health trauma recovery entirely. These may include conceptualizations notions of holistic personal recovery (Wright et al., 2021), and ones that honor cultural strengths and survivorship (discussed below). The studies also highlight the need moving forward to identify key practices and components of quality aftercare programs in survivor recovery, document them, and identify their impact (Muraya & Fry, 2016). A fuller critique of the trauma-informed framework follows in the second sub-section below on critical theories, as well as potential models for addressing some of the critiques.

Cross-Cultural/Emancipatory/Critical Theory Framework

The second sub-section presents theoretical literature from the fields of critical race theory and transcultural psychiatry, then identifies ways that these literatures are relevant to recovery work with survivors of sex trafficking, presents existing empirical studies emerging from this theoretical framework in the anti-trafficking scholarship, and concludes with a synthesis of this framework's contribution. A robust conversation exists in the transcultural psychiatry and community psychology fields that critiques the use of the PTSD diagnosis in cross-cultural work (i.e., with refugees), for being constrained by individualistic and biomedical western cosmology (Gozdziak, 2004; Lykes, 2002), and failing to contend with intersecting oppressions (Gozdziak, 2004; Lykes, 2002; Mollica, 2011) and structural inequalities that give

rise to suffering for marginalized populations (Zarowsky, 2004). These critiques have not been robustly applied to the field of sex trafficking survivor recovery, however. That is despite recommendations to import strategies for working with trafficking survivors from presumably similarly traumatized and marginalized individuals (i.e., refugees) (Zimmerman et al., 2011).

This framework offers both critiques of the trauma-informed approach, and potential models for addressing some of the critiques, including suggestions towards the oft-stated goal of cultural-appropriateness (USDOS, 2020). Scholars working at the nexus of trafficking recovery and intersectionality theory provide not only models for increasing cultural relevance (Carter, 2003; Farley et al., 2011; Pierce et al., 2009), but importantly offer integrative approaches to recovery work that aim to address posttraumatic symptoms while simultaneously accounting for trafficking survivors’ experiences of structural inequality and population-based and historical marginalization (Carter, 2003; Farley et al., 2011). Through holding an awareness of intersectionality, these scholars also promote scholarship and praxis that is culturally and historically-situated, engages emancipatory-consciousness (Carter, 2003; Farley et al., 2011; Pierce et al., 2009), and engages social action in trafficking recovery (Vollinger, 2021).

As previously mentioned, the structure of each sub-section differs according to the available literature in that arena of the field. The theoretical discussion in this sub-section is comparatively longer than in prior sub-sections because the critical literature epistemologically and methodologically inclines towards richly-textured, exploratory, theoretical and conceptual contributions, with less comparative emphasis on (post) positivist empirical studies. Limited empirical studies exist in the field of sex trafficking survivor recovery that use a critical, intersectional lens (Vollinger, 2021), despite frequent recommendations for culturally-sensitive approaches and calls for more research into population-specific trafficking recovery efforts.

Theory: Critical Race Theory & Transcultural Psychiatry Perspective

Critical race theory (CRT) posits that individuals are inextricably linked to social context. CRT attributes ordinariness to racism engrained in social structures, affirms the power of whiteness and the dominating power of anti-blackness, and rejects essentializing individuals by proposing the intersectionality of privilege and oppression (Delgado & Stefancic, 2012). Kimberle Crenshaw (1991) most recently coined the term intersectionality, an analytic tool designed to help illuminate the complexity of the social world and individuals’ experiences in it. It has been used as a form of critical praxis/practice and critical inquiry/research to help researchers and practitioners challenge and transform status quo power relations (Vollinger, 2021). In Crenshaw’s seminal work about intersectionality and violence against women of Color, she described the process of shifting the narrative of violence against women from a private matter and an aberration to one seen as part of a “broad-scale system of domination that affects women as a class” (Crenshaw, 1991, p. 1241). Crenshaw argued that the violence experienced by many women is shaped by the intersectional particularities of race, gender, class, and more.

The trauma lens has been critiqued for functioning as a form of individual and collective control, where clinical practitioners may participate in racist systems unconsciously. Cross (2005) differentiates old from new racism where, in the former, colonialist systems were explicit systems of power with “power applied to physical body” (p. 267), and the latter is an invisible system of unearned privilege that wields “power applied to social body” (p. 267). Kleinman and Desjarlais (1995) favor viewing experiences of suffering as a persistent historical collective experience, and not medicalized trauma residing in individual bodies.

Critical theorists argue that the function of new racism is to invisibilize the perpetuation of this system by its beneficiaries (Cross, 2005), those in positions of power. New racism is

described as everyday practices of even liberal society, and as a structural and systemic phenomenon that may be unintentional, but nonetheless acts (Cross, 2005). bell hooks is quoted by Cross (2005), naming “progressive, well-intentioned, aware intellectuals who apply their terrorizing power on others” (p. 266).

Participatory Action Research (PAR) scholars critique helping an individual cope with structural violence while failing to participate in social change (Cross, 2005; Krueger, 2010; McIntyre, 2006). Critical social work scholars Sowers and Rowe (2007) describe the western frame prevailing in global social work. Canadian social work scholar Adrienne Chambon (1994) uses a Foucauldian lens to highlight how mental health professionals enact power by imposing particular truths on clients and communities. Piven and Cloward (1983) point out that even social reformers may enact oppression through their social reform efforts. CRT and critical social work scholars promote decolonizing multicultural counseling practices cognizant of history, racism and social constructionist theory (Besthorn, 2007; Goodman, 2015; Gorski, 2015; Witkin, 2007).

Transcultural psychiatry and community psychology scholars have widely critiqued the trauma framework, when used in cross-cultural refugee mental health work, as inadequate and not universally applicable, Eurocentric, neo-colonial, and failing to contend with issues of intersecting oppressions (Gozdziak, 2004; Kleinman, 1987; Lykes, 2002; Mollica, 2011). In contrast to the trauma framework, these critical and cross-cultural scholars do not consider the biomedical trauma model relevant for all cultures (Kleinman, 1987; Kleinman et al., 1997; Lykes, 2002; Pupovac, 2002). Kleinman (1987) critiques psychiatry’s ethnocentric “presumed universalism of forms and content of mental disorders” across cultures (Lykes, 2002, p. 93).

An anthropologist who studies refugee mental health and trafficking recovery, Gozdziak (2004) refers to the biomedical model as an “individualistic framework of Western psychiatry

and psychology and a worldview that privileges biology over culture” (p. 205). Anthropologist Byron Good (1994) contended that his field has shown “biomedicine to be one system among many” (p. 26) and challenges “biomedicine’s hegemonic claims” (p. 26). Kleinman et al. (1997) critiqued the “medicalization of suffering” which he referred to as normative human experience, and not pathological illness needing to be treated. Activist scholars in anthropology, Gozdziak (2004), and community psychology, Lykes (2002), have critiqued the trauma model as reductionist and individualistic for its biomedical worldview that ethnocentrically positions the individual at the center of experience or cosmology. These scholars propose that it dislocates individuals and communities from historical context, collectivity, and the possibility of communal agency (Gozdziak, 2004; Lykes, 2002).

Some consider the trauma model to be pathologizing and disempowering for clients (Gozdziak, 2004), as well as colonizing (Gozdziak, 2004; Summerfield, 2000) by oppressively reinforcing expert status of providers over clients. Gozdziak (2004) notes that Illich (1976), Summerfield (1999), and Pupovac (2002) have all contended that biomedicine and its pathologizing diagnostic categories may serve to obfuscate resilience, and render so-called traumatized people incapacitated and dependent on outside therapeutic actors. Some critics of the trauma-informed framework in cross-cultural work extend their critique to providers, arguing that it allows westerners to retain a position of privileged expert solving the problem of the colonized (Lykes, 2002). Critical medical anthropologists critique the role of the western medical paradigm in pathologizing human experience cross-culturally through disease/disorder classifications, misunderstanding cultural idioms of distress, and pathologizing post-colonial expressions (Gaines, 1992; Jenkins & Valiente, 1994; Mezzich et al., 1999; Stoller, 1994). Together, these scholars critique the broad application of the trauma framework to mental health

intervention cross-culturally, suggesting its inadequacy (Lykes, 2002), and emphasize the lack of preparation of Western trained medical and mental health professionals to work with non-Western persons (Gozdziak, 2004).

Critical scholars question the assumption in mainstream psychological literature of focusing on an individual trauma victim/survivor, as if individuals can be dislodged from social-political context. Victim/survivor status assumes that the individual level is the space where a person was impacted and continues to be, and where that individual may best access treatment to cope and heal. Lykes (2002) cites Bracken et al. (1995), who has critiqued the notion of an individual at the center of experience or cosmology. Lykes (2002), discussing her work with an Indigenous Guatemalan Mayan Quiche community impacted by state-sponsored violence, specifies that the result is a notion of individual disconnected from context and time, from history, collectivity, political struggle, and the possibility of communal agency. Lykes (2002) points out that while progress was made throughout the 1990s to better contextualize, for example, children within the context of their families and communities in order to research and/or intervene (following Bronfenbrenner, 1979), trauma intervention work remains constrained within individualistic western cosmology.

Referring to therapeutic work with refugees, clinician Julia Bala (2005) notes the complex conundrum of the mental health professional when conceptualizing clients. She asks, “should we see the refugees as survivors, as victims, as medical casualties, as traumatized people or as marginalized citizens?” (P. 170). She emphasizes enlarging the conceptual framework to escape dichotomous binds of *either* working with traumatized individuals dislocated from context *or* situating sufferers’ problems within interactions of system levels (Bala, 2005). Bala

notes that, “the problems are located in neither the political nor the personal domain, but in their nexus” (p. 174). That is, where people and systems intersect and overlap.

The trauma literature has been critiqued historically as running the risk of missing issues of structural violence. Summerfield (1995), however, suggests that both individuals *and* the social settings in which they are embedded can experience ruptures. Lykes (2002) too notes that, “any understanding of trauma must be read within its social, cultural, and political contexts over time, not as a relatively static entity located and to be addressed within affected individuals” (p. 95). Trauma is broader than an individual, internalized intrapsychic experience; rather, it is a communal, cultural, and psychosocial phenomenon that is constituted in the dimension of time (Lykes, 2002). As such it impacts a community’s sense of and meaning making about historical past, the present, and its children’s future intergenerationally.

Activist critiques argue that western practitioners are under-prepared to engage with structural issues. Lykes (2002) refers to the PTSD literature in the U.S., which is commonly used to guide intervention and capacity building globally, and relied on in cross-cultural work with immigrants, refugees, and trafficking survivors, as inadequate to guide practice due to its invisibilizing of complex social experiences. She notes that an attempt to understand structural violence and oppression through a biomedical framework “deeply constrains the understandings available to those who seek to accompany survivors, medicalizing and pathologizing what are fundamentally political, economic, cultural, and psychological phenomena” (p. 93). In other words, providers may then lack a lens to conceptualize individuals as deeply embedded in context, and as competent to define and act on their own suffering agentically. CRT too posits an anti-oppression framework for mental health as a counter-narrative to the biomedical, and bio-psycho-social models (Corneau & Stergiopoulos, 2012). Despite the critical importance of such a

frame, Corneau and Stergiopoulos (2012) remind readers that the literature regarding implementation of anti-racism models in practice are under-developed.

Clinical Relevance for Survivors of Sex Trafficking

These important insights from the critical global mental health scholarship and from Critical Race Theory are relevant to the field of sex trafficking recovery work, because they offer insights that may allow practitioners to take a step back, and reconsider commonly held assumptions about goals and means of intervention. They provide analytic tools towards (re)thinking how to implement frequent calls in the field for culturally sensitive, victim-centered service provision. Critical theories may lead to conceptualizations of treatment with trafficking survivors that extend the trauma-informed framework. They are meaningful to consider given the great diversity of backgrounds amongst survivors of trafficking, and given the fact that survivors often have multiple marginalized social identities, are frequently embedded in complex systems that are known to present barriers to care, and given the lack of theoretical foundation in the field currently.

Scholars have frequently called for more research on the development of culturally sensitive clinical interventions for survivors of trafficking within the trauma-informed frame (Hopper, 2017). Farley et al. (2011) and Gozdziak (2004) emphasized clinicians' lack of preparation to work cross-culturally, especially with Indigenous trafficking survivors. There are frequent calls for culturally sensitive intervention in trafficking work, improvements in training, and clinical research (Martinho et al., 2020). Gajic-Veljanoski and Stewart (2007) emphasized the need for culturally sensitive services in sexual assault, prostitution, and substance abuse services. The U.S. TIP Report (USDOS, 2020) recommended that therapists provide culturally and linguistically appropriate clinical care that accounts for survivors varied geographic

backgrounds by attending to differences in communication style, and expectations about health care, power dynamics and trust. The HHS 2010 report recommended that to successfully deliver culturally competent care, clinicians must “familiarize themselves with the beliefs, values, and practices of the various cultures of their patients” (no page).

Critical race theory (CRT) offers insights into the strategies for doing culturally-sensitive work with survivors of trafficking with an awareness of intersectionality, and offers analytic tools to support conceptualizing and leveraging structural, systemic, and historical barriers to recovery, including awareness of power, oppression, and social change. CRT and the concept of intersectionality have similarly only been minimally considered in the trafficking recovery scholarship (Vollinger, 2021). Despite the scholarly consensus to import strategies for working with presumably similarly marginalized and traumatized individuals including refugees (HHS, 2010; Zimmerman, 2011), there has been limited importing of the well-established critiques, debates and recommendations surrounding trauma-informed care cross-culturally. These cautions pertaining to refugee recovery work may also benefit the trafficking recovery field.

Critical race theory and transcultural psychiatry, among other critical perspectives, challenge the trauma-informed approach, and forthcoming in third sub-section, the social ecological framework, inviting a close consideration of the impact of historical and contemporaneous colonialism and racism. The critical literature offers guideposts for implementing the broad recommendations for culturally-sensitive, victim-centered intervention, which appear in the trauma-informed and social ecological scholarship, with greater nuance and specificity, with the aim of undertaking emancipatory recovery work alongside survivors of sex trafficking.

Survivors constructed as passive service recipients versus agentic actors. Critical social work scholar Moshoula Capous Desyllas (2007) suggests the challenge of applying a survivor/victim rights, empowerment frame, when survivors of sex trafficking have been frequently constructed as passive, without agency, and from the Global South. This detracts attention from the more common phenomenon of domestic trafficking and, in Desyllas’ (2007) words, U.S. Policy “harms women through so-called 'protection' and continues to colonize" (p. 62). The impact of how survivors are constructed impacts policy and trafficking professionals’ lenses. There is not space in this study to discuss vigorous debates within feminist theory: are survivors of sex trafficking exploited victims, or unfairly criminalized women who choose sex work and deserve labor rights protection?

Patients and trafficking survivors are forced to engage in social service systems to access benefits. There may be enormous pressure on trafficking survivors to adopt pathologized status, to embody and enact trauma, for TVPA benefits eligibility, as Kinzie (2006) suggests is true for refugees. Summerfield (2005) describes refugees as forced to take on a sick role, rather than have opportunities for meaningful citizenship. Foote and Frank (1999) describe that “the objective of (therapy) is to produce the self required by the institution” (p. 163). Replicating unspoken, even if subtle, coercions must be monitored when working with trafficking survivors.

Transcultural psychiatrists suggest another force that leads to pathology may be the clinical gaze with which a sufferer is met. Through her book of fictional case vignettes, Shipler Chico (2017) cautions anti-trafficking mental health professionals against attachment to a rescuer role as a defense against feelings of helplessness and vicarious traumatization, as it may compel clients to adopt pathologized status for continuation of support. Shipler Chico (2017) describes it as re-victimization, where a survivor is forced into “prostituting her tragedy and manipulating

her victimhood in order to obtain benefits” (p. 12). Kinzie (2006) and Summerfield (2005) suggest a similar pressure exists for refugees.

This underscores the impact of clinicians’ framing of survivors, and suggests that survivors themselves are best suited to name their needs. PAR posits that marginalized communities must have a critical role in conceptualizing, framing, researching, and leading the interventions purportedly meant to serve them. Otherwise, Jackson and Mazzei’s (2012) notion of the dominant “center” continues to create myopic views of truth, speak for marginalized communities, and interventions may be harmful and oppressive. Likewise, there are frequent calls in the trafficking recovery literature to integrate survivor voice into research, practice, and leadership decisions (Wright et al., 2020), and for empowerment frames.

Critical thinkers have identified the structural conditions of inequality and discrimination that disproportionately contribute to social suffering. These authors discuss the role of racism in creating mental health symptomology, reminding how racism and structural violence interweave with social suffering. Kleinman and Kleinman (1995) importantly asked about the conditions that transform a victim of violence into a sufferer of pathology. Summerfield (1995) described PTSD symptoms as “an indictment of the social conditions which produced them” (p. 26) as opposed to private suffering. Corneau & Stergiopoulos (2012) highlighted the impacts of racism on mental health outcomes and diagnoses, as related to chronic stress and psychological exhaustion from constant deployment of defensive and adaptive strategies. Some Transcultural Psychiatrists have suggested that immigrants’ mental health diagnoses owe primarily to racist host country conditions (Littlewood & Cross, 1980; Littlewood & Lipsedge, 1997). Kinzie (2006) cited 17 studies reporting increased rates of schizophrenia when an individual’s societal position was comparatively disadvantaged, noting racial discrimination at play. Some studies

have likewise found higher levels of diagnosed schizophrenia amongst trafficking survivors (Levine, 2017).

Critical feminist theory specifically provides a lens to illuminate links between systematic gender discrimination and sex trafficking of women, noting that gender conflates with other social identities, including race, socio-economic status, sexuality, and ability status. Feminist theory revealed sex trafficking as a gender-based crime (Mahalingam, 2019), but some scholars argued that cultural, racial and ethnic oppression heighten risks for being trafficked specifically for women of Color (Bryant-Davis & Tummala-Narra, 2017). Butler (2015) and Pandya and Pandya (2011) identified the link between trafficking and racism, yet assert that the literature fails to adequately explain the nexus between the two.

Applying CRT and intersectionality principles to trafficking discourse and praxis supports the need for tailoring intervention for distinct groups according to an awareness of intersectionality. Using this theoretical lens, racist assumptions within clinical theories and multisystemic environments in which survivors of trafficking interact are theoretically presumed (Corneau & Stergiopoulos, 2012), and addressing inequality and discrimination must be integral to recovery work.

Empirical Research/Critiques: Critical and Cross-Cultural Scholarship in Trafficking

Cultural sensitivity means attending to discrimination and structural inequality. The aforementioned Family Violence Prevention Fund (2005) study recommended culturally-sensitive practice amongst trafficking service providers, noting that mental healthcare must be sensitive to the socio-cultural context from which victims come. Their recommendations, however, focused on provider sensitivity to culturally-specific food preferences. Macy and Johns (2011) also recommended culturally appropriate aftercare services for international trafficking

survivors based on their systematic review, including suggestions that providers consult with survivors on food preferences since basic needs like food and clothes involve cultural preferences. Awareness of the need for cultural-sensitivity amongst providers who work with survivors of trafficking is useful, however reducing this largely to food preferences is a more limited understanding than that offered by critical and emancipatory approaches. Social workers supportive of critical theory have suggested that clinical aims must go beyond cultural familiarization to culturally integrated and participatory clinical work (Goodman, 2015; Gorski, 2015).

Macy and Johns (2011) recommended that mental health providers inquire about survivor preference in recovery approach, since “Western counseling methods that involve talking and disclosure may not be effective or preferred by survivors from other cultures” (p. 93). Highlighting work by Martín-Baró, Fanon and Dawes, Lykes (2002) further encouraged mental health professionals to serve as collaborative advocates for oppressed people. She argued for conceptualizing sufferers’ struggles not as individual pathology but rather as the result of systemic and structural conditions, and suggested the value of a situated power analysis for responding to the psychological impacts of violence (Lykes, 2002).

In the refugee mental health literature, authors have debated: do survivors of conflict need trauma treatment, or attention to daily stressors and survival needs? (Miller & Rasmussen, 2010; Neuner, 2010). Zarowsky (2004) noted that anxiety among Somali refugees living in Ethiopia owed to immediate and long-term survival needs, and not to posttraumatic symptoms. Similarly, in Farley et al.’s (2004) previously mentioned nine-country trafficking study of sexually exploited women, participants’ top request was structural support such as housing and employment assistance, not mental health support. Likewise, in focus groups with Clawson et al.

(2003), trafficking survivors articulated a structural analysis of their vulnerability factors, their trafficking-related distress, and structural-level prevention recommendations.

Social work scholars Alvarez and Alessi (2012) noted the need both for efficacy studies related to interventions with trafficked persons, and the application of critical perspectives to the trafficking discourse, that highlight the structural inequalities caused by the impact of globalization in the Global South that created conditions of vulnerability to trafficking. Surprisingly, much research on entrapment factors for trafficking victimization fails to explicitly discuss racism as a factor, although recent literature names racism and structural discrimination as contributing to dehumanization of particular groups (Shipler Chico, 2017).

Some scholars have considered extent to which vulnerability for trafficking is increased for people of color (Reid, 2012). Reid (2012) described key researchers who differentially attributed sex trafficking vulnerability to lower socioeconomic status (i.e., Lloyd, 2005), and aspirations for amelioration of poverty (i.e., Gozdziak & Bump, 2008). Reid (2012) highlighted feminist theories, which attribute human trafficking to patriarchal abuse (i.e., Gozdziak & Bump, 2008), but noted that these “theoretical explanations fall short of explaining why certain individuals living in poverty or disadvantaged by patriarchal, machismo cultures are exploited in sex trafficking while others are not” (p. 268).

Despite Reid’s (2012) important query and citing of authors who found minoritized status to increase risk for trafficking in North America (i.e., Clawson et al., 2009; Deer, 2010), Reid fell short of naming impacts by race and ethnicity, and does so highlighting Flowers (2001), Acharya (2010), and Tyler (2009), who found buyer demand for white and light skin as well and black and brown bodies. Reid’s paper on Life Course Theory and trafficking vulnerabilities progressively dropped race and Indigenous status from her analysis as it progressed and they are

absent from her final framework, thus invisibilizing their presence from earlier studies cited, and obscuring their impacts.

Emancipatory and decolonizing approaches to healing. Models have recently developed that adapt some of these critiques for use with survivors of trafficking to advance practice. These aim to increase cultural relevance, attend to historical legacies of sexual violence, slavery and colonization in treatment by using a population-based frame, and consider intersectionality and social action in research. Some scholars have suggested that tailored clinical response for survivors of trafficking and commercial sexual exploitation must account for important differences by cultural background and racial/ethnic group identity, including the ways that slavery and colonization historically and contemporaneously impact marginalized populations, in the form of ongoing systemic racism (Bryant-Davis & Gobin, 2019; Carter, 2003). Carter (2003) noted that services needed by African American women survivors of prostitution differ from those needed by white women due to the “repeated and sustained harms of racism” (p. 216). She suggested that service providers must see and understand sexual exploitation of Black women as linked to historical slavery and ongoing structural racism, and also advocates for multi-pronged service approaches that include not only stabilization services, medical, mental health and addiction recovery support, but also emancipatory consciousness-raising. Finding limited scholarship focused on the cultural recovery context for U.S.-based survivors, Bryant-Davis & Gobin (2019) undertook a critical review of the scholarship and clinical practice literature. They aimed to provide treatment guidelines for working with sex trafficked African American girls and women, and recommended drawing from womanist (Black feminist) psychology, and focusing on strengths and cultural congruency.

Studies emerging out of Indigenous communities in the U.S. have called for more research and attention to the development of culturally sensitive intervention for Native women and girls that address the centuries-long history of abuse and indifference (Deer, 2010; Matthews et al., 2010; Minnesota Office of Justice Program, 2012; Pierce & Koepplinger, 2014). A significant contribution of this scholarship was to illuminate the links between population-level historical antecedents (multigenerational legacies of sexual violence and colonialism) and sex trafficking vulnerability suffered by Indigenous women today (Farley et al., 2011; Pierce, 2009). Farley et al. (2011) identified race/ethnicity specifically as a factor in Native American women’s trafficking, noting sexual degradation, hate-based comments, and homicidal threats based on women’s skin color

This literature, which has tracked sex trafficking prevalence rates, PTSD and service usage among survivors (Farley et al., 2011; Pierce, 2009), provided clinical recommendations to blend trauma-informed treatment approaches with culturally-specific healing practices and a population-level social justice agenda of Indigenous women’s rights. Farley et al. (2011) argued for blending attention to individual therapeutic needs and structural-level supports, and framing them within a population-level discussion of violence against women, thus shifting the framework from an individual conceptualization of sufferers to a population-level frame. Deer (2010) also argued for an intersectional analysis.

This scholarship directly names the population-level legacies of colonialism and racism that continue to ensure Indigenous women’s ongoing vulnerability to trafficking, and insists that those legacies be taken up by clinical treatment (Farley et al., 2011; Pierce, 2009). Authors recommend a “decolonizing” healing model (Farley et al., 2011, p. 53) that contends with the interplay of historical trauma, community and family violence, child abuse/neglect, racism and

ethnic oppression in treatment (Farley et al., 2011). That is, authors argue that mental health recovery work must consider the effects of colonialism and racism, suffered by individuals and populations alike, to facilitate therapeutic, decolonizing and emancipatory recovery work (Farley et al., 2011; Pierce, 2009). Some agencies that serve Native American as well as African American sexually exploited women advocate treatment/recovery models that combine an individual complex trauma approach with a population-focused, emancipatory framework (Carter, 2003; Farley et al., 2011; Pierce, 2009).

Consideration of how trauma therapists can work effectively with trafficking survivors at the intersection of trauma-informed frameworks and anti-racist ones is an important inquiry.. The sparse research with African American and Native American sex trafficked women suggests that race/ethnicity, indigenous status, and gender are inextricably linked with sex trafficking victimization, as well as with trauma exposure. These literatures challenge the notion of an essentialized traumatized individual, dislocated from social context, instead suggesting that the commercial sexual exploitation of Black women is a continuation of historical slavery (Carter, 2003), and sex trafficking of Indigenous women is part of modern-day colonialism (Farley et al., 2011; Pierce, 2009). These literatures uniquely frame vulnerability and treatment through an intersectional, decolonization, and anti-racism lens (Farley et al., 2011; Matthews et al., 2010; Pierce, 2009). Yet, they also simultaneously discuss trafficking impacts through a biomedical PTSD lens and a population-level lens which acknowledges colonialism and racism, and in the case of Indigenous survivors, by simultaneously suggesting use of Western as well as Native healing approaches. These models offer integrated approaches to trafficking treatment that could serve as models to be generalized to other trafficked populations.

Intersectionality contributions. Some anti-trafficking scholars have argued powerfully for using intersectionality as an analytic lens to conceptualize and design trafficking recovery interventions, and that they must include action towards social justice (Vollinger, 2021). Social work scholars Marchevsky and Theoharis (2008) and Alvarez and Alessi (2012) argued for using intersectionality as a theoretical lens to identify how overlapping categories of race, gender, age, and class combine to produce and perpetuate social inequality (Crenshaw, 1991; Marchevsky & Theoharis 2008). Vollinger (2021) advocated for including intersectionality into theoretical frameworks guiding practice and research with survivors of sex trafficking in the United States. Vollinger (2021) argued that shifting from an individual-level analysis to a social/systemic analysis allows for attention to issues of racism, intersectionality, and structural oppression as related to sex trafficking recovery work, and importantly, for consideration of social justice and transformational action.

Vollinger (2021) undertook a systematic review of empirical research conducted with adult survivors of sex trafficking in the United States. She examined articles according to the extent to which they employed intersectionality as a research lens into their studies at all stages of research, and the extent to which they incorporated social justice and action stages into their dissemination of findings. Twelve articles ultimately met inclusion criteria. She found that intersectional components were incorporated into the hypothesis and sampling stages of research as well as interpretation of findings, however, adherence was low in operationalization (perhaps due to lack of validated measurements) and analysis stages. Adherence was also low related to social justice and action. Vollinger (2021) found that existing trauma scholarship with survivors of trafficking failed to adequately analyze the intersectional experiences of multiple social identities within oppressive social structures in the U.S. She found that the studies she analyzed

largely constructed sex trafficking as an individual-level issue, leading to recommendations that addressed it at that system level and prevented recommendations related to laws, policy, institutional practices, and with social justice implications, "which can only be considered if there is a shift towards viewing sex trafficking in terms of structural practices" (p. 616). She noted that the field had ample room to grow in this direction.

Sub-Section Conclusion. The second sub-section presented theoretical and empirical scholarship jointly from the fields of critical race theory, transcultural psychiatry, and sex trafficking recovery. The transcultural psychiatry and community psychology fields have robustly critiqued the use of the trauma frame cross-culturally (i.e., with refugees). Critiques include that it reduces sufferers to individual biomedical units (Gozdziak, 2004; Lykes, 2002), and that it is Eurocentric, neo-colonial and fails to contend with intersecting oppressions (Gozdziak, 2004; Lykes, 2002; Mollica, 2011). Also critics contend that it is pathologizing and disempowering for survivors of violence (Gozdziak, 2004; Summerfield, 2000), and obscures the structural inequalities that give rise to suffering for marginalized populations (Zarowsky, 2004). These scholars argue that problems exist in nexus points where the personal and political domains meet (Bala, 2005), and that possibilities for recovery also reside in communal agency (Lykes, 2002). Despite recommendations to import strategies for working with trafficking survivors from the refugee mental health field (Zimmerman et al., 2011), these critiques of refugee mental health work have not been applied to the sex trafficking survivor recovery field.

Critical theories offer alternative paths towards the goal of culturally-appropriate service provision (USDOS, 2020) that are emancipatory and intersectional in nature. These scholars offer integrative approaches to recovery work that provide not only models for increasing cultural relevance (Carter, 2003; Farley et al., 2011; Pierce et al., 2009), but that aim to address

posttraumatic symptoms while simultaneously accounting for trafficking survivors’ experiences of structural inequality and population-based and historical marginalization (Carter, 2003; Farley et al., 2011). These scholars hold an awareness of intersectionality and promote integrated scholarship and praxis that is culturally and historically-situated, engages emancipatory-consciousness along with concern for mental health (Carter, 2003; Farley et al., 2011; Pierce et al., 2009), and endeavors to undertake social action (Vollinger, 2021).

These critical scholars, taken together, implore researchers and practitioners to use a structural lens to address not only mental health concerns, but also to act against the legacy of systemic inequality that promotes disproportionately high prevalence of social suffering for minoritized groups, including sex trafficking survivors. Notably, the studies related to Indigenous women by Farley et al. (2011) and Pierce (2009) and African American women by Carter (2003) were absent from all previously discussed systematic reviews, including from Vollinger’s (2021) study on intersectional research in trafficking recovery. This may be because those studies fell outside each study’s inclusion criteria. Still, important theoretical insights related to intersectionality, and emancipatory and decolonizing approaches emerge in those literatures, yet are obscured in the scholarship related to trauma-informed mental health recovery with survivors of sex trafficking. The final sub-section below considers social ecological models which help conceptualize survivors as embedded in multidisciplinary and multisystemic contexts. This framework helps to address some of the critiques discussed above.

Social Ecological Approach: Multisystemic and Multidisciplinary Recovery Context

The third and final framework this study contends with is the social ecological approach. One potential avenue for addressing the previously critiqued tendencies to de-contextualize survivors is to closely consider the recovery contexts in which survivors are embedded. Indeed, a

number of scholars have recently recommended that the trafficking recovery field employ a social ecological approach to best conceptualize recovery work with survivors of trafficking (i.e., Finigan-Carr et al., 2018; Hopper, 2017; Salami et al., 2021). This framework allows for consideration of the contexts in which survivors are nested, barriers to recovery within multiple systems and resources available to survivors within those contexts.

Barriers to recovery have been found within multidisciplinary and multisystemic recovery environments. These include poor service response coordination and communication related to survivors’ complex needs across systems (Clawson & Dutch, 2008; Macy & Johns, 2011; Potocky, 2010; Powell et al., 2018), lack of common institutional vision (Menon et al., 2020), and lack of multidisciplinary provider training to guide response (Muraya & Fry, 2016). Calls persist to improve multidisciplinary and multisystemic recovery response (Macy & Johns, 2011; Martinho et al., 2020; Menon et al., 2020; Muraya & Fry, 2016; Nazer & Greenbaum, 2020).

While more research is needed, some scholars have begun exploring the perspectives of mental health providers within recovery contexts to shed light on barriers and resources. Collectively, these scholars advocate the value of documenting the practices and perspectives of mental health professionals (Domoney et al., 2015; Magnan-Tremblay et al., 2019; Muraya & Fry, 2016), as well as examining the critical perspectives of survivors themselves. That includes exploring the impact of survivor mentors in recovery work (Rothman et al., 2020), survivor perspectives on conceptualizing mental health recovery (Wright et al., 2021), and the impact of partnerships between survivor mentors and clinical professionals (Contreras & Kallivayalil, 2019).

The previous sub-section discussed a critical theoretical framework that guides cross-cultural, intersectional work with marginalized and non-Western individuals and populations, and offers challenges to the trauma-informed as well as the social ecological systems approaches described in this sub-section. The additional perspective of the social ecological model may help address some of those critiques. That is, it broadens the analytic lens to frame individuals not as dislocated from social and cultural context, but as embedded and mutually interacting (Finigan-Carr et al., 2018; Hopper, 2017; Salami et al., 2021).

As with prior sub-sections in this chapter, the following discussion introduces a brief overview of social ecological theory. It then describes recent social ecological models developed for use in trafficking recovery work specifically that conceptualize survivors as nested within complex multidisciplinary, multisystemic environments with multiple intervention points. Then, the empirical literature is presented examining these multidisciplinary recovery environments, including known challenges and opportunities, and the perspectives of the multidisciplinary providers’ who work within them. The sub-section concludes with a brief synthesis.

Theory: Social Ecological Approach

Bronfenbrenner’s (1979) Ecological Systems Model attempted to contextualize individuals by explaining the impact of environmental factors on individual human growth and development. Focusing on one’s surrounding environment shifted attention from the biology of human behavior to systems, and to the ways in which individuals are shaped by the many contexts in which they are embedded (Bronfenbrenner, 1979). Bronfenbrenner’s (1979) ecological systems framework nests human development in the context of interlocking systems that act upon an individual, and upon which an individual may act. It assumes distinct yet inter-

related relational and developmental contexts, depicted often visually with an individual nested in the middle of an overlapping network of concentric circles, or system levels.

The model has evolved over the decades, and Santrock (2011) recently described individuals as embedded within five systems. The innermost layers that Santrock (2011) visually depicted are microsystems, comprised of family, school, and community, and mesosystems where microsystems interact. For those systems, co-construction is considered possible (Santrock, 2011). Moving distally, Santrock (2011) depicted the exosystem, which impacts microsystems but offers theoretically limited individual agency to co-construct. Moving further outward are macrosystems, including beliefs of culture and ideology of politics/religion, where individuals are considered to have limited power to effect change. Finally the chronosystem, the most outward system layer, is where cumulative experiences over time, environmental events, and life transitions are conceptually situated (Santrock, 2011).

The social ecological model allows consideration of the systems within which individuals interact and the many actors working within those systems. A multisystemic framework for mental health intervention emerged out of Bronfenbrenner’s (1979) work, offering a model for conceptualizing individuals as embedded within overlapping contexts, where there exists reciprocal interplay between and amongst systems (Henggeler & Schaeffler, 2016). Multisystemic therapy (Henggeler & Schaeffler, 2016) was developed to conceptualize clinical problems within and between multiple system domains, and to consider ways that a person’s broader ecology may create barriers that impede recovery. Wraparound work is also based on an ecological model and systemic teamwork approach amongst multidisciplinary providers that addresses the varied contexts in which people live (Mana & Naveh, 2018; Walter & Petr, 2011). Multidisciplinary work refers to collaboration and cooperation of professionals from across

different disciplines, with the aim of combining knowledge and experience to enhance outcomes (Choi & Pak, 2006).

The field of developmental psychology has critiqued Bronfenbrenner's model for relegating culture to the macrosystem, as if it were a separate, external entity. Critics instead conceptualize culture as core to how individuals understand themselves (Rogoff, 2003; Vélez - Agosto et al., 2017). These literatures contribute a more nuanced view of the intimate role that culture and personal identity markers (including race and ethnicity) play in individuals' lives. Vélez -Agosto et al. (2017) built off of Rogoff's (2003) critique to conceptualize culture as an "intricate part of proximal development processes" (p. 900), where culture, race, and ethnicity can be conceptualized as, in fact, central processes to human development. Walter & Petr (2011) suggested advancing an ecological approach to promote social justice and systems change, which is not traditionally part of that realm.

Clinical Relevance for Survivors of Human Trafficking: Multisystemic and Multidisciplinary Work

Social ecological theory provides a useful model to consider the multidisciplinary, multisystemic recovery contexts that surround survivors, and the ways in which individual survivors are embedded within them. The theory offers analytic tools to consider the barriers that impede trafficking survivor recovery and the resources available to help overcome those barriers. This section will discuss clinical applications of the theory to trafficking recovery work.

There are frequent calls in the trafficking recovery literature to engage in cooperative, collaborative multidisciplinary work (Macy & Johns, 2011; Menon et al., 2020; Muraya & Fry, 2016) that is often multisystemic by definition. Based on the extreme exploitation often suffered by survivors of sex trafficking and complex recovery needs, providers may be from disciplines as varied as social work, psychology, psychiatry, substance abuse treatment, medicine and public

health (doctors, nurses, pharmacists, health educators, etc.), housing/shelter advocates, peer mentors, educators, lawyers (and criminal justice system professionals), immigration enforcement officers, foster care providers, policy makers. Likewise, sex trafficking recovery work sometimes overlaps and conflicts with sex worker labor rights advocacy, and is another discipline where there is fertile ground for collaboration (Coaston, 2021). Social ecological approaches provide tools to begin to conceptualize this layered recovery environment and to better construct intervention approaches.

To be trauma-sensitive and rights-based across multiple disciplinary domains and service systems is complicated in practice. The U.S. Federal Strategic Action Plan for 2013-2017 advocates for “victim-centered” approaches as ones that minimize re-traumatization by deploying service providers to support a “victim’s rights, dignity, autonomy, and self-determination, while simultaneously advancing the government’s and society’s interest in prosecuting traffickers” (p. 10). Hinging survivors’ benefits on participation in prosecution, however, has been critiqued as coercive (Alvarez & Alessi, 2012; Clawson, et al; Desyllas, 2007), and may in fact compromise survivor recovery through re-traumatization and inhibit help-seeking by undocumented women, for example, who may be concerned about immigration enforcement (Salami et al., 2021). The multisystemic approach to conceptualizing victim-centered, trauma-informed recovery services suggests protective coordination amongst social services, the criminal justice system, possibly the immigration system, the foster care system and more. Complicated risks and challenges arise, however, for mental health providers and the survivors they accompany within these multidisciplinary, multisystemic recovery contexts. The empirical literature outlining these is discussed in the empirical research section below.

In the absence of a theoretical foundation guiding the field, some recent trafficking recovery scholarship has turned to Bronfenbrenner’s ecological systems theory to develop an antitrafficking-specific social ecological model to conceptualize multisystemic intervention with survivors of human trafficking and advance the field. Hopper (2017) developed the Multimodal Social Ecological (MSE) framework in an attempt to address trafficking survivors’ mental health recovery and empowerment needs through varied modalities at multiple system levels of intervention. Her framework aims to offer a useful lens through which to consider clinical and non-clinical intervention across layers of the recovery context in which survivors interact.

Hopper’s (2017) MSE framework specifically aims to address complex trauma symptomology at every system level by promoting the development of survivors’ competencies, including regulatory capacity, relational capacity, and positive sense of self and future orientation. Hopper (2017) recommended working collaboratively with survivors using a complex trauma framework not only for symptom reduction, but also to promote these competencies at the personal/individual, social-environmental, and contextual/systemic levels. While Hopper (2017) acknowledged there has been no research in the area of complex trauma treatment with survivors of trafficking, she proposed the MSE framework as one which may support comprehensive, trauma-informed, culturally sensitive, developmentally adapted, and empowering interventions.

Similar to Bronfenbrenner (1979), Hopper’s (2017) MSE intervention framework located the individual level in an inner concentric circle containing survivor competencies (i.e., regulatory capacity, relational capacity, and sense of self and future orientation). The social-environmental is distally positioned one level out, with the systems level in the outermost concentric circle. Cutting across all levels are principles of sound intervention with survivors,

including: trauma-informed; culturally adapted; empowerment framework; and developmentally appropriate.

Hopper (2017) identified particular clinical and non-clinical interventions that may be useful at the varied levels for survivor recovery. For example, mental health intervention at the individual level may involve sensorimotor psychotherapy, EMDR, narrative therapy, and psychopharmacology (Hopper, 2017). At the social-environmental level, mental health providers may employ group support, psychosocial interventions, and promote increased community support. At the systems level, it may involve fostering of survivor leadership, advocacy, and changes in larger social/political systems. Hopper (2017) suggested that non-western healing modalities and expressive arts modalities can be integrated across system levels.

Due to the wide array of experiences and needs of trafficking survivors, and the impact of multiple systems levels on survivor wellbeing, Hopper (2017) proposed the MSE framework to help design trauma-informed, culturally sensitive, and empowering mental health interventions. Salami et al. (2021) highlighted the MSE framework as useful to guide assessment, treatment, and advocacy as well. Hopper (2017) called for more research on methods to increase access to and engagement with mental health care due to the array of systemic, structural, and emotional barriers for survivors. She suggested survivor leadership in the development of mental health policy for trafficking survivors, that training be standard for mental health service providers on the effects of trauma on trafficking and on trauma-informed service delivery, and recommended the development of multidisciplinary trauma-informed service networks for survivors.

Salami et al. (2021) recently returned to Bronfenbrenner’s (1979) seminal contribution of a social ecological lens, and Hopper’s (2017) Multimodal Social Ecological adaptation of it, for multidisciplinary, multisystemic recovery work with survivors of sex trafficking. Salami et al.

(2021) developed a culturally-sensitive treatment model that aims to act at multiple system levels to aid foreign-born survivors of human trafficking (i.e., at the individual, interpersonal, community, and societal levels). Salami et al. (2021) picked up Hopper's (2017) MSE framework, promoting the potential of focusing on contextual and environmental factors which impact treatment and intervention outcomes in order to better tailor them. Salami et al. (2021) identified promise in the models because they highlight the "interactive and complex dynamic" (p. 295) occurring between social systems, and may offer a useful "sociocultural framework" (p. 295) for working with diverse survivors of trafficking. Salami et al. (2021) note the potential of an ecological systems model:

> Given the emphasis on understanding psychological symptoms by looking to an individual's surroundings and the interaction between environmental systems, the Ecological Systems Model may be particularly helpful in elucidating our understanding of psychological health and other areas for consideration for human trafficking victims who are foreign-born (p. 295).

Salami et al. (2021) similarly depicted a social ecological model with broad intervention targets, with four system levels. The individual level is where therapists should engage culturally sensitive practice, assess traumatic stress, and address therapy barriers. The interpersonal level combines Bronfenbrenner's microsystem and mesosystem, and is where therapists bolster survivors' relationship-based support systems, connect them to community organizations, and assess needs for group therapy. At the community level (Bronfenbrenner's exosystem), therapists collaborate with stakeholders including social workers and teachers, disseminate research, and develop training programs. At the societal level (Bronfenbrenner's macrosystem), therapists remain informed about sociopolitical forces and foster links between research, policy, and

practice. Salami et al. (2021) suggested that mental health professionals are well suited to develop comprehensive treatment programs to support survivor recovery using an ecological framework. They noted that such interventions must contextualize individuals within myriad environmental contexts to provide tailored treatment, and that therapists should work collaboratively with other stakeholders to provide comprehensive care across systems levels.

Finally, Finigan-Carr et al. (2018) proposed a traumagenic social ecological model for working with sex trafficked children and youth. The contribution of this theoretical approach was to broaden the analytic lens, to frame individuals not as dislocated from social and cultural context, but as embedded and mutually interacting. Finigan-Carr et al. (2018) described ecological theory as depicting the interactions between a child’s inherent qualities and her/his environment that influence development in order to see children and adults as “enmeshed simultaneously in multiple environments” (p. 50), including schools, communities, cultures. Finigan-Carr et al. (2018) also relied on Bronfenbrenner’s (1994) notion of the chronosystem - the dimension of time which conceptualizes the impacts of both change and constancy on children’s development - to conceptualize child survivor aftercare as involving multiple systems and distinct disciplinary providers.

Finigan-Carr et al. (2018) also provided an important critique of the ecological theory model. That is, it still positions individuals as the locus of intervention. Finigan-Carr et al. (2018) note that the model focuses attention on prevention and aftercare efforts centered on individual sufferers principally as the intervention target, as opposed to “recognizing the perpetuation of structural inequalities like poverty and discrimination as the root cause of human trafficking” (p. 52). As a result, authors contend that limited solutions can be conceptualized.

Finigan-Carr at al. (2108) instead suggest structural interventions. For example, they critique public/community awareness campaigns that frame the problem of child sex trafficking in “individualistic moral terms” (p. 52) or a problem of criminal perpetrators, when these frames de-emphasize or ignore the “socioeconomic conditions and structural inequalities that create vulnerability to exploitation” (p. 53). Authors contend that prevention efforts focused on individual youth and adults as the intervention target fail to “recognize poverty and inequality as the root causes of human trafficking” (p. 53) and that these have led to “largely ineffective responses to human trafficking that do not address the underlying systemic issues” (p. 53). They still, however, underscore the importance of individual treatment services, and call for research related to trauma-sensitive intervention, given how much is unknown about treatment efficacy.

Empirical research/critiques: Social Ecological Approach and Multidisciplinary Context

Challenges within multidisciplinary and multisystemic recovery context & Calls for collaboration and coordination. Calls for multidisciplinary and multisystemic work are frequent in the trafficking recovery scholarship. Yet the disciplinary providers and systems identified with which to cooperate are highly varied, and barriers abound. The previously mentioned Family Violence Prevention Fund (2005) study not only identified that aftercare recovery interventions modeled on the needs of domestic violence survivors were inadequate, they recognized that trafficking survivors were embedded in varied multidisciplinary systems that were ill-equipped to provide adequate services. A key finding was a need to support survivors through all stages of recovery, including: identification, rights-based education, exit/escape, and aftercare recovery. Their study focused on survivor identification through healthcare access points but did not delve deeply into exploring recovery services. They called for provider training across the multidisciplinary spectrum in assessment, intervention and cultural-sensitivity, as well as peer-

to-peer outreach programs to aid identification of victims. They named relevant professionals (i.e., healthcare providers, community-based social service agencies, and law enforcement), and underscored the importance of providing information to dentists, pharmacists, and low-cost clinics where trafficked victims might seek care.

Scholars have continued to examine the effectiveness of the multidisciplinary web that forms the survivor recovery environment, and continue to locate barriers and make suggestions for improvement. Clawson and Dutch (2008) found survivors lacked a main point of contact to coordinate services, owing to miscommunication and lack of coordination, and that survivors failed to receive comprehensive services as a result. Pierce (2009) found a meaningful number of Native American sex trafficking survivors engaged with social service, mental health, and legal services yearly, yet were often not identified as survivors of trafficking by service providers.

Potocky (2010) examined the effectiveness of the Florida Freedom Partnership (FFP), providing comprehensive and rapid-response services to undocumented international survivors in the U.S. Potocky (2010) used a mixed methods exploratory approach to retrospectively examine the charts of clients (n=43 survivors) who were served between 2003-2007, and a key informant interview with a group of staff. The majority of survivors (76%) were from Latin America, and were primarily young women and girls (86%). The primary service need at intake for most clients was legal services. Despite the limiting post hoc data analysis (five years post program-implementation), the FFP was found to provide effective services in terms of mental health services and food provision, but was found to operate within a challenging environment that failed to meet survivors’ health goals. Potocky (2010) identified a need moving forward for strengthened theoretical frameworks with explicit empowerment approaches to guide service delivery, including peer mentor components and consciousness-raising through rights education.

Macy and Johns’ (2011) previously mentioned systematic review identified the need for more comprehensive guidelines for aftercare services for survivors in the United States. They explored not only trauma-informed care, but the need for a continuum of comprehensive and coordinated aftercare services. Macy and Johns’ (2011) systematic review found that aftercare services must attend to seven core domains which are quite varied, including: basic needs, housing, medical care, mental health, legal/immigration advocacy, employment and life skills, and substance abuse services. Their framework for service provision included: comprehensive needs assessment, ensure safety, be trauma-informed, comprehensive case management, be linguistically appropriate/interpreter services, be culturally-appropriate, and offer specialized housing.

Macy and Johns (2011) identified gaps in the rapidly growing field and a need for more research into the core service domains. They acknowledged, however, that the research they reviewed did not consistently agree on what the core service domains are. Macy and Johns (2011) noted, for example, that uneven recommendations existed related to the utility of 24-hour services and peer support services. Finally, these authors urgently called for service providers to document and evaluate their practices and programs to build the field, and called for interdisciplinary collaboration amongst practitioners, policy makers, and researchers.

Powell et al. (2018) described barriers for survivors in terms of incongruencies between survivor need and provider capacity within multisystemic frameworks. Powell et al. (2018) undertook semi-structured telephone interviews with fifteen U.S.-based nongovernmental organizations (NGOs), exploring mental health service delivery, provider characteristics, challenges to mental health service provision and strategies to overcome the challenges. Similar to Clawson and Dutch (2008) a decade prior, Powell et al. (2018) found that survivors engaged

with a “complex, multisystem labyrinth” (p. 260). They characterized the multiple systems of recovery as a “fragmented patchwork of care” (p. 257), and noted that barriers resulted in uncoordinated services for survivors.

Powell et al. (2018) described the systemic barriers that survivors face in powerful terms. Authors found international survivors to be “entangled by federal and state policies” (p. 262). They found minors “thrust into a vortex of systems” (p. 262) where they were “’owned’ simultaneously” (pg. 262) by different systems that each held different principles and goals (i.e., legal protection, criminal justice, and child protection systems). Authors argued for improved collaboration and coordination amongst systems, including mental health providers, and called for research into mental health service delivery (Powell et al., 2018). Other studies discussed in prior sub-sections have found similar incongruencies and poor coordination amongst service providers. Dell et al. (2019) indicated that survivors of trafficking may come in contact with a broad array of disciplinary providers, agencies, institutions, and systems, including social workers, social service and health care staff, police and immigration officers, youth outreach service workers, and addiction specialists, yet these multidisciplinary and multisystemic teams may be ill-equipped to respond.

Despite the barriers, scholars continue to advocate for comprehensive multidisciplinary collaboration and coordination. Muraya and Fry (2016), whose study was also detailed in the prior sub-section, advocated for multidisciplinary care of child trafficking survivors using a child rights-based care frame, meant to prioritize a child’s best interest at all times. For example, they recommended it should be employed when considering deportation; to validate children as victims of exploitation rather than as criminals or accomplices; to make children aware of their rights and assist them to access them; and to prioritize child privacy and consent. Muraya and

Fry (2016) also recommended multidisciplinary and multisystemic understanding of child rights. That is, they argued that all service providers have knowledge of them, including, mental health providers, social workers, medical staff, law enforcement and attorneys.

Muraya and Fry (2016) found consensus in the literature that service provision should emphasize comprehensive and coordinated case management, including multidisciplinary, multiagency, and multinational coordination to attend to children’s complex and multifaceted needs (i.e., for psychological, legal, medical, and basic needs). They noted a key finding from their work was identifying comprehensive case management as crucial for aftercare, and described case managers’ roles in coordinating service provision based on a needs assessment; acting as sources of continuity and emotional support for youth; and leading multidisciplinary care teams. Muraya and Fry (2016) noted that the literature underscores a need for multidisciplinary, multiagency, and sometimes multinational cooperation for survivors’ holistic recovery, including knowledge sharing and networking, as no one service provider can be self-sufficient in this complex work. They also highlighted consistent calls across the literature for monitoring and evaluation of aftercare programs.

Finally, Muraya and Fry (2016) grouped the range of aftercare services available into three phases - rescue, recovery, and reintegration - noting that depending on the organization, recovery work can last anywhere from several days to over ten years. They described psychosocial and psychological programming as primarily part of the recovery phase, and highlighted frequent research recommendations to use professionally-trained counselors, psychologists and psychiatrists for this work. Muraya and Fry (2016) described the reintegration phase as relating to holistic and sustainable reintegration into society, involving support in varied realms: practical, emotional, education/job training, and social.

Nazer and Greenbaum (2020) specifically emphasized the importance of medical provider involvement with multidisciplinary care teams, to best serve the needs of child trafficking survivors. They highlighted trafficked children’s high level of complex needs that extends far beyond the purview of the pediatrician alone. They advocated for a multidisciplinary team approach and suggest providers use a “trauma-informed, human rights-based, culturally appropriate, and gender-sensitive approach” (p. 211) for trust-building and to promote service access. Nazer and Greenbaum (2020) also suggested that multidisciplinary care team approaches involve community collaborations, broadening their approach to engage other actors within the social milieu. Asquith and Turner (2008) likewise suggested community involvement in reintegration efforts, including through grass-roots organizations and faith-based groups.

Survivors’ complex and multi-pronged needs post-exit have been found to challenge the broad array of disciplinary providers who participate in recovery efforts, including social workers. In their previously discussed systemic review examining interventions for survivors of sexual assault and intimate partner violence, Menon et al. (2020) highlighted the importance of multidisciplinary and multisystemic coordination, given that survivors’ experiences may cause them to intersect with the criminal justice system, especially immigration enforcement. Menon et al. (2020) contended that since multidisciplinary and multisystemic actors and institutions may or may not share a vision for survivors’ post-exit recovery, collaboration amongst healthcare and mental health providers, immigration and legal agencies is crucial. They suggested shared understanding that trafficking is a crime perpetrated against victims, and victims should not be held legally responsible for their exploitation. Menon et al. (2020) underscored that a close working relationship amongst disciplinary providers and systems is important to address the complexity of survivor recovery, especially when embedded in multiple complex systems.

Recent scholarship found that child survivors in the United States interact with a great diversity of systems and disciplinary providers, and recommended comprehensive multidisciplinary coordination to support recovery (Martinho et al., 2020). Martinho et al. (2020) undertook a systematic review of the literature to examine anti-trafficking professionals’ practices and understanding of comprehensive needs of child survivors of trafficking. They examined 17 studies, all developed in the second decade of the 2000s across 14 countries. Participant disciplines ranged from education to health, child protection to social services, justice and religious leaders. Studies reviewed mainly used qualitative semi-structured interviewing. Martinho et al. (2020) found that providers understand child survivors’ needs in terms of individual as well as macro-societal level needs including involvement with varied institutions.

Providers across the studies reviewed underscored the importance of cultural competencies and trauma-informed approaches (Martinho et al., 2020). Martinho et al. (2020) noted several indicators of trauma-informed care to be: safety, trustworthiness, choice, collaboration, and empowerment, and were aware that therapies tailored for Western populations may be limited for use with people from other parts of the globe. Still, authors underscored the scarcity of studies that highlight this need, identifying the “long road” (p. 14) to develop evidence-based practices.

Martinho et al. (2020) suggested the value of multidisciplinary teams to reduce caseload burden on any one professional. In examining professional practices, authors found that a comprehensive and coordinated service response across multiple system levels is needed to address the varied domains impacted by trafficking exploitation, including through cooperative networks of professionals working across agencies, institutions, and systems collaboratively (Martinho et al., 2020). Some professionals in their study cited barriers related to youth

involvement in the criminal justice system, noting that intervention practices in that domain are inadequate, children are mistreated by the system which risks re-exploitation, and the system is failing to meet child survivors’ needs. Authors specifically cautioned against victim-blaming.

Martinho et al. (2020) concluded that much empirical work remains to understand the work and perspectives of those who work directly with survivors. Their findings are limited by lack of any data related to effective practices for identification, screening, and community reintegration of child survivors. Martinho et al. (2020) called for more research on intervention efforts, and emphasized the need to identify whether professionals employ culturally-sensitive, victim-centered, trauma-informed care, and if so, how they implement these efforts.

Some authors already discussed have argued for an organizing framework to engage in recovery work with survivors, yet have found a lack of evidence to guide the work. Similar to Macy and Johns (2011), Dell et al. (2019) called for more research to develop “collaboratively agreed upon core outcome measures” (p. 192) in aftercare recovery as critical to advancing the field. In Salami et al.’s (2021) article proposing a social ecological framework to guide recovery work, they first undertook a systematic search for articles related to foreign-born adult victims of trafficking. They sought to assess the state of current guidelines, and provide an integrative, organizing framework to inform mental health recovery work with this varied population in the United States (Salami et al., 2021). Winnowing down their search from several hundred possible articles to 70, Salami et al. (2021) ultimately found only one article that provided mental health treatment guidelines and a framework specific to aftercare/recovery work with adult international trafficking survivors: the systematic review by Macy and Johns (2011). As noted, Salami et al. (2021) turned to Bronfenbrenner’s ecological systems model and Hopper’s (2017) MSE

framework to guide conceptualizing mental health recovery work with international survivors of trafficking moving forward.

Provider Perspectives. Integral to understanding the trafficking recovery context are mental health providers themselves. Few studies have specifically examined mental health providers’ experiences and perspectives related to mental health service provision with survivors of trafficking within these multidisciplinary, multisystemic care contexts. Muraya and Fry (2016) identified the need, stated across the literature, to better train healthcare workers, social workers, law enforcement, and other disciplinary providers on identification and referral of child survivors. Authors underscored the lack of evidence base in the field to guide practice and policy, and called for more research as well as improved documentation of service providers’ practices, especially within the social sciences and public health fields, to build the evidence base.

Domoney et al. (2015) undertook the first study, to their knowledge, examining trafficking survivor identification within mental health services as well as the challenges experienced by mental health professionals in responding to survivors’ needs. Authors undertook a qualitative analysis of comprehensive clinical electronic health records of trafficked patients in mental health services in South East London, England. Beginning with over 200,000 patients, they ultimately identified notes and records for 130 trafficked patients (n=95 adults and 35 children) from encounters between 2006 and 2012. They engaged content analysis to explore patient identification and thematic analysis to understand the challenges experienced by mental health providers.

Domoney et al. (2015) found multiple challenges faced by providers including: a) social and legal instability of trafficked patients which complicated recovery efforts; b) difficulty

ascertaining patient history; c) patients’ lack of engagement; d) lack of availability of services; and e) difficulties with inter-agency collaboration. Their analysis found that social stressors, including risk of deportation and unstable housing, exacerbated mental health symptoms and that therapy was often postponed as a result. Domoney et al. (2015) found mental health providers made efforts to improve patients’ social stability as a way to support mental health, underscoring the inter-relatedness of social stressors and mental health issues, and suggesting the need for approaches which account for social and psychological factors together. They suggested that challenges with survivor engagement may owe to gender of provider, with survivors of sexual violence preferring women as therapists and interpreters.

In terms of challenges working across systems and service sectors, Domoney et al. (2015) suggested improved communication, finding inter-agency disagreements more common amongst professionals treating trafficked children, related to safety concerns and challenges determining which disciplinary provider or system was responsible for care when children move geographic location. Domoney et al. (2015) also recommended increased efforts to train mental health professionals in trafficking response, and system availability to better support survivors. Their study, however, may be limited by lack of generalizability, as it was based on records from an urban mental health service, associated with the UK’s National Health Service (NHS). This may have limited applicability to U.S. settings, which may be even less well coordinated.

Among the few existing studies, Magnan-Tremblay et al.’s (2019) qualitative study explored how mental health counselors in Canada work with women who are current sex workers, or formerly sex trafficked, to determine how they perceived their futures. Semi-structured interviews were undertaken with 21 mental health counselors offering psychosocial services across sixteen Canadian agencies, in six different Canadian cities in 2016. The interview

was designed to explore therapists’ hopes and fears for their clients, using the Possible Selves Mapping Interview. Authors used interpretive descriptive analysis and employed Hill et al.’s (2005) principles of consensual qualitative analysis, as did this current study.

Magnan-Tremblay et al.’s (2019) found that counselors held both hopes and fears for their clients, including awareness of systemic barriers clients faced. Counselors’ fears centered on the devastating impacts that sex work would have on their clients, including fears that the “oppression and violence associated with life in the sex trade would cause their problems to multiply beyond their control” (p. 1434). Authors found that counselors recognized systemic barriers, including limited support options, lack of resources and severe economic constraints, that promote vicious cycles for women involved in sex work, making it too overwhelming to escape.

Magnan-Tremblay et al. (2019) recommended “holistic intervention” which recognizes and contends with the negative impact of social inequities and structural barriers for female survivors particularly, and which focuses on rebuilding women’s sense of hope and confidence to (re)build fulfilling lives. Importantly, authors found evidence of compassion fatigue and vicarious trauma amongst mental health counselors, necessitating consideration of the psychological stressors providers carry in doing the work. The study was limited by having a sample of entirely Canadian-born university graduates; instead, a more diverse sample might have contributed different insights, with different hopes and fears about survivors’ futures. Sample heterogeneity should include survivors’ voices in interviews and/or data analysis, and this may include peer mentors who provide mental health support services to survivors.

Related to research with peer mentors, also called survivor mentors, Contreras and Kallivayalil (2019) interviewed a peer mentor to explore their contributions to recovery work

and the cooperative working dynamics between peer mentors and therapists. Authors interviewed Stacy Reed-Barnes at RIA House, a community-based service agency dedicated to accompanying adult women with experience in the commercial sex trade, trafficking and prostitution. Ms. Reed-Barnes is a peer mentor and a Masters level social worker (MSW). Contreras and Kallivayalil (2019) reported their belief that engaging survivors of trafficking in healthcare settings will depend upon combining evidence-based tools with close collaborations with knowledgeable peer mentors.

Contreras and Kallivayalil (2019) reported that peers may better establish connection towards a healing therapeutic alliance, and that therapists may be unable to foster initial trust and connection. These authors advocated for collaborations between peer mentors and mental health professionals noting, “successful peer and professional collaborations that generate a robust outreach to victims and survivors need to be researched and evaluated to disseminate the knowledge they are producing and replicate this powerful form of engagement” (January is Human Trafficking Awareness Month, para. 8, 2019). Ms. Reed-Barnes voiced perspectives from the survivors she accompanies, for example, which critique groups held in jails run by professionals as run by outsiders who lack lived experience and thus the ability to earn trust. Ms. Reed-Barnes also advocated for better coordinated services with substance abuse care providers. Via the insights gained from their interview, Contreras and Kallivayalil (2019) underscored the value of collaboration across disciplines and with peer mentors as crucial next steps in anti-trafficking practice and scholarship.

Finally, recent research has found value in survivor mentor programming. Rothman et al. (2020) evaluated the survivor mentor component of My Life My Choice (MLMC), a sex trafficking survivor recovery organization in the Boston area. This was the first study to examine

efficacy of survivor-mentoring programming with this population using longitudinal data. Out of a study sample of 41 youth, 95% identified as female and the average age participant was 15 years old. Rothman et al. (2020) found increased well-being and reductions in substance use, delinquent behavior, and exploitation risk amongst survivors who were mentored by peers who were further along the recovery trajectory and had received training. A lack of a comparison group, however, makes it difficult to interpret the successes as owing to survivor mentoring, or other factors. Still, the findings suggest positive potential for survivor mentor involvement in recovery work.

Rothman et al. (2021) also evaluated the My Life My Choice (MLMC) group intervention, which is a 10-week program co-facilitated by a survivor mentor and a therapist with a prevention focus. The study collected longitudinal and self-reported data from youth participants. 354 youth (ages 11 to 20 years) completed baseline surveys assessing sexually explicit behavior, dating abuse victimization, substance use, and trust in police. Participants demonstrated improvements in knowledge, attitudes, and behaviors over time. Authors attributed success, in part, to the involvement of peer mentors. Authors noted that anecdotally, many participants shared with research staff that they enjoyed the program because it was co-facilitated by a survivor of sex trafficking, suggesting this increased sense of trust and feeling understood. Rothman et al.’s (2021) research suggests the power of survivor mentor involvement in trafficking recovery.

Peer mentors are a valuable mental health provider in trafficking recovery work. While some scholars use the term Survivor Mentor to describe this work (Rothman et al., 2020), community organizations use varied terms. RIA House, Inc., a community-based service provider who works in sex trafficking recovery, uses the terms Peer Mentor as a paid

professional who survived sex trafficking, commercial sexual exploitation or prostitution, and now provides advocacy and case management, mentorship and accompaniment for survivors (RIA House, 2021). Girls Educational & Mentoring Services (GEMS), a prominent empowerment organization serving survivors of sex trafficking, uses the term Survivor Leadership as part of its *victim, survivor, leader* model. Youth Collaboratory, a youth services organization that facilitates mentorship for survivors of trafficking, recommends survivor-led services, or survivor leadership in mentoring programs, because of the increased potential to instill hope in survivors based on lived experience of survival, exit and recovery.

Value of survivor voice in recovery scholarship. Finally, much of the recent literature in the trafficking recovery field has emphasized the critical importance of survivor voice in research and practice. Indeed, survivors are a critical part of multidisciplinary recovery environments, and social ecological models theoretically encourage consideration of ways that survivors are not only influenced by but influencing of the broader recovery context in which they are situated. Wright et al. (2020) recently published a grounded theory protocol seeking to recruit female survivors of modern slavery and human trafficking in the U.K. for qualitative interviews. Authors' stated aim is to generate a theoretical framework for mental health recovery work with survivors that is grounded in the lived experiences of survivors themselves.

Wright et al. (2020) noted that the strengths-based frame "recovery has become the underpinning discourse for mental health service provision globally and in England" (p. 2). An insight from the movement is that "living well involves less emphasis on symptom amelioration, and a stronger focus on addressing psychological and social needs, supporting self-management and building individual and community resilience" (Wright et al., 2020, p. 2). Wright et al. (2020) noted this insight may help broaden attention from a sole focus on trauma symptoms to

additional psychological concerns, including identity, as well as social and cultural challenges (including discrimination, and cultural dislocation).

Just as this current study acknowledges the lack of theory to guide practice and research, Wright et al. (2020) aimed to fill the gap by developing a theoretical framework to guide future mental health recovery intervention, based on the experiences of survivors. They aimed to explore survivors’ mental health needs and strengths, and survivors’ conceptualizations of mental health recovery. Survivors then become regarded as part of the multidisciplinary recovery context. As suggested by social ecological models, survivors are considered to be influenced by and influencing of the broader recovery context. Integration of survivor perspectives, then, may be deemed integral towards realizing a collaborative, fully coordinated service environment.

Sub-Section Conclusion. One possible pathway for addressing the critical theory and cross-cultural cautions related to broad-based, intercultural dissemination of the trauma-informed approach is to closely consider the multisystemic and multidisciplinary recovery context within which survivors interact. Some scholars hold up a social ecological framework as useful to consider context and individual embeddedness, arguing that the framework broadens the analytic lens to frame individuals not as dislocated from social and cultural context, but as embedded and mutually interacting (Finigan-Carr et al., 2018; Hopper, 2017; Salami et al., 2021).

Scholars have examined barriers as well as resources available for trafficking survivor recovery within these multisystemic and multidisciplinary recovery contexts. In terms of barriers, scholars have noted uncoordinated service responses, poor communication and complex needs that overlap multiple service domains (Clawson & Dutch, 2008; Macy & Johns, 2011; Potocky, 2010; Powell et al., 2018). They have also documented lack of shared vision amongst the varied recovery professionals and institutions (Menon et al., 2020), and lack of training

amongst multidisciplinary providers (Muraya & Fry, 2016). There are frequent calls to improve multidisciplinary and multisystemic recovery response (Martinho et al., 2020; Nazer & Greenbaum, 2020). Recommendations are increasingly common for improved cooperation and coordination across multidisciplinary actors, agencies, institutions, and systemic contexts that comprise the aftercare/recovery environment – including transnational cooperation (Macy & Johns, 2011; Menon et al., 2020; Muraya & Fry, 2016).

Still more research is needed on these contexts, the providers’ perspectives within them, and potential resources to leverage towards recovery. Muraya & Fry (2016) called for documentation of provider practices. Domoney et al. (2015) and Magnan-Tremblay et al. (2019) found that mental health providers are aware of systemic barriers that survivors face, and attempt to consider them in treatment, but more research is needed. Survivor voice is also considered critical to improving recovery services (Wright et al, 2020). Rothman et al. (2020) recently undertook the first empirical study examining survivor mentors as meaningful resources in peer recovery. Leaders in the field now recommend that scholars examine the potential of partnerships between survivor mentors and mental health professionals (Contreras & Kallivayalil, 2019).

Despite the promise of using social ecological theory to guide practice, limitations have been noted. That is, the framework continues to conceptualize individuals as the primary focus on intervention and may under-emphasize addressing structural inequality as the focus of intervention (Finnigan-Carr et al., 2018) as well as collective, communal capacities for recovery. Likewise, possibilities for collective “healing”/recovery capacity remain under-emphasized in social ecological frameworks. Collective action for social justice *as* a form of recovery (i.e., community organizing) remains under-emphasized. That is, the model focuses on individuals as

the intervention focus as opposed to the structural inequalities that differentially vulnerabilize particular groups (i.e., poverty and discrimination) and are the root causes of human trafficking (Finigan-Carr et al., 2018).

Conclusion

Despite disturbing prevalence rates of sex trafficking, severe mental health consequences, and increased attention on rescue, protection and prevention efforts (Polaris Project, 2014), there remains a dearth of research on mental health treatment and service delivery (Powell et al., 2018), mental health intervention efficacy (Wright et al., 2021), and clinicians’ perspectives on best practices with sex trafficking survivors (Domoney et al., 2015; Family Violence Prevention Fund, 2005; Martinho et al., 2020), particularly within multidisciplinary and multisystemic recovery contexts (Martinho et al., 2020; Muraya & Fry, 2016). This chapter examined theoretical and empirical literature related to trauma-informed care, critical theory, and the social ecological model, as related to sex trafficking survivor mental health recovery. This conclusion synthesizes key findings, critiques, and gaps across the literatures.

The trauma-informed care framework is broadly considered to be a promising approach for sex trafficking survivor recovery work and thus is frequently recommended (Macy & Johns, 2011; U.S. Federal Strategic Action Plan for 2013-2017). Studies have found high rates of PTSD amongst survivors of trafficking across cultures (Farley et al., 2004; Farley et al., 2011; Zimmerman et al., 2011). The trauma-informed frame has been associated with important guidelines in recovery work including survivor empowerment, survivor-rights, choice, and trauma sensitivity, which cautions against survivors being forced to recount traumatic experiences as a function of prosecutorial involvement (U.S. Federal Strategic Action Plan for 2013-2017). As a result of PTSD prevalence and the nature of the adversities suffered by

survivors of sex trafficking, scholars have recommended intervention approaches developed for use with non-trafficked populations (i.e., refugees and survivors of sexual assault and IPV) based on the presumption of similarity of trafficking survivors’ needs and experiences (Zimmerman et al., 2011). This is despite the scant evidence base establishing trauma-informed intervention effectiveness for survivors of sex trafficking. Indeed, trauma-informed guidelines imported from work with refugee populations, sexual assault and IPV survivors have been found inadequate to support recovery work with sex trafficking survivors, based on longer recovery times, severity of trauma, complex needs and uncoordinated services (Clawson et al., 2003; Shigekane, 2007), and cross-cultural diversity (Menon et al., 2021).

There are frequent calls to develop the evidence base examining trauma-informed intervention effectiveness with trafficking survivors (Dell et al., 2019; Katona et al., 2015; Levine, 2017). Some outcomes studies exist (i.e., Robjant et al, 2017 examined narrative exposure therapy; and Hopper et al., 2018 examined a body-based and arts-based group intervention), but comparison is difficult across different study designs. Calls remain to identify key components of quality aftercare recovery programs, document recovery practices, and determine their impact on survivors (Muraya & Fry, 2016).

Despite importing approaches from the refugee mental health field to support sex trafficking survivor recovery, and recommendations that work with survivors of sex trafficking be culturally-appropriate (USDOS, 2020), the robust critiques of the trauma-informed framework for use cross-culturally (Lykes, 2002) have not been widely applied to the trafficking mental health recovery field. Critical theories suggest that, despite important contributions, the trauma-informed framework alone may be inadequate to address trafficking impacts for diverse populations because it focuses intervention on the individual who has been trafficked, as opposed

to broader structural inequalities. This decontextualized approach risks essentializing survivors into individual, biomedical victims of traumatic adversity, and de-emphasizes the structural and population-level inequalities that contribute to vulnerability (i.e., discrimination and poverty) as well as structural and collective possibilities for recovery (Gozdziak, 2004; Lykes, 2002; Summerfield, 2000; Zarowsky, 2004).

Notwithstanding these important critiques, key scholarship with African American women (Carter, 2003) and Indigenous women who have been sex trafficked (Farley, 2011; Pierce, 2009) offers a framework for integrating individually-focused trauma-informed care with a population-based, culturally-specific, historical frame in treatment. Named emancipatory and decolonizing healing approaches, these innovations aim to sharpen and broaden the intervention context to include emancipatory consciousness-raising about the historical trauma and structural harms suffered by an entire population. These approaches suggest that effective treatment includes family and/or community support developed by the community; traditional or spiritual healing practices; and/or positive or strengths-based group identity work, in addition to individual therapy (Farley et al., 2011). Surprisingly, however, these studies were absent from all systematic reviews cited in this literature review, including Vollinger’s (2021) study on intersectional research. Important theoretical insights may be obscured as the mental health recovery field advances forward towards greater trauma-sensitivity and social ecological contextualization of trafficking survivors.

Recent scholarship has also promoted collective avenues for healing and action (Farley et al., 2011; Vollinger, 2021). Vollinger (2021) recommended integration of intersectionality theory in praxis and scholarship so recovery work may be culturally-sensitive and promote social justice action to reduce trafficking and other vulnerability for marginalized groups (Vollinger, 2021).

Since clinical work with survivors of sex trafficking is, according to the available data, largely cross-cultural work, these critical advances in bringing an intersectionality lens into recovery work may serve the trafficking recovery field. Recent scholars have also critiqued the exclusionary focus on PTSD for survivors of trafficking cross-culturally, and suggested researchers examine non-clinical outcomes to assess mental health intervention effectiveness (Wright et al., 2021).

The perspective offered by the social ecological approach has helped to address some critiques. Social ecological frameworks have helpfully offered opportunities to contextualize individuals within broader social structures, thus widening the intervention context (Hopper, 2017; Salami et al., 2021) and honing tools for complex trauma recovery specifically (Hopper, 2017). Despite the analytical promise of using social ecological theory to guide recovery work with survivors of trafficking, however, some scholars advise caution. With race and culture, history and time conceptualized in distal system levels, it theoretically distances core concepts of identity (Rogoff, 2003), and potential levers of action for making social change away from individuals. Individuals located in the center of cosmology distances survivors from population-based/community identity, which can be a resource in coping and healing (Lykes, 2002). It also conceptually distances survivors from communal strength as the locus of action for social change/community organizing. It fixes the intervention target on (pathologizing) individuals, instead of systems, making it less likely to work towards overcoming structural inequality (Finigan-Carr et al., 2018). Indeed, addressing structural inequalities (i.e. poverty and discrimination) remains difficult for the model (Finigan-Carr et al., 2018).

Each theoretical framework offers important analytic and practical tools, yet may be inadequate alone to contend with the complexity of recovery work with diverse survivors of sex

trafficking. This study aimed to consider three bodies of theoretical literature in an integrated fashion to explore the perspectives of therapists accompanying survivors through recovery work within multidisciplinary and multisystemic contexts in the United States. Given the abundant gaps in the literature, this study took a broad, exploratory lens to gather rich qualitative data related to the work that mental health providers do.

This study took up varied calls in the literature. Together, scholars have named urgent and gaping holes in the scholarship in myriad areas. These include mental health recovery and service delivery (Powell et al., 2018), and trauma-informed intervention outcomes (Wright et al., 2021). Culturally-appropriate services, including provider experience with sub-population groups, are critical and under-examined (Gozdziak & Collett, 2005; Pierce, 2009; Farley, 2011), as are emancipatory perspectives (Gorski, 2015) and applications of intersectionality theory (Vollinger, 2021). Clinicians’ perspectives on care provision are under-studied (Domoney et al., 2015; Family Violence Prevention Fund, 2005), as is multidisciplinary collaboration (Muraya & Fry, 2016) in multisystemic contexts (Martinho et al., 2020; Powell et al., 2018). Finally, peer mentors’ impact and their work in partnership with mental health clinicians is in need of examination (Contreras & Kallivayalil, 2019; Rothman et al., 2020). More research is needed to understand this important work.

This study aimed to better understand the recovery environment and the varied mental health providers who work within it to accompany survivors of sex trafficking. It aimed to address research gaps by exploring the perceptions of mental health providers who work in sex trafficking recovery, to explore if “culturally-sensitive, victim-centered, and trauma-informed care intervention” (Martinho et al., 2020, p. 14) is being employed, and if so, how. The study examined and documented the extent to which mental health providers’ work is trauma-informed

and attentive to systemic and structural forces. Indeed Muraya and Fry (2016) called for improved documentation of service providers’ practices and Domoney et al. (2015) suggested the need for mental health providers to consider emotional and structural considerations in inter-related fashion.

This study also followed Contreras and Kallivayalil’s (2019) call, which underscored the critical importance of examining multidisciplinary partnerships between mental health clinicians and peer mentors. This study explored both therapists’ and peer mentors’ perspectives on their multidisciplinary collaborations and multisystemic work, as well as the dynamics of the peer mentor – mental health professional collaborative partnership. Related, this study undertook Katona et al.’s (2015) call to examine whether interventions can be carried out successfully by non-clinicians – that is, peer mentors who do mental health work and may or may not hold advanced clinical degrees. Katona et al. (2015) also suggested studies examine intervention effectiveness in varied regions and contexts. While this study did not quantitatively measure intervention effectiveness, it explored mental health providers’ understandings of approaches and processes that support and impede recovery.

Finally, this study took up Vollinger’s (2021) call to integrate an intersectionality lens into research. It explored providers’ perspectives on and understandings of intersectionality and emancipatory approaches to mental health recovery work. This study also explored an integrated theoretical framework, attentive to individual and population-based emancipatory aims, such as recommended by Pierce et al. (2009) and Farley et al. (2011).

The three theoretical frameworks discussed led to this study exploring the clinical work mental health providers are doing through multidisciplinary and multisystemic recovery contexts with survivors of sex trafficking, and ways in which they contend with their clients as embedded

in systems and structures. Mental health providers’ perspectives have been found to be valuable in improving recovery efforts with survivors of trafficking and sexual violence (Domoney et al., 2015; Gruenfeld et al., 2017). Trafficking survivors’ voices are also considered essential in formulating recovery response (Wright et al., 2020). However, there is no known research exploring the perspectives of mental health clinicians and peer mentors on the recovery work they do with diverse survivors of sex trafficking, individually and in partnership, within multidisciplinary and multisystemic recovery contexts. This study was an opportunity to contribute to filling the knowledge gap. The next chapter describes the methods used to undertake and carry out this study.

Research Question

The present study’s aim is to explore the treatment frameworks and processes that mental health providers who work with diverse domestic and international survivors within the United States use, their perceptions of effectiveness, and their views on intersectional and emancipatory approaches in the context of working within multisystemic and multidisciplinary recovery environments. Specifically, the study explored the following research question:

> What are the perspectives of mental health providers who work with survivors of sex trafficking in the United States, through multisystemic and multidisciplinary recovery work, related to treatment approach, the processes they find to be effective, and their views on emancipatory approaches?

The following sub-questions guided this study:

- *Who is working in recovery/clinical treatment of sex trafficking survivors in the United States? What is their demographic profile, and varied roles?*
- *What treatment frameworks, approaches, and/or processes do providers engage in, and why? Which processes do they find to be effective?*

- *How do mental health providers work within multisystemic and multidisciplinary contexts of recovery?*
- *How do they negotiate clients' psychological and structural needs in treatment? Which intervention components do they think are most supportive, and why?*
- *What culturally sensitive adaptations do they make, if any, given survivors' diversity?*
- *How do practitioners conceptualize client progress towards "healing"/recovery?*
- *How do practitioners understand emancipatory, decolonizing healing models and to what degree do they employ them? If and how are systemic or emancipatory frameworks employed?*
- *To what degree do providers integrate complex trauma-informed approaches and an emancipatory lens in recovery work that is embedded within multiple system levels, and if so, how?*

The next chapter describes the methods used to undertake and carry out this study.

Chapter III. Methods

This study collected, transcribed and analyzed original one-time interview data to explore the perspectives of mental health providers who work with survivors of sex trafficking through multisystemic and multidisciplinary recovery work, related to their treatment approach, the processes they find to be effective, and their views on emancipatory approaches. This chapter details how the study was designed to address the research question, highlighting researcher positionality, the sample and sampling procedures, data collection, data analysis and data verification.

Study Design

The study employed a qualitative conventional content analysis design, which is appropriate when a research domain lacks an extensive body of literature or substantial theory development to guide practice (Hsieh & Shannon, 2005). Qualitative conventional content analysis aims to describe a phenomenon and gain unique knowledge from participants, without imposing preconceived theoretical constructs (Hsieh & Shannon, 2005). Creswell (2015) describes qualitative research as most suitable for research questions where the literature yields insufficient information on the central phenomenon under study and the variables are not clear, making it necessary to explore participants’ perspectives to obtain a “deep understanding” (p. 20) of the problem. A qualitative content analysis approach differs from grounded theory and phenomenology, which go further in theory development and description of lived experiences. Content analysis, by comparison, aims for model building or concept development (Hsieh & Shannon, 2005) where a researcher might compare her findings to existing theory and aim to reach conclusions about inclusion of previously unknown categories.

The study design was specifically chosen as appropriate for exploring recovery work with trafficking survivors, since the clinical trafficking research has been characterized as limited, with insufficient evidence base and theoretical foundation (Gozdziak & Bump, 2008; Gozdziak & Collett, 2005; Reid, 2012;).

Creswell (2007) notes that qualitative design is useful when a detailed understanding of an issue is needed. Other research designs were considered for this study including mixed methods approaches and other types of qualitative design. Given the limited amount of data available on recovery work with survivors, however, and the under-developed theoretical foundation guiding the work, an exploratory design was deemed most appropriate. Thus, this study engaged a qualitative conventional content analysis design to explore mental health providers’ perspectives on their work with sex trafficking survivors in the United States.

The study design was informed by social constructivist and emancipatory epistemologies. Creswell (2009) describes a social constructivist worldview as one that aims to explore complexity of viewpoints, and uses open-ended questions so that participants can construct meaning themselves as well as through interaction with the researcher. Researchers recognize that meaning making is negotiated socially and historically, and that their positionality shapes their interpretation. It is an inductive approach, where patterns of meaning are generated from the data directly, rather than starting with theory (Creswell, 2009; Lincoln & Guba, 1985).

Emancipatory epistemologies aim to advance social constructivism with an action agenda focused on promoting the self- and critical awareness of researcher and participant, alliance building, and dismantling oppression (Adelman, 1993; Creswell, 2009; Freire, 1972; McIntyre, 2006). While this is not an action research design, the researcher has trained in these approaches, and the study was informed by these literatures. The study considered the critiques of and

possibilities for individual and population-level healing from sex trafficking victimization by exploring clinicians’ perspectives on treatment and recovery. As is typical in qualitative research, it engaged self-reflexivity (Creswell, 2015), while also aiming for the action research goals of sensitivity to “locations of power” (Cornwall & Jewkes, 1995, p. 1668) and engaging participants as colleagues (Adelman, 1993) with important perspectives to share. As a white clinician-researcher seeking rich information from professionals working with marginalized communities, who may also be of the communities served, I aimed to hold self-reflexivity and awareness of privilege and power central in my study design.

Researcher Positionality

According to Creswell (2007), qualitative research relies on a researcher’s use of the self, for rapport building with participants, and to engage self-reflexivity around how one’s personal biography impacts study design, analysis, and interpretation. The positionality of the self, however, is multifold. Suárez et al. (2008) describe positionality in terms of intersectionality, or one’s “location along the various axes of social group identities, which are interrelated” (p. 409). They note that these “intersections of identities may be external and visible, or internal and invisible” (Suárez et al., 2008, p. 409) and that some carry “intrinsic privileges of which we may be unaware while others may simultaneously limit our choices in life” (p. 409). According to the norms of qualitative research, I now leave the conventions of positivist social work scholarship and engage the use of “I,” in order to reflect on how my multiple identities impacted the construction of knowledge in visible and invisible ways.

I am a white, middle-class woman who has studied at multiple elite institutions of higher education; as such I embody epistemological privilege. I am a daughter of immigrants to the United States, who left their European countries of origin almost never to return. One fled gender

discrimination and family discord; the other is a child refugee from the Holocaust who grew up transiting through refugee camps, and shifting from war to war. I persist in the intergenerational healing work imparted by war and migration strain, as I carry the intergenerational privilege of U.S. citizenship and the legacy of survivorship. Likely as a result, I have worked extensively in communities impacted by violence and migration (in North America, Latin America, the Middle East and North Africa), and have been fortunate to study modalities of individual and community healing with western educators, international colleagues, and Indigenous teachers. These modalities include: the arts, trauma therapy, yoga, community-building, and Indigenous spiritualities.

I am trained as an intercultural arts educator and clinical social worker, and have worked since 2012 with international survivors of sex and labor trafficking. My clinical training in complex trauma took place primarily at The Trauma Center, at Justice Resource Institute (JRI), directed by Dr. Bessel van der Kolk, and with Project REACH directed by Dr. Elizabeth Hopper and supervised by Dr. Paola Michelle Contreras. There, I studied body-based approaches to healing complex trauma while simultaneously studying under critical scholars and a medical anthropologist who questioned using the trauma frame universally across cultures. One such scholar-activist and mentor is community psychologist and doctoral committee member, Dr. M. Brinton Lykes. Simultaneous study with a premier trauma-training institute and prominent critical scholars gave rise to formidable questions and conflicts that directly birthed this study.

Finally, I am mother to a three-year-old daughter. My motherhood is implicated in this study: in its choice of topic, in its design, and in its execution. While discussing the impact of motherhood on academic work, Pillay (2007) describes a division that academic mothers commonly experience between their intellectual/work and emotional selves. She suggests that

instead, “motherhood must be implicated in epistemology; it must be inscribed in our scholarship. Thinking is about the wholeness of the self, not the splitting and divisions of self” (p. 158). I began the early research for this dissertation before my motherhood journey. I delayed it during the travails and joys of conception, pregnancy and birthing. I continued it - though sporadically - during the emotional heights and rigors of early motherhood. Finally, I re-engaged it as the COVID-19 pandemic struck, with a new array of challenges and opportunities afoot, including my then twenty-two-month-old at home with me, with limited access to childcare support. This study was undertaken under the particular demands associated with juggling academic work and motherhood responsibilities with a thinned-out safety net during a pandemic.

As Creswell (2015) suggests, my professional and cultural background, and my social location as a therapist-mother in a pandemic may have impacted participant interviews, sometimes increasing a sense of informality, comfort and humor, as my and participants’ dogs barked and children beckoned. It may have impacted interpretations of and conclusions about the data, and tightened timeline constraints.

In terms of professional background, I identified myself in recruitment materials and pre-screening email conversations as a trauma-trained clinical social worker who works with survivors of sex trafficking in the Boston area. I also identified the study as one interested in decolonizing and emancipatory approaches to healing. Both of these designations may have lent themselves to particular recruitment patterns and participant responses. Likewise, my responses to participant comments during each interview contributed to further elicitation of particular conversations. As suggested by Creswell (2009), these interactions served for negotiating and co-constructing meaning based on the meeting of positionalities. Indeed, it is in this meeting of positionalities that the research is grounded, and through which data collection and interpretation

were co-constructed. The impact of researcher positionality, my visible social identities and the invisible lenses through which I interpreted participant responses, cannot be extricated from the study findings.

I care deeply about intergenerational patterns of trauma and healing, including how hope and wellbeing can be passed down to our children. I care deeply about honoring people’s strengths and creativity, as adversity has been a formidable and ongoing challenge throughout time, and has impacted and continues to impact particular groups differentially, more frequently and more severely. This study emerged out of a commitment to better understand and attempt to impart something useful to the field of survivor recovery, which aims to support those who have survived the horrors of exploitation, and those who accompany them. May all flourish.

Sample and Sampling Strategy

The study sought to interview mental health providers who work clinically in the treatment and recovery of international and/or domestic sex trafficking survivors who are in the United States at the time of treatment. Sampling parameters were honed via informal conversations, and referrals were pursued from April 2020-July 2020. Refined sampling parameters were implemented and formal recruitment took place for this present study from August 2020-December 2020.

Participating providers had at least one year of experience working with trafficking survivors. Mental health provider was defined broadly, to allow for an expansive sampling frame that was open to the variety of therapists providing treatment and recovery services, with potentially diverse training orientations and approaches. Criteria welcomed inclusion of community and/or traditional healers and peer mentors. This is congruent with NAMI's (2020) inclusive listing of types of mental health professionals that includes peer specialists. Parameters

were designed to be intentionally broad, so that the sample might be comprised of diverse mental health providers who specialize in recovery work with survivors of sex trafficking, and who have diversities of backgrounds related to training and clinical approach, workplace affiliations, professional role, as well as regional affiliation, and who work with diversities of clients by age, region, race/ethnicity, domestic and/or international sex trafficking exploitation experiences.

The study originally aimed to interview ten to fifteen mental health providers who serve sex trafficking survivors in the United States. The final sample consisted of thirteen participants. A fourteenth participant was interviewed, when the study was briefly opened to mental health providers throughout North America, in an attempt to access perspectives of providers who work with Indigenous communities in the United States or Canada. It was ultimately decided, however, to exclude this participants’ data based on exceeding the designated period for data collection without additional like-representation. Data saturation was reached, even in this small sample, as indicated by rich and insightful perspectives on the main research questions. Saturation for most categories and codes was reached after approximately n=9 interviews, but data collection continued until n=13 to assure inclusion of diverse perspectives in robust amounts.

Some researchers have justified small sample sizes when participants had expertise in the topic (Jette et al., 2003), and others have suggested that saturation is reached long before researchers have traditionally thought (Guest et al., 2006). While methodological guidelines for reaching saturation have often been vague (Guest et al., 2006), some scholars have made specific recommendations. Kuzel (1992) recommended six to eight interviews for homogenous samples, and 12 to 20 for heterogeneous samples. Guest et al. (2006) similarly found that six to 12 interviews sufficed for exploring homogenous samples, while more than 12 interviews may be

required for heterogenous samples. Moser and Korstjens (2018) suggested an estimated 15 to 20 interviews when undertaking content analysis. For this study, the sample’s hetero- or homogeneity (i.e.. demographics, treatment orientation, etc.) was unknown prior to recruitment, however all shared specialization in recovery work with survivors of sex trafficking. As such, the final sample size of thirteen participants fits adequately within these recommendations.

Purposive sampling techniques (Barbour, 2001; Creswell, 2015; Moser & Korstjens, 2018) were employed, where a researcher intentionally chooses participants who can provide rich information (Patton, 2002) to increase understanding about the central phenomenon. This study employed both purposive and snowball sampling techniques since Creswell (2015) notes that several sampling strategies may be used within the same study, either employed before data collection starts or, as is true with emergent design, after the data collection phase has begun. Purposive sampling refers to participant selection based on a researcher’s judgment about who may be most informative, and snowball sampling occurs via referrals by participants and/or gatekeepers with access to participants (Moser & Korstjens, 2018). Moser and Korstjens (2018) note that content analysis often relies on purposive, snowball and convenience sampling.

Researchers have highlighted purposeful sampling strategies that may be used to emphasize similarity as well as variation (Palinkas et al., 2015) since, as Barbour (2001) describes, qualitative research strives to reflect the diversity of a population under study. For example, Palinkas et al. (2015) describe snowball sampling as a purposeful sampling strategy that identifies participants with similar characteristics, who may know others with similar characteristics, and thus reduces variation. Barbour (2001), by contrast, describes purposive sampling as useful for promoting the inclusion of “deviant cases” (p. 1116) typically discounted as outliers in quantitative methods, but helpful for the qualitative research aims of exploring

depth and diversity of experience related to the central phenomenon. Emergent sampling is designed to achieve the goal of identifying both common patterns and unique manifestations across cases (Palinkas et al., 2015). Vollinger also (2021) encourages the exploration of similarities and differences amongst survivors of sex trafficking in intersectional research. In this study, efforts were made to reach mental health providers from diverse regions of the United States, who work with diversities of survivors by age, race/ethnicity and nationality, and who differ by training and role.

Recruitment of participants was through varied techniques including a) organizations and health centers providing mental health care to sex trafficking survivors, b) professional anti-trafficking networks and trafficking healthcare coalitions, c) searches for authors of professional literature on human trafficking clinical care, d) searches of websites of survivor leaders, and e) snowball sampling. The organizations, health centers, and coalitions were selected based on having existing relationships with gatekeepers, and based on them serving sizeable client populations of sex trafficking survivors of varied demographic profiles, including international and domestic survivors. Participants were selected based on gatekeepers providing access to recovery work professionals, and participants’ agreement to be interviewed. Participation in this study was voluntary and could be withdrawn at any time.

Initial contact was made via email or telephone, if following up on a referral. If participants contacted me, based on the published study advertisement, it was always by email and I responded by email. I offered the opportunity to speak in advance about the study, but these conversations always occurred via email. Conversations revolved around confirming inclusion criteria, answering questions related to the interview protocol or study, and scheduling. Four participants were recruited via professional contacts/snowball sampling, and nine were

recruited via contact through a professional listserve focused on trafficking recovery, or through snowball sampling resulting from colleagues on that listserve. A roughly twelve-person waitlist was maintained, but not used ultimately due to reaching saturation, and exceeding the study time horizon for interviews.

With an interest in exploring mental health providers’ perceptions on treatment approach and effectiveness of processes, the study employed purposive sampling to identify “the patterns, categories and variety of the phenomenon under study” (Moser & Korstjens, 2018, p. 11), and snowball sampling to reach saturation. I aimed for “information-rich” (Sandelowski, 2000, p. 338) cases to fully explore the study phenomena. I employed a flexible, emergent, and broadly defined sampling plan, as recommended by Moser and Korstjens (2018), to gather a richness of clinical perspectives by remaining open to a variety of settings and participants. Because Moser and Korstjens (2018) note that sampling plans should be broadly defined and emergent, with inclusion/exclusion criteria altering during data collection or analysis based on questions raised, the study began with broad inclusion criteria.

The study aimed for mental health providers who work with adult female or female-identified (transwomen) sex trafficking survivors. Simultaneously working clinically with individuals who varied from the stated inclusion criteria (i.e., children who were sex trafficked, adult survivors who were children at the time of exploitation, male or transmale trafficking survivors, labor trafficking survivors, asylum applicants, or refugees) was not grounds for exclusion from the study, as long as the participant also did a meaningful amount of clinical work with adult female sex trafficking survivors in the United States. However, employing the flexible, emergent sampling plan recommended by Moser and Korstjens (2018), I found during interviews that the expected differentiation between clinical work with youth versus adults was

not a practical parameter. Many participants described working on grants that served survivors of sex trafficking aged 10-24, for example, or serving clients who range in age from 14 years old to their 50s. As such, the study ultimately made no distinction in data analysis for youth versus adult recovery work.

Providers included licensed professional psychologists (1), licensed and unlicensed social workers (5) and counselors (5), and peer/survivor mentors (2). Some participants had multiple degrees and affiliations: one also had a PhD in social work, one a PhD in counselor education, two had additional Masters degrees, one had some college education, and one licensed social worker also identified as a survivor of sex trafficking. Participant averaged nine years of clinical experience specifically working with survivors of sex trafficking; most (seven) had nine or more years. Participant demographics are further detailed in Chapter 4.

Data Collection Procedures

This study received human subjects approval from the Institutional Review Board (IRB) at Boston College on August 14th, 2020. Several amendments were submitted and approved by the IRB to extend the recruitment/interview timeline, to increase the sample size, and to widen the inclusion criteria to include any therapist in North America who met inclusion criteria. All interviews were conducted between September and December 2020. During summer of 2020, potential participants initially received an email with a recruitment letter (Appendix A), consent letter (Appendix B) which included information about study aims, means of protecting confidentiality, interview details, and contact information. If the clinician was interested to proceed, interviews were scheduled and conducted via Zoom technology, due to issues of geographic distance and COVID-19 social distancing restrictions. Interviews lasted approximately 90 minutes each, with one interview lasting two hours. Additionally one interview

was rescheduled, so that the interview initially lasted 75 minutes, with a follow-up brief conversation lasting 15 minutes. Consent was provided verbally to audio-record all interviews, except for one. For that interview, consent was provided in writing to participate but not to be audio-recorded; with this participant, the researcher took detailed notes during and after the interview to assure credibility of the data. All recordings were transcribed verbatim by a professional transcriptionist and de-identified to protect confidentiality. The researcher conducted all interviews.

A semi-structured interview protocol (see Appendix C) guided interviews, consisting of questions that were exploratory in nature and loosely informed by the developing clinical trafficking research, as appropriate for conventional content analysis. Recommended by Jacob and Furgerson (2012), the interview protocol was first piloted with a “close population” (p. 5); i.e., a mental health therapist who treats diverse immigrant (and other) survivors of complex trauma. The questions and constructs were found to adequately speak to the study aims, and yielded rich and meaningful information. However, it was decided that the scenarios that were included in the interview protocol caused the interview to last two hours. To address this concern, for all but one interview, the scenarios were not used.

Semi-structured interviewing is a nondirective approach that includes guiding questions, but allows interview questions to “change and emerge during data collection” (Creswell, 2015, p. 17), as Creswell notes is often the case in qualitative research. Moser and Korstjens (2018) describe qualitative data collection as “unstructured and flexible” (p. 12), where data collection decisions are made and modified while engaging in the interview process. Interviews took an open-ended approach, which Creswell (2015) describes as the asking of general questions where study participants participate in shaping response possibilities. The researcher brought into the

interviews a “feeling of openness” (Creswell, 2015, p. 18) to participant responses, asking open-ended follow-up questions to elicit further elaboration and clarification where possible. The researcher also engaged a sense of warmth, collegiality, respect, and empathy when challenging situations were discussed. Participants were encouraged to elaborate on responses in ways that were relevant to them, thus mutually shaping the interaction (Holstein & Gubrium, 1995).

Semi-structured interviews addressed topics related to recovery work with survivors of sex trafficking including, professional background and training, years of clinical experience generally and with survivors of trafficking specifically, treatment approach, perspectives on effectiveness of treatment frameworks, goals and challenges in the work, contending with cross-cultural variation, and perspectives on emancipatory treatment approaches. The aim of the original research project included examining if and how clinicians adapt to cultural variation in treatment. Throughout analysis, however, it emerged that much of the data related to clinical work in multisystemic and multidisciplinary environments. As such, the current study focused only on data that referenced multisystemic environments ultimately. As a result, data trauma-informed treatment approaches and cross-cultural adaptations, for example, that did not also reference multisystemic work were excluded from final analysis.

The interview transcriptions formed the primary database for this study, as well as researcher notes, field notebook, and memoing. These recorded initial field notes, post-interview reflections, and insights and questions during data analysis. All electronic information was de-identified and secured using password-protected files on the BC server. I assigned each participant a unique, coded identifier that was used in place of actual identifiers. I separately maintained a record that linked each participant’s coded identifier to her actual name, but this separate record did not include research data. All digital information was maintained on a

password-protected computer. Printed materials were kept in a locked file. Audio files will be erased from the password-protected device one year after the close of the study. The researcher met with dissertation committee members throughout data collection to confer about decisions and to ensure high quality data collection and research.

The study aimed to maintain “sensitivity to the challenges and ethical issues” (Creswell, 2015, p. 204) involved in gathering study participants and data. The study aimed to interview clinicians; as such, concerns that would be paramount if interviewing survivors, such as potentially triggering traumatic memories or coercive experiences, were diminished. However, ultimately three participants identified as survivors of sex trafficking. This researcher aimed to follow participants’ leads; I modified the interview protocol or time allotments when requested by participants, took breaks as requested or stopping interviews entirely. The research aimed to maintain a reflexive stance related to my power and privilege as white United States citizen, higher-education trained and in the role of researcher/interviewer. I engaged reflexivity principles suggested by Action Research (Adelman, 1993) to manage complexities as they arose.

Data Analysis

The study employed qualitative conventional content analysis to explore the perceptions of mental health therapists who specialize in the treatment of sex trafficking survivors. Hsieh & Shannon (2005) call qualitative conventional content analysis a “flexible, pragmatic method for developing and extending knowledge” (p. 1286) about study subjects’ experiences and worldviews. Fourteen interviews were conducted, yielding over 21 hours of interview data, transcribed onto more than 700 double-spaced typed pages. After excluding one interview, the researcher embarked on analyzing thirteen interviews, totaling 1,181 minutes of interview material - approximately 20 hours - equaling 650 double-spaced typed pages of transcript data.

Sampling, data collection and analysis occurred simultaneously, iteratively, and informed each other, as is common in qualitative research (Moser & Korstjens, 2018). I moved back and forth amongst the stages, where concurrent informal data analysis informed subsequent sampling choices. Iterative approaches and emerging design are described as at the “heart of qualitative research” and necessary to “to accumulate rich data and interesting findings” (Moser & Korstjens, 2018, p. 15). Data analysis occurred over a six-month period and followed a qualitative conventional content analysis approach (Hsieh & Shannon, 2005). This approach was chosen for its utility when a research domain lacks an extensive body of literature or substantial theory development (Hsieh & Shannon, 2005). Throughout the process, descriptive codes (Miles & Huberman, 1994) were developed that represented the main ideas pertinent to the research question, “What are the perspectives on mental health providers who work with survivors of sex trafficking on multisystemic and multidisciplinary recovery on treatment approach, effectiveness, and emancipatory goals in treatment?”

The analysis included several inductive phases. The first phase involved multiple readings and initial coding of four transcripts, allowing researchers to develop an overall sense of participants’ perspectives. After conferring with dissertation committee members, three out of four of these transcripts were re-coded to arrive at a greater level of line-by-line specificity. Coding was kept close to participants’ own words, and remained low on abstraction (Hsieh & Shannon, 2005). Descriptive codes (Miles & Huberman, 1994) were developed that represented the main ideas pertinent to the research question. Coding decisions were based on direct mention of key concepts as well as by the context surrounding the data segment.

In this beginning phase, this researcher reviewed transcripts line-by-line (Miles & Huberman, 1994; Morgan, 1993) and met periodically with dissertation committee members

and/or a research peer to read and analyze select sections of transcriptions, compare ideas and emergent codes and reach consensus, thereby enhancing validity. A volunteer research assistant on the project, who was an MSW student (now an MSW graduate) with expertise in sex trafficking recovery work in multidisciplinary environments, independently coded two transcripts to enhance validity. Examples of early codes were tracked in the audit trail document. Examples of early codes included trauma-sensitive techniques, multidisciplinary/multisystem work, peer mentors are critical to recovery, cultural-sensitivity, community & emancipatory strategies, and challenges in recovery work. Summary documents were created for each transcript with initial codes. There were approximately 425 codes at this point in 6 categories. Based on the project timeline and heavy quantity of data, it was determined at this point to home in on data related to multidisciplinary and multisystemic work only. The coding system was refined to attend only to data pertinent to those analyses. At this point, summary documents were re-created for the new analysis focus.

In the middle phase, the researcher coded the remaining transcripts, as related to recovery work within multidisciplinary and multisystemic contexts. The code list was continuously revised as new codes emerged, existing codes were consolidated, and definitions were refined. As an ongoing validity check, I met intermittently with one dissertation committee member to confer about select analytic decisions, and with the study’s volunteer research assistant, to develop a preliminary codebook. I also closely considered old and new data according to the refined focus. By the end of this phase, approximately 47 codes were identified, defined, and organized into four categories (Saldaña, 2016).

In the final phase, I re-applied the set of defined codes to all of the data, confirmed fit, and considered the interrelation of themes. The study’s research assistant supported the lengthy

validation process by meeting several long days in a row to read through approximately 75% of the data together and reach consensus on coding decisions, thus promoting reliability. Ultimately, fifteen codes and four categories were identified and defined.

Throughout content analysis, I contended with defining and delimiting multisystemic and/or multidisciplinary work in participant responses. There was collaborative and continuous wrestling with determining what constituted multisystemic recovery work, what counted as a system in recovery, and what fell outside those bounds. I ultimately defined multisystemic recovery work broadly, in line with ecological approaches and critical theories. Multisystemic recovery work was coded based on direct mention of the term and context surrounding the data segment.

Data Verification

Several procedures were used to ensure the credibility and dependability of analysis. Procedures for ensuring reliability are key to qualitative research design (Creswell, 2009; Lincoln & Guba, 2000). In order to ensure quality and rigor in data analysis, the following procedures suggested by Gibbs (2007) and Creswell (2009) were employed: Immersion through memoing and multiple readings of each transcript, checking transcripts for accuracy, in vivo coding, and ensuring that analytic categories remained grounded in the data. To this end, a detailed codebook was maintained, reflexivity was employed, and a detailed audit trail kept. I consistently confirmed that the definitions of codes were consistent and compared the codes with the data.

Other reliability procedures were maintained, including:

Field Notebook: Researcher maintained a field notebook that documented the data collection process, ranging from gaining entry into the field, interviews, and post-interview

participant communications. The field notebook served as a record to contextualize interview data, supplement the audit trail, and triangulate multiple data sources, thus also ensuring credibility. No direct quotations from preliminary conversations with potential interview participants were used towards analysis until IRB approval was obtained.

Strength of categories: A strategy employed by Hill and colleagues' (2005) to characterize the frequency of occurrence of each category was used to assess reliability in qualitative data. In the final stage of analysis, the study determined the strength of each analytic category found in analysis by using four levels (i.e., general, typical, variant, rare) based on the number of respondents' comments attributed to each category. Hill et al. (2005) recommended these frequency labels "because they allow for comparison across studies and provide a common metric for communicating results" (p. 201). This strategy has been used in qualitative research on gender-based violence (i.e., Gruenfeld et al., 2017; Sorsoli et al., 2008). In this current study, all categories were of general or typical strength (see Table 3).

Researcher experience with methodology: The study's design and analysis plans were similar to a prior study collaboratively undertaken with Boston College mentors Drs. Danny Willis (formerly BC School of Nursing) and Scott Easton (BC School of Social Work) (i.e., Gruenfeld et al., 2016). Creswell (2009) suggests that a consistent approach across projects improves reliability. Having been mentored in qualitative conventional content analysis increased the likelihood for quality and rigor in this project.

Quality of the Data

Procedures for ensuring accuracy and credibility of the findings (i.e., validity, trustworthiness or dependability) are key to qualitative research design (Creswell, 2009; Lincoln

& Guba, 2000). In order to ensure credibility, the following validity strategies suggested by Creswell (2009) were employed:

Reflexivity and researcher positionality: the transparency and honesty of the researcher about how her positionality shaped her interpretation are considered essential in qualitative research, and increased credibility (Creswell, 2015). These included describing how researcher experiences, training, and intersectional identities may have impacted participant interviews, interpretations of the data, and study conclusions.

Peer debriefing: a peer researcher, who could review and ask questions about the study, helped ensure the project would speak to someone other than the researcher, and increased validity (Creswell, 2009). A volunteer research assistant played this important role. A dissertation committee member was also consulted to confer about coding, analysis and findings to increase validity.

External Auditor/Audit Trail: A record detailing sampling decisions and decisions made throughout analysis was maintained for dissertation committee members to review as external auditors, to verify trustworthiness. Procedures for external auditors to cross-check the accuracy of transcriptions, the relationship between research questions and data, and the rigor of analysis enhanced validity (Creswell, 2009).

Presentation of Findings: Like Sorsoli et al. (2008), when presenting findings, I have aimed to offer sufficient data for readers and reviewers to consider for themselves the credibility of my interpretations.

Finally, while not rising to the level of member checking, researcher aimed to promote credibility (Lincoln & Guba, 1985; Creswell, 2009) by confirming the accuracy of small components of the analysis with participants. Although there was insufficient time for member

involvement in analysis of themes, all participants were approached for their perspectives on the accuracy of demographic data analysis pertaining to themselves and their clients, the adequacy of de-identification and participant description measures taken in demographic tables and the manuscript text, and for input on participants’ preferred titles and role descriptors. Considerable effort was made to refer to participants according to their own words and definitions.

Participants were also consulted for their preference of pseudonym and gender-designator. Allen & Wiles (2016) suggest that renaming has psychological and sociocultural significance for participants, that renaming implicates issues of voice and power, and that it holds importance to the process and output of research. As such, Allen & Wiles (2016) suggest engaging with participants regarding the choice of pseudonym. All participants in this study were given the option to choose their own pseudonym. Nine participants opted to be identified by a researcher-chosen pseudonym, and each approved the pseudonym chosen by the researcher. Two participants opted to choose their own pseudonym. Two did not respond to requests for input into choice of pseudonym. In total, 11 participants are identified by a researcher-chosen pseudonym, and two are identified by self-chosen pseudonyms.

This chapter detailed the methods that led the study’s design, implementation, and analytic process. The next chapter details the study findings.

Chapter IV. Findings

Sample Description

Almost all participants in this study identified as women (one identified as gender non-conforming but uses she/her pronouns). See Table 7, Demographic Information of Study Participants, located after References. The sample included a licensed professional psychologist (1), licensed and unlicensed social workers (5), counselors (5), and survivor mentors/leaders (2). Some participants had multiple degrees and affiliations: one also had a PhD in social work, one a PhD in counselor education, two had additional Masters degrees beyond their clinical graduate credential, and one had some college education, and one licensed social worker also identified as a survivor of sex trafficking. Eleven participants identified as therapists, two as survivor mentors (one of those preferred the term survivor leader). Because one therapist also identified as a survivor of sex trafficking, there were a total of three participants in this study who self-identified as survivors of sex trafficking. Nine participants identified as white, one Latinx, one southeast Asian, and two bicultural (European & Native American/Cherokee Indian; white & Asian). Approximately eleven were born in the United States, while two identified as immigrants. All told, four participants grew up overseas, since two of the U.S.-born participants also grew up abroad. Several spent significant time working clinically outside of the United States with trafficking survivors and refugees.

Participant averaged nine years of clinical experience specifically working with survivors of sex trafficking; most (7) had nine or more years. Eight participants endorsed working with nonprofit agencies, two blended private practice work with additional nonprofit work, two more blended private practice work with working in a hospital system, and one worked solely in a hospital system. By region, five participants identified working in New England, three in the

southeast of the U.S., two in the southwest, and two in the mid-Atlantic region; one participant identified working in the Northeast of the United States, including both New England and the mid-Atlantic region.

Participants identified the demographics of their clients. See Table 8, Demographic Information of Study Participants’ Clients (i.e., Survivors of Trafficking), located after References. Clients/survivors ranged in age from 10 to 70 years old. Most participants did recovery work with adult and child/youth survivors. Most served clients who identify as women and girls, although a meaningful number of therapists also described working with boys, men, and transgender survivors. Six therapists identified working with domestic survivors only, while seven therapists work with both domestic and international survivors of human trafficking. Therapists noted that their clients spanned racial and ethnic groups, with almost all therapists reporting working with survivors who are white and women of Color. Clients’ racial/ethnic groups included white (including eastern European), African American, Haitian-American, Dominican-American, African, Hispanic/Latinx (including Central and South American), Asian, Native American, and biracial. Eleven participants noted that their clients speak English, while two reported clients speaking English and/or Spanish.

Nine therapists reported working only with survivors of sex trafficking (two of these identified their clients as survivors of sex trafficking or commercial sexual exploitation); four therapists identified their clients as survivors of either sex or labor trafficking, or both. Therapists noted particularities about their clients including: symptom presentations including sleep issues, mental health struggles, trauma symptoms, and substance abuse; issues with youth violence; T-visa/immigration challenges; domestic violence or rape survivors; survivors of incest; and refugee status clients.

Results

Analysis revealed four principal categories which describe the multisystemic and/or multidisciplinary contexts in which mental health providers engage in recovery work with survivors of sex trafficking. These categories reveal providers’ perspectives on treatment approach, processes of recovery, extent of emancipatory goals, and their views on the opportunities and constraints presented by the contexts in which recovery work is embedded. The research showed that there are multiple complex systems that simultaneously support and challenge survivor recovery, despite striving to serve as resources for therapists and other mental health support staff in recovery work. This chapter will unpack therapists’ perspectives on the ways that they interact with survivors to affirm the opportunities and challenges, and leverage them to effectively meet recovery goals within complex multisystemic and multidisciplinary recovery environments. The four principal categories are: a) structural and trauma-sensitive emotional support are integrated, b) community and emancipatory healing approaches are part of recovery work, c) peer mentors are critical to recovery work, and d) multiple systems challenge survivor recovery.

Each category consisted of multiple codes (see Table 1 for overview of full analysis). It is important to note that participants often referenced their therapeutic approaches, processes, and the multisystemic and multidisciplinary contexts in which recovery work occurs as linked and interacting, which highlights the complex interweaving of opportunities and constraints which therapists, peer mentors/leaders, and survivors negotiate in recovery work. I describe the different components of providers’ multisystemic and/or multidisciplinary work within each of the four categories below by using representative participant quotations, which are identified by researcher-chosen and participant self-designated pseudonyms.

Table 1. Full Analysis: Approaches to Mental Health Recovery within Multisystemic, Multidisciplinary Contexts

Category 1: **Structural & Trauma-Sensitive Emotional Support are Integrated** a) Partnerships increase capacity to provide quality care b) Leveraging structural support for therapeutic aims c) Therapists mitigate challenges of multisystemic involvement d) Trauma-sensitive principles are interwoven throughout engagement	Frequency: General • General • Typical • Typical • Typical
Category 2: **Community & Emancipatory Healing Approaches** a) Using community-based spaces & resources b) Community- and Culturally-embedded relationships are resources c) Survivor networks and survivor community d) Intersectional analyses	Frequency: General • Typical • Typical • Typical • General
Category 3: **Peer Mentors Are Critical** a) "Relational services" b) Therapist/Peer Mentor partnership c) Help mitigate challenges in multisystems	Frequency: Typical • Typical • Typical • Variant
Category 4: **Multiple Systems Challenge Survivor Recovery** a) Criminal justice system b) Non-profit social services & mental healthcare c) Challenges at sector/system intersections d) Challenges in systems related to therapeutic intervention	Frequency: General • Typical • Typical • Typical • Typical

Note. A category/code was labeled as *general* when it applied to 12-13 cases, *typical* when applied to 7-11 cases, and *variant* when applied to 2-6 cases (*N*=13).

Category 1: Structural and Trauma-Sensitive Emotional Support are Integrated in Multisystemic Work

Structural and trauma-sensitive emotional support referred to therapists' efforts to provide and foster stabilizing structural support, along with trauma-sensitive emotional/therapeutic support. These were found to integrate and overlap in multisystemic and multidisciplinary recovery work. This category illustrates the mechanics and benefits of recovery work embedded in intersecting multisystems, as supported by partnerships, by therapists' creative engagement leveraging structural supports as well as mitigating structural challenges, and by their use of trauma-sensitivity. The four key dimensions include: wraparound,

multisystemic and/or multidisciplinary partnerships increase capacity to provide quality care; therapists leverage multisystemic and structural support work to foster therapeutic aims; therapists help mitigate the challenges of multisystemic embeddedness; and trauma-sensitive principles are woven throughout engagement. This category was of general strength, discussed by all thirteen participants. (See Table 2 for frequency details and examples of illustrative data).

Table 2: Category 1 Close-Up: Structural & Trauma-Sensitive Emotional Support are Integrated

Category 1: **Structural & Trauma-Sensitive Emotional Support Integrated**	Frequency: General • 13 participants
a) Code: **Partnerships increase capacity to provide quality care** ***"****It would be really hard for me to think about doing this work when it's just me, in this silo." (Casey)*	Frequency: General • 13 participants
b) Code: **Therapists leverage structural support for therapeutic aims** *"We have connected her with other service providers, so I have been present for some of the meetings… (The survivor) takes the lead and it's very helpful in the therapeutic process because then, in therapy, I'm able to reference back to those moments with her and then be able to use very factual examples of… how far she has come in this process." (Tierra)*	Frequency: Typical • 9 participants
c) Code: **Therapists mitigate challenges of multisystemic involvement** *Role was to "step in and stop the chaos from getting to her (client)… To try to interrupt her becoming blamed for whatever else was happening." (Maya*)	Frequency: Typical • 8 participants
d) Code: **Trauma-sensitive principles are interwoven throughout engagement** *"We can't come in with an agenda of, this is going to work for all people, and if it doesn't work for you, then something is wrong with you… (We) make sure that the survivor has control and choice, the voice and choice of trauma-informed practices." (Molly)*	Frequency: Typical • 11 participants

Note. A category/code was labeled as *general* when it applied to 12-13 cases, *typical* when applied to 7-11 cases, and *variant* when applied to 2-6 cases (*N*=13).

1.a. Partnerships increase capacity to provide quality care.

All participants identified a range of partnership types. These included wraparound service partnerships, as well as multisystemic, multidisciplinary, multi-agency, and/or multi-staff partnerships, which integrate emotional and structural support, resulting in increased capacity to

provide quality care to support survivor recovery. Some of these partnerships included working on clinical teams, with probation officers, DCF (Department of Children and Families) workers and attorneys, with therapists external to one's own agency, within hospital systems and anti-trafficking networks. Two over-arching dimensions of this code were: i) partnerships improve quality of care and ii) partnerships increase access to care for survivors.

While each dimension (sub-code) was sufficiently robust to be a separate code, they were merged into one code for parsimony, due to analytical overlap in the data, and because partnerships' power to improve quality of and access to care are integrated components of increasing capacity for high quality care provision. That is, the data indicated that improved quality and access to care are linked, and essential components for increasing capacity to provide quality care. This code captures the power of partnerships to increase staff and system capacity to provide quality care to survivors of sex trafficking. The care enhancements resulting from partnerships, as described by participants, include comprehensive service provision, supportive clinical teams functioning as community, increased availability and flexibility of therapists and services, improved survivor identification, support overcoming cultural barriers, and improved access to treatment opportunities and provider training through multisystemic partnership.

i. Components suggestive of improving quality of care. Multiple therapists described working in comprehensive wraparound, multisystemic, and/or multidisciplinary partnerships that increased capacity to provide quality care, within environments that integrate structural and trauma-sensitive emotional support. Stacey described provision of comprehensive services through her agency's residential safe home, where providers view therapy as "whole-person care" (Stacey) which prioritizes necessary structural and emotional supports for independent living. Stacey noted:

> When you're going to your therapist… they're focusing on mental and emotional stuff.… But, in this program, we focus on all of them which is very overwhelming for someone who *doesn't* have complex trauma!... The whole person care is physical, emotional, mental, social, spiritual, vocational which also includes financial or legal. That's a lot of therapy to be working on.

Stacey described the 30-day safe home program as requiring sobriety, and therefore participation may require multisystemic and multidisciplinary engagement; that is, a "detox" (Stacey) program as well as medical, dental, and gynecological care to assure readiness. She noted that therapy takes a back seat "because we need to stabilize you," but underscored the interweaving of emotional support work: "at the end of the day… it's constant therapeutic environment" (Stacey). To achieve these ends, Stacey succinctly stated, "it's necessary that we do this work together" in multisystemic and multidisciplinary partnership.

Desiree suggested that comprehensive services act as a buffer against vulnerabilities, and best combine structural support domains established by the Aftercare Successful Outcomes Tool (ASOT). After describing her trauma-sensitive therapy work, including psychoeducation on healing from trauma and support for grounding neurophysiology when triggered, Desiree noted limitations if an intervention is single-pronged: "to target just one symptom doesn't really seem to do it. It feels much more complicated than that." She noted that ASOT's domains of healing are multi-pronged, including "physical safety, housing, healthcare, access to employment or education or income" and suggested that a comprehensive, multidisciplinary approach resonates with her perspective on the ground. Desiree stated, "When I think about goals and work with the population, I always think about those things. Like, how can we buffer the vulnerabilities

through these kinds of interventions?… I remember resonating with that (ASOT domains)… I said, 'Oh, my gosh! There's finally someone that kind of gets it!'"

Molly, a survivor and Peer Leader who founded a recovery support organization, described a comprehensive wraparound structural recovery program to help survivors recover, develop, and thrive. She described a multifaceted program on a "continuum of care… for folks at different places in the stages of change," including behavioral health support with substance abuse, job training, financial literacy education, peer-group support, and entrepreneurial and leadership training for survivors seeking to do anti-trafficking work. Molly noted "we've just had so many really cool success stories for individuals… (And) we've been able to hire two of our program graduates into full-time salary positions within our organization that have gone through that (leadership) track."

Therapists described multi-staff clinical teams as partnerships which provide supportive wraparound services, increase capacity for quality care, and reduce therapist isolation. Notably, some therapists experienced wraparound, clinical team models as a form of community for both therapists and survivors. Casey stated:

> I do feel like working with survivors of trafficking and exploitation… needs to be approached from, like, this community perspective. I think it's so much more impactful when it's a group of people working together to support my individual/our individual clients versus just me. It would be really hard for me to think about doing this work when it's just me, in this silo. But I do think that it's so much more effective because there's this sort of community, like wraparound approach, of all these individuals sort of working for this one person or with this one person together.

Several therapists noted that the team approach decreases strain on providers and better supports survivors. In this case, Casey noted that when therapists, peer mentors, and case managers share duties, it decreases strain by “lighten(ing) the load a little bit” off the mentors who had previously been “holding so much and trying to manage so much.”

Penelope viewed a wraparound, multisystemic team approach as a model for community healing which expands on traditional clinical training. Penelope shook her head and motioned throwing something aside when describing “the medical model and diagnoses.” She noted by contrast: “I operated from a community model and I loved it… Graduate school would have taught me to work from a more individualistic therapy model, like I’m the clinician sitting in my office... We, operated as a team approach with multiple - a wraparound coordinator, a clinician, a care manager – multiple systems, multiple people involved.” Penelope described graduate school as inadequately exposing her to effective, team recovery models such as “community models, in doing the work as a clinical team” and noted that multisystemic team approaches improve effectiveness: “I think we bring better things to the table. We have more eyes on things and we each play our unique role.”

Casey described the affective pull that may cause some multidisciplinary providers to engage in community-like, wraparound, multisystemic work and its value for survivors. She described DCF-involved sisters who were survivors of sex trafficking and “pulled at people’s heartstrings. I think the (DCF) providers really wanted to just really care for these girls.” She described an attorney who was “really invested – was one of these people who really loved her (the survivor). And so, I mean it’s really sad to think about: the connection that these kids had were their lawyers or their DCF workers, but they didn’t have family. A lot of the work was about helping them to identify their own – create their own family.” In contexts of youth

survivor work, multidisciplinary providers and multi-staff care teams were described as forms of blended structural and emotional supports that run so deep as to be experienced as community and family, and whose partnerships increase capacity to provide quality care.

Maya attributed a survivor’s positive healing trajectory to trust and support within a multisystemic and multidisciplinary service partnership. She attributed recovery to the interweaving of structural and emotional support, with emphasis on supportive adults and structural support above all. Maya noted, “I don’t know that necessarily anything therapy-wise was the deciding factor (in client’s positive healing trajectory). I think she had more stable adults than others, so between where she was living, myself, our survivor mentor…, guardian ad litem (who) was very supportive,… we were on a team.” She indicated the importance of trust with probation officers in the criminal justice system: “There was one probation officer in particular I had a really good relationship with. He was difficult… but we had a trust that I was able to work with him. He mostly trusted me that I would do what I said.” Emphasizing the critical importance of structural support in recovery, Maya noted, “I think it was just the fact that she had stability and she had… a handful of adults that she could rely on and trust, because I don’t know that it’s always a mental health issue… Mental health, for me, is really just unmet needs. And so, she was able to have those needs met. And so, I don’t really credit it to therapy.”

Some therapists referenced flexibility in their schedules due to working in partnerships that result in greater availability to survivors, and enhanced care. Greta stated, “it’s always the relationship building, making sure they know that… they can really rely on me – not even just from nine to five... It’s like, ‘If there is an emergency, you can reach out to us as well. That is part of what we do.’” She emphasized the integration of structural and emotional supports saying, “It’s not just the counselling, but we try to be holistic and that, really, every need you

might have, we want to help take care from then on." She described using her cellphone to communicate with clients "kind of here and there, texting and calling in-between" therapy sessions, describing it as a flexible form of work ("it's really not formal"), and one that is effective. Likewise, Penelope noted the importance of "good boundaries," but underscored the greater importance of flexible boundaries to improve care quality by increasing survivors' access to therapists. She critiqued the "older models where we never have any communication with our clients except for that 50-minute session," instead asserting: "I don't work from that model – not with this population. I think that, with *this* population, I have found that is very unhelpful."

Multiple participants suggested that working in multi-staff and multi-agency partnerships increases capacity to provide supportive care. For example, several therapists described doing private practice work with survivors while simultaneously partnering with recovery organizations in order to expand their reach to diverse survivors of sex trafficking, and to increase therapists' and agencies' capacity to provide quality care. Penelope described contracting with a trafficking recovery organization that hires survivors, provides services ("advocacy, support services, wraparound"), and offers individual and group therapy. She described doing similar work in her private practice, although noted survivors in her private practice are "more established in the community… (and) they haven't come through the same systems, the same way. They are, like, further along."

By contrast, the survivors Penelope sees through the trafficking recovery agency are "directly out of system involvement." Similarly, Caroline described doing trauma-focused private practice work with survivors of sex trafficking and domestic violence, but also having founded a trafficking recovery organization that focuses on the "care and empowerment of survivors" from a structural and trauma-sensitive emotional perspective. She described noticing

that survivors could be liberated from their trafficked situations, but "they'll go back if there aren't alternatives,… if there isn't a way for them to make money, if they are still so kind of mired down in their trauma symptoms that they just would return instead of being able to go a different path." Of her private practice and agency-work, she stated, "I do both parallel."

Therapists described how multi-agency and multi-staff partnerships improve crisis management services for survivors. Ramona, a peer mentor, described a survivor who was having a panic attack being helped by a "very skilled clinician" in a safe harbor placement: "I watched that clinician kind of walk her through that,… help her get to a place where, I think, she could start to feel safe enough." Stacey described a multi-staff approach to crisis management, where volunteers refer to in-house clinicians if they are "not able to handle… (situations) escalated in crisis." Similarly, Stacey noted that the residential safe home requires resident-survivors to see adjunctive trauma therapists outside of the facility to decrease strain on both survivors and staff. She shared: "it's overwhelming for (survivors) to be in their home - living there, socializing there, (and) doing therapy there," and that survivors' complex needs mean that "we oftentimes don't get a chance to go… into the childhood stuff… because we're working on so many of the just day-to-day crisis that comes up."

ii. Components suggestive of increasing access to care. Therapists also noted that flexible attendance policies increase capacity to provide quality care by increasing access and availability of consistent services, despite clients' intermittent engagement, and that these benefit from partnership collaborations. One therapist described a client's understandable fluctuations in engagement with therapy throughout the pandemic based on "other stuff going on for them… but I'm not going to force it" (Casey). Describing her agency as "really unique," Casey described the benefit of multi-agency collaboration: "We don't have insurance… All of our survivor

empowerment services – (as in) through the mentoring – we bill through DCF or the program that the youth is connected to. And so, I am able to see clients if they're interested and not have to worry about insurance." Desiree likewise described the "challenges around consistent engagement" that her clients experience, and the value of working within an agency with flexible attendance policies, to provide consistent availability. Explaining the "ambivalence" and "mistrust" that her clients commonly experience, she described proceeding "very slowly" and being "very flexible with my 'no showing and rescheduling'." She described this approach as helpful with survivors of trafficking: "I think it's helpful to work with an agency where this is kind of the thing, because if we said, 'Okay. Two no-shows and you're out,'… that's not going to work with the population. Because the chaos that they may be in when they first start reaching out for therapy is so through the roof."

Participants described the benefit of multi-agency and multi-sector partnerships as increasing access to care and treatment opportunities by connecting survivors to diverse recovery services and supports. Survivor mentor/leader Molly shared that during the COVID-19 pandemic, her organization took on multiple referrals to run peer groups virtually when other organizations were "slammed… during all of the shutdown." Without enough facilitators to run peer groups, she noted that agencies began "collaborating with other organizations to send referrals… so we've done a ton of those groups this year." Several participants referenced partnering with prisons to bring "poetry therapy groups within the adult jail (because) there's a lot of survivors" (Penelope), and Penelope described collaborating with a nature-based organization to offer "wilderness therapy" to survivors: "we partnered with another organization and did a trip this past year." Casey described part of her role as developing partnerships with mental health providers in the community who "specialize in working with survivors of

trafficking.” With the aim of providing choice to survivors who may have “apprehension about therapy,” Casey is “developing this network (of providers)… that (my agency) can vouch for essentially.”

Participants also indicated that multidisciplinary and multisystemic partnerships improve survivor identification efforts, thus improving access to care. Despite the challenge of survivors embroiled in the criminal justice system, Greta referenced the value of cross-sector partnerships (including “referrals from court,” “referrals from the local jails,” and “probation”) for identifying survivors within the criminal justice system and connecting them to comprehensive services. Greta detailed meeting clients at court and “going into the local jails and seeing (survivors) there, speaking to them, and then creating a relationship and keeping it going once they get out, and just kind of following them wherever they go.” She underscored the value of doing presentations in local jails to “put it out there and kind of educate a lot of women (saying)… ‘if this is something that you experienced, let us know, and we’ll try to help however we can.’” She recounted a story of one client she met in jail, who had been “sitting separate from all the other girls… (and was) serious and affected from our presentation.” After approaching her, she disclosed suffering trafficking exploitation from age 12 to 25, having been arrested while with her pimp, and “that’s really the only way she got away from her trafficker.” In this context, Greta described offering “counselling and advocacy and case management and really any kind of resources they might need. … (And) there’s a human trafficking police unit that we actually created a task force with. So, if they wanted to pursue bringing charges against their trafficker… we can help with that.” Greta’s work gave voice to the potential of wraparound, multidisciplinary, and multisystemic partnerships for survivor identification and access to care.

Sophia, a clinician who is also a Doctor of Social Work, highlighted her “unique role to identify survivors” in a hospital-based system, while working on a research project in multidisciplinary collaboration with an emergency room physician. She recounted following up on well over 200 encounters with possible trafficking survivors, where “they were at least identified by medical professionals who had been trained in trafficking red flags… and they were concerned enough to send it along to me.” She added, “my experience in the world tells me that trafficking (prevalence) is much worse than what we even know it to be.”

Therapists identified working in multi-staff teams as a means for overcoming cultural barriers. Greta described her work in a small agency, where staff share clients, using a “partner tactic” or a “tag team” approach because “a lot of our clients… require enough help that they could use two different people working with them.” She suggested that the partner approach aids clinical work by helping to overcome barriers based on culture as well as age. Greta shared that some clients are “more comfortable with someone of their own cultural background” and that in a tag team approach, this can be accommodated. Referring to overcoming age-related differences, she described her co-clinician as an older mother with “a motherly elder kind of feel.” Greta noted that, by contrast, she is the same age as many of her clients, which has a “different effect on each client.” Overall, she suggested the power of multi-staff partnerships for increasing capacity to provide diverse survivors comfortable and relevant care that blends structural and trauma-sensitive components.

Another participant described partnership approaches as useful to overcome cultural barriers and increase treatment opportunities. Molly spoke of her interest in offering services to a nearby resettled refugee community, noting: “it’s the population we have not been able to connect with.” She described a plan to use funds, acquired to hire interpreters and consultants, to

begin those cross-cultural conversations. Molly also recounted partnering with law enforcement, to observe during "illicit massage business search warrant execution… (where) language and cultural barriers are so high." Molly underscored that the value of joining these search warrant executions is because "we don't know what we don't know. We don't know what's different until we're there." She promoted combining research knowledge with "going in and observing at the local level and seeing… 'What do we need in order to meet this population where they're at and make sure that they feel comfortable?'" Molly underscores the potential of multisystemic, multidisciplinary partnership to inform mental health providers about the structural and/or emotional support diverse survivors living in the United States may or may not want or need.

Partnerships were finally seen as an important way to enhance capacity and training to better accompany survivors. Ramona described turning to other agencies who were "way more versed" with serving undocumented survivors. She stated, "she needed citizenship… but it was a process that I didn't understand. And so, it was definitely reaching out and working with an organization that was really what they did." She described the importance of "bringing in other people" and "learning in partnership." Caroline and Josephine likewise referenced partnerships that increased capacity, this time based on training other professionals how to best work with survivors of trafficking.

1.b. Therapists Leverage Multisystemic and Structural Support Work to Foster Therapeutic Aims. Many participants referenced ways that they leverage their clients' multisystemic involvement, and the structural demands of recovery, to foster emotional/therapeutic aims. These included outreach and comprehensive recovery support, and therapist accompaniment in systems as opportunities for multidisciplinary/multisystemic collaboration which promote therapeutic

aims. Participants suggested that, ultimately, therapeutic support and accompaniment increase survivors’ capacity to navigate the structural and multisystemic demands of recovery.

Therapists described promoting survivors’ skill development in the arenas of independent living, employment, and self-advocacy in tandem with emotional/therapeutic aims. Casey described her work with young survivors as sitting at the juncture of mental health and structural support, where the therapeutic support intimately interweaves material about structural supports, to promote skills and cognitions that may foster independent living skills. She stated,

> I think there are lots of young women I work with who feel like it would just be much easier to go back on the street or back into the sex industry… A lot of the work that we did… (was) helping them to think through, like, what is their relationship with money? Why would (sex industry work) feel like a better option for them than trying to find a job at a grocery store or a restaurant or whatever?

Casey remarked that her client went on to get a job and open a bank account “during our work together,” and that it improved her self-esteem “developing some independent living skills.” She noted no tension between these traditionally distinct domains (the structural and the psychological) in her work. In fact, Casey highlighted her young clients’ interest in “trying to figure out the life (skills) stuff” as opposed to “diving deep into talking about their experiences of exploitation.” She suggested following clients’ lead when determining how to best use therapy.

Multiple participants emphasized the importance of promoting self-advocacy skills to support survivors navigating the demands of recovery within multisystemic and multidisciplinary environments. Molly spoke of designing job readiness programming that includes preparation for transitioning into workplaces that are not trauma-informed, and the self-advocacy required. She

shared, “So, navigating - there’s triggers. How do you advocate for yourself in that space? Or if you feel like you are being taken advantage of, or maybe workplace laws are being bent, how do you make sure that you stand up for yourself and you’re not experiencing re-exploitation?”

Therapists suggested that multisystemic involvement with DCF, the criminal justice system, and the healthcare system offers myriad opportunities to promote self-advocacy through therapy. Casey advised, “giving them resources and helping them to… understand the systems that are in place… and understand how to advocate for themselves, especially within DCF involvement and legal systems.” Therapists promoted an empowerment focus for survivors embedded in the mental healthcare system to “make her own decisions about her mental healthcare” (Desiree), including “encouraging them and empowering them to think about interviewing therapists to find the right match” (Casey) and by “enabling her to trust herself when things were getting too much, that she could communicate that” (Desiree) with her psychiatrist and therapist.

Empowerment to make one’s own decisions while immersed in multisystemic challenges was seen as key to recovery, especially with survivors of trafficking who commonly “have little to no power and control over their everyday lives – their everyday basic needs” (Caroline). Caroline underscored the value of an empowerment approach that leverages involvement with challenging structures for therapeutic aims. She recalled, “Empowerment to me means helping people make change for themselves, helping people to have power and control over their own lives,” to feel that they have “agency,” that “they’re the ones who can kind of call the shots.” Caroline identified her role as “interacting and giving ideas… giving them some choice, giving them access to different options.” She recounted working closely with a client who was considering pursuing a legal case against her trafficker: “Do you want to pursue a case? Or do

you not want to pursue a case? Weighing the pros and cons with them – what it would mean…. We kind of walked through it, but she made the choice for herself…. That's the empowerment piece."

Tierra called attention to the power of leveraging therapeutic resources (i.e., trauma-sensitive emotional support) to turn potentially oppressive multisystemic and multidisciplinary experiences into supportive ones. She described working with a client in crisis, who was navigating "multiple levels of needs" during the T-visa application process, including suicidal ideation, a deteriorating medical condition and cognitive delays, and highlighted that therapeutic accompaniment in a system may be an opportunity for multidisciplinary, multisystemic collaboration. She stated, "we've been part of her T-visa process, so I was there whenever she would meet with her attorney to submit her affidavit, to go over her declaration... So, a lot of grounding techniques." Further, this clinician pinpointed that an empowering client-therapist relationship in this context *is* systemic accompaniment work, which promotes recovery through self-advocacy and opportunities for positive self-reflection:

> (We) worked on her communication skills and her being able to speak up for herself, and she's been able to do it. We have connected her with other service providers, so I have been present for some of the meetings there, and I literally just have to be there. I don't have to do anything, intervene. She's just the one that takes the lead and it's very helpful in the therapeutic process because then, in therapy, I'm able to reference back to those moments with her and then be able to use very factual examples of how she *is* able to do X, Y, and Z skills, and how far she has come in this process.

Tierra's work exemplifies the potential of a multisystemic approach that leverages system interactions as therapy. The stance requires "a mix of different approaches, a mix of level of

involvement as well,” including advocating for and with clients. Tierra identified the recovery process for survivors as “varied,” with “a lot of this ebb and flow” between structural and emotional aims, where “there’s a lot of back and forth in the process – the healing process.”

Participants mentioned circumstances where survivors themselves took the lead in leveraging system involvement for structural and emotional recovery aims. Maya shared about a client whose positive healing trajectory was attributable to self-advocacy “about living situation… (despite that) the State was really trying to not have that happen… Thankfully, we were able to just help her try to maintain that and hold onto that, but she was actually the one that made the first fork in the road for herself.” Maya noted that stability in chosen living environment allowed her to use therapy to greater effect: “I think having that stability helped her to be able to have the security to use therapy to feel like she can focus, and do well in school which is going to help her feel confident about herself.”

Several therapists spoke of leveraging multisystem involvement to build therapeutic relationship and rapport. Penelope recounted doing clinical work with a survivor at a foster care agency and attending to the survivor’s request to look through a box of her childhood belongings together: “she’s talking about how everything always gets bagged up and moved. She doesn’t have a place.” This non-traditional, experiential approach resulted in powerful therapeutic engagement based on attunement. Maya described using humor with a justice system-involved youth, which resulted in rapport building: “we had a day where we laughed and laughed because we saw a duck that reminded us of their probation officer.” Desiree underscored the therapeutic value of clients having exercised choice to engage with her particular agency: “our agency is specialized, so when they come to us, even if they’re required to attend counseling, they have

some choice." She suggested that by virtue of consciously choosing an agency that specializes in survivor recovery, "it builds a sense of someone's agency, and it can build the alliance nicely."

Multiple participants spoke of leveraging involvement in the criminal justice system for therapeutic aims. For example, Greta described doing weekly therapy sessions at the local jail, where she talks with each client about "what she wants for her future and how to heal." She contended that clinical work in jail was complex but supportive, and even "lucky… to actually sit down with the client… where I know that I do have them for this exact amount of time." In jail, she asserted, counseling sessions are uninterrupted: "They don't really have anywhere else to go and anything else to do. That outlet of being able to come down and have quiet time talking to somebody not living in the jail with them is such, you know, it's a great outlet for most of them." She acknowledged the complexity of jail as an oppressive space ("I have a lot of issues with jail in the first place"), and simultaneously as a context for healing:

> … But I do love that I get to go into jail and sit down and have a safe time and space to speak to my clients where, like, I feel like a lot of healing can actually happen - as much as possible while you're still in jail, you know, not having freedom and, unfortunately, have to go back to a cell and to COs (correction officers) and other inmates.

Greta also referenced leveraging case management work with clients living in a safe home, recently released from jail, for therapeutic aims. She described building counseling sessions into case management support tasks: "A lot of the time, the counseling is kind of disguised, like maybe it's while we're driving… on the way to the grocery store." Greta spelled out the necessity of attending to structural "basic needs," like safe housing and food security, for therapeutic goals: "you really can't focus on healing when you don't know what you're going to eat that night or where you're going to sleep."

1.c. Therapists Help Mitigate the Challenges of Multisystem Engagement.

Many participants indicated that they help mitigate the challenge of embeddedness in complex multisystemic contexts for their clients, through structural and emotional supports. Therapists described buffering stress for survivors embedded in multiple challenging systems, both through emotional support and structural support via advocacy. Maya stressed the goal of her work with survivors is “always personal, spiritual liberation,” but acknowledged the reality was about “just survival… Realistically, the goal was to help them make it out alive… physically… spiritually.” She suggested the stakes were high and the challenges formidable: “they were ready to be eaten alive by some system at any time, and there was so much out of their control, and there was so much out of my control.” Maya referenced advocating for survivors both in emotional and structural terms. In terms of emotional support, she spoke of supporting their sense of self, despite odds: “Almost all of them had somehow against all odds maintained some sense of themselves… So a lot of my goal was to help them hold onto that in spite of more being thrown their way.” She held hope that survivors would not lose themselves “spiritually.” Yet she also referenced structural, “tangible” advocacy goals, such as “getting them not committed… getting them off probation… keeping them a dependent when the State wanted to put them back in a very abusive situation” in addition to educational goal attainment.

Sophia emphasized the importance of advocacy work within hospital-based systems to ensure access to care for survivors with complex medical and mental health needs, as well as structural barriers. She recounted collaborating with a multidisciplinary team of medical staff, a psychiatrist and other behavioral health workers to support a 16-year-old survivor of sex trafficking recently admitted with COVID-19, “significant mental health issues” including complex post-traumatic stress disorder, “significant vaginal bleeding” from likely pelvic

inflammatory disease, and "coming off methamphetamines." Sophia described her role as "advocating with the healthcare system… (because this survivor) was an unfunded patient, she had no insurance, no way of paying for her stay." She cited comprehensive advocacy work, including:

> Advocating for why it was important that she stayed with us longer so that we could find a good placement for her, and then working with those placements to give them a clinical representation of what was going on for her and why we felt she needed their higher level of care, including a locked facility… Advocating with child protective services, advocating with the hospital, advocating with her advocate,… advocating with all of those different providers, and then also stepping in behind the psychiatrist and the behavioral health social worker and saying, "Yes, I agree with this care plan. Yes, I think that this person is being trafficked."

Peer Mentor Ramona suggested the importance of "a good therapist" to advocate and mitigate challenges from involvement with "nonprofit services." She underscored the critical value of "just one person who came from a strengths-based approach or a healing-centered engagement approach or a humanist approach who would come alongside and advocate for (survivors), or just even see them or hear them." After "a slew of negative experiences," one good therapist helped provide corrective, reparative experiences based in advocacy and power-sharing. Maya described a "protector part" to the advocacy role as "trying to remove stressors" for young clients embroiled in the adult systems and problems in her orbit (i.e., "case managers, probation officers, foster care parents, her own family"). She observed that clients often became "the scapegoat for problems of adults," and her role was to "step in and stop the chaos from getting to her (client)… To try to interrupt her becoming blamed for whatever else was

happening.” Maya described her role as “just being a stable adult, providing for their basic needs” (i.e., transport, food, appointments, bank account), and “mentorship.”

Multiple participants cited the influence they have to advocate based on their position of relative power. Stacey described supporting a client transitioning medications in the aftercare period post-program, saying “I chimed in as her clinical case manager, and it happened right away.” Sophia similarly noted, “We can never be an expert on anyone’s circumstances, but the hospital has experts. And so, it’s kind of like saying, ‘I have studied a lot about this, and I think that she’s experiencing trafficking.’” Differences appeared prominent in therapists’ advocacy power, based on how established their program’s aftercare services were. While Sophia referenced having an influential, supportive role in transitioning her patient into post-hospital placement, Stacey described her agency’s aftercare services as emergent: “It’s new and so we’re kind of figuring out, how do we still support these women when they’ve left our program?”

In other hospital-based systems, therapists described bending patient discharge policies in order to reduce barriers to returning to treatment after halting services. Josephine highlighted the importance of remaining consistently available and allowing clients choice to continue or pause treatment. She noted, “we had a clear protocol for discharging clients who had no-showed, and I think what was most helpful for me and for that client is that I disregarded that.” Josephine contended the value of maintaining an “open and ongoing” relationship, where therapists remain available despite prior no-shows. She recounted:

> When she (survivor-client) popped up four months later and her primary care said, “Walk over and find Josephine today,” I didn’t say: “You know what? You’ve no-showed three times in the last two months, so we’ll discharge you and you can call this number.” I’d be like, “Great! I can’t meet with you right now. When can you come by tomorrow?”

Similarly, Elina explained of her work in a hospital-based system: “I never close a case. I don’t think I’ve written a termination note – which is probably bad – in 15 years because people tend to come back at different points.” She described survivors’ understandable desire to take breaks in treatment, sometimes to focus on working and earning income after resolving difficult immigration cases, but then returning while in an abusive relationship, or after having children, or an illness: “and then they return because they can’t keep that stuff buried anymore.”

Maya similarly described her advocacy role as occasionally bending therapeutically unhelpful rules for clinical benefit. Referring to the strains of court mandated therapy, she said, “it was always up to (the survivors), and even when they were court mandated, I always told the children, ‘I will never mandate anything from you.’ I don’t think therapy should ever be mandatory.” She described offering to sign paperwork to satisfy probation officers: “’If you need this for your probation, I will sign whatever you need. And we can sit in a room. I’ll sit outside the room, so you don’t actually ever have to meet with me, and I will sign whatever you need me to sign.’ So, it was always voluntary.”

Finally, therapists described efforts to mitigate the challenges clients face when working with interpreters. Due to extensive work through interpreters, Josephine noted that she developed the “weird skill” of reading clients’ “non-verbal cues” as they speak, “even without understanding the language.” She referenced empathically nodding her head as a client recounted experiences of exploitation through an interpreter, because “I was trying to help (clients) feel understood, and I could get the gist of what was happening.” She underscored the importance of developing skills to work with interpreters, and the gap in clinician training in this area.

1.d. Trauma Sensitive Principles are Woven Throughout Engagement.

Most participants discussed interweaving trauma-sensitive principles throughout engagement, both during emotional and structural support, including letting clients take the lead in multisystemic work and promoting choice. Casey told a story of a young survivor referred to her agency for peer mentor support after a 51A filing and subsequent “multidisciplinary response… (and) investigation.” She recommended, despite having been provided background information on the client, allowing disclosure to be survivor-led: “I find it really important to hear directly. When she’s ready to tell me what was going on for her, then she’ll tell me.” After three months, she said the survivor chose to disclose details in therapy. Molly agreed that survivors should take the lead, as each is “the expert on their life. As professionals and peer support, we can come in with an idea of things that might be helpful but, ultimately the decisions need to be the survivors.” She called hers a “survivor-centered approach,” where professionals orient themselves around “the perspective of listening,” and suspend their own “agenda” for what they think a survivor needs: “we can’t come in with an agenda of, this is going to work for all people, and if it doesn’t work for you, then something is wrong with you.” By contrast, her agency’s goal is “to make sure that the survivor has control and choice, the voice and choice of trauma-informed practices” to try different treatment approaches to determine themselves the most helpful ingredients in their recovery “recipe.” She described the model as adjustable based on culture, age, and gender of survivor because “we’re not coming in with this cookie-cutter, ‘here is what you have to fit into.’” In this way, she indicated that trauma-sensitivity must honestly contend with intersectionality.

Multiple therapists promoted the importance of survivors having voice and choice in their recovery, especially at the intersections where distinct systems and disciplines meet. Desiree highlighted the therapeutic value of clients choosing to engage with her trafficking recovery

agency specifically: “our agency is specialized, so when they come to us, even if they’re required to attend counseling, they have some choice.” She suggested that by virtue of consciously choosing an agency that specializes in survivor recovery, “it builds a sense of someone’s agency, and it can build the alliance nicely.” In other words, participants suggested that when survivors sit at the intersection of systems, structures, and disciplines (i.e., therapy, social services, and the legal system; that is, mandated agency-based therapy), trauma-sensitivity should be held central.

Sophia discussed letting survivors take the lead even during crisis. She described an instance where the hospital medical team was “having a lot of feelings” about a 17-year-old who had experienced acute sexual assault refusing an exam, with medical staff “not understanding her perspective on the issue.” Instead, Sophia’s approach was direct but “very non-confrontational. I’m not going to push anyone.” She reported saying, “’I want to help you today while you’re with us. Do you have any questions for me? What are you needing?’” She described her stance in trauma-sensitive terms: “I take into consideration trauma-informed responding, emotional holding, coregulation of the nervous system, not pushing someone.” Peer mentor Ramona added that the work is “letting people define their own experiences, and then… taking that path to learn about it.”

Therapists described a stance of upholding “unconditional positive regard” in client-therapist relationships as they work towards safety and stabilization. Greta mentioned her agency’s “open-door policy” that contends: “no matter what they do… whether you take a few steps back” into substance abuse, “you really can’t do any wrong in our eyes.” She acknowledged the stance can be “difficult” for providers, but underscored its critical importance for trust and relationship building when a survivor is embedded in multiple systems (i.e., Department of Social Services and the medical system). She described the approach’s

components: “no judgement, ever at all,” “showing them that, no matter how they show up, I’m going to be here, and I’m going to care, and I’m going to continue to check up on them… whether they want to open up or not. That is crucial.” Greta highlighted the positive impact on trust-building of trauma-sensitive structural stabilization work: “I’ll try to personalize it as much as possible. I’ll try to be the ride… That’s where a lot of trust is built for the clients.”

Elina differently emphasized the importance of access to trauma-sensitive relational work, one which privileges relational work over basic needs provision. She specified her hospital-based system’s commitment to “psychodynamic and trauma-focused therapy to be available to everybody, regardless of their ability to pay.” As such, and different from many therapists in this sample, she emphasized adherence to a “respectful 45-minute hour” session, where she avoids “diluting care” with a heavy case management focus. She acknowledged case management services as “a big part of the role but you frame it in the context of a psychotherapy relationship.” In other words, she recommended integrating them for equity and access purposes: “Otherwise we are seeing this kind of two-tier system where wealthy people get psychoanalytically based 45-minute hours with a lot of attention to the frame. And then, poor people get very kind of case management, skills-based work.” Perhaps more possible in a well-resourced hospital system, she described her integrated efforts stemming from a belief that “relational harm is primarily repaired by relational work.”

Many therapists described their safety and stabilization work as trauma-sensitive practice that engages survivors across multiple systems, in emotional and structural support. Elina spoke of using the “loosely-defined stage model” of trauma treatment developed by Judith Herman, with stage one being “safety and stabilization… (including) careful assessment, psychoeducation, containment, and attention to basics like living environment, current safety,

psychopharm – getting them into healthcare, medical healthcare, if needed. You know, getting them resources." Josephine observed that she uses body-based/mindfulness-based tools in treatment, but "if the body isn't a safe place… I end up focusing more on psychosocial stressors and stabilizing things there." She described an interplay between structural and trauma-focused emotional support, depending on the client's needs in the moment or recovery stage. Elina affirmed: "'it depends' is the model." Desiree contended her goal with survivors is first "safety… physical, emotional, psychological safety… From present vulnerabilities, and also past abuse – safety in terms of *feeling* safe." Yet she importantly added the goal of "flourishing," suggesting Herman's stages of trauma recovery beyond stage one stabilization. She contended: "I don't think it's just (survivors') experience of exploitation that should define them. … When I imagine my participants, I picture them as flourishing." She described trauma-sensitivity as holding a vision of flourishing (i.e., an involved working mom, a young person realizing she can say no to sex while dating, or discovering what she wants to do in life). Desiree offered: "That's what flourishing looks like. It's growing in ways that maybe they never even thought possible."

I close discussion of this category with a case example provided by Desiree that illustrates the interweaving of structural and trauma-sensitive emotional support elements for survivors embedded in multisystemic and multidisciplinary contexts, and ways that therapists engage survivor-led, trauma-sensitive approaches at different points in recovery, with an eye towards flourishing.

> She came in literally off the streets, to the office. She said, "I don't know what to do, but I heard you can help." She had been trafficked primarily through the exploitation of her substance use issue and, at the time, she found our agency, she had tried to do treatment. She was mandated to do treatment and she couldn't take it. Her mental health was so poor that she left treatment. It was a substance abuse facility, and she was in distress because a lot of the stories she heard were about mothers whose children were born addicted to substances, and she was in distress because, at that time, she wasn't with her

child, so she left the treatment program. She didn't know what to do. She told me she had remained sober. I wasn't sure if that was true, so she came into our door and just said, "I need help." So, basically, at that time, I did what any social worker would do which was, "Okay. Well, what's going on? What do you need help with?" At that time, she needed a place to live, and she was not wanting to go to treatment. She denied substance use, and… she gave me the most recent two months of her life which had basically been leaving treatment and then kind of chaos. She was also in the hospital which she said was for a medical reason.

So, with that, I worked with her and an intern, and the intern provided a lot of very close kind of stabilization support. So, we tried to find her a shelter that she could go to. We tried to find her any place that might accommodate her. We worked with the DTA (Department of Transitional Assistance). There wasn't much available to her. So, what she decided to do was to stay at her friend's house. I wasn't sure if this was a friend or if it was somebody who was also maybe exploiting her or if it was a possible john, but she said that she felt safe there and that she knew this person for a while and that she was okay. She was okay staying there.

So, then her care transitioned to a job, and she, actually, we helped her get her resume together. We helped her look at different job opportunities, and she found one. We also helped her get connected to a peer recovery support community that was close by to where she was staying so she could drop in and go to meetings and things like that. She got a job. She was able to hold down a job. … And then, basically, about a month after that, her parents saw that she was doing well, and they let her move back in with them. And then, she had a lot of trouble adjusting to the family. There was a lot of kind of fights that would happen. But, over time, I helped her stabilize that. I actually transitioned her into therapy with me, so I was able to provide therapy. She trusted me, and that was part of her DCF service plan. So then, from there, we did therapy together and we looked at what was happening within her family of origin – you know, making sure she didn't relapse and having plans in place in case of relapse, really exploring what happened, making sure she stayed connected to her psychiatrist. And, over time, the case stabilized. And then, the DCF case was able to close, and they gave her back her rights. … She's been in recovery now for two years at least – maybe two and a half…. Her daughter is so wonderful and a joy in her life. She is struggling with coronavirus like the rest of us, and she will use therapy. She's not mandated to attend anymore. She comes to therapy every other week, and she uses it to reflect on, mostly it's about relationships. She's not really going into past trauma which I'm totally fine with, but she's looking at her present relationship – how she is as a mom. She started dating again, so kind of questions around that. And so, the case has really been, I feel like that's kind of an emblematic case because there's just so much chaos, and there's so much need at the beginning, and so much of the work is just literally meeting where they're at. And then, helping to provide more and more holding. That's kind of what it feels like.

Category 2: Community-Based and Emancipatory Healing Approaches are Part of Recovery Work

Providers who are engaged in recovery work with survivors of sex trafficking within multidisciplinary and multisystemic contexts were found to contend with systemic oppression, community-building and emancipatory aims in their work. They did this across four key dimensions: working in community-based spaces, within community- and culturally-embedded relationships, while promoting and facilitating survivor community, and by bringing an intersectional analysis to therapeutic work. This category was of general strength, discussed by all thirteen participants.

Table 3. Category 2 Close-up: Community & Emancipatory Healing Approaches

Category 2: **Community & Emancipatory Healing Approaches**	Frequency: General • 13 participants
a) Code: **Using community-based spaces & resources** *"I meet all of my clients where they're at. I go to their communities." (Casey)*	Frequency: Typical • 8 participants
b) Code: **Community- & culturally-embedded relationships as resources** *"Within community you heal." (Tierra)*	Frequency: Typical • 10 participants
c) Code: **Survivor networks and survivor community** *"That's where the community work is being done, is in these networks that we create for ourselves, these relationships that we create from ourselves that don't fit society's normal narrative." (Ramona)*	Frequency: Typical • 9 participants
d) Code: **Intersectional analyses** *"It's not like 'oh, bad things happen to good people.' It's like bad things happen to the same people – just more and more. It's structurally set up for that." (Elina)*	Frequency: General • 13 participants

Note. A category/code was labeled as *general* when it applied to 12-13 cases, *typical* when applied to 7-11 cases, and *variant* when applied to 2-6 cases (*N*=13).

2.a. Using Community-based Spaces and Resources for Recovery Work.

Multiple participants referenced going to where survivors are for recovery work, and using community-embedded spaces as well as geographical elements from the local, natural world in recovery. Referring to use of survivors' geographical community, Casey shared, "I meet all of my clients where they're at. I go to their communities." She described having built

relationships with family resource centers and libraries for meeting space. Many therapists described doing clinical work while having a “meal together,” taking “walks together,” or “going for a drive together” when therapist and client can sit side-by-side and talk. Casey remarked that nearly all her clients reported a preference for this, since “sitting in an office and looking face to face at me is really not comfortable.” Maya realized with some irony during the interview the power dynamics harkened by where a therapist sits: “The only time that… we’d be across from each other is if they were in a detention center – maybe the hospital – then we would sit more across. Which is, now that I’m saying that, I’m like, ‘Wow! How institutional…’” She consolidated her reflection by critiquing the therapy enterprise at large: “The way we (as clinicians) do therapy is across, and the only other times I sat across were in hospitals or jails… Anyway, otherwise, most of how we met was not in that traditional talk therapy way.”

Casey highlighted the value of “doing something together” in a local community space for relationship building. She found “cooking a meal together and talking through whatever is going on” to be “much more productive” and sustaining in her work, commenting: “It just feels like a genuine human interaction.” Maya described doing things together as developmentally effective for rapport building with younger clients. She cited survivors showing her photos of their weekend on their cell phone, or “we might sit on the floor together” in their home. She described multiple community-based informal spaces where she worked with survivors, including “sitting on curbs, sitting in cars, sitting on their bedroom floor.” Greta described working with clients in their homes, in libraries, and even in courts and local jails, despite the challenges involved with incarceration. Maya referenced working with survivors in their schools, and Stacey described her agency’s efforts to start a community-embedded resource center to

support survivors with both outreach and aftercare services. Likewise, peer mentors Ramona and Molly referenced community-based outreach, accompaniment, and recovery work.

Penelope drew attention to the natural world as a community resource for recovery. She retold a story of working clinically with a survivor while sitting on the banks of a stream. The survivor was throwing rocks “naturally” and Penelope offered a metaphor-based reflection: “If there was something you would want to just launch in your life right now, what would that be?” The survivor cited “something related to using (substances) and now being in recovery, but addiction… About 30 seconds later, her vape falls out of her pocket into the water… She just laughs and she’s like, ‘Ah! Of course!’” Penelope elucidated: “nature acts as another therapist.” She suggested that clients know the power of nature- and community-based spaces in recovery work, and identified examples of survivors requesting to go to specific places for therapy (i.e., walking in a nearby beautiful park, or going to a particular community location because “we need to do this piece of work here.”). Even in industrial spaces, she referenced using the client’s local surroundings for therapeutic ends, such as doing a check-in based on the prompt: “’find one thing that represents… where you’re at today’… I had women find grass,… a pole,… an electric line,… cement,… a car,… a license plate.” Together, therapists highlighted numerous and unexpected community spaces that serve as resources in recovery.

2.b. Community- and Culturally-Embedded Relationships are a Resource in Recovery.

Participants discussed the importance of community- and culturally-embedded interpersonal relationships and practices in recovery, and suggested that social support serves as a systems-level resource which therapists can act upon. Tierra argued for psychoeducation as a useful intervention when oriented towards connecting survivors relationally with their social world, including increasing their capacity to understand others. She initially described psychoeducation

in mainstream trauma-informed terms, focused on an individual's nervous system: "it's been key with clients for them to really understand that there are things that are still out of their control," including their biological stress response. Yet she contended that her approach frames individual recovery as fundamentally community-embedded: "the psychoeducation is provided in that way where, it's not that this applies *only* to you, but it also applies to the people around you and the community around you… It gives (survivors) a connection to something external." She framed therapeutic work as service to others, describing teaching her clients "grounding techniques (as something) that you can *share* with other people." Finally, Tierra pinpointed the internal and relational benefits of her approach: "understanding what's going on in my environment, and why people might be reacting to me in certain ways…. You're no longer internalizing how somebody else interacts with you." The result, she contended, is improved ability to connect with others.

Penelope affirmed the value of promoting improved interpersonal relationships stating, "We know that increased support systems often lead to better outcomes." Multiple therapists described the mechanics of helping survivors learn about forming healthy interpersonal relationships. Greta spoke of working with survivors "just trying to improve relationships" and underscored the importance of "creating healthy boundaries." Elina described the importance of therapists modeling those boundaries. Despite some participants in this sample describing flexible boundaries in recovery work with survivors, Elina promoted "limits to the treatment relationship. It can only work with the boundaries that exist." She underscored the importance of modeling realistic expectations in support of survivor recovery: "You can't create dynamics in the relationship that cannot be met elsewhere… that cannot be met by people outside in the world." She cautioned against becoming "the only person" a survivor can turn to, "which is so dangerous… The whole point is to make them be able to have relationships in the world."

Some participants referenced the importance of contending with relational triggers and trauma processing in community (re)connection work. Stacey described survivors emotionally triggered when relationships in the agency’s safe home echo relationship dynamics from their childhoods. Suggesting that these challenges can nonetheless foster recovery work, she said: “it’s really healing in community. They’re learning how to heal in community.” Caroline contended that therapists must consider the interpersonal nature of a survivors’ trafficking experience: “Who is the trafficker to this person? Is the trafficker a family member?... Is the trafficker a stranger? That matters.” She suggests recovery work’s complexity deepens if the trafficker was family: “Young people whose parents were either complicit or part of it, that is hard because they feel like they’re betraying their family even though they know something was wrong.” She recommended the 3-stage model of “safety and stabilization first, then trauma processing, and then reconnection to community… I think it’s very hard for people to feel like they can reconnect if they haven’t processed at least some of the trauma and grief and loss.” Caroline’s approach suggests that interpersonal and community relationship matters, both in the nature of the trauma and in the process of recovery.

Differently, but importantly, Casey described interest in engaging survivors’ family, both for broader community healing, and as resources in survivor recovery. She noted, “the work is very much focused on the individual (survivor). Not all of them have family connections, but some of them do live with their parents, and I think that the parents experience some guilt and shame… and also don’t totally understand” what occurred or how to best support their child. She suggested the power in bringing together parents “in a supportive way” to provide education around exploitation.

Some participants recommended culturally-embedded practices as resources in community-level recovery work. Tierra described researching "healing practices" that she called culturally "home," to better support survivors from Latin America who are in the United States on account of trafficking. She wondered aloud about the use of healing plants and traditional healers ("a curandera, a healing woman for the community"), and asked: "Okay, how can this be translated into therapy?" She spoke of efforts to be "more culturally – not just aware, but *bringing* those techniques to… try to make it more home for clients." She also posited the importance of "community involvement" in recovery since it "is such a big factor in somebody's healing process," yet wondered how that can look "therapeutically," especially given foreign nationals' "lack of community" in the United States. She noted that an "overflow" of support groups and workshops exist for survivors, but suggested limited impact: "I don't know how much it's really impacting my community of individuals (from Latin America) who have been sex and/or labor trafficked… Is it really reaching them?... (And) how much is it really assisting in the healing process?... Clients are not connecting to those resources." Tierra zeroed in on the cultural importance of healing in community, stating, "Within Central and South America, there is some belief that within community you heal… A little lightbulb keeps going off." Even with trauma-informed yoga workshops, she contended, "it still doesn't feel like what's needed… There's something that is still missing from this process." Tierra contended that the missing thing may be community- and culturally-embedded, culturally "home" resources for healing, grounded within communities.

Survivor Mentor/Leader Molly, too, contended that cultural embeddedness and community embeddedness are linked, and suggested turning to survivor cultural communities for expertise. She stated, "We have to be centering survivors' voices in those conversations… How

do we bring in experts within a specific community to inform how to do that work?” She referenced turning to Indigenous women in Colorado for guidance on working with their communities, as opposed to “commandeering” the process and presuming that “’what applies to all of trafficking survivors will just be a good fit within these communities as well’… (It’s) inappropriate.” She described Indigenous survivors as “expert of their experiences, and their community, and their culture, and they need to be informing how anti-trafficking work looks in those spaces.”

Some participants promoted the use of culturally-home religious stories and practices in recovery. Josephine described conferring with “cultural brokers” in a community to learn stories from clients’ religious texts that might support recovery (i.e., she cited a story from the Quran centered on: “you can pray to God, but you’ve got to do stuff too”). She noted, “with highly religious clients, that has been helpful.” Stacey referenced her agency’s Christian mission, noting they offer “connection to the faith… (as) another avenue of healing” and help connect survivors to a church “to find a community that (they) are comfortable with.” She described agency staff interweaving faith by offering “spiritual mentoring” and praying for clients, while “in the normal social work world, you don’t do that.” She suggested a relational aim: “if we are showing them grace – which is something that comes for us from God – they can learn how to have grace for other people who have harmed them.” Penelope emphasized the power of recovery work that integrates family, spirituality, and community: “If somebody asked me, ‘Should we do (recovery work) from this angle where it includes the family and community and spiritual practices and other?’ I would say, ‘Yes, yes, yes.’… I’ve just seen it work.” Yet she underscored the critical importance of survivor-led definitions: “It depends on how (survivors) define community. Like, getting clear how *they* define spirituality, how *they* define family, how *they* define these things.”

Finally, Peer mentor Ramona described her community work not just as a geographic place, or group of people, but rather as a state and space of equal-power sharing. Ramona described “community work” as distinct from professionalized peer mentor work. In community work, Ramona contended, the “power dynamic that just intrinsically happens” between agency professionals (including peer mentors) and clients can lessen, and “some of the (agency) rules and guidelines… aren’t as applicable.” She asserted that that the most “effective” healing work happens outside of institutions. In community work, she reported “always striving for a power-with model… (where) you’re coming to this relationship by choice, and I’m coming to this relationship by choice, and we’re working together.” A community-embedded healing relationship, she suggested, fosters trust, self-esteem, and healing:

> Community work for me is just doing the work that I’ve *always* done: meeting people where they’re at – validating, strengths-based approach… trying to create the space for people to be able to trust themselves – to trust that they are good, to trust that they are not broken, to trust that they are moving towards healing and they don’t have to do a million things. Their bodies and their minds are going to move in that direction.

2.c. Survivor Networks and survivor community support recovery.

Many participants discussed the power of survivor networks and survivor community to provide both structural and emotional support to survivors. This was coded separately from “community- and culturally-embedded relationships” since survivors’ mutual support is analytically distinct from non-survivor interpersonal relationships (i.e., with family or the broader community), and because it was sufficiently robust. Ramona related that “survivors are connected with one another. There are survivor networks. They’re on social media, and then they exist outside of social media as well.” Desiree likewise described a local survivor group, founded

by a survivor (who later became a peer mentor and social worker), that began in-person but had grown to over 400 active Facebook members by the time of interview. She identified it as “led by the community and it has community ownership.” Caroline contributed that she encourages survivors to “reach out to other survivors” via the networks, although she promoted survivor empowered choice and self-initiation: “if they want to connect with (other survivors), they will. I don’t feel like I need to do that for them… If they make that choice, they can do it.”

Survivor mentor/leader Molly described her community- and network-building work as emanating from lived experience: “I have five years of lived experience as a survivor – domestic sex trafficking and commercial sexual exploitation. After exiting… I have gone to school.” Molly described achieving undergraduate and Masters degrees, and then founding an organization that grew out of her experiences, centered around direct service and “survivor centered research.” She continued, “I have a social media network that was mine while I was being trafficked. And so that is a national network that kind of spread through word of mouth after I exited because I started talking about my experiences exiting, and trying to find employment, and trying to find a therapist.” She noted that this network grew from 50 people in 2012 to over 2000 people by 2020, including rapid growth during the COVID-19 pandemic. She referenced the emotional and structural support that the network provides to those currently being exploited, in the form of psychoeducation and monthly care packages to approximately 100 recipients.

Participants described the potency of survivor networks and community for offering powerful, reliable, and non-traditional support. Penelope glowed, sharing, “you want to talk about a community that helps their people? These women know how to show up for each other… No one is going to go hungry at the table… If someone needs a ride to work, somebody is going

to show up." She described the model as "more of a collectivist model that I'm seeing them live out – not because they were told to do it, but they just do it – versus an individualistic model." She suggested an ethic of power-sharing and support based on lived experience, noting that in tough times, "they all come alongside of that person…. They're not going to let someone else slip through the cracks if they can help it." Ramona discussed the "hope" she feels about "the real healing and real possibility and real potential for how communities will take care of themselves when the system fails them." She referenced the power of those who "step out of the idea of nuclear family, people who step out by choice or circumstance, people who take on more of these 'radical' ideas" to create communities for themselves. She underscored oppression of varied groups who suffer trafficking:

> The genocide of Black folks in this country and Indigenous people and the oppression of women… has not wiped them out. The oppression of trafficking has not wiped us out… White supremacy has shot itself in the foot. By oppressing people for so long, I think you end up with incredibly resilient and astounding people… who will go to extreme lengths to change systems, and to reimaginings, and to create new tables, and to create new ways of doing things… And I think that's where the hope lies… That's where the community work is being done, is in these networks that we create for ourselves, these relationships that we create from ourselves that don't fit society's normal narrative.

Elina referenced the hope that community brings even during the isolating COVID-19 pandemic: "with the pandemic, because it's very difficult to bring people together, but… we hold that dream of community, and I think that in and of itself creates hope."

More than half of participants described the benefits of agency-based peer groups and events, in terms of connection and opportunities to build community. Greta discussed the

“community aspect” of group therapy in jails as “healing” because survivors can be acknowledged and recognized both by a therapist and other survivors “who can identify with those things… Agreeing and relating… is huge.” Some participants referenced the power of psychoeducation tools to offer connection: “people really do feel alone in these experiences, so it does help them to hear that other people also have that” (Caroline). Caroline and Josephine noted that “groupwork” and “building community support” (Caroline) are helpful. Greta highlighted agency-based peer events that are “open to community” and focused on “building community,” including “virtual groups” due to COVID-19 restrictions. Notably, however, Molly underscored the limits of virtual work: “peer groups are hard to do virtually.” Casey and Greta described in-person agency-based events, where survivors participate in and/or give back to survivor community continuously over time. Desiree underscored the importance of “building community, not just the individual work,” by hosting agency gatherings with a “community building intention.” She highlighted the power of such gatherings noting, “we had been hearing again and again from different survivors, ‘we want to be connected,’ and I know how important that sense of belonging is for mental health and psychosocial wellbeing.”

Desiree spoke directly to the positive outcome of survivor community gatherings. She described benefits such as “a spirit of sisterhood… and connections, and a depth of resonance with each other that I can’t provide individually.” She shared that after one such survivor event, “I noticed a shift in (a survivor’s) treatment after that actually. She felt like she was able to open up to me a lot more… Something kind of clicked in that moment. That was kind of interesting.” Desiree referenced Judith Herman’s work to highlight the critical importance of therapists engaging survivor community in their treatment efforts: “it reminds me of the complex trauma – stage 3 – of belonging and community and connection and giving back. I don’t know how else to

create spaces for healing without that communal context, to really get the next level of healing in.” Desiree highlighted the value of survivor community versus peer mentors, as potentially differently supportive, noting that a peer mentor may be viewed aspirationally as a “role model.. (to) be like someday,… but maybe the exception.” Whereas survivor community may provide a greater sense of the “collective,” and “an experience of belonging” by being “less on a pedestal.” Desiree emphasized the limits of her hypothesis: “that would be my guess, but it’s hard to know without asking (survivors) directly about that.”

Therapists suggested the value of peer groups at different points in recovery. Molly suggested that peer groups well support survivors who are “relatively stabilized with basic needs” as they transition to a stage of meaning making. At that point, she said, “I want to connect with peers who have experienced the same thing. I need to understand what happened to me. I need language around what happened to me.” Sophia spelled out the value of peer groups to provide “support,” “normalization,” and even attachment, during crisis phases, and underscored that they can make the difference in recovery work. She told the story of a survivor who arrived in her hospital system suffering severe physical and emotional impacts from trafficking exploitation, and who was categorized as a “kid (who) can’t be helped.” Sophia expressed concern for such youth who “nobody helps” because “there’s no evidence-based treatment. We say that their trauma is too significant.” Instead she offered this youth therapeutic presence and peer support: “we did not do anything fancy… We put her in a group with other girls who had experienced that, so that could be something clinically, right?” Sophia emphasized the value of close therapist involvement with peer support efforts at this stage:

> It was like, “I’m going to unconditionally sit with you when you’re angry, when you tell me ‘I don’t want you to be my therapist, I don’t like you, I don’t like this group, this isn’t working’. We’ll just sit.”... A huge piece of this trafficking work is attachment work.

Greta spoke extensively about the benefits of survivors speaking at agency events as part of their recovery path. She shared, “We always have opportunities, if they feel they’re ready, to speak about what they’ve been through… publicly with us.” She described opportunities to speak at the jail where survivors first heard the agency presentation on trafficking, to model for others: “’this is what I’ve been through and this is where I am now’.” She mentioned survivors speaking at public events, including townhalls and colleges, underscoring the value of their participation: “A lot of it is realizing, you didn’t have to go through what you went through for nothing. You can help other people with your experience… I think it helps them more than I could ever imagine.” She noted that survivors receive positive feedback that “makes them feel so good that people are so moved by their story, and people have been through similar things… and they have been inspired by their story.” She described publicly speaking as healing: “(survivors) just feel empowered that they shared (their story) and that so many people were listening and receptive… I think it is healing for a lot of our clients.” Greta noted that it becomes a part of the healing “to-do list,” as in: “one day, when you’re comfortable enough to tell your story, we’re going to have (an opportunity for you) like we always do.”

Ramona contended that a mutual healing component to “community work” resides in making meaning of her trafficking experience in service of survivor community: “If I am going to live through what I lived through, then this is how I’m going to make meaning of it – it’s trying to help other people feel like they can get some level of healing even though the world continues to be a harmful place.” Pondering the boundaries between community-based and

emancipatory or decolonizing work, Desiree stated, “I don’t know if it’s a decolonizing thing, but I think community and creating a sense of identity outside of just yourself, I feel like that’s kind of important.” Exploring her work in emotional terms, Ramona choked up as she described the positive impact on her life of involvement with survivor community, in terms of healing, support, and credibility:

> As I have been an instrument in healing for other people… they have been an instrument in healing me… If I didn’t have the survivor community supporting me through what I’m going through right now, if I didn’t have the social capital, and then if I didn’t have those relationships, where I would be is completely different.

Other participants who are also survivors referenced the value of peer support groups and interaction with other survivors in their own recovery processes. Molly argued for the value of the My Life My Choice curriculum (a therapist/survivor co-facilitator model) and Ending The Game, describing her growth during the latter: “when I went through the training, I could relate so much to the concept. I was like, ‘Oh, I’ve lived this. I’ve never looked at it this way!’” Sophia, a therapist and Doctor of Social Work, disclosed her survivor status during our interview, sharing that her realization about having been sex trafficked emerged while working with young survivors. She shared,

> I was a survivor of trafficking. But not in the context of what we usually think of trafficking. I ran away from home a lot and engaged in survival sex... I worked for years in emergency rooms as a social worker, with runaway youth who I believed were experiencing trafficking. It’s where I became cognizant of, “oh, this happened to me.”

Sophia’s disclosure underscores the power of peer/survivor interactions for consciousness-raising, the mutual healing potential of survivor connection, and the ways that therapists grow

from their work with survivors. It also highlights the complex, meaningful, and varied pathways to recovery that survivors undertake, where survivors are also healers, therapists and researchers.

2.d. Intersectional analyses in recovery work.

All participants in this sample discussed some form of intersectional analysis in their multisystemic recovery work with survivors. This was defined as awareness about the existence and negative impacts of systemic oppression, bringing a systems-frame to therapeutic work with survivors, and contending in treatment with participants' intersectional identities which have resulted in discriminatory experiences. The interview protocol sometimes prompted these conversations by asking about participants' awareness about, training in, and/or use of "emancipatory and decolonizing healing approaches." In other cases, these topics arose naturally as participants described their work and perspectives. The following discussion will first overview participant awareness of, interest in, and training in emancipatory and decolonizing healing approaches. Next, participant perspectives on use of intersectional analysis and a systemic oppression frame in therapy will be discussed.

Table 4 (below) details participant responses when asked explicitly about their views on, and use of emancipatory and decolonizing healing approaches in their work. Eleven out of thirteen participants voiced explicit interest in emancipatory and decolonizing healing approaches, although most lacked familiarity or training. Several participants described a lack of familiarity, despite affirming interest in the approach as described by this researcher. Casey noted, "I'm not familiar… (but) I'm intrigued." Several participants described lacking training in it, but feeling "excited to hear that this is even being talking about" (Tierra), and noting that they "absolutely agree" (Penelope) and "definitely agree" (Greta). One participant reported having

pursued adjunctive training in emancipatory and decolonizing approaches during clinical training, recognizing their importance, while others affirmed a desire to “learn more” (Sophia).

Survivor mentor Ramona expressed relief discussing emancipatory and decolonizing healing approaches, noting “that is what I’ve known intuitively about my work, and just lacked the vocabulary to articulate it as such.” She described it as “the direction,… the framework I do the work from, and where I think the work needs to go in order to be successful… Solutions are coming from the community itself.” After this researcher defined emancipatory and decolonizing healing approaches for the purposes of the interview, Ramona described it as “a breath of fresh air (to learn) that that’s where people are taking this idea of what trafficking work should look like.”

Two participants expressed reservations about emancipatory and decolonizing healing approaches. Josephine shared concern that some survivors may lack a sense of belonging within their family or community. She stated, “What about when there isn’t family, and there isn’t groups... (or survivors) aren’t safe in that community? Then what does that look like?” Elina cautioned that emancipatory efforts not veer into fundamentally colonizing projects. She related, “I’m just very skeptical of emancipatory efforts by therapists in general… I’ve seen emancipatory efforts go very wrong and not meet patients where they are, really to further our own agenda.”

Table 4. Detail of Intersectional Analyses Code: Exposure to/Training in Emancipatory or Decolonizing Intervention Approaches

Participant	Heard of/Trained in?	Interest in?	Comment
Ramona	-	Yes	"That is what I've known intuitively about my work, and just lacked the vocabulary to articulate it as such. That really just resonated with me, and it feels like the direction, it feels like the framework I do the work from and where I think the work needs to go in order to be successful. I think, me, as a survivor coming out of it, and then getting into community-based work, (it) sounds like what I do. Solutions are coming from the community itself… I wouldn't say I'm challenged by it. To me, it feels like a breath of fresh air that that's where people are taking this idea of what trafficking work should look like. There were so many things that, when you were speaking, I wanted to comment on or say 'yes' to."
Casey	No	Yes	"I'm not familiar with it [decolonizing or emancipatory healing approaches]. I have not heard about it. I'm curious now. And I actually – I don't - I'm not sure I think it would challenge what we're doing now…. I guess I'm intrigued."
Tierra	No	Yes	"I am not trained in that (emancipatory/decolonizing healing) type of approach, but I am super excited to hear that this is even being talked about."
Josephine	No	Yes	"Well, what about when there isn't family and what about when there isn't groups? I love that idea. I think that sounds awesome. *But,* when you're talking about people that don't have family or group contact or aren't safe in that community, then *what does that look like?"*
Penelope	No	Yes	"I have not been trained specifically in those models. What I have – just by the nature of doing this work for a while – I've seen this in real-time. So, what you're saying, I would absolutely agree. "
Greta	No	Yes	"I love that. I have not been trained in that. I guess I haven't even really hard of it in those terms either, but I definitely agree with that approach, for sure, just from what you've read, and I try to definitely do that as much as I have the opportunity on my own."
Elina	Yes	-	"Oh, sure, yeah… I think these are, you know, important efforts… I'm just very skeptical of emancipatory efforts by therapists in general. I'm skeptical of all of it… I think, in the actual work, I think I've seen these emancipatory efforts go very wrong and not meet patients where they are. Really to further our own agenda. That's been true of the field in forever."
Maya	-	Yes	"It's integrated into her talking about clinical work. She says "They (clients) know it pretty intuitively (that things in greater social structures weren't their fault). They know it. It's really just validating what they know." AND "I think one thing that would be meaningful is that the main way that I got that training (in decolonizing and emancipatory approaches) is I had to go outside of counsellor education."
Sophia	No	Yes	"I sadly have not heard of that, and I have not been trained in that which is very surprising to me, especially because I feel like (my graduate training program) has a lot of really good things like that, but that's not something that ever came across my plate until now. As far as being interested in it, it sounds very interesting. It sounds like something I would want to learn more about."
Molly	Yes	No	"I'm familiar, generally speaking, with the concept of decolonizing. I love that. I'm like, 'Sign me up for this!;…. I'm not trained in it. I'm not that familiar, but I can draw some assumptions that I would probably very much support the idea."
Desiree	-	Yes	"I very much agree with that approach – that treatment style. I really do…. I'm really grateful for that question. It's making me think a lot more, specifically around that approach, and I imagine some of it informs my work, but I would be so curious to learn more."
Caroline	No	-	"I haven't heard of it as that – stated in that way."
Stacey	-	-	"I'm so open to doing the right thing because, again, this world of therapy and theory, it's all - the white man created it, and most people who are working in it are white women. And so, what do we need to do to reach everybody? There needs to be some sort of change."

This discussion will now explore the broader content of participants’ responses in relation to intersectional analyses in recovery work and a systemic oppression frame. Nearly all participants acknowledged a structural, systemic component to the trauma of trafficking that differentially exploits at the intersections of marginalized identities. Survivor mentor/leader Molly described identifying with “radical feminism,” which she explained as having a systemic analysis: “we have some systems that, actually, they’re not broken. They’re designed this specific way to keep people in specific places in our society.” Ramona similarly expounded: “systems are… doing what they’re designed to do, and that’s to oppress… (It’s) not that they’re not working, and this is just a byproduct. This was by design.” Elina, a psychologist, referred to her hospital-based program as a “feminist program” that takes “a strong stance” on trauma’s structural roots. She asserted: “it’s not like ‘oh, bad things happen to good people.’ It’s like bad things happen to the same people – just more and more. It’s structurally set up for that.” Both peer mentors Molly and Ramona voiced the need to “dismantle” the systems that exist and remake them “with a new framework” (Ramona). Molly shared, “I think there’s only so much fixing of those systems that you can do… Things just need to be deconstructed and we need to allow folks to define what life looks (like) for them” (Molly).

Maya cited overwhelming challenges for domestic survivors living in “an incredibly oppressive, sexist, racist, ableist, homophobic, transphobic society… They’re up against generations and generations and generations of trauma and violence and abuse and rape,… and all of the oppression and then all of the victim-blaming that goes with that.” She declared the challenges profound: “They’re up against all of the skeletons in our closet, and those can be hard to identify and fight. And the foundation of those is so strong… It’s really hard to beat up against centuries and centuries of that foundation.” Similarly, Desiree zeroed in on the vulnerabilities

faced by undocumented international survivors related to U.S immigration policy and the “history of colonization,” calling the strains “out of control.” She spelled out the complexity: “I don’t even understand where to begin to address those issues… (with a survivor who) was working without pay, and they don’t feel they can even go to the police because they weren’t supposed to be working in the first place,” and they concurrently face death threats, rape and “horrible things that have no legal remedy… available.” Desiree connected these things to “the sociopolitical history of our immigration policies,” as well as slavery and “intergenerations of trauma, violence and oppression, (and) unequal access to wealth” which compound to create differential vulnerability.

Caroline, whose work was predominantly private practice with white clients, offered an intersectional lens focused on socioeconomics. She cited survivors who were trafficked attempting to help provide for younger siblings and attributed the cause to “socioeconomic” forces although affirmed a vulnerabilizing link amongst “racism and suppression,” socioeconomics and trafficking. She advocated for listening to “what these different vulnerabilities are and how they interact” and proposed a “socioecological model… (of) individual risk factors - interpersonal, societal, and community-based.”

Many participants explained how engaging in multisystemic work with survivors necessitates therapists learning about systemic/structural racism, since it is interlaced through all of the systems in which survivors interact. Peer mentor Ramona advocated for training and awareness: “I feel very strongly that if you want to… serve victims and survivors of trafficking, then you need to get well-versed in other social institutions that intersect with that.” She highlighted specific groups and phenomena about which providers must become more “aware and educated,” including “the ways in which America has been built around white supremacy,”

"the long history of how that has impacted Black people for generations," and "how the gender binary oppresses people, especially trans people and especially women and girls."

Multiple participants, however, cited a lack of available training in community-based, intersectional, emancipatory healing approaches. Stacey cited a lack of training in her graduate program on intersectional identities, especially the LGBTQ community. Maya noted that to access training on decolonizing and emancipatory healing approaches, she had to step outside of her clinical doctoral program. Maya reported being influenced by the Black Lives Matter movement in 2016 and the killing of Michael Brown, and it crystalizing frustration with her doctoral program: "I couldn't take it anymore… The last chapter situation, the blah blah blah, disclaimers about cultural competency… I just couldn't listen to this bullshit every day." Augmenting her counselor training in the African American Studies department of her university was "a huge leap" (Maya) in her work. Desiree likewise reported receiving no training on this approach in social work school, but instead gaining exposure through graduate work in religious studies.

Several therapists referenced increased awareness of racial justice issues due to the social mobilizations that peaked during summer and fall 2020, and discussed ways that they bring a systemic frame to therapeutic work. Greta, a white therapist, described the impact of recent social mobilizations on raising her consciousness about the "systemic racism" her clients face and about "her own privilege." She shared, "ever since the George Floyd killing and Black Lives Matter becoming so prevalent,… I really have learned so much more history of… (what) other cultural groups have been through." She stated that she is "committed to learning more… because it does come up all the time, especially with so many of my clients just involved in so many different systems – institutional racism is everywhere." She expressed some awareness

about ways that "systemic issues," "systems, and the systemic racism," and "colonization… work against – always has and still does – so many marginalized communities." Casey, also a white therapist, described having overt conversations in recent months with clients about "what's going on in the world or talking about the fact that I'm a white therapist, and they might identify as a Black woman, and how that feels for them." Greta also emphasized speaking to her clients about "racial injustice" more frequently since inequalities became more evident to her during COVID-19.

Therapists discussed efforts to balance a systemic focus with therapy being survivor-led. Greta described wrestling with how to hold a survivor-led frame in recovery work if that survivor was not versed in discussions about systemic racism: "sometimes clients don't even maybe know the full history… and that it's not just them – that there's a huge systemic issue." Greta identified the ethical tension she holds: "I try as much as I can to not take away any of the time from the session with the client with… (topics) that I want to talk about… (but I) do bring that up as much as possible." She expressed a desire for more training: "I feel like those conversations, that I do sometimes get to have, really I don't know the effects on my clients. But I do think it's really important." Tierra described being cautious bringing up such topics, saying they arise "when appropriate." She noted frequently discussing the "root causes of sex trafficking… and gender-based violence" with some clients, yet with others, "it doesn't connect… right away." She stressed that a systemic focus is survivor-dependent: "If a client brings it up, and it has meaning for the client, then I keep working with it. But if a client didn't bring it up, it might not be part of therapy." She suggested that strong rapport is a precursor to "exploring some of the societal issues that are connected to their own trauma history."

Therapists referenced bringing a power analysis to their recovery work. Penelope critiqued the effectiveness of “power-over” models, which wield “authority” over a survivor. She questioned the long-term effectiveness of such approaches, sharing, “the power-with models, I tend to be drawn towards. I’ve also seen a punitive model not work long-term.” Josephine offered a power analysis, where she attempts to work against the power dynamic that accompanies her being a white, cisgender U.S. citizen therapist. She noted, “I’m put in a position of power that isn’t necessarily deserved… (because) I’m affiliated with some type of institution and I’m the white lady on the other end of the phone.” She described a power differential “that I have to work against because, if I don’t try to work against it, it can be really detrimental and people can feel really disempowered.”

Participants discussed the mechanics for integrating intersectional analyses into their recovery work. Greta described leading with acknowledging her awareness of racism’s impacts. Penelope articulated openness to any topic related to intersectional identities in her treatment space. She shared, “There is no emotion that I don’t allow in the office. There’s no conversation I won’t enter into… We talk about: injustice matters, race matters, your beliefs matter, what you experience matters, who you’re angry at, what person or what system.” She recommended offering equal space to discuss trauma impacts as much as intersectional analysis: “how did race impact that, how did gender impact that,… how did the system that you grew up in?…It’s that intersectionality.” She added an important component of the work as a “white female” therapist is acknowledgment of her intersectionalities; that is, “owning my own-ness in that space.” Tierra offered a creative way to bring a systemic frame to therapy, grounded in one’s particular (intergenerational) intersectionalities, through the use of an expanded genogram. She shared,

> What happens when you start expanding out the genogram, and who are you connected and not connected to?... It brings me back to that community piece… We’re not functioning in a silo. We are part of this bigger picture. Whether we are aware of it or not, there are other things happening around us - institutional interactions.

Maya promoted a systemic frame in therapy by shifting the locus of pathology from individual survivors to the systems surrounding them. That is, an intersectional/structural analysis. She suggested “externalizing the sense of shame and blame” that survivors bear, so they may “understand how their external conditions are really to blame for the circumstances that they’re in, and not themselves.” Desiree similarly questioned “ideas… that colonize people’s experiences” and mentioned her “approach of trying to take those other people’s ideas off of them” and instead “let their own self… speak for themselves, and their own thoughts and feelings guide their choices.” She pondered if this was the essence of “decolonizing therapy.”

Balanced with a systemic/structural analysis, however, Maya described having learned from survivors themselves that some may need space to take individual responsibility for past actions. She noted this was a “tricky… delicate… learning curve” for her to differentiate self (victim)-blaming from a healthy urge towards “self-responsibility.” She detailed a “turning point” when she realized “that there were things that they can, and need to spiritually take responsibility for within themselves, and I can’t shut that down because I’m afraid it’s going to sound like victim-blaming.” Overall, Maya described her work as empathic and survivor-led, with a priority on “validating what they know… (Because) so much is working against them all the time that they’re just in a whirlpool, so it’s hard for them to listen to themselves… (and) access what they know… But it comes from them.” Remembering past client sessions about

trafficking and colonization, Tierra, too, noted that survivors do “a lot of the guiding in that conversation.”

Tierra, who mostly works with international survivors from Latin America, described processes for introducing systemic, decolonizing thinking to her clients in therapy; that is, by promoting consideration of how historical systems and institutions inform present ones. She shared,

> You might not be… residing in a country where there is a civil war, but what happens when you go to social services benefits office, or when you deal with law enforcement?... Some of these institutions are based out of colonization, and how (do) those things reflect each other? So, as much as you might say that “the civil war, in such and such a place, happened decades ago. What does that have to do with us now?” “It’s because the past informs the present.” And that’s sometimes how that conversation goes.

Tierra added that she links individuals’ struggle to collective, population-level struggles. After inviting survivors to consider how historical systems and institutions inform their present struggles, she nests discussion of a client’s traumatic experiences in a broader population-based frame. Tierra shared,

> Then, I bring it back to the trauma piece. Why we do trauma work is that we’re trying to make sense of our past, understand it, so it doesn’t continue to affect us in our present and our future.… I view it in my head as the same, but when I’m talking to the clients, I pose it as a parallel process. Like, your individual trauma is also this collective experience of trauma.

In similar terms, Desiree highlighted the therapeutic power of linking individuals to the collective via survivor events. She reported that one survivor felt “a place of belonging

(because)… she connected her individual struggle to the collective and that was powerful for her."

Casey described ways that family-based intergenerational trauma dovetails with population-based historical trauma for populations. She noted holding an awareness of the "community, family, spiritual… (and) historical context" in her mind, but "I don't explicitly talk about that with any of my clients." She specified historical context to mean intergenerational within survivors' individual histories, as well as the historical context of "human trafficking and slavery."

Some therapists discussed contending in treatment with participants' intersectional identities which have resulted in discriminatory experiences. Again Tierra referenced a client who was "interested in talking about these issues because… (he) was very aware that people were discriminating against him because of the way he looked." She described discussing with him discriminatory experiences in his country of origin and how it was "replicated here when he migrated to the U.S.," and noted his "relief" when having those conversations. Similar to Greta who held ethical tensions, Ramona acknowledged clinical "hesitation" wondering, "'okay, when does it get too much?' Because we're talking this big-picture thing, of things that are outside of your sphere of control. How much is it going to overwhelm the client? How much is it really helpful?" She noted that "instinctual clinical skill kicks in" to help her make that determination.

Participants referenced agency-level work raising consciousness about intersectionality and racial justice issues. Casey noted that her agency has been doing "a lot of work around diversity and equity and racial justice. And so we've been taking a really close look at our self and our culture, and how we work with it - (with the) young people in our program." She expressed awareness that, with increased concern about racial justice in summer and fall 2020,

the agency had to "figure out how we are going to move forward in doing this work in this current climate with the youth that we serve." She commended her agency for bringing in outside DEI (diversity, equity and inclusion) experts, describing the work as "messy" but helpful for strengthening their diverse team. Stacey described her faith-based agency's efforts to read the book *Pursuing God's Heart for Racial Reconciliation,* and incorporate its lessons into staffs' personal lives and work. She stated, "if this is a ministry, it needs to completely interrelate with what we're doing racially."

Different from the other participants in this sample, when asked about her multicultural work with survivors of diverse backgrounds, Sophia noted that she does not "think about culture a lot, which is weird because I'm a social worker so I should." Instead, her intersectional analysis focused more squarely on privilege: "I think more about privilege versus not privilege" as opposed to cultural differences.

Category 3: Peer mentors are Critical to Multidisciplinary and Multisystemic Work

Peer mentors (also called survivor mentors) were found to be critical in multisystemic and multidisciplinary work with survivors of sex trafficking. Key dimensions were: "relational services" (e.g. outreach and rapport building based on shared experience), mutually supportive partnership with therapists, and mitigating the challenges of multisystemic embeddedness. This category was of typical strength, cited by eight participants.

Table 5. Category 3 Close-up: Peer Mentors are Critical to Multisystemic, Multidisciplinary Work

Category 3: **Peer Mentors are Critical**	Frequency: Typical • 8 participants
a) Code: "**Relational Services"** *"(My role is)not clinical services - and I guess it's a little bit more difficult to define - like, relational services. Someone who could say, 'Me, too. This is the path out. Yeah, these systems are troubling. This is how you navigate these.'" (Ramona)*	Frequency: Typical • 7 participants

b) Code: **Therapist/Peer Mentor Partnerships** *"(My work) would have been completely impossible without survivor mentors… (for doing) culture-specific… trauma-informed (work)." (Maya)*	Frequency: Typical • 7 participants
c) Code: **Mitigate Challenges in Multisystems** *"I fought as hard as I could for this kid on every front that I was able to." (Ramona)*	Frequency: Variant • 3 participants

Note. A category/code was labeled as *general* when it applied to 12-13 cases, *typical* when applied to 7-11 cases, and *variant* when applied to 2-6 cases (*N*=13).

3.a. "Relational Services."

Multiple participants described the importance of peer mentors in survivor recovery, characterizing them as "the core of the work" (Casey), "the heart of our program" (Casey) and "critical to the work with survivors" (Ramona). Ramona spoke extensively about engaging in outreach to trafficked people to offer connection, empathy, and guidance based on her personal experience. She related, "I am a survivor of trafficking… When I got out of it, I found there was a lot of issues with the system," specifically the "justice system and nonprofit systems" including a lack of "excellent or great care for survivors." She "immediately" began outreaching to other survivors: "either really specifically - women who I had been trafficked with - or just at different community centers," or through "word of mouth" referrals. Peer mentor participants described outreach as based on empathic "personal connection" (Molly), and involving guidance for navigating the systems of recovery. Ramona characterized her emergent role as "not clinical services - and I guess it's a little bit more difficult to define - like, relational services. Someone who could say, 'Me, too. This is the path out. Yeah, these systems are troubling. This is how you navigate these.'"

Peer mentors identified important elements of the work related to relationship building with survivors, and across cultural divides. Ramona recounted meeting during a crisis on a youth's back porch as that youth was being actively trafficked, she and her family were being

threatened by the traffickers, and DCF had just been called. Ramona described sitting down with the youth and relating to her "why I was in this work, and I told her I was a survivor… I shared some (of my story) with her, and just worked on building relationship and rapport… in the context of everything that was happening." Survivor mentor/leader Molly noted that it is through normalization of like-experiences that "we're able to anchor relationally to one another." Molly stressed that peer connection persisted even across language and cultural barrier: "you don't really need much language to communicate:… 'I see you.'"

Peer mentor work was described as both crisis response and long-term support. Casey, a therapist who partners with peer mentors in her work, described peer mentors as there for crisis, on quick text dial, and "who (survivors) go to constantly, any time of the day… for anything you can possibly imagine." Ramona described offering a sense of familiarity, comfort, and consistency during crises by providing transportation to survivors transitioning to safe harbor facilities "because we'll stop and get Skittles and your favorite food just to try to make the experience of leaving your home,… your comfort zone to go live somewhere else with strangers (more comfortable). We were just more in tune with that [than DCF and DJJ (Department of Juvenile Justice) staff]." Ramona also referenced mentors' long-term support of survivors and their families, stating "especially with kids who went missing, it felt like a critical component of continuity of care – to make sure they were getting the same person coming back… who was well-versed in their case and had rapport and relationship… with everyone involved." Casey noted that her agency matches survivor mentors with youth for a "lifelong relationship and ongoing support around leaving The Life."

Several participants described the depth of connection and trust that results from the "similar lived experience" (Molly) of trafficking exploitation. Molly described it as "something

that I can’t stress the importance of enough, and that’s what feedback we get from clients all the time.” Desiree underscored the relational bond that survivors speak of, related to their peer mentors: “(Peer mentors are) able to meet (survivor-clients) in a place that’s so deep that they feel understood, they feel seen, they feel known, they feel not judged. I think it’s the nature of meeting someone who’s been through this kind of experience. I think there’s an automatic kind of bond.” Ramona emphasized her further ability to relate based on “intersections in her (own) identity” (i.e., including growing up near the poverty line and identifying as gender nonconforming. Note: Ramona specified she uses she/her pronouns). Ramona highlighted that her intersectional identity helps “facilitate understanding and empathy for other intersections of identity, and gives me a framework for understanding how other people might feel, or how (trafficking) might impact other people.”

Peer mentors underscored survivors’ choice to engage with mentors. When recounting the story above about a youth in crisis, Ramona mentioned that she was “completely aware that (the youth) may not be invested in meeting with me.” Survivor mentor/leader Molly also highlighted choice: “we get to walk with people as long as they want our support.” Nonetheless, Molly identified the work as often long-term: “you really get to see kind of the entire journey, if they allow us into their lives for the duration.” Molly suggested these long-term relationships were personally sustaining: “A lot of times, service providers interact in a very limited snapshot, and oftentimes that tiny little piece is not pretty. It’s messy. It’s ugly. It’s painful. It’s frustrating and exhausting. If that’s how you’re seeing, you’re just like: ‘there’s no hope.’. We really get to see this kind of journey.” Molly suggested that, in witnessing change across time, peer mentors and survivor leaders are in important positions to hold and reflect back hope - for survivors, for

the providers who work with them, and for the agencies and systems in which survivors are complexly engaged.

Participants suggested that many survivors prefer to work with peer mentors over licensed mental health clinicians. Molly cited the greater “level of safety when disclosing things” to peer mentors that comes with a sense of “you understand what I’ve been through. You get it.” Sophia noted the same: “the survivors want to see other survivors. They don’t really care about the psychologists.” She added that many of those doing strong anti-trafficking recovery work in her state of Texas are survivors without formal mental health training: “they’re doing a lot of the clinical direct work without any of the tools that some of us learned in higher education. Probably more successfully.” Sophia did not mention whether she discloses her dual background as therapist and survivor, and how that might impact her work. Notwithstanding the preference on the part of survivors that some participants described, it bears mentioning that some peer mentors do receive clinical training. Casey noted that her agency provides peer mentors clinical training, and that some are in Masters programs for social work or psychology. Participants suggested that mentors provide “role model” (Desiree) inspiration to survivors by showing them “how to move forward, and that it’s possible,” and by modeling “a way that (survivors) can use (the trauma of trafficking) positively:… to own it and be stronger from it” (Greta).

Notwithstanding its importance, Ramona underscored difficulty defining her role. She critiqued the terms “survivor mentor” and “peer mentor” as calling to mind “going out for ice cream or professional mentors” when it is neither. She suggested an unwelcome power imbalance: “if I’m serving professionally in a role as a peer, I kind of lose my status as a peer because now, I have power over you – and not that I want this!” She critiqued the impact of increased “authority and access” on survivor-clients, and noted her struggle “coming up with

terminology that really… defines that role.” Ultimately, she underscored the unique value of survivor voice in recovery work, and peer mentors: “I think people who survive this have so many incredible insights to offer about what’s effective and what’s not, and what feels harmful” (Ramona).

3.b. Therapist/Peer Mentor Partnerships.

More than half of the participants in this sample referenced the relationship between peer mentors and therapists as a mutually supportive partnership in service of survivor recovery. Peer mentors described supporting survivors’ “transition into therapy” (Ramona) by offering information about therapeutic modalities and promoting a connection to a therapist. Ramona specified working successfully with clients who were initially “resistant to therapy” to increase their comfort and readiness over time. Desiree, a therapist who partners with peer mentors, described the “survivor and clinician partnership” as ultimately supportive for transitioning into therapy. She noted that because of the partnership, and due to the trusting attachment between survivor and mentor, peer mentors can successfully refer survivors to therapy saying, “’I know Desiree and she’s great!’... Then when they come to speak with me, they already have a warm hand-off which has been helpful.” Desiree noted that without that referral by a survivor mentor, “it’s a lot more effort to… earn that trust.”

Peer mentors refer to therapists if they feel a survivor’s recovery clinically warrants it. Therapist Casey noted that if mentors are concerned about a mental health issue (i.e., anxiety or depression) and “don’t feel comfortable addressing or navigating those things, they might encourage their mentee to participate in therapy” if the survivor chooses that. Casey underscored the mentor’s role as bridge: “the initial meeting is always the three of us together where the mentor is the one who’s the connector.” Peer mentors may then provide check-ins on therapy,

while they offer ongoing support. Desiree described the depth of the partnership: “it’s really helpful. It’s like having an extra set of eyes and heart really… There’s an extra heart available, but not just keeping track of the person’s progress, but it’s really being with the person.”

Survivor mentor/leader Molly described a partnership dynamic while co-facilitating survivor support groups with therapists wherein peer mentors function as information translators. Molly stated, “Sometimes the therapist will present something from more of a therapeutic or clinical framework. Being the co-facilitator, you can understand what they’re saying… but you also come from a place of, ‘this isn’t translating culturally or language-wise.’” She described peer mentors as “the square translators,” facilitating communication and helping “bridge disconnects” between “the square world… and The Life world,” sometimes through examples from one’s own trafficking or recovery experience. Casey noted that therapists and survivors co-write peer group curricula in partnership. Caroline referenced doing trainings with survivors.

Therapist Maya described benefitting from the cultural translation that peer mentors provide. She emphasized that in her clinical practice, she was missing “the understanding of what (survivor) culture looks like and what certain things mean.” She provided the example of learning about “first Fridays;” that is, “oftentimes people are looking to purchase sex on the first Friday of the month when they’ve been paid.” She offered that her work “would have been completely impossible without survivor mentors” increasing her capacity to do “culture-specific… trauma-informed” work.

Therapists who partner with survivors describe the work as “survivor-led,” with their role being to “support the mentor” (Casey). Casey described peer mentors as “constantly” available to survivors, whereas her therapy work was scheduled weekly. She noted that, while survivors can and do reach out to her during the week, she exercises caution so as to promote the mentor-

survivor relationship: “I have to be really careful because I don’t want to take over that relationship of the mentor… (It’s) so important… I don’t want to overstep that.” She described the differences in recovery focus between therapists and mentors, noting that peer mentors “might talk to (a survivor) about the experience of exploitation and try to work with her around preventing relapse or returning to her exploiter.” Casey noted she might also work on preventing re-exploitation, but her main therapeutic focus centers more psychologically on relationships: “she wants to be in relationships. So thinking about how her past might make it challenging to start a new relationship and work through some of those things.”

Peer mentors and therapists described mutually learning from each other professionally. Therapists described turning to mentors for their expertise. Casey shared that she “relied heavily on… the expertise of the mentors to be able to start doing that work.” She described turning to survivor-colleagues in agency leadership as “mentors” for her. She emphasized the value in “getting wisdom from the women who have this lived experience.” Sophia agreed: “the best people to learn from are survivors… That is the one thing we’re getting right in Texas. There are a lot of survivor-led programming… I would always prefer the survivor-led programming.” Still Ramona expressed caution about relying on survivors to be teachers. Instead, she advocated for reducing the burden on individual survivors, underscoring the public availability of information about trafficking accounts which does not rely on survivors teaching and sensitizing others.

Peer mentors similarly referenced learning from therapists. Ramona expressed feeling “underprepared” to do the work initially, facing a “steep learning curve” related to “being culturally sensitive.” She described turning to colleagues in her organization for support: “I really leaned on those people for understanding, kind of developing me in those areas… I had my own personal framework and could be empathetic, but then there were just things I didn’t

have a grasp on when I first came on.” She described being recommended books and podcasts by her organization, and learning through supervision and informal conversations with colleagues. Desiree also mentioned a paid survivor fellow training program, hosted by her agency, which offers ongoing clinical training to mentors-in-training.

3.c. Peer Mentors Help Mitigate the Challenges of Multisystem Engagement

The three self-identified survivors in this sample detailed peer mentors’ important role helping mitigate the challenges faced by survivors as they navigate embeddedness in multisystemic and multidisciplinary environments. This code likely would have been more robust if there had been more peer mentors in the sample. Ramona recounted one client’s (pseudonym: Anna) difficult story of embeddedness in multiple systems, where she faced compounding obstacles that trapped her in the juvenile justice system.

The specific challenges are further explored in the discussion of category 4, while examples specific to peer mentor support are elaborated here. Ramona described providing psychoeducation to DCF staff in times of crisis, “trying to get them to understand this is not a defiant and rebellious kid who doesn’t want help. This is an exploited child who doesn’t feel she has safe places to go and to be.” Ramona worked to coordinate with service partners to support complex client needs by advocating for safe harbor placement, facilitating communication amongst the varied systems and agencies involved, and attempting to help reduce her charges in the criminal justice system. Ramona identified that Anna was about to be “kicked out” for “super minor infractions” (i.e., “mouthing off” to staff and using the internet off hours). Ramona described her advocacy efforts and their limits: “I explained to the staff and advocated hard for her not to be removed from that placement… She had a suspended commitment sentence, so if she wasn’t successful in that placement, then she was going to a DJJ program. That was the deal

that we had been able to work out with the State and the judge. They discharged her anyways and… she then went to a DJJ commitment facility.”

Ramona explained her efforts as a “constant advocate.” When Anna suffered a later-substantiated assault at the hands of a guard in the DJJ commitment facility, Ramona reported it and wrote letters weekly, despite visitors being barred from the facility and letters withheld during investigation. After release, Anna went on probation and Ramona described it as “a nightmare” where “she was just set up to fail the entire time.” Ramona described ongoing advocacy for Anna in court: “the public defender, the assigned juvenile probation officer, and the state attorney just went up to the judge and said, ‘(Anna’s) not present.’ I’m like, ‘We’re right here.’… But that was the assumption.” Ramona described the compounding challenges when a youth becomes juvenile justice involved, and then “really minor stuff” becomes “criminalized.” Ramona characterized her full commitment: “I fought as hard as I could for this kid on every front that I was able to.”

Ramona described supporting clients through the strains of court-mandated therapy, by encouraging survivor “voice” and “boundaries” in multidisciplinary and multisystemic arrangements. She described letting survivors know that “they’re allowed to have a voice in therapy. That they can work on the things that they want to work on. That they can put up boundaries about what they’re ready to talk about and what they’re not ready to talk about… If you are just not meshing well with your therapist, that you can request a different therapist.” She described offering clients validation when therapeutic interventions were unhelpful or inadequate: “(Anna) particularly didn’t want to be told to breathe, particularly when she was in that [DJJ commitment] facility. … Breathing wasn't enough… Her anger… (and) her fighting back was an appropriate response to what was happening… We would talk through those

things." Ramona described her challenge-mitigation role then as validating the limits of available recovery resources and joining: "No matter how hard we fought to change outcomes,… it just always felt like it wasn't enough… So, just even affirming that – affirming that 'the system's not fair. You *have* been set up to fail – this really *does* suck.'"

Other participant-survivors spoke to mitigating challenges for survivor-clients as well. Molly described the service gap in the field, where survivors can lose services if they relapse into substance abuse. She noted that her agency does not view relapse as, "a disqualifier for services… Folks don't get exited because they relapse… I think our (trafficking recovery) community has just really struggled to get onboard with understanding" substance use as a coping skill. She noted that even if a survivor disappears for several weeks, when she contacts her peer mentor, "she (gets) an instant reply."

Finally, some participants understood their work as mitigating challenges dually within systems and psychologically within survivors. Molly described her work as advocating for "the reduction of barriers to accessing services" and noted that once that is accomplished, "it is up to the survivor to engage in those services. If they are still not able to engage in a service… there may be a psychological barrier,… a fear or a social stigma." She specified that a peer mentor's role is helping mitigate the challenge of multisystemic embeddedness, even when that challenge resides within survivors: "because not all barriers are systemic barriers. Some of them are inside ourselves, but we still need support, and it doesn't warrant being blamed." Molly noted that her work includes "working on that – talking through that, figuring out what does peer support look like in that."

Category 4: Multiple Systems in which Survivors are Embedded Challenge Recovery

Multiple challenges emerged within the broader systems and disciplines in which survivor recovery is embedded which strain recovery. Key dimensions include: the criminal justice system (including the immigration system), the health and human services sector (including the non-profit/social service and mental health agencies), the intersection points between and amongst systems, and challenges in systems that specifically interact with therapeutic intervention. This category is of general strength, cited by all thirteen participants.

Table 6. Category 4 Close-up: Multiple Systems Challenge Survivor Recovery

Category 4: **Multiple Systems Challenge Recovery**	Frequency: General • 13 participants
a) Code: **Criminal Justice System** *"Even the clients that I see in jail, most of them can't even focus on any of their emotional or traumatic issues at all because they're just so worried about what's going on with their court case… I just feel like the system has just continuously failed them even when they're doing their best and trying so hard to move forward." (Greta)*	Frequency: Typical • 9 participants
b) Code: **Non-profit/social services & Mental Health Care** *"'This is what I think this group of people needs, and I'm going to raise funds and try to shove these services down people's throats and hope that it works, and then get mad at them when it doesn't work.'… (It) exhausts resources… burns people out… misleads donors… (and) hurts survivors." (Molly)*	Frequency: Typical • 9 participants
c) Code: **Challenges at Sector Intersections** *"There's a lot of safety nets in place,… child protective services, law enforcement. In Texas, we have a huge push from the Office of the Governor… so there is a big safety net push in the greater community. But it doesn't keep the kids safe, and their direct experience does not change." (Sophia)*	Frequency: Typical • 10 participants
d) Code: **Challenges in Systems Related to Therapeutic Intervention** *"I feel like the anti-trafficking field is just a flaming hot mess generally…. We are a decade into domestic anti-trafficking work. It's a new frontier. It's the Wild West… 'Okay, domestic violence. Well, trafficking survivors also experience some level of interpersonal violence. And so, let's just take domestic violence programs and replicate them, but just repackage them as trafficking'… I think there's a lot of gaps." (Molly)*	Frequency: Typical • 11 participants

Note. A category/code was labeled as *general* when it applied to 12-13 cases, *typical* when applied to 7-11 cases, and *variant* when applied to 2-6 cases (N=13).

4.a. Criminal Justice System

Participants discussed formidable challenges in the criminal justice system that complicate survivor recovery efforts. While the United States criminal justice system is distinct from its immigration enforcement system, they are coded together here for parsimony and because of their practical overlaps. That is, the U.S. Immigration and Customs Enforcement (ICE) is a federal law enforcement agency, immigration law violations can lead to criminal prosecution, and local police play a role in immigration enforcement.

Ramona gave extensive voice to the story of Anna, a young survivor of sex trafficking who faced barriers to recovery repeatedly at the hands of the criminal justice system. Ramona described numerous instances where the police failed to protect or believe her. When Anna’s grandmother, who “adamantly” sought “solutions and services” for Anna, called the police for help locating Anna, Ramona contended the family was blamed: “(Anna’s grandmother) was constantly told (by the police), ’Stop calling us. We’re not here to track down your child. You need to be more responsible for this kid.’” Ramona shared that when police came to the house where she was being trafficked, Anna tried to hide, per the instructions of her trafficker: “The police spotted her when she went to hide... She was arrested for resisting arrest, and she reports that she was called a racial slur in the arrest, and that she was handled really roughly… Her only charge was resisting arrest. From that point forward, she was juvenile justice involved.” Ramona suggested the irony of police protection turning to criminal enforcement and re-victimization: “She spent a lot of time in the juvenile justice system based on that - where police officers had shown up to ‘rescue a child’ out of a trafficker’s home. Instead, she was assaulted and discriminated against and arrested.”

Participants explained that once a survivor entered the justice system, exit was difficult. Ramona described an ongoing saga, where initial justice system involvement led to more escalated enforcement. Reportedly, Anna acted out violently in the safe harbor placement, “and then accrued more charges,” and eventually was placed in a DJJ commitment facility. Ramona indicated that, in the DJJ facility, therapists inclined towards using “pharmaceutical restraints… for managing behavior.” She joked ironically: “clinicians in these settings, it’s almost like they can produce psychopaths.” Ramona stressed, “lockdown facilities are no place to heal from trauma… The system doesn’t allow (therapists) to actually implement trauma-informed practices.” Penelope described her clients ages 12-18 as “slipping through the cracks” of the justice system. That is, they lacked family to advocate for them in court, or they cycled through foster care. Penelope noted a common element across her clients was a lack of “anybody initially to advocate for them and redirect them out of that justice system. And so, they ended up deeper in the justice system.”

Participants also underscored that the negative consequences of justice system involvement are long-lasting. Greta noted that a criminal record challenges stabilization as it becomes “impossible to find a good job now with the record… (which) halts all their other goals.” She referenced the ongoing strain of justice system involvement on survivors psychologically: “even the clients that I see in jail, most of them can’t even focus on any of their emotional or traumatic issues at all because they’re just so worried about what’s going on with their court case.” Greta squarely named the criminal justice system as a barrier to recovery: “I just feel like the system has just continuously failed them even when they’re doing their best and trying so hard to move forward.”

Sophia even referenced challenges in law and policy designed to protect survivors. She noted, “we know that trafficked victims are moved around to different places, and so there’s multiple jurisdictions involved.” In Texas, where a “sexual assault exam has to be approved by law enforcement… it gets squirrely about what county it’s in.” She contended that this jurisdictional confusion negatively impacts survivors. Sophia suggested that an already “convoluted” process for a youth who lives in one county, was sexually assaulted in another, and her family lives in another, becomes more complicated when that youth was “trafficked in multiple counties… (and has) multiple child protective service county workers.” She stated, “It made something that’s complex even more complex.”

Multiple participants in this sample referenced the ways in which racism is interwoven through the justice system, challenging recovery. Maya referenced a foundation of “centuries and centuries” of oppression that challenges survivor recovery, of which the justice system is part. Participants cited examples of survivors facing racism at the hands of police. Ramona reported that her client Anna was called “a racial slur” during her arrest, and Stacey spoke of a client who overheard an officer call her “nothing but a dirty whore drug addict” in Spanish. She stated, “that’s what they’re up against.” Likewise, Ramona suggested that her client Anna was treated differently due to race: “As a black girl, she definitely wasn’t seen as a victim of trafficking.” Maya suggested her white client was treated preferentially: “I do think implicit bias is part of it… She wasn’t arrested (and) she wasn’t charged, which she easily could have been.” Stacey shared, “There are these major differences (in how survivors are treated by race)... There’s a lot of emancipation that needs to happen in the legal system.”

Therapists illustrated how racism in the criminal justice system interrupts the entire recovery pipeline. Stacey stated that People of Color may find that recovery programs are not

even presented as options – just incarceration. Noting that most of her clients are white, Penelope detailed her “theory” on the challenge: “My theory is that… some of it goes all the way back to the justice system, and who is being sentenced to longer sentences and who is being released, and who even has access to our services. Who even has access to recovery services? - Which then have partnerships with recovery organizations, that then are referring to our organization?” She expressed understanding that the statistics she is seeing may be skewed: “I don’t actually believe that there’s fewer survivors that are minorities.”

Stacey identified the high levels of mistrust that negatively impact help seeking. She shared, “communities of People of Color have a harder time trusting professionals,… trusting the police. The people who are supposed to help them don’t help them. And so, why attempt to get help if they’re just either going to get taken advantage of (or) you’re not going to get taken seriously?.. So, they’re not reaching out for assistance.” Elina suggested that international survivors may have been coerced by traffickers to mistrust the criminal justice system, which impacts identification and recovery. She noted, “they’re brought here, and they don’t realize that they have access to any kind of rights. In fact, they feel they are criminals… (The trafficker) said the legal system and people who knew about it, would see her in that light – like she somehow benefitted or she participated in what’s called a crime.” Describing a client who is an international survivor of trafficking, Elina described these as “major issues in her treatment.”

Finally, three participants who work with international survivors referenced challenges to recovery within the immigration system processes themselves. Greta described challenges to stabilization due to being undocumented: “there’s just so much she can’t do because of that – her (immigration) status.” She noted that “urgent needs… (and) roadblocks” related to being undocumented make therapeutic engagement difficult. Elina described the drawn-out nature of

immigration cases in the courts, complicating international survivors' recovery. She shared, "I've had cases that have dragged on for ten years, and so our three-stage model of safety and stabilization and then exploration doesn't – that safety place doesn't exist for a long time." She described her work as accompaniment through a traumatizing system:

> A lot of it is just accompanying them through this endless legal process, if they are even lucky enough to find a lawyer and get a case approved… The lack of safety, the constant threat of return, and the criminal justice system - or rather immigration itself - is so retraumatizing… (My professional mentor) would say they couldn't have designed it to be more retraumatizing or less trauma-informed. It's almost like they arranged all of this to make it as adversarial as possible.

Elina described the prominent therapeutic challenge of clients needing to re-tell their trafficking stories in "gory horrible detail" to their attorneys during the T visa application process: "you do something and then it's completely undone."

Tierra indicated that survivors interpret a coercive element to the T-visa application process which impacts treatment. She shared that they feel a "pressure (to) engage in therapy because it's connected to my immigration process. And I think that adds a different level of power dynamics within that relationship." She told the story of one client who said, "I don't really like talking to you, but I'm still waiting on my case, so I still have to meet with you." She clarified that the client was not, in fact, required to attend therapy as part of the T visa process, but he continued attending anyway. Elina referenced the "gaps in… understanding" that clients may suffer, where they may experience assessment/evaluation as "reinterrogation… (because) in their home country, often medical providers and health systems were, if not actively repressive, they were at least complicit." Clients may wonder if therapists are connected to ICE or the

police. She noted, “you have to be really careful about power dynamics… (and) really explain all of that in much more detail, and make sure that trustworthiness is built.” Tierra described the persistent level of anxiety that clients manage when undergoing immigration struggles. Elina noted that because the immigration process is so difficult, even if clients secure a work permit, some may never return to therapy: “I’ve come to represent something so bad about their lives – that period – that they have a phobia of ever returning.”

4.b. Non-profit social services and mental healthcare system.

The vast majority of participants remarked on challenges to survivor recovery that reside within the structures of non-profit and human service agencies, including those with a mental health focus. Survivor mentor/leader Molly critiqued the “well-intentioned” people who come in without lived experience, wielding an agenda. She voiced the approach ironically: “’This is what I think this group of people needs, and I’m going to raise funds and try to shove these services down people’s throats and hope that it works, and then get mad at them when it doesn’t work.’” She described that as a “harmful” practice, which “exhausts resources,” “burns people out,” “misleads donors,” and “hurts survivors.” She highlighted the danger of doing this work without an evidence base. Ramona spelled out the problem in stark terms, calling “the nonprofit industrial complex… colonized and very oppressive.” She described it as a difficult system to navigate, for her and for her clients. She cited “systemic barriers and… societal issues that are manifested in those systems” including race, gender, and nonprofits’ use of “coercive tactics to produce outcomes that they want, and make services inaccessible for people who they believe don’t achieve those outcomes.” Ramona summed it up saying, “overall… it’s very difficult to find people who won’t enclose an agenda upon you and what your healing should look like, and I think it’s critical that there be more people within that system - or the system changes to allow

more people (with humanistic lenses that center strengths, healing, and walking alongside survivors) - to thrive in that system.” Ramona added powerfully: “the mental health system within the nonprofit service sector, social services -the system is geared to be oppressive and trying to do work differently within those systems, for me, it will just burn you out and eat you alive. It’ll either change you or you’ll leave it.”

Peer mentor Ramona told grim stories of non-profit agencies functioning in coercive and re-exploitative ways. She recounted the story of one survivor who was photographed, with the understanding that the agency was taking family photos to gift to survivors. She explained: “when the survivors arrived, they were assigned these vague releases and were told that the nonprofit might use some of the photos to go out to just donors who have already donated – a thank you.” Reportedly, one survivor was informed through the survivor community that her picture had been used “on a postcard that was going out to businesses that said, ‘Help us!,’ yet she doesn’t publicly identify as a survivor.” She told stories of survivors of trafficking being gaslit, manipulated, “re-exploited or denied services.” For example, she shared that when that same survivor “confronted that nonprofit about what happened, they... told her that she needed to pay that back (first month’s rent they provided her), and told her that her trauma made it difficult for her to understand things, and withdrew services from her.… She no longer wanted services, but any supports they had in place (they withdrew).”

Nearly half of all participants in this sample recounted stories of survivors “kicked out” of multiple nonprofit and mental health support systems, to the detriment of their recovery process. Elina characterized the stakes for her clients that cause them to lose services from multiple mental health systems. Indicating the suffering that results from exploitation experiences, Elina explained: “you should never have had to meet me… There should be no

reason that somebody like me (a trauma therapist) should have ever met (you). By the time you come to see somebody like me, things are so bad… Things are terrible.” She noted a sizable portion of her client population has been “banned from other systems,” including mental health hospitals and residential facilities, for being “too difficult, too borderline… They’re too risky… They’re too suicidal.” Sophia told the story of a 15-year-old youth who had “failed multiple residential centers, multiple intensive out-patient programs, multiple substance use -, been kicked out of therapy from a trauma therapy specialist.” She noted that clinicians in her hospital system with “much more fancy degrees than mine” and “more years of experience” discouraged her from accepting this same 15-year-old youth into a peer support group, due to not being “stable enough medically and mentally.” Sophia recounted accepting the youth into the peer group anyway, and noted the youth succeeded with her support.

Other therapists described working to undo the relational harm that may be caused by termination of services. Penelope indicated she works from a harm reduction and strengths-based model, where she celebrates the positives in relapse: “’You made it 35 days this time. Awesome! What did we learn?’” She critiqued the “one mess-up, you’re out” framework, which limits long-term recovery relationships. Penelope shared, “there’s so much damage that can happen through that, and that even goes back to attachment wounds,… family wounds… I believe a lot in the repair.” Acknowledging that her clients have typically already been in recovery for a few months, versus crisis or detox support, she described her therapeutic approach as “the two-degree change model” where two degrees of change over one month, six months, can result in profound change. She shared, “It’s two degrees of change versus changing everything and then it being too much for the client. I’ve seen that work really well.” Penelope critiqued the “one-month process” which expects a “180-shift that’s too quick and they’re just going to go right back.”

A couple of participants spoke to the ethical and emotional strain of exiting survivors from services, when the agency requires it for having broken program rules or for “safety concerns for the greater community” (Stacey). Stacey shared, “it is the hardest part about this work – absolutely hardest – because there might not be any referring and they might be going to the street… We might be going to send them to relapse… Sometimes we have to dismiss women for the choices that they’re making, even if it’s led by their depression. It’s hard.”

Many participants in this sample referenced challenges with non-profit, mental health agency-based assessments. Referring to a residential program in which she previously worked, Casey noted, “I feel like (the assessments) took away from other pieces of work that I could have been doing, and… impacted the relationship I had with the young woman because she didn’t want to do it.” Tierra noted the limitations of using worksheets, assessments, and scales with her clients who are foreign nationals: “I think it has to do with the language that is being used, and then actually the visual of it... It just does not connect. It’s not something used.” She described taking a “client-centered” approach with one client from Central America, and being supported by her agency: “it was just not happening. It was not going anywhere. So we didn’t do them.” Penelope asserted that clients have been overly-assessed: “the clients I serve have been assessed times twenty.” Peer Mentor Ramona commented that in agency systems, supervisors and funders “geared me away from my ethics,… even social work ethics,” and linked this to assessment. Despite having been hired to develop the program in a “survivor-informed way,” Ramona expressed concern about having to administer an “18-page… assessment” in a client’s first 30 days, which she described as “really just a research survey – a way to gather information for grant funding purposes.” Ramona characterized it as “disempowering,” explaining, “I felt, as far as building rapport and trust, bringing out the survey and asking really deeply personal questions

so early on in the relationship took away… All the (agency) paperwork… interfered with the work,… (and) hurt the work.”

Some participants noted that services and approaches are uncoordinated across providers, agencies and disciplines, and that this both challenges survivor recovery and wastes resources. Molly critiqued “information silos… (in) the nonprofit sector direct services at large.” She told the story of a survivor working on stabilization, who was connected to four agencies. Molly’s agency had helped her secure housing, but some needs remained, including cleaning equipment and kitchen items. In the survivor’s various appointments with each agency’s case manager, to which she worked hard to secure transportation, services were duplicated repeatedly. Molly told the story:

> The first place gave her, I think, a mop bucket and a box of Saran Wrap… The next place… gave her a couple of pots and pans, and a box of Saran Wrap. The third place, I think, gave her… something that wasn’t even on her list… and a box of Saran Wrap. Then, she came to us, and I was like, “Well, yeah. Look at our shelves of what we have here, and we can send out a request to our supporters.” She’s like, “Oh, you guys also have Saran Wrap!” - which is how I came to find out she has a lifetime supply of Saran Wrap. I just was like, “What is happening right now?” So, she’s going to clean her carpet with Saran Wrap?

Molly highlighted that when services are uncoordinated and communication is poor amongst social service agencies, survivors’ needs go unmet despite agencies believing their work is successful. She suggests that social service agencies may be coping with the complexity of recovery work, and the collective lack of clarity about how to best engage in it, by inadvertently turning a blind eye to service gaps:

> So many agencies are offering the exact same thing,… whether it's tangible like Saran Wrap or, "Well, we have therapy."… Everybody has the same services, and we're not communicating with each other. So, one need is being above and beyond met to the point of ridiculousness, and then every single other need is just going unmet with the assumption that somebody else can help you with that.

She underscored the issues of miscommunication, uncoordinated approaches across the trafficking recovery field, and poorly allotted resources that must be better coordinated: "There's gaps. I think there's miscommunication because there's information silos… I think there's 3,000 anti-trafficking nonprofits in the U.S. right now, which is absurd because I'm like, 'Okay, but where's all the resources to go with all of these organizations?'"

Penelope also argued that services are uncoordinated and functioning in disconnected spheres, whereas survivors need linked, holistic services. She motioned her hands in four distinct locations, saying, "there's the recovery services, there's the psychiatric services, there's the medical model, and then there's the trauma-informed. And they don't always overlap as well as I would hope, and I think that's a real challenge." She cited her client's lack of "access to good medical, trauma-informed services… - medical or physical therapy – the holistic care" and the need for "merging" medical services with a trauma-informed lens. In fact, Sophia discussed difficulties with service coordination between her hospital and the trafficking grassroots community due HIPAA, where healthcare providers are restricted from sharing important information about COVID-19 prevalence with the grassroots professionals doing survivor follow-up post-discharge. She shared, "it gets complicated (but)… I've been trying to communicate to the (anti-)trafficking community: 'We really have to be concerned about COVID. Because many of the kids that are coming up with significant concerns for trafficking

are also COVID positive.’” Finally, two participants suggested that the terminology used about survivors impacts service coordination. Ramona critiqued the term “runaway,” as it may give providers a judgmental lens with which to communicate about survivors, preferring “chronically missing.” Sophia critiqued the terms “high risk behavior” and “promiscuous,” as seen in medical charts, whereas she believes survivors act in understandable and predictable ways based on the challenges they face.

Therapists cited persistent access issues to services that negatively impact recovery. Sophia questioned why her faith-based hospital system has seen no transgender youth survivors. She stated, “We’re getting referrals for girls, and we do take those who identify as female as well, but we just haven’t had a transgender youth yet interested in our program, so I always put that in my brain too.” Likewise, Sophia suggested that males may be getting screened out by medical staff. She shared, “while using a diagnostic screening tool, we’ve been able to pick up more males than before, so that tells me there’s bias in our capacity.” Elina described a lack of training amongst therapists that can impact survivors accessing attuned recovery services: “even clinicians don’t necessarily understand what (trafficking) means.” Molly, too, referenced access issues to trauma-informed services. She noted that community-based behavioral health centers are financially and geographically accessible to survivors (i.e., they accept Medicaid, offer sliding scale services, and are located along bus routes), but that their therapists lack a high level of training in complex trauma. She shared, “the folks that really can do complex trauma work are not accessible for the folks who really, really need it.” Molly critiqued Medicaid for not covering helpful adjunctive services, including chiropractic care and acupuncture.

Molly cited structural concerns with crime victim compensation programs covered under Medicaid which she described as “designed to address one-time crimes,” and therefore

inadequately attend to sex trafficking survivor recovery. She shared, “crime victim compensation is really hard to navigate… This individual has a lifetime of trauma. They go work with that therapist for six sessions, start to establish trust, and then, ‘sorry, funding’s up!’ I think that’s where the barriers are.” Sophia agreed that resources are too limited. She referenced the push for healthcare organizations to increase their education and awareness about trafficking, but stated, “that’s a huge task that’s going to require resources. Nobody wants to take ownership of that piece.”

Multiple clinicians referenced challenges to recovery in the mental health and social service fields related to linguistic barriers, use of interpreters, and lack of comfort working cross-culturally. Casey described her wish to “be respectful” of non-English speaking clients by referring them to bilingual clinicians, but cited difficulties: “it’s really hard to find clinicians who speak other languages, so that has been a huge barrier.” The three hospital-based clinicians spoke extensively about use of interpreters. Josephine described situations where “something (gets) lost in interpretation” giving rise to doubt: “Okay. Does this have to do with what the interpreter said, or how the interpreter heard me and then communicated it to the client? Or does this have to do with how the client understood that? Or is the client consciously avoiding my question? Or is there a cognitive difficulty that’s happening?” The use of interpreters and associated second-guessing can be “frustrating” (Elina) and time-consuming. Especially on the phone, Elina noted “you basically get half the session with all the back and forth.” Overall Elina described this dimension of cross-cultural work as a “mixed bag” where “the incredible reliance on the interpreter is very profound.” Molly described difficulties working with a poorly trained interpreter after an FBI raid of an illicit massage business. She described the interpreter as “not trained on trauma-informed work… not informed on trafficking at all.” She noted that the

interpreter failed to discuss cultural issues with the FBI agents, including how the content of their questions was translating and male-female gender dynamics in the room, and that it compromised their work liberating two trafficked women who were Chinese nationals.

Differently, Elina highlighted white clinicians' discomfort working cross-culturally, and ways that they "distance further… (using) tropes of cultural competence." She shared, "it's so hard to get anybody to (work with trafficking clients). Even at a trauma clinic… they use the notion of, 'well, I don't know if I can be culturally competent' to distance themselves from cases." Elina a Southeast Asian provider not born in the United States, described her white U.S.-born colleagues refusing to do evaluations for court and "splitting of the treatments" as a "manifestation of the trauma." She remarked that her colleagues frequently turn to her for such cases: "whenever it looks (like international trafficking)… everybody looks at me like I'm the only person." Josephine underscored that a problem with cultural competency in mental health work is framing it as client-focused (i.e., "responding to *their* issues of them being diverse") as opposed to it being clinician-focused. That is, "recognizing that there's actually a culture that we've created here that is also part of the problem…. We (clinicians) also have our own culture, and how we need to reflect on what culture we're bringing forward here." Josephine referenced her hospital-based work, sharing "when we talked about being culturally sensitive, it felt like we were discussing them as a problem and how do we adjust to them… Not necessarily: how are the systems that we're forming inherent(ly) part of that problem?"

4.c. Challenges at Sector/System Intersections.

Almost all participants referenced challenges to recovery existing at intersections of multiple systems and disciplines, where survivors fall through the cracks of overlapping systems. Some described ineffective services and safety nets, where despite multiple services, survivors

are not kept safe. Sophia highlighted that overlapping safety nets fail to successfully support survivor recovery: “there’s a lot of safety nets in place,… child protective services, law enforcement. In Texas, we have a huge push from the Office of the Governor… so there is a big safety net push in the greater community. But it doesn’t keep the kids safe, and their direct experience does not change.” Sophia highlighted the challenge of youth “cycling through” despite multiple available services: “I see a kid who has had five different CPS workers, and has been to three different residential treatment centers, and has had 15 different types of therapeutic interventions, but none of them are working, and that’s frustrating.”

Participants referenced barriers to recovery in the form of mistrust: amongst providers, survivor mentors, and the systems of care designed to support. In terms of providers, Sophia described “tension” between professionally trained providers and survivor-led organizations working on task forces together. She specified her preference for survivor-led programming, but shared her belief that those who are “logical and education-based and pragmatic” and those working in the district attorney’s office “don’t agree. That’s always a struggle.” Sophia added that trained professionals recreate trauma for survivors if they suggest that “those (professionally) trained are doing more important work than (survivors)… Systemically we’re perpetuating (a colonizing view)” that way. She also described the challenge of mistrust in her hospital-based system, which falls under the umbrella of a “bureaucratic” national healthcare entity noting, “the hospital is reluctantly allowing me to do the work that I’m doing because other people in the community say that it’s so important, and other people are funding it.”

Participants asserted that challenges at sector intersections contribute to mistrust amongst survivors who are clients. Josephine recounted the story of a youth sex trafficked while in foster care who, even into adulthood, “didn’t trust the systems to act in her best interest, and I don’t

blame her because there (has) been a lot of… lack of consistency from child protection and the legal system from the time she was a kid." Penelope concurred, that "systems have let down – over and over and over again – the survivors that I work with… so there's little faith in the system. Over time, if a client has been hurt 50 times, it's really hard." She expressed concern for challenges at the "political… (and) systematic level" including "all the systems they've been involved with." She specifically referenced misunderstanding amongst providers from intersecting systems about "continuum of care… (and) Maslow's hierarchy of needs." Penelope stated, "how are we expecting her to come to therapy when she's hungry and doesn't have a place to live? And so… lack of alignment with the client and really seeing it from – if I was hungry, I wouldn't want to come to therapy either. I'd be distracted too."

Finally, Stacey indicated the mistrust that results from forcing social service agencies to uphold survivors' probation requirements. She spoke of court mandated therapy, where provisions are established for felony expungement if a survivor engages in therapy, and noted, "they have to meet probation (requirements)… If they're not doing what they are supposed to be doing legally, and they're not following our program… that can affect their legal standpoint." She noted this leads to relational harm where a survivor perceives the power that social service agency holds: "'Well, I'm going to have to go back to jail if you kick me out.'"

Some participants highlighted the extent to which systems and staff are overburdened at these cracks, and that existing supports lack capacity to attend to survivors' needs. Greta stated simply: "as far as (our) county, it really is us that are doing the most with the human trafficking population… It's too much." Stacey described the challenge of survivors, who may mistrust their outside-agency trauma therapists, turning to safe-home staff for trauma therapy needs: "we can't quite possibly do that and all of the other things of whole-person care." She outlined the contours

of the demand on staff who work at system intersections: “I’m a clinical case manager - so a case manager is a job in itself. … And then, a clinician is a job in itself. And then, I also do group therapy. And so, there’s not enough (time)… in even a day… There are so many other things that are happening on this day-to-day.” She told the story of a client who needed “mental health support consistently” to attend medical appointments, stating, “I can’t. I’m not four people. On top of all my other clients!” She suggested the need for a systemic change to better address survivors’ complex needs: “I feel like there needs to be an additional part of their recovery and growth. When they’re leaving (the residential program), at the end of the day, none of them are really ready to be on their own 100 percent.”

Numerous participants cited overlapping structural barriers to meeting survivors’ complex needs in the form of lack of housing, transportation, childcare, and social services. They described these service gaps as multifold, simultaneous, and compounding, and that together formed formidable obstacles to survivor engagement and recovery. Greta described lack of “housing (as) the biggest issue that we face.” Stacey concurred that “there’s no safe housing, and then they’re either being put in domestic violence shelters or places for substance use disorder.” She described complications placing a trafficking survivor in a domestic violence shelter, where staff “don’t know how to go there or how to really manage a situation” and residents may “clash” due to distinct experiences of abuse: “this type of trauma is specific… There needs to be separation.”

Stacey advocated for programs that attend to “dual diagnosis… mental health and substance use disorder” related to trafficking exploitation. Molly differently explained gaps in care with domestic violence shelters. She described a local shelter, with funding for trafficking survivors, using the same intake screener for all clients which effectively screens out trafficking

survivors. Molly told the story of a survivor who had been trafficked by her intimate partner, who was in jail:

> They went through the (screening) questions, and they did not qualify because the policy of the domestic violence shelter is, if your abuser is in jail, you are safe… In a traditional intimate partner situation, I can see how that would be more broadly applicable when you don’t understand how trafficking happens and how people are re-exploited. So, we’re like, “Okay. So, this individual is going to go to sleep at the bus stop, which there’s going to be a trafficker that is going to pull up and offer housing to this individual.” So, I think that those types of gaps continue. And so, then that shelter is reporting, “Well, we serve trafficking victims,” but they’re actually screening them out. And then, they’re saying, “Well, we’re not getting any trafficking victims...” It just creates this, like, vicious cycle, and survivors are still not being served.

Further, participants cited multiple overlapping issues. Molly described a lack of resources generally in her rural area. Maya cited recovery obstacles due to poverty, lack of social services and transportation. Casey described lack of transportation and childcare overlapping. Sophia referenced multifold issues: “they don’t have (health) insurance, and you can’t find the guardian, and you’re concerned about trafficking, and there’s COVID.” Greta articulated the fallout from sitting at the intersection of multiple systemic challenges. She shared,

> A lot of it is, unfortunately, just being stuck from all of the different systems working against them. Unfortunately, I really feel like that’s the reason why so much of their progress in therapy or healing is slowed down or… halted. Because they have so many other things standing in their way to becoming independent and feeling empowered, and being able to be successful and have a life of their own.

Participants identified ways that these challenges converge to increase survivors’ risk for re-exploitation. Tierra described how lack of safe and stable housing increases re-exploitation risk for unaccompanied minors. Maya detailed how gaps in service provision of basic needs (i.e., “food, clothing, shelter”) contribute to re-exploitation risk:

> When there’s no other way for them to get their basic needs met, they’re put in a position where (not escaping, rather remaining in relationship with their trafficker) is the only option that they have… Healing from trauma takes a lot of reparative experiences, and you really aren’t able to do that when you’re just getting by day-to-day.

Ultimately, Maya characterized her clients as “joyful and meaningful to work with” but noted: “the system was very difficult to work with.” Ramona added, “the structures and societal institutions are really resistant to change.”

4.d. Challenges in systems related to therapeutic intervention.

Therapists named various challenges in systems of recovery as they specifically intersect with therapeutic intervention in treatment rooms. Many of the elements already discussed in this chapter converge in this code, yet the code is distinct in its focus on the contexts in which therapy occurs, the tools used, and the conditions that surround therapists’ and survivors’ work in treatment spaces. Participants described an overarching cultural lens undergirding clinical work that itself challenges survivor recovery. Maya described, “what they’re up against when it comes to therapy - how the mental health profession is also marinated in so much oppression… Mental health providers have pathologized people who have experienced marginalization and oppression because of our roots in history as a profession.” Emphasizing that survivors are up against therapists themselves, Maya cited the need to “decolonize my own mind” and described it as a “swim upstream every day.. and sometimes I fuck up.” Elina gave voice to “the paternalism of

our field, which is colonial in itself, (as) really problematic." She referred to a culture of "dominance" emerging from a "deeply insecure field (where) people have no confidence whatsoever in what they're doing." She continued, "we (psychologists) are always trying to distinguish ourselves from social work and then from psychiatry. You know, 'We're better than social work, but we're less than psychiatry'. I mean, psychology is just pathology unto itself." Elina described professional insecurity as leading a need for "dominance manifest in… the way we're trained now." That is, a "proliferation of three-letter treatments and all this money spent on all these trainings" as efforts to establish some dominant footing.

Providers cited the lack of evidence base for the recovery field as a challenge to therapeutic intervention. Elina referred to the "proliferation" of treatments as a "capitalist enterprise by this point… with no real research background." She suggested that after 50 years of psychotherapy outcomes research, "none of them are outperforming any of them." Survivor mentor/leader Molly shared, "I feel like the anti-trafficking field is just a flaming hot mess generally…. We are a decade into domestic anti-trafficking work. It's a new frontier. It's the Wild West." She drew attention to the ways in which trafficking recovery work borrows from apparently like-fields, despite the lack of evidence base to guide practice. Molly observed:

> There's no best practices, so we're pulling from parallel movements of work with anti-poverty or anti-racism, gender-based violence... My personal opinion is trafficking wouldn't exist if all of those movements had fixed the problem. So, you have folks who become vulnerable because they experience domestic violence, and then they experience homelessness, and they fall through every single crack in those systems and – guess what? Then they end up being trafficked because there's no supports for them. And so, I think pulling from parallel movements is a helpful starting place, but I don't think that

> you can just say…, "Okay, domestic violence. Well, trafficking survivors also experience some level of interpersonal violence. And so, let's just take domestic violence programs and replicate them, but just repackage them as trafficking." You're like, "No, actually if that was a solution, they could just go through the domestic violence program, and it would work." So, I think there's a lot of gaps. I mean, things are improving. I think research is really important… People are like, "Is it evidence-based?" I'm like, "There's no evidence. We're working on it."

Likewise, Desiree expressed a longing for evidence to guide recovery work: "I wish there was an evidence base for this population…. I just wish that there was more of a black-and-white approach to these relationships." Desiree described an evidence base for addressing trauma symptoms and noted that she incorporates trauma-sensitive psychoeducation techniques into her work, but commented on its limits: "to target just one symptom doesn't really seem to do it. It feels much more complicated than that." Desiree continued: "I haven't really seen anything about a normed or validated treatment intervention for people who have been through exploitation." Suggesting that the work is multifaceted and multisystemic, she articulated her clinical research question: "How can we buffer the vulnerabilities through (multisystemic) interventions?"

Participants discussed techniques and treatment frames that were unhelpful in recovery work. Ramona voiced survivor feedback received during a check-in that pushed back on the therapy framework. She shared, "She made it clear she didn't like (mandated) therapy. She didn't like having to talk about her story." Penelope critiqued "too individualistic of models where they're not community-oriented." She clarified, "if an individual client wants to bring their greatest support system to therapy the first couple of times, great. That's your support

system. Bring them in. Models that push out that person’s support system – whether that’s an animal, whether that’s a friend, whether that’s a family member – to me do not have the lasting impact and are not as helpful.” Caroline described residential youth requiring more time than a traditional 45-minute hour permitted, and the challenge of engaging them therapeutically when “the amount of time and focus they needed was something I didn’t feel like I could give them.”

Maya described the constant demand of “pressing” things outside of therapy that inhibited survivors’ progress with recovery. She noted, “so they may have a few weeks where they’re able to really gain some insight or find some relief through therapy, but because so much is unstable in their lives, that will be taken away really quickly.” Stacey agreed, wishing survivors had the space to “actually rest and not have to worry about learning how to budget” or deal with criminal sentencing, or other matters. She shared, “It’s hard to gain these skills in-between stabilization and just taking a second to breath… In this utopian world, they would have this window from stabilization to solely, just healing within one’s self, and then worrying about life skills and building independence.”

The majority of participants pointed to negative perceptions of therapists, based on past “negative experiences with clinicians” (Ramona) that challenge recovery efforts in the present. Penelope described a client who had seen “13 therapists, systems… She’s looking at me like, ‘you’re not going to last.’” Penelope shared how she attempted to offer a reparative experience: “I didn’t come in with my agenda and my notebook of 50 million assessments and 50 worksheets that she was supposed to complete. It was really like ‘I heard her’.” Greta indicated that some of her clients had attempted therapy with professionals repeatedly, but “(therapists) did more harm than good. So they don’t have good feelings about that. They don’t want to try again. They don’t trust it.” Maya characterized her clients’ perspectives in strong terms: “A lot of the people that I

worked with, they’re like, ‘I hate therapists. I hate all my therapists. I’m not talking to you.’” She referred to attending therapy itself as a trigger. Sophia noted the challenge of working successfully with survivors who are in a trauma response, being held involuntarily in a hospital mental health unit: “my capacity to do clinical intervention is impeded.” Desiree referred to past “treatment failures” and challenges when “people have been forced to go to counseling since they were kids.” Caroline described the mistrust that is paramount, attributable to past treatment failures with white therapists. She shared the importance of “having an understanding that whatever their experience has been – perhaps with white people – that maybe it wasn’t so good… They’ve had a lot of people who have said they’re going to help them, and have probably let them down.”

Finally, nearly all participants discussed the challenges therapists face in doing this work. These primarily centered on burnout and lack of training. In terms of burnout, Elina shared, “I think therapists have burnt out and been beaten down.” She described the proliferation of training programs as a form of therapy for therapists: “I think that is a major benefit for them.” Penelope referenced the “high level of burnout,” and the risks - losing good therapists. She shared, “we can’t afford to lose the people who have been in this field who bring a lot of wisdom and knowledge and insight into this field.” Penelope named financial strain on providers: “There’s a low pay rate. It’s hard.” She noted that this forces some therapists to work with higher paying clients, or those with better health insurance. Penelope stated that we, as a field, “need to take care of the caregivers and invest in them and their growth and their learning, because the better human I am and the better trained I am, the better therapy and services I’m going to bring… We can’t miss that.” Maya described feeling hopelessness sometimes, especially at the

time of interview during the COVID-19 pandemic: “the hopelessness is totally there… The amount of suffering that has always been but especially right now… is so high.”

Finally, referring to lack of training, participants described their graduate training programs as having inadequately prepared them to do recovery work with survivors of sex trafficking. Casey noted that trafficking was “not discussed in my graduate program at all.” She indicated first learning about it while working with trafficked youth in residential treatment. Stacey described lacking training to work with LGBTQ and transgender survivors. She shared, “in my school, there wasn’t enough… They didn’t really hone in and fixate on the therapeutic interventions that we would be using, specific for different diverse populations.” Josephine described her graduate training as focused on “how a client is different than you – rather than understanding what you’re also bringing into the room as a white person.” She summed up clearly the difficulty of doing recovery work with survivors of trafficking with limited evidence base: “In school, we are reinforced to do evidence-based practices and, most of the time, these evidence-based practices have not been tested or administered in diverse groups. And so, then we’re left with being encouraged and reinforced with modalities that might not necessarily be appropriate.”

Summary

This study examined the perspectives of multidisciplinary mental health providers (i.e., clinicians and peer mentors) who work with survivors of sex trafficking, guided by the following research question:

> What are the perspectives of mental health providers who work with survivors of sex trafficking in the United States, through multisystemic and multidisciplinary recovery

work, related to treatment approach, the processes they find to be effective, and their views on emancipatory approaches?

“Effectiveness” was not operationally defined in quantitative terms. Rather, the study examined providers’ perspectives on approaches to mental health recovery work that they found helpful and supportive in aftercare with survivors, or that they believed survivors found useful. The study employed a qualitative conventional content analysis design, appropriate for research domains that lack substantial evidence base or theory development (Hsieh & Shannon, 2005), as is the case with scholarship in mental health recovery with survivors of sex trafficking. With myriad gaps in the scholarship and theoretical foundations of the field, an exploratory qualitative design was deemed useful to contribute to the scant evidence base.

Analysis identified four principal categories and fifteen codes that, together, represented participants’ main ideas relative to the research question. The four categories are: 1) structural and trauma-sensitive emotional support are integrated, 2) community and emancipatory healing approaches are part of recovery work, 3) peer mentors are critical to recovery work, and 4) multiple systems challenge survivor recovery. Analysis relied on Hill et al.’s (2005) strategy to assess the strength of categories, using four levels (i.e., general, typical, variant, rare). All categories were of general strength, except for the category related to peer mentors’ critical contributions. This category being of relatively lesser strength may owe to sampling limitations. That is, there was an insufficient number of peer mentors and those who partner with them in this sample to reach Hill et al.’s (2005) threshold for general strength. That threshold was 12-13 cases.

Overall, the findings reveal that mental health providers engage with survivor recovery at multiple ecological-system levels, including by blending individual trauma-sensitive therapy

and/or mentorship with structural-level support, as well as accompaniment at the level of geographic and survivor-community. And that providers are aware of and interested in emancipatory approaches, but report lacking training in them. Findings also reveal that peer mentor-clinician partnerships are mutually helpful, and that peer mentors play a key role in recovery work. Finally, providers reveal that various complex systems in which survivors are imbedded challenge recovery, including the criminal justice and immigration system, the social service sector and mental healthcare system, and at nexus points between and amongst systems. Therapists and peer mentors describe their important roles in leveraging and mitigating some of those challenges. The following chapter discusses the study findings and implications for the field of social work.

Chapter V. Discussion

Available research suggests concerning prevalence of sex trafficking exploitation in the United States, with disproportionate victimization of girls and women of Color. Scholarship has established the complicated interweaving of individual and structural-level entrapment factors and illuminated deleterious impacts on survivors' mental health and social outcomes. Nonetheless, there remain gaping holes in the scholarship examining mental health recovery, service delivery, and reintegration post trafficking. Within this landscape of limited clinical research, little is known specifically about the effectiveness of trauma-informed mental health interventions, the complex task of tailoring culturally appropriate services for diverse survivors, and extent to which emancipatory approaches are integrated with trauma-informed approaches into treatment. Likewise, the research base is in a nascent state related to exploring mental health providers' perspectives on recovery work with survivors of sex trafficking, clinicians' collaborations with peer mentors, and the work of varied mental health providers within multidisciplinary and multisystemic recovery contexts.

The purpose of this study was to explore the perspectives of a small group of mental health providers with multiple years of experience working with survivors of sex trafficking in the U.S., through multidisciplinary and multisystemic recovery work, related to treatment approach, the processes they find to be effective, and their views on emancipatory approaches. In order to address these critical gaps in clinical knowledge, it is useful to explore the subjective perceptions of mental health providers who work in sex trafficking recovery in the U.S.

This study collected, transcribed and analyzed original semi-structured interview data with thirteen participants who were mental health providers engaged in mental health recovery work with domestic and international survivors of sex trafficking in the U.S. (n=11 clinicians;

n=2 peer mentors). Three of the thirteen participants identified as survivors of sex trafficking; that is, one participant was a clinician and a survivor. The transcripts from these interviews were coded using qualitative conventional content analysis and then interpreted to respond to the research question. With numerous gaps in the evidence base and theoretical foundations guiding the work, an exploratory qualitative design was best suited to contribute to building the scholarship. Original qualitative data collection was deemed useful since no known data exists documenting providers’ perspectives on these topics.

Acknowledging that the field lacks a clear or definitive theoretical foundation, and theoretical underpinnings are still evolving, this study considered the insights of three theoretical frameworks that are currently deployed by mental health providers and scholars in the field of mental recovery with survivors of sex trafficking. The frameworks undergirded study design and analysis in an effort to explore providers’ perspectives on their work with survivors who often experience extreme adversity, marginalized intersectional social identities, and complex multisystemic involvement. The three theoretical frameworks were: trauma-informed care; emancipatory and cross-cultural approaches emerging out of critical theory; and the social ecological approach. Multidisciplinary and multisystemic recovery work was an *a posteriori* analytic frame employed due to what emerged in the data.

This chapter presents a) an integration and further interpretation of findings reported in the previous chapter; b) implications for theory, practice, and policy; c) strengths and limitations of the study; d) recommendations for future research; and e) conclusions.

Integrative Interpretation of Findings

As reported in the previous chapter, the qualitative content analysis facilitated the researcher’s identification of four categories related to mental health providers’ approach to

recovery work with survivors of sex trafficking within multidisciplinary and multisystemic contexts. These were: 1) mental health providers integrate structural and trauma-sensitive emotional support, 2) community and emancipatory healing approaches are part of recovery work, 3) peer mentors are critical, and 4) multiple systems in which survivors are embedded challenge recovery. To my knowledge, this is the first study to explore mental health providers’ experiences with service provision/accompaniment of survivors with a focus specifically on their work within multidisciplinary and multisystemic environments. It is also the first study, to my knowledge, to explore these perspectives amongst mental health clinicians and survivor mentors, as well as views on their clinical partnerships in recovery work. As such, these findings are emergent and make comparison to past research difficult. Still, some comparisons can be made.

Congruent with Domoney et al. (2015) and Magnan-Tremblay et al. (2019), this study found tremendous value in exploring mental health therapists’ perspectives on their work with survivors of trafficking. It took up Contreras and Kallivayalil’s (2019) call to explore collaborations between mental health professionals and peer mentors as a crucial next step in anti-trafficking research. It also added qualitative detail to Rothman et al.’s (2020) call for research on supportive survivor-mentorship. It became clear throughout this study that mental health therapists and peer mentors wanted to participate. Recruitment for this study was smooth, and the study maintained a waitlist. Many clinicians and peer mentors sought the opportunity to share their perspectives and experiences. The interview data were also rich and extensive. Ultimately, data related to recovery work not linked to multisystemic and multidisciplinary work was excluded both for pragmatic reasons (i.e., researcher capacity within time-to-degree university constraints), and also because data related to multisystemic and multidisciplinary work were rich and frequently mentioned.

Katona et al. (2015) suggested that researchers document survivors’ experiences to mine their crucial insights into treatment challenges and needs and seek to determine effectiveness of mental health recovery intervention in varied regions and contexts. By the nature of interviewing mental health therapists and survivor mentors, especially from varied regions of the United States, this study went some way towards filling that research gap. Finally, there have been frequent calls to develop the evidence base related to trauma-informed intervention efficacy with survivors of trafficking (Dell et al., 2019; Katona et al., 2015; Levine, 2017). While this study did not quantitatively assess trauma-informed intervention effectiveness with survivors of trafficking, it aimed to contribute thick description of therapists’ and survivor mentors’ perspectives that might inform future research efforts.

Likewise, there is limited research related to approaches that fall outside the trauma-informed framework. For example, there are calls to examine non-clinical outcomes to assess mental health intervention effectiveness (Wright et al., 2021). There are also calls to examine emancipatory and intersectional approaches in recovery work with survivors of trafficking, as well as cultural specificity of approaches with varied sub-groups (Carter, 2003; Farley et al., 2011; Pierce et al., 2009; Vollinger, 2021). Finally, some scholars suggest promise in exploring the potential for a social ecological lens in recovery work (Finigan-Carr et al., 2018; Hopper, 2017; Salami et al., 2021), and scholars recommend examining multidisciplinary collaboration (Muraya & Fry, 2016) in multisystemic contexts (Martinho et al., 2020; Powell et al., 2018).

Category 1: Structural and trauma-sensitive emotional support are integrated

This study found that mental health providers perceive their work to be an integration of structural and trauma-sensitive emotional support. This finding is a potential response to Domoney et al. (2015), who argued for the need for approaches that account for both social and

psychological factors when attending to mental health recovery needs. This study illuminates greater detail into the mechanics of this integration.

The finding that providers integrate emotional and structural support mirrors and extends findings from the refugee mental health literature that suggested that refugees preferred attention to immediate and long-term structural needs as opposed to posttraumatic symptoms (Zarowsky, 2004). It likewise extends Farley et al.’s (2004) study which found women across nine countries preferred structural supports *over* mental health support, but coincides with literature emerging from Indigenous scholarship which found integrated attention to both domains of need was powerful and helpful (Farley, 2011). These findings also concurred with multiple previous studies and recommendations about the value of multidisciplinary cooperation that is trauma-informed and attentive to victim/survivor-rights (Menon et al., 2020; Nazer & Greenbaum, 2020; U.S. Federal Strategic Action Plan for 2013-2017).

1.a. Partnerships Increase Capacity to Provide Quality Care

The participants in this sample described engaging in multidisciplinary and multisystemic partnerships to increase capacity to provide quality care, both in terms of i) improving care quality, and by ii) increasing access to care for survivors. The role of multidisciplinary and multisystemic partnerships themselves facilitated the needed integration of services. The study found that providers integrated structural and trauma-sensitive emotional support and engaged in multidisciplinary and multisystemic partnerships to increase quality of care provision and increase survivor access to services. Together these sub-domains of the code spoke to the role of partnerships themselves in increasing capacity to provide quality care. In her book chapter introducing the Multimodal Social Ecological framework, Hopper (2017) called for more research on methods to increase access to and engagement with mental health care due to the

array of systemic, structural, and emotional barriers that survivors face. Providers in this study identified methods in the form of varied partnership types, including wraparound service partnerships, as well as multisystemic, multidisciplinary, multi-agency, and/or multi-staff partnerships, which integrate emotional and structural support, resulting in increased capacity to provide quality care to support survivor recovery.

While some research has found that mental health providers lack training related to varied topics in trafficking recovery work, including identification and intervention with survivors of trafficking (Family Violence Prevention Fund, 2005), this study revealed that providers also may lack training in multidisciplinary and multisystemic partnership work. Penelope characterized her graduate training as encouraging her to work from an “individualistic therapy model,” whereas her trafficking recovery work was “a team approach with… multiple systems, multiple people involved.” She perceived that her graduate training inadequately prepared her for team-based recovery work and argued that such partnership approaches increase accompaniment support and intervention effectiveness: “We have more eyes on things and we each play our unique role” (Penelope).

Conflicting results emerged related to therapist engagement with survivors in jail settings. Greta suggested it was an effective place to access survivors and connect survivors to therapeutic services. Yet Contreras and Kallivayalil’s (2019) interview with peer mentor Ms. Reed-Barnes suggested caution, arguing that mental health professionals in jail settings are less effective at gaining survivors’ trust, according to the survivors she accompanies. This dynamic warrants further study. Future research should explore the possibilities and challenges of jail-based mental health support, as facilitated by therapists versus peer mentors.

1.b. Leveraging Structural Support for Therapeutic Aims

Mental health providers described leveraging structural supports within multidisciplinary and multisystemic contexts to enhance therapeutic aims. This extends Domoney et al.'s (2015) work, who mainly found challenges within inter-agency and inter-system collaboration. In this study, both challenges were found, as well as opportunities to leverage the complex multidisciplinary and multisystemic interactions to support survivor recovery.

As suggested theoretically by Hopper's (2017) and Salami et al.'s (2021) social ecological models, therapists indeed described leveraging survivors' involvement in varied systems and structures for therapeutic aims. Like Hopper's (2017) multimodal social ecological model, Tierra described grounding/regulation work with a survivor in order to help her self-advocate within complex immigration and social services. In this study, the interactions appear cyclical, as in Tierra's example: presumably, regulatory capacities had been developed and/or strengthened, which the client was able to exercise when taking the lead in a social service meeting. Tierra later highlighted her client's progress back to her in therapy to promote further development of confidence and self-esteem. The example suggests an individual survivor acting within, and perhaps upon the systems level via self-advocacy. This data illustrated the complex and mutually reinforcing ways that survivors and therapists work together towards individual therapeutic goals and systems-level advocacy goals in the same treatment.

1.c. Therapists Mitigate Challenges of Multisystemic Involvement

Therapists spoke of sometimes subverting systems to mitigate the challenges and barriers to recovery that they present, by bending the rules governing those systems. This diverges from and extends Hopper's (2017) MSE intervention framework, which focused on increasing client competency. Instead, providers in this sample described exercising their competence to act upon

systems, in cooperation with and in support of survivors, by bending protocols related to client discharge and no-shows. Perhaps Salami et al.'s (2021) model comes closer to the data from this sample, as Hopper's (2017) framework is geared towards the nuances of complex trauma treatment as opposed to multisystem involvement. These findings extend Hopper's (2017) MSE model to include insights about the agentic role of therapists (and later discussed, of peer mentors), as well as the partnership dynamic between providers and survivors. Aligning with Martinho et al. (2020) who specifically cautioned against victim-blaming, therapists in this sample also described their role in reducing victim blaming, and in providing corrective, reparative experiences to survivors when their other multisystemic, multidisciplinary interactions had been oppressive.

1.d. Trauma Sensitive Principles are Interwoven Throughout Engagement

The trafficking recovery literature has commonly recommended trauma-informed approaches (Macy & Johns, 2011; Muraya & Fry, 2016; Wright et al., 2021), and underscored that therapy should emphasize survivor choice, autonomy and agency as an antidote to coercive experiences during exploitation (Salami et al., 2021). The participants in this study underscored the same, even describing infusing choice into situations of court-mandated therapy. Survivor mentor/leader Molly cited the importance of "the voice and choice of trauma-informed practices."

Domoney et al. (2015) found that some mental health therapists in their sample employed a phase-based treatment model, where current threats to survivors' social stability had to be ameliorated, and social supports had to be put in place before beginning therapeutic work. While one participant in this sample (Elina) discussed a phased, longer-term approach to care with survivors that prioritized psychoanalytic work even in the context of multiple case management

needs, most providers described a fluid model where current threats, social support, and therapy were intermingled as survivors were willing to engage.

While some scholars have found that mental health providers lack training to engage in trafficking recovery work, including on the effects of trauma and on trauma-informed intervention (Hopper, 2017), these study findings suggest that providers are aware of trauma-informed approaches, implement them to various degrees, and extend their applications in novel ways. These novel trauma-informed adaptations sometimes must maneuver around systemic constraints to maintain trauma-sensitivity. They also bring the trauma-informed intervention out of individual therapy into survivors’ broader multisystemic recovery milieu. One therapist additionally discussed “unconditional positive regard” (Greta) in the same context as trauma-informed approaches, where therapists should remain open to survivors despite any relational challenges. This therapist indicated doing a form of trauma-sensitive structural stabilization work that combined emotional and structural support across multiple systems, aligning with Hopper’s (2017) MSE model.

Category 2: Community-based and emancipatory healing approaches are part of recovery work

In the second category, referring to community-based and emancipatory healing approaches employed by mental health providers in recovery work, participants described a variety of practices they use to leverage resources within survivors’ geographic contexts, as well as survivors’ community- and culturally-embedded relationships. Providers also discussed engaging survivor communities and survivor networks as resources in recovery, as well as ways that they integrate intersectional analysis into their multidisciplinary and multisystemic work.

2.a. Using Community-Based Spaces and Resources for Recovery Work

Participants in this sample described leveraging geographic community spaces as well as the natural world in recovery work. This was not discussed in the trafficking literature, but is an important component of wraparound service provision (Walter & Petr, 2011). Levine (2017) noted interventions with promise that included expressive arts and equine therapy. Based on Penelope's recounting of using the natural world as a therapeutic support, wilderness and nature-based therapies may be promising directions to explore with survivors of trafficking.

Participants described creative uses of therapeutic space, sometimes construing intervention as a mobile activity. These providers referenced going on walks or drives with survivors, in an attempt to sit side-by-side to enhance comfort and equalize power imbalances. Participants described their concerted attempts to overcome the inequalities inherent in a provider – client relationship. Maya recounted her realization that sitting across from client harkened "institutional" interactions, reminiscent of jail settings or hospitals, which are steeped in power imbalances. These promising approaches to engagement speak to critical scholars' key concerns about the disempowering nature of therapeutic practices that reinforce providers' expert status by pathologizing clients, solving their problems, and ultimately disempowering and incapacitating those they seek to accompany (Gozdziak, 2004; Lykes, 2002; Pupovac, 2002; Summerfield, 1999; Summerfield, 2000). The mental health providers in this study appeared aware of those lessons and took actions to overcome limitations in the therapeutic dynamic.

2.b. Community- and Culturally-Embedded Relationships are Resources

Participants described nuanced culturally-embedded relational practices that widened the frame typically available in the trauma-informed literature. Tierra indicated deploying a typically individual level intervention (psychoeducation), but described offering it as applied to the interpersonal and community systems levels, so that "it's not that this applies *only* to you, but it

also applies to the people around you and the community around you… It gives (survivors) a connection to something external.” Tierra described teaching survivors grounding techniques as resources to “*share* with other people.” This may shift a client’s focus from her own physiological stress response to her interpersonal relationships, including her power to connect to and help others in her own community. The focus on agency at the interpersonal/community level suggests a construction of recovery that involves helping others.

The research base related to the impact on survivor wellbeing of helping others is limited. Bruhns’ (2014) doctoral dissertation suggested benefits for adult female peer mentors involved in service activities and advocacy on behalf of others, however, future research should examine the outcomes during varied stages in survivor recovery, not just during professional peer mentor work. Tierra’s comments suggest that there may be a benefit to encouraging survivors to take action in support of their community long before one decides to become (or not become) a peer mentor.

This also extends Salami et al.’s (2021) social ecological model conceptualization. Tierra illuminated the possibility that a survivor may act on multiple system levels simultaneously. The communal focus may increase cultural appropriateness for some populations as well. Tierra’s example suggests the existence and potential of novel approaches to therapy with survivors of trafficking that combine previously discrete treatment frames: psychoeducation about one’s neurobiology (trauma-informed/embodiment-focus treatment frame) and community/interpersonally-focused engagement. The potential fusion of approaches warrants further study.

2.c. Survivor Networks and Survivor Community

The participants in this study offered strong support for the value of survivor networks and survivor community for connection and recovery. Scholars have cautioned that survivors often experience relational distress due to past experiences of abuse and exploitation that can manifest in interpersonal struggles and hypervigilance in relationships (Hopper, 2017). Contreras et al. (2017) suggested the insufficiency of currently available evidence-based treatments, in that they address mental health symptoms, but do not adequately address survivors’ relational needs. The capacity for survivors to connect within relationships and broader community is a recognized goal of recovery. Peer mentors and therapists in this study, by contrast, endorsed the primacy and strength of survivor networks and community. Participants emphasized the value of survivor relationships, networks and community for survivor identification, communication, ongoing support, and for a sense of connection and belonging. Indeed, Desiree suggested that survivor community provides a “depth of resonance… that I can’t provide individually” as a therapist.

Limited scholarship currently examines the value of and dynamics within survivor communities. The findings from this study contribute to the knowledge base in this domain. Participants in the sample predominantly described survivor community as deeply supportive, where survivors “show up for each other” (Penelope). Penelope characterized it as a “collectivist model… versus an individualistic one.” One peer mentor (Ramona) suggested that survivor community reflects and fosters societal transformation: “this is where the community work is being done; (it) is in these networks… that don’t fit society’s normal narrative.” These study findings contribute to the nascent evidence base by describing the dynamics within survivor

communities, according to this sample. Findings predominantly underscore providers’ belief in the supportive value of survivor community for recovery.

Wright et al. (2021) advocated for a widening of the recovery frame, so that scholars might consider non-clinical, holistic notions of personal recovery for survivors that go beyond PTSD symptom amelioration. Indeed, (re)connecting to supportive survivor community may be a useful outcome to track in recovery research, both as an aim unto itself, and as a proxy variable for trust-building and relational repair as well as for structural stabilization outcomes. These findings suggest alignment with critical scholarship’s promotion of de-centering individuals as the locus of intervention, in favor of connecting and contextualizing individuals to/within their communities and population-groups to gain better access to the strength of collectivity (Lykes, 2002).

2.d. Intersectional Analyses in Recovery Work

Participants stated an interest in intersectional and emancipatory approaches upon hearing them defined in the interview, but predominantly expressed not having been aware of them as such and being under-trained in them. Still, some participants endorsed the approach as one they intuitively follow. Their desire for further training concurs with scholarship that has found mental health providers to lack training related to varied topics in trafficking recovery work (Family Violence Prevention Fund, 2005; Hopper, 2017).

Salami et al. (2021), in detailing their support for an ecological systems model for recovery work, acknowledged that specialized training may be needed. This study similarly found that providers expressed interest in intersectional framing of their work with survivors, but expressed lacking training in how to implement it. This approach may include leveraging of the varied systems level in which survivors interact, via assessment, treatment and advocacy as

suggested by Salami et al. (2021). Providers in this sample expressed interest and enthusiasm, but lack of training in emancipatory and intersectional approaches. One therapist cited lack of training about the LGBTQ community specifically. Those who succeeded in accessing training on emancipatory healing approaches described barriers, forcing them to step outside of their professional credentialing programs (in counseling psychology and social work) to access it.

Extending the work of Salami et al. (2021), however, is the focus on intersectional and emancipatory approaches that emerged in this study. To my knowledge, those approaches are infrequently cited in the scholarship, and this study contributes considerable nuance into understanding provider perspectives and approaches. Therapists in this study described employing intersectional and/or emancipatory approaches in the form of fostering discussion of racism and colonialism, when of interest to clients. Participants emphasized not forcing it, however, and thus promoted following survivors’ lead.

Salami et al. (2021), too, suggests that therapists inquire about clients’ experiences of discrimination, acculturative or migration-related stress because clients themselves (foreign-born in Salami et al.’s analysis) may not think to link these to present day therapeutic concerns. This is despite the fact that they act as chronic sources of stress and may exacerbate trauma and other symptoms (Salami et al., 2021). Salami et al. (2021) recommended that therapists ask about such issues at intake, to support survivors themselves making the connections between chronic social stress and present individual challenges. While the therapists in this study described such work, they did not emphasize doing so at intake; rather they mentioned doing so intermittently throughout the treatment relationship, and in response to survivors’ own interests and concerns. This data suggests a more nuanced, phased approach to discussions about discrimination and migration-related stress in recovery work, that is survivor-led.

Category 3: Peer mentors are critical

Macy and Johns (2011) noted uneven findings related to the power and effectiveness of peer support services. The data from this sample, by contrast, wholeheartedly endorsed the critical value of peer mentor participation, partnership, and indeed leadership in recovery work. Potocky (2010) identified a need moving forward for strengthened theoretical frameworks, with explicit empowerment approaches, to guide service delivery practices including peer mentor components and consciousness-raising through rights education. Data from this study support Potocky’s (2010) call for peer mentor involvement as an empowerment approach, however these data suggest that it may be empowering for survivors, peer mentors, and the therapists with whom they partner.

Contreras and Kallivayalil (2019) underscored the value of collaboration across disciplines and with peer mentors, as crucial next steps in anti-trafficking practice and scholarship. This study found potential in that call. Related, Katona et al. (2015) called for research to determine whether interventions can be carried out successfully by non-clinicians. These data suggest they can, and that peer mentor involvement is critically additive.

3.a. Relational Services

Despite Macy and Johns (2011) uneven findings related to the utility of 24-hour service provision and peer support services, this study found that most providers recognized the need for and value in both. As early as 2005, the Family Violence Prevention Fund (2005) recommended peer-to-peer outreach programs to aid identification of victims. Indeed, Peer Mentor Ramona cited the value of doing “community work” and “relational work” where she successfully identified and connected with survivors as a peer. She seemed to suggest, however, that her access was easier the closer she remained in time and focus to her exploitation experience. This

suggests the power of survivor-mentorship may change across time, and is an area to examine in future research.

While Macy and Johns (2011) noted uneven findings related to peer support programs, recent research suggests its value. Rothman et al.’s (2021) evaluation of the My Life My Choice (MLMC) group intervention, co-facilitated by peer mentors and therapists, as well Rothman et al.’s (2020) evaluation of MLMC’s survivor-mentorship program specifically both demonstrated promise. Rothman et al. (2020) indicated increased well-being and reductions in substance use, delinquent behavior, and exploitation risk amongst survivor mentees resulting from having survivor mentor engagement. Still, there remains little research examining the impact of peer support programs and survivor-mentorship in recovery. The present study contributed to this nascent literature base.

Findings also suggested complex nuance related to terms used in the field that warrant further investigation. Ramona indicated ambivalent reception to both the term “peer mentor” and “survivor mentor.” She argued that a professional title might distance her from her lived experience of being a survivor, and that this may exacerbate power imbalance with survivors, thus compromising her work. Molly expressed a preference for the term “survivor leader,” perhaps as the founder and leader of an organization. Sophia did not mention whether she discloses her survivor status to clients/patients in her work as a hospital-based clinical social worker, and how disclosing or not disclosing might impact her work. These differences in terminology, self-identification, and disclosure reveal complexity for the recovery field and for the survivors working within it as they endeavor to define their work and build relationships.

The literature currently uses varied terms, including peer mentor, survivor mentor, and survivor leader to describe this role. Rothman et al. (2020) studied the impact of “survivor

mentorship” on survivor recovery. Contreras and Kallivayalil instead refer to “peer mentors” and call for research examining “successful peer and professional collaborations” (January is Human Trafficking Awareness Month, para 8, 2019). Contrasting with the distinction drawn between peers and professionals, NAMI (2021) refers to peer specialists as mental health professionals. Smith (2018) defines survivor leaders as survivors who show leadership to peers and colleagues. Future studies should explore survivors’ perspectives on these terms and the concept of professionalization to create mutually agreed upon understandings of the role(s), if not consistent terminology. Future research should also explore the impact of (not) disclosing survivor status when survivors hold dual roles as clinicians.

3.b. Therapist/Peer Mentor Partnership

Consistent with the emergent contribution by Contreras and Kallivayalil (2019), this study found therapist and peer mentor partnerships to be successful, effective, and mutually supportive in terms of service delivery and co-training. Contreras and Kallivayalil (2019) called for research on successful collaborations between peer mentors and mental health professionals. This study went some way to answer that call and revealed the nuanced dimensions of peer mentor engagement and the partnership between peer mentors and therapists. These involved collaborative clinical/recovery/accompaniment work as well as mutually supportive training on clinical skills (therapist to peer mentor), and/or specialized knowledge about survivors’ contexts (peer mentor to therapist). The partnerships appeared to be mutually supportive and promoting of further work together, and thus a successful treatment model. Importantly, these partnerships were described in positive terms by both peer mentors and therapists. Some data suggested that these mutually supportive partnerships may also help reduce provider burnout due to overburdened caseloads which were noted by Magnan-Tremblay et al. (2019) and Powell et al.

(2018). In the case of these providers, the burnout/overwork concern related to over-burdened survivor mentors.

3.c. Peer Mentors Help Mitigate the Challenges of Multisystem Engagement

Data reveal that peer mentors play an important role in mitigating challenges experienced by survivors in multidisciplinary, multisystemic recovery contexts. Multiple scholars cited the importance of multidisciplinary cooperation to reduce barriers to care for survivors (Powell et al., 2018; Menon et al., 2020), but few mentioned the role that peer mentors can play. Rothman et al. (2020) recently found positive impacts from survivor-mentorship on improvement of survivor/mentee well-being, including reduced substance use, delinquent behavior, and exploitation. They noted limitations in their study, however, making it difficult to discern survivor mentor impact from other factors. The present study offers rich description about peer mentors' perception of their role.

Peer mentors in this study described serving a critical role in working to mitigate challenges suffered by survivors as they navigated complex multisystemic and multidisciplinary environments. They illustrated how their work made positive outcomes more possible through persistent, high-contact advocacy, by promoting survivor empowerment during court-mandated therapy, and by affirming systemic constraints. Since there is a dearth of research documenting peer mentors' practices in recovery work, but an acknowledgment that the care systems in which they work are uncoordinated (Clawson & Dutch, 2008; Macy & Johns, 2011), this study contributes meaningfully to the evidence base. It highlights challenging dynamics within the recovery environment, and the creative and powerful ways that peer mentors attempt to overcome the challenges to support survivor recovery.

Category 4: Multiple systems in which survivors are embedded challenge survivor recovery

The last category highlights the complex and multiple overlapping systems that simultaneously exclude and oppress survivors of sex trafficking, despite striving to serve as resources for therapists accompanying them in recovery work. Scholars have found barriers to trafficking recovery within multisystemic and multidisciplinary recovery contexts meant to support healing. These include poor coordination and communication amongst the multiple service domains (Clawson & Dutch, 2008; Macy & Johns, 2011; Potocky, 2010; Powell et al., 2018), divergent goals of professionals and institutions (Menon et al., 2020), and lack of training (Muraya & Fry, 2016). Calls are frequent to improve multidisciplinary and multisystemic recovery response (Martinho et al., 2020; Nazer & Greenbaum, 2020) by improving cooperation and coordination across the actors, organizations and systemic contexts that constitute the aftercare environment (Macy & Johns, 2011; Menon et al., 2020; Muraya & Fry, 2016). The current findings support and extend prior research.

4.a. Criminal Justice System

The mental health providers in this study described multiple formidable challenges within the systems of recovery meant to serve. They described challenges in the criminal justice system and the immigration system, which was consistent with Domoney et al.’s (2015) findings that mental health providers face challenges supporting survivors as they navigate social and legal instability. Ramona painfully detailed the story of her young client, Anna, who became ever-more entrenched within the juvenile justice system, even as it began as a helping intervention.

These findings align with prior research that has found increased incidence of running away, violent victimization, gang involvement, substance use, and involvement with law enforcement for child survivors of sex trafficking as compared to children who have suffered other forms of abuse or victimization (Hershberger et al., 2018). As mentioned, Rothman et al.

(2020) examined ways that survivor mentors may help to lessen some of these challenges. Nonetheless, participants in this study contended that many challenges remain. These included experiences of violent victimization in a juvenile justice facility, racial discrimination at the hands of law enforcement, disregard and presumption of non-participation by the judicial system.

Concurring with Vollinger (2021) and Finegan-Carr et al. (2018), participants in this sample characterized many of these challenges as related to structural inequalities. For example, Elina characterized the immigration system as "retraumatizing… (and designed to be) as adversarial as possible." Echoing Carter (2003), Pierce et al. (2009) and Farley et al. (2011), many participants also linked the challenges to historical oppression, where "centuries and centuries" (Maya) of racism and oppression continue to impact survivor recovery. These data illustrate the extent and severity of challenges that remain to be tackled, that continue to interrupt and challenge survivor recovery.

Participants in this study suggested that these challenges contribute to mental health provider burnout, disillusionment and hopelessness. Ramona suggested struggling with burnout and hopelessness in her work as peer mentor. Magnan-Tremblay et al. (2019) also found a sense of hopelessness amongst counselors who accompany female survivors of sex work in Canada. Findings from this study, however, add to the research base. Despite the challenges of disillusionment, Ramona described finding hope and support in survivor community; it is "where the hope lies." Future studies should explore this emergent evidence that suggests the potential of peer mentors and survivor community to help sustain recovery workers, and to help overcome and "re-imagine" challenges within multisystemic contexts themselves. With the 4th "P," there is acknowledgement that partnership is crucial to overcome obstacles. Survivor networks are

specifically named as partners with non-governmental organizations and other coalitions towards this end (USDOS, 2011).

4.b. Non-Profit Social Services and Mental Healthcare System

These study findings suggest alignment with the critical literatures, which critique mental health providers for using power and coercion in their work, even if subtly. Critical scholars have contended that the mental healthcare system and the trauma model can re-enact colonizing and oppressive tendencies when working cross-culturally, and that these obfuscate client resilience (Gozdziak, 2004; Lykes, 2002; Summerfield, 2000). Molly similarly critiqued the "well-intentioned" non-profit actors who "shove these services down people's throats and hope that it works, and then get mad at them when it doesn't work." Like Rothman et al. (2020), who warned of wasted resources until the field better understands what works in child sex trafficking survivor recovery, Molly too argued that resources are being wasted. That was epitomized in her example of a survivor receiving "a lifetime supply of Saran Wrap" from multiple agencies when she instead needed a broom.

The perceptions of therapists and survivor mentors in this sample added nuanced understanding about the inner workings of the non-profit and mental healthcare system. The sample in Domoney et al.'s (2015) study cited difficulties with inter-agency collaboration and a need for improved communication between health, mental health, and social services. Powell et al. (2018) also found that the mental health nongovernmental organization community argued for streamlining services. Authors emphasized the importance of building partnerships between the non-profit social service sector and the healthcare system, specifically with mental healthcare, and argued for improving provider capacity (i.e., developing a trafficking-trained mental health workforce) (Powell et al., 2018). These study findings concurred with the scholarship that has

found poor communication and coordination of resources. While in previously discussed categories in this analysis, therapists and peer mentors perceived their work as mitigating challenges and leveraging resources, these data make clear that formidable systemic challenges remain.

Additionally, while this study collected data about the value of therapist and interpreter services, there was no mention of the importance of gender for establishing safety for survivors, as suggested by Domoney et al. (2015). This may be because all participants in the sample were women, or when identified as gender non-conforming, used she/her pronouns. The impact of gender (of therapist and interpreter) to support or challenge survivor recovery should be explored in future studies.

4.c. Challenges at Sector/System Intersections

Therapists and peer mentors perceived multiple challenges where sectors and systems intersected and overlapped. This suggests that, despite safety nets that appear to span multisystem levels, survivors can still be left facing barriers or falling through the cracks between systems. This should be considered in future research as related to the social ecological models (Hopper, 2017; Salami et al., 2021) presented for use in trafficking recovery work. Participants in this study referenced the mistrust that results within survivors towards the systems meant to serve. Likewise, they identified burnout as a result of working at the intersection of multiple overburdened and poorly coordinated systems. Greta characterized the work simply as "too much," detailing her multiple roles: clinical case manager, clinician, and group therapist.

Participants echoed existing research that has contended that services designed for supposedly similarly-impacted populations are insufficient (Clawson, 2003; Shigekane, 2007). Stacey described limitations when trafficking survivors are placed in residential shelters with

domestic violence survivors, including potential for "clashes" between residents due to poorly trained staff. This aligns with Powell et al.'s (2018) contention that the field needs a more fully trained mental healthcare workforce. These study findings offered rich description underscoring serious disconnects when domestic violence shelter services attempt to serve survivors of trafficking, for example. Molly shared a story of a shelter that appeared to serve survivors of trafficking in the community but was actually screening survivors out. These findings concur with and extend the concerns of previous studies.

4.d. Challenges in Systems Related to Therapeutic Intervention

Finally, therapists and peer mentors cited challenges within systems related to therapeutic intervention. Molly generally described the trafficking field as a "flaming hot mess," "the wild west," and a "new frontier." Her words align with existing research that has repeatedly highlighted gaps in the knowledge base related to intervention effectiveness and service delivery (Wright et al., 2021).

Participants described graduate training programs as inadequate preparation to do recovery work with survivors of sex trafficking. This finding is in conversation with Powell et al.'s (2018) finding for a need to better train mental health professionals to be prepared to work with survivors of trafficking. Some participants noted that human trafficking was "not discussed in my graduate program at all" (Casey). Casey specified the lack of training on particular sub-groups, including the LGBTQ and transgender community. She noted a lack of training related to working with "different diverse populations" (Casey). Josephine described the deficit in graduate training through a critical, intersectionality lens, where she contended graduate certification programs focused on client difference/diversity as opposed to encouraging a self-reflective lens (i.e., examining whiteness). Josephine underscored the conundrum of being trained to do

supposedly evidence-based recovery work that has not been tested with diverse survivors of trafficking and may be unhelpful.

Finally, participants characterized challenges as existing between different mental health disciplines. Elina described the field of psychology, in her case, as “colonial,” paternalistic, “deeply insecure,” and enacting dominance over other mental health fields including social work. Future studies should examine differences in perceptions between different types of mental health providers to more closely examine undercurrents that impede and promote partnership. Finally, concurring with previous scholars (i.e., Wright et al., 2021), participants in this study cited a need for evidence-based treatments for survivors of trafficking and offered rich data related to things that do not work in their experience.

Implications

The data from this study confirm that therapists concern themselves with structural as well as trauma-sensitive emotional components of recovery work as interwoven support interventions. This speaks to the question explored by refugee mental health scholars: “do survivors of conflict and violence need trauma therapy or attention to daily stressors?” (Miller & Rasmussen, 2010; Neuner, 2010; Zarowsky, 2004). Indeed, the participants in this study referenced blending both domains in sex trafficking survivor recovery work. Participants described doing the work via wraparound partnerships, using therapeutic support to increase survivors’ capacity to navigate structural challenges, mitigating systemic challenges where possible, and interweaving trauma sensitivity into multisystemic work.

Most participants described engaging community-based and even emancipatory perspectives in their work, and most expressed firm interest in understanding those perspectives better and employing more of them. Most described recovery work that is embedded in

survivors’ communities, geographically, relationally and culturally. Participants also described the power of community network support, suggesting that clinicians recognize that survivors heal/recover with those of like background and experience. Almost all participants referenced bringing an intersectional analysis to their work, which involved awareness of systemic and institutional racism, exploring experiences of discrimination in therapy, and attending to power differentials with a situated power analysis.

Therapists and peer mentors in this study described the important role that peer mentors play, describing a power-with model that extended to collegial partnerships across lines of difference in terms of education and credentialing level. Those involved in these partnerships described peer mentors as core to the work, offering relational and empathic services that help clients navigate a challenging multisystemic and multidisciplinary recovery context, and where the partnership is mutually respected and survivor-led.

Finally, all participants described the existence of challenges interwoven through the systems of recovery themselves, including the criminal justice system, nonprofit social service and mental health care system, at system nexus points, and in treatment rooms with therapists themselves. While some voiced more critical perspectives, and others more trauma-informed approaches, all within multidisciplinary and multisystemic contexts, participants overall described a theoretically integrated approach to mental health recovery work. Data related wholly to trauma-sensitive or trauma-informed work was present, but was determined to be less novel than the multisystemic material. Also, data related to trauma-informed work overlapped with other phenomena of interest, including multicultural and cross-cultural practice. There were providers who spoke about contending deeply with cultural differences from a systemic

perspective. Many participants discussed multicultural and trauma-sensitive issues in a deeply systemic way.

Mental health providers’ perspectives on their work in multisystemic and multidisciplinary contexts may contribute to developing more appropriate policies and practices in social work, social service and mental health agencies, in hospital-based settings, and within the criminal justice and immigration enforcement systems as related to working with survivors of sex trafficking. Noticing convergences and divergences in approach and perspective may yield important insights for considering directions for future research related to aftercare and recovery support with survivors. Implications for the social work field will be discussed.

Implications for Theory

Chapter Two included overviews of three theoretical frameworks that currently contribute to practice guidelines, especially as the theoretical underpinnings of the field are not yet agreed upon. The first was the lens of trauma-informed care, which tends to privilege phase-based, individual and biomedically-oriented embodiment-focused treatment approaches to trafficking recovery. The second included cross-cultural and emancipatory approaches, which emerge from transcultural psychiatry and critical race theory and suggest the possibility of a population-level or emancipatory framework in recovery work with survivors of sex trafficking. This theoretical framework is sensitive to survivors’ embeddedness in systems that are historically and disproportionately marginalizing to particular groups with intersections of marginalized social identities (i.e., People of Color, women and girls, LGBTQ and transgender individuals, foreign nationals from the Global South) and considers possibilities for social change. The third was through the lens of a social ecological approach, which informs multidisciplinary and multisystemic intervention.

Despite striving to serve as resources to therapists accompanying survivors of sex trafficking in recovery work, many participants in this study suggested the multiple systems that comprise the recovery milieu simultaneously oppress and exclude survivors. The data suggested that therapists and peer mentors interact to affirm these challenges for survivors and attempt to leverage them to be effective, to meet the goals set out by survivors and providers in recovery work. Given the continual recommendations for multidisciplinary cooperation in sex trafficking survivor recovery, it is essential to conceptualize recovery work in the context of broader systems, which provides space to consider the possible resources within those systems and the challenges to recovery. This can contribute to programs that, in the balance, hold systems out more as resources than as obstacles, and may also provide insights for policy. Participants in this study described the recovery context as complex and with myriad challenges, yet with opportunities for leveraging resources to support recovery. The novelty of the perspectives articulated by participants centered on their multidisciplinary and multisystemic work. This was not originally expected but emerged as a core of the data – that this is largely multisystemic and multidisciplinary work. This suggests that theories that support examination of contextual factors are important ones to turn to in building recovery models. Going beyond a trauma-informed model, both social ecological theory and critical theory provide tools to consider context, albeit in different ways.

This study brought together multisystemic and multidisciplinary literatures, which function largely in a trauma-informed framework, with the literature on intersectionality and critical theory. It drew them together as seen through the eyes of clinicians, one of whom is a survivor of sex trafficking, and through the eyes of peer mentors. This is an important convergence of insights for understanding how multidisciplinary mental health providers might

rethink their work. Multisystemic work necessitates contending with the challenges and barriers to recovery interlaced throughout the multisystemic and multidisciplinary contexts of aftercare services in which survivors are embedded. This can entail shifting the frame of pathology to the system versus the survivor, and shifting the recovery focus to systems that entangle survivors as well as to resources in communities and networks. This shift may be useful in building a theoretical framework to guide practice.

The fact that survivors are embedded in multisystemic and multidisciplinary contexts means scholars and practitioners should continue to consider both individual trauma impacts and systemic, structural, and group-based concerns together in an integrated way. Hopper’s (2017) work suggests an ecological, multisystemic framework, however, critical race theory and intersectionality encourage consideration of how racism and oppression are interlaced through those systems, and challenge individuals and population groups. In fact, findings suggest a possible extension to Hopper’s (2017) MSE model, related to the agentic role of therapists and peer mentors, and the partnership potential of mental health therapists and survivors. This might be depicted on Hopper’s (2017) MSE framework as another through-line, “provider partnership,” as opposed to an additional outer system layer.

The theoretical frameworks used in this study led this analysis to explore how therapists contend with clients as embedded in multisystems and as contextualized within population-based histories and contemporaneous material realities. Deepening thinking into if and how providers engage culturally-sensitive, victim-centered, and trauma-informed intervention approaches, as suggested by Martinho et al. (2020), may contribute to a firmer theoretical foundation to guide research and practice in the field, as well as policy suggestions to help overcome challenges within the many multisystemic contexts with which survivors interact.

Given the recent and politicized interest in critical race theory in United States politics, it is a challenging time to turn to critical and anti-racist frameworks to advance work in support of survivors of sex trafficking. On the other hand, since human trafficking is a topic of shared concern across the political spectrum, it may be a productive moment to identify the usefulness of a CRT frame in trafficking recovery efforts, to better contend with the structural forms of violence that impacts particular groups differentially.

Implications for Practice

The following practice recommendations are preliminary, as this was an exploratory study with 13 survivors, and results may not be generalizable. Nonetheless, clear implications for practice emerge. Mental health providers should consider working in partnership with peer mentors. Contreras and Kallivayalil (2019) suggested that these approaches hold promise, which bore out in this research. Participants in this study largely had experience working in clinical partnerships with clinicians and peer mentors, and described functioning with trust and appreciation for mutual skills and knowledge.

Most providers suggested the value of connecting survivors with survivor community and networks. Findings suggest that supportive community amongst survivors of trafficking may be a profound resource in recovery. As past research suggested mixed findings related to peer support, programs that engage in such partnership should continue efforts to measure their impact.

Findings revealed that providers do indeed integrate trauma-sensitive support with structural support. Findings were mixed, however, related to extent to which providers integrate trauma-sensitive support with emancipatory/population-based recovery approaches. The mixed findings suggest that providers are trying to find their way to adapt techniques for diverse

survivors of trafficking and are proceeding with uncertainty. Some participants expressed a need for more training (i.e., re LGBTQ populations, and to understand how to better serve the needs of Latin American immigrant survivors with culturally-appropriate supports). Nearly all participants expressed interest in emancipatory work, and evidenced work on these fronts. That is, providers mentioned discussing issues of race, racism, and historical marginalization with client-survivors, where therapists moved at a pace comfortable for survivors. But providers also expressed a desire for/interest in more training. Future research should work to develop this vein of practice, as almost all providers endorsed meaningful interest, and this researcher's defining of emancipatory healing approaches[5] coincided with one peer mentor's sense of how the work should be done.

Clinicians especially described inadequate training beginning in their graduate programs, both to work with survivors of human trafficking broadly, to work with specific sub-populations, and to employ emancipatory, intersectional, community-based recovery approaches. Therapists noted their lack of training, but also expressed an interest in gaining more training. Practice would benefit from improved training at the graduate level as well as dissemination of ongoing, post-graduate trainings related to these topics. This may happen through professional development/CEU formats. Notably, some workshops already cover related topics. For example, the professional development workshop "#RacialTraumaIsReal: Assessment & Treatment of the Psychological Consequences of Racism Across the Lifespan" (Jernigan-Noesi, 2021) blends awareness of mental health with attention to racism and historical marginalization. Training partnerships might be developed. Relevant trainings may also emerge from other sectors (i.e.,

[5] See Appendix C (Semi-Structured Interview Protocol, Section 4) for this researcher's definition of emancipatory healing approaches provided to participants, based on Farley et al.'s (2011) conceptualization of decolonizing healing.

community organizing or anti-racism, such as “People’s Institute for Survival and Beyond”). The data from this study could help guide training programs, as well as policy level decisions related to national social work graduate curriculum.

Providers should also continue to explore potential community- and culturally-embedded forms of recovery support. Tierra described sensing that there was more she wanted to offer survivors of sex trafficking from Latin America that was culturally-home, as opposed to trauma-informed yoga (TSY), yet she reported struggling to know what that was. The interventions that practitioners experiment with should be studied for implementation across different groups to determine their utility. Practitioners and researchers are in a hopeful position to collaborate towards these ends, in order to quickly assess their cutting-edge experimentation and exploration. TSY, for example, may be more a useful intervention with one sub-group (who, for example, has been exposed to Eastern healing as a resource) versus those who have not and may benefit from more culturally-“home” approaches.

Other possibilities to explore include the therapeutic use of psychedelics and plant-based medicine for complex trauma amongst survivors of trafficking, as such approaches regain scientific momentum. Recent scholarship has underscored the potential of MDMA-assisted psychotherapy for helping veterans overcome entrenched and treatment-resistant PTSD symptoms including suicidality (Mitchell et al., 2021). MDMA-assisted psychotherapy may be a useful avenue to explore with survivors of trafficking. Likewise, promising research has emerged from the Amazon of South America, a “home”-cultural context for some survivors, at Takiwasi Center (2021). Takiwasi successfully combines Amazonian plant-based treatments emerging from Indigenous healing traditions, with Western psychological approaches to treat trauma and substance abuse issues (Rush et al., 2021). Such treatment approaches have been found to be

effective for participants from South America, North America and Europe (O'Shaughnessy et al., 2021). These promising approaches should be examined for use in sex trafficking survivor recovery, for amelioration of PTSD symptoms, substance abuse issues, and related to complex or developmental trauma symptoms. They may also be useful approaches as a culturally-embedded means of community (re)building. The therapeutic use of psychedelics may hold promise for sex trafficking survivor recovery, and is another potential frontier for research and practice.

Implications for Policy

These policy recommendations are tentative, as they are based on an exploratory study with a small sample size. Multiple challenges emerged in the varied systems of care and recovery in which adult and child survivors are entangled. For example, court-mandated therapy may be ineffective and its description by a therapist in this study (Maya) read as coercive. Maya responded by making court-mandated therapy optional, as a means of being trauma-informed. It may be beneficial to rethink traditional approaches to court-mandated therapy to maximize survivor choice. Therapists in this study suggested respecting non-participation as essential. Further, non-participation could be considered an optional form of participation (i.e. survivors showing up could be considered sufficient participation to reduce coercion and resistance to therapy). Findings suggest that the systems of recovery may in fact be placing therapists and peer mentors in difficult ethical quagmires, where they must decide to follow the rules of the system and be enforcers of coercive actions, or shirk the rules and risk consequences to themselves or their clients. Participating in coercive actions, even if meant to help, may trigger a survivor mentor who has had her/his humanity compromised by being forced to enact abuse/coercion upon others as part of her/his exploitative experience. This is untenable in a recovery context, and it was apparent from the voices of Maya and Ramona particularly. Future studies could

examine varied therapists’ approaches to court-mandated therapy, and their outcomes in survivor recovery. Studies could examine the outcomes of optional non-participation along with forced participation.

Some participants offered context about the limitations of attendance policies at mental health clinics and hospitals for survivors of trafficking. These participants seemed to feel they needed to bend, break, or re-write attendance policies in order to provide adequate care to survivors who needed the leeway to enter and exit care as they were able to participate. Clinics should consider adapting their attendance policies to not exclude the survivors they seek to accompany. Further, different perspectives emerged on so-called “3-strikes” agency policies that were ultimately not part of analysis, but suggest useful directions for future research. The “3-strikes” policy refers to survivors being discharged from care after breaking agency rules three times. Most agency-affiliated participants did not mention having “3-strikes” policies or were able to subvert them without risking their jobs. Too rare to include in analysis, Stacey repeatedly described painful examples of discharging survivors, sometimes to homelessness, for breaking rules at the residential safe home. She was the only participant who articulated her practice in this way. Agencies may benefit from close consideration of the inclusiveness and flexibility of their policies given the unique needs of sex trafficking survivors.

Based on these study findings, mental health organizations should seek to work in recovery/treatment teams partnering therapists with peer mentors. Participants in this study described the peer mentor work as a “critical,” essential contribution. Future studies should explore the outcomes comparatively of solo practitioners versus treatment teams (described below).

Some data emerged in this qualitative dataset about therapists’ work with transmen, transwomen, and boys. This study was focused on work with women and girls, and so did not specifically seek data on trans individuals or boys. Nonetheless, Stacey spoke of the safe home policies where she works that may exclude trans and male survivors. She spoke of “getting a crisis call from someone who’s transgender and not being able to offer them a bed because they weren’t born with a vagina. How do you navigate that?” There is limited data in this study, but the occasional mention of these topics suggests that issues for trans individuals may dovetail in complicated ways with services for girls and women. Additionally, the research is clear that sex trafficking is a paramount risk for trans individuals.

Implications for Macro Social Work

Reflecting through a macro social work lens, options appear to move beyond the current focus on downstream issues, such as treatment, recovery, and policing of traffickers, and shift the frame to community action. These downstream solutions treat symptoms without challenging the problem. Anti-trafficking professionals cannot break up the giant offenders who traffic (criminal networks) or the individuals who do. Coordinating a multi-sector response is one approach, but there are other options. We might focus discussions on the core problem, the bedrock underlying sex trafficking: the de-humanization of particular populations of people, primarily women and girls of Color. One difficulty, perhaps, is that this phenomenon is not new. There are numerous social movements, however, both historical and contemporary, that could support organizing around such efforts (i.e., feminism, anticolonial movements, civil rights, international human rights, international child rights, anti-racism).

We must focus on basic questions, a deeper reckoning, especially as political and social life in the United States is ever-more divided: How should we understand the worth of people?

What frameworks and structures are required to ensure that the recovery sector serves the genuine needs of survivors and those at risk of being exploited? And, once in the system, what measures will protect survivors from discriminatory and harming power-over behaviors of actors within each sector, even if their action appears aligned with their genuine purpose (i.e., criminal justice)? Important policy work is being undertaken to de-criminalize sex work, in favor of the buyer, so the sex worker is not arrested. Safe Harbor laws are another important step, de-criminalizing child involvement in sex work to reduce barriers to help-seeking and aftercare recovery.

Other actions to take might be understood in the framework of prevention, community wellbeing, or even community organizing. That is, communities must be sufficiently resourced. Legislators must act in ways that underscore: there are no throw-away neighborhoods; there are no throw-away humans. This includes U.S. and non-U.S. citizens (i.e., undocumented survivors). It means viewing immigration issues from a human wellbeing lens, understanding that people flee their home countries in pursuit of survival, for themselves and their children, and confront risks of further victimization on the journey. Some of these who flee are those who live trafficked in the U.S., making up part of the underground economy of illicit sex work, among other industries. Solutions must include not only improved recovery efforts post trafficking, but also concrete internationally- and locally-coordinated efforts to prevent the need to flee for survival. As some argue that climate change is one of these risks, and that is an ever-growing concern, this problem is not likely to disappear; it is likely to worsen.

Macro issues are the concerns of social workers. Social work trainees are introduced to clinical and well as macro approaches to social work. Yet, macro social work is often constructed as legislative advocacy. Meso approaches may be a useful focus in social work

education: ones that merge a clinical and macro focus towards prevention efforts, community-building, and even community organizing to support trafficking prevention and recovery. Indeed, participation in community organizing and social change can be potential pathways to support recovery.

Strengths and limitations of the study

This study had many strengths, including recruitment of participants who specialize in recovery work with survivors of sex trafficking. Several participants were survivors themselves, and many more regularly partnered with peer mentors and survivor-leaders in their clinical and training work. The study was able to gather enormous amounts of rich data through in-depth interviews. Some of this was put aside for future analyses. Additionally, the waitlist for and interest in the study was robust. Potential participants regularly made contact throughout the recruitment period. Once enrolled in the study and during interviews, participants shared positive endorsements of their interview experience, about the protocol, and stated interest in learning of the study’s findings. Desiree shared, “I think your questions are so interesting and helpful.” Penelope noted, “I think you got the very authentic (responses)… I’m really appreciative of how you’re doing this.” Molly stated, “I’m really excited. I’d love to read your final paper.”

This study also emerged out of extensive literature review searches, and theoretical writing related to complex trauma frameworks and their critiques over approximately nine years, and this lens over time was a strength. The researcher had the opportunity to closely consider issues in clinical care with survivors of sex trafficking when the literature base was extremely limited, through approximately 2016, and again through a small but growing number of studies from approximately 2017 to 2021. In fact, new studies relevant to this topic continued to emerge weekly throughout the final stages of manuscript writing and publication. The researcher served

as a clinician with international survivors of human trafficking between 2012 to 2020, and this proximity to the clinical material and to the perspectives of clinical colleagues was also helpful. Finally, the researcher undertook extensive data analysis over an extended period of time.

Nonetheless, this study, like all studies, had limitations that should be considered while interpreting results. First, the overall study timeline was relatively short. The timeline for this original qualitative study, from study design, dissertation proposal defense and IRB application to advertising the study, participant outreach and recruitment to interviewing, transcription, analysis, and writing, was approximately sixteen months.

The difficult macro events, including COVID-19 combined with social movements related to George Floyd’s murder in police custody, may have impacted the response rate and availability of clinics and clinicians in the summer and fall of 2020. Likewise, some participants and potential participants reported high levels of work and client demand impacting their availability, in part owing to strains due to the cultural and public health pressures, risks, and losses shared globally during this cultural moment. These may have impacted interest and the interviews themselves, which took place at home, amidst everyone’s blended work and family lives. Notably, the vulnerabilities and adversities associated with COVID-19 and police violence were and are not equally distributed across communities, populations, or countries.

This study uncovered important insights from therapists and peer mentors, but was limited by a small sample size, from a positivistic perspective. While the sample size was appropriate for qualitative conventional content analysis, future studies could add quantitative components to increase sample size, and improve comparison and generalization ability. Additionally, the research question inquired about “effectiveness,” understood as processes that support recovery. Data from a quantitative study designed to examine intervention

“effectiveness” - interventions delivered by therapists, peer mentors, and/or or by therapist-peer mentor partnerships – may complement these study findings. Future research may benefit from randomized control trials with a control group.

The sample demographics lacked diversity by race, ethnicity, and survivor-status. Ten participants identified as white, twelve identified as female (one identified as gender non-conforming, but uses she/her pronouns). Roughly eleven were born in the United States. These demographics likely impacted their perspectives and may have caused perceptions of clinicians who are non-U.S. citizens or women of Color to appear as outliers in this sample. Likewise, the category related to peer mentors ultimately appeared less robust (typical as opposed to general), because there were fewer participants in the sample who either were survivors or partner with survivors in their work. More than half the sample (7) did, and of those, 100% discussed their work with peer mentors in positive terms. Seven participants was not enough, however, to meet the threshold for “general,” according to Hill and colleagues’ (2005) assessment mechanism for reliability in qualitative research.

Another potential limitation was the centering of mental health providers’ voices in the study design, despite Napoli’s (2019) suggestion that mental health providers should decenter themselves, set aside the “expert” mantle with diagnostic and treatment power, and be in “reciprocal relationship” (p. 80) with clients. The study, however, did not presume who could be considered a “mental health provider” for trafficked women nor did it presume what counted as treatment, in an attempt to capture the breadth of existing clinical treatment and recovery approaches. Due to its broadness, three participant voices were survivors of sex trafficking. That is a strength.

A limitation is that this study collected data from therapists primarily and survivor mentors secondarily, but did not also collect data from survivors/mentees themselves. Survivor voice is considered essential in research (Hopper, 2017; Wright et al., 2020), and would provide much needed support for study findings. In this study, survivors/mentees were not interviewed and therefore is a limitation for learning about survivors’ experiences and treatment needs. Talking directly to survivors would be useful in future research. Likewise, a quantitively-focused randomized control trial (RCT) such as described below in future research may be useful to overcome this study limitation. Wright et al.’s (2020) study on survivors’ conceptualization of mental health recovery is forthcoming helpfully, but more studies will improve knowledge and support (or challenge) their forthcoming findings. Also, a future study zeroing in on survivor perspectives on working with therapists and peer mentors may be useful.

Another limitation is that this study interviewed only three survivors of sex trafficking; two were professional survivor mentors, and one who was a clinician. The lack of balanced representation of survivors in this sample was a limitation. In the future, interviewing survivors of different roles in recovery work, as well as interviewing treatment teams would be interesting. Additionally, interviewing more participants who hold dual backgrounds (i.e. survivor and clinician) would be useful. The lack of representation of these varied demographics limits the validity of the findings. Finally, some therapists in the study partnered across the disciplinary spectrum with peer mentors, but not all did. Comparative results are limited by the study design, which was meant to be exploratory in nature.

Finally, this study was not designed to explore providers’ perspectives on differences in their work across gender identity. While some participants endorsed working with boys or men, it was not a focus on the empirical or theorical literature search, or of the interview protocol. As

this remains an emergent area of research in the trafficking recovery field, future studies should explore clinicians’ and peer mentors’ views on recovery work with male- and trans- identified survivors of sex trafficking.

Future Research

The problems in the systems brought to light by the study are not solvable by one resource or discipline, including therapy and therapists. They are complex. Recovery may best happen embedded in multisystemic and multidisciplinary contexts. In doing multidisciplinary work, it is important to understand the perspectives of other providers in the systems to mutually leverage the opportunities at the nexus points for the stabilization and recovery benefit of survivors. This study revealed emergent findings related to the nuanced dynamics of doing multidisciplinary and multisystemic work. Future studies should continue to explore the varied partnerships, challenges, and opportunities to leverage empowerment, healing, and emancipatory strategies.

The data suggest that clinicians are working in multisystemic, multidimensional ways, across systems, disciplinary practitioners, and population realities. Not all participants undertake this work in the same way, but most do undertake it in some way. Therapists are contending with individuals as clients embedded in larger systems as they deal with the systems themselves. Some described dislocating the individual from the center of the treatment frame, and instead holding the survivor network at the center of the treatment frame. That shift is a potential avenue for future research. As the locus of attention shifts, treatment intervention shifts meaningfully, as seen through these participants’ work. Participants revealed doing work that decenters individual issues, conflicts, limitations and struggles, and instead contends with larger structures and systems. This includes considering how cultural differences intersect with those systems, and

ways that culture and population-based history differentially vulnerabilize particular people and groups.

Future studies should comparatively examine the differences in intervention outcomes, perceptions of effectiveness, and satisfaction levels of solo mental health providers versus those working in treatment teams. This study did not comparatively look at providers who worked with an agency/team versus those who primarily worked in private practice, but these data exist in the interview material and there were suggestions of meaningful differences in treatment approach amongst these differently situated therapists. What are the relative benefits of private practice work (Caroline), versus mixed private practice & organizational affiliation (Penelope and Elina), versus agency-based work that is the most systemically-embedded, but also has peer mentor community (Desiree and Casey)? These nuances were not the focus on this study, but divergent data emerged in each area, suggesting that further study is warranted to better understand the impacts and relative merits of each path. Powell et al. (2018) found potential in integrated mental health institutions, suggestive of the benefits of one-stop shopping and minimizing gaps in services for survivors of trafficking in recovery. Studies should examine the differences in outcomes. That is, one therapist suggested that survivors who are “further along” (Caroline) in recovery may have distinct needs from those who have recently exited. It may be that a treatment team model is most useful at particular phases in recovery. This should be examined to fine-tune timing of intervention components with survivors.

Providers did not talk about the role of community organizing for social justice as a form of recovery. Finegan-Carr et al. (2018) suggested that a social justice/action lens might better address the root causes of human trafficking – structural inequality and poverty. Vollinger (2021), too, emphasized the importance of social action in trafficking recovery practice and

scholarship. Future research might examine mental health recovery outcomes via a comparison study. For example, what is the impact on “recovery” of mental health intervention versus (sex worker) rights group advocacy/involvement or other lobbying for social action/social change? Recovery may need to be conceptualized broadly, as suggested by Wright et al. (2021), to include holistic, clinical and non-clinical outcomes (i.e., PTSD or CPTSD symptoms, relationships, confidence, self-concept, economic stability, indicators of empowerment, belief in one’s ability to make change, voting/citizen participation, substance abuse, and more). Which forms of intervention, with recovery defined in what way, give rise to the greatest sense of wellbeing, of regulatory capacity (to borrow from Hopper, 2017), of emotional and structural stability, safety, economic stability? Are they mental health focused, or something else?

Future studies should undertake in-depth explorations detailing providers’ and peer mentors’ partnerships, their experiences doing recovery work, and how they conceptualize healing. This study made progress towards that end, but this study’s semi-structured interview format was constrained by a 90-minute clock. Also, while it did achieve rich conversation, this study lacked site visits, which were impossible during COVID-19. Future studies should continue and deepen the inquiry in line with this study, and thus increase understanding of the recovery field.

Research moving forward should examine different sub-groups of providers, including peer mentors, survivor leaders, and therapists of different credentialing paths, as well as other types of therapists (substance abuse counselors, spiritual counselors, yoga teachers and more) for better comparison purposes. New, rich and important findings may emerge about resources and barriers within multisystemic, multidisciplinary work, as well as treatment approaches, processes found to be effective, and emancipatory approaches.

It may be useful to interview providers of different population/cultural groups, including Indigenous therapists/healers/mentors, and/or those who work with them. An earlier version of this study aimed to recruit providers from U.S. Indigenous communities. It may be useful to engage in exploratory research to examine if and/or the extent to which integrated approaches to recovery work (mental health and decolonizing/emancipatory approaches to healing, as recommended/found by Farley et al., 2011) are being carried out. If so, how are they being implemented, what are the promising outcomes and what are the challenges? Additionally, Johnson (2012) pointed out that there is comparatively little research on Indigenous communities in the Northeast of the U.S, despite the presence of reservations and Indigenous communities in NY, ME, NH and MA. Future research should examine trafficking prevalence for Indigenous communities in the Northeast, and if an issue, explore ways to support survivors by region. This work may continue to contribute to theory, practice and policy.

Future studies should continue to examine challenges in the multisystemic and multidisciplinary contexts in which survivors attempt to recover. Providers in this sample described myriad constraints to healing, in the form of racist and discriminatory experiences, aggressions and abuses within the juvenile justice system, coercive tendencies on the part of the non-profits designated to serve survivors of trafficking, and more. Challenges must be continually examined and addressed to aim towards creating/sustaining a healthy, supportive recovery environment. Also, a peer mentor in this study suggested that “good” therapists leave based on the constraints and oppressive practices within mental health non-profit work. This must also be explored to assure the field can maintain providers who are trained and valuable.

Hopeful and powerful data emerged about the value of survivor community. Other studies have questioned the value of group survivor contexts based on the nature of relationship

challenges this population may suffer, due to chronic relational trauma and/or experiences of exploitation. Participants in this study, however, largely spoke powerfully and positively about the potential of survivor community to support stabilization and healing. Future studies should explore survivors’ own conceptualizations of “community,” to learn directly about the experiences, needs, and assets of survivors of trafficking in this regard. Caroline suggested there may be differences between survivors (by population, nationality, socio-economic status) that meaningfully impact and inhibit a sense of shared community. Exploring concepts of support and community-belonging within a group as diverse as survivors of sex trafficking in the U.S. is important to avoid the generalized presumptions that all survivors will benefit from the same recovery context. To my knowledge, no known studies have comparatively explored, or explored at all, how survivors of sex trafficking from different demographic sub-groups conceptualize community, belonging, trauma, or healing/recovery. These may be powerful areas for future research.

Future studies could examine the impact that Facebook and other online social media sites have on connection and recovery, both in terms of supporting and impeding efforts. Critiques abound of this medium and the commodification of personal information. Facebook has also reportedly discovered human traffickers using its site to recruit and exploit, and survivors themselves have debated the relative merits and dangers of social media platforms for sexual exploitation (Coaston, 2021). Molly referenced having formed a supportive survivor online network even before escape. Notwithstanding the complex issues, the internet is a powerful platform and merits further consideration for its power to connect as well as divide.

Levine (2017) named interventions with potential promise to support recovery with survivors of trafficking. He cited various forms of expressive therapies, animal therapy, narrative

exposure therapy, and EMDR, but noted a lack of clinical trials on any of these modalities. The arts provide a promising pathway for healing at an individual level, connection and repair at a community level, and also for action towards social change. Hopper (2017) noted that “expressive modalities may be used for systems change” (p. 174), describing the power of documentary theater and film for awareness raising about trafficking and to reduce social stigma about survivors’ experiences of exploitation. She argued that these should be implemented by clinicians with special training in expressive therapies. While training is important, the field may benefit from reducing the disciplinary divisions between and amongst training programs. Social workers can and should gain training about using the arts in their macro, meso, and clinical work. Indeed, art educators work at the nexus of the arts and what some would consider the social work domain (i.e., working in under-served communities, jails, and more). Specialized training should also consider the impact of arts-based intervention across cultural context, including global social work. Creative expression is related to re-storying a community’s narrative towards strength, hope, dignity and potential. There may be much potential, and limited understanding, of the impact of varied artistic processes (creation, editing/refining, performance, audiencing) on recovery/engagement/well-being, and ways that the arts support and provoke across cultural context and transnationally.

As discussed under limitations, a quantitative study, perhaps a gold standard randomized control trial, may be useful in the future examining intervention effectiveness. That is, these studies could reveal important data related to the effectiveness of trauma-informed intervention, as well as community-focused interventions, peer mentor interventions, collaborative therapist-peer mentor interventions, and more. Many scholars have called for examining intervention efficacy moving forward. Recent limited research examined the impact of survivor mentors as

part of intervention work (see Rothman, 2020). This study illuminated potential avenues for future quantitative analysis. Variables to examine in future studies may include intervention effectiveness of the different types cited above. Specific to peer mentor-therapist collaborations, future studies may benefit from measuring effectiveness of therapist-peer mentor partnerships versus solo therapists and solo survivor leaders. Related, validated measurement instruments with distinct sub-groups of provider and survivor must be developed to engage in ongoing research. These instruments must be sensitive to diverse sub-groups of survivors.

Also, a 360 degree study might examine variables of interest across actors; that is, for therapists, peer mentors, and survivor mentees involved in the partnership. What, if anything, is gained that is unique to the therapist-peer mentor collaboration, as measured through indicators of effectiveness at the staff level (therapist and peer mentor), the client/mentee/survivor level, and the agency/institutional level. Variables of interest at the staff level may include: job satisfaction, staff retention, well-being/health (lack of compassion fatigue and burnout), and educational attainment. At the survivor level, they may include stabilization outcomes, substance use, re-exploitation rates, educational attainment, and employment. At the program/institutional level, they may include financial viability, staff retention and training, grant attainment, and partnerships with other institutions. Multidisciplinary coordination and communication has been considered a limitation and a goal in recovery work. This study suggests there may be multiple system levels at which the field can work to enhance coordination and partnership.

Future research should also explore the question of jail as a context for therapeutic intervention. Greta described successfully using jails as access points for identification and care, but Ms. Reed-Barnes suggested their ineffectiveness, according to the survivors she accompanies (Contreras & Kallivayalil, 2019). Again, a 360 degree study may be valuable to explore the same

variable of interest from the perspectives of survivors, therapists, peer mentors, and peer mentor-therapist treatment teams. Similarly, a full-circle perspective on the current study’s research question is: what are the perspectives of varied actors - in health care, mental healthcare, survivor leaders and survivors recently exited - who interact with multisystemic and multidisciplinary recovery environments in the United States and beyond - related to treatment approach, the processes they find to be effective or supportive/helpful, and their views on emancipatory approaches? These inquiries across disciplines and actors may advance the field.

Finally, additional issues were present in some interviews, not related to a multisystemic perspective and were therefore excluded from this study, however should be examined in future studies because they may inform practice approaches. For example, data were collected related to providers’ work with trafficking survivors abroad. This data was largely excluded, since the focus of this study was providers serving survivors in the U.S. at the time of the recovery. It may be useful to consider lessons learned abroad, however, with an eye towards improving practice with survivors in the United States (especially foreign nationals). Josephine noted her international work conditions differed meaningfully from those in the U.S.; still, lessons may yet be learned. Mental health providers in other countries may be doing emancipatory work, for example, that could help advance analysis and recovery work in the U.S.

The scholarship may benefit from examining survivor recovery work not just from a strength-based perspective, but from a joy-based perspective. Desiree described a perspective that made “flourishing” an aim – a recovery aim of full humanness. Similarly, Maya characterized her clients as “joyful and meaningful to work with” versus “the system (which) was very difficult to work with.” This coincides with Magnan-Tremblay et al. (2019) suggestion that interventions must seek to help rebuild survivors’ hope and confidence towards leading

fulfilling lives. As some participants in this study discussed, Magnan-Tremblay et al. (2019) also called for positive approaches to recovery versus approaches that focus exclusively on treating difficult symptoms, or minimizing harm. Future research may benefit from exploring notions of healing and recovery towards flourishing. Likewise, participants in this study discussed the challenge of burnout as formidable for providers. This coincides with the findings of Magnan-Tremblay et al. (2019) and also Powell et al. (2018) who discussed the challenge of provider capacity. The embodied experience of joy, connection, and flourishing, for survivors as well as mental health providers, is a worthwhile topic for future study.

Lastly, data emerged related to providers’ work during the COVID-19 pandemic, particular to ways that they adapted their practices to maintain connection and presence. Interesting data emerged that may merit further study. For example, Desiree described one impact of doing clinical work (in person, masked) with survivors during the pandemic was heightened reliance on “eye contact” and “whole-body language. And, of course, with trauma, you know, of course it makes sense that that might be even more helpful… I notice little subtle shifts in body that I maybe would have missed before.” Desiree also discussed doing more clinical work via telephone which led to practice changes: “I’m listening to subtle changes in tone of voice and pacing and hesitancies… It’s very interesting when you’re restricted of the normal way of working.” Future studies should examine the impact of COVID-19 on trafficking recovery efforts, both in ways the pandemic exacerbated risk as well as practice changes that may merit replication and study.

Conclusion

Presently, little is known from the experiences of mental health providers (e.g., counselors, therapists, clinical case managers, peer mentors) who serve sex trafficking survivors,

in terms of their perspectives on the multisystemic and multidisciplinary contexts in which they work, and the efficacy of complex trauma treatment recommendations in practice. Likewise, little is known about the culturally sensitive adaptations they make, management of the dynamics of race and coloniality in the treatment relationship, and whether and how emancipatory healing models are employed. Finally, few studies have examined the impact of survivor mentors on mentee outcomes (Rothman et al., 2020), and no known studies have explored perspectives on the clinical partnerships between survivor mentors and clinicians, despite consensus that survivor voices are critical to inform practice and research.

Social work’s mandate is to address issues of human rights, social and economic justice. In order to analyze and act on issues related to human trafficking, an integrated structural/systemic and clinical analysis may be required. Social workers are in a unique position to be at the front lines of trafficking intervention in varied settings (Hodge, 2007). They may benefit from adopting a nuanced perspective to meaningfully intervene (Alvarez & Alessi, 2012). Collaboration with survivors is essential, as well as with those agencies and systems that already have deep collaborations with survivors.

Social workers may be able to uniquely contribute at this intersection, by extending the trauma-informed lens and social ecological models, to include cultural and historical situatedness at intersections of oppression. It may be useful to integrate the trauma-informed literature and the structural and multisystemic literatures. Bessel van der Kolk, in his seminal piece (1994) declared that trauma resides in the body; memories are not past, but remain present as living memory in the body, and return at inopportune times, no longer congruent with present reality. The Miriam Webster (free online) dictionary names alternative definitions for the body, including “a group of individuals organized for some purpose.” Broader implications for the

‘body keeping the score’ become apparent – social bodies keep scores; populations register suffering; communities hold the potential for healing together. Social workers are uniquely positioned to hold and conceptualize interventions that span the psychic distance between and amongst clinically oriented psychological and body-based treatment conceptualizations, and systems-level conceptualizations that consider culture, race, power and intersectionality.

Recovery work with survivors of sex trafficking may require a variety of approaches, tools, theories, multidisciplinary practitioners, multisystemic contexts, and social change efforts to begin to lessen certain groups’ disproportionate risk for trafficking exploitation, and the steep challenges towards recovery. It may well require individual-level healing, community-level support, and system change within the structures surrounding survivors. It may take a population-level focus, as well as an individual one, and an inter-systems lens to consider how to mitigate risk and move towards recovery.

As the daughter of parents who, while not trafficked, fled childhood adversity, I have observed that recovery work is complex and intergenerational/transgenerational. Efforts to support sex trafficking survivor recovery work may benefit not only the survivors that mental health providers accompany, but also their families and communities, their children and grandchildren – in short, family lineages, communities, and population groups with not only histories, but stories yet to be lived.

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Table 7. Demographic Information of Study Participants

Participant	Professional Role	Background/Credentials	Workplace Affiliation	Years of Work Experience (w/ sex trafficking survivors)	Cultural Identity (as defined by participant)	Language(s) Spoken in Clinical Work
Casey	Clinician	LMHC (M.A. Counseling Psychology)	Non-profit Agency (Massachusetts)	17 years	White/Caucasian; grew up abroad	English
Ramona	Peer Mentor	College coursework in sociology (plans to get PhD) Survivor of sex trafficking	Non-profit Agency (Florida)	9 years	White female; gender non-conforming. (Grew up close to poverty line)	English
Tierra	Clinician	Licensed Clinical Social Worker (MSW)	Non-profit Agency (New Jersey)	8 years	Latinx, Woman of Color, Immigrant with documents (grew up in U.S. & abroad, S. America)	Spanish & English
Penelope	Clinician	LMHC (M.A.)	Mixed private practice & non-profit agency (Florida)	5 years clinically (9 years in anti-trafficking work)	White female; grew up abroad (W. Africa)	English
Josephine	Clinician	LICSW (MSW)	Non-profit Agency & Hospital-based system (Massachusetts)	7 years w/ human trafficking survivors; 3.5 years w/ sex trafficking survivors specifically	White, cisgender female, US citizen	English
Greta	Clinician (Victim advocate counselor)	MHC/obtaining LMHC (M.A. Mental Health Counseling)	Non-profit agency (New York)	3 years	White female; young	English
Elina	Clinician (Clinical Psychologist)	PhD in Psychology	Mixed private practice & hospital-based system (Massachusetts)	20 years	Southeast Asian female, immigrant	English
Maya	Clinician (& professor)	LMHC (M.A.) & PhD in Counselor Education	Non-profit agency (Florida)	1 year (4 years clinical work & research)	Female, bicultural – white & Chinese. (Identifies as receiving white privilege)	English

Participant	Professional Role	Background/Credentials	Workplace Affiliation	Years of Work Experience (w/ sex trafficking survivors)	Cultural Identity (as defined by participant)	Language(s) Spoken in Clinical Work
Sophia	Clinician	LMSW (MSW) Doctor of Social Work Survivor of sex trafficking	Hospital-based system, faith-based (Texas)	10 years clinical work w/ trafficking survivors; (3 years strictly w/ sex trafficking survivors)	Cis-gendered Caucasian female (mixed background is European & Native American – Cherokee Indian), spiritual	English
Molly	Survivor Mentor/Leader & Subject matter expert (Co-Founder of non-profit agency; Director of Research)	B.S. Finance M.A. in Sociology Survivor of sex trafficking	Non-profit Agency (Colorado)	7 years direct service/peer mentor (5 years trafficked, 9 years exited)	US-born citizen, Caucasian female	English
Desiree	Clinician	LICSW (MSW) M.A. in Religious Studies	Non-profit Agency (Massachusetts)	5 years w/ survivors of sex trafficking; (1 year in trauma work prior)	Caucasian female, not a native Spanish speaker	English & Spanish
Caroline	Clinician (& Founder of anti-trafficking foundation)	M.Ed. in Counseling Psychology	Private practice & privately operating foundation (Northeast of the United States)	11 years	Caucasian female (European background)	English
Stacey	Clinician	MSW (planning to get licensed)	Non-profit Agency, faith-based: Christian (Massachusetts)	7 years w/ survivors of sex trafficking; (9 years clinical work)	White Italian American, female, she/her pronouns	English

Table 8. Demographic Information of Study Participants' Clients (i.e., Survivors of Trafficking)

Participant	Client Age	Client Gender	Type/Location of Trafficking (for majority of clients)	Client Cultural Background (as defined by participant)	Client Language(s) Spoken	Types of Trafficking	Symptoms/Presenting Problems
Casey	14-24 yrs. old mostly 18+	Cisgendered girls	Domestic survivors (from MA)	Caucasian, African American (Haitian-American, Dominican-American)	English	Sex Trafficking	Sleep issues, depression, anxiety, parenting struggles, relationship challenges, PTSD (or trauma symptoms), substance use, general symptom management
Ramona	Adolescents & adults (10-24 yrs. old)	Mostly women & girls (also men, boys & Transgender survivors)	Domestic survivors (from FL)	Embedded in child welfare & juvenile justice system. Half Caucasian, half People of Color (mostly girls of color - Black, Hispanic/Latina, Asian)	English	Sex Trafficking	Youth violence, panic attacks
Tierra	Wide range (14-50s). Youth clients: 14-15 yrs.	Mostly women (also men & transgender survivors - transmen & transwomen)	Foreign nationals; some domestic survivors	From Central & South America (some from W. Africa). LGBTQ individuals & unaccompanied minors	English, Spanish (also Haitian Creole & Portuguese via interpreter services)	Mostly sex trafficking (some mixed sex/labor trafficking)	T-visa/immigration relief; polyvictimization throughout the life course
Penelope	Youth (12-18) Adults (18-70) all ages	Adults: Majority women (also boys & girls)	Domestic survivors (from FL)	Adult women: majority white, some Black, Hispanic and Native American/part Native American Youth (below poverty line; foster care & runaway youth)	English	Sex Trafficking	Complex trauma symptoms
Josephine	Adults: all ages adolescents: not specified	Domestic survivors: adults & some adolescents (mostly women).	Domestic survivors & International survivors (from South & Central America). Also	Asylum seekers, refugees. Women & children who were sex trafficked	English, multi-lingual (uses interpreter services)	Sex trafficking & labor trafficking	Youth at risk for sex trafficking T-visa & asylum seeking services

Participant	Client Age	Client Gender	Type/Location of Trafficking (for majority of clients)	Client Cultural Background (as defined by participant)	Client Language(s) Spoken	Types of Trafficking	Symptoms/Presenting Problems
		International survivors: women & children	during work abroad, survivors from Asia & Africa.				
Greta	Majority adults (18-30s) entire range (12-65)	Females & female-identifying	Domestic survivors (from NY)	About half of clients white. About half of clients Black & Hispanic/Latina	English (refers to another clinician if survivor speaks Spanish)	Sex trafficking	Rape, sexual assault, DV
Elina	Adults (18+)	Primarily women (female assigned at birth). Some male-identifying (labor-trafficking)	Domestic survivors (from MA). International survivors (Central America & Middle East)	Diverse client backgrounds (by race & nationality)	English, multi-lingual (uses interpreter services)	Sex trafficking & labor trafficking	Victims of family incest (sex-trafficking), asylum seekers, refugees & immigration cases
Maya	12-25 years-old (80% minors, 20% 18+)	Women (cisgender & others identifying as women)	Domestic survivors	Women of Color (Black, Asian, & multi-racial). Majority living in poverty. 50% of youth were dependents of the State.	English	Sex trafficking	Majority living in poverty
Sophia	Adolescents & adults (average age 15 years old)	Vast majority (96%) Females. Some males	Most domestic survivors (from TX). Some international survivors (from El Salvador & Honduras)	Majority Hispanic (30%-40% not born in the U.S.). Some Caucasian, some African American	English, Spanish (uses interpreter services)	Sex trafficking	Sexual assault & sexual abuse prior to trafficking
Molly	Adults Some adolescents (13-17 yrs. old)	Vast majority (99%) cisgender females. Some transgender survivors; some male survivors	Domestic survivors	Approx. half currently experiencing exploitation and other half have exited. Disproportionately women of Color.	English	Sex trafficking & commercial sexual exploitation	Currently experiencing exploitation

Participant	Client Age	Client Gender	Type/Location of Trafficking (for majority of clients)	Client Cultural Background (as defined by participant)	Client Language(s) Spoken	Types of Trafficking	Symptoms/Presenting Problems
Desiree	Adults 18+	Mostly women, some transgender survivors; some men	Most domestic survivors & some international	Latina/Latino, Asian, Caucasian, & Black	English, Spanish, multi-lingual (uses interpreter services)	Sex trafficking & exploitation	Childhood trauma survivors (physical & sexual abuse, neglect). Co-occurring substance use disorders
Caroline	Mostly adults 18+ Some youth (12-18)	All female	Domestic survivors (US citizens). International (asylum seekers in the U.K)--from Eastern Europe & Africa	Domestic work: adult survivors of child abuse, domestic violence, sexual assault, and human trafficking. Homeless youth --> African American, white, Hispanic. International work: Survivors of sex trafficking, torture, asylum seekers (from E. Europe & Africa).	English, multi-lingual (uses interpreter services)	Sex trafficking & some labor trafficking	Domestic clients: all trafficking overlapped w/ intimate partner violence (i.e., groomed by a boyfriend)
Stacey	Adults (average age in 20s & 30s)	Women	Domestic survivors (from New England area). Some international survivors	Majority are white--some biracial, Black, Hispanic. Majority experienced childhood trauma	English	Sex trafficking	Majority, if not all, have childhood trauma. Many with substance use disorder, attachment disorders

- Under "client language spoken," note that this represents participants' report of the language the participant works in clinically. In some cases, participants were multilingual themselves, but not working clinically in their other language(s) spoken. In other cases, English speaking participants referred out, for example, Spanish speaking survivors to therapists at other agencies. In the course of analysis, Greta's agency partnered with a domestic violence agency that has Spanish-speaking counselors and advocates, and so now those referrals are made in-house.

Appendix A: Recruitment Materials

Study Recruitment Email

Study Title: *Therapists' Perspectives on Mental Health Treatment and Effectiveness with Survivors of Sex Trafficking in the United States*

Dear Colleague,

I hope this email finds you and your loved ones healthy and well. [Insert personal greeting if it's a known colleague]. [If I was referred to this person, insert "___ referred me to you, thinking you might have interest"]. I invite you to participate in a research study, conducted for doctoral dissertation work at Boston College School of Social Work. Because of your valuable clinical experience and knowledge of working with survivors of domestic and/or international sex trafficking in the United States, you have been identified as a potential participant. The title of the study is: *Therapists' Perspectives on Mental Health Treatment and Effectiveness with Survivors of Sex Trafficking in the United States***.** Taking part in this research project is voluntary.

The purpose of the study is to explore mental health therapists' perspectives on treatment approach and effectiveness with survivors of sex trafficking in the United States, in order to advance understanding and recovery support. Additionally, given how diverse survivors are, the study aims to explore therapists' perspectives on culturally appropriate adaptation and the potential for blending complex trauma and emancipatory healing approaches in treatment.

If you agree to take part in this study, you will be asked to participate in a one-time interview between August and October 2020. The interview will be conducted via telephone or online via Zoom, will last about 60 to 90 minutes, and will consist of questions related to your perspectives on treating survivors of sex trafficking in the United States. The interview will be audio-recorded, if you consent to it, and interview data will be de-identified to protect your confidentiality. Risks or discomforts from this research are minimal. There is no direct benefit to you for participating in this research. Taking part in this research project is voluntary. You don't have to participate and you can stop at any time.

After considering this request, you can contact me by phone or email with any questions, and/or with your decision whether or not to participate. Please contact me at Liz Gruenfeld: elizabeth.gruenfeld@bc.edu or (XXX) XXX-XXXX. As a licensed social worker with clinical experience, I realize the demands on your time. Thank you in advance for consideration of this request. I look forward to speaking with you soon.

Warm Regards,

Liz Gruenfeld
Liz Gruenfeld, Ph.D. Candidate, Ed.M., MSW (LCSW)

Boston College School of Social Work
Elizabeth.gruenfeld@bc.edu
(XXX) XXX-XXXX

Twitter Recruitment Advertisement

Study Title: *Therapists' Perspectives on Mental Health Treatment and Effectiveness with Survivors of Sex Trafficking in the United States*

Call for participants: Research with mental health providers serving survivors of sex trafficking in the U.S., on perceptions of tx & cultural effectiveness. Zoom Interviews in Oct. 2020! Participation is voluntary. Contact Liz Gruenfeld, PhD Candidate: elizabeth.gruenfeld@bc.edu

Appendix B: Informed Consent

Boston College Consent Form
Boston College School of Social Work
Informed Consent to be in study:
Therapists' Perspectives on Mental Health Treatment and Effectiveness with Survivors of Sex Trafficking in the United States
Researcher: Liz Gruenfeld
Study Sponsor: Boston College School of Social Work
Type of consent: Adult Consent Form

Invitation to be Part of a Research Study

You are invited to participate in a research study. You were selected to be in the study because you have experience and expertise providing mental health services to survivors of domestic and/or international sex trafficking in the United States. Taking part in this research project is voluntary.

Important Information about the Research Study

Things you should know:

- The purpose of the study is to explore mental health therapists' perspectives on treatment approach and effectiveness with diverse survivors of domestic and international sex trafficking in the United States, in order to advance understanding and survivor recovery support.
- If you choose to participate, you will be asked to participate in a one-time interview between August - October 2020, by telephone or via Zoom (online video conferencing technology). The interview will take approximately 60 to 90 minutes. There is a possibility you may also be asked to participate in a brief follow-up interview lasting approximately 15 to 30 minutes.
- Risks or discomforts from this research are minimal.
- There is no direct benefit to you for participating in this research.
- Taking part in this research project is voluntary. You don't have to participate and you can stop at any time.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why are we doing it?

The purpose of the study is to explore mental health therapists' perspectives on treatment approach and effectiveness with diverse survivors of domestic and international sex trafficking in the United States, as well as therapists' perspectives on culturally appropriate adaptation and the potential for blending complex trauma and emancipatory healing approaches in treatment, in order to advance understanding and survivor recovery support. The project has four major aims:

- To understand the clinical treatment frameworks used by mental health clinicians who work with survivors of sex trafficking in the United States.

- To explore therapists' perceptions of treatment effectiveness with survivors.
- To identify cross-cultural adaptations clinicians make in treatment with diverse survivors.
- To explore therapists' understandings of emancipatory healing models and their perspectives on blending complex trauma and emancipatory healing approaches to treatment.

The total number of people in this study is expected to be 10-15 mental health therapists.

What will happen if you take part in this study?

If you agree to take part in this study, you will be asked to participate in a one-time interview between August and October 2020, scheduled for a mutually convenient time. The interview will be conducted via telephone or online video technology (Zoom), to address travel and safety concerns due to Covid-19. We expect the interview to take about 60 to 90 minutes.

If you agree, I will make an audio recording of the interview via Zoom to assist with data analysis, using the setting that records the session onto a password-protected computer rather than into the Cloud. The audio recording will be immediately transferred to a separate password-protected folder on the secure Boston College server after the interview concludes and deleted from the password-protected computer. I will also audio-record the interview on a separate password-protected recording device, as a backup in case of technology failure, and delete this version from the recording device immediately after the interview concludes. The information collected on the audio recording will be transcribed by this researcher or by a contracted transcriptionist and used for data analysis. Interview data will be de-identified to protect confidentiality, and stored as password protected files. Please note that if you decide not to authorize audio recording, you are still eligible to participate in the study.

The interview will consist of questions related to your perspectives on treating survivors of international and/or domestic sex trafficking in the United States, especially given survivors' cultural diversity. You will also be asked to consider a hypothetical clinical scenario, to facilitate discussion about the complexities of your clinical work.

In some cases, a brief follow-up interview may be necessary to clarify response from the first interview. When necessary, the follow-up contact will last approximately 15 minutes and will be conducted within 60 days of the initial interview. Finally, you may be contacted to elicit your perspective on the accuracy of analysis (i.e., related to interview themes or overall analysis). If so, you will be contacted once between November 2020 and February 2021 for a follow-up 15-30 minute conversation. Please note that if you decide not to participate in a follow-up conversation, you are still eligible to participate in the study.

How could you benefit from this study?

Although you will not directly benefit from being in this study, others might benefit because of your contribution to knowledge building about clinical care with survivors of sex trafficking. This study will contribute to understanding more about clinicians' perspectives on treatment approach and effectiveness with survivors of sex trafficking in the United States. It will also contribute to understanding clinicians' perspectives on

cross-cultural adaptations they make and use of emancipatory frameworks with diverse survivors.

What risks might result from being in this study?

While minimal, there are some risks you might experience from being in this study. There is an unlikely chance that you could feel uncomfortable or upset discussing your experiences providing treatment to clients who have been trafficked. If you would like to talk to someone about these feelings, I will refer you to services in your area.

How will we protect your information?

The records of this study will be kept private. In any sort of report we may publish, we will not include any information that will make it possible to identify you. Research records will be kept in a locked file.

All electronic information will be coded and secured using password-protected files. I will assign to each participant a unique, coded identifier that will be used in place of actual identifiers. I will separately maintain a record that links each participant's coded identifier to his or her actual name, but this separate record will not include research data. All digital information will be maintained as password protected files in the secure Boston College server.

If you consent to audio recording of the interview, the interview will be audio-recorded via Zoom directly onto a password-protected computer rather than in the Cloud. The audio file will be de-identified to protect confidentiality, and stored as a password-protected file in a separate folder on the Boston College server. The backup audio-recording will be deleted from the recording device immediately after the interview concludes. The information collected will be transcribed by this researcher or by a contracted transcriptionist. All transcripts will be carefully reviewed prior to data analysis to remove any personally protected information. Audio files will be used to support data analysis, and will be erased from the password-protected server one year after the close of the study.

The Institutional Review Board at Boston College and internal Boston College auditors may review the research records. State or federal laws or court orders may also require that information from your research study records be released. Otherwise, the researchers will not release to others any information that identifies you unless you give your permission, or unless we are legally required to do so.

What will happen to the information we collect about you after the study is over?

I will keep your research data (excluding audio files) to use for future research. Your name and other information that can directly identify you will be kept secure and stored separately from the research data collected as part of the project.

I may share your research data with other investigators without asking for your consent again, but it will not contain information that could directly identify you.

How will we compensate you for being part of the study?

There will be no compensation for your participation in this study.

What are the costs to you to be part of the study?

There is no cost to you to be in this research study.

Your Participation in this Study is Voluntary

It is totally up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer, and you can take breaks at any time. If you decide to withdraw before this study is completed, I will erase all electronic files associated with your participation and destroy all written interview notes.

If you choose not to be in this study, it will not affect your current or future relations with the University.

Contact Information for the Study Team and Questions about the Research

If you have questions about this research, you may contact Liz Gruenfeld at elizabeth.gruenfeld@bc.edu or (206) 334-6234. You may also contact faculty advisors:
Tom Crea at thomas.crea.2@bc.edu or (617) 552-0813,
Scott Easton at scott.easton@bc.edu or (617) 552-4047, and/or
Brinton Lykes at lykes@bc.edu or (617) 552-0670.

Contact Information for Questions about Your Rights as a Research Participant

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the following:

Boston College
Office for Research Protections
Phone: (617) 552-4778
Email: irb@bc.edu

Your Consent

By consenting to this document, you are agreeing to be in this study. Make sure you understand what the study is about before you consent. I will give you a copy of this document for your records. I will keep a copy with the study records. If you have any questions about the study after you consent to this document, you can contact the study team using the information provided above.

I understand what the study is about and my questions so far have been answered. I agree to take part in this study. I understand that if I consent to audio-recording, the interviewer will audio record me saying my name and that I agree to participate. I understand that if I consent to brief follow-up consultations, the interviewer will audio record me stating my agreement to participate.

If I do not consent to audio-recording, but agree to be interviewed, I will sign below.

_____
Printed Subject Name *(if participating, but declining to be audio-recorded)*

_____
Signature Date

Optional Activities
(if participating, but declining to be audio-recorded)

Consent to be Contacted for Brief Follow-up Consultation between August 2020 – February 2021:
I give the researchers permission to contact me for brief follow-up consultation, related to clarifying my interview responses and/or for my opinion on analysis.

***YES*_____ *NO*_____**

_____
Signature Date

Appendix C: Interview Protocol

Semi-Structured Interview Protocol
(Guiding questions are flexible and can be modified during the interview process)

Introduction: Thank you for your willingness to share your knowledge and experiences, and for participating in this research study. I'm going to ask questions to learn about your professional background and your clinical work with survivors. *I may also invite you to consider an activity or hypothetical case scenario to facilitate discussion about your clinical approach.* Please feel free to exclude any personally identifying client information, as you feel is needed.

Section 1. Background/Training Orientation

1. So, tell me about your professional background.
    a. [If not mentioned] Can you tell me about your **education & training** (licensing/credential)?
    b. How many **years** have you been a clinician/seen clients?
    c. How many **years** have you worked with women who survived sex trafficking?
    d. In what kind of practice or agency do you work currently?

2. Can you tell me about the clients with whom you have worked who have been trafficked?
    a. What **percentage** of your client population is made up of women who have been trafficked?
    b. Can you describe the general **demographics** of your clients who have been trafficked (e.g., gender, domestic/international trafficking, sex/labor, adults/children, race/ethnicity/cultural background, country of origin)?
        a. [If percentage of trafficking survivors on caseload is very low] Can you generally describe the treatment issues and/or demographics for the majority of your clients?

3. Can you think about one client in particular with whom you have worked who has been trafficked and tell me how you would describe the work you do/did with her?
    a. [Potential follow-up questions, depending on what is/is not said] How do you describe the format of your clinical work (individual treatment, group treatment, other)?
    b. What are some of the main elements, interventions, or tools you offer?
    c. Are these or have these been similar across the diversities of clients that have been trafficked with whom you have worked/are working?

Section 2. Exploring treatment approach and perceptions of effectiveness

Thank you. I'd like to ask more details about your work with trafficking survivors in (insert the language they use for their work – i.e., clinical treatment, recovery, aftercare, mental health support), in order to better understand your approach and what you think has worked/is working. [*The following questions will depend on how previous questions were answered*].

1. How might you describe the goals of your work with survivors? (*OR: How would you describe your practice orientation?)*
    a. [Depending on response to Q.1.3.] In the specific example your described above you mentioned that you use XXXXX (tool/approach/model/theoretical orientation). Can you tell me more about this approach, model(s) or theoretical orientation(s) and how you use it to achieve the goals you have described?
    b. (OR if no client cited in Q.1.3.]: What theory or model guides your approach?)
        i. I.e., complex trauma/trauma-sensitive treatment; decolonizing/emancipatory healing; anti-racism/population-level/structural treatment approach; community approach; traditional/spiritual healing; other?

2. What challenges do you see your clients facing in therapy after having exited the trafficked situation, or the client you mentioned in particular?

3. How do you understand the causes or roots of survivors' challenges?
    a. What influenced you to make you understand it this way?

4. [Based on the same client you mentioned above, or a new one if not interesting example before] Can you tell me a story about what one of your client's recovery trajectories from trafficking looked like?
    a. What elements of your work with her seemed most supportive in her recovery process, and how were they supportive?
        i. (i.e., therapy/complex trauma treatment, structural supports/social services, community support, activism, traditional healing, peer survivor support, arts-based, religion/spirituality, other),
    b. On what do you base that assessment? (OR how did you know? What told you that?)
    c. What role, if any, do you think you as her therapist, played in her recovery from the multiple effects of trafficking? *(OR how did you understand your role in her recovery?)*
        i. Can you think of a metaphor for your role?

5. Have you ever found existing treatment approaches, activities, or guidelines inadequate to guide your clinical work with survivors?
    a. [If so] How did you come to know that, and how did you proceed/respond? Can you describe one experience that clarifies or exemplifies that experience?
    b. What do you think might improve practice related to [insert the language they used for area of inadequacy]? (OR: What kinds of enhancements or improvements to that existing treatment approach, activity or guideline can you imagine?)

6. What have survivors told you they think are the most helpful models, techniques, or elements for their healing/recovery?
    a. Least helpful?

***Possible Activity* - Mini-Tour**
[To replace question 1a, 4, 5a from above, depending on the information elicited from the preceding interview questions]:
You've mentioned you work primarily with x (y, z) demographic of survivors of sex trafficking. I wonder if you could describe how you see the nature of the challenges of one of your clients (or a hypothetical client), her strengths, and how you might approach clinical work with her. For instance, if I were a fly on the wall in one of your early sessions, what might I be observing in terms of the factors you would be seeking to identify in order to conceptualize your client, her experiences and her challenges (case formulation). What might I observe vis-à-vis your development of a treatment plan?

1. Could you describe the main things that might happen in a typical session with a survivor?
2. Could you describe the main things that happen during a course of therapy with a client?6
3. Could you describe where, if at all, existing treatment approaches, activities or guidelines seem inadequate to guide your work?

Possible Scenario Option A* - Hypothetical client w/ changing demographics*:
[Depending on the information elicited from the preceding interview questions].
Now I'd like you to consider a (hypothetical) scenario, so I can better understand how you think about working with clients. I'm going to read it out loud, and I'll share my Zoom screen so you can read along if you'd like.
"Elsa is 30 year old Mexican women, and is a survivor of sex trafficking who now lives in Boston. She grew up in a rural village in Mexico and reports a history of food insecurity and early sexual assault by police officers there. When she was 15, she went to Mexico City to find work to help support her community. She was threatened by gang members multiple times. She met a boy whom she befriended.

He offered to help her find good paying work and pay her travel to the U.S. She reports that he made her feel loved and safe. After an arduous journey to Boston, her boyfriend took her to a restaurant to work as a waitress. But after her first day, he forced her to return at night to have sex with other men. Her boyfriend told her she owed him money for the travel, that she didn't know anyone and had no papers, so she went. Over time, he gave her marijuana, which she thinks was laced; Elsa reports developing an addiction. She was trapped in this situation for 3 years before escaping with the help of a John. Elsa is now struggling with addiction and feelings of hopelessness."

Can you tell me a story that captures how you would respond to Elsa as her clinician? You might include, among any other issues that you think are relevant:

1. What, if any, additional information you need in order to provide therapy to Elsa?
2. How would you describe the approach(es) you would engage in working with her?
3. How would you anticipate the time with her unfolding? Any particular challenges or problems you might encounter? With what anticipated outcomes?

[Unlikely additional questions:] What if I change some details of this story, and tell you Elsa is an African American woman from New York City who was trafficked to Boston – and everything BUT the international migration story is the same. How does that impact how you think about your approach? What if I tell you that Elsa is a white women from Minnesota… or from Romania, trafficked to Boston? How, if at all, does that change your approach?

Section 3. Perceptions of cultural adaptation:

You mentioned in your descriptions of the clients with whom you have worked who have been trafficked that they are from XXX countries/ethnic racial groups/etc. Now I'd like to ask you some questions about how your own and their backgrounds inform the ways in which you develop your work with them.

1. Can you tell me how you identify yourself and/or your cultural background (i.e., race/ethnicity, nationality, gender, something else) – and if others identify you in the same way? If others don't identify you in the same way, how do you negotiate those multiple identities? Or ways of self versus other identification? How has it informed your work with culturally diverse or ethnically-racially diverse clients?

2. The literature notes that sex trafficking survivors living in the United States are a diverse group, predominantly Women of Color from the U.S., Mexico and Honduras, primarily Black women in the U.S., and disproportionately Native American women as well. That is, some scholars suggest that therapists may encounter meaningful cultural differences amongst survivors and that therapists may not be adequately trained to manage those differences in treatment. How well prepared did you feel after completing your professional training to work with diverse sex trafficking client?

3. What do you understand when someone talks about clinical work needing to be "culturally sensitive" or practices needing to be "culturally appropriate"?
    a. Did you need to adjust or adapt the approach in which you were trained, to work with diverse clients who have been trafficked from the groups that you have identified among your client population?
    b. I'm curious how you decide when and with whom to use which framework or technique and how that might change from client to client. *[Based on prior responses about working with culturally diverse clients]:* Based on the client you mentioned from XXXX background, can you clarify how you made the decision to use the approach you used?
        i. [AND/OR] Can you tell me about how you adjusted or adapted your approach when working with the *client you described from XXXX background verses with the client you described from YYYY background*, and what made you know you needed to adjust (i.e., cultural differences, other differences)?

ii. [Or if no relevant client examples were given]: Can you share an example from working with a client(s) who was/were NOT trafficked where you adjusted your approach based on cultural/ethnic/racial background, and clarify how you made the decision?

c. What specific challenges or problems have you encountered in such work?

4. [Adapting to/building on above responses]: If there are instances when your background differed from that of a client (by cultural identity, racial/ethnic background, nationality, gender, or something else), can you tell me a story about how difference(s) may have impacted treatment?
    a. How did you respond and adapt?
    b. How effective do you think the adaptations were, and how did you know?
    c. How does working with a survivor who *shares* meaningful aspects of your identity or background affect how you work?

5. [If not already been answered]: How well prepared do you feel *now* to work with diverse sex trafficking clients?
    a. What resources would help you feel better prepared now to work with diverse sex trafficking clients? What resources would have helped you feel better prepared when you first completed your professional training?

<u>Section 4. Integrating emancipatory and/or population-level components</u>:
Some scholars have recommended a therapeutic approach called decolonizing or emancipatory healing, suggesting that it blends individual complex trauma approaches with acknowledgment of historical trauma and structural harms suffered by an entire population – such as racism, slavery, genocide - and frames sex trafficking as a systemic assault or as a present-day extension of historical harm. And they suggest that more effective treatment would include: family and/or community support developed by the community; traditional or spiritual healing practices; and/or positive or strengths-based group identity work, in addition to individual therapy.

1) Have you ever heard of or been trained in emancipatory or decolonizing healing approaches? *(Maybe also: How would you describe or define it?)*

2) If so, can you talk about how you have incorporated elements of the approach in your work?
    a. [If yes] Can you tell me a story about how you integrated an individual/complex trauma treatment approach with a more emancipatory treatment framework to best support a client?
        i. What specifically was the focus of your work and why? How did it unfold?
        ii. Have you or your colleagues encountered resistance from your colleagues or your clients to engaging in this kind of clinical work?

3) If you have not incorporated such elements in your practice, how, if at all, might it challenge what you're doing now?

***Possible Activity* – New Therapist Orientation**
[Option for anyone who does not give much information in Section 4 questions about approaching a client using emancipatory perspectives. If they talk a lot about it in Section 4, will not include]
Drawing on the above understanding of emancipatory healing approaches, I'm curious how you would orient a new therapist into the clinic or agency where you work. I'd like you to imagine that you have been asked to orient this new therapist or someone entering the profession who is being asked to work at your clinic and to respond to trafficking clients in this work, that is, using an emancipatory healing approach. What three things do would recommend they consider in their work?

[If participant needs more guidance, the interviewer could offer prompts:]

a. What would be your advice?
b. What resource(s) or technique(s) would you recommend guide their work?

What should they hold central in their work with survivors?

c. Out of all the things we've discussed today, which experience is most important to impart?

Optional Miscellaneous (if time allows): **Questions**

1. How do you avoid or manage vicarious traumatization?

2. [If part of an organization/agency/professional network] I understand you're involved with (insert affiliation here). Can you tell me about your work with them?
    a. How does your clinical approach with survivors align or diverge from (insert affiliation here)'s approach?

Section 5. Wrap-up

1. Is there anything else about the issues we've been discussing you'd like to tell me that I haven't asked about?
2. Do you have any other questions for me?
3. Do you know of other mental health therapists who you think I might contact who might be willing to be interviewed about these issues? Would you be willing to refer me to them?

Alternative Scenario Option B: **Hypothetical busy cross-cultural morning**

[Possible scenario depending on the information elicited from the preceding interview questions. Offer if interviewee appears very skilled in the preceding question areas AND in order to ask about how s/he switches among distinctive groups, this hypothetical inquires about facility/expertise with shifting across cultural groups].

Now I'd like you to consider a (hypothetical) scenario, so I can better understand how you think about working across cultural groups. I'm going to read it out loud, and I'll share my Zoom screen so you can read along if you'd like.

"You have three new client appointments this morning. You know that each is a woman who escaped sex trafficking. Elsa is scheduled at 9am. She's from an Indigenous community in Mexico, and speaks limited English. She lives with her two young U.S. citizen children, and reports feeling sad often, struggling to parent, and missing her eldest daughter still in Mexico. She's undocumented and applying for a T-Visa. Bianca comes in at 10am; she is from Romania and was trafficked to Dubai by her uncle, and later to the U.S.. Bianca was sponsored for a Green Card by an aunt; she's struggling with addiction, self-harm and suicidality. At 11am, Tiffany is coming from a local anti-trafficking agency that works with African American girls who were involved in commercial sexual exploitation. She is 19 now, struggling with anxiety and 'losing time', but wants to complete high school and be active in the Black Lives Matter movement."

1. Can you share how you might approach that morning, or how you've approached similarly diverse clients in your work?
2. What questions does this raise about clinical work with diverse survivors of trafficking?
    a. About the training therapists receive?