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Human Trafficking & Commercial Sex Exploitation: Treatment Recommendations for an Invisible Population

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Document Type

Capstone

Degree Name

Psy.D.

Department

Graduate School of Professional Psychology

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Keywords

Human trafficking, Modern slavery, Trauma focused therapy

Subject Categories

Psychology

Publication Statement

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Human Trafficking & Commercial Sex Exploitation: Treatment Recommendations for an
Invisible Population

A DOCTORAL PAPER
PRESENTED TO THE FACULTY OF THE
GRADUATE SCHOOL OF PROFESSIONAL PSYCHOLOGY
OFFICE OF GRADUATE STUDIES
UNIVERSITY OF DENVER

IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE
DOCTOR OF PSYCHOLOGY

BY
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July 7, 2015

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Abstract

This article addresses the issue of human trafficking, also termed modern slavery, specifically focusing on the treatment of survivors of Commercial Sexual Exploitation (CSE). Treatment recommendations are made based on a trauma-focused, relational model aimed at reinstating psychological well-being in the survivor. This article reviews the literature on three related bodies of research due to the absence of direct psychological literature. Literature on captivity, control and torture, literature on the treatment of refugees and asylum seekers, and literature on sexual abuse treatment for those who have been victimized through the sex trade. Additionally, practical aspects of human trafficking are discussed in order to clarify the complexity and severity of the psychological impact that this illegal market causes on its human commodity. Policy and protocol, commercial sexual exploitation, and the basic operational structure of human trafficking syndicates are examined to create a candid representation of the survivor's experience.

Keywords: human trafficking, modern slavery, trauma focused therapy

Human trafficking, also termed modern day slavery, is the world's second largest illegal trade in revenue, immediately following the drug trade (U.S. Department of Health & Human Services, 2006). It is estimated that human trafficking generates \$150 billion annually (International Labour Organization [ILO], 2012), and hence has surpassed the illegal arms trade in terms of profits. Human trafficking enslaves approximately 20.9 million people worldwide, the majority of whom are women and children. Over 11 million women and half a million children (ages 18 and under) are known to be trafficked every year (ILO, 2012).

The elements of coercion, deception and manipulation, which result in victims being subjected to exploitation of services or slavery, are those that characterize trafficking. Trafficking is servitude regardless of whether the exploitation occurs at the beginning of the journey, during the journey when help is offered, or at the end of the journey (Rafferty, 2013). Sex trafficking, as one of the many forms of human trafficking, consists of the entrapment of an individual for the purpose of a commercial sex act, or a sex act that occurs in exchange for something of value (Office on Violence Against Women, 2000). Sex trafficking, also referred to as Commercial Sexual Exploitation (CSE), is currently the most rapidly expanding form of global criminal activity (Gozdziak & McDonnell, 2007), with 98% of its victims being women and children (ILO, 2012). Unlike illegal drugs or arms, which can only be sold once by a vendor to a consumer via a single transaction, a human being sold into prostitution can be sold repeatedly, ad infinitum, by the same seller until that person becomes too old, sick, or dies. There is a cumulative effect on human beings who are repeatedly sold for the use of their bodies for the purpose of sex, physical labor, or both. Human beings, unlike commodities, become

increasingly traumatized and further internally and externally damaged with repeated sale of their bodies, unlike drugs and arms.

Although the general literature concerning sex trafficking emphasizes terms, definitions, statistics, and public policy, a significant deficit exists regarding the psychological experiences of victims (Cechet & Thoburn, 2014). This shortcoming is likely due to the covert and heinous nature of sex trafficking (Muftic & Finn, 2013). However, the immediacy of needs among an ever expanding group of survivors necessitates a comprehensive, committed response from clinicians and advocates alike, when considering the sheer numbers of people trafficked and the associated financial gains involved in the exploitation of human beings. Without a primary awareness followed by a judicious understanding of the psychological experiences of survivors, it is nearly impossible to develop culturally appropriate services for victims (Hom & Woods, 2013).

The personal psychological accounts and stories of sex trafficking are invaluable due to a deficit in the literature. Moreover the main focus of data on sex trafficking tends to be related to legal policy, ranging from domestic to international regulations. When considering the insidious nature of sex trafficking, as well as its continued proliferation, the dearth of research in such a specific area impedes the attempts of mental health providers to treat and reintegrate survivors. In particular, since victims of human trafficking span many countries and cultures, providing culturally responsive and competent treatment is vital. In this theoretical paper, I will address the significant deficit in the psychological literature regarding treatment guidelines for internationally trafficked women who are sexually exploited. Additionally, although there is a broad range of women who are internationally trafficked, I will focus on those who are

trafficked from Mexico into the United States for the purpose of CSE. This particular population was selected for two primary reasons.

First, the United States itself has historically been one of the largest destination, or import countries for human trafficking, specifically sex trafficking (Mizus et al., 2003). Additionally, the United States is shaped by a "culture that glamorizes pimping and prostitution" (Shared Hope International, n.d.-b, p. 2). Furthermore, the demand for sex workers is greatest in countries with organized women's movements, where the status of women is high, and where there are relatively few local women available for CSE (D'Cunha, 2002). For example, the brothels of the United States, Canada, Germany and Australia are filled with women trafficked from Latin America, Asia and Eastern Europe (Leidholdt, 2003).

Second, Mexico shares a 1,989 mile border with the United States. This neighboring nation has a per capita income one-fourth that of the United States (Central Intelligence Agency [CIA], 2009). Additionally and of great consequence, Mexico is notorious for its drug cartels who are now transitioning into organized prostitution rings, which is the financially lucrative business of CSE. Lastly, a particular central region in Mexico, which will be discussed later in this paper, is currently considered the human trafficking capital of the world.

Due to the absence of specific psychological literature regarding therapeutic interventions for victims of human trafficking, the treatment recommendations provided in this paper will be derived from reviewing and synthesizing the following three related bodies of literature: (a) literature on captivity, control and torture; (b) literature on treatment of refugees and asylum seekers; and (c) literature on sexual abuse treatment for those who have been victimized specifically through the sex trade.

Before examining these three bodies of literature, an understanding of the broader context within which human trafficking occurs will clarify the complexity and severity of the psychological impact that this enterprise causes. Specifically, the following three aspects of human trafficking will be discussed: (a) policy and protocol, (b) commercial sexual exploitation, and (c) its operation.

Human Trafficking

Definitions, Demographics, and Impact

The United Nations General Assembly (2003) protocol on human trafficking defines trafficking as “the recruitment, transportation, transfer, harboring or receipt of persons, by means of threat or use of force or other form of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payment or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation” (United Nations Office on Drugs and Crime [UNODC], 2003). Human trafficking became a focal point for the U.S. government in the late 1990s with official laws, such as the Trafficking Victims Protection Act, coming into existence to serve trafficking victims for the first time in 2000.

The most widely endorsed definition of *trafficking* is found in the Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children; or simply the Palermo Protocol, which supplements the UN Convention against Transnational Organized Crime (UN, 2000). The Palermo Protocol (alternatively referred to as the Trafficking Protocol), was the first international document to explicitly define human trafficking. Exploitation includes the following practices: (a) prostitution and other forms of sexual exploitation, (b) forced labor

or services, (c) slavery or practices similar to slavery, (d) servitude, or (e) removal of organs. The Protocol further distinguishes between trafficking of adults and children, and stipulates that because children cannot consent under international law, child trafficking can occur with or without consent of a victim. Although the most widely endorsed, the Palermo Protocol has not been routinely adopted across the globe, thereby complicating attempts to estimate the number of children being trafficked. In the United States, for example, the Trafficking Victims Protection Act (TVPA) of 2000 does not require victims to be transported from one location to another, for the crime to fall within the definition of trafficking (United States Department of State, 2012). Because the prevention and intervention strategies required are different when individuals are transported or exploited far from home, Dottridge (2008) suggested that the term “trafficking” should be reserved for instances involving actual movement of the individual, in order to distinguish it from other forms of slavery or slavery-like practices. Consequently, I will discuss trafficking in terms of the transport of human beings from one location to another.

Finding reliable statistics on the extent of human trafficking is exceedingly difficult due to the covert nature of this illegal and extremely profitable trade. Therefore, the exact number of people trafficked annually is vehemently debated and largely unknown (Ezeilo, 2009; Smith, 2011). Furthermore, available data has been criticized as elusive, confusing, and unreliable due to uncoordinated data collection methods and statistics riddled with methodological problems, thereby compromising the validity and reliability of data (Gozdziak & Collett, 2005). Other factors include the clandestine nature of trafficking itself, and the fact that trafficking is a criminal activity. Additionally, lawmakers and public officials find it difficult to acknowledge the magnitude of the problem (Smith, 2011). Finally, the lack of precise, consistent, unambiguous,

and standard operating definitions as to what constitutes the act of trafficking, trafficker, trafficked person, and child, negatively impact reliable data (Andrews 2004; Gozdziaik & Collett, 2005; ILO, 2009a; IPU & UNODC, 2009; OSCE, 2010). Despite these caveats and inconsistencies in the available data, the most widely cited statistics are those provided by the ILO (2002, 2005, 2008, 2012). For example, the ILO (2008) noted:

The ILO has developed the first-ever global estimate on the numbers of persons who are held in forced labor with a breakdown of those who have been trafficked into labor as well as commercial sexual exploitation. Out of 12.3 million forced labor victims worldwide, around 2.4 million were trafficked. The figures present a conservative estimate of actual victims at any given point in time, estimated over a period of ten years. It is often assumed that people are mainly trafficked for the purpose of commercial sexual exploitation. ILO estimates indicate, however, that 32% of all victims were trafficked into labor exploitation, while 43% were trafficked for sexual exploitation and 25% for a mixture of both. Women and girls make up an overwhelming majority of those trafficked for the purpose of sexual exploitation at 98%. (p. 3)

The most recent report published by the ILO (2012) does not separate human trafficking victims as a subset of the global forced labor estimate. In other words, human trafficking is defined by exploitation, and not solely based on movement. The 2012 report indicates that there are approximately 20.9 million victims of forced labor at any time, whereby 25% of victims are under the age of 18 (5.5 million). Additionally, the ILO reported the following: (a) 68% (14,200,200) are victims of forced labor exploitation by individuals or enterprises in the private economy (e.g., construction, domestic work, or manufacturing), and 27% of those victims are under the age of 18; (b) 22% (4,500,000) are victims of forced sexual exploitation (98% are female), with children under age 18 accounting for 21% of the total; and (c) 10%

(2,200,000) are victims of state-imposed forced labor (e.g., in prisons or in work imposed by the state military or by rebel armed forces), with children under age 18 accounting for 33% of the total. These estimates do not account for those who were trafficked for non-work-related activities such as organ removal, forced marriage, or adoption. Lastly, these estimates sharply contrast with commonly reported estimates provided by the UNODC (2009), which reported that the most prominent form of trafficking (accounting for 79% of the total) is for commercial sex exploitation. The majority of trafficking victims identified by states are women and children who make up 88% of all victims (66% of victims are women, 13% girls, 9% boys, and 12% men).

Health and safety standards for trafficking victims in exploitative settings have been described as being abysmally low. Furthermore, the degree of violence experienced by victims can range from coercive strategies, such as physical and verbal threats, to extreme physical abuse or torture-like violence (IOM, 2009). The following acts of psychological torture, as defined by Amnesty International, have also been reported: (a) induced debility, resulting in exhaustion, weakness, or fatigue (e.g., from food or sleep deprivation); (b) isolation; (c) monopolization of perception (including obsessiveness and possessiveness); and (d) threats of harm to the victim, or her family and friends (Rafferty, 2013). A number of other tactics have been identified to control victims including: (a) threat or continued use of force (physical, psychological and/or sexual violence); (b) debt bondage, whereby traffickers bear the transportation costs, and the victims incur costs as debt threats against family members; (c) social isolation; (d) food deprivation; (e) restriction of personal freedom or confinement; (f) threat of deportation; and (g) confiscation of identification cards and legal documents (Hodge & Lietz, 2007).

The lack of systemic care for survivors is multifaceted. Typical shortcomings among treatment and service providers include: (a) having a poor understanding of human trafficking, (b) misidentifying survivors, (c) lacking competency in providing minimum standards of care for survivors (e.g., stereotyping, criminalization, and marginalization of victims), and (d) failing to provide systemic care such as housing, vocational support, trauma-focused therapy, addiction treatment, and comprehensive medical care (Farley & Kelly, 2000; Hardy et al., 2013; Hom & Woods, 2013). In a subsequent section, I will not only specify indicators that a person may have been trafficked, but will also review minimum standards of care, in addition to suggesting specific therapeutic approaches to guide clinicians in providing appropriate and responsible trauma-focused clinical care.

Commercial Sexual Exploitation - Prostitution

Commercial sex businesses include street prostitution, massage parlors (brothels), escort services, strip clubs, outcall services, lap dancing, phone sex, Internet and video pornography, and prostitution tourism. The victims of commercial sex trafficking are likely to drift among these various permutations of the commercial sex industry, especially among those who engage in prostitution for more than a few months (Dalla, 2000; Kramer, 2003). Risk and safety are inextricably bound to the social phenomenon of prostitution, as the continual provision of sexual practices of some kind in direct exchange for material rewards, usually money. Thus, the longer a woman is commercially sexually exploited, the greater the risk of injury sustained through physical and sexual violence, Sexually Transmitted Infections (STIs), unwanted pregnancies, and forced abortions (Besler, 2005). Furthermore, in multiple studies, prostitutes were found to be approximately 18 times more likely to be murdered than other

women of their age and race (Potterat et al., 2004; Farley & Barkan, 1998; Castillo & Jenkins, 1994).

In a study of women prostituted in nine countries, Farley et al. (2003) interviewed 854 individuals from Canada, Colombia, Germany, Mexico, South Africa, Thailand, Turkey, the United States, and Zambia. Inquiries in this study about current and lifetime history of sexual and physical violence revealed that 71% of respondents had been physically assaulted, 63% raped, 89% wanted to escape prostitution but felt they had no other means for survival, and 68% met criteria for PTSD (posttraumatic stress disorder) under the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., Text Rev. 2000) criteria. Furthermore, the severity of PTSD symptoms was strongly associated with the number of different types of sexual and physical violence experienced over time (Farley et al., 2003).

In the Mexican sample of the Farley et al. (2003) study, 123 women were interviewed. These women represented a wide range of commercial sex businesses, including street prostitution, brothel, strip club and massage parlor, and all whom worked in the major sex industry cities of Mexico City and Puebla. Furthermore, Tenancingo, Mexico, currently called the sex trafficking capital of the world, is located in close geographic proximity to Puebla and Mexico City, the origin point from which many trafficked women are recruited.

In all of the countries studied, Farley et al. (2003) asked the women to complete a Prostitution Questionnaire that inquired about lifetime history of physical and sexual violence and the Chronic Health Problem Questionnaire (CHPQ). Respondents also completed the PTSD (posttraumatic stress disorder) Checklist (PCL), a self-report measure assessing the 17 DSM-IV

symptoms of PTSD (Weathers, Litz, Herman, Huska, & Keane, 1993; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996).

Among the Mexican sample, 48% reported having been threatened with a weapon in prostitution, 59 % physically assaulted, 46% raped, 54% sexually abused as a child, and 57% hit or beaten during childhood by a caregiver until injured or bruised. Additionally, 34% reported use of drugs and 71% reported use of alcohol as methods for coping with, or becoming numb to, the inherent danger and stress of the work. Fifty-four percent women met diagnostic criteria for PTSD under DSM-IV. To meet diagnostic criteria for a diagnosis of PTSD, the individual must have presented with at least one of five symptoms of intrusive re-experiencing of trauma symptoms (criterion B), at least three of six symptoms of numbing and avoidance (criterion C), and at least two of four symptoms of physiological hyper-arousal (criterion D). Given the extremely high rates of interpersonal violence reported by the respondents in this study, the assumption was made that the only 13% of respondents who denied every directly experiencing violence themselves had witnessed it.

The typical experiences of the victims of CSE represent a gauntlet of victimization and violence endured prior to entry, while in the trade, and around the time of and following their exit. The complex amassment and chronicity of these traumatic experiences contribute to the challenges of treating this population. The impact for women of being trafficked for sex/prostituted appears universal across cultures and age groups, yet its severity may vary with the degree and extent of exposure. Most survivors of sex trafficking meet criteria for a lifetime diagnosis of PTSD, anxiety, and/or depression, and a substantial proportion continue to experience these symptoms even after obtaining psychological help (Farley et al., 2003;

Roxburgh et al., 2006; Zimmerman et al., 2008). Furthermore, the longer girls and women are involved in the sex trade, the greater their risk for negative consequences and the fewer opportunities they have for positive life changes (Davis, 2000; Kurtz et al., 2005; Valandra, 2007). Considering “whether traditional mental health care services are appropriate for this group who has complex histories and high levels of psychiatric morbidity,” (Roxburgh, et al., 2006, p. 8) is therefore of vital importance. The provision of comprehensive, culturally sensitive services will be addressed in a subsequent section of this paper.

Although these perspectives are important in conceptualizing the scope of the sex trade, direct service providers need a theoretical understanding that enables them to comprehend the direct psychological impact on victims, and the unique cultural factors that contribute to their resiliency and survival from some horrific circumstances (Hardy, Compton, & McPhatter, 2013). The following section will describe the basic operational structure of a functioning human trafficking organization, with the intent of not only explaining the power structures at play, but also clarifying the inherent dangers in attempting escape for the victims.

Trafficking in Persons Report - Mexico

The Department of State prepares an annual Report on international human trafficking entitled Trafficking in Persons Report (TIP) using information from U.S. embassies, government officials, nongovernmental and international organizations, published reports, news articles, academic studies, research trips to every region of the world, and information submitted to tipreport@state.gov. This email address provides a means for organizations and individuals to share information with the Department of State on government progress in addressing trafficking.

The Department of State places each country in the 2014 TIP Report into one of four tiers, as mandated by the TVPA. This placement is based on the extent of government action to combat trafficking, as opposed to primarily on the size of the problem in that particular nation. These analyses are based on the extent of a government's efforts to reach compliance with the TVPA minimum standard for the elimination of human trafficking which are consistent with the Palermo Protocol.

A Guide to the Tiers:

Tier 1

Countries whose governments fully comply with the TVPA's minimum standards for the elimination of trafficking.

Tier 2

Countries whose governments do not fully comply with the TVPA's minimum standards but are making significant efforts to bring themselves into compliance with those standards.

Tier 2 Watch List

Countries whose governments do not fully comply with the TVPA's minimum standards, but are making significant efforts to bring themselves into compliance with those standards, and where:

- a) the *absolute number* of victims of severe forms of trafficking is very significant or is significantly increasing;
- b) there is a failure to provide evidence of *increasing efforts* to combat severe forms of trafficking to the persons from the previous year, including increased investigations, prosecution, and convictions of trafficking crimes, increased assistance to victims, and decreasing evidence of complicity with severe forms of trafficking by government officials; or
- c) the determination that a country is making significant efforts to bring itself into compliance with minimum standards was based on commitments by the country to take *additional steps over the next year*.

Tier 3

Countries whose governments do not fully comply with the TVPA's minimum standards, and are not making significant efforts to do so.

Mexico is a Tier 2 country, and is considered a large source, transit and destination country for men, women and children who are subjected to sex trafficking and forced labor. Groups considered most vulnerable to human trafficking in Mexico include women, children, indigenous persons, individuals with mental and physical disabilities, migrants, and LGBT Mexicans. Mexican women and children, and to a much lesser extent men, are exploited in sex trafficking within Mexico and the United States. For the purposes of this paper, only Mexican women trafficked into the United States for the purpose of commercial sexual exploitation will be considered. These women are typically lured by fraudulent employment opportunities, deceptive offers of romantic relationships, or extortion, including through the retention of identification documents or threats to notify immigration officials of victims' immigration status.

Although the Mexican government is not considered fully compliant with the minimum standards for the elimination of trafficking, it is making significant efforts to do so. For example, in 2012 the government issued implementing regulations for an anti-trafficking law, and continued to operate a high-security shelter in the capital for female sex trafficking victims participating in the legal process against their traffickers. Organized criminal groups, often referred to as cartels, profit from Mexican citizens by forcing them to engage in illicit activities.

The majority of Mexican women in prostitution originate from rural areas, have survived extreme poverty and family violence, and are frequently fleeing abusive homes to migrate to cities with more opportunities for employment (Castillo, Gomez, & Delgado, 1999).

Conservative estimates of trafficking indicate that 1,000,000 women are moved annually across

borders of Latin American countries for the purpose of prostitution (Kovaleski, 2000; Maki & Park, 2000).

Tenancingo, Mexico is widely considered the sex trafficking capital of the world due to the majority of its 10,000 residents being involved in prostitution. In a Newsweek article published in 2015, journalist Max Kutner wrote, “for young men, becoming a pimp means joining the family business.” Two hours southeast of Mexico City, men from Tenancingo “recruit” women from elsewhere in Mexico, often by pretending to fall in love with them, then bring them back to Tenancingo where forced prostitution begins.

Criminals who once trafficked weapons and drugs have made women their latest commodity (UNODC, 2015). Lori Cohen, director of the anti-trafficking initiative at Sanctuary for Families noted “It’s hugely profitable,” stating that smuggled drugs are quickly sold, yet with a woman “you bring her across the border once and you just keep using her body over and over again until she breaks down” (as cited in Kutner, 2015, para. 9).

In the case of “Janet” (a pseudonym), a native of Puebla, Mexico, she was befriended by a man from Tenancingo who introduced himself as Ricardo, and built her trust over a year-long period. A 23-year-old factory worker and mother of a young daughter, Janet had recently ended her relationship with her child’s abusive father and lived with an older female relative. After relocating with him to his family home in Tenancingo, Janet learned that his real name was Antonio and that he was a pimp. “Ricardo” forced her into prostitution in neighboring Mexico City prior to promising an opportunity for legitimate work in the United States, where extended family in New York would help them. Conditions were even worse in Queens, New York where

Janet reported spending her time between local brothels, as well as brothels as far north as Boston and as far south as North Carolina.

Seasonal crop farmworkers typically live in barracks for a few months at a time. Year-round livestock farmworkers are reported to live in cheap houses or trailers so that they remain very isolated from the rest of the American society. Furthermore, because of their undocumented status, workers rarely leave these rural locations, relying instead on supervisors and middlemen to deliver anything from groceries to medical aid to women. This is where sex workers like Janet come in. Renan Salgado of the Worker Justice Center of New York says of this dynamic, “The average citizen wouldn’t see them... they are set up to be invisible.” Also of the Worker Justice Center, Gonzalo Martinez de Vedia describes this environment as volatile and ripe for violence, “You have an entire population that is sitting at home for an entire season. Single men. There’s a lot of drinking, substance abuse.” Lori Cohen described workers tendency to take out their frustration on female visitors in stating “I think there’s a perception that when... you pay to have sex with someone, that means that you pay for the right to do whatever you want with that woman. The violence that our clients have experienced at the hands of their buyers is really shocking.”

“I felt like an animal,” Janet said, “The men were very aggressive. They would grab me. They were pushing me. They would grab me by the neck. They would penetrate me really hard. So when they finished, it was like my salvation” (as cited in Kutner, 2015, para. 21). Additionally, many men appeared to be on drugs, some refused to pay, and many refused to wear condoms. Janet says that she had so many abortions, always done with Cytotec pills

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(Constantini, 2015), which are widely used in the trafficking world, she lost track of how many she endured:

While the women laid down rags, the men, filthy and reeking of sweat after spending all morning in the fields, quickly finished eating and formed lines outside the sheds, with as many as 50 men waiting for a woman. One by one the men paid \$30 to rape Janet and the other women. Most of them, having gone a long time without sex, lasted only a few minutes with Janet. Some were so violent she was sure they would have seriously hurt or even killed her if it weren't for Ricardo watching over the operation. She remembers seeing that happen once, to a woman who came without a driver or a pimp; she says the farm workers threw the body in a dump. (as cited in Kutner, 2015, para.3)

As implied by the term commercial sexual exploitation, a primary component of the victimization of those in the sex trade ensues from victims in essence being treated as commodity to meet the financial and/or sexual needs of their exploiters (Poulin, 2003). Commodification is an extension of the objectification that is internalized through the debasing, often incestuous, sexual and physical abuses and violence suffered (Dalla et al., 2003; Karandikar & Prospero, 2010). Reinforced by the messages from traffickers/pimps that victims have little value or skills other than selling their bodies, perpetrators control the individual female's physical world; forcing them to dress in a sexually provocative manner, at times leaving them undressed for quick customer access, and requiring that they work every day that they are not menstruating, and in some cases even on those days when they are menstruating (Bucardo et al., 2004).

Client demand also influences and directs the commercial sex industry (Yen, 2008). As with other commodities, customers pay for sex with women who are chosen based on desired physical characteristics such as age, race, and/or specific features that fulfill the “john’s” sexual fantasies. For traffickers/pimps, CSE is a form of sexual violence that results in immense economic profit due to low investment costs, quick returns, high-profit turnover and high resale value (Samarasinghe, 2008; Yen, 2008).

Common Responses to Trauma and Victimization

Factors of resiliency look fundamentally different for people traumatized from sex trafficking than from other sexual traumas, because of the chronic nature of experiences such as torture, rape, assault and forced abortion (Farley & Kelly, 2000). While no two experiences of human trafficking are exactly the same, traffickers have been found to use similar methods to keep their victims enslaved. An understanding of common responses to trauma can be used to determine whether an individual has been trafficked.

Common responses to trauma and victimization include a weakened physical state, bruises, cuts or other untreated medical ailments, and excessive somatic complaints unaccounted for by a medical diagnosis. Heart palpitations, extreme changes in eating patterns, loss of memory related to the traumatic event, and frequent bouts of tearfulness have also been noted in trafficking survivors (McNiel, Held, & Busch-Armendariz, 2014). Detachment, feelings of self-blame, emotional numbing or emotional responses that do not fit the situation are also indicators, as are flashbacks or nightmares, anxiety and fear, and difficulty making decisions and/or concentrating. Lastly, avoidance of eye contact in a manner not related to the

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culture is also symptomatic of someone who has been victim to trafficking (Hom & Woods, 2013).

According to the United Nations Office on Drugs and Crime (2011), general indicators of people who have been trafficked include the belief that they must work against their will, being unable to leave their work environment, and showing signs that their movements are being controlled. Other indicators include feelings that they cannot leave, overt display or fear or anxiety, and being subjected to violence or threats of violence against themselves or against their family members or loved ones. People who have been trafficked frequently suffer injuries that appear to be the result of an assault or impairments typical of certain jobs or control measures. They are also likely distrustful of authorities, feel threatened with being handed over to the authorities, express fear of revealing their immigrant status, and not be in possession of their passports or other travel identity documents. These individuals may have false identity or travel documents, be found in or connected to a type of location likely to be used for exploitation people, be unfamiliar with the local language and not know their home or work addresses (National Human Trafficking Resource Center [NHTRC], 2014). Clinicians and advocates of all types should be aware of individuals who allow others to speak for them when addressed directly, act as if they were instructed by someone else, are under the perception that they are bonded by debts, have limited or no social interactions or have limited contact with their families or with people outside of their immediate environment. Lastly these individuals may come from a place known to be a source of human trafficking, therefore placing the impetus on the clinician to become knowledgeable of the populations most vulnerable to exploitation in their geographical area (IOM, 2009).

Women who have been trafficked for the purpose of sexual exploitation may be of any age, although the age will likely vary according to the location and the market. Sexually exploited women may be moved from one brothel to the next, or work in various locations. This not only serves to provide variety to the “johns” looking for variety of product (human beings), it also serves to keep sexually exploited women disoriented to her location, creating more dependency on her handlers for continued survival (Wilson, & Butler, 2014). These women are further controlled by being escorted wherever they go. They may have tattoos or other marks indicating “ownership” by their exploiters, and work long hours or have few if any days off. More overt signs include women sleeping where they work, living or traveling in a group, sometimes with other women who do not speak the same language, having very few items or clothing, and clothing that is typically worn for doing sex work. These women may only know how to say sex-related words in the local language of the client group, have no cash of their own, and be unable to show any identity documentation of any kind (UNODC, 2011).

Organizational Operation

While a wide range of people are involved in human trafficking, from the stereotypical pimp with several prostitutes “working” for him, to the large companies that utilize slave labor, it is obvious that there is no one face of human trafficking. For the purposes of this paper however, it is helpful to breakdown and differentiate the typical methods of running such an enterprise in illegal human labor. Aronowitz (2009) created a useful list of the typical roles played in the operation of human trafficking. The following list does not include the smallest trafficking operations where one or two people are the mainstay, yet the list remains fairly comprehensive (Aronowitz, 2009). Investors, recruiters, transporters, corrupt officials and/or

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protectors, informants, guides and/or crew members, enforcers, debt collectors, money launderers, and support personnel make up Aronowitz's list of participants in a trafficking organization.

To be clear, a "*protector*" is not someone who protects the victim, but rather is an intimidating physical presence whose role is to protect the trafficker's investment and ensure that no one escapes. The protector is the one who makes sure that a victim is cleared through customs, and is hidden away from the curious eyes of neighbors or anyone else who might offer support or means for escape for victims. A "*guide*" is paid to help a trafficker move victims cross borders and away from secure checkpoints. A "*debt collector*" is the person in a larger organization whose job is to ensure that the money flows up the chain from the lower-rung personnel to those higher up in the organization. "*Support personnel*" consists of locals who provide transportation, food, housing, and/or logistics for a limited period of time.

In the world of labor trafficking, the trafficker is just as likely to be female as male. However, in sex trafficking the trafficker is overwhelmingly male. For example, in an Urban Institute (2014) study of underground commercial sex economy in eight US cities, all of the convicted pimps interviewed were male. Furthermore, law enforcement agencies and studies indicate that sex traffickers, particularly those working in source countries (nations of origin) recruit victims of their own ethnic background or nationality (Free the Slaves and Human Rights Center, 2004). This relationship may determine the method used to recruit the individual victim, although "courting" and the promise of marriage is a common theme seen in nations as disparate as Albania and Mexico (Aronowitz, 2009).

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In summary, three aspects of human trafficking have been discussed: (a) policy and protocol, (b) commercial sexual exploitation, and (c) its operation. In the next sections I will examine the following three bodies of literature in order to generate treatment guidelines for commercially sexually exploited women: (a) literature on captivity, control and torture; (b) literature on treatment of refugees and asylum seekers; and (c) literature on sexual abuse treatment for those who have been victimized specifically through the sex trade.

Ritual Abuse: Captivity, Control, and Torture

A single traumatic event such as a motor vehicle accident, mugging, or other random act of violence, can occur almost anywhere. Sustained, repeated trauma, by contrast, occurs only in circumstances of captivity. If the victim is able to escape, she will likely not be abused a second time. Repeated trauma, therefore, occurs when the victim is made into a prisoner, who is unable to escape due to being held under the control of the perpetrator of her captivity. Such conditions have widely been documented in prisons, concentration camps, and slave labor camps. These conditions also exist in religious cults, brothels, other institutions of organized sexual exploitation, and in domestic violence situations in the home. Furthermore, captivity, which brings the victim into prolonged contact with the perpetrator, creates a unique relational dynamic characterized by what Judith Hermann labels “coercive control” (Herman, 1997, pg. 74).

In the case of commercial sexual exploitation and religious cult members, the victim is taken captive by a combination of force, intimidation, and enticement. Amnesty International published a “chart of coercion” in 1973 as a part of a publication entitled, “Report on Torture,” drawing upon the testimony of political prisoners from widely differing cultures, and detailing

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the methods that enable one human being to enslave another (Amnesty International, 1973). In this report, accounts of hostages, political prisoners, and survivors of concentration camps described methods that were astoundingly consistent. The same techniques continue to be used to subjugate women in prostitution, pornography, and in the home (Lorber, 2005). For example, organized crime syndicates often instruct one another in the use of coercive methods for systematically breaking women into commercial sex work. What is traditionally referred to as “seasoning” by pimps, methods of establishing control over another person are based on the systematic, repetitive infliction of psychological trauma, organized in techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness in the victim and to destroy her sense of self in relation to others (Herman, 1997).

Although violence is a universal method of terror, perpetrators typically use violence only as a last resort. The key is keeping the victim in constant fear with threats of violence so actual violence becomes unnecessary. If violence is used, the perpetrator will strategically utilize it against an individual victim in the presence of other victims, which serves to reinforce group obedience. These strategies are particularly true of sex trafficking victims under the control of organized crime syndicates working far from home. The traffickers traditionally discover and approach these women in their home environments, and have extensive knowledge of their family and friends, and how to access them. Threatening to torture or kill a victim’s family members is an exceptionally effective means of controlling a victim’s behavior, and ensuring her loyalty and continued participation in money-making opportunities (i.e., sexual exploitation). As a more common example, battered women frequently report that their

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abuser has threatened to kill their children, their parents, their pets, or any friends who might harbor them should they try to escape (Aronowitz, 2009).

Fear from disobedience is also increased by inconsistent and unpredictable outbursts of violence, and by the erratic imposition of trivial and vindictive rule setting. The objective of these methods is unequivocally communicating to the victim that the perpetrator is omnipotent, that defiance is pointless, and that her life depends upon winning his mercy through absolute compliance. The goal of the perpetrator is not only to instill into his victim the fear of death, but also gratitude for being allowed to live. Survivors of domestic, political and cult captivity have often described occasions in which they were convinced that they were about to be killed, only to be spared at the last moment. After several cycles of reprieve from almost assured death, the victim may come to view the perpetrator, paradoxically, as savior (Lacter, 2011).

In her book *Trauma and Recovery*, Judith Herman (1997) described the process of “pair bonding,” between perpetrator and victim as follows:

This is the traumatic bonding that occurs in hostages and survivors of abuse who come to view their captors as saviors. The repeated experience of terror and reprieve, especially within an isolated context of a love relationship, may result in a feeling of intense, almost worshipful dependence upon an all-powerful godlike authority. Some victims speak of entering a kind of exclusive, almost delusional world, embracing the grandiose belief system of the perpetrator and voluntarily suppressing their own doubts as proof of loyalty and submission. Similar experiences are regularly reported by people who have been inducted into totalitarian religious cults. (pp 92)

In addition to inciting fear, the perpetrator seeks to destroy the victim's sense of autonomy. This is achieved by scrutiny and control of the victim's body, including bodily functions. The perpetrator oversees what the victim eats, when she sleeps and for how long, when she goes to the toilet, and what she wears. When the victim is deprived of food, sleep, or exercise, this control results in physical debilitation, yet even when the victim's basic needs are met adequately, the assault on her bodily autonomy serves to shame and demoralize her (Herman, 1997).

Ritual abuse and cult crime became frequent topics on TV talk shows and in print media in the 1980s and early 1990s (MacHovec, 1992). Examples include extensive media coverage of an April, 1989 event when 15 bodies were unearthed at Matamoros, Mexico, some of whom were ritually murdered with Afro-Caribbean cult objects left at the scene. In 1978, the infamous Jim Jones cult saw men, women and children, led by the "Reverend," commit mass suicide in Guyana. This shocking tragedy was followed by the McMartin Case in California in 1983, in which ritual abuse at day care centers were alleged by more than 35 victims. A final example is the seven defendants who were charged by 11 children with ritual abuse in 1985. These defendants were later tried, convicted and sentenced to a total 2619 years in prison.

Testimonials of the damaging effects of cult involvement have been extensively documented (Allen, 1982; Alonso & Jeffrey, 1988; Gould, 1988; Hassan, 1988; Kahaner, 1988; Keiser & Keiser, 1988; Kriegman & Solomon, 1985; Terry, 1987). Reported ritual abuse impacts three major risk populations, each with unique vulnerabilities: children, adolescents and adults. Child victims are usually preschool or primary school age, and do not initiate cult involvement (MacHovec, 1989). Their smaller size, susceptibility, innocence, and dependence on adult

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caretakers make them preferred targets to abuse and degradation that destroys their will (Gould, 1988). Adolescents on the other hand are recruited or voluntarily dabble in cults, occult ideas, or fantasy games. Since they are physically larger and more discriminating, there is greater risk of psychological or emotional harm than physical or sexual abuse as in young children. Adults themselves are more susceptible to larger, organized, cult-like organizations (MacHovec, 1992). Former adult cult members have reported experiencing deception and fraud when recruited, rigid daily schedules, repeated lectures and controlled discussions, lack of privacy, inadequate diet, insufficient rest, and lack of medical attention (Hassan, 1988; MacCollam, 1979).

Forensic reports have revealed that child ritual abuse occurs most frequently between the ages of two and six (MacHovec, 1992). Similar to repeated traumatic physical and sexual abuse, ritual abuse can sometimes precipitate dissociative disorders, amnesia or fugue states, depersonalization, derealization, trance states, phobias, anxiety disorders, or most commonly PTSD (Lacter, 2011). According to MacHovec (1992), "It has been my experience that younger children tend to dissociate, older children develop adjustment and anxiety disorders" (p. 32). MacHovec went on to cite the child's "limited life experience," and "rich imagination, suggestibility, and trust of elders," as contributing factors in his or her susceptibility to cult or ritual abuse (p. 32). He stated that the aforementioned factors contribute to inconsistency and impaired reality testing of child victims as witnesses, thereby increasing their susceptibility to being led by direct questioning or misled by their abusers.

One adult survivor of a religious cult recalled incidents from her early childhood in which her mother would put her in a life or death situation and then seemingly rescue her, just in

time. On one occasion, this individual recalled to her therapist how her mother had locked her in a trunk and shut her in the cellar where, her mother told her, that no one would hear her if she screamed. In the trunk, her mother also placed insects that this individual feared. She recalled the feelings of panic and terror, of suffocation and the thought that she would surely die. Gradually this adult survivor recounted that she “gave up” and found herself drifting into a dissociated space, aware that she could barely breathe any longer. At that point, in this survivor’s memory, her mother opened the trunk and pulled her out, sobbing, asking her how she ended up locked in such a place, telling her that she loved her desperately and would always find her no matter where she was lost (Wingfield Swartz, in Swartz et al, 2011, p. 43).

In religious cults, members may be subjected to strict regulation of their diet and dress, in addition to exhaustive questioning regarding their deviations from these rules. Similarly, sexual and domestic prisoners frequently describe long periods of sleep deprivation during sessions of jealous interrogation, as well as meticulous supervision of their clothing, appearance, weight and diet. In the case of female prisoners, whether in political or domestic life, control of the body almost always includes threats of sexual violation or violence. Once the perpetrator has succeeded in establishing day-to-day bodily control of the victim, he becomes the source of not only fear and humiliation, but also of solace. The hope of a meal, bath, a kind word or some other ordinary creature comfort can become compelling to a person deprived over a long enough time period. The perpetrator may further debilitate the victim by offering addictive drugs or alcohol.

Treatment for cult victims begins by emphasizing restoration of a lifestyle with optimal psychosocial and personality development, and normalized adjustment to self, others and

society. Cognitive needs such as improving coping skills, critical thinking, decision making, and reality testing are likely goals of treatment. Common affective needs, on the other hand, include overcoming guilt, anxiety, insecurity and depression. Environmental needs include a stable life situation that creates a foundation of safety and security. Support for coping with interrupted personal growth due to the cult, sometimes from well-meaning friends and family, may also be an issue within individual therapy. In psychological treatment, MacHovec described a “delicate balance” between the cult survivors’ realization of personal autonomy and reliance on support from others (MacHovec, 1992, p. 34).

Treatment of Refugees and Asylum Seekers

Individuals who migrate across international borders are particularly vulnerable to exploitation by traffickers while en route to, or upon arrival at, the destination. This is especially true when their immigration status is unclear, they have no money, and they are cut off from their natural support systems (Boak, Karklina, & Jurova, 2003; Van de Glind, 2010).

Refugees and asylum seekers form a high-risk group for psychopathology, especially PTSD (Eksi, 2002). In order to be considered a refugee in terms of international law, people must be living outside of their country of origin, have a well-founded fear of persecution in their native country, for reasons of political opinion, race, nationality, religion, or membership in a particular social group, and this fear should either prevent or discourage them from enjoying the protection of the state of origin, therefore rendering them unable to return (United Nations High Commissioner for Refugees [UNHCR], 2009). Asylum seekers are those seeking the legal protection and other forms of assistance that recognition of refugee status endows, having had to flee their country of origin. The prevalence of PTSD among these groups varies from a

reported 4% to 86%, while Major Depressive Disorder (MDD) and anxiety disorders show similar variability in terms of prevalence (Hollifield, et al., 2002). The great discrepancy in terms of prevalence of serious psychiatric symptomology may be due to variations in severity, frequency, and duration of traumatic events, as well as methodological limitations of studies exploring this dynamic (McNally, 2003). What is clear, however, is that experience of torture has been proven to significantly increase the risk for suffering psychopathology among survivors who also evidenced elevated rates of PTSD, anxiety, depression and somatic complaints (Eksi, 2002; Shrestha et al., 1998; Van Ommeren et al., 2002).

The primary focus of research on the mental health of refugees has been on documenting patterns of psychiatric symptomatology by using questionnaires or structured clinical interviews designed to identify psychiatric syndromes such as PTSD and MDD. Despite the obvious limitations of near exclusive reliance on this approach in the past, many compelling findings have resulted from the psychiatric symptom-focused approach to documenting refugee distress. Specifically, exposure to political violence is associated with an increased risk of both acute and chronic post-traumatic stress reactions (Fox & Tang, 2000; Miller, Weine et al, 2002; Shrestha et al., 1998; Thabet & Vostanis, 2000). The salience of PTSD symptoms across a continuum of refugee studies evaluating diverse cultural realities suggest a set of highly intercorrelated symptoms of distress that develop in the wake of exposure to horrifying experiences over which people have little or no control.

The methods employed by human traffickers continue to progress and advance as law enforcement, human rights activists and even clinicians work to keep up. According to the United States Department of State Office to Monitor and Combat Trafficking in Persons (2014),

forced criminality is a frequently under-identified and distinctive characteristic of human trafficking. This is particularly salient when considering the victims of CSE, who are not only frequently trafficked illegally across international borders, but also engaged in the illegal trade of prostitution, itself a criminal activity. Traffickers have been observed forcing adults and children to commit crimes in the course of their victimization, a tactic that often results in further submission on the part of the trafficked individual out of fear of prosecution coupled with a lack of trust of police, often complicit and on trafficker's pay rolls. Crimes include theft, illicit drug production, transport and sales, terrorism, murder and prostitution.

For example, in Mexico, organized criminal groups have coerced children and migrants to work as assassins in the production, transportation, and sale of drugs. In November 2013, police arrested six adults accused of forcing their children to commit burglaries in Paris and its suburbs. The victims were reportedly physically beaten for failure to deliver a daily quota of stolen goods (TIP, 2014). In Afghanistan, insurgent groups force older Afghan children to serve as suicide bombers. Non-state militant groups in Pakistan force children, some as young as 9 years old, to serve as suicide bombers in both Pakistan and Afghanistan. Children and men, primarily from Vietnam and China, have been forced to work on cannabis farms in the United Kingdom and Denmark through the use of verbal and physical threats and intimidation (US Department of State, 2014).

At the end of 2013, the number of refugees and individuals seeking asylum outside their home country was greater than 17 million (United Nations High Commissioner for Refugees [UNHCR], 2014). Severe, ongoing political conflicts around the world have resulted in rates of forced displacement at the highest level since World War II (UNHCR, 2014). The United States is

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one of the top resettlement countries in the West. In the past decade alone, over half a million ethnically diverse refugees resettled in the United States and more than 250,000 individuals were granted asylum (Department of Homeland Security, 2012). Refugee status is a legal designation granted by UNHCR or a government entity to individuals who have fled their home country because of persecution based on their race, nationality, religious or political beliefs, or social group membership, as defined in Article 1 of the 1951 United Nations Convention on the status of refugees (UNHCR, 1951). Asylum seekers are individuals seeking refugee or other protected status whose claims have not yet been evaluated (UNHCR, 2013). Thus, by definition, these individuals have been exposed to trauma and extreme stress prior to fleeing their country of origin. Additional stressors are often encountered during the migration process including separation from family, stays in unsafe refugee camps, and difficulties obtaining refugee status (Ryan, Benson, & Dooley, 2008).

Once resettled, refugees are typically faced with adapting to a new culture, learning a new language, and rebuilding their lives. Life in a new country may include a range of difficulties including discrimination, limited social support, and barriers to finding employment (Miller & Rasmussen, 2010). Asylum seekers have the additional burden of insecure residency status and in some cases prolonged stays in immigration detention while awaiting the adjudication of their case (Kalt, Hossain, Kiss, & Zimmerman, 2013; Robjant, Hassan, Katona, 2009). Given the considerable exposure to pre- and post-migration stressors, it is not surprising that high levels of psychological distress have frequently been documented among samples of refugees and asylum seekers (Hollifield et al., 2002; Keller et al., 2006; Steel et al., 2009). The exact prevalence of specific disorders is difficult to determine, however, given the diversity of

the population, methodological differences in existing research and a lack of culturally validated assessments (Murray, Davidson & Schweitzer, 2010). It is likely that these reasons explain why prevalence estimates of (PTSD) and MDD, the two most frequently evaluated disorders in the literature, have ranged widely from 5% (Fazel, Wheeler, & Danesh, 2005) to 30% (Steel et al., 2009). In comparison, data from the National Comorbidity Study Replication (Kessler, Chiu, Demler, Merikangas, & Walters, 2005) showed a past year prevalence of PTSD and MDD in the United States of 3.5% and 6.6%, respectively. Thus, rates of these disorders are at least as high, or even higher, among samples of refugees than in the general population. Fazel, et al. raised the important point that even if the frequency of disorders were on the lower end of the range, there would still be tens of thousands of refugees suffering from PTSD and MDD.. Given the potentially debilitating effects of these disorders and the likelihood that symptoms interfere with successful adaptation following migration, it is important to determine the efficacy of existing trauma-focused therapies for treating this population.

The efficacy of trauma-focused therapies for reducing symptoms of PTSD among individuals who experienced a range of traumatic events including combat-related trauma, sexual assault, domestic violence, motor vehicle accidents, and childhood abuse has been well established. Meta-analyses of this literature suggest treatment generally results in clinically significant improvement in symptoms (Bradley, Greene, Russ, Dutra, & Westen, 2005) with existing models of therapy yielding similar results (Benish, Imel, & Wampold, 2008). However, results of these studies were conducted almost exclusively with Western samples and may not generalize to refugees from non-Western cultures. Refugees have often been exposed to multiple traumatic events, sometimes over the course of many years (Ryan et al., 2008; Miller &

Rasmussen, 2010) and continue to face a host of unique, ongoing psychosocial stressors (Almedom & Summerfield, 2004; Miller, 1999; Murray et al., 2010; Summerfield, 1999) that could interfere with successful treatment outcome. The stress of moving from a familiar, albeit dangerous, environment to a foreign country and soon thereafter undergoing psychological treatment could be re-traumatizing. Even if the treatment is culturally adapted, it is likely to be conducted with an interpreter that potentially influences the process and outcome of therapy (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005; Mirdal et al., 2012). These and other unique considerations warrant further investigation of treatment efficacy with this population.

Compared with other populations, relatively few randomized controlled trials of trauma-focused therapies have been conducted with refugees. Existing studies have generally shown promising results, however, effect sizes have varied widely and not all treatments have resulted in statistically significant improvements. There have been several narrative review papers summarizing treatment issues with refugees (e.g., Murray et al., 2010; Nicholl & Thompson, 2004; Nickerson, Bryant, Silove, & Steel, 2011; Palic & Elklit, 2011; Slobodin & de Jong, 2015), a meta-analysis of mental health interventions for individuals in humanitarian settings (Tol et al., 2011), and a study that reported an average effect size for seven studies that involved the treatment of refugees and other war-affected samples with one treatment approach (Gwozdziwycz & Mehl-Madrona, 2013).

In a study by Gwozdziwycz, and Mehl-Madrona (2013) meta-analytic techniques were used to estimate the overall effect size for the reduction of PTSD and depression symptoms among refugees undergoing trauma-focused therapy in randomized controlled trials. Their review focused exclusively on trauma-focused interventions that were compared to control

conditions. Therefore, results did not provide information on the relative efficacy of trauma-focused models compared to other treatments. Results of this meta-analysis supplied evidence that the psychological distress of refugees can be effectively treated with existing models of trauma-focused therapy, with the caveat that it is not clear whether trauma focused approaches are superior to nonspecific interventions. Although results are encouraging, there is clearly a need for more research with this population to better understand their experiences and needs, and ultimately provide more consistently effective services. Studies that take into account cultural factors and diversity in life experience are crucial for advancing the field.

Sexual Abuse Treatment

The National Violence Against Women Survey (Tjaden & Thoennes, 2000), conducted on 8000 men and 8000 women found that 18% of American women said they had been the victim of a completed or attempted rape at some point during their lifetimes. The same report found that violence against women is most often committed by an intimate partner with 64% of women who reported being raped, physically assaulted or stalked were victimized by partners. Violence against women is committed by strangers, acquaintances, caregivers, authorities, intimate partners, and other family members. Sexual assault occurs through use of varying levels of coercion, ranging from the experiences of wives to serve the sexual needs of their husbands, but not the reverse, to physical force.

Additionally, violence against women has been recognized as a major health and human rights issue and as a primary cause of morbidity and mortality (Dutton, Kilpatrick, Friedman, & Patel, 2003). The World Health Organization [WHO] summarized large-scale studies in both industrialized and developing countries (Krug, 1999). Findings indicated that men had physically

or sexually abused at least one in five of the world's female population at some time in their life. Many including pregnant women and young girls, who were subject to severe, prolonged, sustained and repeated attacks over many years.

Attachment theory provides a developmental perspective on early relational trauma between children and caregivers, which typically results in the child's development of disorganized attachment patterns. Research shows that attachment disorganization is based on the child's fear of the caregiver or the child's perception as being frightened of the caregiver. The child faces an impossible dilemma when the caregiver, who is supposed to love and protect the child, is also the source of fear and threat (Hesse, Main, Abrams, & Rifkin, 2003; Main & Solomon, 1990). Add to this the intensified trauma of a child or adolescent's primary sexual experiences hailing from sexual abuse from a so-called caretaker. The complexity of the trauma is increased, as is the treatment of the individual in therapy.

The work with traumatized patients who have learned to use dissociative processes to protect against overwhelming affects involves initial stabilization. This is achieved through a therapeutic relationship based on safety and security, regulation of affect and titration of psychological arousal (especially during the exposure part of the treatment), supporting optimal functioning in everyday life, and reducing maladaptive responses to external and internal stimuli (Steele & van der Hart, 2009). Dissociation can mean alternate and disconnected identities, or ego dystonic feelings, somatic sensations, and relational conflicts. Such phenomena are experienced by the patient as "not me" states. In her seminal text on survivors of trauma, Herman (1997) outlined a stage model for the treatment of trauma that includes

instilling safety, a period of working through remembrance and mourning, and finally reconnecting with others through reconciliation with oneself.

A relational approach in the treatment of trauma can help investigate and elaborate on the intersubjective implications of the traumatic experience. These intersubjective processes include the cycle of rupture and repair, enactments, and spontaneous relational moments in the treatment. A focus on these relational dynamics between patient and therapist can help to recognize and integrate dissociated self-states that can highlight and eventually change maladaptive relational patterns. Contemporary relational and interpersonal authors suggest that the self is not a unitary entity but is composed of multiple states and experiences that are frequently disconnected and dissociated, both as an outcome of traumatic experiences and as a function of unconscious everyday life (Bromberg, 2011; Stern, 1997).

Traumatized patients organize their experience around separate and incompatible self-states that allow them to compartmentalize unbearable memories and relational experiences. These polarized self-states inevitably manifest in the patient–therapist relationship through what Benjamin (2004) called the “doer done to” dilemma. This conflict is enacted when each member of the dyad takes on binary roles in relation to the other. For example in treating the survivor of childhood sexual abuse therapists often describe treatment in terms of enactment of abandoning mother and abandoned child (Ringel, 2014). In this paradigm, patient and therapist become victim and perpetrator or victim and abandoning/rejecting caregiver, thereby enacting the early trauma between the patient and significant others as well as between incompatible self-states within the patient. It is suggested that a way out of these polarized positions is to arrive at a third relational dimension where patient and therapist can find a new,

collaborative ways to relate to one another (Aron, 2006; Benjamin, 2004) or when the patient can hold conflicting self-states without the need to dissociate (Bromberg, 2011).

Empathic sensing, attunement, and responsiveness by the therapist are important modes of understanding and relating. However, the therapist's own unresolved traumatic schema may be elicited during the treatment, and because the therapist's subjectivity is an inherent aspect of the intersubjective treatment process, it is important to be cognizant of these affective responses and to work through potential enactments that may occur during the treatment (Davies & Frawley, 1994). Therapists' own emotional schema, which is based on past relational experiences, becomes activated in response to intersubjective interactions with patients. This may involve the therapist's own unresolved traumatic experiences culminating in their desire to save and protect the patient or may involve their feelings of anger, fear, guilt, and shame elicited in response to patients' traumatic narratives and, demands of, or disappointment in the therapist. Enactments are inevitable based on the interplay of traumatic schemas between patient and therapist and are an important opportunity of working through traumatic themes. It is important for therapists to be aware of their affective responses elicited during treatment and to manage them in order to minimize reactive avoidance, withdrawal, or retaliation that may reconfirm the patient's deeply embedded traumatic schemas.

Considering the insidious nature of human trafficking and the complexity of the trauma endured via CSE, it is important that clinicians are grounded in the current literature and aware of the potential symptomatology to emerge. In view of the interwoven layers of traumatic experiences survived by one individual human being it may feel overwhelming for the mental health clinician to know where to begin with treatment. The following section speaks to this

dilemma with the aim of humanizing the CSE survivor within the treatment provider's eyes while facilitating the process of recovery.

Treatment Recommendations: The Psychological Aftermath of Human Trafficking

The trauma associated with trafficking and its psychological effects can be devastating, and if left unaddressed, can undermine the survivor's recovery and potentially contribute to vulnerability and re-victimization. Because traffickers dehumanize and objectify their victims, victim's innate sense of power, visibility, and dignity often become obscured. Traffickers also use coercive tactics and force to make their victims feel worthless and emotionally imprisoned. As a result, victims can be said to lose their sense of identity and security.

A variety of psychological symptoms can surface over a period of time especially after victims escape or are rescued from the trafficking environment. Levine (2010) describes fear as exacerbating and extending immobility, in addition to making the process of exiting that immobility B fearful and potentially violent. This can hold true for the survivors of CSE, often held largely immobile, controlled at the hands of their traffickers. These women frequently respond to newfound freedom with pent-up, fear-fueled rage, and violence that is often directed at non-threatening sources like doctors and therapists. Thus, it is critically important to incorporate psychological support and treatment within victim's services and protocols, and to move at a pace that is responsive to the survivor, allowing her to make decisions that impact her life during each stage of treatment.

The Trafficking in Persons Report (2012) proposed the following measures for reinstating psychological well-being in survivors of human trafficking. First, one must establish a dependable safety network for victims, ensuring that all their basic needs are met. One must

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also ensure privacy and confidentiality to protect victims and their families and friends. Next, solicit the support of medical experts, social workers, and psychologists who are trained in human trafficking and can provide trauma-specific therapy. It is also of utmost importance to simultaneously attend to the survivor's physical well-being, as sometimes there are physical symptoms existing simultaneously with, or indicative of, underlying psychological disorders. Providing collaborative therapies that are culturally sensitive, while fostering an empowering environment in which victims actively participate as consumers of therapy and other services is the ideal. Throughout this process clinicians must assess and reassess victims for self-injurious and suicidal behavior in addition to screening for post-traumatic stress disorder (PTSD), substance abuse/dependence, depression, and anxiety which are common responses to trafficking survivors. One must continuously provide unconditional support, especially amidst victims' potential denial, distrust, reticence, shame, and/or anger while actively working towards social and familial reintegration. Lastly, rebuilding identity and re-establishing skills-sets, self-esteem, and personal interests are imperative in reinstating well-being in survivors.

In her ground-breaking work, "Trauma and Recovery," Herman (1997) described trauma as a force that robs victims of a sense of power and control of their own lives. Therefore restoring power and control to the survivor is at the forefront on the way to recovery and should take priority over all other treatment goals, as no other therapeutic work can be achieved if power and control has not been adequately secured (Herman, 1997). Furthermore, as with any traumatized population no other therapeutic work should even be attempted until a reasonable degree of safety has been achieved. This element is considered especially salient for the human trafficking survivor to whom a sense of overall security and well-being may seem

foreign after months or years in captivity. The concept of safety is quite literal as she will first require her basic Maslowian needs to be met.

Therapeutically, this initial stage may take days to weeks with acutely traumatized individuals, or months or even years with survivors of the most chronic and long-lasting cycles of abuse. The work of this primary stage of recovery therefore, becomes increasingly complicated in proportion to the severity, duration, and early onset of abuse.

Survivors feel unsafe in their bodies and with their emotions; therefore, their thought processes will also likely feel out of control. Feeling unsafe in relation to other people is also to be expected in these individuals who have been betrayed in their primary relationships and forced to rely on their abusers for survival for extended periods of time (Foa, Hembree, & Rothbaum, 2007). Establishing safety starts with focus on control of the body and states of arousal and hyperarousal then moves outward towards control of the environment (Herman, 1997). Issues of bodily integrity include attention to basic health needs, regulation of bodily functions such as sleep, eating, and exercise and management of post-traumatic symptoms and control of self-destructive behaviors. Environmental issues include the establishment of a safe living situation, particularly difficult when treating survivors of CSE who have been trafficked far away from home and their natural support systems. Financial security, mobility, and a plan for self-protection that encompasses the full range of the individual's daily life become of foremost importance because no one can establish a safe environment alone. The task of developing an adequate safety plan will always include a component of social support, therefore relying on the available anti-trafficking resources in one's own community.

Basic medical care to address both physical and psychiatric issues is pertinent to comprehensive treatment of this population. Once established, control of the body should focus on restoration of the biological rhythms of eating and sleeping, most likely controlled and manipulated by traffickers/pimps in CSE work. This should also reduce hyperarousal and intrusive symptoms (Levine, 2010). If the survivor is highly symptomatic, psychotropic medication may be considered to aid the individuals in reaching a basic level of homeostasis their bodies may have not achieved in months or even years.

Until recently, psychological literature surrounding trauma has tended to focus on one singular, traumatic event. The clinical understanding of trauma exposure therefore tended to emphasize fairly uncomplicated psychological reactions to a single, simply delineated traumatic event. Such reactions to trauma have been defined by a singular sort of posttraumatic stress, various manifestations of anxiety and depression. Posttraumatic stress, the most commonly cited disorder, has been linked to a variety of specific traumatic experiences including military combat, rape, physical assault, motor vehicle accidents, and natural disasters (Briere, 2004; Green & Solomon, 1995). And although the effects of single traumatic events can be considered well established, it is uncommon for individuals to have experienced only one traumatic event in their lives (Classen, Palesh & Aggarwal, 2005) thus necessitating a new conception of complex or repeated trauma. For when multiple traumas occur and accumulate over time, they are likely to be associated with more severe and complex psychological reactions (Briere, Kaltman, & Green, 2008; van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). Add to this the likelihood that survivors of multiple traumas have a history of extended childhood abuse and/or neglect (Cook et al., 2005; Courtois, 2004) and magnitude of the individual's experience

of trauma may be better understood. Furthermore, such experiences not only produce long-term sequelae themselves yet become risk factors for future revictimization (Classen et al, 2005) in addition to responding to later traumas with more severe or extreme symptomatology (Bremner, Southwick, Johnson, Yehuda, & Charney, 1993).

Other variables further complicate the clinical picture as more severe and complex posttraumatic outcomes are frequently associated with preexisting nervous system hyper-reactivity (Yehuda, 1997). Included in these variables are anxiety, depressive and personality disorders (Breslau, 1991), excessive use of drugs or alcohol (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999), a generally avoidant response style (Briere, 2004), and an insecure, specifically disorganized parent-child attachment relationship if experienced early in life (Pearlman & Courtois, 2005) all of which both mediate the effects of trauma exposure and may themselves arise from prior trauma (Felitti et al, 1998; McCauley et al., 1997).

It can be said that creating a safe environment for the survivor of CSE is fundamental to continuing on with any form of psychotherapy (Levine, 2010). Due to the arduous and demanding tasks of the first stage of recovery, specifically the major changes the survivor is being asked to make, it may be tempting for the clinician to overlook the requirements of safety and rush into the latter stages of therapeutic work; an arena in which the clinician likely feels more comfortable (Feeny, Hembree, & Zoellner, 2003). Furthermore, patients at times may assume that healing in therapy comes mainly from throwing themselves headlong into the graphic, painful nature of past abusive trauma memories, perhaps believing that this will cure the traumatic memory entirely. This can be a dangerous scenario for the patient, the survivor of CSE and human trafficking, as a great deal of foundational work must be completed prior to

entering into any exposure work or even telling of traumatic memories. Dissociation and other physiological trauma responses must be addressed carefully and progressively in an extremely sensitive manner, taking into account substance use and abuse and how the individual may have relied on substance to numb out the pain of sustained trauma (Foa, & Kozak, 1986).

Common elements of exposure-based treatments for PTSD include breathing retraining, psychoeducation regarding the nature of PTSD and related symptoms, in vivo exposure, and imaginal exposure and processing. Therapies that include these elements have a variety of specific names such as trauma-focused cognitive behavioral therapy, exposure therapy, prolonged exposure, and cognitive behavioral therapy for PTSD. For the purpose of this paper the term exposure therapy can refer to all of these variants, which are all considered appropriate methods for treating the complex nature of PTSD symptoms in trafficking survivors. Furthermore, central to any of the aforementioned therapeutic forms lies imaginal and in vivo exposure (van Minnen, Hendriks, & Olff, 2010).

A significant concern expressed by clinicians is how they will be able to handle hearing the details of various traumatic events while witnessing the accompanying client distress (Feeny et al., 2003). After starting to deliver exposure therapy, most therapists are surprised to find that they are not as distressed or dysregulated as they anticipated they might be. One of the main reasons for this is that the focus in therapy is primarily on the client and helping the client manage his or her affect. That is, contrary to the expectation that the therapist sits and passively listens to the details of the trauma story, the therapist actively employs his or her clinical skills to simultaneously monitor how the client is doing (e.g., how distressed they are), paying attention to what is being said or not said (e.g., content, tone, pacing), and attempting

to identify underlying themes or issues that are emerging for later processing. The amount of therapist work, even in the midst of listening, helps mitigate the therapist's own distress during revisiting. Additionally, just as repeated exposure decreases a client's distress, the therapist's distress also decreases with repeated exposure to listening to the client's memory. Owing to this fact, many therapists are surprised at their own ability to hear about traumatic events, be empathetic and supportive, and be present for their clients to promote engagement with the trauma memory (Becker, Zayfert, & Anderson, 2004).

The clinical uptake of effective psychotherapies for posttraumatic stress disorder (PTSD) lags behind what we know about their efficacy. Exposure therapy, one of the best-validated interventions for PTSD (e.g., Institute of Medicine, 2007), unfortunately remains underutilized by front line clinicians (Feeny et al., 2003). When asked about their clinical practices, clinicians often cite client factors such as the presence of comorbid disorders and multiple childhood traumas and therapist factors such as fears of client symptom exacerbation and dropout as reasons they would not use exposure therapy (van Minnen, Hendriks, & Olf, 2010). Further, one of the most commonly reported reasons for not utilizing exposure therapy for PTSD is a lack of training and experience (e.g., Becker, Zayfert, & Anderson, 2004).

Imaginal exposure refers to repeated and prolonged engagement, revisiting, and processing of the trauma memory, typically done in session for increments of 30 – 45 minutes (Foa, Hembree, & Rothbaum, 2007; Foa & Rothbaum, 1998). In imaginal exposure, the client is guided by the therapist through a detailed revisiting of the trauma narrative. Instructions include having the client recount aloud the full story of the trauma in the present tense, including as much detail about events, surroundings, sensations, thoughts, and feelings as he or

she can remember. When the client completes one full revisiting of the trauma narrative, he or she is instructed to start over again from the beginning, and this is repeated several times over the course of the session. One of the main functions of this repetition is to ultimately diminish the fear response through extinction processes. Throughout revisiting, the therapist helps guide the client toward exploring the most emotionally evocative aspects of the memory by asking probing questions designed to elicit emotions and thoughts. Across sessions, the focus of the revisiting shifts to the most distressing aspects of the memory, termed “hot spots.” Following each imaginal exposure, there is an opportunity to “process” the experience; the client and therapist talk about how the exposure went, what it was like for the client, and discuss any unhelpful thoughts or beliefs that may have arisen during the exposure. During this portion of the session, the therapist highlights meaningful work the client did during exposure, helps to address key themes emerging during exposure, and may ask open ended questions to guide examination and shifting of beliefs thought to be central to maintaining the client’s PTSD.

Dissociation, at its core, permits psychological survival, whether the repeated trauma is sexual exploitation, slavery via forced physical labor, or military combat. Dissociation can be viewed as an elaborate avoidance and escape mechanism in which overwhelming human cruelty and conversely human suffering, results in the fragmentation of the mind into different parts of the self. These parts observe, experience, react, and protect this fragmentation by not letting certain parts of the self fully experience the harm. When considering the encumbrance of the recurrent, even lifelong trauma experienced by women who have been sex trafficked, the protracted use of dissociation for survival is easy to conceptualize (Ross, Farley, & Schwartz, 2003). That is, survivors will likely continue to utilize dissociation on the day-to-day yet no

longer to their benefit. For although the dissociation protects the person from the emotional impact of trauma, it increases risk of further victimization as the survivor tends to dissociate in response to actual danger cues that are similar to the original trauma(s). For example, although she may realize she is about to be raped or beaten she may not be able to mobilize other, healthier defense strategies aside from dissociating and tolerating the impending abuse. It is the role of the therapist therefore to begin exploring the function of dissociation in the survivor's life, noting it when it appears in the therapeutic realm and aiding the client in beginning to relinquish it as a primary means for surviving the world around her. Over time, this should serve to begin putting control back in the hands of the survivor, making her feel more secure in her day-to-day interactions with other people, with her cognitions and ultimately in trusting herself to navigate the world around her.

Utilizing a global perspective as a lens for conceptualizing sex trafficking, the two main theoretical orientations that have traditionally emerged from the literature are socioeconomic theory and feminist theory. Although the influence of socioeconomic theory and feminist theory on understanding the global market in sex trafficking is prevalent in the literature, theory is never discussed directly, nor is it applied to any population other than adult women sold into the sex trade (D'Cunha, 2002; Lorber, 2005). For example, socioeconomic theory influences the literature on sex trafficking of adults because it purports that there is an underlying relationship between social standing and economic activity (Becker, 1974). This is illustrated by that fact that every country's role in the sex trafficking industry is directly related to local and global economic environments, the country's poverty and employment rates, level of human development, and per capita income (Farr, 2005). Thus, countries that are typically in

the role of trafficking women and children out of the country are more likely to be economically unstable than the more affluent destination countries. This affects women in particular, as they are significantly more likely to experience economic vulnerability due to a deficit in sustainable career options and a lack of educational opportunities (Farley & Kelly, 2000). This becomes more prevalent in economically unstable countries.

Feminist theory is closely tied to economic theory. A central function of feminist theory is the examination of the impact of women's social and class roles on the economy and the power differential that exists between men and women (Frisby, Maguire, & Reid, 2009). For example, although the United Nations estimates that women make up 66% of the world's workforce, they receive only 10% of the world's income and own 1% of the world's property (Farr, 2005), which is compounded by the fact that when women are able to attain employment, they are forced to work for significantly lower wages and in poorer working conditions than their male counterparts (United Nations General Assembly, 1989). Regardless of the county of origin, women almost always have a lower status, less economic opportunity, and less power. They are also considered less desirable in the world in the workforce than male counterparts, which makes women an easy target for human traffickers (Farr, 2005). In the United States for example, women earn on average 77 cents for every dollar earned by men (American Association of University Women, 2013). Additionally, low socioeconomic neighborhoods are exposed to a disproportionate amount of legal prostitution (i.e., strip clubs, pornography stores, street prostitution), which creates an environment where female children and adolescents, as well as adult women, are not only harassed by pimps and johns on a daily basis, but are actively recruited into the sex trade (Farley & Kelly, 2000).

Among this cultural milieu are the cross-cultural issues of gender and racism. Gender is a dynamic issue in sex trafficking; it has to do with the individual factor of sex, but also with how women are treated culturally and how women cope with cultural adaptation issues (Mayes-Buckley, 2012). When paired with racism, gender offers a comprehensive picture of cultural factors that influence victimization and conversely resilience in women who have been involved in and survived the sex trade.

Research suggests that the United States is shaped by a "culture that glamorizes pimping and prostitution" (Shared Hope International, n.d.-b, p. 2), growing numbers of young women are lured into commercial sex trade businesses "to service the demand resulting from the normalization and promotion of commercial sex across America" (Shared Hope International, n.d.-b, p. 2), resulting in what has essentially become a "shopping mall where buyers can choose from a variety of human products of various ages and colors" (Shared Hope International, n.d.-b, p. 1). This culture of tolerance can be conceived as fueled by the glamorization of pimping, as embodied in multiple venues of daily life, including clothing, songs, television, video games, and other forms of entertainment. Through a quick online search, anyone can easily locate information for throwing a successful "pimp and ho" party or download one of many free ringtones based on popular songs including "Pimpin' All Over the World" by rapper Ludacris and "P.I.M.P." by rappers 50 Cent and Snoop Dogg. In *Keep Pimpin'*, a free online game (<http://www.keeppimpin.com/index.php>), as a player one acts as the pimp and is tasked with the following actions "slap your hoes, pimp the streets, kill the competition, and ally with your friends to take the pimp world by storm." Additionally, the song "It's Hard Out Here for a Pimp" took top honors for Best Original Song at the 78th Academy Awards. In

each of these examples, which only scratch the surface of those that exist, being a "pimp" is equated with being "cool" or "winning" (Shared Hope International, n.d.-a), reflecting how pimps are "treated in popular culture as admirable rebels, as hip and stylish" (Lagon, 2008, p. 1). At the same time— while adopting slogans, phrases, and images from "the world's oldest profession"—most individuals who engage in such practices fail to acknowledge the degradation, beating, and demoralization that the vast majority of female prostitutes experience at the hands of pimps (see, for example, Farley, 2003; Farley & Barkan, 1998).

To truly make a difference, governments, in this case that of the United States, must acknowledge that trafficking is a violation of the Universal Declaration of Human Rights adopted by the General Assembly of the United Nations (United Nations [UN], 1948) 60 years ago and that the factors that fuel sex trafficking must be eliminated. These factors include economic inequality and desperation, lack of employment opportunities, gender inequality and discrimination, a general lack of education and awareness, and finally the unrelenting demand for cheap and available sex with or without regard to the rights of human being providing her body for the act. The effects on women's physical, sexual and psychological health and well-being can be devastating and are only compounded by limited or complete lack of access to health or mental health services. Furthermore, all too often the victims of this trade are punished for their immigration violations or prostitution criminalities, more harshly than their captors, rather than treated as victims.

Limitations of this Paper

A major limitation of this paper is that the outcomes are largely from the perspective of service providers who work directly with women impacted by sex-trafficking, or conversely,

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policy makers who have little to no direct contact with trafficking survivors yet work to implement progressive, protective legislation. While the experiences and perspectives of these two aforementioned groups provides a sound basis for conceptualizing the needs of commercially sexually exploited women, further depth and accuracy would have been acquired with methodical interviewing of survivors themselves. However, given the violent nature of sex trafficking, finding and obtaining such a sample would have posed a risk for both the survivors of sex trafficking and those researchers seeking them out for interviewing (Hom & Woods, 2013). Furthermore, Zimmerman and Watts (2004), noted that those who interview exploited populations often unintentionally put the survivors and themselves at risk for harm. Safety for both the women and the researchers would need to be ensured in any research with a commercially sexually exploited sample.

Access to groups of women surviving commercial sex exploitation is difficult due to the covert and illegal nature of human trafficking itself. It is also made more precarious by the participation of crime syndicates, such as the Mexican drug cartels, who are known for ruthless violent means of keeping witnesses silent. The danger inherent in talking about one's trauma as a sex trafficking survivor extends well past the realm of psychological adjustment and into practical survival concerns that any individual in contact with a survivor of human trafficking must take seriously.

In this paper, I reviewed and synthesized the existing literature on captivity, control and torture; the treatment of refugees and asylum seekers; and treatment for those who have been victimized through the sex trade. In reality, the survivor of CSE could represent any and all of these aforementioned categories, making the treatment of such an individual multifaceted,

complex and daunting to the uninformed clinician. I also sought to educate mental health professionals and first responders on the primary identifying factors of potential human trafficking victims. Awareness is the first step in identification of victims, destigmatization of sex workers and ultimately comprehensive, trauma-focused treatment.

Recommendations for Future Research

The experiences of survivors of CSE represent a gauntlet of victimization and violence endured while in the trade, upon initiation to commercial sex work and even following their exit. The complex accumulation and chronicity of traumatic experiences that the average survivor has endured only contributes to the challenges of treating this population as a whole. The impact for sex trafficked women appears universal across cultures and age groups, however its severity may vary with degree and the extent of exposure. The majority of survivors will meet criteria for a lifetime diagnosis of PTSD, anxiety and/or depression and a substantial proportion will continue to experience symptomatology even after obtaining psychological help (Farley et al., 2003; Roxburgh et al., 2006; Zimmerman et al., 2008). This begs the question then, will traditional therapy means suffice, and can we as clinicians plan for the long road ahead when conceptualizing complex trauma that will likely require years, even decades, worth of intensive therapeutic work?

The longer women are involved in the sex trade, the greater their risk for destructive outcomes and the fewer opportunities they will have for positive life changes (Davis, 2000; Kurtz et al., 2005; Valandra, 2007). Further research should at first consider whether traditional mental health care services are appropriate for this group who has “complex histories and high levels of psychiatric morbidity” (Roxburgh et al., 2006, p. 8). Considering the limited resources

most community mental health centers and social service agencies are met with, the “one-size-fits-all” approach that is often prescribed will likely result in an ineffective array of services for this specific and complex population of survivors (Valandra, 2007). Additionally, without addressing the issues at the core of CSE, the demand created by consumers of the sex industry, efforts to help its victims will be perpetually undermined as the culture at large continues to glamorize and uphold the scandalous and erotic appeal of sex work (Hughes, 2004).

Research concerning best practices to effectively address the lifetime of trauma experienced by victims of CSE is a primary recommendation for future scholars. Furthermore, due to the paucity of research at present, investigators could primarily analyze the effectiveness current treatment approaches utilized by community mental health and social service agencies that have been providing services to survivors of CSE (Wilson & Butler, 2014). Randomized, control studies could allow investigators to rigorously evaluate outcome measures, working within the existing structures and avoiding re-traumatizing CSE survivors by attempting one-on-one interviews as a primary means of data collection. Additionally, evaluating the applicability of interventions that have been proven effective with other severely traumatized populations, such as victims of sexual assault, domestic violence, refugees and asylum seekers and combat veterans could prove worthwhile.

Although research is vital in the identification of interventions capable of addressing the all-encompassing victimization and violence suffered by those women subjected to CSE, the factors discussed herein underscore the challenges and necessity of addressing the unique and multifaceted treatment needs of victims and survivors. With the unrelenting upsurge of victims

of both domestic and international sex trafficking, there is considerably urgency to make the harm visible (Farley, 2003) before acting accordingly.

It is vital that governments develop and implement policies to identify trafficking victims who are forced to participate in criminal activity in the course of their victimization and provide them with appropriate protective services. In addition to general awareness training on human trafficking, training law enforcement and judicial officials about the principles of non-punishment and non-prosecution of victims is key to increasing the likelihood that individuals will be properly identified by the authorities, and thereby secure access to justice and protection.

One example in the United States involves victims of human trafficking forced to commit commercial sex acts, and who are then prosecuted by state or local officials for prostitution or prostitution-related activity. Many states, including New York State, have passed laws to allow trafficking victims to overturn or vacate these convictions where criminal activity was committed as part of the trafficking situation. In 2009, three Vietnamese children were arrested for working on cannabis farms in the United Kingdom, convicted for drug offenses, and sentenced to imprisonment. An appellate court, however, overturned the convictions in 2013, holding that the children were victims of trafficking (TIP, 2014). This case reflects a growing awareness that victims of human trafficking involved in forced criminality should be shielded from prosecution. It also demonstrates the difficulties that law enforcement and judicial officials face when combating crimes and enforcing the law.

These two examples not only demonstrate the complex nature of trafficking itself, yet pull from disparate geographical locations thereby exhibiting the multinational, multicultural

aspects of modern slavery and the victims left in its wake. Grassroots organizations have been established in source and destination countries all over the world, often working with very limited resources to serve an acute population of survivors. The provision of anonymity and therefore security is promised at safe houses and treatment centers across the globe, yet the experiences of survivors of human trafficking remain the primary means for keeping up with the more heinous aspects of this global trade.

I would propose a more advanced network of response via connecting service providers internationally. With advancing technology and the immense need for reliable statistics, a secured electronic database could be utilized to track patterns in human trafficking in real-time. The database would first need to de-identify the survivor while communicating her entry and exit points, nation of origin, and experiences of victimization en route. This proposal could serve to not only connect survivors to the services they need, but also provide them with some agency for contributing to social justice and their own reintegration process.

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