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BEST PRACTICE INTERVENTIONS FOR DOMESTIC MINOR SEX TRAFFICKING: A SURVIVOR'S PERSPECTIVE

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BEST PRACTICE INTERVENTIONS FOR DOMESTIC MINOR SEX TRAFFICKING: A SURVIVOR'S PERSPECTIVE

A Project

Presented to the

Faculty of

California State University,

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In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

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ABSTRACT

The purpose of this study is to explore methods of intervention for domestic minor sex trafficking (DMST). Due to the secretive nature of the DMST industry, victims are not only difficult to identify, but are also difficult to gain access to in order to provide effective intervention. This study seeks to overcome these barriers by gaining the perspectives of DMST survivors. This study has a qualitative design, in which 8 survivors of DMST, who are now adults, were interviewed to determine appropriate methods of intervention for child welfare social workers. In doing so, intervention was broken down into three categories; prevention, intervention, and recovery. The findings of this study indicated the need for an interagency approach to victim identification. Furthermore, the findings of this study highlighted the need for services that incorporated spirituality and a network of support; such as mentorship, life coaching, and support groups.

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I would like to thank my thesis advisor and other professors who provided me with encouragement, support and guidance in completing this project. I would like to thank the members of my cohort. I was fortunate enough to be a part of a cohort that was highly skilled, talented and experienced. It will be an honor to be among them in the field of social work.

I would like to give a special thanks to my family for their ongoing love and support. I especially want to thank my parents, who left their family and friends to migrate to the U.S. with only a dream of better opportunity. It is because of their perseverance and selflessness that I have the opportunity to pursue my educational goals.

I owe my deepest gratitude to my beautiful wife and children. My wife's strength, courage, and passion for life are truly inspirational. I can only hope to be half the person she is. As to my children, it was the vision of their future that motivated me to complete this program. To my wife and children, I love you with all my heart.

DEDICATION

I would like to dedicate this project to the eight women who participated in this study. They had the courage to share their experience in hopes to bring about change. Their strength, knowledge, and perseverance not only inspire me to be a better social worker, but a better person.

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CHAPTER ONE

INTRODUCTION

In this chapter, I will outline the issue of domestic minor sex trafficking (DMST) by discussing its history, its prevalence, and its relevance to social work practice. I will then discuss the purpose of this study, which is to develop strategies for DMST intervention, especially with regard to child welfare agencies.

Problem Statement

In 2000, the U.S. Congress passed the Victims of Trafficking and Violence Protection Act (VTVPA) in order to combat the increasing concerns of sex trafficking in the U.S. The VTVPA defines sex trafficking as the "recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act" (as cited by Kotrla, 2010). The VTVPA focused on the growing number of sex trafficking victims who were being brought to the U.S. from other countries (Hughes, 2007). The VTVPA provided these foreign nationals with services to remove them from the enslavement of sex trafficking. However, the VTVPA ignored the population that made up the majority of sex trafficking victims in the U.S., which were its own citizens, a significant number of which were minors (Hughes, 2007).

Banks and Kycklehahn (2011) prepared a report for the U.S. Department of Justice, which examined human trafficking investigations conducted by federally funded task forces between January 2008 and June 2010. Data revealed that of 2,200 investigated incidents of sex trafficking, 1,000 investigations involved allegations of sexual exploitation or prostitution of a child. It is important to note that these are only the incidents that were investigated. Due to the secretive nature of this industry, extensive data does not exist to fully understand the scope of this problem. However, it has been estimated that 200,000 to 300,000 occurrences of sexual exploitation or prostitution of a child take place in the U.S. every year (Hardy, Compton & McPhatter, 2013). This industry is commonly referred to as domestic minor sex trafficking (DMST), which was a term created by Shared Hope International, an organization designed to combat sex trafficking.

DMST places victims at significant risk of harm. Not only are DMST victims subjected to sexual acts with various individuals, but they are subjected to beatings and rapes by the individuals who enslave them and coerce them into sex trafficking; these individuals are commonly referred to as pimps (Clawson & Grace, 2007). Due to these circumstances, DMST victims are vulnerable to sexually transmitted disease (STD), pregnancies, and substance abuse (Clawson & Grace, 2007). Additionally, DMST victims are likely to experience mental health symptoms, such as post traumatic stress disorder (PTSD), fear, anxiety, hopelessness, low self-esteem, and suicidal

ideation (Clawson & Grace, 2007). In order to understand why children get involved in such a horrific industry, it is important to understand the risk factors that leave them vulnerable to pimps.

There are several risk factors that can be used in identifying potential victims of DMST, such as being a victim of physical or sexual abuse, being a runaway, being homeless, having poor academic performance, and having low socioeconomic status (Hardy, Compton & McPhatter, 2013). Additional risk factors include having caregivers that are experiencing mental illness and/or substance abuse (Hardy, Compton & McPhatter, 2013). Smith, Vardamon and Snow (2009) conducted a study for Shared Hope International in which they gathered data from federally funded human trafficking task forces located in 10 U.S. locations. According to the data collected from the task force in Dallas, Texas, 93% to 95% of DMST victims were exposed to physical and/or sexual abuse at home. According to data collected from the task force in Boston, Massachusetts, Smith et al. (2009) found that more than 90% of DMST victims were recruited from foster homes or group homes. The common denominator among these risk factors is that they leave children vulnerable, thereby making them targets for opportunistic pimps. However, considering the risk factors, DMST victims would be as likely to have contact with child welfare social workers as they would a pimp. Therefore, the opportunity for intervention exists. It is important that these opportunities are acted on with a sense of urgency, as doing so will prevent children from being subjected to the horrific

consequences of DMST. For children who are already involved in DMST, proper intervention would remove the victim from their situation, and give them the resources to have successful rehabilitation.

Purpose of the Study

Despite the available knowledge regarding risk factors, several barriers exist that make intervention for victims of DMST difficult. In order to grasp the barriers of DMST intervention, consider the following hypothetical situation, but keep in mind this is the harsh reality for thousands of children:

> Danielle is a 14-year-old girl who is a victim of physical abuse at home. She has been dealing with the physical abuse since she was the age of eight; therefore, it has resulted in low self-esteem, a low sense of self-worth, and feelings of loneliness and isolation. With no positive emotional support at home, Danielle is only comforted by an individual named Robert, who advises Danielle he is 19-years-old. Robert is friendly, charming and funny. Danielle enjoys the time she spends with Robert; therefore, she does not think twice when Robert asks her to be his girlfriend. Robert continues to charm Danielle, often buying her gifts and taking her out on dates. He convinces Danielle that her abusive parents would never approve of her relationship with an older boy. So, Danielle agrees to run away. She knows Robert will take care of her the way her parents never did. Within a few months, however, Robert becomes verbally and physically abusive. He then introduces drugs into

their relationship. There are no more gifts or dates. Instead, Robert gets Danielle involved in stripping, pornography, illegal massage/sex parlors, and eventually prostitution. Robert is no longer a boyfriend; he is a pimp. Danielle is a confused and vulnerable 14-year-old child. She sees no way out and subsequently lives the life of a prostitute until she is an adult. At the age of 20-years-old, Danielle is arrested for drug possession and prostitution. She is again lonely and isolated. She wants help, but asks herself, “Who would help someone who is a criminal, a druggie and a prostitute.”

One of the barriers of DMST intervention is the abusive relationship between the victim and pimp, which is similar to the cycle of abuse in a relationship involving domestic violence (Hardy, Compton & McPhatter, 2013). Due to these circumstances, the victim may be reluctant to disclose the abuse perpetrated by their pimp; this may be from fear of further abuse and/or fear of losing their only means of support.

Another barrier is that many victims of DMST do not view themselves as victims (Hardy, Compton & McPhatter, 2013). As with Danielle’s hypothetical situation, victims of DMST are typically involved with illegal activity other than prostitution, such as substance abuse. Therefore, victims perceive themselves as criminals, and subsequently do not seek help in order to avoid consequences from law enforcement.

Arguably the most difficult barrier to overcome is public perception. As with Danielle's hypothetical situation, DMST victims eventually reach adulthood. By that time, their behavior is judged by the moral and ethical values of society (Kotrla, 2010). The victim is not viewed as a victim of DMST. Instead, the victim is viewed as a prostitute who chooses to engage in such activity (Kotrla, 2010). This perception negatively influences the availability of resources (Hughes, 2007). If DMST victims are perceived as criminals, then the public will be less likely to support services that are specifically suited to meet their needs. This further perpetuates the victim's tendency to perceive themselves as criminals, which results in DMST victims being reluctant to seek help, or being standoffish when presented with the opportunity for help.

There are several barriers that make DMST intervention difficult. However, as previously stated, child welfare social workers have access to children at risk of being trafficked. Therefore, child welfare social workers not only have the opportunity to prevent children from being victimized, but can also prevent existing DMST victims from remaining in the industry until adulthood. In order to provide such intervention, effective strategies must first be developed, and then implemented into practice.

The purpose of this study is to explore strategies for DMST intervention. Considering the secretive nature of the DMST industry and the difficulty in accessing DMST victims, it appears the most plausible source for information would be former victims. Therefore, this study has a qualitative design, in

which former victims of DMST, who are now adults, will be interviewed to determine strategies for intervention. The findings of this study have the potential to inform best practice interventions for child welfare agencies. This can be accomplished by utilizing the information obtained from this study to develop staff trainings and assessment tools, as well as identify appropriate services to meet the specific needs of DMST victims or children at risk of being victimized.

Significance of the Project for Social Work

It is important for child welfare social workers to utilize effective assessment strategies when working with children who exhibit the aforementioned risk factors that leave them vulnerable to DMST. Doing so may prevent children from being involved in DMST entirely, or at least prevent them from being involved in DMST until adulthood, when the consequences for their behavior are more punitive. In order to accomplish this task, it is imperative for child welfare social workers to be knowledgeable and skilled in identifying risk factors for DMST, providing intervention to victims or potential victims, and referring victims or potential victims to appropriate services.

As previously stated, it has been estimated that 200,000 to 300,000 occurrences of sexual exploitation or prostitution of a child take place in the U.S. every year (Hardy, Compton & McPhatter, 2013). This research study is significant because it seeks to explore best practice interventions for child

welfare social workers, who already provide services to children who meet the risk factors for DMST. Information for this study will be gathered from former victims of DMST, as they have direct knowledge and experience of the industry and what is needed to escape. It is expected that the findings of this study will help to reduce the occurrences of DMST that take place in the U.S. every year. For clarification, the participants of this study believed it to be more appropriate and empowering to be referred to as survivors. Therefore, from this point forward, the term “victim” will refer to individuals currently involved in DMST, while the term “survivor” will refer to the participants of this study, as well as other individuals who have successfully escaped the DMST industry.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In this chapter, I will discuss the existing literature regarding interventions for domestic minor sex trafficking (DMST). Research has provided promising methods for intervention that have produced positive outcomes for DMST victims. These methods will be discussed. Additionally, this section will explore attachment theory and its role in DMST intervention, especially with regard to rehabilitation.

Promising Methods for Intervention

The sex trafficking industry has only recently captured the attention of policy-makers, as indicated by the development of the Victims of Trafficking and Violence Protection Act (VTVPA) in 2000. However, the VTVPA was developed in response to international sex trafficking (Hughes, 2007). It has only been within the past five to eight years that DMST has come to the attention of policy-makers. Prior to the past decade, DMST victims were simply viewed as criminals, not victims (Hughes, 2007). Due to these circumstances, combined with the difficulty in accessing the DMST population who are not already receiving services, existing literature regarding DMST intervention is limited. However, research has provided promising results for successful intervention.

Clawson and Grace (2007) conducted a research study focusing on the services provided to DMST victims by the U.S. Department of Health and Human Services (HHS). The study had a qualitative design, as data were obtained from interviewing various individuals from programs or facilities that had regular contact with the DMST population. These individuals included directors and staff of residential facilities, housing programs, juvenile corrections facilities, programs for runaway and homeless youth, child protective services personnel, and law enforcement. The responses from these individuals were evaluated in order to inform best practice interventions for DMST victims.

Clawson and Grace (2007) found that a significant problem with DMST intervention was identifying victims. Part of the problem could be due to the secretive nature of DMST. However, Clawson and Grace found that the agencies which were represented by the study participants lacked a standard protocol for identifying DMST victims. Clawson and Grace argued that regardless of the DMST victim's reluctance to seek or accept help, it is necessary for every agency that has the potential for coming into contact with the DMST population to have a standard protocol for identifying the victim and providing intervention.

Clawson and Grace (2007) found there was a significant need for residential programs for DMST victims. Considering homelessness is one of the primary risk factors of DMST, it is surprising there are only four residential

facilities in the entire U.S. that are specifically designated for DMST victims (Clawson & Grace, 2007). Participants in the study indicated DMST victims typically had difficulty forming relationships; therefore, it would be ideal for these residential services to either be small and more intimate, or have a high staff to client ratio. Considering the information gathered from the participants of this study, it was determined that DMST victims would most likely benefit from intervention that included education services, housing services, medical screening/routine care, intensive case management, life skills and job training programs, family involvement and/or reunification, and counseling services.

Of these services, Clawson and Grace (2007) also highlighted the importance of the caseworker-client relationship, which they argued was important for the DMST victim's rehabilitation process. A healthy relationship with the caseworker, intensive case management, and counseling services would be imperative to the DMST victim's ability to build self-esteem, self-efficacy and self-worth (Clawson & Grace, 2007). Considering these circumstances, it appears mentoring is an important aspect of DMST intervention.

The study conducted by Clawson and Grace (2007) provided insight to potential methods of intervention that prove to be promising. However, the data collected in their study were from service providers. In order to gain further insight regarding appropriate intervention for DMST, it would be important to gain the perspectives of the victims themselves.

Pierce (2012) conducted an evaluation of services provided by the Minnesota Indian Women's Resource Center (MIWRC). The MIWRC provided support services to American Indian and Alaska Native women, adolescent girls and their families. Services included harm reduction programs for substance abuse, emergency housing, education services, and support and advocacy for gender violence (Pierce, 2012). In 2008, the MIWRC discovered that several of the individuals it provided services to were disclosing incidents of DMST. Concerned that this was a growing trend among the American Indian and Alaska Native female population, the MIWRC contracted with Pierce to conduct a research study.

Pierce (2012) implemented a qualitative data collection method, in which she invited advocates from MIWRC and its affiliated programs to a round table meeting to discuss the growing concerns of DMST. Pierce organized two round table meetings; one was held in Minneapolis, Minnesota, and the other was held in Duluth, Minnesota. In total, 30 individuals participated in the round table meetings. In addition to Pierce's qualitative research design, she also gathered quantitative data from the Commercial Sexual Exploitation Risk Assessment form that was used by MIWRC during intake. Case managers utilized the assessment form at intake, and during face-to-face meetings every six months after the individual's enrollment in services. Pierce also utilized feedback forms filled out by individuals receiving services from MIWRC.

Information gathered from the round table meetings indicated that the most prevalent risk factors for sex trafficking were homelessness, abandonment, and abuse, neglect or exploitation by family members or caregivers. Additionally, the prevalence of gang activity and/or prostitution in the neighborhood was also identified as common risk factors. Pierce argued that a harm-reduction approach to DMST intervention would be very effective. That is, the most effective approach to intervention would be to reduce the risk factors that leave adolescent girls more vulnerable to DMST. If the issues regarding home relationships, homelessness, and substance abuse were addressed, then children would be less susceptible to DMST.

The evaluation of the Commercial Sexual Exploitation Risk Assessment form provided limited data. Fifty-eight girls had initially been assessed at intake, but only 17 agreed to participate in follow-up interviews. Although limited, information gathered from the 17 girls indicated that their participation in MIWRC support services made significant improvements in their overall well being. The majority of the 17 adolescent girls reported less drug use, less alcohol use and lower incidents of homelessness. Additionally, the majority of the 17 girls reported having developed healthier and more supportive relationships with their family members (Pierce, 2012).

The feedback forms utilized by Pierce (2012) offered the most significant insight into effective intervention, as it gathered the thoughts of the

adolescent girls receiving services. Of the 39 adolescent girls who provided feedback, the most significant findings were the following:

> Girls attending Phoenix Project support groups most frequently reported experiencing “huge improvement” in “feeling confident that you have the right to be safe and make your own choices” (82%), “knowing when someone is trying to exploit you sexually” (77%), and “avoiding sexual situations that you do not want” (77%). The types of support described as “a huge need” by this group of girls included “having a safe place to stay” (73%), “having the support of adults who won’t blame or judge” (73%), and “getting information to American Indian youth that there is help out there” (73%). (p. 50)

Considering these findings, the most effective means of intervention appears to be a harm-reduction approach, combined with positive support and mentoring from non-judgmental adults. MIWRC participation logs further indicated that attendance was high when guest speakers presented at groups. Popular topics among the adolescent girls were education in sexual exploitation, domestic violence, sexual assault, gang violence, and emotional health (Pierce, 2012).

Considering the findings of the existing literature, it appears the first significant aspect of DMST intervention is identifying the victim. According to Pierce (2012), this can be accomplished by incorporating standard protocol for DMST identification. As indicated in Pierce’s study, the Commercial Sexual

Exploitation Risk Assessment form utilized by the MIWRC was instrumental in identifying DMST and providing appropriate services. Additionally, Pierce argued that although adolescent girls may deny being involved in sex trafficking during the assessment, the fact they are asked the questions allows them to know there are other people in their situation, thereby raising awareness. After the individual is properly identified as a DMST victim, the existing research suggests the most effective intervention is harm reduction, education on the dynamics of DMST and related trauma, and support. Additionally, an important aspect of successful DMST intervention appears to be mentoring from a nonjudgmental adult.

Attachment Theory and Intervention

Bowlby (1973) was the main researcher involved in the development of Attachment Theory. In this theory, attachment was a term that referred to the lasting emotional connectedness between human beings, specifically between child and caregiver (Bowlby, 1973). In Bowlby's view, "The quality of interactions between infant and caregiver(s), beginning at birth, motivated specifically by a child's needs for safety and protection, are central to lifespan development" (Page, 2011, p. 31). There are four factors that contribute to the level of attachment between child and caregiver: (1) caregiver's amount of time spent with the child, (2) caregiver's reactions to the child's needs, (3) caregiver's emotional responsiveness and commitment to the child, and (4)

the caregiver's availability to the child over long periods of time (Lesser & Pope, 2007).

Ainsworth, Blehar, Waters and Wall (1978) conducted empirical studies to test the tenets of Bowlby's theoretical research. Their most notable experiment was the "Strange Situation" (Ainsworth et al., 1978). During this experiment, infants were observed as they responded to a situation in which they were briefly left alone, and then reunited with their caregivers. Also, infants were observed as they responded to the presence of a stranger in the room while their caregiver was absent. By conducting this experiment, the following four patterns of attachment were established: (1) secure attachment, (2) anxious-avoidant attachment, (3) anxious-resistant attachment, and (4) disorganized attachment (Lesser & Pope, 2007). Although Bowlby and Ainsworth's work focused primarily on attachment in early childhood, subsequent research has shown correlations between attachment patterns in early childhood to attachment patterns in adolescence and early adulthood (Lesser & Pope, 2007). It has been found that poor attachment patterns in adolescence and early adulthood can result in negative self-concept, poor peer relationships, poor emotion regulation, and antisocial behavior, especially in response to abuse and neglect experienced during childhood (Lesser & Pope, 2007).

Considering the tenets of attachment theory, it can be argued that children with poor patterns of attachment are more susceptible to DMST.

Children who experience abuse or neglect are more likely to develop poor patterns of attachment, such as anxious-avoidant attachment, anxious-resistant attachment and disorganized attachment (Page, 2011). These poor patterns of attachment are internalized, which negatively affects the child's ability to have healthy interactions with peers and significant others (Page, 2011). This may result in children exhibiting negative behaviors that are similar to the aforementioned risk factors of DMST. Children with poor patterns of attachment are subsequently vulnerable to opportunistic pimps, some of which portray themselves as the loving caregiver that had been absent from these children's lives.

Although pimps exploit their victims, they also provide for their basic needs, such as food and shelter, and superficial needs, such as name brand clothing and accessories. The tenets of attachment theory not only explain how children may be more susceptible to DMST, but also explain why a victim would be unwilling to leave a pimp that has fulfilled the role of caregiver even despite the fact they are being subjected to exploitation and abuse. This idea can be explained by the following:

> A child whose attachment figure inflicts abuse or trauma faces an unresolvable dilemma: attachment behavior is instinctively activated toward the very source of distress, a desire for proximity with the person who presents the most immediate threat. (Page, 2011, p. 50)

Research indicates that facilitating healthy patterns of attachment with safe individuals is essential to effective DMST intervention. Existing literature regarding interventions for DMST is limited. However, studies regarding post-traumatic stress disorder (PTSD) may offer insight to interventions for DMST, as PTSD is prevalent among victims and survivors (Clawson & Grace, 2007).

Amatya and Barzman (2012) conducted a study regarding the treatment of trauma and Post Traumatic Stress Disorder (PTSD) among children. Amatya and Barzman discussed the importance of schemas, which they defined as "a conceptual framework based on life experiences that help the individual organize information and interpret and adapt to the environment" (p. 2). Amatya and Barzman argued that experiencing trauma can negatively affect children's schema, thereby leading to a negative outlook on life and a poor perception of self-competence (Amatya & Barzman, 2012). This may lead to maladaptive coping mechanisms for trauma, which may include delinquent behavior. In order to improve children's coping mechanisms for trauma, Amatya and Barzman argued the following.

> Following the line of thought of the core schema theory, attachment figures that strengthen the child's schemas of the self as competent and the world as safe can play a role in mitigating the negative effects of trauma and the likelihood of PTSD. (p. 2)

Joubert, Webster and Hackett (2012) conducted a study that reiterated the importance of addressing attachment with trauma intervention. Joubert et

al. examined the effects of disorganized attachment among 60 adolescents with a history or maltreatment. Results of the study indicated that there was a substantial association between disorganized attachment and symptoms of trauma and dissociation.

Although the literature regarding attachment theory does not speak specifically of DMST intervention, it is clear that DMST victims experience severe trauma during their involvement in the industry. Attachment theory appears to play a key role in addressing trauma and PTSD; therefore, it may also play a key role in DMST intervention. This can be accomplished in therapy, where the therapist can assist the DMST victim in recognizing their current patterns of attachment. Additionally, the therapist can facilitate change in current patterns of attachment by incorporating the DMST victim's relationship with current caregivers, or individuals in the victim's life that assume the role of primary caregiver.

Improving patterns of attachment can also be accomplished through participation in social support groups and mentor programs. With services geared towards improving patterns of attachment, children will be able to improve their ability to have healthy interactions with peers and significant others, which will have positive effects on their sense of self-worth. Such services will reduce risk factors that leave children vulnerable to pimps. Additionally, such services will allow existing victims to escape the industry by

shedding light on the harmful and dysfunctional relationship that exists with their pimp.

Summary

Although limited, the existing literature regarding DMST has provided promising methods for intervention. The first aspect of successful intervention is proper identification of DMST victims. The next aspect for successful intervention involves appropriate services; including, but not limited to, education services, housing services, medical screening/routine care, intensive case management, life skills and job training programs, and family involvement and/or reunification. Attachment Theory provides a theoretical framework for addressing trauma and PTSD symptoms experienced by DMST victims. This can be addressed through counseling services, and maintained by support groups and mentorship. Understanding the relationship between trauma and DMST is subsequently an essential aspect of DMST interventions. Effective intervention not only has the potential to prevent children from falling victim to DMST, but it also has the potential to prevent victims from remaining in the industry until adulthood.

CHAPTER THREE

METHODS

Introduction

In this chapter, I will discuss the study's research design, the participants involved, the methods for collecting data, and the procedures for protecting the participants and the information they provided. Furthermore, I will outline the purpose of this study, the question it seeks to answer, and its limitations.

Study Design

The nature of domestic minor sex trafficking (DMST) is highly secretive, which is exacerbated by the fact that victims are not viewed as such (Hardy, Compton & McPhatter, 2013). Instead, victims are viewed as criminals, which is a perception that is held by the general public and the victims themselves (Hughes, 2007). Not only do victims fear criminal prosecution, but they fear retaliation from their pimps. Due to these circumstances, DMST victims who are actively involved in the industry are difficult to gain access to, which made the prospects of a quantitative research design very difficult. However, little is known about the DMST industry, and the limited research regarding DMST has focused primarily on service providers. Therefore, it would be highly beneficial for DMST research to incorporate the perspectives of victims, as they can offer first-hand information that can be used to shed light on the

underground industry. Utilizing information from a victim's experience should be the first step in developing effective DMST interventions. In order to overcome the difficulty in accessing DMST victims, this research study had a qualitative design, which included semi-structured interviews with eight survivors of DMST who are now adults.

The qualitative design allowed for an in-depth exploration of the survivor's experience in DMST; including the risk factors that made them vulnerable to DMST, the circumstances surrounding their initial victimization, their experience in the industry, the means by which they escaped the industry, and the means by which they avoided re-victimization. If the goal of this study is to inform best practice interventions for DMST, then it is logical to utilize the perspectives of individuals who successfully escaped the industry. The data gathered from these interviews can be used to inform child welfare social workers on best practice interventions for DMST victims. Considering the discussion in Chapter Two regarding the role of attachment theory in intervention, the following research question was developed: What role, if any, does mentorship have in DMST intervention?

Although the study's qualitative design was a significant strength, it also presented limitations. Only eight survivors were interviewed; therefore, the generalizability of the information obtained from these interviews to the entire population of DMST victims and survivors was limited. For example, the eight survivors who were interviewed could only be accessed because intervention

had been successful in removing them from the industry. Therefore, even if the interviews revealed a general method for successful intervention, this does not mean the method would be successful with other DMST victims. There may be other DMST victims for whom this identified method may have been used and was not successful. However, these DMST victims are not accessible or available to provide such discrepancy; therefore, any identified method of successful intervention will face no opposition.

Sampling

The underground nature of DMST made it difficult to access victims of this industry. Therefore, methods of purposive sampling were used to obtain participants for this study. An informal network of DMST survivors was identified, which included survivors residing in various counties in Southern California. Survivors who agreed to participate were subsequently interviewed, and were then asked for referrals to other survivors who would be willing to participate in the study. To protect confidentiality, my contact information was forwarded from the consenting participant to other individuals whom they knew to be DMST survivors. If the referred individual was willing to participate in the study, then they contacted me on their own; absolutely no identifying information for the referred individual was obtained from the consenting participant. As a result of this sampling method, eight participants were obtained for this study.

Data Collection and Instruments

Data was collected by utilizing semi-structured interviews. The purpose of this study was to explore best practice interventions for DMST victims, and to then utilize the collected data to make recommendations for child welfare social workers in providing services to DMST victims. Therefore, questions were aimed at discussing the following three general topics: (1) the DMST victim's recruitment to the industry, (2) their contact, if any, with child welfare agencies, and (3) specific interventions that were effective in successfully removing them from the industry and keeping them from being re-victimized.

Due to the underground nature of DMST and the expectation that every survivor's experience would be unique, the interview had a semi-structured design. It was expected that this design would allow freedom in exploring various aspects of the survivor's experience. However, after the first survivor was interviewed, it was determined the semi-structured design resulted in an interview that did not run smoothly and was somewhat awkward. It appeared that the semi-structured design was perceived by the survivor as being disingenuous and disrespectful to the subject-matter at hand. Therefore, subsequent interviews were conducted using an unstructured design, which was only guided by the aforementioned three general topics. It appeared that the survivors were more receptive to this study design, which led to more open and free flowing interviews.

There is limited information on male DMST victims and there are no known agencies providing services specifically for male DMST victims. Due to these circumstances, this study only included female participants. All participants were 18-years-old or older and had no current involvement in the DMST industry. Although female participants are more accessible than males, victims of DMST, in general, are a difficult population to gain access to. Therefore, being female, over the age of 18, and having no current involvement in DMST were the only inclusion criteria.

Procedures

Eight research participants were obtained from an informal network of DMST survivors who reside in various counties within Southern California. An email was sent to this network of survivors, which included detailed information regarding this study. Survivors who wished to participate in this study responded to the email, and were then contacted via telephone to schedule an appointment for an in-person interview. The interviews took place within each survivor's respective county of residence, at an agreed upon location. To compensate for travel and time, each survivor was given a $25 Visa gift card. Each interview was approximately 30 to 45 minutes in length, and was audio-recorded. The contents of each interview were transcribed to a Microsoft Word document; after which, the audio-recording was deleted.

Protection of Human Subjects

This study was approved by the California State University, San Bernardino Institutional Review Board: School of Social Work Subcommittee.

Each participant was provided with informed consent, both verbally and in writing. Additionally, each participant was informed, both verbally and in writing, that they would be interviewed with closed-ended and open-ended questions. Participants were advised the interview would be audio-recorded and later transcribed to an electronic document. They were further advised that the audio-recording would then be deleted, and they would only be referred to in the electronic transcription as “participant,” followed by a number (1-8). After the participant was provided with this information, they were then given the opportunity to discontinue their participation in the study. Even after the participant gave consent to participate in the interview, they were advised that they could withdraw their consent at any time during the interview, and that the information obtained from the interview would not be included in the study. After the interview was completed, the participant was provided with a debriefing statement.

The contents of the audio-recorded interviews were transcribed to a Microsoft Word document, and were then deleted. Each interview was only identified as “participant,” followed by a number (1-8); no identifying information, including demographics, was included in the Microsoft Word document. The Microsoft Word documents were kept on a flash drive that

required a password to access the data. These procedures were implemented to protect the confidentiality of each participant.

Data Analysis

The transcriptions of each interview were analyzed to identify common themes among the statements made by participants, specifically regarding the three identified topics to be explored: (1) the DMST victim's recruitment to the industry, (2) their contact, if any, with child welfare social workers, and (3) specific intervention strategies that were effective in successfully removing them from the industry and keeping them from being re-victimized. By exploring these themes, methods of intervention were identified in order to inform best practice interventions for DMST, especially with regard to child welfare social workers.

Summary

The purpose of this study was to explore best practice interventions for DMST from the perspective of survivors. This study had a qualitative design, which initially involved a semi-structured interview design. However, after interviewing the first survivor, it was determined that an unstructured interview design was more effective. The participants of this study included eight DMST survivors who are now adults. Data collected from these interviews was analyzed in order to identify common themes among the statements made by participants, specifically with regard to three general topics: (1) the DMST

victim's recruitment to the industry, (2) their contact, if any, with child welfare social workers, and (3) specific intervention strategies that were effective in successfully removing them from the industry and keeping them from being re-victimized. These themes were used to inform best practice interventions, especially among child welfare agencies that have contact with children at risk of DMST or are already involved in DMST.

CHAPTER FOUR

RESULTS

Introduction

In this chapter, I will discuss the identified themes of participant interviews. In reviewing the transcripts, risk factors for domestic minor sex trafficking (DMST) were consistent with that of the existing literature. Furthermore, DMST intervention from the perspective of survivors can be identified by the following three phases: prevention, intervention, and recovery. A discussion concerning the components of each of these three phases will be guided by statements made by the participants.

Presentation of the Findings

Demographic Information

The purpose of this study was to utilize the findings to make recommendations for child welfare social workers in providing services to DMST victims. Therefore, it is important to note demographic information as it relates to participant involvement with child welfare agencies. Four of the eight participants were dependents of juvenile court at one point during their childhood due to various types of abuse and neglect by their caregivers; therefore, they had an open case with a child welfare agency. Three of these four participants emancipated from the juvenile court system after reaching the age of majority; two participants reached the age of majority and had their cases closed while on runaway status, while the third participant reached the

age of majority and had her case closed while in foster care. The fourth participant had her case closed after reunifying with her caregiver. Of these four participants, three were actively involved in DMST while they had open cases with a child welfare agency; the fourth participant became involved in DMST after her case was closed. This demographic information is further illustrated in Table 1.

Table 1. Demographic Information

		Participants							
		1	2	3	4	5	6	7	8
Demographic Information	Open Case w/Child Welfare Agency	X			X			X	X
	Placed in Foster Care	X			X			X	X
	Reunified w/ Caregiver				X				
	Emancipated while in Foster Care or Runaway Status	X						X	X
	Initial DMST Victimization w/ Case Open	X			X				X
	Initial DMST Victimization w/ Case Closed							X	
	DMST Victim w/ no Child Welfare Involvement		X	X		X	X		

Risk Factors

All eight participants exhibited risk factors consistent with previous research findings. Despite the fact only four of the eight participants had direct involvement with a child welfare agency, the other four participants suffered abuse or neglect from caregivers that simply did not come to the attention of a child welfare agency. Risk factors present in the homes of various participants included, but were not limited to, sexual abuse by caregivers and/or close family members, drug use by caregivers, domestic violence between caregivers, caregiver absence/poor supervision, and exploitation by caregivers. Risk factors exhibited by the participants included, but were not limited to, poor academic performance, poor school behavior, substance abuse, running away, promiscuity, contracting a STD, suicidal ideation, and delinquent behavior. These risk factors are further illustrated in Table 2.

Table 2. Risk Factors

		Participants							
		1	2	3	4	5	6	7	8
Risk Factors	Victim of Abuse or Neglect	X	X	X	X	X	X	X	X
	Poor Academic Performance	X			X	X	X	X	X
	Poor School Behavior				X	X	X	X	X
	Delinquent Behavior (other than DMST)	X			X		X		X
	Substance Abuse	X		X	X	X		X	X
	Suicidal Ideation	X	X			X		X	X
	Promiscuity	X	X	X		X			X
	Contracted STD	X						X	
	Runaway from Home or Placement (at least once)	X		X	X			X	X

The risk factors illustrated in Table 2 were exhibited by the participants while they were still minors. Therefore, these risk factors should have been recognized by mandated reporters in the community (i.e. law enforcement, teachers, medical professionals) and brought to the attention of a child welfare services agency, which highlights a need for an interagency approach to DMST intervention, especially with regard to prevention. Considering the

information obtained from the participants, intervention can be broken down into the following three stages: Prevention, Intervention and Recovery.

Prevention

Participants indicated that prevention would require an interagency approach. In order for a child welfare agency to effectively identify DMST victims and provide them with adequate services, DMST victims must first be brought to the attention of the child welfare agency by community members and mandated reporters. Considering statements made by the participants, it appears several agencies did not conduct an adequate assessment of presenting risk factors, which may have identified the participant as being vulnerable to DMST victimization.

The following excerpt demonstrates how school personnel did not take action to assess the participant or provide intervention despite the participant demonstrating serious behavioral issues:

> Surprisingly enough, people knew I was a troubled kid. I was very aggressive. I beat up one of my teachers and I think instead of them putting in the time to do the paperwork to follow through, the teacher just kept telling me that I would be okay. (Participant 4, October 2014)

The following excerpt demonstrates how a child welfare agency, a juvenile probation agency, law enforcement, and school personnel did not respond to the needs of a participant despite her exhibiting serious behavioral issues:

> Well at the time I had been betrayed by any system that ever was. I had a recording (of the perpetrator admitting to molesting me) and nobody…no one protected me. I became a monster. I started becoming as bad as I could and doing whatever I could to be the worst person possible. Somebody that nobody would want to be around…someone that could act out in anger and not care…I wasn't a CPS kid anymore, I was a probation kid. (Participant 5, October 2014)

These statements suggest that prevention is not a task that can be adequately addressed by only one agency. Instead, it takes an interagency effort of several public and private entities; including, but not limited to, child welfare, probation, law enforcement, school personnel, medical professionals, and mental health professionals. An interagency model can be used to implement various preventative measures offered by the participants.

Three of the eight participants stated educating children on DMST would be beneficial in preventing victimization. The other five participants stated education would be a beneficial component of DMST prevention, but by itself would be inadequate. However, all eight participants stated educating the community on DMST would be essential to adequate prevention, especially child welfare social workers, law enforcement, medical professionals, mental health professionals, group home staff and foster caregivers.

Intervention

The Need for an Interagency Approach

As with prevention, participants indicated an interagency effort toward adequate assessment and victim identification are necessary components of intervention. Several participants, especially those of which were involved in DMST while having open cases with a child welfare agency, indicated that several agencies failed to identify them as DMST victims despite exhibiting signs of such involvement. The following excerpt is an example of group home staff and medical professionals failing to conduct an assessment despite the participant displaying concerning risk factors:

> So when I got back [to the group home from 6 months of being trafficked while on runaway status] no one ever asked me where I was, what was I doing, no one said, 'Hey, you're 15 years old. How are you taking care yourself? Or where were you sleeping? How are you eating?' Any of those questions. I ended up getting a really bad stomachache and I was taken to the doctor and they found that I had three STDs. Even at that point, nobody asked, 'Hey, how did you get these STD's? What were you doing?' (Participant 1, October 2014)

The following excerpt is an example of a mental health professional failing to conduct a thorough assessment. During a psychiatric hold, the participant was identified as a sexual abuse victim, but not a DMST victim:

> If [the clinician] had the questions to ask me or if they know what to ask I would have (disclosed being a DMST victim), but they didn't ask. I told them I was molested but I think if they had different questions and dug a little deeper, then they would have figured out. It probably would've brought up that I was trafficked as a kid. (Participant 4, October 2014)

The following excerpt is an example of several agencies failing to respond to the needs of a participant despite her reaching out for help while actively involved in DMST:

> Yeah I mean I tried sharing my story with a lot of people…cops, social workers, CPS, therapists, teachers, and that just went nowhere. I mean to go back to what happened in [redacted], after that guy had raped me and told me that he was gonna go somewhere…he told me I was being watched so don't do nothing stupid. I waited a couple minutes and then I grabbed some of those things that I could sell for money and then I went out to security and told him I needed help. He called the cops and the cops pretty much laughed at me and said, 'Well that's what happens when you run away isn't it.' (Participant 5, October 2014)

These statements suggest that identifying DMST victims is the first step to providing adequate intervention. In order to address such an important need, participant statements indicate that an interagency approach must be utilized to develop assessment tools and staff trainings that are consistent

across various agencies. Once identified, then DMST victims can be provided with appropriate services to address their needs.

Engagement

As previously discussed, research indicated that DMST victims typically perceive themselves as criminals, and subsequently develop distrust in agencies with authority; such as child welfare agencies, probation agencies, and law enforcement. Participants indicated that an important factor in overcoming this barrier to intervention is effective engagement. This is illustrated by the following excerpts:

> I know child welfare workers, like the workers and staff and supervisors are going to trainings about sex trafficking. The next step is going to the youth, and really getting rapport with them, and educating them on this stuff. I believe that would've helped me a lot. (Participant 1, October 2014)

Another participant emphasized the need for engagement in regard to child welfare social workers providing services to troubled youth.

> A lot of (child welfare) workers lose the empathy that they should have for the kids. Yeah, some of these kids are liars, but if you treat every kid like they're a habitual liar, then you lose some of the kids who aren't. I believe (child welfare) workers are taught to identify certain things in kids and when they do, then they make certain assumptions about that

> kid. I think (child welfare workers) just don't try hard enough to have empathy for that child. (Participant 2, October 2014)

Another participant emphasized the need for effective engagement by law enforcement:

> You know, a lot of survivors kind of feel the same way towards cops…I wouldn't have trusted (an officer)…Cops now are trying to work with survivors and maybe if that would've happened back then it would've been easier for me to talk to them. (Participant 6, November 2014)

Six of the eight participants stated that agencies, specifically child welfare agencies and law enforcement, should use DMST survivors to enhance engagement with DMST victims, or children exhibiting risk factors which leave them vulnerable to DMST. The rationale for this approach can best be explained by the following excerpt:

> (A survivor) would've given me someone different to talk to other than a cop…someone who kind of knows what I was probably going through. And just them being a survivor and sharing the story with them… it's a little different. There's a connection between two survivors that won't exist between a survivor and a cop. It's an immediate connection. (Participant 6, November 2014)

Concrete Needs

Participants offered several ideas for immediate intervention. While one participant did not find psychiatric care and counseling services to be helpful,

the other seven participants stated psychiatric care and trauma-focused counseling services were a significant need for DMST victims. The need for adequate counseling services is illustrated by the following excerpt:

> I think trauma-focused counseling would've been helpful. Nothing like that didn't exist back then…but I know it exists now and I think it would be very helpful to refer these kids there after they go through traumatic events…when they come back home after six months and they disclose being trafficked…because there's a chance they come in and go through PTSD. (Participant 7, December 2014)

Another participant further emphasized the need for adequate counseling services, as she continues to experience adverse psychological effects related to her victimization. This is indicated in the following excerpt:

> I still have not done any type of counseling even as an adult…I mean, I still have anxiety…have a little bit of OCD. I don't like when people stare at me too long. I mean, not necessarily in conversation, but, you know, if people just look at me for too long. Certain smells still trigger me…being kissed on the forehead bothers me…it really really bothers me. There's quite a few things that have a still have a big effect on me. (Participant 6, November 2014)

Participants indicated that DMST victims are in need of shelters that are specifically designated for DMST victims. This is indicated in the following excerpt:

> More shelters for [DMST] victims is definitely needed. In [redacted] County, there's nothing for sheltering victims of human trafficking. (Participant 1, October 2014)

For children placed in a foster home or group home, a participant, who had a case with a child welfare agency, indicated a need for DMST victims to be placed in a foster home with no more than 1-2 other children, or a group home with a high staff-client ration. This is important to prevent re-victimization and recruitment, which is alluded to in the following excerpt:

> When you get trafficked and you go back into a group home, it makes you vulnerable to being trafficked again and it leaves you vulnerable to recruiting because you're used to living a different kind of lifestyle, but you don't want to run away alone so you try to get people to run away with you…getting more people in that life. So really, putting me back in a group home made me even more vulnerable to being trafficked again. (Participant 1, October 2014)

Recovery

Spirituality and Self-Worth

All eight participants indicated self-worth to be a core component of recovery. Due to the risk factors associated with DMST, victims are left vulnerable to DMST due to having a low sense of self-worth, which is usually tied to poor family dynamics. It was previously stated that a DMST victim's relationship with their pimp is similar to a domestic violence relationship.

Therefore, DMST victims typically return to their pimp and/or the life they have been accustomed to despite the danger and trauma it subjects them to. Improving the victim's sense of self-worth is subsequently a critical component to breaking this cycle and ensuring the victim does not turn to other means of self-destructive behavior; such as self-mutilation, substance abuse, and violent relationships. Seven of the eight participants identified religion and spirituality as the means by which they improved their sense of self-worth. This is indicated by the following excerpt:

> I believed the life I lived was what I deserved. I thought nobody cared. I felt like that's what I deserved…What really helped me was my relationship with God…my spirituality. (Participant 7, December 2014)

Another participant further illustrated the internal struggle that took place with religion and spirituality on her path to recovery:

> A lot of people are mad. They're going to say, 'Why did God let this happen to me? He saved everybody…is such a protector…why did (God) let this happen to me? So they base it on religion…I started to reject (religion) a little bit because I was not right and I felt like (God) was going to punish me, but no that's not true. God is a gracious God. So for me, and I think other survivors would agree, everybody has their own relationship with God and I had to find my own relationship…I've learned that my God is merciful and caring…is loving and trusting. (Participant 4, October 2014)

In addition to finding strength from within by leaning on religion and spirituality, several participants also reported having a system of support to assist in their recovery.

Mentoring, Life Coaching and Support Groups

Participants indicated that in order to prevent re-victimization, DMST survivors need to have relationships with loving, supportive and non-judgmental individuals. All eight participants indicated they fulfill this need by utilizing a system of support that included a mentor, a life coach or a support group. All eight participants made mention of a special bond between survivors, which highlighted the need for support groups consisting of survivors. The need for a network of support is highlighted in the following excerpt:

> I really wish there was support groups where you met with other victims of human trafficking and it wasn't a silly thing for sharing stories, but to help pull strengths out of each other, build self-esteem and self-worth and…you know…empower each other. (Participant 8, December 2014)

Another participant highlighted the need for mentoring and life coaching in the recovery process:

> I've had the same life coach for about 10 years now. I also have several mentors, but in different areas or my life…people always tell you that you need to go to counseling, you need therapy, but a life coach is able

> to assess your life in a different way…form a nonjudgmental standpoint. (Participant 2, October 2014)

Another participant emphasized the bond that develops between a survivor and their mentor or life coach, and the importance it bears in the recovery process.

> I think the most important thing is letting (victims) know that they are loved…and that they understand that not everybody is out to hurt them. There are people that want to help them and not use them…life coaching is also great…it's spending time with them at least one hour, half hour to one hour, to a day with them…I think it's because they need that relationship…that one on one relationship…not only with their parents, but also with someone else. (Participant 3, October 2014)

Children are vulnerable to DMST due to poor family dynamics. Therefore, survivors have to develop healthy relationships with other adults in order to substitute for their dysfunctional family relationships. The following excerpt is from a participant who identified this need:

> I didn't have my parents. I was in this mess because of them. So, I had to find other people to support me…and my mentors and my support group did that. (Participant 8, December 2014)

Summary

Statements made by participants indicated that the most significant barrier to effective intervention is victim identification. Participants indicated

that an interagency approach is necessary in developing assessment tools and staff trainings that are consistent across various agencies, which, in turn, will improve victim identification. Participants highlighted the need for child welfare social workers to foster engagement with potential victims, current victims, and survivors. Concrete needs included psychiatric care, trauma-focused counseling services, shelters specific for DMST victims, and foster homes and group homes that meet these needs. As for recovery, participants indicated that improving the survivor's sense of self-worth is imperative to successful recovery. Methods for accomplishing this task included religion and spirituality, and a network of support, such as mentoring, life coaching or support groups.

CHAPTER FIVE

DISCUSSION

Introduction

In this chapter, I will discuss the significance of the results. The findings of this study highlight the need for an interagency approach to victim identification, and the significance of support networks and spirituality with regard to intervention. Considering these findings, I will then discuss the implications for social work policy, practice and research.

Discussion

Due to the secretive nature of DMST, the most significant barrier to intervention is victim identification. The risk factors exhibited by the participants were consistent with the risk factors identified by Clawson and Grace (2007), and Hardy, Compton and McPhatter (2013), which further supports my belief that DMST victims are as likely to come to the attention of child welfare social workers as they are a pimp. The predominant risk factors exhibited by the participants included, but were not limited to, abuse/neglect by a caregiver, poor academic performance, poor school behavior, substance abuse, running away, promiscuity, suicidal ideation, and delinquent behavior. Considering these risk factors, DMST victims are likely to experience intervention from entities other than child welfare agencies, such as schools, mental health agencies, law enforcement, probation departments, and

community-based agencies. The involvement of various agencies is a factor that Clawson and Grace (2007), and Pierce (2012), considered significant, as their respective studies included members of various agencies in the effort to inform and improve DMST intervention. However, the factor that was not considered by Clawson and Grace (2007), and Pierce (2012), is the need to engage these various agencies in an interagency effort for DMST intervention.

To illustrate the need for an interagency approach, take into account the excerpt included in Chapter 4, page 45. The participant disclosed that she exhibited behavior which brought her to the attention of school staff, mental health professionals, medical professionals, and law enforcement. Additionally, the participant disclosed that she received heightened attention from group home staff and her child welfare social worker. Despite the participant's behavior and the multiple agencies to which her behavior brought her to the attention of, she was never assessed for DMST victimization. Therefore, the participant was never identified as a DMST victim and did not receive appropriate intervention. The other participants had similar experiences; despite receiving overlapping interventions from various agencies, they were never assessed for DMST victimization.

The findings of this study indicate there is a gap in communication between agencies. This is likely due to a lack of education among agencies in risk factors for DMST. Agencies may simply be concerned with the risk factors that can be addressed by their services. The substance abuse counselor only

addresses the participant's substance abuse issues, the mental health professional only addresses the participant's suicidal ideation, the medical professional only addresses the participant's STD, the group home staff only addresses the participant's behavior, the school staff only addresses the participant's academic performance, and law enforcement only addresses the participant's delinquent behavior. Agencies must be made aware that it is the combination of all these risk factors that contribute to the child's vulnerability to DMST.

It was presumably the participant's child welfare social worker who was managing her case and subsequently carried the responsibility of brokering the aforementioned services. Therefore, the only entity that had the opportunity to even be aware of the overlapping interventions being provided to the participant was the child welfare agency. The very definition of DMST assumes that every victim is a minor. Additionally, it has already been discussed that the risk factors that bring children to the attention of pimps are the same as those which would bring them to the attention of child welfare agencies. Due to these circumstances, child welfare should be the lead agency in an interagency collaboration to educate service providers and members of the community on DMST, and inform best practice interventions for its own social workers and other service providers.

An interagency collaboration can help to overcome the communication barriers between agencies. Additionally, an interagency collaboration can

ensure consistent training and education of DMST among various agencies. Furthermore, the interagency collaboration can develop or adopt an assessment tool for DMST victim identification. Clawson and Grace (2007), and Pierce (2012), found that consistency was needed within an agency for the policy and practice of victim identification and service delivery. The findings of this study are consistent with that of Clawson and Grace (2007), and Pierce (2012). However, instead of developing consistency within an agency, DMST identification and service delivery would be more effective if practice and policy was consistent across several agencies. This will improve victim identification, and will prevent victims from experiencing overlapping interventions.

Recommendations for Social Work Practice, Policy and Research

The following research question was presented: What role, if any, does mentorship have in DMST intervention? The answer is that mentorship plays a significant role. Additionally, participants identified life coaching and support groups as being important factors. Therefore, the focus of intervention should not simply be narrowed down to mentorship, but should encompass a wide-range of support networks in general.

All eight participants were victims of abuse or neglect as children by their caregivers. Considering research regarding DMST, it can be assumed that the participants subsequently developed poor patterns of attachment

during their childhood. As previously discussed, poor patterns of attachment can result in negative self-concept, poor peer relationships, poor emotion regulation, and antisocial behavior (Lesser & Pope, 2007). This further supports my belief that a child is susceptible to DMST due to opportunistic pimps recognizing the child's emotional vulnerability, and then portraying themselves as the loving and supportive caregiver that the child lacked in their life and desired to fulfill. The findings of this study are consistent with that of Amatya and Barzman (2012), which indicated that victims of trauma, such as being a victim of DMST, require attachment figures that strengthen their self-esteem and sense of self-worth. Therefore, if a child was provided with an appropriate network of support, then an individual or group of individuals could serve as the victim's loving and supportive attachment figure, as opposed to a pimp. A support network would subsequently play a significant role in prevention if provided to children exhibiting risk factors that make them vulnerable to DMST. If the child is already involved in DMST, then support networks could replace the role fulfilled by the pimp. Therefore, not only can support networks, such as mentorship, life coaching and support groups, play a significant role in prevention, but in intervention and recovery as well

Several participants identified the importance of receiving support or intervention from other survivors. Participants described the survivor-to-survivor bond as being strong, and often instantaneous. Therefore, a mutual-aid approach to intervention may be highly beneficial to DMST victims and

survivors. A mutual-aid group consisting of only DMST victims and survivors would serve as an empowering experience, whereby victims could improve their self-esteem and sense of self-worth, while enhancing their strengths and resources.

Another significant finding was that all eight participants identified spirituality as a significant factor in prevention, intervention and recovery. Although this finding was not expected, it was not surprising considering the relationship between attachment and support networks in DMST intervention. Participants indicated a desire to be supported by loving, caring and non-judgmental individuals. Participants also indicated the need to improve their self-esteem and sense of self-worth by being accepted and forgiven for their actions while involved in DMST. As previously discussed, support networks can fulfill these needs. However, another source can be a higher power; an entity or higher being that is forgiving and whose love is unconditional. Regardless of the exact reason for which spirituality was identified as an important factor for intervention, its significance cannot be denied. Therefore, further research is needed to fully understand the role of spirituality in DMST intervention.

Child welfare social workers who are working with DMST victims should be brokering services to meet their concrete needs, such as shelter, appropriate placement (if child has an open child welfare case), and counseling to address the trauma of being trafficked. However, a

comprehensive approach to intervention should also include services to assist the DMST victim in the recovery phase of intervention, which, in turn, will prevent re-victimization. A comprehensive approach would include the development of an adequate network of support, as well as the availability of services that incorporate spirituality.

Limitations

This study only included eight participants; therefore, the generalizability of the findings to the entire population of DMST victims is limited. For example, the eight survivors who were interviewed could only be accessed because intervention had been successful in removing them from the industry. They identified support networks and spirituality as significant factors in their experience with leaving the industry and preventing re-victimization. However, there may be other DMST victims for whom support networks and spirituality were not successful. Due to the inaccessibility of active DMST victims, there were no participants to provide discrepancy, if any, to the information provided by the eight survivors who participated in this study.

Conclusions

The most significant barrier to DMST intervention is victim identification. Considering the various risk factors exhibited by potential victims and active victims, it is expected that overlapping interventions would be provided by

various agencies. An interagency collaboration can overcome the barrier of victim identification by creating consistent policy and practice among various agencies. After a child is recognized as having high risk for DMST victimization or is identified as already being a victim, then the child can be referred to appropriate services without experience overlapping interventions from various agencies.

The generalizability of the findings to the entire population of DMST victims was limited by the fact that this study only included eight participants. However, it is significant that all eight participants expressed strong sentiment regarding the importance of support networks and spirituality in DMST intervention. Considering the role of attachment theory in DMST intervention, it was believed mentorship and other support networks would be important factors in intervention. However, the strong sentiment regarding spirituality was not expected and subsequently requires further exploration in future studies.

APPENDIX A

QUESTIONNAIRE

Interview Questions

1. How did you become involved in sex trafficking? What circumstances in your life do you feel contributed to your involvement in sex trafficking?

2. How did you get out of the sex trafficking industry? Did any agency, specifically the child welfare agency, play a role in your removal from the sex trafficking industry? If so, how?

3. (Prevention) At the time you first got involved in sex trafficking, did you have any involvement with social workers, specifically child welfare workers? If so, did the social worker provide intervention and/or services geared specifically for sex trafficking? If so, how effective was the intervention and/or services?

4. (Intervention) At any time during your involvement in sex trafficking, did you have any involvement with social workers, specifically child welfare workers? If so, did the social worker provide intervention and/or services geared specifically for sex trafficking? If so, how effective was the intervention and/or services?

5. What are your thoughts on the ability of social workers, specifically child welfare workers, to provide intervention and/or services for victims of sex trafficking?

6. How can social workers, specifically child welfare workers, improve their ability to provide intervention and/or services for victims of sex trafficking.

7. What resources are needed for victims of sex trafficking?

8. How can resources be improved to maximize prevention and/or intervention for sex trafficking?

Created by Kurt Louis Manio, 2014

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

The study in which you are being asked to participate is designed to explore intervention strategies for domestic minor sex trafficking. This study is being conducted by Kurt L. Manio under the supervision of Dr. Cory Dennis. This study has been approved by the School of Social Work Subcommittee of the Institutional Review Board, California State University, San Bernardino.

In this study, you will be asked to participate in a semi-structured interview, which will consist of both closed-ended and open-ended questions. The process should take no longer than 45 minutes to complete. All of your responses will be held in the strictest of confidence by the researcher. Your name will not be reported with your responses. After the interview is complete, your responses will be assigned a pseudonym. The only identifying information that will be included in the data analysis is your age, gender and ethnicity. You may review the results of this study on completion after September, 2015 at the Pfau Library, California State University, San Bernardino.

Your participation in this interview is totally voluntary. You are free to not answer any questions and withdraw at any time during this study without penalty. When you complete the interview you will receive a debriefing statement describing the study in more detail.

This study may have limited benefit to you. However, it may be beneficial to adolescents at risk of domestic minor sex trafficking or are already involved in domestic minor sex trafficking.

There are minimal foreseeable risks to you by participating in this interview. The questions you are asked may leave you feeling some discomfort due to the personal nature of the questions; therefore, you may withdraw from this interview at any time.

If you have any questions or concerns about this study, please feel free to contact Dr. Cory Dennis at (909) 537-5507.

ACKNOWLEDGEMENT

By placing a check mark in the box below, I acknowledged that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I acknowledge that I am at least 18 years of age. I further acknowledge that the researcher will use an audio recorder during the interview.

_____ _____

Place a Mark Above Today's Date

APPENDIX C

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

The interview you have just completed was designed to investigate intervention strategies for adolescents at risk of being recruited for domestic minor sex trafficking or are already involved in domestic minor sex trafficking. This research study is beneficial because it has the potential to decrease the number of victims involved in domestic minor sex trafficking by improving the interventions and services provided to them by child welfare social workers. Thank you for your participation and for not discussing the content of this study with other participants. If you have any questions about this study, please feel free to contact Dr. Cory Dennis at (909) 537-5507. If you would like to obtain a copy of the results of this study, please contact the Pfau Library at California State University, San Bernardino (CSUSB) after September 2015.

Kurt Manio, Student

CSUSB Master's in Social Work Program

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