Evidence-Based Mental Health Treatment for Victims of Human Trafficking

Erin Williamson, Nicole M. Dutch, and Heather J. Clawson

I. Introduction

In 2008, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services published an issue brief, entitled *Treating the Hidden Wounds: Trauma Treatment and Mental Health Recovery for Victims of Human Trafficking*, which focused on the mental health needs of victims of human trafficking.[1] This issue brief highlighted the impact of trauma on this population and the need for trauma-informed care. The same year, ASPE sponsored a National Symposium on the Health Needs of Human Trafficking Victims, which reiterated the complex health issues of this population and discussed the role of healthcare workers in addressing these needs.

CONTENTS

While these forums, as well as others, have served an important role in documenting the mental health needs of victims of human trafficking, questions regarding the best treatment options for this population remain. To date, limited research has been conducted to assess the impact of various mental health therapeutic treatments, hindering mental healthcare providers' understanding of which therapeutic methods work best when treating this population. To begin addressing some of the questions regarding mental health treatment, this issue brief examines the evidence-based research for treating common mental health conditions experienced by victims of human trafficking.

II. Mental Health Needs of Victims of Human Trafficking

A number of studies have identified the serious and often complex mental health needs of victims of human trafficking.[2] The majority of research related to the mental health needs of this population focuses on the significant levels of posttraumatic stress disorder (PTSD) (International Organization for Migration, 2006; Pico-Alfonso, 2005; Zimmerman et al., 2006). Victims of human trafficking have often "experienced, witnessed, or [been] confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" and their response to these events frequently involves "intense fear, helplessness, or horror." This exposure and common reaction are two of the main criteria for PTSD (American Psychiatric Association [APA], 2005, p. 467). While there is some evidence

[1] This issue brief can be found at http://aspe.hhs.gov/hsp/07/HumanTrafficking/.

[2] A more complete discussion of the physical and mental health consequences of human trafficking can be found in Clawson, H. J., Dutch, N. M., & Williamson, E. (2008). *National symposium on the health needs of human trafficking: Background document.* Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

that preexisting conditions related to social supports, history, childhood experiences, personality variables, and preexisting medical disorders can factor in the diagnosis of PTSD, exposure to trauma is the most important feature in the development of PTSD. An official diagnosis requires that symptoms be present for more than 1 month, before which a differential diagnosis of acute stress disorder may be made (APA, 2005). PTSD often presents itself within the first 3 months after a traumatic event; however, it can also have a delay in presentation for months or even years (APA, 2005). While both adults and children can be diagnosed with PTSD, studies have demonstrated that women tend to be more vulnerable than men to developing PTSD upon exposure to life-threatening events (Seedat, Stein, & Carey, 2005). In about half of patients, a complete recovery occurs within 3 months (APA, 2005); however, PTSD has been shown to last significantly longer in women than men (Breslau et al., 1998).

PTSD Associated Symptoms and the Percent of Trafficked Women Ranking These Symptoms as Severe

Recurrent thoughts/memories of terrifying events	75%
Feeling as though the event is happening again	52%
Recurrent nightmares	54%
Feeling detached/withdrawn	60%
Unable to feel emotion	44%
Jumpy, easily startled	67%
Difficulty concentrating	52%
Trouble sleeping	67%
Feeling on guard	64%
Feeling irritable, having outbursts of anger	53%
Avoiding activities that remind them of the traumatic or hurtful event	61%
Inability to remember part or most of traumatic or hurtful event	36%
Less interest in daily activities	46%
Feeling as if you didn't have a future	65%
Avoiding thoughts or feelings associated with the traumatic events	58%
Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events	65%

(Zimmerman et al., 2006)

In addition to PTSD, victims of human trafficking have been found to suffer from other anxiety and mood disorders including panic attacks, obsessive compulsive disorder, generalized anxiety disorder, and major depressive disorder (Alexander, Kellogg, & Thompson, 2005; APA, 2005; Family Violence Prevention Fund, 2005; Zimmerman et al., 2006). One study found that survivors of human trafficking reported the following anxiety and depression symptoms: nervousness or shakiness inside (91%), terror/panic spells (61%), fearfulness (85%), feeling depressed or very sad (95%), and hopelessness about the future (76%) (Zimmerman et al., 2006).[3]

Individuals with traumatic histories of physical and/or sexual abuse have also been found to be at increased risk for the development of dissociative disorders (International Society for the Study of Dissociation, 2004). The correlation between dissociation and human trafficking has been demonstrated through both research and the testimony of mental healthcare providers (Williamson, Dutch, & Clawson, 2008; Zimmerman, 2003). Dissociative disorders are characterized as a "disruption in the usually integrated functions of consciousness, memory, identity, or perception" (APA, 2005, p. 519). One study conducted in Europe found that 63 percent of victims of trafficking have memory loss (Zimmerman et al., 2006). Dissociative

[3] Note: Zimmerman et al. (2006) conducted a study using multiple questionnaires to test for PTSD and anxiety and depression symptoms. Participants were administered these questionnaires; therefore, discrepancies between data reported in the text and data reported in the chart are due to differences in the response on the questionnaires.

disorders can present themselves suddenly or gradually and can be either transient or chronic (APA, 2005). Some victims may simply not be able to recall certain events or details of events while others may continue to disassociate in an effort to prepare for future threats (Zimmerman, 2003). When making a diagnosis of dissociative disorders, mental healthcare providers should assess dissociative states through a cross-cultural perspective as they are common and accepted in many societies. For example, in some societies dissociative states such as voluntary trances are not pathological and do not cause clinically significant distress or functional impairment. Local instances of culturally normative dissociative states vary cross-culturally in terms of the behaviors exhibited during altered states, the presence or absence of dissociative sensory alterations (e.g., blindness), the various identities assumed during dissociation, and the degree of amnesia experienced following a dissociative state. By assessing dissociative states through a cross-cultural perspective, providers can identify whether individuals are undergoing culturally normative dissociative states that align with their cultural beliefs or whether they are experiencing states causing clinical distress or impairment (APA, 2005).

Substance-related disorders are often found to be co-morbid in victims of human trafficking (International Organization for Migration, 2006; Zimmerman, 2003). While a few victims of trafficking reported prior substance addictions, the majority of victims who reported alcohol and drug use said they began using after they were in their trafficking situations (Raymond et al., 2002; Zimmerman, 2003). Some victims reported using alcohol and drugs to help them deal with their situations; however, others reported being forced or coerced to use drugs or alcohol by traffickers (Raymond et al., 2002; Zimmerman, 2003).

Complex trauma, defined as "a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts" (Courtois, 2008, p. 86) is receiving increasing attention in the mental health field. While this disorder is not currently incorporated into the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), mental healthcare providers, particularly those working in the field of child trauma, are advocating for its inclusion in the DSM-V (Moran, 2007). Complex trauma has been linked to trauma endured during periods of extended captivity and has been directly associated with human trafficking (Courtois, 2008). Victims suffering from complex trauma often experience depression, anxiety, self-hatred, dissociation, substance abuse, despair, and somatic ailments. Individuals exposed to this type of trauma are also at heightened risk for self-destructive and risk-taking behaviors as well as re-victimization, and tend to experience difficulty with interpersonal and intimate relationships (Courtois, 2008). Future incorporation of this diagnosis into the DSM-V may have significant implications for the diagnosis and treatment of victims of human trafficking.

While victims of human trafficking can suffer from a range of mental health problems, the most prominent and those for which there is significant research documenting their presentation tend to be anxiety disorders, mood disorders, dissociative disorders, and substance-related disorders. While the future diagnosis of complex trauma in this population is possible, the uncertainty of its inclusion in the DSM-V prohibits extensive examination of evidence-based research regarding the treatment of this disorder.

III. Evidence-Based Mental Health Treatment

Trauma-informed services are a crucial part of a victim's recovery (Clawson, Salomon, & Grace, 2008). In trauma-informed care, treatment is guided by practitioners' understanding of trauma

and trauma-related issues that can present themselves in victims. Trauma-informed care plays an important role in service delivery by providing a framework for accommodating the vulnerability of trauma victims. It is not, however, designed to treat specific symptoms or syndromes (Office of Mental Health and Addiction Services, 2008). The treatment of specific mental health symptoms and syndromes requires evidence-based therapeutic and sometimes pharmacological approaches.[4]

Evidence-based mental health treatment is guided by the idea that scientific evidence should be assessed when determining and implementing treatment options for patients (Drake et al., 2001; Howard, McMillen, & Pollio, 2003). It stresses the importance of grounding practice decisions in empirical evidence that supports specific treatment options for particular types of clients. Additionally, services should be implemented with adherence to evidence-based methodology; otherwise, treatment can be ineffective and in some cases can even cause harm (Drake et al., 2001). Effective implementation requires training in therapeutic techniques. In the field, mental health practitioners engage in evidence-based practice by successfully integrating scientific findings with professional judgment and clients' personal preferences (Howard, McMillen & Pollio, 2003). Non-licensed counselors may not only lack the unique skill set required for proper treatment implementation, but they may also lack testimonial privilege in court. Therefore, victims may be re-victimized if these counselors are called upon to testify during court proceedings since these counselors may have to disclose information that the victims believed to be confidential[5] (Office for Victims of Crime, 1998).

Evidence-based practices target improved outcomes in terms of symptoms, functional status, and quality of life. Therefore, progress is not only assessed in terms of relapse and re-hospitalization, but also positive outcomes such as independence, employment, and satisfying relationships are evaluated (Drake et al., 2001). Over the years, evidence-based practices have been shown to improve healthcare outcomes as well as conserve resources by removing unnecessary and ineffective healthcare treatment (Agency for Healthcare Research and Quality, 2003).

HIERARCHICAL STANDARDS FOR EVIDENCE-BASED STUDIES

1. Randomized clinical trials
2. Quasi-experimental studies with comparison groups not assigned through randomization
3. Open clinical trials that lack independent comparison groups
4. Clinical observation as expert opinion (generally, these should not be considered research evidence)

Due to the fairly new development of anti-human trafficking activities and initiatives and the recent recognition of the phenomenon of human trafficking in the field of mental health, there is little evidence-based research on the treatment of victims of human trafficking. However, as noted in other reports on human trafficking, it appears the health needs of this population are similar to those of other marginalized groups such as migrant laborers, victims of sexual abuse or domestic violence, and victims of torture (Clawson, Dutch, & Williamson, 2008; Fassa, 2003; International Organization for Migration, 2006; Zimmerman, 2003). Therefore, pending sufficient evidence-based research on the direct treatment of human trafficking victims and the treatment of mental health disorders experienced by these individuals, research conducted with similar populations can be examined to provide a foundation for the treatment of this population.

[4] This issue brief focuses more on the therapeutic treatment of victims rather than the pharmacological treatment of victims of human trafficking.
[5] For more information regarding testimonial privilege, consult individual State statutes.

IV. Evidence-Based Treatment for Symptoms and Diseases Associated with Human Trafficking[6]

Processing the psychological consequences of human trafficking requires long-term, comprehensive therapy. Mental health therapy is typically based on one or more theories of psychological treatment, the most prominent being behavioral, cognitive, and psychodynamic. Behavioral therapy focuses on increasing desired behaviors and decreasing problem behaviors through environmental manipulation. Cognitive therapy works to change behaviors and feelings by altering how patients comprehend and understand significant life experiences. Psychodynamic therapy explains behavior and personality as being motivated by inner forces, including past experiences, inherited instincts, and biological drives, and targets patients' unconscious (APA, 2008).

Over the years, research has found that complete psychiatric evaluations are preferable when working with victims of human trafficking. Comprehensive psychological evaluations offer mental healthcare providers a complete understanding of patients' psychological needs, including those related to prior traumatic experiences and presentation of co-morbidity. Psychological evaluations can also assess patients' functioning and availability of basic resources (e.g., food, shelter, clothing, income), both of which can have a significant impact on mental health as well as the benefits derived from treatment (Ursano et al., 2004). Once patients have received a full psychological evaluation, scientific literature should be examined to determine the most effective evidence-based treatment options available for care.

EVIDENCE-BASED THERAPEUTIC TREATMENT OPTIONS FOR PTSD

Cognitive Therapy – aims to challenge dysfunctional thoughts based on irrational or illogical assumptions.

Cognitive-Behavioral Therapy – combines cognitive therapy with behavioral interventions such as exposure therapy, thought stopping, or breathing techniques.

Exposure Therapy - aims to reduce anxiety and fear through confrontation of thoughts (imaginal exposure) or actual situations (in vivo exposure) related to the trauma.

Eye Movement Desensitization and Reprocessing – combines general clinical practice with brief imaginal exposure and cognitive restructuring (rapid eye movement is induced during the imaginal exposure and cognitive restructuring phases).

Stress Inoculation Training – combines psycho-education with anxiety management techniques such as relaxation training, breathing retraining, and thought stopping.

(Rauch & Cahill, 2003)

Empirical evidence on the treatment of PTSD increasingly supports the use of cognitive-behavioral therapy that incorporates cognitive restructuring and exposure therapy (Rauch & Cahill, 2003; Ursano et al., 2004). Cognitive-behavioral therapy combines cognitive therapy, including cognitive restructuring, with behavioral interventions such as exposure therapy, thought stopping, and breathing techniques. When exposure therapy is introduced, patients confront their fear through progressively intense exposure to the anxiety-provoking stimuli until habituation is

[6] This section is based on information provided in clinical guidelines published by leading medical associations as well as thoroughly vetted studies and meta-analyses published in scientific journals.

reached. Exposure therapy can involve imaginal exposure, with confrontation occurring through thought only, or in vivo exposure, during which patients are exposed to the actual stimuli (Rauch & Cahill, 2003). For example, medical professionals serving victims of sex trafficking cite provocative images of victims posted online during their victimization as a major factor in computer aversion (Williamson, Dutch & Clawson, 2008). Exposure therapy for computer aversion might begin by having patients imagine and work through what it would be like to simply type on a computer. The imaginal exposure would then slowly increase in intensity until patients were asked to imagine and work through what it would be like to find images of themselves online. Exposure treatment relies on patients' active engagement in challenging their automatic fearful assumptions and responses through an objective assessment of what results from exposure to feared stimuli (Otto, Smits, & Reese, 2004).

In addition to cognitive-behavioral therapy that includes cognitive restructuring and exposure therapy, eye movement desensitization and reprocessing and stress inoculation training have both been found to be effective treatments for PTSD (Bradley, Greene, Russ, Dutra, & Westen, 2005; Rauch & Cahill, 2003; Ursano et al., 2004). Eye movement desensitization and reprocessing focuses on processing memories, and combines general clinical practice with brief imaginal exposure and cognitive restructuring. During the imaginal exposure and cognitive restructuring phases, mental healthcare providers induce bilateral stimulation through rapid eye movement, bilateral sound, or bilateral tactile stimulation to decrease the vividness and/or negative emotions associated with the traumatic memories. Stress inoculation training, on the other hand, combines psycho-education with anxiety management techniques such as relaxation training, breathing retraining, and thought stopping (Rauch & Cahill, 2003). Cognitive-behavioral therapy, exposure therapy, and stress inoculation training have been found to be particularly successful in preventing the development of chronic PTSD as well as speeding recovery from PTSD when used with female victims of sexual violence (Rauch & Cahill, 2003; Ursano et al., 2004).

According to the American Psychiatric Association, randomized control trials do not support the effectiveness of psychological debriefing, or applying very brief intervention shortly after traumatic events, with patients presenting symptoms of PTSD (Rauch & Cahill, 2003; Ursano et al., 2004). Psychological debriefing has actually been found to increase symptoms of PTSD in some settings (Ursano et al., 2004). While the use of psychological debriefing is not supported, early supportive intervention, psycho-education, and case management have been found to facilitate victims' continued utilization of mental health services (Ursano et al., 2004).

Cognitive-behavioral therapy is also at the forefront of evidence-based treatment for other anxiety and mood disorders (McIntosh et al., 2004; Otto, Smits, & Reese,, 2004; Weersing, Lyergar, Kolko, Birmaher, & Brent, 2006). While many practitioners continue to employ psychodynamic therapy, family systems intervention, or a combination of techniques from multiple theoretical practicum, the effectiveness of these treatment options lack evidence-based support at this time (Weersing, Lyergar, Kolko, Birmaher, & Brent, 2006). However, lack of evidence regarding other types of interventions does not necessarily mean they are ineffective, but rather that recommendations regarding the use of these treatment methods cannot be made based on current available research.

For individuals presenting with anxiety disorders, cognitive-behavioral therapy that combines psycho-education with exposure therapy and cognitive restructuring is especially beneficial in helping patients reevaluate automatic thoughts related to fears so they can eliminate dysfunctional

thoughts and create new frameworks for interpretation (Otto, Smits, & Reese, 2004). Cognitive-behavioral therapy, when offered by trained mental healthcare providers, has demonstrated long-term effectiveness (8–14 years) in patients suffering from anxiety disorders (McIntosh et al., 2004).

The most common diagnostic mood disorder among victims of human trafficking is major depressive disorder. Effective, evidence-based treatments for major depressive disorder include cognitive-behavioral therapy and interpersonal psychotherapy (Karasu, Gelenberg, Merriam, & Wang, 2000; McIntosh et al., 2004; Weersing, Lyergar, Kolko, Birmaher, & Brent, 2006). Unlike, cognitive-behavioral therapy, which targets dysfunctional thoughts while integrating behavioral interventions, interpersonal psychotherapy focuses on interpersonal relationships and the correlation between mood and interpersonal connections. The goal of interpersonal psychotherapy is to help patients improve their mood by seeking improvements in their interpersonal relationships (National Institute for Clinical Excellence, 2004).

Patients with substance-related disorders should be assessed to differentiate between use, misuse, abuse, and dependence. Psychotherapy, sometimes coupled with pharmacological treatment, can be an essential part of treatment of substance-related disorders. Evidence-based treatment includes cognitive-behavioral therapy, motivational enhancement therapy, behavioral therapy, 12-step facilitation, and psychodynamic/interpersonal therapy. Additionally, self-help manuals, behavioral self-control, brief interventions, case management, and group, marital, and family therapies can also benefit individuals suffering from substance use disorders (Kleber et al., 2006). Motivational enhancement therapy is a client-centered approach that induces motivation to create a personal decision and plan for change (Miller, 2003). Twelve-step facilitation programs for a variety of substances are based on the theoretical framework that willpower alone is not enough to attain sobriety and that long-term recovery involves spiritual renewal and acceptance of a higher power (Nowinski, 2003). When victims of human trafficking present with substance-related disorders, no matter what therapeutic method is used, treatment should focus on both the trauma and the consequential issues of victims' drug abuse; if treatment only focuses on the consequential issues of victims' drug abuse without addressing the underlying trauma that caused the drug abuse victims will be less likely to succeed in treatment and more likely to relapse (Alexander, Kellogg & Thompson, 2005).

While significant research has been and continues to be conducted regarding the treatment of various anxiety and mood disorders, there is a more limited understanding regarding the treatment of dissociative disorders. According to the Mayo Clinic, treatment for dissociative disorders typically involves psychotherapy that incorporates various techniques, including techniques such as hypnosis, to trigger dissociative symptoms and help patients process their trauma. Treatment can include cognitive therapy as well as art therapy, where expression through art can help individuals who may have difficulty expressing themselves through words (Mayo Clinic, 2007).

In the absence of research pertaining to the mental health treatment of victims of human trafficking, mental health professionals working with this population must educate themselves on the evidence-based research related to the treatment of common diagnoses and similarly marginalized populations to ensure proper provision of the best mental health care possible. Mental health care providers should also educate themselves about effective pharmacological treatments for patients presenting with anxiety, mood, dissociative, and substance-related disorders. Some evidence suggests that selective serotonin reuptake inhibitors can effectively

complement the psychotherapeutic treatment of PTSD as well as other anxiety and mood disorders (Seedat et al., 2005; Ursano et al., 2004; Weersing, Lyergar, Kolko, Birmaher, & Brent, 2006). Mental health care providers must remain up-to-date about new medications and research regarding pharmacological treatment to ensure proper coordination with psychiatrists and other medical providers, and to incorporate new scientific findings about medications.

Child Victims

Child victims of human trafficking require specialized attention by mental healthcare providers. The most common presentations for victims of child sexual exploitation are substance-related disorders, dissociative disorders, impulse control, conduct disorder, attention-deficit/hyperactivity disorder, antisocial personality traits, and most or all of the Axis IV psychological and environment problems. Mood and anxiety disorders such as obsessive compulsive disorder and PTSD are also common; however, presentation for these disorders may be less overt due to self-medication and/or use of other survival skills (Alexander et al., 2005). Some studies have found that concurrence of victimization and developmental milestones can exacerbate psychological consequences (Office for Victims of Crime, 1998).

Little is known about the presentation of PTSD in children. Lack of information is due, in part, to the fact that identification of PTSD in children has been more recent than its recognition in adults (Pfefferbaum, 1997). One study found that while children might initially respond to trauma through a "fight or flight" response, long-term trauma without relief can result in children responding through immobilization followed by dissociation (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Some evidence suggests that girls are at higher risk for re-victimization than boys, while boys are more likely to develop aggressive behavior as a result of their victimization. This evidence suggests the need for distinct, targeted treatment for boys and girls (Office for Victims of Crime, 1998).

Reviews of controlled trials for the psychological treatment of sexually abused children have found that the best treatment for these children is cognitive-behavioral therapy. It is important to note that the majority of these studies have focused on younger children. While studies of older children have not demonstrated such consistent findings, the results from cognitive-behavioral therapies remain more compelling than those associated with other therapeutic models (Putnam, 2003; Ramchandani & Jones, 2003). As mentioned previously, other types of therapeutic interventions may be effective in treating children victims of sexual abuse; however, the limited number of randomized controlled studies investigating these models precludes thorough assessment of their efficacy and assurance they do no harm (Ramchandani & Jones, 2003).

While evidence suggests that a significant percentage of children who have been sexually assaulted may experience long-term psychological problems and/or a later onset of problems, it also shows that the majority of children do not benefit from long-term therapy (Putnam 2003; Ramchandani & Jones, 2003). Therefore, therapy for these children must strike a balance between not being so short-term and symptom-driven that it misses children whose symptoms present later, and not being excessively long and keeping children in therapy beyond the point at which they benefit.

International Victims

Individuals' ethnicity is often directly related to their world view and thus their experiences. Ethnicity can affect how individuals seek assistance, define their problems, attribute psychological difficulties, experience their unique trauma, and perceive future recovery options. Ethnicity can also directly influence patients' outlooks on their pain, expectations of mental health treatment, and beliefs regarding the best course of treatment. Many cultures do not differentiate psychological, emotional, and spiritual reactions from more physical reactions; rather, they focus on the impact of trauma on the body as a whole. Additionally, cultural factors influencing individuals' beliefs about threats and response to danger can play an important role in how individuals respond to violent crimes (Office for Victims of Crime, 1998).

Healthcare providers should remember that every culture has a distinct framework or perspective about mental health and, as a result, distinct beliefs about the benefits of seeking mental health services. Counseling, in general, is a predominantly western practice and in some cultures folk healing, healing rituals, and secret societies are the commonly accepted forms of healthcare provision (Williamson, Dutch & Clawson, 2008). Mental healthcare providers should familiarize themselves with the beliefs, values and practices of the various cultures of their patients so they are able to provide culturally competent care.

V. Conclusion

Among the most devastating mental health consequences for victims of any crime can be the destruction of basic life assumptions; that one is safe from harm, one is a good and decent person, and the world is meaningful and just (Office for Victims of Crime, 1998). For victims of human trafficking, mental health problems can be compounded by the misconceptions about and limited understanding of the issue of human trafficking. Additionally, lack of social support and stigmatization by friends, family, and social institutions can exacerbate victims' mental health conditions (Office for Victims of Crime, 1998). Long-term population-specific studies are needed to provide evidence for the best treatment options to help victims of trafficking psychologically process the trauma they have experienced. However, until these studies are conducted and their results made available, mental health practitioners can base treatment options for this population on existing research findings and interventions found to be successful with other similarly victimized populations.

References

Agency for Healthcare Research and Quality. (2003, September). *Medical examination and treatment for victims of sexual assault: Evidence-based clinical practice and provider training* (Report to Congress: AHRQ Publication No. 03-R210). Washington, DC: Author.

Alexander, M. P., Kellogg, N. D., & Thompson, P. (2005). Community and mental health support of juvenile victims of prostitution. In S. W. Cooper, R. J. Estes, A. P. Giardino, N. D. Kellogg, & V. I. Vieth (Eds.), *Medical, legal and social science aspects of child sexual exploitation: Vol. 1* (pp. 397–421). St. Louis, MO: G. W. Medical Publishing, Inc.

American Psychiatric Association. (2005, January). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed.). Washington, DC: Author.

American Psychological Association. (2008). *Psychology matters: Glossary*. Retrieved from http://www.psychologymatters.org/glossary.html#p

Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry, 162,* 214–227.

Breslau, N., Kessler, R. C., Chilcoat, H. D., Schultz, L. R., Davis, G. C., & Andreski, P. (1998) Trauma and post-traumatic stress disorder in the community: The 1996 Detroit area survey of trauma. *Archives of General Psychiatry, 55,* 626–632.

Clawson, H. J., Dutch, N. M., & Williamson, E. (2008). *National symposium on the health needs of human trafficking: Background document.* Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Clawson, H. J., Salomon, A., & Grace, L. G. (2008). *Treating the hidden wounds: Trauma treatment and mental health recovery for victims of human trafficking.* Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological trauma: Theory, research, practice, and policy, S*(1), 86–100.

Drake, R. E., Goldman, H. H., Leff, H. S., Lehman, A. F., Dixon, L., Mueser, K. T., et al. (2001, February). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services, 52*(2), 179–182.

Family Violence Prevention Fund. (2005). *Turning pain into power: Trafficking survivors' perspectives on early intervention strategies.* San Francisco, CA: Author.

Fassa, A. G. (2003). *Health benefits of eliminating child labour*. Geneva, Switzerland: ILO Publications.

Howard, M. O., McMillen, C. J., & Pollio, D. E. (2003, March). Teaching evidence-based practice: Toward a new paradigm for social work education. *Research on Social Work Practice, 12*(2), 234–259.

International Organization for Migration. (2006). *Breaking the cycle of vulnerability: Responding to the heath needs of trafficked women in east and southern Africa.* Pretoria, South Africa: Author.

International Society for the Study of Dissociation. (2004). Guidelines for the evaluation and treatment of dissociative symptoms in children and adolescents. *Journal of Trauma & Dissociation, 5*(3), 119–150.

Karasu, T. B., Gelenberg, A., Merriam, A., & Wang, P. (2000, April). *Practice guideline for the treatment of patients with major depressive disorder* (2nd ed.). Arlington, VA: American Psychiatric Association.

Kleber, H. D., Weiss, R. D., Anton Jr., R. F., George, T. P., Greenfield, S. F., Kosten, T. R., et al. (2006, August). *Practice guideline for the treatment of patients with substance use disorders* (2nd ed.). Arlington, VA: American Psychiatric Association.

Mayo Clinic. (2007, March 1). *Mental health: Dissociative disorders, treatment and drugs.* Retrieved from http://www.mayoclinic.com/health/dissociative-disorders/DS00574/DSECTION=treatments-and-drugs

McIntosh, A., Cohen, A., Turnbull, N., Esmonde, L., Dennis, P., Eatock, J., et al. (2004, December) *Clinical guidelines and evidence review for panic disorder and generalized anxiety disorder.* Sheffield, London: University of Sheffield/London, National Collaborating Centre for Primary Care.

Miller, W. R. (2003, June 18). *Motivational enhancement therapy: Description of counseling approach*. Bethesda, MD: National Institute on Drug Abuse. Retrieved from http://www.nida.nih.gov/adac/ADAC9.html

Moran, M. (2007, February 2). Development trauma merits *DSM* diagnosis, experts say. *Psychiatric News, 42*(3), 20.

National Institute for Clinical Excellence. (2004, December) *Depression: Management of depression in primary and secondary care* (Clinical Guideline 23). London: Author.

Nowinski, J. (2003, June 18). *Twelve-step facilitation.* Bethesda, MD: National Institute on Drug Abuse. Retrieved from http://www.nida.nih.gov/ADAC/ADAC10.html

Office for Victims of Crime. (1998, August). New directions from the field: Victims' rights and services for the 21st century, mental health community (NCJ No. 172819). *OVC Bulletin.* Washington, DC: Author.

Office of Mental Health and Addiction Services. (2008, December 2). *Trauma.* Retrieved from http://www.oregon.gov/DHS/addiction/trauma.shtml

Otto, M. W., Smits, J. A. J., & Reese, H. E. (2004). Cognitive-behavioral therapy for the treatment of anxiety disorders. *The Journal of Clinical Psychiatry*, *65*(Suppl. 5), 34–41.

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and 'use-dependent' development of the brain: How 'states' become 'traits.' *Infant Mental Health Journal, 16*(4), 271–291.

Pfefferbaum, B. (1997, November). Posttraumatic stress disorder in children: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(11), 1503–1511.

Pico-Alfonso, M. A. (2005). Psychological intimate partner violence: The major predictor of posttraumatic stress disorder in abused women. *Neuroscience and Biobehavioral Reviews, 29*, 181–193.

Putnam, F. W. (2003, March). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, *42*(3), 269–278.

Ramchandani, P., & Jones, D., P. H. (2003). Treating psychological symptoms in sexually abused children. *The British Journal of Psychiatry, 183*, 484–490.

Rauch, S. A., & Cahill, S. P. (2003). Treatment and prevention of posttraumatic stress disorder. *Primary Psychiatry, 10*(8), 60-65.

Raymond, J. G., D'Cunha, J., Dzuhayatin, S. R., Hynes, H. P., Rodriguez, Z. R., & Santos, A. (2002). *A comparative study of women trafficked in the migration process: Patterns, profiles, and health consequences of sexual exploitation in five countries (Indonesia, the Philippines, Thailand, Venezuela, and the United States).* New York, NY: Coalition Against Trafficking Women International.

Seedat, S., Stein, D. J., & Carey, P. D. (2005). Post-traumatic stress disorder in women. *CNS Drugs, 19*(5), 411–427.

Ursano, R. J., Bell, C., Eth, S., Friedman, M., Norwood, A., Pfefferbaum, B., et al. (2004, November). *Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder.* Arlington, VA: American Psychiatric Association.

Weersing, V. R., Lyengar, S., Kolko, D. J., Birmaher, B., & Brent, D. A. (2006). Effectiveness of cognitive-behavioral therapy for adolescent depression: A benchmarking investigation. *Behavior Therapy, 37*, 36–48.

Williamson, E., Dutch, N., & Clawson, H. C. (2008). *National symposium on the health needs of human trafficking victims: Post-symposium brief.* Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Zimmerman, C. (2003). *The health risks and consequences of trafficking in women and adolescents: Findings from a European study.* London: London School of Hygiene & Tropical Medicine.

Zimmerman, C., Hossain, M., Yun, K., Roche, B., Morison, L., & Watts, C. (2006). *Stolen smiles: A summary report on the physical and psychological health consequences of women and adolescents trafficked in Europe.* London: London School of Hygiene & Tropical Medicine.