Sex trafficked survivors' recovery: program evaluation of Transitions Global Cambodian safe house

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Transitions Global Cambodian Safe House

by

Robyn J. Honeycutt

Presented to the Faculty of the
Graduate Department of Clinical Psychology
George Fox University
in partial fulfillment
of the requirements for the degree of
Doctor of Psychology
in Clinical Psychology

Newberg, Oregon
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Abstract

The majority of sex trafficked victims are women and girls who have been physically and psychological coerced. Both private and government agencies have targeted this modern day form of slavery, producing efforts of prevention, intervention, and restoration for survivors. This study evaluated the restorative accomplishments of Transitions Global Cambodian safe house program, currently serving 22 sex trafficked females, ages 14 to 22. The specific focus of this evaluation was to gain an understanding of the experiences these young females have endured and the salient aspects contributing to their process of recovery. Semi-structured interviews were used with selected participants and staff members. Pre-test archival intake data and post-test data obtained during the evaluation, including the Hopkins Symptom Checklist, Harvard Trauma Questionnaire Part IV, and demographic information and program records were also analyzed. Qualitative data were gathered through interviews and observations of the girls’ participation in the program over an 18-day period. Suggestions for improving the program are discussed, as
well as questions for future research. It is hoped that further research will provide empirically supported best practices for the treatment of sex-trafficked survivors.
Acknowledgements

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Chapter 1

Introduction

The American Psychological Association (APA) has endorsed various policies that affirm and protect the welfare and dignity of all people, including those who are oppressed and marginalized by society. The APA has taken positions against torture (APA, 2009), male violence against women (APA, n.d.a.), and against the sexualization of girls (APA, n.d.b). An emerging area of interest among mental health professionals is the violation of human rights against victims of the sex trafficking industry (Chi-Ying Chung, 2009). APA Division 35, the Society for the Psychology of Women championed the fight against trafficking in its first film, The Psychology of Modern Day Slavery. This 2012 vimeo was created to motivate and educate psychologists regarding the problem of human trafficking, calling them to action and awareness, and detailing anti-trafficking work that can lead to the prevention of trafficking (Bryant-Davis, 2012).

Defining the Sex Trafficking Problem

The United States Department of State set forth the definition of sex trafficking in the Trafficking Victims Protection Act of 2000. It is defined as “a commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age.” (U.S. Dept. of State, 2009) A commercial sex act is the exchange of any sexual act for anything of value. Accordingly, the business of sex trafficking is for profit. This relatively low risk enterprise with minimal criminal penalties produces high profits and enormous harm to
victims. While anyone can become a trafficking victim, the majority of those targeted are women and girls. Traffickers use both psychological and physical force to obtain their victims. These tactics commonly include situations such as described in the Sex Trafficking Fact Sheet, 2009:

- “A promise of a good job in another country
- A false marriage proposal turned into a bondage situation
- Being sold into the sex trade by parents, husbands, boyfriends
- Being kidnapped by traffickers” (p. 1).

Once in bondage, a variety of methods are used to condition victims to remain, including “starvation, confinement, beatings, physical abuse, rape, gang rape, threats of violence to the victims and the victim’s families, forced drug use and the threat of shaming their victims by revealing their activities.” (Sex Trafficking Fact Sheet, 2009, p. 1) The victims also face numerous physical and mental health problems placing them at high risk for contracting diseases, infections, injuries, addictions, long-term emotional difficulties, or death.

The 2009 U.S. Department of State Trafficking Persons Report estimates that at any given time “at least 1.39 million are victims of commercial sexual servitude, both transnational and within countries” (p. 10). Other estimates are even higher (Barnitz, 2001) with some judging numbers up to 2.2 million children sold into the sex trade each year (Witness Justice e-Newsletter, 2008). The covert and criminal nature of this hidden economy hinders a precise appraisal of its magnitude, but there is agreement on the source of the problem. Sex trafficking exists and thrives because of the demand for its product. Factors contributing to the demand include those who purchase sex acts, exploiters who profit from the industry and its supporting services, countries tolerating or legalizing prostitution for sex tourism, and cultures that
encourage and glamorize sex through the internet and media (Hughes, 2006). In his book *Sex Trafficking*, corporate executive Siddharth Kara (2009) reported that, “the commercial exploitation of trafficked sex slaves generated $51.3 billion in revenues in 2007, the result of millions of men purchasing sex from slaves every day. After costs, the slaves’ exploiters cleared $35.7 billion in profits, or a global average of $29,210 per slave.” (p. 19). In fact, sex trafficking is noted to be the third most lucrative criminal enterprise after the sale of arms and drugs (The Captive Diaries, 2009). Demand and economic return encourages the proliferation of sex trafficking. The continuous demand requires that every woman and child rescued from this industry be immediately replaced. This expanding surreptitious market poses a seemingly impossible dilemma for those in opposition. As expressed by the United Nations, “It is invisible, mobile, global, escalating, and a highly profitable business,” (Emke-Pouloupoulos, n.d., p. 4).

When women and children are traumatized through sexual exploitation, the emotional and physical consequences are far-reaching. Treatment strategies and services have increased to meet these specific emotional and physical needs of trafficked persons. In a study documenting the health symptoms of trafficked women and adolescent girls, Zimmerman et al. (2008) measured the physical and mental symptoms of 192 women and girls interviewed within 14 days of their entry into posttrafficking care. According to their research, more than half of the women and adolescent girls (57%) scored at or above the cut-off point in the posttrauma-symptom subset of the Harvard Trauma Questionnaire, suggesting posttraumatic stress disorder (PTSD). Data obtained in another exploratory study, conducted in the United States, focused on uncovering common diagnoses and treatments of victims of sexual exploitation in human trafficking. Thirty
service providers reported similar findings. “The most common type of diagnosis encountered among those providing treatment was PTSD” (Black, 2008, p. 98) at 88.5%.

However, one can presume that trauma extends far beyond a prevalent diagnosis. The victims’ suffering may often continue throughout their lifetime. These women are frequently economically disadvantaged, socially displaced, emotional and mentally weakened, and physically ill. Among the many problems these women face, many will not survive because of disease. “Injuries and abrasions sustained during sexual contact heighten physical vulnerability to AIDS transmission. And young girls’ physically immature bodies are highly vulnerable to injuries, significantly heightening their risk of infection. Moreover, having other sexually transmitted diseases (STDs) heightens the risk of contracting HIV.” (Burkhalter, 2004, p. 1). This alone is monumental, but unfortunately the ramifications go beyond the physical destruction of the body to the violation of the human spirit.

Sex is an integral dimension of the human being, of the self. When it is treated as a thing to be taken, the human being is rendered into a thing, an objectification that not only violates human rights but also destroys human dignity… It is a violation of the most intimate and personal aspect of the self. (Thompson & Buller, 2009, p. 4)

**Responding to the Problem**

In recent years efforts to combat sex trafficking have grown. Out of these efforts, comprehensive approaches have evolved to include education and prevention, intervention and rescue, and restoration with the goal of physical and emotional healing for sex trade survivors. Both private and government agencies have targeted this modern day form of slavery, which exists solely for the purpose of supplying buyers with sex. Education is used to promote
increased awareness of this issue. Using the motto, “An ounce of prevention is worth a pound of cure,” awareness campaigns make “Be Smart, Be Safe” brochures available in efforts to educate women at risk and to impede the sex trade industry (Humantrafficking.org, 2009).

Unfortunately, preventing abduction and abuse does not help those already enslaved. Domestic sex-traffickers, commonly referred to as pimps, target vulnerable youth, runaways, and the homeless, with an average age of entry into prostitution at 12-13 years old (Polaris Project, 2009). Interventions involve rescuing victims and holding their captors accountable. Organizations provide aftercare to survivors of oppression, equipping them to rebuild their lives and responding to the complex emotional and physical needs that are often the result of the abuse (International Justice Mission, 2009).

Though there is not an extensive literature in psychology regarding prevention or intervention with former sex-trafficking victims, it seems clear that a need exists. Many of the effects of sex-trafficking on victims and survivors are psychological. Chi-Ying Chung (2009b) writes,

The abuses of power have consequences with short- and long-term psychological effects on individuals, their families, and communities. Psychologists can no longer ignore the psychological impact of the abuses of power and therefore a primary focus of their work must be towards the elimination of abuses of power through human rights and social justice. This can be achieved on multiple levels that incorporate individual-community, systemic, and global levels. (p. 89)
On a fundamental level, understanding the magnitude of the problem is essential. Being willing and prepared to offer education to clients, their families, and the general public, are primary ways to provide preventative and restorative measures.

 Trafficking networks to and from the United States are flourishing (The Future Group, n.d.), therefore it is unlikely that the problem will escape psychologists in either private or primary care practices. It may be helpful to adopt forms of assessment and treatment that use indigenous healers as well as “expands mainstream Western psychotherapy to include such techniques as narrative therapy, dream work, drama, art, storytelling, and drumming. This approach is particularly important when working with individuals and families in relationship to child trafficking issues,” (Chi-Ying Chung, 2009b, p. 89). As in every psychotherapeutic healing relationship, it is essential that cultural respect be paramount. Chi-Ying Chung (2009) emphasizes that “psychologists must work from a holistic framework that includes acknowledging, recognizing and understanding cultural values, beliefs, attitudes, historical, psychopolitical, socioeconomic and environmental perspectives and how these factors all contribute to the abuse of power” (p. 90).

 For psychologists committed to advocacy, there are political efforts that offer support, such as providing feedback to policymakers, advocating for governmental and international change, and supporting efforts to provide alternative work options for survivors. (Chi-Ying Chung, 2009b). Still others may use their expertise to continue research and program evaluation, helping to strengthen the work that is being accomplished with sex trafficking survivors. Unlike traditional experimental research designs, program evaluation tends to use less rigorous
methodologies that have a high degree of ecological validity in a real-life context. Posavac and Carey (2003) note that

program evaluation is a collection of methods, skills, and sensitivities necessary to determine whether a human service is needed and likely to be used, whether the service is sufficiently intensive to meet the unmet needs identified, whether the service is offered as planned, and whether the service actually does help people in need at a reasonable cost without unacceptable side effects. (p. 2)

The purpose of this study is to provide a program evaluation for an organization in Cambodia that offers services to former sex trafficking victims.

**Transitions Global**

Transitions Global was founded in August 2007, by James and Athena Pond. This couple’s work began two years earlier, with Cambodian and Vietnamese survivors of sex trafficking, in Phnom Penh, Cambodia. Their goal is to provide girls, 13-19 years of age, with the opportunity both to heal from their past and to gain the life, social, and business skills necessary to prepare them to function as independent and healthy adults. The program focuses on the girls’ rehabilitation and reintegration into the community, providing comprehensive aftercare services. “This is accomplished through a continuum of care consisting of psychological, social, educational, and health services, as well as, job training and placement, keeping the individual girl’s needs and desires at the forefront” (Volunteer Network to End Human Trafficking, p. 1).

The Transitions Global model, addressing the needs of minor victims of sex trafficking (MVST), has been used to develop similar programs in other countries, including Greece and Indonesia. They are also in the process of establishing four new shelters in Mumbai, India over
the next three years, which will serve the needs of Indian, Nepalese, and Bangladeshi girls that have been sexually trafficked. Transitions Global also began its Domestic Trafficking Initiative after becoming aware of the need for aftercare services for American girls that have been sexually trafficked. (Midchix & Madhens, p. 1)
Chapter 2

Methods

Participants

Participants in this study were twenty-five Cambodian females, ages 14 to 23 years old, who have received services from Transitions Global within the past four years. At the time of this evaluation, 17 of the participants were residents in the Transitional Living Center (TLC; with a mean age of 16.5 years), 5 were in Secondary Transitional Apartment Residences (STAR; with a mean age of 20 years), and 2 were graduates (with a mean age of 22.5 years) of the program living independently. Other participants were Transitions Global staff and affiliates of the site in Phnom Penh, Cambodia, including the founder and director of the program, clinical director, two social workers, two caseworkers, four house moms (n = 10). Interviews of TG affiliates included discussions with a Cambodian researcher, a psychologist in Cambodia, the yoga instructor, and several aftercare organizations for sex-trafficked victims in the Phnom Penh area.

Instruments

Two semi-structured interviews were written for use with selected residents and all staff members (see Appendix A). At the organization’s request, the residents’ interview did not address history of trauma, in order to avoid unnecessary re-traumatization. The focus was primarily on benefits they have gained through the program and hopes they have for their future.
The staff interviews were used in order to collect information about the girls’ process of recovery.

**Harvard Trauma Questionnaire (HTQ).** The HTQ (Mollica et al., 2003) has been translated into Cambodian for use with Southeast Asian refugees (see Appendix B). It is a cross-cultural instrument which has been used to measure trauma, torture, and posttraumatic stress disorder. It consists of four sections inquiring about a variety of traumatic events, as well as the emotional symptoms considered to be uniquely associated with trauma. The first section includes questions about 17 traumatic life events determined to affect Southeast Asian refugees. The second part contains open-ended questions about the individual’s traumatic experience, and the third part asks about events that may have led to head injury. The fourth part inquires of 30 trauma symptoms measuring posttraumatic stress disorder (PTSD) and specific symptoms of refugee trauma. Responses in part four include a Likert-type scale with four possible responses ranging from *(Not at all, A little, Quite a bit, Extremely* rated 1 to 4, respectively). Only the fourth section of the HTQ was used for this study in order to minimize the possibility of re-traumatization.

**Hopkins Symptom Checklist-25 (HSCL-25).** The HSCL-25 was originally designed in the 1950s as an anxiety and depression screening assessment tool. The Harvard Program in Refugee Trauma (HPRT) later translated the HSCL-25 to be used in multi-cultural settings (see Appendix C). The HSCL-25 contains two parts. Part 1 has 10 items, which assesses symptoms of anxiety and part 2 has 15 items, which assesses symptoms of depression. Responses are selected for each question, from four categories *(Not at all, A little, Quite a bit, Extremely* rated 1 to 4,
respectively). The assessment is scored by averaging the scores from parts one and two. The HPRT (2010) reported that it has been consistently shown in several populations that the total score is highly correlated with severe emotional distress of unspecified diagnosis, and the depression score is correlated with major depression as defined by the *Diagnostic and Statistical Manual of the American Psychiatric Association, IV Version* (DSM-IV).

**Procedures**

The founder and director of Transitions Global expressed interest in a program evaluation of his organization’s work in Phnom Penh, Cambodia. Drawing from a program evaluation model designed by Dominguez and McMinn (2005), the organization’s leaders were asked to determine the questions they would like addressed, rather than using standardized, pre-determined questions. This method was selected in order to maximize the benefits to this organization, narrowing the focus to address the issues they deemed most important. The Director requested that the evaluation be focused on benefits gained by the girls during their stay in the program. Collaboration with the clinical director of the program led to establishing the goals of the program evaluation and to determine the necessary ethical procedures required. A local Cambodian translator was employed to translate the informed consent and to read it to the girls and staff before they participated in the assessments and interviews (see Appendix D). Verbal assent was obtained from each participant in this study.

The resulting decision, after collaborating with the Transitions Global staff, was that the emphasis of this evaluation would be on the perceived changes in the residents well being, as noted from their self-reports and the staff’s observations. In 1948 the World Health Organization...
proposed a definition of health that has not been amended since that time. It states that health is “a state of complete physical, mental and social well-being, not merely the absence of disease,” (p. 28). Based on this holistic view of health, the proposed program evaluation will address the residents’ perceptions of improved physical and emotional healing; changed thinking, attitudes, and behavior; and increased social, educational, and occupational skills.

An interview was conducted with the clinical director, whose answers reflected knowledge gained through her personal experiences with each of the TG residents. The clinical director communicated the feedback she had received from the girls regarding their experiences at TG, along with her own impressions. Other interviews were conducted with selected residents currently participating in the program, graduates of the program, TG staff members, and affiliates. Qualitative observations were made of the girls in their daily activities, and archival data were collected from the girls’ intake into the program. Quantitative data was obtained from assessments given 10 weeks prior to this research and at the time of the research, including Part IV of the Trauma Symptoms Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptoms Checklist. Additional information was obtained through the examination of the program’s model. All data were placed in categories and analyzed for commonly recurring themes, revealing the most beneficial aspects of TG’s treatment model. After data analysis, results were communicated with the Transitions Global director.
Chapter 3

Results

Qualitative Results

From interviews conducted and observations made, a picture of survivors’ experiences with Transitions Global (TG) emerged. After contemplation of the research experience, 30 categories were initially proposed, representative of the emphases of TG’s treatment program. These were later reduced to 27 categories as it was decided to merge 3 categories with homologous attributes. After the categories were determined, written and recorded notes were examined from two perspectives, including this researcher and a colleague. Because of the multilingual nature and wide variety of data collection efforts, and because a somewhat diffuse program evaluation focus was chosen over specific research questions, it was deemed unreasonable to compute independent inter-rater reliabilities on these categories. Instead a more collaborative, dialogical approach was used to evaluate each of the interviews and personal observations. All written and recorded data sources were first analyzed and indexed by text to their corresponding sub-category. At this point, the research advisor and a graduate assistant were also asked to examine the results and a suggestion developed, to collapse the sub-categories into themes. The data yielded the following five themes (see Appendix E) representing primary benefits the survivors gained while in treatment at TG: Psychological Recovery, Increased Independence, Positive Social Relationships, Improved Physical Health, and Reintegration into Community. The theme of Psychological Recovery was most prominent. Secondary to this,
Increased Independence, Positive Social Relationships, and Improved Physical Health were discussed a great deal. A final category identified was Reintegration into Community.

**Psychological recovery.** Psychological Recovery is an extremely important and complex theme. TG recognizes that mental health recovery is primary to their program. A great amount of time and resources are spent on the psychological well being of survivors. Therefore, it is not surprising that this theme emerged as often as it did. For the residents at TG, psychotherapy and counseling provides a foundational structure for psychological healing. The home atmosphere exudes safety and a sense of security, encouraging emotional expressiveness and providing the basis for emotional stability. Yoga is also an integral part of the treatment of trauma; survivors are required to attend weekly yoga classes. Though attending spiritual services are not mandatory in TG’s program, some of the residents find their spiritual and religious beliefs contribute to their psychological health as well.

Weekly counseling is a vital part of the TG treatment plan with sessions ranging from one to three times a week, determined by the residents’ psychological needs. The Integrative Treatment of Complex Trauma for Adolescents (Briere & Lanktree, 2008) is foundational to the therapeutic services provided; however TG also encourages their counselors to take an integrated approach, drawing from any therapeutic modality that fits the individual’s treatment goals. The emotional processing taught in therapy, such as identifying and validating feelings, is new to many of the survivors. In order to endure the trauma of forced sex, the girls have learned to dissociate from the reality of their horrors. The goal of therapy is to build rapport and trust with each girl, providing emotional support and validation of their trauma narrative. For example, psychoeducation equips the residents with a cognitive understanding of their physiological and
emotional responses to their trauma memories. Girls learn to use coping strategies such as affect regulation and distress tolerance skills to reduce anxiety and other symptoms of trauma. With consistent treatment, staff reported that residents do gain an increased sense of safety, the ability to cope and regulate emotions, and a desire to engage in healthy relationships that include trust. For example, one girl “had complete meltdowns when she first came to TG, crying, head banging… completely destructive. She just couldn’t pull herself out of it. Staff would work with her for hours, building up her self-esteem, talking her through it. We helped her to write a trauma narrative and now she can identify where her fears are in that story.”

Counseling ensures there is a healing structure in place as the girls’ explore particular areas of growth, goals, and even dreams for the future. For example, immediate goals for some victims include seeking prosecution of their perpetrators, often resulting in reduced feelings of powerlessness and increased hope. One resident worked on anxiety-reducing techniques in counseling sessions but experienced limited success. During the trial of her perpetrators a significant change took place; she overcame fears when she was given the opportunity to testify. The resident explained, “When I saw them in handcuffs, I realized they’re not in control of me anymore.” Seeing her perpetrators convicted and sentenced to prison provided a cathartic healing experience. In this instance, therapeutic techniques had limited effectiveness until justice validated her experience. For other residents, moments of emotional release and healing are experienced through the practice of yoga.

Yoga is a vital part of the TG treatment model, complimenting the trauma recovery process by instilling a sense of mental strength and control. By trial and error, the resident’s yoga instructor discovered that mindfulness offers great benefits to survivors. She explained, “We
began with group discussion, teaching anatomy, and practicing yoga positions, then discovered that by connecting and building trust, the girls were ready to go from outward awareness to inward awareness.” The yoga instructor found that although the girls resisted mindfulness, it was a great healing tool and coping strategy. Mindfulness is practiced through connecting physical awareness with associated emotional sensations. The instructor explained that simply rolling your shoulders can be a startling connector. Sitting in meditation and doing breath work is so hard and brings up horrors. [For example,] When a girl is in the dolphin pose looking around with her head up, it is understood that she is fearful. Agency, awareness, and strength are in the movements.

After going through the process of recovery at TG, many residents have become yoga instructors. One young woman stated, “Before yoga, I didn’t know what was inside me. But now I know how to name what is inside me and how I feel. A door opened and the cloud was cleared. Putting it into language is a therapy.” Along with emotional benefits, yoga teaches motivation through the hard work of physical and mental practice, providing concrete changes in body and mind. Doing yoga is both a physical and emotional triumph for victims of sexual slavery. Unlike the experience of being stripped of control over their bodies, yoga returns their power and restores a sense of physical control; the girls are becoming trained in their ability to match physical poses with the feelings associated with them. The physical triumph of being able to do yoga is a associated with the triumph of controlling their emotions.

In a country where religion is prevalent, TG does not focus on the spiritual and religious views of the survivors they work with. While most of the TG staff are Christian, religion is not emphasized in their work. TG staff explains, “We don’t believe it is ethical to impose Western
religion on someone recovering from trauma. If you tell them Jesus loves them, they all want to please you so they become a Christian.” Another staff member noted their desire to avoid presenting the residents with the spiritual dilemma of how a good God could allow them to have suffered such trauma. Residents are allowed personal spiritual and religious expression and are provided transportation to religious services when they request to attend. Throughout the therapy journey, survivors are encouraged to create and nurture dreams about their future and life purpose, leading to increasing independence.

**Increased independence.** The theme of Increased Independence was reported within the data by language describing Personal Autonomy, Education, Job Skills Training, Employment, Recreation and Leisure. The further girls progress in their recovery process, the more able they are to explore goals for their future. TG emphasizes helping survivors to create and sustain dreams for their future and life purpose. Each girl is encouraged to create a dream book and are asked, “What do you want to do?” Residents share the path of seeking recovery, while their dreaming for their future is individual and unique.

Every girl at TG is not just dreaming, but working toward their dream with the tangible support of TG. Twenty out of the twenty-two residents in the program are enrolled in schools or vocational training specific to their desired trade, and graduates are living their dreams. Common aspirations include cooking, tourism, teaching, farming, social work, graphic arts, yoga, and childcare. In one instance, prior to coming to the center, one girl had no education. She was tutored at the center every afternoon, studying English and Computer for a year. She dreamed of being a tailor and so TG sent her to sewing school but she struggled in learning the trade. Then she was sent to another school to increase her secretarial skills but she could not retain
information. TG was committed to continue searching for a job skill that she could find success in; eventually she found her fulfillment in becoming a yoga instructor.

The girls in the STAR program share an apartment as a transitional stage between living at the shelter and full reentry into society. During this time, they are trained in life skills necessary for independent living, including learning financial management. Each girl is required to save a percentage of her earnings. These girls typically have never had their own money or have felt pressured to send what they had to their poor and sick family members. As one resident explained their cultural belief, “A good daughter does what her family wants her to do. If the family feeds you, you owe that back to them.” TG helps the girls to plan for their own future. After saving 60% of her earnings for some time, one resident was also able to take a loan from TG in order to purchase land in her name rather than in her family's name. TG staff explains,

This girl had grown up with a mother who was sick and impoverished. She agreed to go to work with her friend… and was manipulated to sign a document she couldn’t read [in order] to get food for her family, then was forced to have sex with 10 to 20 men a day. Today, as a landowner, she feels pride in having this responsibility and is steadily working at two jobs in order to repay her debt. While hard work and responsibility are taught at TG, the residents are also provided the opportunity for well-rounded living that includes time for recreation and leisure.

The resident environment encourages normal adolescent activities and interactions. Some of the girls’ favorite things to do at the home are karaoke, dancing, dressing up and art. Pictures drawn by the residents line the walls of TG. Group outings to the beach, water park, zoo, bowling, and to the mall for ice cream are regular occurrences. As Cambodia is also known for
its national holiday celebrations, recreation and leisure often include celebrating cultural holidays. While it is not always safe for residents to have contact with their family members, when possible TG encourages the girls to spend holiday times with their loved ones. One dad calls frequently to thank TG for caring for his daughter. She can't live with her parents because her perpetrator is their neighbor, but when the family invited the TG residents out to their home for the Cambodia New Year, the TG staff and girls enjoyed this family’s hospitality. Part of increasing independence and having a healthy sense of self is the ability to attach in beneficial ways with others. TG encourages and supports positive social relationships, first within the walls of TG, and then through the process of reestablishing positive social relationships with the residents’ families of origin and their broader community.

**Positive social relationships.** Positive Relationships, Established Friendships, Safe and Secure Home, Guidance Mentors, and Parental Figures comprise the theme Positive Social Relationships. Throughout the recovery process, TG desires to foster and enhance positive relationships. Relationships are established with guidance mentors who are often parental figures. This includes the household director (with TG since it’s inception), house moms (parallel to a parenting role), interns who act as brothers and sisters (teasing and playing with the residents), case managers (coordinating care) social workers (providing counseling), and the directors who champion them on throughout their recovery journey.

TG is also committed to employing Cambodian staff and has found that benefits far outweigh possible problems; these men and women offer invaluable cultural expertise interacting with the residents. In particular, men of character working at TG, model appropriate male behavior, helping the girls learn respect for themselves and for their gentlemen leaders. The men
receive training addressing the issues facing residents and are careful to give appropriate touch as well as to avoid being alone with the girls. One staff member commented,

The girls desperately need healthy male models. Our men are unbelievable with them, gentle and cognizant of their issues and of the areas where they need to be careful. Case assignments are often based on whether a girl would benefit most from a male or female therapist. A male counselor often offers a reparative relationship that changes her life.

TG’s safe home and community is a place where trust, respect, and security are fostered. Living in an environment where these values are sought and lived out, is often a reparative and life-changing experience for the residents. Their past experience of home and community bore betrayal, deceit, and lost innocence at the hands of perpetrators who were often previously trusted family members and neighbors. TG intentionally provides protection for the girls in route to and from school or work, for as long as it takes them to recover a sense of safety. A staff member noted that one girl was anxious the first day of school so her counselor rode with her and continued to accompany her in the van each morning until the girl relaxed and felt ready to go to accompany the other girls without her. The girl was very close to the counselor and treated her like a mom.

Another aspect of providing an emotionally safe home for the residents, involves providing adequate support in a group living environment. The girls spend much of their time together and consequently experience normal adolescent conflicts. When needed, the girls know that the counseling room is set apart as a safe place to be used only for counseling. While the rest of the home is in a constant flurry of activity and change, the counseling room remains predictable and unchanged. There the girls are taught to express their frustrations and understand
that they have needs, opinions, and desires. Then they are encouraged to express themselves in appropriate ways with their group sisters and parent figures. The house moms and counselors offer mediation when conflicts arise and encourage bonding during family activities such as eating together and bedtime routines. Girls share bedroom space in comfortable rooms they have helped decorate. One counselor observed, “They take a lot of joy from each others’ company and encourage each others’ successes. One girl got a 100 on an exam and everyone exploded with cheering.”

TG’s founders also provide stable parental figures. The directors have sacrificed a comfortable Western lifestyle to provide Cambodian sex-trafficked victims the opportunity to become survivors. They treat each girl as an adopted daughter, delighting in her recovery and her journey towards becoming a woman. The girls readily return this exchange of love and admiration. When meeting to interview two of the graduates of TG, the young women sat by Athena Pond during the ride to the café. They were very glad to see her, hugging and chatting with her. As she talked to them about their families and jobs, she freely offered parental like advice and support and they eagerly accepted her direction.

Residents also learn to interact with visitors in a healthy way, learning social skills through welcoming guests and supporters of TG. The girls willingly tell their stories and share their lives with these visitors, giving hugs, performing songs and dances, and showing hospitality. From the beginning of treatment, TG seeks to include the residents’ family of origin in care and treatment, realizing that despite their abusive histories, the girls still desire to have relationship with their families. Always considerate of safety, family members are also welcome visitors.
**Improved physical health.** Improvement in Physical Health was demonstrated by the following categories: Nutrition and Health Care, Access to Medical Care, Protection from Reentry into Sex Trafficking, Abstinence from Drugs and Alcohol, and Decreased Somatization.

Assessment of the girls’ physical status is part of the intake process. When the girls arrive at the center, they are often malnourished and physically ill. Most have never learned about healthy nutrition or had access to a well-balanced diet. At TG meals are prepared by house moms and are required to include protein and vegetables for at least two meals each day. Initially the residents are given unlimited servings of food, until they understand they will not be deprived of food. Many come from situations where they were always hungry, never knowing when they would receive their next meal.

Some TG residents arrived with multiple health care issues after a dearth of medical resources. They are taught basic hygiene skills and are provided products to care for their bodies. Each resident is taken to a medical examination and is given needed treatment. All medical progress is tracked, including incident reports and medication logs, kept up to date on the office wall. Common physical maladies include sexually transmitted diseases, dental problems, body odor, stomachaches, hepatitis, and ovarian cysts. Most girls respond quickly to improved medical care with only a few requiring ongoing treatment.

Unfortunately some residents contracted diseases from their abusers that have life-long effects. One young woman explained, “I found out I was HIV positive when I was 14. It felt unfair. I’m the only one at the shelter who has it.” The TG staff was supportive throughout her process:
We told her that we loved her, that we care for her. We don’t hold back in any way in caring for her. We tell her she’s not alone, that we’ll always love her. We try to help her and be with her as much as possible.

One of the residents’ basic needs, provided during the rehabilitation process, is physical protection during their emotional recovery. While participating in TG’s program, every precaution is taken to ensure that 100% of the girls are protected from re-entry into sex trafficking. All of the girls are required to abstain from drug and alcohol use, that could derail their progress, and lead to emotional and health problems. When a resident feels physically healthy and she is confident that these needs will be met each day, this prior obstacle is removed and she can focus her energies on emotional healing, learning to make choices that will decrease the probability of re-entry into the sex trade. Integrating physical well being with emotional healing is essential as the residents’ prepare for reintegration into their communities.

Reintegration into community. This final theme was observed through the residents’ Reintegration with Family and Community, Service to Community, and Public Speaking about their experiences. The ultimate goal of TG is for residents’ who have received emotional, physical, and relational healing, to reenter their communities in new and meaningful ways. Reentering the community includes sharing apartments with other TG residents, getting married, starting a family, or moving back to their hometowns. For example, one graduate is now married and lives with her husband and his family. She shared, “It doesn’t feel like it’s been a challenge to start a new life since leaving the program. In the shelter people are really helping us to stand on our own two feet and be like other people. They taught me to face real life outside the shelter, what to do and what not to do. I was told I still have a long future ahead, that really encouraged
me.” Some of the girls find it rewarding and are given the opportunity to share their experiences of recovery with others in their community and around the world.

When sex-trafficked survivors tell their stories, they often find deeper meaning and purpose for their lives. The barbarity of sex slavery will never be understood or condoned, however in the telling of their experiences, others are inspired by their resilience. Supporters move beyond compassion to action, providing resources and funds to ensure continued rescue and recovery of sex-trafficked victims. TG facilitates the opportunity for some residents to travel and speak to worldwide audiences, sharing their personal stories of suffering and transformation. Two STAR residents have stood before large groups, as living, breathing witnesses to the depths of human depravity and the heights of human courage. Another resident shared her story of survival with a group of visitors to TG. A staff member reflected, “She felt emotional and those emotions were congruent with her story. We were impressed with her ability to express herself powerfully while also expressing the emotion of her experience.”

Through interviews and observations this study presented a look into the efforts of one couple who were appalled at the worldwide problem of sex trafficking, and took steps to make a difference in the lives of sex trafficked survivors in Phnom Penh, Cambodia. The results of their work have been reviewed in this research. The holistic approach taken at TG provides survivors with the necessary treatments for physical and emotional recovery, as well as promoting future focused thinking. In addition to the personal recovery of each girl, TG encourages their residents to give back to the community through work and the retelling of their experiences, so that others may also be rescued and receive healing from their traumas. The founders’ commitment to a
“whatever it takes” kind of treatment enables the staff to seek out individualized treatment for each girl. This was seen as a great benefit and a contributing factor in the girls’ recovery process.

**Quantitative Results**

Quantitative analyses detected no significant changes between the TG residents’ pre- and post-test assessments, measuring the following: PTSD Symptoms, Self-Perception of Functioning, Anxiety Symptoms, and Depression Symptoms (see Table 1). An assessment protocol was established for TG intakes, ten weeks prior to this research. As a part of this protocol, in March of 2010 all residents at TG were given the HTQ Part IV and the HSCL.

Table 1

*Scales from Part IV: Trauma Symptoms of the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptoms Checklist (HSCL)*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-Mean</th>
<th>Post-Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD Symptoms</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Self-Perception of Functioning</td>
<td>1.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Anxiety Symptoms</td>
<td>1.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Depression Symptoms</td>
<td>2.0</td>
<td>1.9</td>
</tr>
</tbody>
</table>

*Note.* The Harvard Program in Refugee Trauma (HPRT) recommends a cut-off of ≥ 2.00 to indicate probable PTSD and a cut-off of ≥ 1.75 to indicate emotional distress and major depression.
These assessments were repeated during this research and results were compared. The following table notes the similarities in results between these two test administrations, including the observation that residents were experiencing clinical symptoms of emotional distress, major depression, and probable PTSD at the time of both administrations.

Qualitative data help provide insight in regard to the intensity of emotional trauma symptoms TG residents’ experienced, implicating the challenges faced by organizations and professionals providing recovery services. Upon entering treatment, the survivors were in a state of insecurity and instability, initially struggling to express their trauma narratives. As one TG staff member noted, “dissociation is the Cambodian baseline, so many of the people are focused primarily on surviving, unaccustomed to talking about their feelings and emotions.”

Compounding the challenge of understanding cultural dispositions toward suppressing emotional expression, the TG residents had been conditioned through their sexual victimization to repress all feelings of pain or personal desire, robbed of identity and stripped of hope for the future. Given this history, it is not surprising that they enter treatment with clinical symptoms of emotional distress. The post-test data suggests that the careful approach taken by TG to provide these survivors with the needed time and support to process their abuse was sufficient for them to begin healing without retraumatization. As the residents were physically and emotionally provided for, they were liberated to honestly consider the damage done to them and to begin the healing process. The unremarkable change in symptomology over 10 weeks of treatment was viewed as neither detrimental nor surprising, In fact it suggested that as residents expanded their emotional understanding and expression in treatment, the safe and supportive family
environment buoyed their ability to regulate and process these emotions. Given what these survivors had been through, these were encouraging results.
Chapter 4

Discussion

This research was intended to distinguish the benefits offered residents of the Transitions Global safe house in Cambodia and to identify the salient aspects of their psychological, emotional, and physical recovery from sex-trafficking victimization. The qualitative observations from this research provide insight into the benefits of holistic treatment of sexual trauma, suggesting that healing is multi-faceted. The mission of Transitions Global can be characterized by their commitment to offer their residents opportunities for emotional and physical healing, education and job skills, guidance in behavioral change, and hope for the future.

A surprising finding emerged as the research commenced in that TG does not see termination of services as a desirable long-term goal. The director of TG explained her philosophy of the group home environment. Comparing the TG program with other group homes experiences, a subtle yet significant contrast unfolded. Other sex-trafficking recovery organizations in the Phnom Penh area have similar philosophies of aftercare for victims, but their commitment to long-term relationship has limits. One organization states they are, “committed to following up with each woman and child for up to two years after they reintegrate into community” (Hagar Cambodia, 2011, p. 1). While providing recovery services is of benefit to anyone who has been sexually abused, long-term parental influence is unique. From the beginning, the founders and directors of TG decided to treat their residents as if they were their
own daughters. This surprising commitment is likely a contributing factor to the TG residents’ ability to regain trust and lasting relationships in their recovery work.

During the graduate interviews, when one of the young women expressed the desire to open a coffee shop with her sister, the director’s first words were, “How much money do you need to do this?” The director continued to have an invested interested in this girl’s dreams and future even after she was finished with the program and had moved into the community. This personal supportive family touch appears to help the residents feel safe and hopeful about their lives and futures. The director shared,

We see the results in our graduates; the graduates come home like they’d come home for dinner, they spend the afternoon on the couch, on holidays such as Khmer New Year they come home. Family style living and expectations helps counteract the ‘bunch of traumatized kids living together’ problem that many group homes encounter.

Another surprising discovery was the manner in which certain Western ideas were embraced while others were shunned. Western individualism is promoted in the TG program by encouraging the STAR residents to save money and pursue independence. Every resident is encouraged to dream about their future, yet apart from the resources offered by TG, their futures in Cambodia would be limited. Cambodia is the 37th poorest country in the world with an annual income in 2010 of $2,084 (Global Finance, 2011). In this environment, the idea that a person could become whatever they want to be is incongruent with the reality of the culture. On other issues TG does not embrace Western ideas, such as the importance of spirituality in holistic therapy. The TG director expressed opposition to any spiritual emphasis because she did not
want to force spirituality or religion on the residents. Her concerns were regarding the confusion residents might have about “how a good God could allow such terrible events in their lives.”

Dissociation has been conceptualized as an initial means of coping with the upheaval of trauma. (Nemiah, 1998) It is also theorized that individuals who experience more severe sexual abuse as children are at particularly high risk for dissociation (Gershuny, Najavits, Wood & Heppner, 2004). It was suspected that the participants in this research would be clinically depressed, anxious, and have PTSD symptoms resulting from the traumas associated with abduction, forced sex, and fear of dying. It was also presumed that because of the likelihood of dissociative states, the survivors would require extensive psychological treatment to provide the needed emotional safety to process their traumas. The quantitative results from this research may suggest that the safety afforded to TG residents through psychotherapy was adequate to encourage the residents to risk trusting their counselors and to acknowledge the emotional effects their trauma experience has had in their lives, without a significant increase in PTSD, anxiety, or depression symptomatology. This conclusion is based on insignificant differences found between pre and posttest results over a 10-week period of treatment.

Limitations of the Study

The primary limitations of this study were the lack of ability to secure personal interviews with each of the TG residents and the refusal of TG to allow viewing of their treatment plans. Prior to this research, translators were employed and it was understood that residents would be available for interviews. However, time limitations and schedules interfered with this aspect of the research and most of the information gathered about the residents, their sex-trafficking narratives and their recovery process was obtained through TG’s clinical director.
She had personal interactions with each resident and was an excellent historian. Nevertheless, using the interview format with each resident would have provided first hand information to draw inferences from regarding the resident’s impressions of the program and its benefit to their recovery process. TG’s refusal to allow their treatment plans to be reviewed and their hesitation to discuss program formatting were disappointing in this research study. The organization did not disclose this intention to withhold access to these documents until after the research was approved and had begun. Therefore, information about the program was limited to interviews and observations. The TG director explained their intent to marketing a program manual and did not want the information to be available publicly before that time.

Other limitations to this research include the short span of time between pre and post test assessments and the variability in amount of treatment each of the participants had at the time of these assessments. As a cross-cultural study, researcher limitations also included lack of familiarity with the culture under observation and limited perspectives on the analysis of the data.

**Questions for Future Research**

This study provides insight into the benefits obtained through group treatment for sex-trafficked survivors, highlighting five salient themes that emerged from interviews and observations of the residents. After talking with the director of TG, it was apparent that the family atmosphere and strong financial support base enables TG to provide residents with many future opportunities. Not every after care organization has access to similar resources. Analysis of TG’s treatment and program plans, comparing specific diagnoses, treatment offered, and outcome results, would give a broader understanding of the long-term benefits of specific
treatments for survivors. It would also be beneficial to compare pre- and post-test assessment results from intake to graduation. Because TG is a relatively young organization, incorporated in 2007, and assessment protocols were not begun until March of 2010, this research could be conducted in the next several years.

**Conclusion**

The knowledge gained from embarking on this research has supplied insight into the holistic recovery experience of sex-trafficked survivors. The efforts and commitment of Transitions Global, founders and staff, has culminated in giving their residents the opportunity for healing from their victimization experiences, offering familial support beyond the in-house treatment program goals, and providing an uncommon hope for the future of these Cambodian females. TG’s comprehensive approach to provide physical, psychological, and social recovery, while persistently seeking to improve their program, has exampled moving beyond concern to engaging in action. As organizations and psychologists may desire to advocate and work within this recovery model, TG will be encouraged to more openly share the logistics of their program, promoting duplication of this commendable effort.
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Appendix A

Semi-Structured Interviews
**Semi-Structured Interviews**

**Semi-Structured Interview Regarding All Residents**

1. Demographic data of the resident? Socioeconomic status? History of education? Family constellation? Childhood history, including quality of significant family relationships?
2. When did she come to TG? Where did she come from? Who referred her? How was she rescued? What was her emotional state when she got here?
3. What kind of trauma did the resident suffer before being trafficked? What was her living situation like?
4. At what age was she trafficked? How did she become trafficked? Account of how they entered commercial sex work. Working and living conditions while in the brothel? What was rescue/stabilization like for her?
5. What has the process at TG been like for the resident? What progression through the behavioral levels? Transition to the STAR program? Graduated from program?
6. What are her health issues and were they the result of trafficking? How has TG helped with her health issues? STDs? HIV? Chronic medical issues?
7. Psychological impact of trauma? Relationship to age and developmental level? Somatic complaints?
8. Meaning of the experience to the survivor? Meaning in the family? Meaning in the larger social context?

**Semi-Structured Interview for Staff**

1. What is your job and your responsibilities with Transitions Global? What influenced you to want to work here?
2. What kinds of skills do you help the girls to acquire during their time in the program?
3. What are common challenges the girls face in their emotional and physical recovery?
4. How are the residents encouraged to process/express the anger they feel?
5. Are self-harm or suicidal thoughts an issue for the residents? If so, how do you help them?
6. What kind of behavior issues do you experience with the residents?
7. What therapeutic interventions are in place to help the residents heal from their past traumas?
8. Please discuss aspects of this program that you feel are especially beneficial to the residents.
9. What kind of celebrations do you have for the girls? E.g. birthday, holidays, etc. What do the girls enjoy doing? What seems to bring them happiness?
10. How do you decide when a resident is ready to be live in the S.T.A.R. house?

**Semi-Structured Interview for Graduates**

1. What did you enjoy most about living at the center?
2. What new skills have you learned since coming to the program?
3. What has been most helpful to you?
4. Who do you look up to and want to be like? What is it about this person that you admire?
5. Please tell me what makes you laugh and smile.
6. What do you hope to do when you finish the program?
7. Are there any questions you would like to ask me?
Appendix B

Harvard Trauma Questionnaire
Harvard Trauma Questionnaire

Instructions
We would like to ask you questions about your past history and present symptoms. This information will be used to help us provide you with better medical care. However, you may find some questions upsetting. If so, please feel free not to answer. This will certainly not affect your treatment. The answers to these questions will be kept confidential.

Part IV: Trauma Symptoms
The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives. Please read each one carefully and decide how much the symptoms bothered you in the past week.

<table>
<thead>
<tr>
<th></th>
<th>(1) Not at all</th>
<th>(2) A little</th>
<th>(3) Quite a bit</th>
<th>(4) Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Recurrent thoughts or memories of the most hurtful or terrifying events</td>
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<td></td>
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</tr>
<tr>
<td>2</td>
<td>Feeling as though the event is happening again</td>
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<tr>
<td>3</td>
<td>Recurrent nightmares</td>
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<td>4</td>
<td>Feeling detached or withdrawn from people</td>
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<tr>
<td>5</td>
<td>Unable to feel emotions</td>
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<tr>
<td>6</td>
<td>Feeling jumpy, easily startled</td>
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<tr>
<td>7</td>
<td>Difficulty concentrating</td>
<td></td>
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<td></td>
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<tr>
<td>8</td>
<td>Trouble sleeping</td>
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<tr>
<td>9</td>
<td>Feeling on guard</td>
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<td></td>
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<tr>
<td>10</td>
<td>Feeling irritable or having outbursts of anger</td>
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<tr>
<td>11</td>
<td>Avoiding activities that remind you of the traumatic or hurtful event</td>
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<td></td>
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<tr>
<td>12</td>
<td>Inability to remember parts of the most traumatic or hurtful events</td>
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<td></td>
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<tr>
<td>13</td>
<td>Less interest in daily activities</td>
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<td></td>
<td></td>
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<tr>
<td>14</td>
<td>Feeling as if you don’t have a future</td>
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<tr>
<td>15</td>
<td>Avoiding thoughts or feelings associated with the traumatic or hurtful events</td>
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<tr>
<td>16</td>
<td>Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events</td>
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<td>17</td>
<td>Feeling that people do not understand what happened to you</td>
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<tr>
<td>18</td>
<td>Difficulty performing work or daily tasks</td>
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<tr>
<td>19</td>
<td>Blaming yourself for things that have happened</td>
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<tr>
<td>20</td>
<td>Feeling guilty for having survived</td>
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<td></td>
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<tr>
<td>21</td>
<td>Hopelessness</td>
<td></td>
<td></td>
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<tr>
<td>22</td>
<td>feeling ashamed of the hurtful or traumatic events that have happened to you</td>
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<tr>
<td>23</td>
<td>Spending time thinking about why these events happened to you</td>
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<tr>
<td>24</td>
<td>Feeling as if you are going crazy</td>
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<tr>
<td>25</td>
<td>Feeling that you are the only one who suffered these events</td>
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<tr>
<td>26</td>
<td>Feeling others are hostile toward you</td>
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<tr>
<td>27</td>
<td>Feeling that you have no one to rely on</td>
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<tr>
<td>28</td>
<td>Finding out or being told by other people that you have done something that you cannot remember</td>
<td></td>
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<tr>
<td>29</td>
<td>Feeling as if you are split into two people and one of you is watching what the other is doing</td>
<td></td>
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<tr>
<td>30</td>
<td>Feeling someone you trusted betrayed you</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

Hopkins Symptom Checklist (HSCL)
I will read some symptoms or problems to you that people sometimes have. Please listen carefully to each one and tell me how much the symptoms bothered or distress you in the last week, including today.

<table>
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<th>Kµan</th>
<th>bŋicbnŋ Ûc</th>
<th>xoʔMgbg AÛr</th>
<th>xoʔMgé RkElg Extremel \y</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1: ANXIETY SYMPTOMS</strong></td>
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<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td>1. P½yxøacmYyrMeBceday\tehtupl Suddenly scared for no reason</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. manGarmuN_P½yxøac Feeling fearful</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. ggttmuxcg;dYl vilmux böexSaykMlaMg Faintness, dizzy, or weakness</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. karRCyIRcal bëj½rxøÜnedayP½yxøac Nervousness or shakiness inside</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. ebHdUgelaxaMg bòedIrjab; bòbukedIrmRTUg Heart pounding or racing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. jabj½rxøUnrjaN Trembling</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. GarmuN_twgEtg bôrMeClbrMCYl Feeling tense or keyed up</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. QWk.al Headaches</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. mankarP½yxøaMg bôson;esøar Spells of terror or panic</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. GarmuN_rsab;rsI; Ggȟýumsux Feeling restless, can't sit still</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

I will read some symptoms or problems to you that people sometimes have. Please listen carefully to each one and tell me how much the symptoms bothered or distress you in the last week, including today.
### Part II: DEPRESSION SYMPTOMS

<table>
<thead>
<tr>
<th></th>
<th>Kµan Not at all</th>
<th>bŋbicbn ḟÚc</th>
<th>xɔaMg bgÁÜr Quite a bit</th>
<th>xɔaMgéRk Elg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>manGarmµN_exSaykMlaMg sʃk; Feeling low in energy, slowed down</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2.</td>
<td>sʃIben₃asxøUnÈgGMBıerOgGV₁Edle kItmaneLïg Blaming yourself for things</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3.</td>
<td>yMERskedaygay² Crying easily</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4.</td>
<td>Gs;karsb,aykŋu̱karrYmdMeNkbckGs;deRmk Loss of sexual interest or pleasure</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5.</td>
<td>minsUvXoan júaMminsUv)an Poor appetite</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6.</td>
<td>Bi)akeKglk; bɔeKglk;BMu)anyUr Difficult falling asleep, staying asleep</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7.</td>
<td>manGarmµN_Gs;sgÇwmGMBIGnaKt Feeling hopeless about the future</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8.</td>
<td>manGarmµN_RsgUtRsgat; Feeling blue</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9.</td>
<td>manGarmµN_Eeka mŋak;Èg Feeling lonely</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10.</td>
<td>manKMiniteg;sMlab;xøUnÈg Thoughts of ending your life</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11.</td>
<td>manGarmµN_dUcCaCab;Gnŋak; cab;xøUn Feeling of being trapped or caught</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12.</td>
<td>RBYy)armOeRclneBk BlbBaðaepSg² Worrying too much about things</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>13.</td>
<td>Gt;manGarmµN_ellGV₁²TaMgGs; Feeling no interest in things</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>14.</td>
<td>manGarmµN_faGV²k½Bi)akTaMgGs; Feeling everything is an effort</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15.</td>
<td>manGarmµN_faxøUnÈg'tmantMël Feeling of worthlessness</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Appendix D

Informed Consent for Research
GEORGE FOX UNIVERSITY
GRADUATE DEPARTMENT OF CLINICAL PSYCHOLOGY
INFORMED CONSENT DOCUMENT

Directions: Please complete this form and return it to the researcher before testing and interviews.

You are invited to participate in this program evaluation study led by Robyn Honeycutt, M.A. The purpose of the evaluation is to examine the benefits you have experienced while staying here. The researcher is studying this information as part of her education as a doctoral student at George Fox University in Portland, Oregon, USA. The following information is provided to help you in making a decision as to whether or not you would like to participate.

You will be asked to do two things in this project. First, you will be asked complete a questionnaire, which will take about 20 minutes of your time. You will also be asked to be involved in an interview, which should take approximately 40 minutes. This interview will be recorded so that the interviewer can better understand and remember what is said. The identities of those who share stories in these interviews will be disguised to protect information shared. Participation in this research is voluntary and up to you. You do not have to answer any or all questions.

Even though your participation is voluntary, the information we receive from you will help others understand how to help children in overcoming obstacles in their lives. There are no known risks to participating in this study.

If you decide to be involved, it is important to answer the questions as honestly as possible. All of the information you share will be private. Your name will identified by a number and will not be associated with your name. I will not be able to identify how any one person responds to items on the questionnaires. Your responses will remain anonymous and confidential.

If you decide to participate, you also give me permission to use the information you share in this study for presentations at professional meetings. The information gathered from the group of people that participate could also be shared in published articles or books. You need to know that I am interested only in group data and your name will not be used in any such presentations and/or publications. Once again, this assures your privacy.

If you have any questions or concerns while completing these questionnaires, please ask. If you have questions or concerns, you can contact Robyn Honeycutt, M.A. at (503) 341-6496 or honeycuttrobyn@aol.com or Dr. Mark McMinn of the George Fox University Graduate
Department of Clinical Psychology. Dr. McMinn is available at (503) 538-8383 or at mark.mcminn@gmail.com

By signing this letter, you acknowledge that: a) you were advised of the above, b) your questions have been answered satisfactorily, c) all personal information will be held strictly confidential, d) you give permission for information shared to be used in professional meetings and publications, assuring your confidentiality and anonymity, and e) you are free to withdraw from the study at any time.

________________________________________  ______________________________
Printed Name                                                                Signature

In my judgment, the subject is voluntarily giving informed consent to participate in the study.

Researcher Investigator’s signature __________________________________________

INFORMED CONSENT DOCUMENT

In Khmer

esckpIENnaM³
sUmbMeBjTMrg;xageRkamenHehlysUmpéfICUneTakan;GňkeFVIkarRsavRCavmuneB
IEd(Gňk TTY)lanTMrg;sisKka.
GňkRtUv)anGeBaqljcUlrYmenAkňuguksikSaRsavRCavEdldwknaMeday Robyn Honeycutt,
enHKWCakarsikSa EdlTak;TgeTAnwg rebobénkarekIteLlgvijnUv
PaBesfomsat;mpgeToTrbs;ekµg¬b"⁄k'smbtPaBedlm,ledaHRsay
bBőaáEdlsšitenAsšanPaBd{4lm}ak;GňkRsavRCavnwgsikSanUvBt'manTaMgenH
k{4UcCaGb;rMénRKUeBTńTaMgLayedlenAE saklviTüal½y George Fox kňuRbeTs
Portland rdæ Oregon shrdæGaemrik. enAral;EpňkénBt’ manTaMgGs;enHnwgRtUwpļ;CUn
edlm,ICYybégáItUvkaršerMc cit'c,as;las;mYyfaetlGňkgc;UlrvYm rW mincg; UlrYm.

GňknwRtUv)ansYredim,lbMeBjnUsVsMnYrxôHCamYyry清BIEldplb;CUncMnYn20naTIsMrab
sMrab;eFVIva. karcUlrYmkňuGkarRsavRCavenHKWeFVledaysšuRK½citp
ehlyvaGaRs½eTAeIglňkpaI:. GňkmIncaM(ac;mincaM)ac;eqôly
eRcInNas;NanUvral;sMNYrEdl)andak;CUnenaHeT.RbsinbI(GňkséRmccitptypeUlrYm
GňkRtUv)ansYmUsMNYr vas;þp;Blr a[kMriténkaryl;dwgrbs;emerons
òmbtPabRs;GňkkňuGkMLugeBlmankarRBYy)armÖepSg².

eTaHblCakarcUlrYmrbs;GňkCakarsšuRK½citp³½eday
k{4Bt’manEdlGňkTTYlICYyByIrrebbobCYyekµg³y:ag
Sex Trafficked Survivors

RbsineblkarseRmccitškůugkarcUlrYmsikSa
vanmansar’sRxan;Nas;eqøytybeTAnwgsMnYrRbkbedayPaBesµaHRtg;
nwgGacTTYlykjan.RKb;Bt’manEdGników)anqþ;CalkčNëÉkCn.eQuaHrbs;GůknwgRtUv)ansmaCi
kmñak;saÅl;ehIynwgminGacsÅal;nNamañk;EdleqøytybnuUverOgravrbs;GůksYr.kareqøytybrbs;Gů
knwgMrłweddayKañeQuaH niq manTMnucitš.RbsineblGůksMerccitšcUlrYm
Gůkk½)annUvkarGnuBaOatedIm,leRbIR)as;Bt’manEdGński)anEckcaynUvkarsiksAenH
sMráb;eFV1bTbgòajñigkarRbCMuepSg²pgEdr.Bt’manRtUv)anptl;eGaymnusSenAkuŋuRkum
Edlkarpþl;eGay TaMgenaHRTuve)ahBumÖCaGtβbTbœCaesoePA. GůkKYrdwgpgEdrfa
’)ancab;GarmüNëTaeEtTinñ½yenAkuŋu RkumEt mYyb:ueNaNH
ehlyeQuaHrbs;GůknwgminRtUveRbIR)as;eñAeBleFV1bTbgðaj bêk¼CasaFarNëNamYyenaHeT
KRWTUv )anrab;rgnUvPaBêkCnrsbs;Gůk.

RbsinebI’ mansMNYr Rwk½mankarRBYY)armÖNamYykůugxNëBlbMeBjsMNYr
sUmmtþasYredaymankarP½yxaœc jittjwmenaHeLly.
CagenHeTAeTotRbsinebImanbBaôasUmTak;TgeTA Robyn Honeccut, enA 503-341-6496
bêk¼ Email: honeyccutrobynaaol.com.

sUmceuHttélxaenARKdasenH ra;MenHdwgrbs;Gůk
a(Gûk)anTTYIBt’manEdl)anpl;CUxagell
b(šMNYrbs;GůkRtUv)aneqøylyrYceEdl(GacTTYlyk)an
c)ral;B’tmanEdl;xòÚnerobCMya;gmanTMnucitš d)kar GnuBaOateGayGûksMrab;Bt’man
edlIm,IEckcay EdlRtUv)aneRbIR)as;CalkN³pøÛvkarenaeBIRbCuMehlyngwkart kic©
edayeqøytybeTarakmanTMnucitšedayKaünkarijwwtjIm ehlynwg Gaf¼kM)ag nwg
e)karkecejBlkar siksArbs;GůkRk;eBlevla.

e)hBumöeday htélx

enAkůugkarak;esckplIrbs;˚
KWkarpþl;CUuTMrg;)aykarN¾cUlrymedaysµRK½citšsMrab;karcUlrYmenAkůugkarsksAen
H.

htélxa GûkesulbGegàtkarRsavRCav
Appendix E

Interview Data
### Interview Data

<table>
<thead>
<tr>
<th>Improved physical health</th>
<th>Times Mentioned</th>
<th># of Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition and Health Care</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td>Access to Health Care</td>
<td>27</td>
<td>22</td>
</tr>
<tr>
<td>Decreased Somatization</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Has not reentered sex trafficking</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Yoga (for health benefits)</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Abstain from drug/alcohol use</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>112</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological recovery</th>
<th>Times Mentioned</th>
<th># of Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy/Counseling</td>
<td>35</td>
<td>23</td>
</tr>
<tr>
<td>Dreams about Future/Life Purpose</td>
<td>34</td>
<td>22</td>
</tr>
<tr>
<td>Emotional Stability</td>
<td>28</td>
<td>15</td>
</tr>
<tr>
<td>Self-Acceptance</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Exhibits Resilience</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Ability to Express Feelings</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>Spiritual/Religious Beliefs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Yoga (for mental well-being)</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Sense of Safety and Well-Being</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>164</strong></td>
<td><strong>110</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increased independence</th>
<th>Times Mentioned</th>
<th># of Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Autonomy</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Education</td>
<td>33</td>
<td>21</td>
</tr>
<tr>
<td>Job Skills Training</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>Has Job</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Engages in Recreation/Leisure</td>
<td>30</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>114</strong></td>
<td><strong>77</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positive Social Relationships</th>
<th>Times Mentioned</th>
<th># of Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Relationships</td>
<td>34</td>
<td>17</td>
</tr>
<tr>
<td>Able to Establish Friendships</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Safe and Secure Home</td>
<td>25</td>
<td>23</td>
</tr>
<tr>
<td>Guidance Mentors/Parental Figures</td>
<td>43</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>113</strong></td>
<td><strong>69</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reintegration into community</th>
<th>Times Mentioned</th>
<th># of Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reintegration with Family/Community</td>
<td>30</td>
<td>17</td>
</tr>
<tr>
<td>Service to Community</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Public speaking about their experiences</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>43</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>
Appendix F

Curriculum Vitae
Education

2007 - Present  Doctor of Clinical Psychology (Psy.D.) Program
Graduate Department of Clinical Psychology,
George Fox University, Newberg, OR
APA Accredited
G.P.A. – 3.88

2004  Bachelor of Science
Multnomah University, Portland, OR

Supervised Clinical Experience

08.11 – Present  George Fox University Psychology Internship:
Providence North Portland Medical Group, Portland, OR
Implementing the Medical Home model of primary care with the integration of behavioral health services, provided primarily co-location services to patients with both medical and mental health diagnoses. Collaborated with medical doctors and other staff regarding case conceptualization and effective therapeutic interventions for patients. Performed psychological assessments, providing written reports and feedback to physicians and patients.

George Fox University Adjunct Professor, Newberg, OR
Prepared lectures, class activities, and exams, teaching a 3-hour General Psychology course to 35 undergraduate college students. Facilitated learning through lecture using PowerPoint, interactive class activities, and offering individual help as needed.

George Fox University Behavioral Health Clinic, Newberg, OR
As the assessment coordinator, consulted with Yamhill County Youth and Family Services and facilitated the assessments for their clientele. Worked with George Fox doctoral students, assigning clients, offering consultation regarding the selection of assessment protocols and feedback to clients. Also provided mental health services to uninsured and underinsured citizens of Yamhill County and the surrounding areas, including psychotherapy, psychological assessment, and group therapy. Provided didactics for doctoral students of Clinical Psychology.
Supervisors: Joel Gregor, Psy.D, Vanessa Casillas, Psy.D

08.10 – 05.11

Pre-Internship Practicum:
Management Position, Health and Counseling Center, George Fox University, Newberg, OR
As practicum manager, performed client screening and scheduled appointments, reviewed doctoral practicum student’s charting and provided feedback, supervised one practicum student in a masters level program. Worked at a college counseling clinic providing mental health services to undergraduate and graduate students. These services included: intake interviews; diagnosis; treatment planning; individual psychotherapy, both short and long term; and learning disability assessment, testing, and written reports. Clinical intakes were dictated. Clients were from diverse ethnic groups, religious traditions, and sexual orientations. Attended consultation and weekly supervision, both individual and group.

Supervisor: William Buhrow, Psy.D.

08.09 – 07.10

Practicum II:
Kaiser Permanente, Skyline Mental Health Clinic and North Lancaster Mental Health Clinic, Salem, OR
Worked within a multi-disciplinary healthcare team at community based outpatient clinics providing mental health services to Kaiser Permanent members. These services included: intake interviews; diagnosis; treatment planning; individual psychotherapy, both short and long term; couples psychotherapy; family psychotherapy; personality assessment; neuropsychological assessment, testing, and written reports; and co-facilitated distress tolerance and interpersonal effectiveness skills groups. Patients ranged in age from 7 to 87 were from diverse ethnic groups, religious traditions, and sexual orientations. Became proficient at dictated clinical intakes and assessment reports. Attended consultation and weekly supervision, both individual and group.

Supervisors: Catherine DeCampos, Psy.D./CFNP, Robert Schiff, Ph.D.

05.09 – 08.09

Supplemental Practicum:
Portland Veteran’s Administration, Portland, OR
Traveled to veterans’ homes as part of a multi-disciplinary primary healthcare team, providing clinical and neuropsychological assessment to homebound military veterans with co-occurring disorders (medical, cognitive, and psychiatric). Wrote assessment reports and met with patients to give recommendations. Patients ranged from 65 to 84 years of age. Attended weekly consultation and individual supervision.
Supervisor: Angela Plowhead, Psy.D.

08.08 – 04.09

Practicum I:
Roseburg Veteran’s Administration Healthcare Systems, Eugene Clinic, Eugene, OR
Worked within a multi-disciplinary healthcare team at a community based outpatient clinic providing mental health services to veterans and their families. PTSD and severe mood disorders were common diagnoses of the veterans. Services included: intake interviews; diagnosis; treatment planning; individual psychotherapy, both short and long term; couples psychotherapy; family psychotherapy; personality assessment; neuropsychological assessment, testing, and written reports. Patients ranged in age from 18 to 59 and were from diverse ethnic groups, religious traditions, and sexual orientations. Attended consultation and weekly supervision, both individual and group.

Supervisor: Rex Turner, Ph.D.

01.08 – 04.08

Prepracticum II:
George Fox University, Newberg, OR
Provided outpatient services to volunteer undergraduate students. Services included intake interviews, individual psychotherapy, diagnosis, and treatment planning. Responsibilities included report writing, case presentations, and consultation with both supervisor and clinical teams. All sessions were taped and reviewed by supervisor. Received weekly individual and group supervision.

Supervisors: Mary Pederson, Ph.D. and Lisa Jones, M.A.

08.07 – 12.07

Prepracticum I:
George Fox University, Newberg, OR
Received individual psychotherapy skills training with graduate students, including intake interviews, listening skills, and videotaped simulated therapy.

Supervisors: Mary Pederson, Ph.D. and Lisa Jones, M.A.

Relevant Professional Experience

08.10 – Present

Supplemental Practicum:
Graduate Assistant for History and Systems of Psychology Graduate Class, George Fox University, Newberg, OR
Responsible for grading and offering feedback on weekly homework for doctoral students.

Supervisor: Kathleen Gathercoal, Ph.D.

09.09 – 12.09

Supplemental Practicum:
Graduate Assistant for Advanced Counseling Undergraduate
Class, George Fox University, Newberg, OR
Responsible for facilitating weekly small group discussion, clinical role-plays, and homework review for undergraduate students. Attended weekly group consultation and supervision.
Supervisor: Kristina Kays, Psy.D.

Prior Clinical Experience

04.07 – 08.09
Domestic Violence Group Co-Facilitator:
A New Life Christian Counseling, Portland, OR
Co-facilitated weekly groups for male batterers, both court-mandated and self-referred individuals. Focus was on challenging and confronting participants’ beliefs and patterned behaviors of control and violence, while creating a safe and respectful environment for change.
Supervisor: Brad Pederson, M.A.

04.04 – 09.07
Residential Counselor:
Youth Guidance Association, Portland, OR
Services included: counseling adolescent female residents and responding to their emotional and social needs; facilitating treatment groups, teaching behavioral techniques; crisis interventions; conducting intakes, report writing and case presentations; participating in weekly supervision, staff meetings, and case reviews; consultation with multidisciplinary staff members and outside agencies; and training new staff. Received individual and group supervision.

08.06 – 06.07
School Liaison:
Youth Guidance Association, Portland, OR
Onsite counselor at Alpha Alternative High School, was responsible for: coordinating educational services on behalf of the YGA residents; conducting entrance and exit examinations; consulting with educators and case workers regarding special needs and Individualized Education Programs (IEPs); daily interactions with residents focused on behavior modification to address issues of anger management, time management, problem solving, appropriate communication, and academic achievement. Received individual supervision.
Supervisors: Virginia Glaspie M.A., and Tanya Muirbrook M.A.

Research Experience

09.08 – 04.11
Research Vertical Team
George Fox University, Newberg, OR

08.11

APA Poster Presentations and Symposium
Accepted for the annual meeting of the American Psychological Association, Washington D.C.

2009
Peer rater for qualitative doctoral dissertation study

08.09

APA Poster Presentation
George Fox University, Newberg, OR

Other Work Experience

2003 - 2007
Administrative Assistant:
A Better Way Counseling Center, Portland, OR
• Facilitated insurance authorization and billing for clients.
• Balanced accounts: payable and receivable, and billed using QuickBooks.
• Improved office organization.

1997 - 2003
Emergency Room Admitting Representative:
Portland Adventist Medical Center, Portland, OR
• Expertise in working in crisis environment, anticipating needs and responding quickly during emergencies.
• Skilled at interacting with patients, obtaining medical complaints and history.
• Supported medical staff and co-workers, quickly adapting to shifting situations.

Community Service

2010
Counseling Mentor
Precious Women Counseling Services, Phnom Pehn,
Cambodia
Internet meetings for case discussion with founder/ director, Seng Solida.

02.07 – 10.08
Victim Advocate Group Leader
A New Life Christian Counseling, Portland, OR
• Provided a safe environment for victims and survivors of domestic violence to talk about their experiences.
• Offered emotional support and education for abused women, helping them to assess risks, develop safety plans, and address issues of anger, depression, anxiety, grieving, and forgiving.

10.04 – 10.08
Rape Victim Advocate First Responder
Multnomah County District Attorney’s Office, Portland, OR
• Provided comfort and counsel to victims during their initial hospital examination and police questioning.
• Provided information to victims about their rights and available services.
• Received the Multnomah County Volunteer Award for Community Service – 4/25/07.

04.03 – 04.06.08
Student Volunteer
Christian Association for Psychological Studies, CAPS, Phoenix, AZ

2003 - 2007
Counselor, Leadership Tract Team Leader, and Dean of Women
Western Seminary’s Veritas Summer Seminary, Portland, OR
• Involved in the organization and operation of a High School youth program focused on developing young leaders in the church.
• Follow-up throughout the year involved individual counseling and group reunions.

1993 - Present
Speaker, Director, and Counselor
Eagle Fern Youth Camp, Estacada, OR
• Prepared and delivered 20 speeches; Assistant and primary director, 8 summers; Counselor, 10 summers, multiple grade levels K-12.

Additional Professional Training
Working with Abusive Men – Allies in Change Counseling Center (20 hours)
Chris Huffine, Psy.D. &
Chris Wilson, Psy.D
Responding to Sexual Assault – Multnomah County District Attorney Rape Victim Advocate Training, (20 hours)  
Annette U. Selmer, M.S., L.P.C.

Mindfulness-Based Eating Awareness Training – Columbia River Eating Disorder Network (8 hours)  
Jean L. Kristeller, Ph.D.

Eating Disorders: From Pregnancy to Parenting – Columbia River Eating Disorder Network (8 hours)  
Lucene Wisniewski, Ph.D., F.A.E.D.

Bipolar Disorder in Children and Adolescents – APA Workshop, Toronto, Canada  
(7 hours)  
Eric A. Youngstrom, Ph.D.

The Coaching Relationship and Foundations of Coaching (16 hours)  
Linda Miller, M.A., M.C.C., Jane Creswell, M.C.C. & Norman Thiesen, Ph.D.

Current Guidelines for Working with Gay, Lesbian, and Bisexual Clients: The new APA practice guidelines  
Carol Carver, Ph.D.

Multicultural Counseling: An Alternative Conceptualization  
Carlos Taloya, Ph.D.

Emergency Evaluation of the Psychiatric Patient  
John Mitchell, MD

Treatments that Work: Practical Tools for Effective Therapy  
Elsbeth Martindale, Psy.D.

An Introduction to the MMPI-2-RF 2009 – Annual Northwest Assessment Conference, George Fox University  
Yosef S. Ben-Porath, Ph.D.

Treatment and Education of Autistic and Communications-Handicapped Children  
Gary Mesibov, Ph.D.

Primary Care Psychology  
Julie Oyejama, Psy.D.

Towards a Global Christian Psychology: Reconsidering Culture and Context  
J. Derek McNeil, Ph.D.

WAIS-IV: An Overview and Assessment of ADHD in Children, Teens, and Adults  
Bruce Bracken, Ph.D. & Larry Weiss, Ph.D.

Psychodynamic Group (met monthly for 2 years)  
Kurt Free, Ph.D.

Peace Within Thy Walls – PASCH, Peace and Safety in the Christian Home, International Conference (12 hours)  
Catherine Clark-Kroeger Ph.D. & Nancy Nason-Clark Ph.D.
Assessment Training

16 Personality Factors (16PF)
Beck Depression Inventory-Second Edition (BDI-II)
Benton Visual Retention Test
Boston Naming Test – Revised
California Verbal Learning Test (CARE)
Controlled Oral Word Association (COWA)
Delis-Kaplan Executive Function System
Grooved or Purdue Pegboard
Halstead-Reitan Neuropsychological Test Battery
Independent Living Scale (ILS)
Millon Clinical Multi-Axial Inventory-Third Edition (MCMI-III)
Mini Mental Status Exam (MMSE)
Minnesota Multiphasic Personality Inventory-Third Edition (MMPI-II)
Peabody Picture Vocabulary Test-Third Edition (PPVT-III)
Personality Assessment Inventory (PAI)
Posttraumatic Stress Disorder (PTSD) Checklist-Military Version (PCL-M)
Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)
Rey-O Complex Figure
Test of Memory Malingering (TOMM)
Trauma Symptom Inventory (TSI)
Trail Making A & B
Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV)
Wechsler Individual Achievement Test-Second Edition (WIAT-II)
Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV)
Wide Range Achievement Test-Fourth Edition (WRAT-IV)
Wide Range Assessment of Memory and Learning-Second Edition (WRAML-II)
Wide Range Intelligence Test (WRIT)
Wisconsin Card Sort
Woodcock Johnson III – Tests of Achievement

Professional Affiliations

2008 - 12 American Psychological Association, Student Member
2008 - 12 Society of Clinical Psychology, Division 12 of the APA, Student Member
2008 - 12 Trauma Psychology, Division 56 of the APA, Student Member

References Available Upon Request