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Characteristics of Sex Trafficking Survivors Success in an Aftercare Program

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Abstract

In recent years, there has been greater awareness of the impact of human sex trafficking within the United States. Dozens of initiatives and programs have formed to combat the trafficking pandemic, leading to new understandings of the complexity involved with fighting against sex trafficking and the care involved with rehabilitating and empowering survivors of this injustice. Several studies have focused specifically on which pieces of aftercare tend to support greater healing in survivors over time. This care incorporates multiple discipline areas, including mental health, life skills, and healthcare services. Even so, there is a gap in literature highlighting connections between success in completion of aftercare rehabilitation programs and which characteristics increase likelihood for success in reintegration to society. The purpose of this study was to identify which factors in applicants entering a sex trafficking rehabilitation program will have greater success of rehabilitation and reintegration into society. The study hypothesized that applicants who have greater interpersonal connections and history of fewer adverse experiences were more likely to complete and fully reintegrate following the aftercare program. These factors were measured through archival chart review of previous applicants within a specific, faith-based aftercare program to code and analyze success or failures in completing the program. The findings examined connections between program graduation rates and the coded items related to personal characteristics and facilitation of success. Results indicated few associations between program success and personal characteristics. Specifically, participants who reported a history of post-traumatic stress disorder (PTSD) were associated with graduation from the program. Additional statistics revealed strong comorbidities between mental health disorders which is consistent with prior literature. Overall, the study suggests implications for the impact of resiliency and trauma as it relates to program success.

Keywords: sex industry, sex trafficking, trauma, program evaluation, rehabilitation

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Characteristics of Sex Trafficking Survivors Success in an Aftercare Program

Chapter 1

In recent years, there has been greater awareness of the impact of individuals within the sex industry in the United States. Dozens of initiatives and programs have formed to respond, leading to new understandings of the complexity involved with fighting against sex trafficking and the care involved with rehabilitating and empowering survivors of such an injustice. A number of studies have focused specifically on which pieces of aftercare tend to support greater healing in survivors over time, in which this care incorporates multiple discipline areas, including mental health, life skills, and healthcare services. Additionally, a variety of literature identifies the impact of resiliency in the recovery process of sex industry survivors. As such, there is a significant need for research that highlights the connection between increased success in completion of aftercare rehabilitation programs for survivors and which characteristics and qualities within this increase likelihood for success in reintegration into society.

Prior to continuing into a discussion of the literature and methods of this study, it is important to highlight the intentional use of language and terminology throughout this document. Specifically, though the program focuses on supporting women who have experience in sex trafficking they have at times expanded this to include other components of the sex industry, including prostitution, pole dancing, and pornography. As Graham et al. (2019) state, “We would like to underscore that not all people who have been trafficked would describe themselves in this way, and that individuals’ self-identification and self-description are paramount” (p. 119). Likewise, due to these more nuanced differences between applicant experiences, the term *sex*

industry will be used to encompass the variety of backgrounds and differences of self-identification and description that is common for individuals within this population.

In a recent meta-analysis, Lepianka & Colbert (2020) reviewed the characteristics and healthcare needs of women who have been victims of sex trafficking within the United States. Their review analyzed two groups of survivors: non-US-born, and US-born women who were trafficked in the United States. The results of their study noted that non-US-born survivors who were part of a system lacking social structure and legal resources tended to have higher rates of sex trafficking or exploitation while in the United States. Additionally, both women born inside and outside of the United States report higher levels of abuse and maltreatment than individuals who have no connection to sex trafficking. Specifically, for women who are US born, survivors of trafficking are more than twice as likely to have a history of childhood abuse, tend to have a longer duration in the sex trade, have higher rates of involvement with prostitution, and increased experiences of violence (Lepianka & Colbert, 2020). These survivors have a variety of healthcare needs and conditions, yet literature reveals patterns of insufficient care and insensitivity from doctors or practitioners, in which these gaps largely impact the growth and healing of survivors (Lepianka & Colbert, 2020). In a similar study conducted by Graham et al. (2019), 53 peer-reviewed articles were analyzed and compared to measure the effectiveness of sex trafficking aftercare and support services. This study noted the variety of measures and scales that programs and organizations across the world have used to support growth and reintegration of survivors of sexual exploitation. This study shed light into the various ways that researchers have measured program "success" and the multiple domains that are prioritized when providing support to this specific population. Across the literature assessed, many researchers focused on providing support to address survivors' physical, sexual, reproductive, and mental

health, experiences of trauma or abuse, and substance use or addiction needs (Graham et al., 2019). However, there are fewer studies that focus predominantly on assessing survivors' coping skills, perceived levels of stress, or individual risk and protective factors that impact aftercare support.

Survivor Risk Factors and Chains-of-Risk Model

A variety of risk factors have been identified as known characteristics that serve to increase the likelihood of negative outcomes in this population. In one study with sex-trafficking juvenile survivors, three main causal conditions were identified as major risk factors for victims who are minors that ultimately led to an increased risk of being trafficked: dysfunctional family dynamics, financial strain, and a disruption/single event in the family household (Hargreaves-Cormany & Patterson, 2016). In exploring these risk factors, the authors note a specific factor present across diverse backgrounds of youth noting, "a more salient vulnerability factor is the lack of socio-emotional support within the STJ [sex-trafficking juvenile] survivors' life reported by all of the participants interviewed," (Hargreaves-Cormany & Patterson, 2016, p. 38). In a similar study conducted with adult female survivors of human trafficking in Moldova, researchers identified a link between specific risk factors of survivors and the prevalence of mental disorders after reintegrating into society from the sex trade (Abas et al., 2013). The study found that 79.2% of participants reported a history of child abuse and/or neglect. The participants who endorsed history of child abuse were also more likely to meet criteria for a mental disorder 6 months after exiting sex trafficking, most commonly post-traumatic stress disorder (PTSD). Additionally, the study suggests that a diagnosis of depression within this population is influenced by the co-occurring risk factors of multiple adverse childhood experiences, a lack of education beyond 14 years of age, traumatic experiences from trafficking, and long-term

environmental struggles (Abas et al., 2013). Similarly, a study comparing the relationships between various risk factors to survivor physical, sexual, and mental health outcomes found significant group differences (Muftić & Finn, 2013). The women were separated based on experiences of sexual exploitation within the United States: international trafficking victims, domestic trafficking victims, and sex workers who had not been trafficked. The results suggested domestic trafficking victims experienced worse health outcomes when compared to international trafficking victims, specifically noting poor physical health, increase in sexually transmitted infections, suicidal ideation, and addiction. Additionally, the study identified individuals who experienced street prostitution reported an increase in sexual health problems, addiction, and co-occurring health issues, as well as victims who had childhood physical and/or sexual history had poorer physical health outcomes (Muftić & Finn, 2013).

Research conducted by Schwarz et al. (2019) focused primarily on identifying key areas of risk that may impact an individual's vulnerability for trafficking and exploitation through case study data from populations within the Kansas City, MO–KS area. Utilizing grounded theory, they identified four key areas from working with service providers, most often social workers, in the area as specific factors that impact such vulnerabilities, including economic insecurity, housing insecurity, education, and migration status. Additionally, their study suggested human trafficking is largely influenced by a combination of factors that impact the trajectory of an individual's risk for exploitation, which is consistent with the chains-of-risk model (Schwarz et al., 2019). This model, as argued by the authors as a helpful lens to view the complexity of risk factors involved in sex trafficking, suggests “There is not one factor that can be isolated as the root cause of trafficking; rather, it is the complex connection of factors that perpetuate exploitation” (Schwarz et al., 2019, p. 120). The chains-of-risk framework suggests links

between exposures or experiences increasing the likelihood of continued negative experiences that repeat and impact an individual. In such a model, the exposure or adverse experience layers and builds upon one another, acting as a system that continues to increase risk for adverse outcomes or exposures (Ben-Schlomo & Kuh, 2002). The chains-of-risk model most notably supports a preventative approach to the issues of trafficking and exploitation, as it identifies specific moments or experiences where establishing intervention and additional support may then isolate the chains of risk. By preemptively providing support at onset of initial risk or experience, the snowball effect of continued adverse exposures is, in theory, halted in order to support a different trajectory for individuals. Even so, by halting such a trigger effect, the impact of the initial or prior adverse exposures do not disappear or discontinue impact on individuals, and thus, both preventative and recovery supports are necessary (Ben-Schlomo & Kuh, 2002).

Protective Factors and Resiliency

While the literature has shown a variety of risk factors impact long-term aftercare services that are necessary for growth and reintegration following the sex trade, it has also highlighted supports and protective factors that guide healing for survivors. In a study by Gray et al. (2012), research focused on exploring resilience in sex trafficking youth survivors in Cambodia as compared to youth in the same country who did not experience such exploitation. As the researchers predicted, the results suggested that youth with a history in the sex trade displayed increased levels of resiliency later in life and more psychological steadfastness compared to youth without a history of trafficking. The female youth who were previously victims of sex trafficking had a greater tolerance against stress and were notably better equipped to “confront adversity and reduce psychological disruptions” (Gray et al., 2012, p. 365). These protective factors serve as strengths and possible supports to draw upon when working with such

a complex population. In a similar study, Knight et al. (2023) interviewed survivors of sex trafficking to gain their perspectives surrounding risk and protective factors, in which results suggested themes centered on the impact of resiliency. Interviews were conducted for 16 survivors who reported a history of domestic trafficking within the United States. These interviews were then qualitatively coded, specifically looking for content related to risk and protective factors, in which the authors then identified two overarching themes as these factors relate to resilience: (a) deep connections with oneself and others to help build resiliency, and (b) the negative impact of "help" on survivors' resilience (Knight et al., 2023). The first theme centered around survivors referencing resiliency was found in their ability to value and connect to both them and others helped them to feel a renewed sense of purpose and healing across all areas of their life. The second theme reflected common survivor experiences in which services and support provided to help them resulted in increased harm. The interviews identified supports that were not inclusive or had limitations in accessibility across survivor demographics and experiences often led to increased hurt and shame that transformed a protective factor into a risk factor for further exploitation and harm.

Additional research focused on sex trafficking survivors in Nepal, highlighted a variety of characteristics that impact long-term outcomes of this population (Crawford & Kaufman, 2008). Most notable from this study, the researchers emphasized specific aftercare factors that greatly impacted the success and reintegration of survivors to their native community and family system. These attributes included the presence of local anti-trafficking programs in or near the communities that women and girls were trafficked from, as well as the presence of job skills training as a built-in component of the aftercare model used within these anti-trafficking rehabilitation programs (Crawford & Kaufman, 2008). As research has focused on which factors

serve as protective or risk indicators for survivors of sexual exploitation, an analysis of components of aftercare or rehabilitation programs that serve such specific populations is also necessary.

Aftercare and Rehabilitation Program Success

Research focused on the impact of interpersonal relationships with survivors in the midst of exiting the sex trade suggests that positive relationships may foster greater resiliency for survivors long-term (O'Brien, 2018). In a qualitative study of domestic minor sex trafficking survivors in the United States, the results suggested that the presence of a strong and stable interpersonal relationship post-trafficking experiences encouraged them to persevere in new life struggles rather than return to trafficking. Although these relationships were described as difficult for survivors to form, as many of the survivors reported never previously having had a healthy relationship; the results indicate that an interpersonal relationship fosters resiliency. This was most especially relevant when analyzing survivor to survivor interpersonal mentorship connections (O'Brien, 2018). Other studies have made similar conclusions that assessed the impact of a survivor-mentor program of United States youth who were involved in commercial sexual exploitation (Rothman et al., 2020). The results suggest that the mentorship program, spanning a full year, led to significantly decreased experiences of youth engaging in delinquent behavior, using illicit drugs, avoiding sexually explicit behaviors, and an increase in reliance on social supports and positive coping skills. As noted by Graham et al. (2019), a variety of measures from previous studies emphasizes ways to evaluate the success of aftercare programs in differing domains. This meta-analysis suggests that successful aftercare programs tend to include a more holistic approach toward empowerment and reintegration, rather than focusing solely on areas of physical or mental health. Specifically, the study illuminates the importance of

attending to employment status and skills, education or training engagement, life skills, legal needs, and spiritual well-being (Graham et al., 2019). Despite such important research existing and continuing to unfold, there remains a significant gap in research focusing on which factors and characteristics of survivors impact the retention and success rate of aftercare rehabilitation programs.

In a similar field that often intersects with the work of such trafficking rehabilitation programs, alcohol and drug recovery centers provide services and resources to populations that parallel those of sex trafficking and industry survivors. The services within these facilities have a variety of structures and organizations, including professional treatment centers, mutual health organizations, and recovery community centers. As a more recently developed and funded structure, recovery community centers are "a third tier of recovery support services…that are neither treatment nor MHO [mutual health organization] that encompass an all-inclusive flexible approach combining professionals and volunteers" (Kelly et al., 2020, p. 2). Such a model provides services that are unique compared to mutual help organizations like Alcoholics Anonymous in that in addition to professional addiction support they provide rehabilitative services like connections to social services, employment, and educational agencies. Within this model, the emphasis is recognizing there is no one way towards recovery, but rather recognizes the individual differences and therefore specific needs of each individual when providing recovery support (Kelly et al., 2020). One research study compared community-oriented living facilities, called Oxford houses, to usual-care services like outpatient treatment or self-help groups to identify the impact of mutual help-oriented supports on resident abstinence, incarceration rates, and employment (Jason et al., 2006). In this study, individuals from Illinois with substance abuse histories were randomly assigned to be residents in an Oxford house or

receive usual-care services once discharged from a substance abuse treatment center and followed-up over a 24-month period. Residents who were placed in the Oxford houses, a place in which is independently operated by residents who pay for their own weekly household expenses and agree to absolute abstinence from both alcohol and drugs, revealed greater outcomes regarding decreased substance use, lower rates of incarceration, and higher monthly incomes. The authors surmise this may be due to the residents creating a stronger bond with one another within the communal living facilities due to similar recovery values and a common goal of abstinence (Jason et al., 2006). Such results have significant implications surrounding the influence of community and peer relationships in recovery and rehabilitation processes.

Many research studies have focused on the impact of engagement in faith-based rehabilitation or practices regarding overall mental and physical health outcomes. In a study identifying the associations between religion and spirituality, researchers found levels of prayer and religious attendance within populations of homeless women who were victims of abuse were correlated with sleep and physical health outcomes (Brewer-Smyth et al., 2020). Additionally, literature supports a positive impact of faith-based and religious engagement on promoting mental health and well-being, in which the social supports and altruistic themes accompanied by such religious engagement assist in greater resiliency and overall lower levels of stress. In a meta-analysis, some findings suggested more religious or spiritual individuals may have less physiological impact of stress hormones as a result of increased engagement in practices that encourage self-forgiveness rather than rumination over one's sins, ultimately leading to greater levels of resiliency post-adverse childhood experiences (Brewer-Smyth & Koenig, 2014). Similarly, researchers conducted interviews with graduates from a faith-based correctional program in Indiana to measure the effectiveness and impact on participants post-reentry

following their incarceration. Such a program required clients to attend weekly meetings with mentors and religious church services (Roberts & Stacer, 2016). Interviews with 13 graduates from the program focused on what expectations they had at the onset of their time in the program, their experiences throughout the program, and what benefits did they receive from engagement and successful graduation. Overall, graduates noted feeling accepted and supported by the church communities they were assigned with and reported the spiritual aspects of such a program differentiated it from prior treatment or rehabilitative programs they had encountered. Specifically, 12 of the graduates reported significantly positive relationships with their mentors within the program, while 10 of them noted feeling supported and held accountable by such a relationship (Roberts & Stacer, 2016) Such similar programs suggest the interplay between recovery and rehabilitation when including faith-based components into treatment.

Program Evaluation

Despite many initiatives and programs existing to support survivors from the sex industry, limited literature focuses on program evaluation to examine the efficacy and success of such programs. Even so, in recent years a variety of federal and state-funded programs have been created specifically to measure the effectiveness of current treatment and rehabilitative programs. Specific to Los Angeles, the city created a program called the Los Angeles County Evaluation System (LACES) to collect data and assess already existing programs in place to decrease substance abuse in the greater LA County. In order to measure overall improvement in functioning for patients and individuals, the LACES program analyzed levels of impairment for patients at the beginning of treatment and then again 12 months following admission via interview through the Addiction Severity Index. Ultimately, by collecting such detailed information at the outset of admission and then within a 12-month period following admission,

the LACES program was able to document potential changes in patients' functioning from baseline as compared to later assessment points and identify the effectiveness of treatment (Crèvecoeur et al., 2002). Specific to faith-based organizations, there is a significant need to utilize evidence-based practices in which interventions and program success can be measured accurately. As Terry et al. states, "many religious traditions value providing services to the public that are intended to increase well-being and/or reduce suffering…while FBOs' [faith-based organizations'] services can be measured in terms of program outputs, it is often unclear whether these outputs correspond to achieving the desired program outcomes," (Terry et al., 2015, p. 214). Their research recognizes the impact of latent variables on such faith-based organizations, in which they are described as components that impact treatment but are difficult to identify and measure. The topic of mental well-being when engaging in such support is a commonly experienced latent variable, as such a concept cannot be directly observed in all environments. As such, it is recommended that such organizations and programs utilize evidence-based practices to support the communities more accurately and effectively they serve (Terry et al., 2015), resulting in the intersection of faith and psychology, and involving psychologists within the FBO to support such evaluations of validity.

Current Study

As a result, the purpose of this study is to identify which factors in applicants entering a sex trafficking rehabilitation program will have greater success of reintegration into society from the sex industry. The study hypothesizes that applicants who have greater interpersonal connections, access to holistic and supportive aftercare services, and history of fewer adverse childhood experiences are more likely to complete and fully reintegrate following the aftercare program. These factors will be measured through archival data chart review of previous

applicants within a specific, faith-based aftercare program to chart success or failures in completing the program.

Chapter 2: Methods

Participants

This study utilizes archival data from a faith-based transition program developed to support and empower survivors of sex trafficking. The data was gathered through a records review of the program's application folders from all individuals who have applied for and engaged in the program in a 7-year period spanning 2013–2020. All applicants are adult women who have experience, in some form, within the sex trade industry. The reintegration program is in Kansas and is connected to a non-denominational church in the local community. Table 1 provides a summary of demographic characteristics of the sample, including age, ethnicity, years spent in the industry, and number of mental health diagnoses, including bipolar disorder, borderline personality disorder, dissociative identity disorder, PTSD, and schizophrenia. This program provides holistic services and support to participants, with a specific integration of the Christian faith into the overarching program. This faith-based approach includes encouraging program participants to engage in weekly bible studies, church attendance, and mentorship with volunteers from the program. Applicants in the program engage and are considered to have graduated from the transitory program when they have met the goals of the program, including completion of a job apprenticeship, participation in life skill classes, and physical and mental health stabilization. Additionally, individuals within the program may also develop personalized treatment goals to reach prior to graduation. Yet, to complete the program, individuals must meet the initial three goals of the aftercare program. Typically, the average length of time in the program is 18 to 24 months. Prior to starting the program, all individuals complete and sign an

umbrella informed consent to allow the program to store and use their information/documents as needed.

Table 1

Demographics

Variable	% of population
Age in years	
18–25	24
26–39	64
40–57	12
Ethnicity	
White	60
Black/African American	12
Latinx	15
Multiracial	8
Other	5
Years spent in industry	
Less than 1	11
1–5	35
6–10	37
11–20	13
21–30	4
Number of mental health diagnoses	
0	12
1	46
2	19
3	21
4	0
5	2

Note. $N = 60$.

Materials

Data was analyzed from participants' original pen and paper application into the program. A blank copy of this application is included in Appendix A. Within this application, there are 10 items specifically highlighted used to measure the causes of retention in the program as listed in Appendix B. Records review of applications over the identified 7-year timespan was assessed to differentiate factors that lead to success for individuals who graduate from the program or to identify patterns in one's inability to successfully meet program goals for those who leave prematurely.

Procedures

Once paper applications were collected, they were deidentified, directly input to a digital spreadsheet, and coded for the demographic information provided, as well as other items including social supports, if applicants have children, faith background, length of time in the sex trade, medical history, and history of child abuse/neglect (see Appendix B). Paper applications were de-identified by manually redacting personal and identifying information, including geographic locations, dates, and names, before being scanned into a locked and secure device to later be coded. Following the coding of the applications and the information, statistics were run to analyze the data.

Hypothesis

The predicted outcome of this research is that participants in the program who have greater interpersonal connections, access to holistic and supportive aftercare services, and have a history of fewer adverse childhood experiences are more likely to complete and fully reintegrate following the aftercare program.

Chapter 3: Results

Pearson Chi-Square Test of Association

As the purpose of the study is to identify the relationship between various identity markers and responses within the applications completed by participants entering the rehabilitative program, correlations were run to assess for such relationships. Because most of the data were categorical (i.e., nominal, or ordinal data), contingency tables and associated contingency coefficients were calculated.

A chi-square test for association was conducted between each variable on the archival applications and those applicants who graduated from the program. An additional chi-square test of association was conducted between each variable on the archival applications and applicant ethnicity to see any significance. Assumptions of the test were met; specifically, all expected cell frequencies were greater than five.

Table 2 displays the predictive value of each categorical variable as it relates to program success. Only one variable, having a prior diagnosis of PTSD, was able to predict success in the program, $\chi^2(1) = 4.62$, $p = .03$.

Table 3 displays the predictive value of categorical variables that were noted as statistically significant as it relates the ethnicity of applicants for the program. Applicants who identified as White were able to predict a historical diagnosis of an eating disorder, $\chi^2(4) = 10.71$, $p = .03$ as well as predict applicants being in contact with their family of origin $\chi^2(4) = 12.36$, $p = .015$.

Table 2

Chi-Squared Tests for Each Variable and its Association With Success in the Program

Variable	*df*	χ^2	*p*
Ethnicity	4	2.81	.59
Having exited the sex industry	1	<0.001	.99
Having children	1	0.43	.51
Having prior medical conditions	1	3.10	.08
Having HIV	1	0.82	.37
Having a gastrointestinal medical condition	1	<0.001	.99
Having a respiratory condition	1	1.25	.26
Having diabetes	1	0.02	.88
Having cancer	1	0.04	.84
Having heart disease	1	1.25	.26
Having history of an eating disorder	1	3.13	.08
Having other medical conditions	1	0.77	.38
Having a physical disability	1	0.02	.88
Having a history of self-harming behaviors	1	0.46	.50
Having a trauma history	1	<0.001	.99
Having a history of suicidal ideation	1	0.38	.54
Having a history of alcohol/drug use	1	0.77	.38
History of sexual abuse	1	0.42	.52
History of rape or sexual assault	1	0.01	.93
Having contact with family of origin	1	1.39	.24
Having a prior diagnosis of ADHD	1	3.45	.18
Having history of special education services	1	0.76	.38
Having a prior diagnosis of bipolar disorder	1	0.04	.85
Having a prior diagnosis of borderline personality disorder	1	1.57	.21
Having a prior diagnosis of dissociative identity disorder	1	2.21	.14

Variable	*df*	χ^2	*p*
Having a prior diagnosis of schizophrenia	1	0.13	.72
Having a prior admission into a psychiatric hospital	1	0.02	.88
Having a prior admission into a substance detox facility	1	0.66	.42
Having a prior admission into both a psychiatric hospital and a substance detox center	1	0.02	.90
Having a prior diagnosis of post-traumatic stress disorder	1	4.62	.03

Table 3

Chi- Squared Tests for Statistically Significant Variables and its Association with Applicant Ethnicity

Variable	*df*	χ^2	*p*
Having history of eating disorder	4	10.71	0.03
Being in contact with family of origin	4	12.36	0.015

Eta Correlation Coefficient

To analyze possible associations between applicant variables with the number of reported mental health disorders the eta correlation coefficient was used to determine correlation between nominal and ratio variables. Considering effect sizes $\eta = 0.5–0.8$ as moderate, only four variables revealed a moderate association for the number of mental health disorders reported: bipolar disorder $\eta = .57$, borderline personality disorder $\eta = .66$, PTSD $\eta = .50$, and schizophrenia diagnoses $\eta = .61$. A summary of these results can be found in Table 4. Additional eta correlation coefficients were used to determine strength of associations between applicant age to variables from their application and the number of years an applicant spent in the industry with variables from their application. However, all generated effect sizes were insignificant and considered low. A summary of these results is included in Tables 5 and 6.

Table 4

Eta Correlation Coefficient Value Between Variables With Number of Mental Health Disorders Reported

Variable	Number of mental health disorders reported
Ethnicity	.15
Having exited the sex industry	.15
Having children	.19
Having prior medical conditions	.06
Having HIV	.07
Having a gastrointestinal medical condition	.1
Having a respiratory condition	.05
Having diabetes	.05
Having cancer	.02
Having heart disease	.13
Having history of an eating disorder	.14
Having other medical conditions	.05
Having a physical disability	.02
Having a history of self-harming behaviors	.01
Having a trauma history	.13
Having a history of suicidal ideation	.06
Having a history of alcohol/drug use	.13
History of sexual abuse	.01
History of rape or sexual assault	.08
Having contact with family of origin	.21
Having a prior diagnosis of ADHD	.25
Having history of special education services	.20
Having a prior diagnosis of bipolar disorder	.57
Having a prior diagnosis of borderline personality disorder	.66

Variable	Number of mental health disorders reported
Having a prior diagnosis of dissociative identity disorder	.47
Having a prior diagnosis of schizophrenia	.61
Having a prior admission into a psychiatric hospital	.26
Having a prior admission into a substance detox facility	.26
Having a prior admission into both a psychiatric hospital and a substance detox center	.26
Having a prior diagnosis of post-traumatic stress disorder	.50

Table 5

Eta Correlation Coefficient Value Between Variables With Age of Applicants

Variable	Age of applicants
Ethnicity	.28
Having exited the sex industry	.02
Having children	.36
Having prior medical conditions	.09
Having HIV	.07
Having a gastrointestinal medical condition	.02
Having a respiratory condition	.05
Having diabetes	.14
Having cancer	.22
Having heart disease	.05
Having history of an eating disorder	.16
Having other medical conditions	.06
Having a physical disability	.06
Having a history of self-harming behaviors	.15
Having a trauma history	.14
Having a history of suicidal ideation	.30
Having a history of alcohol/drug use	.39
History of sexual abuse	.05
History of rape or sexual assault	.01
Having contact with family of origin	.02
Having a prior diagnosis of ADHD	.17
Having history of special education services	.15
Having a prior diagnosis of bipolar disorder	.14
Having a prior diagnosis of borderline personality disorder	.03
Having a prior diagnosis of dissociative identity disorder	.14
Having a prior diagnosis of schizophrenia	.01

Variable	Age of applicants
Having a prior admission into a psychiatric hospital	.08
Having a prior admission into a substance detox facility	.04
Having a prior admission into both a psychiatric hospital and a substance detox center	.17
Having a prior diagnosis of post-traumatic stress disorder	.06

Table 6

Eta Correlation Coefficient Value Between Variables With Years Spent in Sex Industry

Variable	Years reported in sex industry
Ethnicity	.17
Having exited the sex industry	.18
Having children	.36
Having prior medical conditions	.24
Having HIV	.03
Having a gastrointestinal medical condition	.03
Having a respiratory condition	.20
Having diabetes	.02
Having cancer	.25
Having heart disease	.08
Having history of an eating disorder	.20
Having other medical conditions	.06
Having a physical disability	.13
Having a history of self-harming behaviors	.14
Having a trauma history	.12
Having a history of suicidal ideation	.11
Having a history of alcohol/drug use	.04
History of sexual abuse	.03
History of rape or sexual assault	.17
Having contact with family of origin	.07
Having a prior diagnosis of ADHD	.19
Having history of special education services	.14
Having a prior diagnosis of bipolar disorder	.06
Having a prior diagnosis of borderline personality disorder	.07
Having a prior diagnosis of dissociative identity disorder	.02
Having a prior diagnosis of schizophrenia	.08

Variable	Years reported in sex industry
Having a prior admission into a psychiatric hospital	.09
Having a prior admission into a substance detox facility	.36
Having a prior admission into both a psychiatric hospital and a substance detox center	.12
Having a prior diagnosis of post-traumatic stress disorder	.06

Pearson Correlation Analysis for Numbers of Mental Health Disorders

A Pearson's correlation was run to assess the relationship between the number of mental health disorders reported by applicants and the age of applicants. There was no statistically significant correlation between applicant age and the reported number of mental health disorders, $r(55) = .03$, $p = .42$. An additional correlation was run to determine the relationship between the number of mental health disorders reported by applicants and the years spent in the industry. There was no statistically significant correlation between years in the industry and the reported number of mental health disorders, $r(47) = -.05$, $p = .37$. Table 7 summarizes these results.

Table 7

Pearson Correlation Value for Number of Mental Health Disorders Reported in Relation to Age and Years in Industry

Variable	Number of mental health disorders
Age	.03
Years in industry	-.05

Chapter 4: Discussion

Treatment and support of individuals exiting the sex industry continues to be a nuanced and multifaceted approach due to the complexity of survivor experiences and histories. This study focuses on which factors of an applicant's background impact program success within a sex trafficking rehabilitation program and reintegration into society. A total of 60 archival applications to a rehabilitative program were reviewed and responses coded to be compared with success in graduation from the program. Specific interest was focused on variables surrounding interpersonal connections with family of origin and history of traumatic experiences, as well as medical and psychiatric history. Results revealed that a prior diagnosis of PTSD is associated with applicants successfully completing the program.

Discussion of Initial Hypothesis

Due to the categorical nature of the study, chi-square test of association was the primary statistical analysis used to explore applicant variables related to program success. After the analyses, results revealed that applicants who reported a prior diagnosis of PTSD have an association with greater program success. Potential understandings for this pattern may likely be explained by the impact of applicant resiliency. As defined by the American Psychological Association (2020), "Resilience is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands" (Resilience section, para. 1). As applicants who reported a diagnosis of PTSD have experienced traumatic experiences, they likely have developed individualized abilities to cope and respond to stress responses and therefore have

learned new strategies to be flexible, support emotional health, and remain engaged on goals of finishing the program (Brewer-Smyth, 2022). Individuals who are resilient can search for support and resources necessary to cope with stressors and appropriately respond when faced with challenges–challenges that may include engagement in a structured rehabilitation program.

Discussion of Association

The eta coefficient correlation was used to identify any moderate or high effect sizes to determine strength of association between ratio and nominal variables. When analyzing applicant variables to the number of mental health disorders reported by applicants, the results indicated that applicants who reported a prior diagnosis of bipolar disorder have a moderate association with the number of mental health disorders reported. Likewise, applicants who endorsed a history of PTSD, prior diagnoses of schizophrenia, or borderline personality disorder were also moderately associated with the overall number of mental health diagnoses reported. These results are consistent with prior literature on comorbidities in severe and persistent mental illness and provide relevant information for rehabilitation programs to consider when determining needs and supports required for applicants accepted into such programs, which is to be discussed further in the limitations section.

Discussion of Relationships Between Variables

The number of mental health disorders reported by applicants were correlated with age of applicants and the number of years applicants spent in the sex industry to clarify any relationship between variables. For both variables analyzed, neither result indicated a relationship between the number of mental health disorders. As such, there is no relationship between the number of mental health disorders applicants reported with their age when applying for the program, nor is

there a relationship between the number of mental health disorders applicants endorsed with the number of years they spent in the sex industry.

Limitations

The present study contained many limitations. First, many portions of the applications reviewed and coded for data had missing information that resulted in inconsistent sample sizes for various variables. Specifically, initial applications to the program included unclear wording on the questionnaire, such as, “have you been raped?” or a boxed statement of “I have exited the sex industry,” with no room for clarification of what the sex industry encompasses. Many items were left unanswered by applicants, likely due to confusion or discomfort from non-trauma informed items. These applications were the sole documents submitted to screen for whether applicants would be accepted into the program, and the program did not request additional documentation or assessments surrounding medical or mental health history to address potential needs upon entering the program. Additionally, the program currently does not include reliable screening assessments to determine overall well-being upon entering the program, to determine risk of harm to self or others, or assess levels of substance use. Another limitation is that applicants come from a variety of backgrounds that each hold their own understandings of the phrase “the sex industry” that vary even from the definition used within the program. As such, histories noted from applicants include a variety of experiences within the sex industry, including sexual exploitation, sexual assault, prostitution, nude dancing, and sex trafficking. Lastly, there is limitation due to the nature of the study being centered upon the concept of success, in which this is primarily considered graduation from the program; however, applicants who complete the rehabilitative program do not always reintegrate into society due to high rates of recidivism and sometimes continue to be victims of violence.

Implications

Implications from this study are centered upon the impact of the rehabilitative program and how applicants from various backgrounds and experiences can successfully graduate from such a program. As the tests of associations reveal, an applicant's level of resiliency and prior diagnosis of PTSD likely help them to better persevere through the challenges and healing within the program. An applicant's desire to be motivated to reintegrate into society and experience post-traumatic growth allows for better program success. As the current program applications do not require screenings for adverse childhood experiences, PTSD screeners, or brief motivation assessments, this may be a helpful shift in identifying increased resiliency within applicants. Additionally, the program does not receive detailed medical or psychiatric history outside of self-report diagnoses from applicants. Even so, the results of the study highlight the impact of mental health diagnoses; specifically, PTSD, bipolar disorder, and borderline personality disorder, on applicant mental health when initially applying for the program. The inclusion of broad mental health screeners or assessments as part of the application process can better clarify psychiatric needs that may determine how well the program can accommodate each applicant, most especially applicants who may have severe and persistent mental illness.

Future Directions

Future research should aim to provide program evaluation support to revise current applications to include more trauma-informed questions while also incorporating additional questions to determine further medical/mental health needs when applicants are accepted into the rehabilitative program. The introduction to mental health screeners to determine applicant well-being in a pre-post study would provide helpful insight into determining the influence of psychiatric history while individuals are engaged in the program, rather than solely at the outset

of application. Brief assessments like the Personal Health Questionnaire-9 that are public access would be beneficial in providing succinct understanding of applicant's current mental health symptoms at the start of the application process and then again later as they graduate from the program. Additionally, due the perceived impact of resiliency on applicants' graduation, a resiliency measure may also be beneficial to gauge levels of resilience within applicants. An assessment such as the Connor-Davidson Resilience Scale that has five unique components, including spiritual influence, would also provide additional insight and provide quantitative data the organization can then utilize throughout treatment in the program. The utilization of the Personal Health Questionnaire-4 while participants are engaged in the program every 6 months could also help the organization track movement on applicant mental health.

Although the current program does include medication management and therapeutic services through an outpatient clinic, the introduction of such screeners can better assist in accommodating individual needs at the start of program engagement. This could also serve to provide a way for the program to better identify which applicants are a greater fit for the program and helping direct applicants to different resources that better support their needs.

An additional study focusing on post-graduation from the program could identify the way success from the program translates into greater reintegration into society. This could include follow-up interviews or questionnaires, completed by graduates, that target current functioning and utilize similar mental health questionnaires from applications that can then be compared to one another. Such a study would answer the question of how specifically the program is supporting graduates long-term and the impact made on these individuals.

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Appendix A: Program Application

The Homestead Program Application

Referred by: _____ Date: _____
Applicant Name: _____ Birth Date: _____
Address:_____
Phone: Home (____)_____ Work (____)_____ Cell (____)_____

Date of birth:_____**Age**:_____

Ethnicity: ____African American ____Asian ____Caucasian ____Hispanic ____Other

City, State, & Country of Birthplace:_____

Physical Characteristics:

Height:_____Weight:_____Eye Color:_____Hair Color:_____

Marital Status:____Single ____Married ____ Divorced_____ Separated_____

Yes/ No STATEMENT/QUESTIONS:
I have exited the sex industry. If yes, DATE: _____
Length of time I worked in the sex industry: _____
I speak fluent English_____
I am 18 or older_____
Do you have children?_____
If yes, do your children have care while you would be residing at the Homestead? _____
The Homestead provides long-term, transitory care; therefore, your initial recovery work must have been completed before entry into the Homestead Program. Summarize your healing/recovery journey from the day you exited sex industry to present:

_____
_____
_____
_____

Physical

Please circle any of the following that you currently have or have had in the past. For all of those that are circled, please explain briefly in the remarks section below.

- HIV/Aids
- Major Gastrointestinal Problems
- Chronic Respiratory Condition
- Diabetes
- Cancer
- Heart Disease
- Tuberculosis
- Eating Disorder
- Physical Disability

Remarks:

_____
_____
_____
_____

Do you have any allergies? List all known allergies:_____

List any and all medication(s) that you take:

Medication: Dosage: Reason: For How Long:

List any dietary restrictions/limitations:_____

Mental/Emotional

Check any of the following that apply to you. If you had trouble in the past but not presently, check yes. If problem started in the past and still exists, check yes. If problem started in the last two years and still exists, check yes.

Yes/ N0 STATEMENT/QUESTIONS:

I have had a problem with cutting/self injury._____If yes, when was the last time you thought about cutting/self-injury?_____.

I have suffered significant trauma._____

I have had suicidal ideations or thought of suicide._____If yes, when was the last time you thought about suicide?_____Have you ever attempted suicide?_____.

If yes, how many times?_____. IF yes, when was the most recent time you attempted?_____.
I have had problems with violent behavior._____. If yes, when was the last time you engaged in violent behavior?_____. Please briefly describe the type pf violent behavior you've engaged
in._____.
I have abused or been a addicted to alcohol/drugs_____
If yes, please specify:_____
Has there been a history of sexual abuse?_____
I have experienced sexual trauma._____
Are you connected to any members of your family of origin?_____

Have you ever experienced confusion about your sexuality? _____ If yes, please explain:_____

_____

The Homestead is a group home and will potentially have six other ladies in the home. Do you have any problems or concerns with having roommates?
If yes, please explain: _____

Counseling and Treatment: YES/NO ANSWERS:
Have you ever been diagnosed or treated for:
ADD/ADHD _____
Bi-Polar Disorder _____
Borderline Personality Disorder_____
Dissociative Identity Disorder_____
Obsessive Compulsive Disorder_____
Post Traumatic Stress Disorder_____
Schizophrenia_____
Used Saboxin_____
Have you ever received psychiatric care or been in a psychiatric hospital, rehabilitation or substance detoxification program?_____ If yes, briefly
explain:_____

_____

Substance Abuse

When was you last use of the following:
Alcohol_____
Marijuana_____
Methamphetamine_____
Amphetamines_____
Opiates (not prescribed)_____
Benzodiazapines (not prescribed)_____

Any other substance not listed above (name substance and last use)_____
Have you ever used a drug via injection:_____

Have you ever attended the following treatment and if so, when and where were your last treatment episodes?
Outpatient_____
Detox_____
Inpatient_____
Reintegration_____

Did you successfully complete treatment?_____
Did you ever leave treatment early?_____

Is there family history of substance use disorder?______
Do you have sober friends?_____
Has anyone expressed concern to you regarding your substance use?_____

Educational/Occupational

Level of Education:_____
Vocational Training:
_____
_____
_____
_____
_____
Other:
_____
_____

Have you ever been in any special education classes? _____ If yes, please list:_____

List any identified education-related problems (including learning disabilities, reading comprehension problems, behavioral problems):_____

The job apprenticeships that we will have available with the Homestead Program are listed below. Please check the following that would be of interest to you.

Dental Assistant
Assistant Real Estate Broker
Dog Groomer
Optician
Florist
Property Management

Work History (Most Recent First)
Employer: _____ Position: _____
Type of Business: _____ Salary: _____
Dates: _____/_____ Reason for Leaving: _____
**********_____
_____
Employer: _____ Position: _____
Type of Business: _____ Salary: _____
Dates: _____/_____ Reason for Leaving: _____
****
******_____
Employer: _____ Position: _____
Type of Business: _____ Salary: _____

Future Employment Desires:_____

Legal

Yes/ No Questions:
Do you have any pending legal issues?_____ If yes, please explain:_____
_____
Are you currently on parole?_____ If yes:
City:_____
State: _____

Financial

Yes/ No Questions:
Do you currently have a source of income?_____
Would that personal income continue while you would reside at the Homestead?_____
Do you have personal bills/payment obligations?_____
Do you have the means to take care of the pending financial issues while residing at the Homestead?

Who will assist you with finances for your personal or medical needs while at The Homestead (church ministry,family,or individual)?_____

Legal Disclaimer

The Homestead will not make any requests for payments in regards to the program, living accommodations, or catering arrangements. Please understand that The Homestead Ministry expects all those accepted into the program to ensure that arrangements are made for the payments of personal bills/loans outside of the program, as we do not accept any liability for personal debts accrued during your stay at The Homestead.

Spiritual/Religious

Current Religious Affiliation (if any):_____
Childhood Religious Upbringing: _____
Have you ever witnessed or been involved in occult activities?_____YES _____NO If yes, please write a detailed explanation of your involvement with occult activities:_____
_____
_____
_____
Have you ever been abused in any of these activities? _____YES_____NO If yes, please explain_____
_____
_____
_____
Anything else you would like to share:
_____
_____
_____
_____

Miscellaneous

Yes/ No Questions:
Do you have a car?_____
If yes, would you like to bring your car to the program?_____
If yes, do you have car insurance?_____
Do you have medical insurance?_____

Why would you like to participate in the Program?
_____
_____
_____
_____

Probationary Period

The first 30 days at The Homestead are a Probationary Period making sure that The Homestead Program is a good “fit” for you and that you are truly ready for what The Homestead Program has to offer. If at the end of the first 30 days (or at any point in time) it is obviously a non-fit situation as determined by the Executive Director, please state your departure plan below:

If I am not ready for The Homestead Program, please contact:

Name:_____Association to you:_____
Phone:_____email:_____

How will the above named contact get you to your next destination?

Who will pay for your transportation to your next destination?

I have answered all the above questions honestly and to the best of my knowledge. I understand that if I have failed to answer these questions truthfully or knowingly withheld any

information, it may negatively impact my application with The Homestead or be considered grounds for discharge from the program.

Applicant: (Signature) _____ Date: _____
Applicant (Print Name)_____

For office use only:

The applicant _____ has been approved/denied for residential stay into the Homestead Program.

_____ _____
Program Director Signature of Approval
Date

Appendix B: Items for Coding

- Age
- Ethnicity
- Date of Birth
- "I have exited the sex industry"
- Years spent in the sex industry
- Do you have children?
- Prior medical conditions
- History of self-harm/self-cutting
- History of trauma
- History of drug or alcohol abuse/addiction
- History of sexual abuse
- Present relationship with family of origin
- Prior psychiatric diagnoses
- Education experience