The impact of working with human trafficking survivors

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The Impact of Working with Human Trafficking Survivors

Human trafficking is a growing public health crisis, one that is estimated to have affected at least 40.3 million people worldwide. Existing literature focuses on the lack of proficiency in identifying victims of trafficking by professionals in multiple front-line services, with a lack of focus on the psychological cost, to individual service providers, of providing aftercare to one of society's most vulnerable populations. This aftercare requires complex support delivered by specialist services that are routinely underfunded. Whilst existing research focuses on support and burnout in professionals within related settings, such as social workers and health care providers, little focus has been given to the impact of supporting survivors of human trafficking. The current study conducted semi-structured interviews with nine female volunteers at an anti-trafficking charity, to explore the effects of providing support to survivors of human trafficking. Participants held a variety of roles within the charity (e.g., counsellor, senior caseworker, voluntary caseworker, local co-ordinator, team administrator or community facilitator). A thematic analysis identified two main themes, with associated subthemes; First, the impact of working with survivors (Burnout and vicarious trauma; Privilege and awareness) and, following on from this, the methods used to manage this impact (Boundaries; Counselling; Supervision and team support). These findings provide important insight into the effects that supporting survivors of human trafficking have on service providers and highlight that there is still significant work to do in terms of providing appropriate support to those working with this extremely vulnerable population.

Keywords: human trafficking; support work; mental health; vicarious trauma; burnout

Introduction

Unseen, a United Kingdom (UK) based anti-slavery charity, define human trafficking as "the movement of people by means such as force, fraud, coercion or deception, with the aim of exploiting them" (Unseen, n.d.). Captors use various means to ensure victim compliance including isolation, intimidation, shame, and hopelessness (Baldwin at al., 2015). According to Unseen, human trafficking is a highly prevalent form of modern slavery (Unseen, n.d.); although accurate statistics around the prevalence of human trafficking are elusive due to the hidden nature of the crime, inconsistent monitoring, and self-underreporting by victims (Chambers, 2019; Jones et al., 2007), it is theorised to affect an estimated 40.3 million individuals globally (Zimmerman & Kiss, 2017). The United Nations (UN) (2000) outlines four key areas of exploitation; (i) sexual exploitation, (ii) forced labour, (iii) domestic servitude and (iv) criminal exploitation. It is a rising global problem in areas of law enforcement and public health, due to the long term psychological, physical, and social consequences for survivors (Ramirez at al., 2020; Clause et al., 2013). The focus of this paper is on human trafficking for the purposes of sexual exploitation, specifically on the experiences of charity workers who support survivors of sexual exploitation following their escape from human trafficking.

Currently, human trafficking is regarded as one of the most lucrative forms of organised crime, with the sexual exploitation of women and girls alone accruing 32 billion dollars annually (Thompson & Haley, 2018). Human trafficking is thus a social pandemic with cases found across the globe. Traffickers prey on the most vulnerable, such as those in poverty with no support, young children, and women (Adam & Webb, 2018; Sari & Khairunnisa, 2014; Varga & Weaver, 2013). In the UK alone, an estimated 150-1,500 women are trafficked per year to work in the sex industry (Kliner & Stroud, 2012). Given the varied

purposes for trafficking identified by the UN, it is reasonable to assume that many more individuals are trafficked into the UK annually for domestic servitude, forced labour and criminal exploitation alongside sexual exploitation.

Once an individual is identified as a victim of human trafficking there are ongoing challenges in relation to the quality of care they receive, as shown in preliminary research highlighting additional challenges faced by survivors after their escape (Pascual-Leone et al., 2017). Once an individual is identified by the government, they are processed through the National Referral Mechanism (NRM) process in order to confirm an official status, a process that can take up to 90 days. Whilst the decision is being made, the individual will receive a range of intensive medical and psychological support whilst being placed in a safe house. However, if they receive a negative decision this support ends within 48 hours, and, even if they receive a positive decision, governmental support ends within two weeks. Victims are thus left vulnerable without support, unless they are able to access independent charities, such as the charity explored in this research, to assist them in re-building their lives and integrating back into society.

To advance social justice and develop stronger support systems for some of the most exploited populations in the world (Hodge, 2014), Powell at al., (2017) build on Cole's (2009) suggestions regarding collaborative systems to identify the needs of survivors and highlight the importance of standardized training amongst health care providers to ensure that they are patient-centred and evidence-based, incorporating survivor-input on cultural and gender competencies. Such systems should feature professionals from a range of services including law enforcement, social care providers, health care providers and mental health professionals. However, as noted above, the current process for support often relies heavily on independent charities to act as the first point of contact for survivors. Empowering healthcare

workers with the appropriate training and awareness can enhance aftercare and allow survivors to build trust in the system that supports their recovery (Chambers, 2019), at a pivotal moment in the process of escape and recovery, if the interaction is a positive one (Miller at al., 2016). The ideal outcome of contact with services for survivors is that they have trust in, and feel supported by, services during this pivotal moment of escape, and during the process of recovery. Given the responsibility placed on independent charities it is important to understand the impact of working with survivors on workers within these services, in order to facilitate the best outcome for the service user, as well as the staff involved in their ongoing care.

However, when working with clients with acute trauma, empathic connections can be severed through low resources, staff shortage, high staff turnover, reliance upon temporary intermediate staff, and insufficient relevant education and training (Bowers at al., 2009). Within the network of professions that are vulnerable to these risks, such as social workers (Ashley-Binge & Cousins, 2019), health care providers (Powell at al., 2017), trauma therapists (O'Brien & Haaga, 2015) and mental health workers (Kiley et al., 2018), numerous studies identify how the prolonged occupational exposure to demanding interpersonal client trauma with inadequate support can lead to psychological strain (Devilly et al., 2009), impacting the longevity and quality of service an individual is able to provide (Meany-Walen et al., 2018). Arguably, research denotes empathy to be a central feature in the professional relationship between client and counsellor that is necessary to facilitate client recovery (Klein & Hodges, 2001). Issues arise when workers emphasise self-effacement and self-sacrifice over their own needs and wellbeing (Ramirez et al., 2020). Indeed, workers may find that the very factors that make them effective at providing successful treatment (e.g., empathy and the ability to form a therapeutic alliance) may also be some of the primary mechanisms in the

development of negative emotional reactions. This may then lead to a hesitance to engage in future therapeutic interactions or to ask questions that may elicit challenging disclosures, subsequently disrupting the quality of the service delivered. Conversely, a sense of foreboding and extremes of worry can arise that then results in overzealous protection. This can manifest in workers manipulation of client decision making to ensure the avoidance of the worker's anticipated risks to the client's safety and wellbeing. Such manipulation, or 'overriding' of participant decision making is countertherapeutic and only serves to allay the anxieties of the practitioner, rather than benefiting the service user (Ramirez et al., 2020).

Research by Baird and Jenkins (2003) and Pascual-Leone et al. (2017) explores the occupational hazards of working with trauma victims in domestic violence support staff, with exposure to survivors' trauma compromising the care providers' wellbeing in forms of emotional exhaustion, such as 'vicarious trauma' and 'compassion fatigue'. Whilst this research focused specifically on domestic violence support services, parallels are readily drawn with human trafficking support services. Both groups face significant trauma and often need similar support (for example support with housing and escaping an abuser). Within this research, vicarious trauma is defined as an individual's response to another individual's trauma, involving intense fear, horror, and helplessness (Mailloux, 2014), whilst compassion fatigue is increased physical and mental fatigue that results from empathetic listening to client-stress (Cuartero & Campos-Vidal, 2019). McCann and Pearlman (1990) posit that vicarious trauma occurs when service providers experience images and emotions associated with the painful, traumatic memories shared by survivors as part of their empathic engagement and eventually internalise these as part of their own memory. This leads to long term consequences, including an alteration in worldview and behavioural, affective, and emotional responses (Molnar et al., 2017).

Research by Tsutsumi et al. (2008) critiques the current United Nations support guide for human trafficking that demands explicit focus on mental health and psychosocial support, as this can, currently, only be achieved through external help. The pressure and responsibility independent charities face when being the only source of support for this complex vulnerable group is an area of research that is overlooked when exploring the effects of working with vulnerable populations. Research by Trifilleti et al. (2014) acknowledged that by routinely caring for individuals who were experiencing trauma, pain and suffering compromised the health of the care provider, demonstrating the need and ability of being able to regulate ones emotional responses in a high responsibility role, as further research findings from Vaes and Murotore (2013) predicted that humanizing a patient's suffering positively predicted symptoms of 'burnout' amongst health care workers. Crucially, carrying a client's trauma can lead to a constellation of symptoms for the care provider themselves (Fahy, 2007; Harrison & Westwood, 2009; Shapiro at al., 2007), leading to a need to identify appropriate coping strategies. Kliner and Stroud (2012) suggest that those who are less experienced, less educated, younger, and less supported are more likely to develop burnout, and that staff with autonomy, good supervision and co-worker support in supportive environments are less likely to experience compassion fatigue. A prominent theme throughout the literature on working with client trauma is the need to create a culture of self-care as a strategy to prevent impaired professional competence (Barnett & Cooper, 2009) and to avoid compromising client treatment outcomes (Barnett & Hillard, 2001). In relation to working with particularly vulnerable groups, previous findings attribute high turn-over of staff in child welfare departments to vicarious trauma, burnout and an absence of adequate supervision and co-worker support (Van Hook & Rothenberg, 2009).

For example, Domoney at al. (2015) note that health care providers working with survivors of child sexual exploitation (CSE) experience social instability, difficult interaction with law enforcement and the legal system, lack of supportive family, lack of client engagement and limited resources as well as poor coordination between services. Notably, Buchanan et al. (2006) found that therapists with high caseloads of traumatized clients were more likely to exhibit trauma symptoms themselves. However, Kliner and Stroud (2012) found no relationship between caseload size and burnout in service providers working with survivors of sex trafficking, and found symptoms of secondary traumatic stress (e.g., somatic pain, excessive drinking) present in individual service providers with high and low caseloads.

Existing literature provides insight into the impact on service providers of working with client trauma; burnout as a phenomenon is well-studied and is frequently associated with stress from "emotionally demanding situations" (Kliner & Stroud, 2012, pp. 10). Therefore, it is essential that service providers are aware of the potential effects of their role and have access to appropriate support resources. Trauma-informed self-care (TISC) is an awareness of one's response to trauma that motivates an individual to seek positive coping strategies, such as supervision, training and having a healthy work-life balance (Pope & Keith-Spiegel, 2008). Salloum et al. (2015) found that TISC influenced child welfare workers, with those who engaged in TISC experiencing higher levels of compassion satisfaction, defined by Figley (1995) as the experience of pleasure from helping others. Additionally, the study highlighted that individuals who experienced vicarious trauma were likely to need specialised therapeutic support to assist in their recovery, and on-going support and training was found to ensure work-force wellbeing for effective practice (Miller et al., 2018; Salloum et al., 2015). Pascual-Leone et al. (2017) suggest debriefing with colleagues or working as part of a treatment team

is recommended as is self-care, 'sufficient' supervision, and a supportive organisation. Workers need to be able to discuss not only issues with clients but also how these issues affect the worker personally. Ramirez et al. (2020) posit that involvement of trusted and competent colleagues is vital, as is self-reflection around knowing when to seek support and when to refer out to another practitioner, as do Kliner and Stroud (2012) who's findings illustrate the need for organizational support and training for staff working with vulnerable populations.

Thus, whilst working to support vulnerable people can be rewarding, it can also be incredibly stressful and can lead to vicarious trauma and burnout (Kliner & Stroud, 2012). Notably, Kliner and Stroud (2012) found that service providers reported working with survivors of sex-trafficking was more challenging than working with survivors of other types of trauma, suggesting that effects on individual service providers are context specific, and that working with survivors of human trafficking broadly may be particularly challenging.

Previous research shows that survivors of human trafficking experience similar morbidities and comorbidities to survivors of other traumatic events, including mental health issues such as PTSD and depression (Ramirez et al., 2020) and substance misuse (Hopper & Gonzalez, 2018); however, it is important to note that trauma is not universal and different experiences result in different complexities. Crucially, recent research highlights that human trafficking survivors face a range of "biopsychosocial vulnerabilities" (Ramirez et al., 2020, pp. 1) that mark out their lived experience as distinct from those who experience other forms of trauma, that can make working with this population at least, emotionally challenging, and at worst, traumatising for individual service providers. Furthermore, the impact of working with individuals who experience complex mental health issues following acute trauma must be acknowledged when attempting to cognize what supporting survivors of human trafficking

entails (Hemmings et al., 2016; Le, 2017). Therefore, it is important to specifically explore the experiences and support needs of those who work with human trafficking survivors.

To date, there is little research that focuses solely on the effects of working with human trafficking survivors. A notable exception is a study by Kliner and Stroud (2012), that focused specifically on the effects of working with survivors of sex-trafficking. People are trafficked for a range of reasons and the trauma experienced by survivors of human trafficking will differ greatly, leading to a broad range of support needs. Indeed, as noted by Pascual-Leone et al. (2017), human trafficking support services face special challenges when working with survivors, including but not limited to, language barriers, mistrust of professionals and difficulty finding ongoing support for clients. Such a broad spectrum of challenges may lead to a range of distinct experiences and support needs for those working to support this population.

When considering the growth of human trafficking and notable gap in current literature, alongside the potential for negative consequences for those working with this vulnerable group, there is a clear and justified need to create practices for care providers that enable them to work in a safe and supported way. The aim of the current study was to begin to close the gap in existing knowledge regarding working with survivors of human trafficking. As Pascual-Leone et al. (2017) suggest, these support services face special challenges when working with survivors. As such, the study sought to explore the impact of such challenges on individual service providers and to begin to examine the support needs of these workers. The research questions the study aimed to answer were:

(i) What impact does working with survivors of human trafficking have on support workers?

(ii) What tools do support workers who work with survivors of human trafficking use to manage the impact their role has on them?

Methods

Ethical Approval

Ethical approval was granted by the lead researcher's institutional ethics committee.

Participants

A volunteer sample of nine participants was obtained through an anti-trafficking charity based in the North of England. The sample size was utilised as it both fit within the staffing levels of the service and met Braun and Clarke's (2013) recommendations for sample size. Workers from this charity were approached due to the third author's involvement with a voluntary support programme run by the service. Due to the specific nature of the service provided by the charity, all employees at the charity are women, and therefore all participants were women. All participants held a role within the charity (e.g., counsellor, senior caseworker, voluntary caseworker, local co-ordinator, team administrator or community facilitator) and had prior experience within the support worker/charity sector. The majority of participants were educated to postgraduate level.

Design and Procedure

Semi-structured interviews were used to provide enough scope to fully explore the topic, whilst allowing the participants to respond to the interview questions flexibly, sharing information and experiences they felt were relevant in as detailed a way as they felt appropriate. This approach enabled participants to give a widespread narrative that captured shared and unique experiences, whilst allowing the researchers to guide and probe answers to generate meaningful data (Minton et al., 2018).

Questions focused on: (i) experiences of womanhood (e.g., gender equality, vulnerability, female traffickers, motherhood); (ii) experiences of working alongside the criminal justice system (e.g., strengths and weaknesses of the system, working with law enforcement and legal professionals); (iii) views on men relevant to role (e.g., male traffickers, male survivors); (iv) impact of role on personal wellbeing (e.g., identity, mental health, boundaries); (v) role of culture and (vi) spiritual beliefs.

Interviews lasted 25-60 minutes in length and were subsequently transcribed verbatim by the third author. Ethical requirements as set out by The British Psychological Society (2018) were adhered to throughout. Participants gave written consent after reading an information sheet detailing what the study and their participation in it entailed. Participants were made aware of their right to withdraw within the terms as described in the participant materials, as well as their right to refrain from answering any questions, to ask any questions or to take a break at any point. Pseudonyms were used in the final written report and any potentially identifiable features of the data were removed.

Methodological approach

Thematic analysis (TA) is a method for identifying patterns across a dataset, enabling data to be organized in a meaningful way and subsequently analysed/interpreted (Clarke & Braun, 2017). Specifically, Braun and Clarke's approach to TA (e.g., 2006; 2013) "provides a robust, systematic framework for coding qualitative data, and then using that coding to identify patterns across the dataset in relation to the research question" (Braun & Clarke, 2014, pp. 1-2). As such, it was decided that TA would enable the researchers to identify patterns (commonalities and differences) within participants' accounts of the challenges of working to support survivors of human trafficking, and thus to answer the current study's research questions.

Epistemological and Ontological Framework

It is important to acknowledge the contextual and co-constructed nature of interviews (Potter & Hepburn, 2005) and the researchers' role in the analytic process, such that it is not possible to 'give voice' to participants without researcher input impacting on their accounts in some way (Fine, 1992). Broadly, the current study takes a critical realist approach (e.g., Willig, 1999), examining participants' accounts of their experiences and their meaning making, as well as, to some degree, the ways in which this meaning making is situated at the broader societal level.

Analysis and Discussion

The six stages of TA as proposed by Braun & Clarke (2006) were followed to conduct a data driven, bottom-up analysis. Lincoln and Guba's (1985 as cited by Nowell et al. 2017) trustworthiness criteria were drawn on at various stages of analysis (e.g. theoretical and reflective observations were noted during initial familiarisation with the data; codes, themes and theme names were reviewed collaboratively at appropriate stages of analysis). Familiarity with the data was achieved by thoroughly reading and re-reading the transcripts, with initial points of interest noted. Following this process of immersion in the data, codes were applied to the transcripts to indicate units of shared meaning across the dataset, wherever relevant to the research questions. Coding was an iterative process, with the application of a new code at times resulting in the need to revisit the coded transcripts to ensure that earlier instances of the new code (i.e., data which fit within this unit of shared meaning) had not been missed, or a code needing to be changed to encompass a newly identified element of shared meaning. The coding process continued until all data were coded wherever relevant to the research questions, and all codes had been applied to every instance of shared meaning. Codes were then clustered to form themes around a "central organising concept" (Braun & Clarke, 2012, p. 89), which helped to clarify the core idea within each theme. Themes were then reviewed until each theme represented a distinct aspect of the data, with the themes overall providing a "meaningful and lucid picture" Braun and Clarke (2012, p. 65) of the dataset. Themes were then named according to the essence of the theme.

The analysis presented encompasses the entire dataset, in line with Braun and Clarke's (2006, p. 83) assertion that a TA that provides a "rich, overall description" of the data is especially useful when the topic is not well examined in previous literature. Two themes were identified

in the analysis. These were split into two distinct, but interrelated areas and broken down into five subthemes; (i) the impact of working with survivors (Burnout and vicarious trauma; Privilege and awareness) and (ii) the methods used to manage this impact (Boundaries; Counselling; Supervision and team support).

Theme 1: The effects of working with human trafficking survivors

As noted in the literature review, burnout and vicarious trauma is a prevalent phenomenon in professions that centre on front line work with survivors of traumatic experiences. In the present study, participants discussed the nature of burnout but also explored the unexpected consequence of raised awareness about their own privilege as a result of their work with survivors of human trafficking.

Burnout and vicarious trauma

Previous research has defined vicarious trauma and burnout, or compassion fatigue, as a ubiquitous occurrence amongst mental health professionals who face a high level of professional contact with traumatized clients generally (Benuto et al., 2018; Bride, 2007; Fahy, 2007) and with survivors of human trafficking specifically (Ramirez et al., 2020). A study by Ting et al. (2011) found that social workers experienced high levels of perceived stress initially after being confronted with client suicidal behaviour (CSB) that had the potential to develop into long-term perceived stress if not processed properly. This was evident in the current study; participants opened up about how distressing interactions, such as exposure to CSB and stories of rape involving clients, coupled with the difficulty faced when attempting to create healthy boundaries, impacted wellbeing and personal relationships.

These findings support those reported by Dworkin at al. (2016) in their research with rape crisis centre staff. Participant Two shared

> "Almost every day I was crying. I wasn't really coping at all. I think I had all the stories of their exploitation just in my head. Erm, and I was really struggling with like re-traumatisation…when clients told me this is how I want to kill myself, I just couldn't cope with having those conversations every day…nobody else was coming to support them it was just me…I was finding it really draining…And I think I do still struggle with getting those images out of my head… I had like an image of you know, a person who I had supported…I found it really challenging… I think it affected my relationship as well with my partner… I think sometimes hearing so many stories of people being raped…It's really affected me in my relationship. I don't think I'd really realised that".

Vicarious trauma is described by previous research as a process rather than an event, marked by physical and behavioural indicators, that allow an individual to become aware of any unusual manifestations in their health that demand therapeutic intervention (Salston & Figley, 2003). Participant Six described this process when experiencing vicarious trauma, unable to understand their response until they had therapeutic intervention from their counsellor:

> "I just couldn't even speak, and I remember obviously Muslim, outwardly Muslim, and I generally don't pray 5 times a day Muslims are supposed to pray…I went upstairs I did the obligatory wash that you do, and I went straight into prayer, and even in prayer I was in this different state…. the very next morning I had my counselling

session and I told her something really weird happened… I was muted and she said she was like oh right because you know what was happening there? She said you're trying to use a grounding technique to bring you back and the mutation was because you're taking on her trauma…I didn't even know it affected me and if I didn't have the counselling I wouldn't have known why I was like that."

Participant One defines the difference between being a 'warm fire' for someone, as opposed to taking on their trauma (Cuartero & Campos-Vidal, 2019), and furthermore recognises the importance of acknowledging their work's positive impact on their clients to fuel compassion satisfaction against compassion fatigue (Ramirez et al, 2020; Figley, 1995):

"My therapist calls it being a warm fire. And it's just like, being with the person…I can just be a warm presence, so that that person doesn't have to go through it alone…and we're able to, erm, see the difference and act to change it. But not, in as much as we can, erm, have our own well-being damaged. Because then we're not going to be useful…I can't burn out because I'm so sad because of all the horrible things that I see… when you have that goal in mind, of like I cannot burn out, because I am really effective, I'm a good caseworker, and *Charity Name*, is meeting a really good need…if I don't take care of myself the cost is I can't do this forever…be there but not taking it on."

Participant Nine refers to their experiences of vicarious trauma as 'emotional scars' that still have negative and positive present-day effects, with the latter reflecting the notion of compassion satisfaction (Figley, 1995) and how negative trauma-based experiences can be utilised as a catalyst to expand professional skills and personal growth if support is put into

place through training, supervision and personal therapy (Linley & Joseph, 2007), promoting resilience when dealing with future cases and preventing burnout (Jenkins et al., 2011):

> "I remember particular clients and then I'll get a bit of a pang of sadness about things that might have happened…the phrase that's popped into my head is emotional scars of doing the work but that sounds really negative but like, it definitely had an imprint on me, erm, but it's also affected me in terms of you know, being a lot more confident in advocating for people, or erm. Being able to put across my point or, you know like those skills as well I've definitely improved from doing this work."

Alongside the overwhelmingly negative impact of burnout and vicarious trauma, participants also identified a more complexed and nuanced phenomenon that centred on being made aware of their privilege through their work with survivors.

Privilege and awareness

With the prominent theme of poignant experiences shaping internal transformations through challenging encounters, a prevalent consequence of internal impact was the alteration of external views of the world, with an increase in awareness of privilege being shown repeatedly for every participant, thus being the most frequent theme of all that advocated a competence in socio-political issues as a requirement for ethical practice (Hays et al., 2007). Aligning with this, Participant One shares how they have now 'come out of the cave' from this reflective exposure:

> "I think in very sharp contrast. Like high ultra-definition, 4K, like, yes, as much like talking like this aware that like, I'm you know an educated white woman, that came

from a middle class upper middle-class background…I think I've become much more aware than I ever would be. Um and I don't think I can ever be different now. It's like you've come out of the cave."

Correspondingly, Participant Eight shares the same awareness of privilege, as well as new insight into oppressive practices within the current system (Ladd at al., 2018; Matos, Gonçalves & Maia, 2018):

"It helps me put my own life and worries and stresses in perspective. It makes me really value that a lot of the everyday things that we take for granted…the thing on me personally I think it's the impact on me is dealing with what our own system in this country does to very vulnerable people and that the home office and the G4S and even the council and other services are actually incredibly oppressive, and often work in ways that are really triggering to trauma".

Participant Five further expands on how working in this vocation has brought light to their privilege, and to the injustices that survivors face in society (Le, 2017; Thompson & Haley, 2018):

"It's made me aware of my own privilege. Erm, and seeing that hostility erm, has made me angry…I saw with my own eyes the clinical aspect of it…I wasn't expecting that, but I think to experience it and to sense it and to feel that hostility, erm, made me realise that erm, as I see it, there are people here that aren't welcome. And I found that very, very difficult to deal with. For a long time."

Contemporary research (Case, 2015; Bender at al., 2010) brings forward the benefits of integrating intersectional privilege with therapeutic practices and mental health support facilities to enhance multicultural competencies when supporting diversity, allowing privileged groups to act as an alliance through awareness and effective therapeutic care, that was strongly encouraged by Participant Nine:

> "There's those power imbalances and I think if you were to ignore the fact that you have privilege as a caseworker in this role, erm, and you don't acknowledge the power of differences you're not going to be able to do effective work with somebody, erm and that is definitely not something that I. Would of kind of realised before doing this sort of work… I think you have to acknowledge those differences and sometimes just be thankful your yeah, your privilege, and it does open your eyes."

Though an extremely difficult role and responsibility to undertake, all participants strongly exhibited their passion to continue within this sector and how it has changed them for the better through finding inspiration and strength after reflecting on the challenges their clients face (Brockhouse et al., 2011; Silveira & Boyer, 2015); additional findings by Coleman at al. (2018) suggested that working with client trauma builds resilience, awareness, mindful reflection and empathy for therapists to utilise in their own personal lives, Participant Five elaborated on this unified perspective and appreciation:

> "I think the effect it's had on me, the positive effect it's had on me. Erm, is more than I imagined actually…I think I went into this erm, with the hope that I'd be able to support, not have the answers for, but offer support and walk alongside someone.

who'd, who was erm wanting to move on with their life…I don't think I realised how much it changed me in the process really. Yeah. Hopefully for the good."

Consciousness raising, in terms of being made acutely aware of, and reflecting on, one's own privilege, as a direct result of working with survivors of human trafficking, is a key finding of the current analysis. Such findings are not well addressed in previous literature examining the impact of working with survivors of traumatic events. Thus, this highlights an important gap in existing knowledge, given the clear personal and professional benefits this awareness provided for participants in this sample.

Alongside discussing their experiences of burnout, participants also identified the key methods used to aid in management of the impact of burnout and vicarious trauma.

Theme 2: Methods used to manage the impact of working with human trafficking survivors

The methods outlined by participants centred on individual and collective factors. Individually, participants explored developing boundaries in their work with clients and accessing counselling as part of their role. Participants also identified the importance of a collective foundation to their professional practice, in the form of supervision and team support.

Boundaries

The ability to create healthy boundaries between work and personal life allows for the creation of a mental barrier that permits caseworkers to hold the process, but not be a part of it when supporting clients working through trauma (Kosanke et al., 2016). Developing this ability to disconnect from a client is an element of the role that has been explored in previous

research investigating the hazardous nature of enduring repeated engagement with traumatic experiences (Arnold et al., 2005; Alkema, Linton & Davies, 2008; Craig & Sprang, 2010). This exposure can induce an array of negative outcomes including vicarious trauma, compassion fatigue and burn-out, collectively re-phrased as 'the cost of caring' (Boyle, 2015). Research by Lianekhammy et al. (2018) found that amongst social workers, attending to oneself outside of work through holistic health practices enabled health promotion behaviours, that reduced the risk of depression and anxiety. Furthermore, prior research (Harrison and Westwood, 2009; Thompson et al., 2018) notes the importance of having healthy relationships and mindful hobbies outside of work to engage with levity, balancing out any negative experiences that may arise after being exposed to client trauma. Nurturing these areas of self-care and fostering a healthy balance between taking care of clients and oneself (Webb, 2011) was reflected in the current study, participants emphasised that creating boundaries was an essential form of self-care and was necessary to promote well-being, as demonstrated by Participant Nine:

> "I think everybody would be lying if they said they could go home and completely switch off. I've definitely had days where I've gone home and just thought, just couldn't switch off. But I think as I've got older or more experienced, I just think well actually, you know I'm not going to be able to switch off completely but let's do something else, let's go to the gym or go swimming and switch off and try and do other things and then remember that the best way to support my clients is to also look after ourselves."

Craig and Sprang's (2010) study found that greater experience with client trauma predicted higher levels of compassion satisfaction (Figley, 1995), with a decrease in

compassion fatigue. Similarly, participants in the current study found creating boundaries to be a vital discipline that developed over time through extensive experience and training within the role. Shapiro at al. (2007) discuss the notion of experience mitigating negative consequences, reporting that younger and newly qualified health care professionals demonstrated a vulnerability to occupational stress compared to more experienced practitioners. The impact of inexperience was acknowledged by multiple participants when discussing their initial experience of the role. This is typified in the response from Participant Seven below:

> "When I first started and I heard stories I wouldn't sleep sometimes for nights, because they were so gruesome, some of them not all of them, some of them were just really horrible…sometimes my head just couldn't deal with it."

Participant Six reported the same issue when recalling their initial experience in the role:

> "I remember when I first started this job I read somebody's witness statement with, where there was graphic detail about how she was abducted and raped, and I couldn't that night I couldn't sleep…this kind of job is two ways where you go in a meeting and you're not just taking you're giving as well and there's this exchange that happens between you and the client… there are occasions during the three years where I have been like totally like knocked back by what I've heard and what I've seen, erm and then I've had to go away and really process it."

The concept of equally 'giving' yourself in the exchange with a client (Participant Six) was additionally shared by Participant Nine through an unorthodox client experience,

outlining how they support survivors at work, but also have a survivor living at their home, compromising boundaries between work and personal life (Speight, 2012):

> "They need to know this, and they need me to sort that and that's you know that's absolutely fine. But then I get home and then I've got. This girl sometimes also needing you know quite a lot and being a parent, you've got people needing you a lot and sometimes I'm just like I just need not to be needed by anybody I just need to go away somewhere."

This risk has been established in previous research from Audet (2011) that outlines the concerns of altering client-therapist boundaries, posing matters of tenuous role differentiation between personal and professional relationships that may impact the direction of the therapeutic process. The need for clearly defined boundaries is advocated for by Participant Eight when stating that, if they could not create these boundaries, they would be unable to support clients safely:

> "If I was a counsellor and all of the issues kind of impacted me personally, I wouldn't be able to do the job…there's somebody drowning in a river and you need to put one foot in the river to be near them to pull them out, but you also have another foot firmly on the bank, if you fall into the river with them you'll drown too…I can manage that by always keeping one foot on the bank."

Participant One highlighted a similar stance by identifying the duality of boundaries that protect both client and professional, recognising how the responsibility of creating

boundaries was not only important for the care provider to be able to support the client, but for the client to receive the most effective care (Menashe at al., 2014):

> "Love isn't going to heal these people. Expertise is going to. Erm, and so make sure you have both, the passion and the expertise. That's something we've always always said. Erm, because you just end up hurting people, you know. You just get in over your head because people don't know what's like. If you don't have any experience dealing with trauma…you're just going to end up hurt and hurting other people. And so always warn against that. We always tell people to make sure that they take good care of themselves. Have good boundaries."

Contrastingly, Participant Six voiced the importance of having flexible boundaries to make a genuine connection with a client for effective work, with previous research by Roberts (2005) defining this connection as the core of therapeutic work that provides reflective opportunities between the lives of client and therapist:

> "When I first started this job, I realised I had very rigid boundaries…I've realised you can't do this job like that…you do have to give a level of yourself… they have to know that you're being genuine that there's a part of you being given."

Research focusing on the positive outcomes of trauma-based exchanges when giving a 'genuine part of yourself' (Participant Six) to a client within healthy professional parameters has been found to enhance compassion satisfaction (Figley, 1995) and personal growth, enrich therapy plans, strengthen the client-therapist relationship (Pope & Keith-Spiegel, 2008), and furthermore make the therapy experience feel less 'clinical' and more 'humanized' (Audet,

2011). This can be developed through utilising experiences of vicarious trauma as a tool alongside receiving therapeutic intervention and supervision, increasing an individual's ability and expertise to work effectively with trauma-based interactions, that nevertheless clarifies the importance of creating initial boundaries, but through experience and support, allowing these boundaries to be adapted to each unique client experience (Adams at al., 2008; Craig & Sprang, 2010; Linley & Joseph, 2007).

Boundaries serve to keep both professional and client safe during their therapeutic interactions. Although difficult at times to maintain, particularly regarding 'switching off' following sessions with clients, all participants recognised the importance of maintaining these professional boundaries. One of the factors participants identified that helped maintain these boundaries was access to counselling as part of their work.

Counselling

Most participants vocalised an essential need to have professional therapeutic intervention in the form of counselling as a way to process client trauma ordeals in a manner that does not breach confidentiality or impact on well-being. This finding supports those of Kliner and Stroud (2012) who reported that participants found counselling and supervision to be useful in managing the stressful impact of working with vulnerable service users. The current literature advocates the need for mental health care workers to have training related to traumatic stress, as well as the importance of participating in personal therapy to prepare and support against the psychological hazards of working with client trauma (Palm at al., 2004; Trippany at al., 2004). Participant One illustrates the importance of having specialised support to support clients with complex mental health issues, whilst avoiding feeling isolated with a duty of care (Dane & Chachkes, 2001):

> "I think it would be really hard to not internalise if you didn't have somebody there who knows what they're talking about. Like, I think it's important that it's a professional that knows the area…if you've not got that support of your team. You are just isolated. I think that be really hard to deal with, I don't think I would have lasted a year if I didn't have like that support in place."

Research by Ting et al. (2006) found that mental health social workers isolated themselves after dealing with suicidal clients to avoid any potential legal consequences that may result from sharing client information as part of processing traumatic interactions, thus creating an un-healthy coping mechanism that affected their professional equilibrium. Participant Three additionally highlighted this issue:

> "I think it's really important, because if you don't have that you're just going to burn out. Because you're taking on everybody else's shit and not, you don't have anywhere to process it. Or you're going to end up slipping up and breaching confidentiality because you just need to talk to someone."

Correspondingly, research by Bercier and Maynard (2015) highlights the need for future research to focus on the neglected phenomenon of care provider responses to client trauma, to advance efforts in care provider wellbeing. Participant Six further emphasized the vulnerability of having no counselling alongside this role, as it would prevent workers from having a safe confidential space to process client trauma, as well as understanding their own physical and psychological responses to it:

> "I think I would do it. I just think I wouldn't realise how much trouble I'd be getting into, in terms of my mental health. I wouldn't realise it, I think it's the counselling that highlights…I think it would be very dangerous to do this job, because I'd be doing it, but I'd be making myself very unwell and I'd burn out very quickly."

Participant Eight portrays counselling as a part of their self-care to support their life outside of the role, that coincides with supporting themselves within their role; using the same reflective practices to create a healthy life balance of counselling and being counselled, mirroring how self-care is recommended to their clients. This reflective form of self-care between client and counsellor was recommended in previous research on counsellors experiencing vicarious trauma (Trippany at al., 2004):

> "I also pay for an additional session each month where I see my counsellor twice a month, erm that's really helpful…I'm aware that in doing two jobs that are very demanding takes its toll on me…knowing the value of talking and processing things that you're going through how helpful it is for my clients, but also for me just to have a place to kind of debrief myself kind of almost, and keep a check and to reflect and to process and reframe issues that are difficult" (Participant Eight)

The importance of individual counselling sessions was obvious throughout the sample. Having the opportunity to make space for discussion and sharing of negative repercussions of working with clients without concerns about breaching confidentiality was clearly important if workers were to continue their work with clients. This was coupled with group support, with participants highlighting the need for supportive colleagues to ensure they were able to support survivors successfully.

Supervision and team support

Research denotes the importance of social support in work environments for mental health professions as a protective mechanism against stress and burn-out (Boren, 2014; Sundqvist et al., 2018). Present in each interview was the necessity of having a strong support network and regular supervision, echoing the recommendations of Kliner and Stroud (2012). Like the function of counselling, participants shared how important it is to be able to 'offload' to somebody else at work, sharing the responsibility of caseloads in order to build a strong affinity of support and trust within a multidisciplinary team (Ben-Zur & Michael, 2007). Participant Eight declares

> "I know that I'm not the only person supporting their wellbeing, so whether they're clients at *Charity Name* or*Charity Name*, erm they might have a caseworker here at *Charity's Name*, there are other things that they are connected with erm, that's one of the things that makes working here possible…I know there are other people holding them, and sort of sharing that sort of responsibility more holistically, so that enables me to walk away from that session of an hour and not feel kind of burdened by what they've said".

Participant Seven highlights the advantages of working within a team environment that empowers them to feel supported through being able to "offload" when needed, that in turn helps them to incorporate both their professional and personal values (Dempsey & Halton, 2017):

> "I didn't deal with it awfully well because from the charities that I was at I had no support, and I had nowhere to offload, so I would offload on my husband. Erm, but he didn't really get it…in this charity if you are having problems with a certain case, there's always somebody to offload on, always. I have no hesitation whatsoever, of going to a particular person in the office…people here in the office they understand, and so you know you actually get help."

This finding builds on that of Kliner and Stroud (2012) who reported participants felt there was a lack of support in their service. This highlights the importance of a supportive work environment that allows workers space to process the complexity of the cases they deal with. Despite the positive relationship between client trauma experience and compassion satisfaction (Craig & Sprang, 2010; Figley, 1995), participants still signalled a crucial need to have the space to disburden themselves to routinely process trauma in a safe way, showing a lack of immunity to trauma regardless of training and experience (Bent-Goodley, 2018; Martin-Cuellar et al., 2018). Participant Eight shared

> "I don't think I would be working ethically or safely if I didn't have some other accountability or another way in which I can kind of verbally work through what's going on erm, with my clients to get support in dealing with individual cases but also in managing my own, making sure I'm cared for".

Moreover, in support of open communication as a form of support in similarly high level safe-guarding roles, Isaksson Rø et al., (2016) explored peer support amongst doctors, finding that seeking a second professional opinion can induce appropriate early intervention aid before serious consequences arise, benefitting all. This was shown in the current study, as

participants advocated supervision as a highly integral requirement of the role, Participant Five explained

> "The best way for me to be supported to support others…I think the best way is for me to have somebody to regularly talk to, supervision actually…I think that allows you to articulate things to reason things out, to explore maybe where somethings touched you. Erm, or you are affected by something…it means that you don't feel you're on your own and any sort of insecurities you've got…that's the most important thing to be well supervised and to be well supported. By the organisation that you work for. And valued actually".

Furthermore, participants encouraged open communication regarding their own wellbeing to manage responsibilities within the team and work effectively together. Research supports the advantages of this through creating a 'family' work dynamic where individuals can be open and comforted with their stress related problems at work (Bourassa, 2012; Dane & Chachkes, 2001). Participant Nine illustrates this finding:

> "I said to my manager I'm going to have a bad week because this is happening, and this is going on in my life and this is where my head is at. And they were able to kind of support me with my work and I wouldn't have maybe felt comfortable to do that in other organisations…I think you do have to be honest with where you are as well like, if you're not feeling great don't try and take on more than you can."

Team support, sharing responsibility and open communication were all key to ensure participants were able to fulfil their role safely and effectively. Participants were

overwhelmingly positive about the support they had from their team, a welcome contrast from the findings of Kliner and Stroud (2012).

Participants also reflected on the ways in which working with survivors of human trafficking had impacted on their personal growth, highlighting a shifting of perspective in relation to their own privilege. This is a novel finding and one that has not been previously investigated in the existing literature.

Conclusion

Thematic analysis provided insight into themes across the dataset, whilst also including a level of interpretation of participant's accounts of the reality of finding a balance between being a warm fire and burning out when working with victims and survivors of human trafficking. To support others, participants advocated the importance of being supported themselves through numerous self-care practices and professional therapeutic intervention, as well as regular supervision and team support in the workplace to manage caseloads, and to confidentially explore work-related stress to reduce feeling isolated with such a profound responsibility. Unique to the role of working with human trafficking survivors, providing empathy and sentience when working with a vulnerable population was a central feature in all roles within the charity, as well as applying practical knowledge to help support clients with legal and housing challenges. In alignment with existing research on working with client trauma in related professions, the study found vicarious trauma and burnout to affect individuals who struggled to create boundaries between work and personal life, that was shown to be most prevalent when first working with clients. These crucial components

enabled individuals to demonstrate compassion and take satisfaction and inspiration from helping clients, to enhance skills, promote wellbeing and self-growth with an increased awareness of their privilege and the additional challenges survivors face in society; this fuelled individuals to feel empowered and motivated in continuing to support survivors of human trafficking, making survivors and their stories visible. The findings of this study highlight the need for more funding for independent charities to support individuals with positive trafficking status to enable them to receive extensive on-going recovery support whilst minimising risk of negative impact on workers.

Limitations and further study

The present study shares specific methodological weaknesses with the earlier work of Kliner and Stroud (2012), in that participants were drawn from one organisation. However, as Kliner and Stroud (2012) suggest, there are very few agencies offering support to trafficking survivors in the UK and so any research will be limited as a result. Nevertheless, this limitation does not negate the findings of the current study and their importance in highlighting the need for further research. Whilst it is possible that the issues identified in this study are indicative of the particular environment (i.e. the specific support service), it appears unlikely given the overlaps between the present paper and previous work (e.g., Kliner and Stroud, 2012). However, further research with similar agencies would aid in clarification around this. The present study focused only on one area of human trafficking, it is possible that working with other areas of human trafficking may lead to differing issues and coping methods. Future research may choose to explore this through comparison studies, as an example.

This study also utilised a small/moderate sample, again due to staffing levels at the charity in question; whilst the sample size is appropriate for a TA study (Braun and Clarke, 2013), further research may choose to compare experiences in multiple charity services, in multiple geographic locations and may utilise a larger sample size. All participants were women, however, all employees at the organisation were women, and so this reflects the wider culture of the service in question. Future research may wish to explore the possible differences in gender regarding the impact of working with survivors of traumatic experiences.

Future research may also provide further insight into this area of study by focusing on a more in-depth comparative analysis between those who are inexperienced and those with extensive experience in the role; this could be implemented through using larger samples and obtaining participants from multiple charities to produce more generalised knowledge and understanding about potentially collective experiences. Furthermore, future research may choose to utilise focus groups, rather than individual interviews, to ascertain whether group discussion elicits any alternative perspectives. Additionally, future study in this field may utilise the current study as an introductory framework, to gain insight into the effects of working with human trafficking survivors through understanding the importance of appropriate training, privilege awareness and alliance, counselling, supervision, regulation of work/life balance, caseload management and team support.

Declaration of Interest

Authors have declared no conflicting interests.

References

Adam, B., & Webb, S. (2018). The Exploitation of Children: Understanding Human Sex Trafficking. *Journal of the American Academy of Child & Adolescent Psychiatry*, 57(10), S105–S105. https://doi.org/10.1016/j.jaac.2018.07.513

Adams, R., Figley, C., & Boscarino, J. (2008). The Compassion Fatigue Scale: Its Use with Social Workers Following Urban Disaster. *Research on Social Work Practice*, 18(3), 238–250. https://doi.org/10.1177/1049731507310190

Alkema, K., Linton, J., & Davies, R. (2008). A Study of the Relationship Between Self-Care, Compassion Satisfaction, Compassion Fatigue, and Burnout Among Hospice Professionals. *Journal of Social Work in End-Of-Life & Palliative Care,* 4(2), 101–119. https://doi.org/10.1080/15524250802353934

Arnold, D., Calhoun, L., Tedeschi, R., & Cann, A. (2005). Vicarious Posttraumatic Growth in Psychotherapy. *Journal of Humanistic Psychology*, 45(2), 239–263. https://doi.org/10.1177/0022167805274729

Ashley-Binge, S., & Cousins, C. (2019). Individual and Organisational Practices Addressing Social Workers' Experiences of Vicarious Trauma. *Practice*, 1–17. https://doi.org/10.1080/09503153.2019.1620201

Audet, C. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly*, 24(2), 85–100. https://doi.org/10.1080/09515070.2011.589602

Baird, S., & Jenkins, S. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, 18(1), 71–86.

Baldwin, S., Fehrenbacher, A., & Eisenman, D. (2015). Psychological Coercion in Human Trafficking: An Application of Biderman's Framework. *Qualitative Health Research*, 25(9), 1171–1181. https://doi.org/10.1177/1049732314557087

Barnett, J. E., & Hillard, D. (2001). Psychologist distress and impairment: The availability, nature, and use of colleague assistance programs for psychologists. *Professional Psychology: Research and Practice*, 32, 205–210

Barnett, J., & Cooper, N. (2009). Creating a Culture of Self-Care. Clinical Psychology: *Science and Practice*, 16(1), 16–20. https://doi.org/10.1111/j.1468-2850.2009.01138.x

Bender, K., Negi, N., & Fowler, D. N. (2010). Exploring the relationship between self-awareness and student commitment and understanding of culturally responsive social work practice. *Journal of ethnic & cultural diversity in social work*, *19*(1), 34-53.

Bent-Goodley, T. B. (2018). Being Intentional about Self-Care for Social Workers. *Social Work*, 63(1), 5–6. https://doi-org.hallam.idm.oclc.org/10.1093/SW/SWX058

Benuto, L., Newlands, R., Ruork, A., Hooft, S., & Ahrendt, A. (2018). Secondary traumatic stress among victim advocates: prevalence and correlates. *Journal of Evidence-Informed Social Work*, 15(5), 494–509. https://doi.org/10.1080/23761407.2018.1474825

Ben-Zur, H., & Michael, K. (2007). Burnout, social support, and coping at work among social workers, psychologists, and nurses: the role of challenge/control appraisals. *Social Work in Health Care*, 45(4), 63–82. https://doi.org/10.1300/J010v45n04_04

Bercier, M., & Maynard, B. (2015). Interventions for Secondary Traumatic Stress with Mental Health Workers: A Systematic Review. *Research on Social Work Practice*, 25(1), 81–89. https://doi.org/10.1177/1049731513517142

Boren, J. (2014). The Relationships between Co-Rumination, Social Support, Stress, and Burnout among Working Adults. *Management Communication Quarterly*, 28(1), 3–25. https://doi.org/10.1177/0893318913509283

Bourassa, D. (2012). Examining Self-Protection Measures Guarding Adult Protective Services Social Workers Against Compassion Fatigue. *Journal of Interpersonal Violence*, 27(9), 1699–1715. https://doi.org/10.1177/0886260511430388

Bowers, L., Allan, T., Simpson, A., Jones, J., & Whittington, R. (2009). Morale is high in acute inpatient psychiatry. *Social Psychiatry and Psychiatric Epidemiology*, 44(1), 39–46. https://doi.org/10.1007/s00127-008-0396-z

Boyle, A. (2015). Compassion fatigue: The cost of caring. *Nursing*, 45(7), 48–51. https://doi.org/10.1097/01.NURSE.0000461857.48809.a1

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.). *APA handbook of research methods in psychology, vol. 2: Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). Washington, DC: American Psychological Association.

Braun, V., & Clarke, V. (2013). Successful qualitative research: A practical guide for beginners. London: Sage

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Wellbeing, 9*(1), 26152

Bride, B. (2007). Prevalence of Secondary Traumatic Stress among Social Workers. *Social Work*, 52(1), 63–70. https://doi.org/10.1093/sw/52.1.63

British Psychological Society. (2018). *Code of ethics and conduct*. Leicester, UK: The British Psychological Society

Brockhouse, R., Msetfi, R., Cohen, K., & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: The moderating effects of sense of coherence, organizational support, and empathy. *Journal of Traumatic Stress*, 24(6), 735–742. https://doi.org/10.1002/jts.20704

Buchanan, M., Anderson, J., Uhlemann, M., & Horwitz, E. (2006). Secondary Traumatic Stress: An Investigation of Canadian Mental Health Workers. *Traumatology*, 12(4), 272–281. https://doi.org/10.1177/1534765606297817

Chambers, R. (2019). Caring for human trafficking victims: A description and rationale for the Medical Safe Haven model in family medicine residency clinics. *International Journal of Psychiatry in Medicine*, 0(0), 1-8. https://doi.org/10.1177/0091217419860358

Case, K. A. (2015). White practitioners in therapeutic ally-ance: An intersectional privilege awareness training model. *Women & Therapy, 38*(3-4), 263-278.

Clarke, V., & Braun, V. (2017) Thematic analysis. *The Journal of Positive Psychology*, *12*(3), 297-298, DOI: 10.1080/17439760.2016.1262613

Clause, K. J., & Byrnes Lawler, K. (2013). The Hidden Crime: Human Trafficking. *Pennsylvania Nurse*, 68(2), 18–23. http://search.ebscohost.com.hallam.idm.oclc.org/login.aspx?direct=true&db=ccm&AN=107963908&site=ehost-live

Cole, H. (2009). Human Trafficking: Implications for the Role of the Advanced Practice Forensic Nurse. *Journal of the American Psychiatric Nurses Association*, 14(6), 462–470. https://doi.org/10.1177/1078390308325763

Coleman, A., Chouliara, Z., & Currie, K. (2018). Working in the Field of Complex Psychological Trauma: A Framework for Personal and Professional Growth, Training, and Supervision. *Journal of Interpersonal Violence*, 886260518759062. https://doi.org/10.1177/0886260518759062

Craig, C., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress & Coping*, 23(3), 319–339. https://doi.org/10.1080/10615800903085818

Cuartero, M., & Campos-Vidal, J. (2019). Self-care behaviours and their relationship with Satisfaction and Compassion Fatigue levels among social workers. *Social Work in Health Care*, 58(3), 274–290. https://doi.org/10.1080/00981389.2018.1558164

Dane, B., & Chachkes, E. (2001). The Cost of Caring for Patients with an Illness: Contagion to the Social Worker. *Social Work in Health Care*, 33(2), 31–51. https://doi.org/10.1300/J010v33n02_03

Dempsey, M., & Halton, C. (2017). Construction of peer support groups in child protection social work: Negotiating practicalities to enhance the professional self. *Journal of Social Work Practice*, *31*(1), 3-19.

Devilly, G., Wright, R., & Varker, T. (2009). Vicarious Trauma, Secondary Traumatic Stress or Simply Burnout? Effect of Trauma Therapy on Mental Health Professionals. *Australian and New Zealand Journal of Psychiatry*, 43(4), 373–385. https://doi.org/10.1080/00048670902721079

Domoney, J., Howard, L. M., Abas, M., Broadbent, M., & Oram, S. (2015). Mental health service responses to human trafficking: a qualitative study of professionals' experiences of providing care. *BMC psychiatry*, *15*(1), 1-9.

Dworkin, E. R., Sorell, N. R., & Allen, N. E. (2016). Individual-and setting-level correlates of secondary traumatic stress in rape crisis center staff. Journal of Interpersonal Violence, 31(4), 743–752

Fahy, A. (2007). The Unbearable Fatigue of Compassion: Notes from a Substance Abuse Counsellor Who Dreams of Working at Starbuck's. *Clinical Social Work Journal*, 35(3), 199–205. https://doi.org/10.1007/s10615-007-0094-4

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), Brunner/Mazel psychological stress series (23), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). Philadelphia: Brunner/Mazel.

Fine, M. (1992). Disruptive voices: *The possibilities of feminist research*. Ann Arbor: University of Michigan Press.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy*, 46(2), 203-219. https://doi.org/10.1037/a0016081

Hays, D., Dean, J., & Chang, C. (2007). Addressing privilege and oppression in counselor training and practice: A qualitative analysis. *Journal Of Counseling And Development*, 85(3), 317–324.

Hemmings, S., Jakobowitz, S., Abas, M., Bick, D., Howard, L., Stanley, N., Oram, S. (2016). Responding to the health needs of survivors of human trafficking: a systematic review. *BMC Health Services Research*, 16(1), 320. https://doi.org/10.1186/s12913-016-1538-8

Hodge, D. (2014). Assisting Victims of Human Trafficking: Strategies to Facilitate Identification, Exit from Trafficking, and the Restoration of Wellness. *Social Work*, 59(2), 111–118. https://doi.org/10.1093/sw/swu002

Hopper, E. K., & Gonzalez, L. D. (2018). A comparison of psychological symptoms in survivors of sex and labor trafficking. *Behavioral medicine*, *44*(3), 177-188.

Isaksson Rø, K., Veggeland, F., & Aasland, O. (2016). Peer counselling for doctors in Norway: A qualitative study of the relationship between support and surveillance. *Social Science & Medicine*, 162, 193–200. https://doi.org/10.1016/j.socscimed.2016.06.037

Jenkins, S., Mitchell, J., Baird, S., Whitfield, S., & Meyer, H. (2011). The Counselor's Trauma as Counseling Motivation: Vulnerability or Stress Inoculation? *Journal of Interpersonal Violence*, 26(12), 2392–2412. https://doi.org/10.1177/0886260510383020

Jones, L., Engstrom, D., W., Hilliard, T., & Diaz, M. (2007). Globalization and Human Trafficking. *The Journal of Sociology & Social Welfare*, 34 (2), 107-122. https://scholarworks.wmich.edu/jssw/vol34/iss2/8

Kiley, K., Sehgal, A., Neth, S., Dolata, J., Pike, E., Spilsbury, J., & Albert, J. (2018). The Effectiveness of Guided Imagery in Treating Compassion Fatigue and Anxiety of Mental Health Workers. *Social Work Research*, 42(1), 33–43. https://doi.org/10.1093/swr/svx026

Klein, K., & Hodges, S. (2001). Gender Differences, Motivation, and Empathic Accuracy: When it Pays to Understand. *Personality and Social Psychology Bulletin*, 27(6), 720–730. https://doi.org/10.1177/0146167201276007

Kliner M., & Stroud L. (2012). Psychological and health impact of working with victims of sex trafficking. *Journal of Occupational Health, 54*, 9–15

Kosanke, G. C., Puls, B., Feather, J., & Smith, J. (2016). Minimizing Intense Relational Dynamics to Enhance Safety: A Thematic Analysis of Literature on Sandtray Work with Adult Trauma Survivors. *British Journal of Psychotherapy*, 32(4), 502–516. https://doi.org/10.1111/bjp.12242

Ladd, S., & Neufeld Weaver, L. (2018). Moving forward: Collaborative accompaniment of human trafficking survivors by using trauma-informed practices. *Journal of Human Trafficking*, 4(3), 191–212. https://doi.org/10.1080/23322705.2017.1346445

Le, P. D. (2017). "Reconstructing a Sense of Self" Trauma and Coping Among Returned Women Survivors of Human Trafficking in Vietnam. *Qualitative health research, 27*(4), 509-519.

Lianekhammy, J., Miller, J., Lee, J., Pope, N., Barnhart, S., & Grise-Owens, E. (2018). Exploring the self-compassion of health-care social workers: How do they fare? *Social Work in Health Care*, 57(7), 563–580. https://doi.org/10.1080/00981389.2018.1471017

Linley, P., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology*, 26(3), 385–403. https://doi.org/10.1521/jscp.2007.26.3.385

Mailloux, S. (2014). The Ethical Imperative: Special Considerations in the Trauma Counseling Process. *Traumatology: An International Journal*, 20(1), 50–56. https://doi.org/10.1177/1534765613496649

Martin-Cuellar, A., Atencio, D., Kelly, R., & Lardier, D. (2018). Mindfulness as a Moderator of Clinician History of Trauma on Compassion Satisfaction. *The Family Journal*, 26(3), 358–368. https://doi.org/10.1177/1066480718795123

Matos, M., Gonçalves, M., & Maia, Â. (2018). Human trafficking and criminal proceedings in Portugal: discourses of professionals in the justice system. *Trends in Organized Crime*, 21(4), 370–400. https://doi.org/10.1007/s12117-017-9317-4

McCann, I. L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131-149

Meany-Walen, K., Cobie-Nuss, A., Eittreim, E., Teeling, S., Wilson, S., & Xander, C. (2018). Play Therapists' Perceptions of Wellness and Self-Care Practices. *International Journal of Play Therapy*, 27(3), 176–186. https://doi.org/10.1037/pla0000067

Menashe, A., Possick, C., & Buchbinder, E. (2014). Between the maternal and the professional: the impact of being a child welfare officer on motherhood. *Child & Family Social Work*, 19(4), 391–400. https://doi.org/10.1111/cfs.12029

Miller, C., Duke, G., & Northam, S. (2016). Child Sex-Trafficking Recognition, Intervention, and Referral: An Educational Framework for the Development of Health-Care-Provider Education Programs. *Journal of Human Trafficking*, 2(3), 177–200. https://doi.org/10.1080/23322705.2015.1133990

Miller, J., Donohue-Dioh, J., Niu, C., & Shalash, N. (2018). Exploring the self-care practices of child welfare workers: A research brief. *Children and Youth Services Review*, 84, 137–142. https://doi.org/10.1016/j.childyouth.2017.11.024

Minton, M., Isaacson, M., Varilek, B., Stadick, J., & O'Connell-Persaud, S. (2018). A willingness to go there: Nurses and spiritual care. *Journal of Clinical Nursing*, 27(1-2), 173–181. https://doi.org/10.1111/jocn.13867

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda. *Traumatology*, *23*(2), 129.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International journal of qualitative methods*, *16*(1), 1609406917733847.

O'Brien, J., & Haaga, D. (2015). Empathic Accuracy and Compassion Fatigue Among Therapist Trainees. *Professional Psychology: Research and Practice*, 46(6), 414–420. https://doi.org/10.1037/pro0000037

Palm, K. M., Polusny, M. A., & Follette, V. M. (2004). Vicarious traumatization: Potential hazards and interventions for disaster and trauma workers. *Prehospital and Disaster Medicine*, 19(1), 73-78.

Pascual-Leone, A., Kim, J., & Morrison, O. (2017). Working with Victims of Human Trafficking. *Journal of Contemporary Psychotherapy*, 47(1), 51–59. https://doi.org/10.1007/s10879-016-9338-3

Pope, K. S., & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: Making decisions, bypassing blunders, and mending fences. *Journal of clinical psychology, 64*(5), 638-652.

Potter, J., & A. Hepburn. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology, 2,* 281–307. http://dx.doi.org/10.1191/1478088705qp045oa

Powell, C., Dickins, K., & Stoklosa, H. (2017). Training US health care professionals on human trafficking: where do we go from here? *Medical Education Online*, 22(1), 1267980. https://doi.org/10.1080/10872981.2017.1267980

Ramirez, J., Gordon, M., Reissinger, M., Shah, A., Coverdale, J., & Nguyen, P. T. (2020). The importance of maintaining medical professionalism while experiencing vicarious trauma when working with human trafficking victims. *Traumatology (Tallahassee, Fla.)*. https://doi.org/10.1037/trm0000248

Roberts, J. (2005). Transparency and Self-Disclosure in Family Therapy: Dangers and Possibilities. *Family Process*, 44(1), 45–63. https://doi.org/10.1111/j.1545-5300.2005.00041.x

Salloum, A., Kondrat, D., Johnco, C., & Olson, K. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children and Youth Services Review*, 49(1), 54–61. https://doi.org/10.1016/j.childyouth.2014.12.023

Salston, M., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of traumatic stress*, *16*(2), 167-174.

Sari, Y., & Khairunnisa, K. (2014). Resilience of Young Women as Human Trafficking Victims. *International Journal of Social Science and Humanity*, 4(2), 159–163. https://doi.org/10.7763/IJSSH.2014.V4.339

Shapiro, S., Brown, K., & Biegel, G. (2007). Teaching Self-Care to Caregivers: Effects of Mindfulness-Based Stress Reduction on the Mental Health of Therapists in Training. *Training and Education in Professional Psychology*, 1(2), 105–115. https://doi.org/10.1037/1931-3918.1.2.105

Silveira, F. S., & Boyer, W. (2015). Vicarious resilience in counselors of child and youth victims of interpersonal trauma. *Qualitative Health Research, 25*(4), 513-526.

Speight, S. (2012). An Exploration of Boundaries and Solidarity in Counseling Relationships. *The Counseling Psychologist*, 40(1), 133–157. https://doi.org/10.1177/0011000011399783

Sundqvist, J., Padyab, M., Hurtig, A., & Ghazinour, M. (2018). The association between social support and the mental health of social workers and police officers who work with unaccompanied asylum-seeking refugee children's forced repatriation: A Swedish experience. *International Journal of Mental Health*, 47(1), 3–25. https://doi.org/10.1080/00207411.2017.1400898

Thompson, I., Wolf, C., Mott, E., Baggs, A., Thompson, E., Callueng, C., & Puig, A. (2018). Luna Yoga: A Wellness Program for Female Counselors and Counselors-in-Training to Foster Self-Awareness and Connection. *Journal of Creativity in Mental Health*, 13(2), 169–184. https://doi.org/10.1080/15401383.2017.1348918

Thompson, J., & Haley, M. (2018). Human Trafficking: Preparing Counselors to Work with Survivors. *International Journal for the Advancement of Counselling*, 40(3), 298–309. https://doi.org/10.1007/s10447-018-9327-1

Ting, L., Jacobson, J., & Sanders, S. (2011). Current Levels of Perceived Stress among Mental Health Social Workers Who Work with Suicidal Clients. *Social Work*, 56(4), 327–336. https://doi.org/10.1093/sw/56.4.327

Ting, L., Sanders, S., Jacobson, J., & Power, J. (2006). Dealing with the Aftermath: A Qualitative Analysis of Mental Health Social Workers' Reactions after a Client Suicide. *Social Work*, 51(4), 329–341. https://doi.org/10.1093/sw/51.4.329

Trifiletti, E., Di Bernardo, G., Falvo, R., & Capozza, D. (2014). Patients are not fully human: a nurse's coping response to stress. *Journal of Applied Social Psychology*, *44*(12), 768–777. https://doi.org/10.1111/jasp.12267

Trippany, R., Kress, V., & Wilcoxon, S. (2004). Preventing Vicarious Trauma: What Counselors Should Know When Working With Trauma Survivors. *Journal of Counseling & Development*, 82(1), 31–37. https://doi.org/10.1002/j.1556-6678.2004.tb00283.x

Tsutsumi, A., Izutsu, T., Poudyal, A., Kato, S., & Marui, E. (2008). Mental health of female survivors of human trafficking in Nepal. *Social Science & Medicine*, *66*(8), 1841–1847. https://doi.org/10.1016/j.socscimed.2007.12.025

United Nations. (2000). *Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime*. Retrieved from: https://www.ohchr.org/EN/ProfessionalInterest/Pages/ProtocolTraffickingInPersons.aspx

Vaes, J., & Muratore, M. (2013). Defensive dehumanization in the medical practice: A cross-sectional study from a health care worker's perspective. *The British Journal of Social Psychology.*, *52*(1), 180–190. https://doi.org/10.1111/bjso.12008

Van Hook, M. P., & Rothenberg, M. (2009). Quality of life and compassion satisfaction/fatigue and burnout in child welfare workers in community based care organizations in central Florida. *Social Work & Christianity*, 36(1), 36-54.

Varga, S., & Weaver, S. (2013). Raising Awareness about Human Trafficking. *New Jersey Nurse*, *43*(4), 10. http://search.ebscohost.com.hallam.idm.oclc.org/login.aspx?direct=true&db=ccm&AN=104041600&site=ehost-live

Webb, K. B. (2011). Care of others and self: A suicidal patient's impact on the psychologist. *Professional Psychology: Research and Practice, 42*(3), 215.

Willig, C. (1999). Beyond appearances: a critical realist approach to social constructionism. In Nightingale, D.J. and Cromby J. (Eds). *Social constructionist psychology: a critical analysis of theory and practice* (pp. 37-51). UK: Open University Press.

Zimmerman, C., & Kiss, L. (2017). Human trafficking and exploitation: A global health concern. (Collection Review). *PLoS Medicine*, 14(11), e1002437. https://doi.org/10.1371/journal.pmed.1002437