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FEASIBILITY OF INFLUENCING CLINICIAN PERCEIVED KNOWLEDGE AND COMPETENCE OF HUMAN TRAFFICKING VIA A CONTINUING EDUCATION WORKSHOP

by

RACHEL N. WAKEFIELD, M.S.

(Under the Direction of Ryan Couillou, Ph.D.)

ABSTRACT

Previous research has examined the complex mental and social health deficits of those who were trafficked that clinicians have to treat therapeutically (Litam, 2017; Pascual-Leone et al., 2017). Other research has explored how continuing education workshops often change the knowledge, competence, and attitudes of attendees to use more effective and evidenced techniques and skills (Neimeyer et al., 2009; Raghavan et al., 2008). However, there is a lack of understanding about how a complex topic, specifically treatment considerations of those who were trafficked, changes the knowledge and competence of continuing education workshop attendees. The purpose of the current study is to explore how mental health clinicians' knowledge and competence of working with human trafficking survivors changes as a result of a continuing education workshop on human trafficking. The study also examines the feasibility of conducting a continuing education workshop on human trafficking. A sample of psychologists completed self-report measures before and after a continuing education workshop on human trafficking. As hypothesized, results indicated sampled psychologists had about the same competence in human trafficking as general samples. However, data indicated sampled psychologists had a greater level of base knowledge

of human trafficking. However, it is difficult to generalize these findings to other psychologists and mental health professionals given the low sample size. Additionally, analyses indicated a continuing education workshop changes perceptions of competence in working with individuals who were trafficked, but no significant changes in knowledge were observed. Also as hypothesized, the workshop was feasible to construct and promote to teach mental health professionals about human trafficking. Other clinical implications and future directions are discussed.

INDEX WORDS: Feasibility, Human trafficking, Modern slavery, Continuing education, Professional development, Mental health, Stigma

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B.A., University of Toledo, 2018

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A Dissertation Submitted to the Graduate Faculty of Georgia Southern University in Partial Fulfillment of the Requirements for the Degree

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CHAPTER 1

INTRODUCTION

Rationale

Human trafficking is considered an international issue impacting an estimated 24.9 to 40 million people in every country in the world (United States Department of Homeland Security, n.d.; Polaris, n.d.). In the United States (US), there are an estimated 14,500 to 17,500 people trafficked into the US annually (United States Department of State, 2020). This number is an underestimate as it does not include individuals trafficked within the US (United States Department of Homeland Security, n.d.; United States Department of State, 2020). Despite the significant number of individuals being trafficked both internationally and in the US, there are numerous gaps in the literature on the psychological and emotional impact trafficking has on individuals who have been trafficked. This gap includes mental health treatment considerations for those who were trafficked, such as how to improve their psychological functioning and well-being. Not only is there a lack of research about treatment considerations, but also a lack of research into the competency of clinicians who treat individuals who were trafficked. Mental health clinicians are, however, still tasked with providing ethical and competent care to those who were trafficked. There are currently no studies looking at the feasibility of improving clinician competence in treating individuals who were trafficked.

Continuing Education Impacting Competency

Most mental health licensing boards in the US require professionals to continue taking courses and workshops to improve their competence, ethics, and knowledge as their specified field grows and changes across time (Neimeyer et al., 2012). The goals of continuing education are to increase knowledge, competency, and ethical practice among the given field (Devonshire

& Nicholas, 2018; Neimeyer et al., 2012). For mental health professions, this includes updated knowledge on best practices, receiving additional information on working with a certain population, and improving overall competence in a given area. Increasing competence in practice can improve the quality of care a client receives (Devonshire & Nicholas, 2018). Additionally, it can increase a clinician's knowledge and awareness of the subject matter, improving confidence and treatment outcomes (Oordt et al., 2009). However, there are challenges associated with building competency, such as effective implementation, via formal continuing education avenues that are tasked to the individual clinician (Neimeyer et al., 2009; Neimeyer et al., 2012). Nevertheless, continuing education in psychology has a history of improving competence and a dedication to continuing to improve competencies of its clinicians as the field evolves (Neimeyer et al., 20212). Given the lack of research on psychological treatment for individuals who were trafficked and the ability to potentially improve competency via continuing education, the present study aims to provide additional context for how clinicians' competency surrounding human trafficking can change.

Purpose

The purpose of the present study is to explore the feasibility of a continuing education workshop improving the competency of mental health clinicians in providing treatment for individuals who were trafficked. Additionally, the study will examine the base knowledge and attitudes clinicians have regarding human trafficking treatment, as well as their knowledge and attitudes towards human trafficking after a continuing education workshop. Specifically, this study answered the following questions:

1. How do clinicians perceive their knowledge and competence in working with individuals who have been trafficked?

2. Can a continuing education workshop improve a clinician's knowledge and competence in working with individuals who have been trafficked?
3. Is there a difference between rural and non-rural clinicians when they self-report their knowledge and competence in working with individuals who were trafficked?
4. Is it feasible (e.g., in terms of interest and technical production) to conduct a training on human trafficking for mental health professionals?

Significance

Research on human trafficking is broadly viewed through a social justice lens and the impact it has on society, rarely focusing on the mental toll it has on individuals who were trafficked (Bandyopadhyay et al., 2007; Gozdziak & Collett, 2009). Research about those who are trafficked typically uses a convenience sample of those removed from being currently trafficked in the United States and how to meet their immediate needs (Gozdziak & Collett, 2009). This leaves a gap in the understanding of the mental health needs of those who were trafficked, as well as how clinicians can meet those needs. Little research has been conducted on how mental health clinicians are equipped and competent in identifying and assisting victims of trafficking they may see within their mental health practice.

No research has been published on the amount of training and education clinicians receive about human trafficking. Clinicians have few resources to assist them in gaining knowledge about how to treat trafficking victims in an effective manner. Continuing education on human trafficking can bridge the gap between research and practice to improve the competence of clinicians in this area. However, few studies have been conducted on the feasibility of improving competency via a continuing education workshop on human trafficking. As a result, this study will provide data on how feasible a workshop on educating about human

trafficking and treatment considerations is in improving competence among mental health clinicians. Results from this study may be significant for continuing educators and academics to educate current and future clinicians on how to be effective and competent when seeing an individual who was trafficked.

Definition of Terms

Human Trafficking.

The commonly cited definition of human trafficking, particularly in the US, is “the use of force, fraud, or coercion to obtain some type of labor or commercial sex act” (United States Department of Homeland Security, n.d., What is Human Trafficking? section). This definition specifically reflects the definition created in the United Nations’ Palermo Protocol, in an effort to reduce trafficking across the world (UN General Assembly, 2000). This definition has grown out of centuries of trafficking and its impact on and implications by public and political opinion beginning with the smuggling and sale of Africans (Chapdelaine, 2015) to the prostitution of children and women in the 1800s (Kempadoo, 2015) to the feminist movements of the late 1800s and early 1900s (Gozdziak & Collett, 2005; Usman 2020) to the inclusion of other forms of trafficking during the HIV/AIDS pandemic of the 1980s (Trafficking of women and girls, 2004; Usman, 2020). Each of these movements have formed and molded the current definition of human trafficking. Yet, the present definition was introduced in 2000 after years of debate between religious and feminist organizations with opposing views on prostitution (Gozdziak & Collett, 2005), despite the understanding of various forms of trafficking, including labor, child soldiers, child brides, and drug smuggling (United States Department of Homeland Security, n.d.). Furthermore, Gozdziak and Collett (2005) note the legal definition of trafficking in the United States has continued to create problems in understanding and tracking human trafficking

due to the lack of operationalized definition to guide the creation of laws and research. For the purposes of this writing, the above definition will be used and discussed in a broad context with the understanding of the individual differences of those impacted by trafficking situations.

Continuing Education

The main goal of continuing education is to assist professionals in growing and evolving in a specified field (Cox & Grus, 2019). It is often referred to as professional development and, more recently, lifelong learning. Learning and continuing education continue throughout the lifespan of a professional to meet educational and occupational needs and to allow for adaptation to changes within the field (Laal et al., 2014). Continuing education comes in many forms (i.e., in-person, online, asynchronous, etc.) and across various education types (i.e., workshops, conferences, direct supervision, readings, etc.). Although continuing education is a requirement for many licensing boards, it is also considered a necessity for professionals to personally learn and grow throughout their career to keep up-to-date with advancements in the field and maintain the integrity of the profession (Cox & Grus, 2019; Devonshire & Nicholas, 2018; Neimeyer et al., 2012). Continuing education, for this research, is defined as a formal workshop or conference aimed at providing additional information and knowledge to mental health professionals in an attempt to increase competence.

Professional Competency

Professional competence is the integration of knowledge, skills, and clinical reasoning used habitually to improve practice for the client and community (Epstein & Hundert, 2002). It is dependent upon context and content, as it requires one to acknowledge when to use certain skills, reasoning, and knowledge (Cheetham & Chivers,1996; Epstein & Hundert, 2002). Cheetham and Chivers (1996) posit a holistic approach to competency, denoting "meta-competency" as the

summation of knowledge, functional or the ability to complete role tasks, personal and behavioral, and values/ethical competencies. A key aspect to the summation of the competencies is reflection and analysis to improve competence over time. For this research, competency is measured using self-report assessments to measure a clinician's beliefs and knowledge about human trafficking and related ethics.

Feasibility

Feasibility studies are used to understand the effectiveness or usefulness of an intervention or new technique (Bowen et al., 2009). Most feasibility studies look at how acceptable, practical, and adaptable the intervention or technique is, while also determining the demand for implementation and integration from the specified population (Bowen et al., 2009; Orsmond & Cohn, 2015). Simply put, feasibility studies determine the practicality of an intervention for improvement in the given field or topic before a randomized control trial is conducted (Tickle-Degnen, 2013). Additionally, the results of many feasibility studies largely consider descriptive statistics, qualitative analysis, and data related to the administrative aspects of the study (Orsmond & Cohn, 2015; Tickle-Degnen, 2013) The present study will determine the feasibility of improving clinician knowledge about human trafficking via a continuing education workshop, as this is an area with limited research.

Literature Review

History of Human Trafficking

An estimated 24.9 to 40 million people are trafficked through sex, labor, drug, and organ trades globally (United States Department of Homeland Security, n.d.; Polaris, n.d.). Despite its prevalence, human trafficking does not have an agreed upon origin. Most scholars agree it came about as a result of the enslavement of African peoples across the globe, but the direct

correlation is under scrutiny. Human trafficking, or modern-day slavery, finds its roots in the trans-Atlantic slave trade dating back to the sixteenth century. The imprisonment, smuggling, and concept of a person as property rose out of the dangerous and inhumane trek to the New World (Chapdelaine, 2015). Other scholars cite the "white slave trade," or the global increase in the movement and sale of white women and girls for sexual exploitation across countries and continents in the late 1800s (Kempadoo, 2015; Gozdziak, 2014 p. 614). Feminists of the time discussed involuntary prostitution as a global discourse and challenge that started the international focus on human trafficking (Gozdziak, 2014, p. 614).

Despite the disagreement of the origins of human trafficking, the beginnings of the feminist movement in the late nineteenth and early twentieth centuries brought the sale of humans, particularly women and children, into the purview of international governments. Early feminists fought for the moral and equal treatment of sex workers and to end the sale of women and children into and out of Europe, which was typically against their will (Gozdziak, 2014, p. 614-616; Gozdziak & Collett, 2005; Usman 2020). However, the focus on the moral corruptness of trafficking women and children for sex was focused on white European women and excluded women and children of color and men. Thus, the understanding of trafficking in the twentieth century was focused on the moral and ethical wrongness of trafficking against white, European women (Usman, 2020). The focus on moral and ethical wrongness was then bolstered by the abolition movements in the US and Europe creating a platform for human trafficking awareness (Gozdziak, 2014, p. 614; Usman, 2020).

With this understanding, the League of Nations, the precursor to the United Nations, created an agreement in 1904 to study how women are smuggled, the routes, and destinations of these women (Chapdelaine, 2015; Gozdziak & Collett, 2005). This agreement was almost solely

focused on the ways, routes, and destinations to which white women were smuggled. At this point the term 'human trafficking' had not been coined and would not be for several decades. In 1950s Europe, the term 'human trafficking' began being used in public spheres and international politics as it began to include prostitution, forced labor, servitude, and similar operations (Usman, 2020). Even with international and public prominence growing, the people primarily benefitting from the increased focus on trafficking were white, European or North American women who were being sold and smuggled into prostitution. Nevertheless, trafficking and slavery were beginning to be understood as the purchasing, selling, or exchanging of people (Gozdziak & Collett, 2005; Usman, 2020).

Halfway through the twentieth century, those fighting against trafficking lost traction and little progress was made anywhere in the world to end or deter trafficking. The AIDS/HIV pandemic of the 1980s began to return attention to human trafficking (Trafficking of women and girls, 2004; Usman, 2020), feminist movements, and migration patterns (Gozdziak & Collett, 2005; Usman, 2020). Little was done politically to challenge trafficking and it still lacked a global definition. The general understanding of trafficking was viewed as smuggling of humans constituting as illegal immigration (Gozdziak & Collett, 2005). In December of 2000, the Palermo Protocol was enacted by the United Nations (UN) in a special assembly in Palermo, Italy (UN General Assembly, 2000; Usman, 2020). The Palermo Protocol was issued to fight the involvement of organized crime syndicates within the realm of trafficking and the smuggling of humans, including the movement across borders, the anticipated movement across borders, or involvement with "substantial" implications in another jurisdiction. It is also the first document to specifically define human trafficking, provide protections, and assist individuals who were trafficked or harmed as a result of human trafficking (UN General Assembly, 2000).

However, many feminist activists view the Palermo Protocol as not comprehensive enough because the unspoken target of the protocol was those being involuntarily prostituted, which were still primarily women (Gozdziak & Collett, 2005). Regardless of those views, the Palermo Protocol was the first UN instrument to define human trafficking, which led to the understanding and prosecution of trafficking today (UN General Assemby, 2000; Shelley, 2010, p. 10-12).

Also in the year 2000, the United States government published the first Trafficking in Persons (TIP) report. This became the first mandated report passed by the US government in connection with eradicating human trafficking (United States Department of State, 2020). The TIP reports were largely in response to the globalization and statelessness caused by the Cold War (Shelley, 2010, p. 3-5). As of August 2021, the US has 11 federal statutes focused on trafficking. These statutes are focused on the different types of trafficking that occur: involuntary servitude, debt servitude, forced labor, sex trafficking of minors, falsifying travel documents and visas, restitution, transportation of minors, and for victims to take civil action against perpetrators (United States Department of Justice [USDoJ], n.d.). Furthermore, US states have individual definitions of trafficking, rape, pay, and prosecution of perpetrators (Polaris, n.d.). These differences across states, coupled with the integration of different cultures and groups across the US lead to difficulties in identifying and prosecuting traffickers. As such, traffickers are able to use these pitfalls of the US to exploit vulnerabilities in foreign and domestic trafficking victims to maintain power and control (Shelley, 2010, p. 242-263).

Number of Individuals Trafficked Today

As previously stated, the current global estimates of trafficking are 24.9 to 40.3 million people (United States Department of Homeland Security, n.d.; International Labor Organization

[ILO], 2017; Polaris, n.d.), generating an estimated $150 billion (USD) dollars per year worldwide (ILO, 2017). There are presently no estimates of how many individuals are trafficked within the borders of the US despite its prevalence in the public perception beginning in the 1990s (United States Department of Homeland Security, n.d.; United States Department of State, 2020). Furthermore, there are methodological issues in gathering accurate data about individuals who are trafficked because of the often-mixed data of trafficking, smuggling, and illegal migration. Continually, some research only counts individuals who were being sex trafficked, instead of collecting data on all types of human trafficking (Gozdziak, 2014; Gozdziak & Collett, 2005). Labor trafficking poses a greater challenge in identifying victims, compared with sex trafficking, because of the definition of labor trafficking varies widely and is considered less important when compared with sex trafficking (Gozdziak, 2014). The ILO estimates about 20.1 million people are in forced labor (e.g., state-imposed, debt bondage, domestic work, etc.) situations due to the use of multiple types of force and coercion (2017). There are currently no reliable estimates of those being trafficked in labor industries within the US, partially due to previously stated reasons and partially because some individuals start being trafficked in labor industries before being moved into other types of trafficking (i.e., sex trafficking) in the US (Bandyopadhyay et al., 2007).

Additionally, with each TIP report published, there is a new methodology for counting individuals being smuggled across US borders that has been lowering the estimated number of individuals being trafficking into the US from 1994 to 2004 (United States Department of State, 2020). However, many activists are unclear on the statistical reliability of the methodology without a partial or reliable source of data (Gozdziak & Collett, 2005). The most recent TIP report estimated 14,500 to 17,500 individuals are trafficked into the US annually. It is important

to note that this number only includes individuals whose destination is the US, not individuals trafficking within US borders, those whose destination is Canada, or those already trafficked into the US in previous years (United States Department of State, 2020).

Another method of estimating the number of individuals being trafficked is creating estimates based on contact with individuals being trafficked or reports of trafficking situations. The Polaris Project, the organization managing the national human trafficking hotline in the US, reported a 20 percent increase in contact by individuals being trafficked or recently out of a trafficking situation via their hotline between 2018 and 2019. Furthermore, they investigated or reported to law enforcement 11,500 situations of trafficking, identifying over 4,300 traffickers. Over 22,000 individuals who were or are trafficked have contacted the hotline in the past four years, since its beginning in 2015 (Polaris, n.d.).

Additionally, the Immigration and Customs Enforcement reported 1,024 cases of human trafficking with 2,197 criminal arrests in fiscal year 2019. The Federal Bureau of Investigation reported 607 cases with 350 arrests in the same year. That denotes 2,547 arrests from two agencies, not taking into account arrests from other federal, state, and local agencies (USDoJ, 2019). Federal reporting and Polaris Project estimates are based on convenience samples of individuals reaching out for assistance or those facing criminal charges. Most human trafficking research, including estimating the number of those trafficked within the US, are based upon convenience samples that often leave out those trafficked within their own home and communities (Gozdziak, 2014, p. 622).

Even though the estimation of number of individuals trafficked in the US is poor, there has been a significant increase in the number of individuals seeking treatment who report a history of human trafficking (United States Department of Homeland Security, n.d.; Ramirez et

al., 2020). This may be due to the increase in the number of investigations of trafficking, which has been steadily increasing in the US for the past several years (TIP, 2020). With an increase in individuals seeking care as a result of being trafficked, there must be proficient providers to treat individuals who were trafficked (Litam, 2017). The federal government is providing millions of dollars to law enforcement agencies and "victim service providers" to remove and rehabilitate individuals who were trafficked; however, agencies and individuals are still advocating for additional funding and engagement (TIP, 2020).

Perceptions of Human Trafficking Today

Within the US, the general public is largely aware of human trafficking and have negative perceptions towards the trafficking of humans (Austin & Farrell, 2017). Despite widespread knowledge of human trafficking, there continues to be a perception problem, particularly within sex trafficking, of victim blaming, lack of understanding of gender- and minority-based trauma, and lacking knowledge of the ethnic and national identity of individuals who have been trafficked (Haney et al., 2020; Okech et al., 2018). The major focus of human trafficking is on the victimization of women and children as they are often viewed of as victims or "trafficked persons" as opposed to men who are often blamed for making choices or being in circumstances that led to them being trafficked (Gozdziak, 2014, p. 617-618). US men largely believe myths about human trafficking, causing them to view trafficking adversely. However, their adverse view of women and children being trafficked was to a greater magnitude than their adversity towards men being trafficked (Cunningham & Cronner, 2016). Furthermore, the general public in the United States has little knowledge of the magnitude of trafficking within its borders or abroad (Austin & Farrell, 2017).

Clinicians and other professionals often fall into the beliefs of the general public, as well, and are not competent enough to notice the signs and symptoms of trafficking in their clients (Cheshire, 2017). There is a general lack of knowledge and awareness among clinicians about human trafficking and the complex presenting concerns that reflects that of the general public (Burt, 2019). However, social work students are more in-tune with knowledge and help-seeking behavior of trafficked individuals than non-social work students (Welch-Brewer et al., 2021), indicating mental health professionals may be more aligned with understanding of human trafficking than the general public (Burt. 2019). Clinicians may have more awareness and knowledge about trafficking but do not feel capable or competent enough to manage and treat individuals who were trafficked, as it is clinicians' ethical responsibility to notice and appropriately treat victims of trafficking (Cheshire, 2017; Ortega et al., 2022).

Treatment Considerations for Trafficking Survivors

Currently, there are no evidenced-based treatments or randomized control trials looking at the effectiveness of any theoretical orientation, approach, or skill with individuals who were trafficked. Current research trends for mental health treatment after trafficking focus on access to care and identification of individuals who are being or were trafficked. This leaves clinicians and mental health professionals at a loss for direction and evidenced options for treatment. Thus, other adjacent issues must be addressed to assist the trafficking survivor seeking therapy. Mental health professionals must seek out treatments of other presenting problems, including sexual trauma, substance use, identity issues, multiculturalism, trauma, stigma, discrimination, depression, anxiety, and other co-occurring diagnoses (Brookfield et al., 2020; Burnes et al., 2012; Macioti et al., 2017; Pascual-Leone et al., 2017; & Sawicki et al., 2019). As a result, those who were trafficked often experience feelings of isolation, increased stigma, increased

discrimination, shame, distrust, self-blame, and other negative experiences when disclosing their trafficking history (Burnes et al., 2012; Pascual-Leone et al., 2017: Macioti et al., 2017). On top of mental health concerns, they often have basic needs that must be addressed before they are able to feel stable and safe enough to share their internal states (Burnes et al., 2012; Contreras et al., 2017; Pascual-Leone et al., 2017). These needs may include food, clothing, legal status, housing, clothing, childcare, and personal safety. These needs are assessed by providers who deem survivors worthy or unworthy of services, creating additional feelings of powerlessness in trafficking survivors (Burnes et al., 2012; Contreras et al., 2017; Pascual-Leone et al., 2017). To reduce these feelings, trafficked clients must trust their clinician to be available for consultation and encouragement about challenging issues to ensure interdisciplinary care for the client (Contreras et al., 2017).

Those seeking mental health care after leaving trafficking situations are not in need of rescue, as many clinicians assume when working with a client who was trafficked. This assumption often leads the clinician to involuntarily push the client into a role of powerlessness where the individual trafficked is discouraged from making their own choices about treatment, life, and well-being, thus creating a similar cycle of coercion and devaluation of autonomy (Contreras et al., 2017). Clinicians are often met with resistance, frustration (Litam, 2017), mistrust (Baker et al., 2010; Pascual-Leone et al., 2017), and complex presentations (Burnes et al., 2012; Contreras et al., 2017; Litam, 2017). Research provides evidence for various lenses to work through: resilience, relational consequences, and trauma-informed care.

Resilience Lens

Research tends to focus on the deficits of those who are trafficked, what additional help and support they need, while ignoring the strength and resilience possessed by those who were

trafficked. This remains the trend when searching out into corresponding literature, such as trauma, substance use, and sex work (Burnes et al., 2012). Knight and colleagues (2021) identify resilience among those trafficked as similar to other victimized populations, indicating clinicians assist survivors in adapting and promoting resilience within themselves. Focus on resilience-based strategies can improve self-esteem, hope, and prosocial behaviors to solve problems (Litam, 2017; Marburger & Pickover, 2020). Resiliency work, though largely new among human trafficking research, will likely be beneficial for clinicians to collaborate with researchers to bolster knowledge, practice, and research bases for future work (Knight et al., 2021)

Relational Consequences

Individuals who were trafficked often have difficulty identifying and working within healthy relationships as a result of the trauma, stigma, abuse, and lack of safety within trafficking relationships (Contreras et al., 2017). When leaving trafficking, these individuals often return to social networks established previously to trafficking, such as family, in search of acceptance and support (Brunovskis & Surtees, 2012). However, they often struggle to reintegrate because of shame and trauma from relationships within trafficking or from fear of social rejection or ostracization (Baker et al., 2010; Brunovskis & Surtees, 2012). These social networks do not provide the support individuals who were trafficked need to reintegrate and move beyond their experiences (Baker et al., 2010). For clinicians, this means establishing a trusting relationship for them to feel heard and accepted, as opposed to relationships with family, the system, and their trafficker that were often fraught with betrayal, abuse, and judgment (Clawson et al., 2008). This is more easily said than done as individuals who were trafficked have complex relational and social needs that clinicians must be aware of, such as fears around violation while in group treatment, fear about having to provide the clinician something in return for services, and fear of

rejection by the clinician (Pascual-Leone et al., 2017). Long-term therapy may increase trust, therapeutic alliance, and understanding of the importance of social support in the lives of trafficking victims over time to create stability in their relationships and willingness to be vulnerable with the clinician to focus on other negative aspects needing clinical attention (Baker et al., 2010; Contreras et al., Pascual-Leone et al., 2017).

Trauma-Informed Care

Trauma is a critical target of treatment for individuals who were trafficked, as all experienced some type of trauma related to trafficking (Clawson et al., 2008). Trauma-informed care focuses on building the safety of individuals who were trafficked and exploring therapeutic issues from the basis of safety for the client (Clawson et al., 2008; Pascual-Leone et al., 2017). Acknowledgement and sharing of trauma through group or individual therapy is essential to shame and mistrust reduction to begin working on other presenting concerns. It also allows individuals who were trafficked to discuss previous trauma, as many individuals who were trafficked experienced a type of trauma as a child (Haney et al., 2008). This creates an environment of strength, personal choice, and safety for the individual to create longer-term change by leading their recovery process (Haney et al., 2018; Steiner et al., 2018). Trauma-informed care often takes into account resilience, cultural, (Clawson et al., 2008; Haney et al., 2018; Hopper, 2016; Tummala-Narra et al., 2011) and relational needs (Clawson et al., 2008; Tummala-Narra et al., 2011). Trauma-informed care is considered the ideal lens for trafficking due to its ability to be overlayed among evidence-based interventions for other common diagnoses (i.e., cognitive-behavioral therapies for depression or post-traumatic stress disorder) (Pascual-Leone et al., 2017), while addressing functioning across other pertinent domains of daily living (Tummala-Narra et al., 2011).

Clinician Factors Impacting Treatment

Treating individuals who were trafficked daunts many clinicians because of the complexity of each case. Individuals who were trafficked often do not report trafficking to their providers because of shame, stigma, mistrust, and their obscured worldview (Contreras et al., 2017; Reid, 2012). Many individuals do not identify their experience as being trafficked, but as survival tactics, bad circumstances, domestic problems, and/or bad relationships (Contreras et al., 2017; Tummala-Narra et al., 2012). Their trafficking was placed within their own experiences and understanding instead of an exploitation of vulnerability (Tummala-Narra et al., 2012). Mental health professionals can assist trafficking survivors to construct their own portrayal of the story based on their current understanding of their experiences and recognition, while the clinician recognizes the story will change as the survivor resolves feelings, trauma, and gains understanding of their narrative (Contreras et al., 2017; Tummala-Narra et al., 2012). However, individuals who were trafficked report difficulty with therapeutic alliance because clinicians struggle to focus on gaining trust, monitor quality of therapy and other needed services, and unknowingly stigmatize or blame the individual. Further, individuals who were trafficked report lack of cultural competency and how unregulated social support can harm the individual (Bandyopadhyay et al., 2007, pgs. 94-97; Reid, 2012). However, clinicians focusing on meeting the client where they are can lead to improved therapeutic outcomes (Litam, 2007).

Further, clinicians negatively impact treatment by not caring for themselves properly (Contreras et al., 2017; Haney et al., 2020; Litam, 2017; Pascual-Leone et al., 2017; Tummala-Narra et al., 2012). Clinicians regularly working with trafficked clients experience compassion fatigue and vicarious trauma at higher rates than many other clinicians (Pascual-Leone et al., 2017). They require additional support and supervision or consultation due to the intense and

complex nature of trafficked clients (Contreras et al., 2017; Litam, 2007; Pascual-Leone, 2017). Pascual Leone and colleagues (2017) recommend consistent debriefing with colleagues, increased consultation and supervision, and maintaining a strong support system to combat personal distress. This, along with personal self-care and distress reducing activities, will typically lead to less burnout among clinicians and improve therapeutic outcomes for individuals who were trafficked (Contreras et al., Haney et al., 2020; Litam, 2017).

Continuing Education

Most states in the United States of America require mental health professionals to obtain continuing education (CE) credits to remain licensed. These trainings are meant to deepen or expand the practitioner's competence in a given area (Buttars et al., 2021; Daniels & Walter, 2002), to reinforce the discontinuation of outdated or harmful practices, and to encourage the use of new evidence-based skills (Bloom, 2005). CE trainings are intended to ensure a social contract between clinicians and the public as a way to garner continued competency, efficacy, and ethics of the given field (Taylor & Neimeyer, 2017). Mandating continuing education causes practitioners to attend more workshops and other trainings to improve their skill set and increase their knowledge (Neimeyer et al., 2009), and maintain professional standards across the career (Cox & Grus, 2019). This is vital with the quickly changing and expanding nature of the mental and behavioral health field. Without CE credits, many practitioners would likely be using outdated information and techniques (Daniels & Walter, 2002; Neimeyer et al., 2009). Harmful therapies often predate evidence-based therapies as research broadens and strengthens over time (Lilienfeld, 2007). However, positive, evidence-based change toward increasing effectiveness of care can be garnered through organizational changes and policies, including effective CE workshops and trainings (Raghavan et al., 2008).

Although there can be changes and improvements made during CE workshops, research is mixed on the effectiveness of long-term implementation and belief change of participants. Many participants report increased confidence and skill implementation, but not changes in their beliefs about treatments at a six-month follow-up (Oordt et al., 2009). It is reported that psychologists believe personal readings and research account for the majority of self-perceived competence, rather than CE or other workshops (Bradley et al., 2012). Further, Cox and Grus (2019) purport the misalignment between the requirement of CEs and competence of the provider over time, as many providers have complaints later in their career about competence. While CEs may support the development of knowledge, involvement in CEs may not lead to clinician competence (Cox & Grus, 2019).

However, continuing education workshops, if well done, have the ability to improve the competence and quality of care provided by a practitioner (Bloom, 2005). Confidence and knowledge among clinicians and paraprofessionals reportedly increased after a one-day workshop focused on working with suicidal individuals, regardless of experience and years in the field (Fenwick et al., 2004; Mirik et al., 2016). Yet, any type of education or reminder about effective practices has the potential to make a positive impact among a practitioner's competencies and use of new information, especially when using interactive training (Bloom, 2005).

There is also evidence continuing education makes a lasting impact on clinician confidence and expertise (Buttars et al., 2021; Mirik et al., 2016). Many clinicians with prior training rate higher understanding and confidence in the subject matter on both pre- and post-training surveys (Mirik et al., 2016). Furthermore, longer CE workshops (half or whole day) tend to be perceived as more effective than shorter (1-2 hour) workshops because of the increased

length of time clinicians have to reflect on and practice new skills and knowledge (Buttars et al., 2021). Time spent in conversation and discussion about the CE topic among professionals increases competence and decreases experiences of burnout. Interactions at CE workshops often extend into peer relationships and continue to increase support and learning of the CE topic (Bradley et al., 2012). Participation in training workshops benefit clinicians beyond the scope of the information presented (Buttars et al., 2021; Bradley et al., 2012).

Despite the mixed perceptions of CE effectiveness, overall, it appears to be an important aspect of continued competency and awareness of trends within the mental health field. This is increasingly important as the mental health field evolves over time. Lack of informed care can prove to be harmful to clients through loss of money, time, relationships, and, in severe cases, decrease in mental well-being (Mirik et al., 2016; Neimeyer et al., 2009). Continuing education remains the best option to ensure the general competency and effectiveness of clinicians at the present time (Taylor & Neimeyer, 2017). It also remains the best option in providing updated information and skill to clinicians, as many clinicians practice outdated skills without specific training and education on best practices (Mirik et al., 2016).

Neimeyer and colleagues (2012) denoted improving competency and further understanding the impact of competency as a pillar of continuing education research and direction. Despite the mixed research of implementation and belief changes as a result of continuing education, there is a strong link between continuing education and improved knowledge of a subject (Bloom, 2005; Buttars et al.; Bradley et al., 2012; Mirik et al., 2016). Knowledge is a core tenant of competency; thus, still improving general competency even if clinicians are not self-reporting changes in their practice (Cheetham & Chivers,1996; Epstein & Hundert, 2002). Litam and Lam, 2021), denote the importance of knowledge and continuing

education around the multiple facets of trafficking and treatment, as internalized beliefs and knowledge can be challenged and advanced for clients who were trafficked.

CE workshops are aimed to provide professionals with additional knowledge, competency, and awareness of skills, changes, and research in the given field (Buttars et al., 2021; Daniels & Walter, 2002; Neimeyer et al., 2009; Taylor & Neimeyer, 2017). This is particularly important in mental health fields that are constantly evolving and changing as more research is produced and synthesized (Mirik et al., 2016; Neimeyer et al., 2009; Taylor & Neimeyer, 2017). As a result, CE workshops are vitally important to continue the trust between the profession and general public in providing competent care (Mirik et al., 2016; Taylor & Neimeyer, 2017). This social contract is important in treatment considerations regarding individuals who were trafficked, as the stigma and treatment considerations surrounding human trafficking can be challenged and knowledge increased in CE workshops (Gozdziak, 2014; Litam & Lam, 2021).

Current Study

Study Aims/Goals

The purpose of the current study is to explore therapist competency and knowledge of human trafficking. Additionally, this study aims to examine clinician awareness and knowledge of how to treat clients who were trafficked. The study aims to explore how feasible it is to change clinician knowledge of trafficking and treatment of trafficking from a continuing education workshop.

Specific research questions are:

1. How do clinicians perceive their knowledge and competence in working with individuals who have been trafficked?

2. Can a continuing education workshop improve a clinician's knowledge and competence in working with individuals who have been trafficked?
3. Is there a difference between rural and non-rural clinicians when they self-report their knowledge and competence in working with individuals who were trafficked?
4. Is it feasible (e.g., in terms of interest, marketability, and technical production) to conduct a training on human trafficking for mental health professionals?

Hypotheses

It was expected results would reveal clinicians, generally, perceive themselves as having low levels of knowledge and competence in working with individuals who were trafficked (RQ1). Additionally, it was expected that clinicians would rate their knowledge and competence as higher after completing the workshop compared with before the workshop (RQ2). Exploratory data will be gathered on clinicians' self-reported competence to determine possible differences based on population density (rural vs. non-rural) (RQ3). Exploratory data will be gathered and analyzed to determine feasibility of conducting a continuing education workshop to improve competence of mental health clinicians about the treatment of human trafficking survivors (RQ4).

CHAPTER 2

RESEARCH METHODOLOGY

Participants

Participants were anticipated to be 36 mental health professionals or providers in training. Participants could have represented fields of psychology, marriage and family therapy, social work and other mental health related fields. To be in the present study, participants needed to attend an in-person training session about human trafficking and treatment considerations for trafficking survivors. The workshop was an introductory course to working with individuals who were trafficked, so participants did not need prior knowledge about human trafficking. All individuals received continuing education credits towards licensure and admittance to the workshop, in conjunction with the organization facilitating the workshop, regardless of participation in the present study.

Setting and Recruitment

Workshop attendees were recruited through word-of-mouth and mental health organizations. Attendees were invited to participate in the present study during the check-in process. All attendees paid a fee, determined by the organization facilitating the workshop, to participate in the workshop.

The workshop presenters were the author and a doctoral-level psychologist with research and experience in working with survivors of human trafficking. The workshop provided general knowledge on human trafficking at multiple levels including international, national, and state levels. Additionally, the workshop included information about treating individuals who were trafficked, including trauma informed care, stigma, and common pitfalls of providers. The workshop was novel for this study. See Appendix A for an outline of the workshop.

The study was conducted at a continuing education workshop. The check-in procedure for the workshop followed the format and schedule provided by the organization. At time of check-in, attendees were provided with the option of participating in the present study. Participants completed the informed consent and study on their internet-receiving device through Qualtrics. Instruction for the continuing education workshop included lecture, discussion, and activities. The workshop lasted four hours with time provided at the end of the workshop to complete the post-assessment survey via electronic device.

Measures

Demographic Form

Demographic information was collected via self-report at the beginning of the survey. Participants identified their age, ethnicity, race, gender, sexual identity, license type, years working in the mental health field, and their theoretical orientation in the pre-assessment completed before the workshop. Participants identified if they had completed training in trauma, knowledge of trafficking, and type of trafficking (e.g., sex, labor, organ, drug, or child) they had worked with since starting mental health practice via yes/no questions. Participants identified the population range of where they practice and therapeutic populations they serve. Questions are listed in Appendix B.

Feasibility Assessment

The present study used questions to assess feasibility based on concepts from Orsmond and Cohn (2015). Questions focused on the relevance, impressions, interest, and acceptability of a trafficking workshop to elicit feasibility of content. Questions asked about mechanics of the workshop to understand the practicality of mechanisms utilized in the workshop. Questions are listed in Appendix C.

Knowledge and Competence Assessments

The below measures obtained information about the knowledge and competence participants have about human trafficking via self-report. Measures have been utilized on mental health professionals, students of related fields, or professionals learning novel techniques, indicating applicability for the present study. The below measures are used to assess competence in working with individuals who were trafficked via knowledge or ability to implement evidenced lenses in working with the given population.

Perceptions, Knowledge, and Attitudes about Human Trafficking Questionnaire. The Perceptions, Knowledge, and Attitudes about Human Trafficking Questionnaire (PKA-HTQ) has three subscales: Self-appraisal of Knowledge/Skills, Worldview of Human Trafficking, and Help-Seeking Behaviors/Personal Beliefs. These factors are based on 16 Likert-type items ranging from 1 (strongly disagree) to 5 (strongly agree) to determine a respondent's perceptions, knowledge, and attitudes about human trafficking. Internal consistency of the Self-Appraisal of Knowledge/Skills subscale was .89 and the internal consistency of the Worldview of Human Trafficking was .78. The Help-Seeking Behaviors/Personal Beliefs subscale had less internal consistency at .66 (Nsonwu et al., 2017). Overall, the scale has satisfactory reliability, as the Help-Seeking subscale is not a focus of the present study.

Human Trafficking Myths Scale. Knowledge will be assessed via the Human Trafficking Myths Scale (HTMS; Cunningham & Cromer, 2016). This 17-item self-report assessment measures an individual's belief in myths about human trafficking. Scores range from 1 (definitely false) to 6 (definitely true) to assess beliefs ranging from characteristics of trafficking victims to victim agency, and the nature of human trafficking. Cronbach's alpha was .81 in the reliability testing.

Perceived Competence Questions. The present study used questions to assess a clinician's perceived competence in working with individuals who were trafficked. Questions were based on concepts from Svetlitzky and colleagues' (2020) competency assessment of a novel training. The questions were altered to reflect specific human trafficking competency. Questions are listed in Appendix D.

Procedure

Informed Consent

Informed consent was gathered electronically at the beginning of the pre-workshop and post-workshop assessments. As previously stated, attendees were informed of the study and provided information at the check-in desk. Members and employees of the psychological organization who ran the check-in desk were trained on how to provide informed consent. Participants were informed they can withdraw from the study at any point without penalty.

Process

Participation in the study was not required to attend the continuing education session or to earn CE credit. Participants were informed prior to attending the session they will have an opportunity to participate in the present study. At the session, individuals had the opportunity to participate in the study by informing the researcher at the check-in table. Participants were provided with a flier with a QR code and link to the study. A QR code for the study was also displayed on the projection screen prior to the start of the workshop. Participants also had the opportunity to request a paper copy to return to the researcher before beginning the education session, if they were unable to use their personal electronic device. Informed consent was obtained from participants before beginning the educational session.

Participants completed the assessments on their personal electronic device or via paper copy within the first ten minutes of the educational session starting. In the pre-assessment, participants completed the demographic form first. The PKA-HTQ, Human Trafficking Myths Scale, and perceived competence questions (Appendix D) was presented in a randomized order. Participants completed two questions creating unique and non-identifying specifiers (e.g., what is the name of your favorite book character?) at the end of the pre-assessment. They were asked to remember this to enter on the post-assessment.

At the end of the session, participants scanned a QR code off the screen or a flier that links to the study. Paper copies were provided upon request again. At the beginning of the post-assessment survey, participants were asked the same unique questions again in order to link the pre- and post-assessments. The post-assessment measures included the PKA-HTQ, Human Trafficking Myths Scale, perceived competence questions (Appendix D), and the feasibility questions (Appendix C) all in a randomized order.

Analytic Plan

Initially, pre-assessment measures were analyzed to determine the level of competence and knowledge clinicians believe they have in working with individuals who were trafficked via descriptive statistics for each measure (PKA-HTQ, HTMS, and perceived competence questionnaire). For each measure, a separate t-test was run (Research Question 1). Then, paired-samples t-tests were run using pre- and post-workshop assessment of clinician reported knowledge and competence of working with individuals who have been trafficked (RQ2). An independent t-test was conducted to compare pre-workshop differences in perceived knowledge and competence of rural/non-rural clinicians (RQ3). The feasibility of the workshop was

determined through descriptive statistics by analyzing data gathered from the feasibility questionnaire in Appendix C (RQ4).

CHAPTER 3

RESULTS

Participants

Participants in the current study consisted of doctoral-level psychologists who attended a continuing-education workshop (for workshop outline, see Appendix A). A total of 5 psychologists participated in the study. In terms of inclusionary criteria, participants were required to be at least 18 years of age and have been in or graduated from a masters- or doctoral-level mental health field. All participants completed the entire pre- and post-workshop surveys and were included in the final sample.

Demographics

Participants ranged in age from 36 to 71 and the average age of the sample was 50.6 (*SD* = 16.23) years. All participants indicated they were licensed clinical psychologists (100%), who have practiced an average of 18.60 years (*SD* = 6.88). In response to the gender identity prompt, two participants identified as cisgender men (40%), two participants identified as cisgender women (40%) and one participant identified as genderqueer (20%). The sexual orientation makeup of the sample was heterosexual (40%), bisexual (40%), and asexual (20%). All five (100%) participants identified as White or of European descent. Three participants reported living in suburban areas (60%). The remaining two participants indicated that they lived in a urban area (40%). No participants indicated that they lived in a rural area or worked with clients who lived in rural areas.

One participant reported seeing clients in an urban setting (20%), while two participants reported seeing clients in a suburban setting (40%). Two participants reported seeing clients in urban and suburban settings (40%). In response to the theoretical orientation question, two

participants identified using Cognitive-Behavioral therapies (33.33%), two identified using Psychodynamic therapies (33.33%), one identified using Postmodern therapies (16.67%), and one identified using Behavior therapies (16.67%). Only one participant selected using more than one theoretical orientation. Three participants (60%) reported previous training in trauma-informed care. One participant identified previous training in working with human trafficking (20%). In regard to the question asking if any participants have or have had a client who had been trafficked, one participant indicated that they had (20%). Relevant demographics are summarized in Table 1.

Table 1

Demographic Characteristics of the Sample

Variable	*n*	%
Race/Ethnicity		
White, of European Decent	5	100
Gender Identity		
Cisgender Woman	2	40
Cisgender Man	2	40
Gender queer	1	20
Geographic Description of Current City		
Rural	0	0
Suburban	3	60
Urban	2	40
License Type		
Doctorate-Level Psychologist	5	100
Years Working in Mental Health		
0-10	1	20
11-20	1	20
21-30	3	60

Preliminary Analyses

Pre-Workshop Assessment Data

Descriptive statistics were conducted on pre-assessment measures (i.e., perceived competence questions, HTMS, and PKA-HTQ) to understand how knowledgeable and competent mental health professionals perceive themselves to be. On the knowledge-based questions of the perceived competence questionnaire, participants scored an average of 0.60 (*SD* = .29) on a scale of 0 (incorrect answer) to 1 (correct answer), indicating participants were correct over half the time on the information-based knowledge questions. In other words, participants got about 2.4 of 4 questions correct (*SD*=1.14). On the perception of knowledge question (item 6), participants rated themselves as a 3.60 (*SD*= .55) on average, indicating most participants believed themselves to be slightly knowledgeable about trafficking on a scale of 1 (highly knowledgeable) to 4 (unknowledgeable). They rated themselves slightly lower in competence, compared with knowledge, on the same questionnaire (*M* = 2.36, *SD* = 0.71). On the HTMS, participants scored an average of 1.51 (*SD* = .35), meaning most of the trafficking myths were identified. The PKA-HTQ was calculated by subtest score. The Self-Appraisal of Knowledge/Skills subtest scores averaged 1.85 (*SD* = 0.52), indicating participants rated their knowledge and skills as relatively low. The Worldview and Help Seeking Behaviors/Personal Beliefs subtests were rated higher, on average, at 4.64 (*SD* = 0.41) and 4.60 (*SD* = 0.55), respectively. Across all measures, participants rated their knowledge and competence as fairly low (outlined in Table 2), but were able to identify the majority of trafficking myths.

Table 2

Pre-Workshop Knowledge and Competence Means

Assessment	Mean	SD	Scale Anchors
Human Trafficking Myths Scale	1.51	0.35	1 (Definitely False) to 6 (Definitely True)
PKA-HTQ			1 (Strongly Disagree) to 5 (Strongly Agree)
Self-Appraisal of Knowledge/Skills	1.85	0.52	
Worldview of Human Trafficking	4.64	0.41	
Help-Seeking Behaviors/Personal Beliefs	4.60	0.55	
Perceived Competence Questions			
Competence Questions	2.36	0.71	1 (Not at all) to 5 (Extremely)
Knowledge Perception Question (item 6)	3.60	0.55	1 (Highly Knowledgeable) to 4 (Unknowledgeable)
Knowledge-Based Questions*	2.4	1.14	Out of 4 questions

*Note * the mean was determined by number of items correct out of 4, not the mean score*

Pre-Assessment Measures to Other Sample and Population Means

A one-sample t-test was used to examine how participants rate compared with available population means. For the PKA-HTQ, the researcher chose to compare the current sample with social work students without human trafficking training means (*n*=265), as the majority of the current sample were mental health professionals without prior trafficking training (Welch-Brewer et al., 2021). In the Self-Appraisal of Knowledge/Skills subtest, participants reported an average total score of 14.80 (*SD* = 4.15). There is no significant difference to the current participants and the available sample means (*M* = 13.42, *SD*=3.92; Welch-Brewer et al., 2021), $t(4) = .744$, $p = .498$, meaning that participants in the current study were rating their knowledge and skills similarly to the sample of social work students. Current participants had higher total scores (*M* = 23.20, *SD* = 2.05) than the comparison group (*M* = 13.86, *SD*=1.38; Welch-Brewer et al., 2021), $t(4) = 10.19$, $p < .05$ with an η^2 of .280 on the Worldview subscale, meaning current

study participants have a greater recognition that human trafficking is a national and global issue compared with social work students. Lastly in the PKA-HTQ, there was a significant difference between the current sample's Help Seeking Behaviors/Personal Beliefs (*M* = 13.80, *SD* = 1.64) and the population mean (*M* = 7.73, *SD*=1.06; Welch-Brewer et al., 2021), $t(4) = 8.26$, $p < .05$. Continually, this has a large effect size with an eta squared of .205, indicating study participants reported more belief that individuals who were trafficked deserve support and are often wary to seek help compared to social work students.

A t-test was used to compare how participants rate belief in misinformation about trafficking compared with the available population means (n=409) for the Human Trafficking Myths Scale (*M* = 2.81, *SD*=0.62; Cunningham & Cromer, 2016). Participants in the current study reported less belief in human trafficking myths than the population (*M*=1.51, *SD*=0.35), $t(4)= -822$, $p < .05$. However, this difference may be due to the current small sample size, as the effect was very small (η^2=.002). Means are summarized in Table 3 and effect sizes are summarized in Table 4.

Table 3

Pre-Workshop Score Comparison with Sample Means

	Current Study		Sample Norms				
Assessment	M	SD	M	SD	t	df	p
Human Trafficking Myths Scale	1.51	0.35	2.81	0.62	-.882	4	.05*
PKA-HTQ							
Self-Appraisal of Knowledge/Skills	14.80	4.15	13.42	3.92	.744	4	.498
Worldview of Human Trafficking	23.20*	2.05	13.86	1.38	10.19	4	.05*
Help-Seeking Behaviors/Personal Beliefs	13.80*	1.64	7.73	1.06	8.26	4	.05*

*Note *p<.05*

Table 4

Effect Sizes of Sample Means Score Comparison

Assessment	t	p	η^2
Human Trafficking Myths Scale	-.882	.05*	.002
PKA-HTQ			
Self-Appraisal of Knowledge/Skills	.744	.498	.002
Worldview of Human Trafficking	10.19	.05*	.280
Help-Seeking Behaviors/Personal Beliefs	8.26	.05*	.205

Note *p<.05

Changes in Knowledge and Competence Post-workshop

Pre- and post-workshop comparisons were examined using a series of paired sample t-tests. Due to the number of analyses run, a Bonferroni correction was applied to set the p-value at .001 to account for the increased probability of Type I error. There was not a significant difference in most of the scores in the pre-workshop assessments compared with the post-workshop assessments (i.e., perceived competence questions, HTMS, and PKA-HTQ), as shown in Table 5. The only significant difference between pre- (M = 14.8, SD = 4.15) and post-workshop (M = 31.80, SD = 1.92) scores was for the Self-Appraisal of Knowledge/Skills subtest of the PKA-HTQ, $t(4) = -8.84$, $p = .001$. There is also a large effect size with an eta squared of .951 (see table 5 for all effect sizes). This indicates there were not significant changes in participant knowledge or myth belief as a result of the workshop, but there was a difference in self-appraisal of knowledge and skills. Effect sizes are summarized in Table 5.

Table 5

Pre-Workshop and Post-Workshop Means Comparison

Assessment	Pre- Workshop		Post-Workshop					
	M	SD	M	SD	SD	t	p	η^2
Human Trafficking Myths Scale	1.51	.35	1.19	.17	.30	2.36	.078	.582
PKA-HTQ								
Self-Appraisal of Knowledge/Skills	14.80	4.15	31.80	1.92	4.30	-8.84	.001*	.951
Worldview of Human Trafficking	23.20	4.15	24.20	1.10	1.00	-2.24	.089	.556
Help-Seeking Beh./Personal Beliefs	13.80	1.64	14.60	.55	1.92	-.93	.405	.178
Perceived Competence Questions								
Competence Questions	2.36	.71	3.36	.41	.58	-3.84	.019	.787
Knowledge-Based Questions	2.40	1.14	3.20	.84	1.10	-1.93	.178	.482

Additionally, pre- and post-workshop comparisons were examined using frequency changes. In Table 6, pre-workshop answers and post-workshop answers show an overall increase in the number of correct answers after the workshop. However, there were more correct answers in the pre-workshop answers for question 8 than in the post-workshop answers. Moreover, there were no differences in the number of pre-workshop and post-workshop answers for question 10.

Table 6

Comparison of Knowledge-Based Questions

	Pre- Workshop		Post- Workshop	
Questions	*N* Correct	*N* Incorrect	*N* Correct	*N* Incorrect
7. Which is considered the most common technique of trafficking?	1	4	4	1
8. What are the needed criteria to determine if an act is trafficking?	4	1	3	2
9. Which orientation is considered the "gold standard" for working with trafficking survivors?	3	2	5	0
10. What is considered the biggest hurdle to trafficking survivors receiving treatment?	4	1	4	1

Rurality

No participants reported living or working in a rural area. Thus, the third hypothesis was not able to be tested. Instead, an independent sample t-test was run to examine possible differences among participant locale (i.e., urban vs. suburban) and pre-workshop competence and knowledge, using the perceived competence questions. Once again, a Bonferroni correction was utilized with a p-value of .01. The t-test revealed a significant overall effect for locale for knowledge, $t(3) = .14$, $p < .01$, but not for perceived competence, $t(3) = 1.66$, $p = .55$ (equal variances not assumed). Overall, these results suggest that individuals in urban locales have similar reported scores on measures of perceived competence knowledge of human trafficking compared to those with suburban locales. However, the pre-workshop trafficking knowledge of those in urban locales ($M = 2.50$, $SD = 2.12$) may be greater than those in suburban locales ($M =$

2.33, *SD* = .58). Due to the low sample size, this difference is further discussed in the discussion section.

Estimates of Feasibility

Feasibility metrics were analyzed using mean scores to understand participants' view of the relevance and effectiveness of a workshop on human trafficking. The means are displayed in Table 7, score categories are broken into quartiles based on the score options for items (one through six or zero/one). Participants rated the relevance of human trafficking to their professional work as *somewhat relevant* (*M* = 2.00, *SD* = .71) with scores falling in the second highest quartile. All participants reported they had an adequate amount of time to complete the data collection associated with this study (*M* = 1.00, *SD* = 0), with all scores in the “yes” or highest category. In regard to overall impressions of the workshop, scores fell within the high quartile range (*M* = 1.20, *SD* = .45), indicating a positive overall impression of the training. Similarly, participants rated the workshop as largely appealing and acceptable (*M* = 1.20, *SD* = .45) with scores falling in the highest quartile. Participants rated the use of technology as *highly effective* (*M* = 1.00, *SD* = 0) as all scores were rated in the highest quartile. Participants rated the effectiveness of teaching about human trafficking and basic treatment considerations as *highly effective* (*M* = 1.00, *SD* = 0), resulting in scores in the highest quartile. However, only three of five participants reported interest in learning about human trafficking without continuing education credits (*M* = .60, *SD* = .55), with scores rated in the moderately high quartile. Alternatively, participants still rated highly that mental health professionals should learn about human trafficking (*M*=1.00, *SD*=0) with scores in the highest quartile. As a result of the associated workshop, participants indicated high rates of interest in human trafficking (*M* = 1.80,

SD = .84). Overall, these metrics indicate that participants view human trafficking training as a feasible and relevant topic for mental health professionals.

Table 7

Feasibility Means

Category	M	SD	Quartile
Relevance of trafficking training to professional work	2.00	.71	High
Impressions of the workshop	1.20	.45	High
The workshop acceptable & appealing	1.20	.45	High
Effective in teaching	1.00	0	High
Interest in trafficking, without CE credits^	.60	.55	Moderately High
Enough time to complete data^	1.00	0	High
Should mental health professionals learn about trafficking^	1.00	0	High
Has your interest in human trafficking changed?	1.80	.837	High

Note ^ indicates a yes/no scale
High and Moderately High refer to the first and second quartiles, respectively

Reliability Measures

Feasibility Questions.

As the feasibility questions are novel for the study, Cronbach's alpha tests were run to understand how the feasibility questions hold together (summarized in Table 8). The questions, *How relevant is the topic of human trafficking to your professional work?* and *Would you be interested in learning about human trafficking if benefits (CE credits) were not attached to this workshop?* were not included in the analysis as it does not relate to the feasibility of conducting a human trafficking workshop. The remaining seven questions were examined and indicate a

partial consistency with one another (α = .691), which is slightly below field standards. However, low item totals and low sample size might restrict the alpha from being higher.

Perceived Competence Questions

The Perceived Competence Questions were split between knowledge-based questions and competence-based questions. Items one through five were analyzed for internal consistency regarding perceived competence. In the pre-workshop, the items had strong internal consistency, indicating they hold together well (α = .935). Similarly, the post-workshop competence questions held together satisfactorily (α = .893). Basic psychometric properties were upheld with the pre-workshop and post-workshop competence questions. Regarding the knowledge-based questions, items seven through 10 were analyzed. Item six was excluded from the analysis as it asks about perception of knowledge, instead of a test of knowledge. In the pre-workshop data, the knowledge-based questions did not hold together well (α = .410). In the post-workshop data, the items negatively covaried and were unable to be accurately measured. This indicates that the knowledge-based questions were not internally consistent. This may also be a result of the small sample and question size. Internal consistency is summarized in Table 8.

Table 8

Reliability of Novel Questions

Assessment	**Cronbach's Alpha**
Feasibility Measure	.691
Perceived Competence Questions - Pre-Workshop	
Competence Questions	.935
Knowledge-Based Questions	.410
Perceived Competence Questions - Post-Workshop	
Competence Questions	.893
Knowledge-Based Questions^	

Note ^ indicates a negative covariance and was unable to be analyzed

CHAPTER 4

DISCUSSION

Review of Purpose

The purpose of the current study was to investigate the role of continuing education's influence on clinician's perception of competence and knowledge about human trafficking. Specifically, I evaluated participant knowledge of human trafficking and competence in working with individuals who were trafficked prior to and after attending a continuing education workshop on trafficking. Additionally, I assessed their reactions and feedback to attending a workshop to understand the feasibility of continuing education workshops on human trafficking. The current study aimed to answer the following questions: (1) How do clinicians perceive their knowledge and competence in working with individuals who have been trafficked?, (2) Can a continuing education workshop improve a clinician's knowledge and competence in working with individuals who have been trafficked?, (3) Is there a difference between rural and non-rural clinicians when they self-report their knowledge and competence in working with individuals who were trafficked?, and (4) Is it feasible (e.g., in terms of interest, marketability, and technical production) to conduct a training on human trafficking for mental health professionals?

Review of Findings

Perceptions of Knowledge and Competence

As expected from Hypothesis One, participants rated their perceptions of competence and knowledge as relatively low on the Self-Appraisal of Knowledge/Skills subscale of the PKA-HTQ, the competence questions, and the knowledge perception question of the Perceived Competence Questions. Clinicians' perception of knowledge and competence of human trafficking contrasts their scores on human trafficking myths, worldview, and personal beliefs

when compared with available sample means. Participants in the current study scored significantly higher on the pre-workshop assessments than the normed means, which could indicate sampled psychologists have a better understanding of human trafficking than they realize. The only score that did not differ from population means was their pre-workshop self-appraisal of skills and knowledge about human trafficking. Taking together the higher scores on knowledge-based questions and lower ratings of perceived knowledge and competence, participants may have higher levels of knowledge about human trafficking than they realize. Further research could aid in exploring if these higher scores of knowledge also translate into higher levels of competence in working with individuals who were trafficked. Further research could also explore if these scores are based on individual or regional differences in knowledge about human trafficking, as the workshop was conducted in a hub of human trafficking and one participant had prior training in human trafficking.

Changes in Knowledge and Competence

Hypothesis Two was partially unsupported. There were no significant differences in measures of knowledge or myth belief between the pre-workshop and post-workshop data. As stated previously, the sample scored higher levels of knowledge than normed means on measures of knowledge and myth belief. The higher pre-workshop scores may partially explain the lack of significant difference, as participants may have already had more knowledge than they recognized. Furthermore, this is in contrast to previous literature on knowledge change that states continuing education workshops are more effective in increasing attendee knowledge compared with competence (Cox & Grus, 2019). Perceptions of competence, conversely, were significantly different between pre-workshop and post-workshop scores. Thus, despite not having more knowledge about trafficking, clinicians viewed their competence and skills regarding treating

individuals who were trafficked as better after the workshop. This does align with previous literature about improving confidence and competence via continuing education workshops (Oordt et al., 2009; Mirik et al., 2016). Moving forward, researchers could continue to understand how continuing education influences knowledge and competence on topics clinicians may be more knowledgeable about than anticipated.

Rurality Differences

Hypothesis Three could not be tested, as no clinicians living or working in rural areas attended the workshop. Instead, the difference between urban and suburban clinicians were analyzed. There were no significant differences between the perceptions of competence in working with individuals who were trafficked based on locale. On the other hand, there was a significant difference between urban and suburban clinicians on their knowledge scores of human trafficking. Urban clinicians appear to have a greater amount of knowledge compared with their suburban counterparts. However, it is unclear if this is a true difference in knowledge based on locale, or a skewing of data due to the small sample size and one of the urban participants had previous training in human trafficking. Further research could aid in determining whether there is a difference among locales in trafficking knowledge.

Feasibility of Human Trafficking Training

In regard to Hypothesis Four, data were gathered and points to the feasibility of conducting a continuing education workshop on human trafficking to improve clinician competence in treatment of trafficking survivors. The workshop was hosted by the state psychological association, which provided technical support and advertisement for the workshop. Participants completed questions about the feasibility and interest in the workshop (question listed in Appendix C). Means indicate relevance, positive impressions, and effective production

of the workshop on human trafficking. Results support that workshops on human trafficking are feasible and relevant to psychologists. Furthermore, clinicians viewed their competence in working with individuals who were trafficked as higher than before the workshop. Taken together, this data supports the fourth hypothesis and the feasibility of conducting a workshop on human trafficking. Further research is still needed to create effective workshops about human trafficking to improve knowledge and skills in mental health professions, particularly with rural clinicians.

Clinical Implications

It is the ethical responsibility of mental health professionals to continue expanding their competence across multiple fields and areas of study. As such, this study attempts to provide data on the effectiveness of a continuing education workshop on increasing clinician perceived competence on a topic. Results indicated it is possible to influence perceptions of competence through a continuing education workshop. Additionally, human trafficking is a national concern (US Department of Homeland Security, n.d.; Polaris, n.d.) that mental health professionals will ethically need to know how to treat effectively. Given the lack of research on treatment considerations for survivors of human trafficking, it is imperative mental health professionals know how to identify experiences of trafficking and how to treat clients who were trafficked. As such, the results of this study indicate that mental health professionals are as knowledgeable about trafficking as the general public. Mental health professionals are also capable of increasing their perceived competence in working with individuals who were trafficked. By targeting mental health professionals and increasing the perceived competence, individuals who were trafficked will likely experience better outcomes. Additionally, the feasibility of conducting a

workshop on human trafficking to influence clinician knowledge and perceptions provides a basis for teaching more mental health professionals about human trafficking.

Rural Implications

No participants reported residing in or working with clients who lived in rural areas. Instead, suburban and urban analyses were conducted. The results suggest there were no significant differences between participants who reported residing in suburban versus urban areas. Previous research indicates there may be multiple reasons for rural clinicians to not attend this continuing education workshop; however, inferences about rural clinicians are assumed without data available. Namely, rural clinicians face a number of barriers, including financial, time, and structural challenges, to attend in-person workshops. As a result, many rural clinicians prefer to use tele-educational methods (Curran et al., 2006). To garner more rural clinicians, future presenters should consider offering workshops via telehealth or in rural areas to remove some barriers. To reduce further barriers for rural clinicians, regional associations should consider hosting conferences and workshops in various locations, including small cities or large towns, to reduce travel and time management barriers for rural clinicians. Additionally, regional organizations who host CE workshops could target advertisement and incentive workshops to promote attendance of rural clinicians. There is no research to support or suggest that rural clinicians would have more or less knowledge, competence, or interest in human trafficking compared with non-rural clinicians.

Limitations

The first, and major, concern of this study is the small sample size and its effects on power. Specifically, there is an increased probability of Type II error, or a false-negative, occurring. It is possible the analyses could have increased the possibility of false negatives when

testing alternative hypotheses. This impairs the generalizability of the research overall. Moreover, the population is fairly homogeneous in terms of education, location of practice, and ethnic makeup, it is difficult to generalize beyond those demographics. Specifically, the findings may not generalize beyond urban and white psychologists. Thus, they may not be generalizable to other mental health professionals or mental health professionals of color. Additionally, given the small *n* size, this data may not generalize to other white, urban psychologists, as the researcher may be experiencing Type II error. In the future, it would be beneficial for future research to evaluate the hypotheses with more diverse samples.

Another limitation involves the use of novel assessments for human trafficking competence and presentation feasibility. Both measures were based on other measures with similar topics to human trafficking (Orsmond & Cohn, 2015; Svetlitzky et al., 2020). They were also deemed face valid by professionals with knowledge of continuing education and human trafficking. Despite attempts to increase the strength of the measures, there lacks previous research on reliability and validity to increase the power of the measures. Thus, there is not a basis of research to support the measures loaded onto the anticipated constructs. Future research should validate the assessments before use to confirm factor loading.

Lastly, there may be social desirability influences within the data. Namely from self-report data and from the author being a presenter. Self-report measures can be influenced by participants answering in the most desirable way. This influences the data and skews it towards the more desirable answers, as opposed to the most accurate answers. This can be particularly true when the participants were answering about their perceptions of personal competence. Additionally, the researcher was also a presenter of the workshop. Thus, her potential connection and rapport over the course of the workshop, may have influenced participants to rate the

workshop more desirable than their true feelings about the feasibility and desirability of a workshop on human trafficking. Future researchers may consider having separate workshop presenters that were not connected with the research at hand.

Future Directions

This study highlighted that psychologists in the current sample have a significant amount of knowledge about human trafficking compared with normed samples. Although this was not an anticipated discovery, it creates a line of future research. Currently, no research has been published corroborating or dissenting from this discovery. Additionally, there could be multiple explanations for study participants being more knowledgeable about human trafficking than the average person, such as regional or individual differences. As such, future research should examine if this increased knowledge about trafficking is from individual, regional, and/or professional differences. In the future, researchers should examine a diverse range of mental health professionals across the nation to understand how knowledge bases of trafficking differ throughout professions and regions.

Further, the participants' knowledge base of human trafficking did not change after the workshop. Further research should seek to examine what the mechanisms for improvement are in continuing education workshops. As the literature is mixed on the effectiveness of continuing education in improving competence, knowledge, and confidence over time, understanding the factors impacting effective training can be a rich area of research. Moreover, future research could examine how these factors can be maintained over time through longitudinal studies on the effectiveness of continuing education workshops in professionals maintaining knowledge and competence about the presented material. This would contribute to more effective and ethical professionals over time, as most professions require continuing education units.

Along those lines, self-appraisal of knowledge/skills was the only significant change between pre-workshop and post-workshop measures. Future research should examine if changes in self-reported competence and perceptions of knowledge are true changes in competence and knowledge or if these reflect a change in confidence within the professional. This could be done through assessing competence over time in working with the target population (e.g., individuals who were trafficked) using observation of skills and performance. This would allow perceptions and actual competence to be delineated, while also allowing the impact of confidence to be studied and understood. Some continuing education programs have similar systems in place that could be used to study the effects of continuing education long-term and how different modalities of continuing education impact factors such as confidence, perceptions of competence, competence, and knowledge.

Similarly, the feasibility of a novel continuing education workshop could be examined for future research. The current study highlighted that the feasibility measure did not have adequate enough internal consistency. As there are no feasibility measures published for continuing education workshops, future research should aim to understand how to increase the research base of feasibility studies. This may also bolster the continuing education literature to understand the important facets of a continuing education workshop in improving the ethics and effectiveness of a profession over time. Future research should also aim to include the feasibility of rural professionals being able to attend the workshops and continuing education units.

In the future, research should examine how to make it accessible for rural populations and clinicians to learn about populations they may interact with, such as individuals who were trafficked. This may include conducting workshops virtually or creating workshops in rural areas to increase accessibility for rural professionals. Moreover, future research should assess the

reasons why rural professionals may not seek out training on human trafficking. As trafficking occurs in all places, and rural clinicians often do not have anyone to refer trafficked clients to, it is an important avenue of research.

Overall, more research is needed to understand the mechanisms of improvement and effectiveness in continuing education, especially regarding how to make workshops accessible to rural professionals. Continually, future research should focus on understanding how knowledgeable mental health professionals are about human trafficking and treatment of survivors. This will increase the effectiveness of continuing education workshops to improve the treatment of human trafficking survivors, as well as feasibility for improvement across multiple professions.

Conclusion

The purpose of the current study was to identify if a continuing education workshop could influence clinician knowledge and competence of human trafficking. This study utilized a quasi-experimental and correlational design to evaluate perceptions of personal knowledge and competence about human trafficking among mental health professionals, as well as the feasibility of conducting a workshop on human trafficking for continuing education credits. The findings advance the current body of literature in several notable ways. First, the study found participants scored higher than normed means on knowledge about human trafficking and myths, but rated their skills, on average, as lower than normed means. Although knowledge and belief scores did not significantly differ before and after the continuing education workshop, scores related to self-perception of competence significantly increased. This may indicate that continuing education does not improve general knowledge but can increase perceptions of competence in working with potentially trafficked clients. However, given the low n-size there are limitations to

generalizing these findings beyond the sample as individual differences can greatly impact the data. Lastly, these results suggest that it is feasible to conduct a continuing education workshop on human trafficking with mental health professionals and influence their knowledge and competence. These findings suggest the importance of continuing education workshops in improving the perceived competence of mental health professionals in working with individuals who were trafficked.

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Appendix A

Workshop Overview

- Hour 1
    - Definition of Human Trafficking
    - Common Myths and Facts of Trafficking
    - Identification and risk factors impacting pathways into trafficking
    - A video of a man discussing his experiences being sex trafficked
        - Group discussion
- Hour 2
    - Overview of traffickers and buyers
        - Recruitment styles
        - Common ways of exploitation, namely with labor trafficking
    - A video of a woman discussing her experiences being labor trafficked
        - Group discussion
    - Barriers to reporting and intersection with other traumatic experiences (e.g., domestic violence)
    - Trafficking at the state level
        - How traffickers move victims through and throughout the state
        - Laws and proposed legislation
        - Safe houses and resources in the area
- Hour 3
    - Clinician ethical responsibilities
    - Impact of language and stigma on individuals who were trafficked
        - How to reduce stigma (personal and cultural levels)
    - How trauma impacts memory
        - Clinical implications for this in trafficking survivors
    - Trauma Bonding
- Hour 4
    - Overview of research literature on treatment of trafficking survivors
        - Resilience lens
        - Relational consequences lens
        - Trauma-informed care
    - Group Discussion on implementation of lenses
    - Local resources

Presented for Georgia Psychological Association with Dr. Dorothy Marsil, a professor and researcher at Kennesaw State University

Appendix B

Demographics

1. Please select your age.
2. How would you describe your sexual orientation?
    a. Asexual
    b. Bisexual
    c. Gay or lesbian
    d. Pansexual
    e. Heterosexual
    f. Prefer not to say
    g. Prefer to describe or is not listed ___________
3. How would you describe your gender or gender identity?
    a. Cisgender man
    b. Cisgender woman
    c. Non-binary
    d. Transgender man
    e. Transgender woman
    f. Two-spirit
    g. Prefer not to say
    h. Prefer to describe or is not listed __________
4. How would you describe our racial/ethnic background? Please select all that apply.
    a. American Indigenous or Alaskan Native
    b. Asian
    c. Black or African American
    d. Hispanic, Latino, or Latin Origin
    e. Middle Eastern or North African
    f. Multiracial/Multiethnic
    g. Native Hawaiian or Pacific Islander
    h. White or European descent
    i. Prefer not to say
    j. Prefer to describe ________
5. What label(s) best describes your training and license? Check all that apply.
    a. Licensed psychologist (Ph.D. or Psy.D.)
    b. Unlicensed post-doctorate of psychology (Ph.D. or Psy.D.)
    c. Unlicensed doctorate of any mental health field
    d. Certified school psychologist (Ed.S.)
    e. Licensed mental health practitioner (LPC, MSW, CAC1, etc.)
    f. Unlicensed mental health practitioner
    g. Current graduate student of psychology or other mental health field
    h. Not listed above ________
6. Please select the number of years you've been working in a mental health field, including during graduate training.
7. Please select your main theoretical orientation(s).
    a. Cognitive-Behavioral Therapy

   b. Dialectical Behavior Therapy
   c. Acceptance and Commitment Therapy
   d. Psychodynamic Therapies
   e. Play or Other Child Therapies
   f. Postmodern Therapies (e.g., multicultural or feminist)
   g. Not listed ___________
8. Have you been trained in working with trauma?
   a. Yes
   b. No
9. Have you been trained in how to work with individuals who were trafficked?
   a. Yes
   b. No
10. How much do you know about agricultural trafficking?
    a. 1 nothing/very little
    b. 2 a slight amount
    c. 3 a moderately amount
    d. 4 quite a bit/expert
11. How much do you know about labor trafficking?
    a. 1 (nothing/very little) 4 (quite a bit/expert)
12. How much do you know about sex trafficking?
    a. 1 (nothing/very little) to 4 (quite a bit/expert)
13. Have you worked with a client that was trafficked?
    a. Yes
    b. No
14. Please select the most accurate population range for where you work/practice?
    a. Less than 10,000
    b. 10,001-25,0000
    c. 25,001-50,000
    d. 50,001-75,000
    e. 75,0001-100,000
    f. 100,001-125,000
    g. 125,000+
15. Please select if the *majority* of your clients are:
    a. Rural
    b. Urban
    c. Suburban
    d. Mix of urban and suburban
    e. I don't see clients
16. Please select the most accurate reflection of where *you* live
    a. Rural
    b. Urban
    c. Suburban
17. Briefly and broadly describe the types of clients you tend to see.

Appendix C

Please complete the following based on your impressions of the workshop today.

1. How relevant is the topic of human trafficking to your professional work?
    a. 1 highly relevant
    b. 2 somewhat relevant
    c. 3 slightly relevant
    d. 4 slightly irrelevant
    e. 5 somewhat irrelevant
    f. 6 highly irrelevant
2. Have you had an adequate amount of time to complete the data collection portions of the workshop today?
    a. yes/no
3. What have been your impressions of the workshop today?
    a. 1 (highly positive) to 6 (highly negative)
4. To what degree has the workshop been acceptable and appealing to you?
    a. 1 (highly acceptable and appealing) to 6 (highly unacceptable and unappealing)
5. Do you feel the presenters used technology and equipment sufficiently?
    a. 1 (highly acceptable) to 6 (highly unacceptable)
6. To what extent do you feel this workshop was effective in teaching you about human trafficking and basic ideas for treatment of survivors?
    a. 1 (highly effective) to 6 (highly ineffective)
7. Would you be interested in learning about human trafficking if benefits (CE credits) were not attached to this workshop?
    a. yes/no
8. Do you think mental health professionals should learn about human trafficking and therapy interventions for survivors?
    a. yes/neutral/no
9. Has your interest in human trafficking changed as a result of this workshop?
    a. 1 much more interested
    b. 2 slightly more interested
    c. 3 interest did not change
    d. 4 less interested

Appendix D

Perceived Competence Questionnaire

1. To what extent are you likely to be effective in assisting an individual who was trafficked in a therapeutic setting?
    a. 1 (not at all) to 5 (extremely)
2. To what extent are you likely to be effective in helping an individual who was trafficked with traumatic stress?
    a. 1 (not at all) to 5 (extremely)
3. To what extent do you feel competent in working with individuals who were trafficked?
    a. 1 (not at all) to 5 (extremely)
4. To what extent do you believe you could ethically treat a client who was trafficked?
    a. 1 (not at all) to 5 (extremely)
5. To what extent are you able to use trauma-informed care with a client who was trafficked?
    a. 1 (not at all) to 5 (extremely)
6. Please rate your knowledge of trafficking.
    a. 1 highly knowledgeable
    b. 2 moderately knowledgeable
    c. 3 slightly knowledgeable
    d. 4 unknowledgeable
7. Questions 7-10 will be knowledge-based items discussed in the presentation. Answers will be multiple choice.