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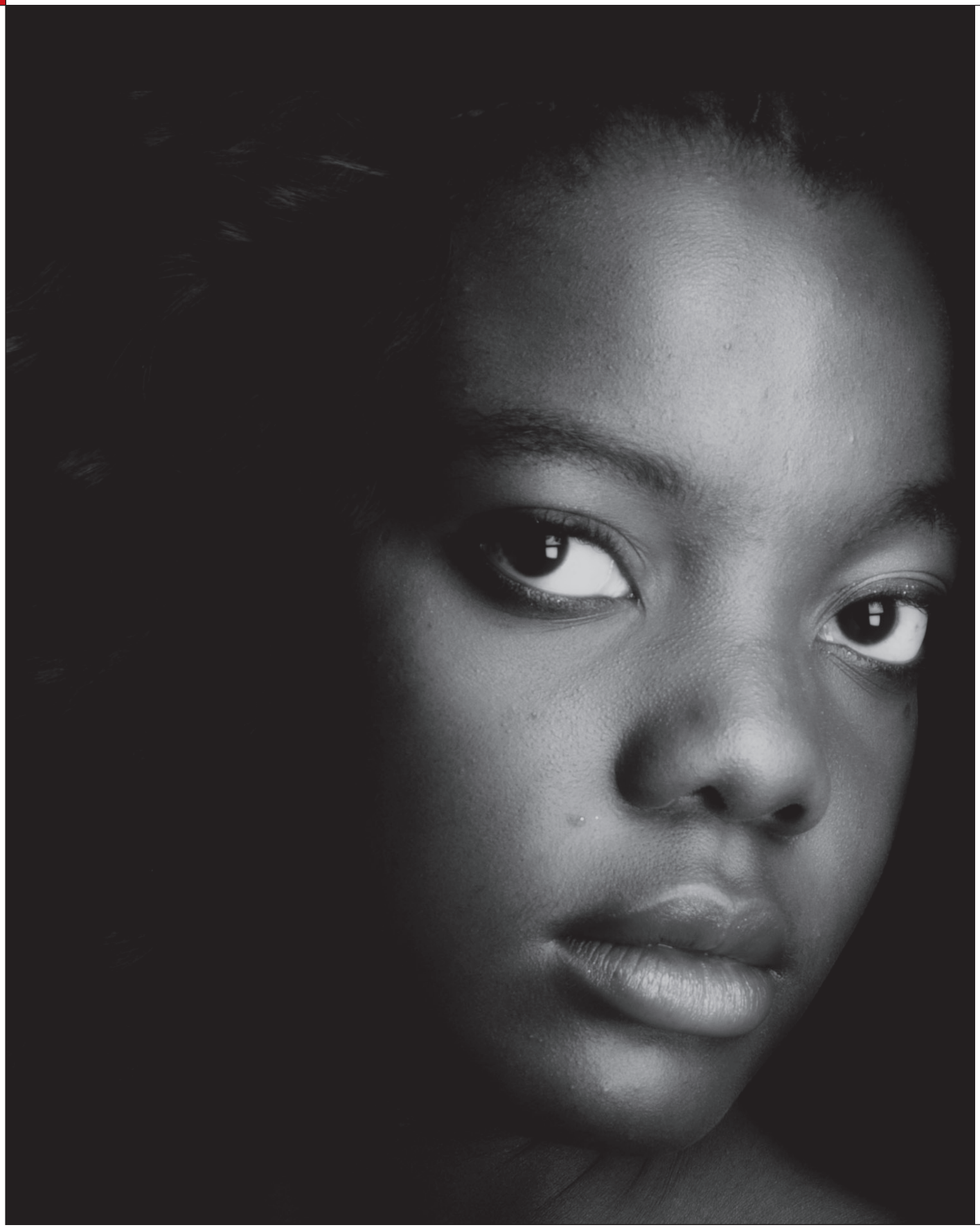

Mental health problems among youth experiencing sex trafficking

Abstract: There are an estimated 4.8 million victims of sex trafficking (ST) globally, and 21% of these victims are children or adolescents. Victims of ST are at risk for mental health problems, and it is critical that primary care providers can accurately identify and treat them.

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Twenty-one percent of the 4.8 million people estimated to experience sex trafficking (ST) globally are children or adolescents.[1] ST, a type of human trafficking, is defined as "the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act.[2]" When children under the age of 18 years are involved, force, fraud, and coercion are not required to meet the definition of ST. Commercial sexual exploitation of children (CSEC) "involves crimes of a sexual nature committed against juvenile victims for financial or other economic reasons… These crimes include trafficking for sexual purposes, prostitution, sex tourism, mail-order-bride trade, early marriage, pornography, stripping, and performing in sexual venues such as peep shows or clubs."[3] Survival sex is also considered to be CSEC, where sexual activity is exchanged for shelter, food, or money.[3,4]

Involvement in ST is associated with numerous physical and psychological health effects. Victims of ST are at increased risk of injury, sexual assault, infectious diseases, substance misuse, malnutrition, major depression, anxiety, posttraumatic stress disorder (PTSD), and suicide.[3,5] Due to the physical health consequences of involvement in ST, many victims seek medical care, but few are identified as ST victims due to the lack of provider awareness and unavailability of a formal screening tool to identify victims. Additionally, while ST victims who are identified may receive the necessary medical care, mental health issues may remain unaddressed.[3] By educating providers to screen for ST and manage the potential mental health sequelae, victims could be identified earlier for improved health outcomes. This article provides an overview of best practices should a primary care provider identify an individual currently being trafficked or treat a survivor of trafficking.

Keywords: children and adolescents, mental health, sex trafficking

Risk factors and screening

Currently, there are limited screening tools that healthcare providers can utilize to identify victims of ST. Moreover, many healthcare providers in the US report never having received formal education on how to properly identify ST.[6] Shockingly, US teens, compared with foreign nationals, are among those with the highest risk of becoming victims of ST within US borders.[7] Additionally, almost 80% of ST victims reported seeing a medical provider within 1 year of their identification as victims.[8] It is known that victims of ST visit both EDs and outpatient clinics for a variety of problems that may be directly related to ST, such as sexual assault; physical injury; infection; exacerbations of chronic conditions; complications of substance use/overdose issues; or pregnancy testing, contraceptive care, and other reproductive issues.[3] However, due to lack of healthcare provider knowledge of the issue of ST among children and a reluctance from trafficked children to disclose their victimization, ST is often missed.[6]

Standardized tools for the recognition and identification of ST have begun to emerge, although widespread use and proliferation remains lacking. The Human Trafficking Screening Tool (HTST) has been found to be more effective than usual care for the identification of ST.[9,10] The HTST is a brief, 19-item instrument that can be completed in less than 5 minutes; an abbreviated, six-item version of the tool can be completed in less than 1 minute. The full HTST 19-item instrument assesses for experience of force, fraud, or coercion in regard to trafficking, in addition to experiences pertaining to commercial sex exploitation.

Although there are limited screening tools available at this time, understanding risk factors that contribute to the possibility of children and adolescents becoming involved in ST can allow healthcare providers to potentially detect child victims of ST. Adolescents who are part of the lesbian/gay/bisexual/transgender/questioning (LGBTQ) community, have substance use problems, learning disabilities, and/or behavioral or mental health disorders are at an increased risk for ST involvement.[3,11] These subsets of the adolescent population are more likely to experience homelessness, which places them at increased risk of engaging in survival sex behaviors and becoming involved in ST.[3,8] Family dysfunction, including a history of abuse, neglect, untreated caregiver psychiatric disorders, substance use disorder, intimate partner violence, and criminality, may also increase the risk of being trafficked.[3] A child or adolescent with any history of child maltreatment, parental drug or alcohol misuse, parental mental illness, societal isolation, or interpersonal violence is at a greater risk for falling victim to ST.[7] Children living in areas of poverty with high crime rates, prostitution, and transient male populations (like truck stops, military bases, and convention centers) may also be at increased risk of ST.[1]

Clinical presentation

Aside from specific risk factors that place the child or adolescent at higher risk, a few specific signs could clue the healthcare provider into possible ST. Suspicion should arise if the healthcare provider notes the patient is "withdrawn or submissive, gives vague and inconsistent histories regarding their injuries or where they live or go to school, or appears to move frequently."[7] The healthcare provider may note tattoos on the patient's body that symbolize the patient has been branded by a trafficker. One of the biggest red flags a healthcare provider may note is a child or adolescent who is accompanied by a controlling adult who refuses to leave the patient alone or chooses to answer all questions for the patient.

Initial management

If the healthcare provider notes any of these signs or has any suspicion that a patient is a trafficking victim, the patient needs to be separated from all accompanying parties and asked specific questions to try and determine if the patient may be a victim of ST.[7] Healthcare providers should seek to build rapport with patients, and should provide information regarding confidentiality, reinforcing that confidentiality may be broken should the individual's safety be at risk.[6] Further, it can be helpful to inform suspected victims of the fact that healthcare providers are mandatory reporters, and to reemphasize that the first priority of care is the individual's safety or well-being. In instances where safety is in question, or if it is suspected that the individual is currently being trafficked, the primary care provider must take steps to ensure the individual's safety. Foremost, providers should attempt to keep the patient on site until law enforcement or social service personnel are notified, as those being trafficked may be less likely to return for follow-up care and their safety could be compromised should they leave the site.[13] If it is not possible that the patient remain on site, healthcare providers should attempt to obtain as much accurate information as possible

regarding current address, housing arrangements, and contact information. It is also critical that healthcare providers are familiar with and aware of their state's mandatory reporting requirements and associated laws.

Once the healthcare provider has recognized that the patient may be a victim of ST, it is extremely important to assess for physical abuse, sexual abuse, and mental health problems in the child, due to the extremely high prevalence of these comorbidities. The healthcare provider must, first and foremost, try to establish a rapport with the patient in order to foster trust. Children and adolescents who are victims of ST are extremely vulnerable and often will only reluctantly divulge information; therefore, direct questioning about sexual activity with other individuals, sexual pictures taken of the patient, and instances of sex in exchange for a want or need (that is, money, goods, shelter) is paramount. Healthcare providers should always obtain consent or assent when completing a physical exam, particularly with invasive procedures, in children who are victims of ST. Additionally, the healthcare provider should try to obtain a thorough history of family dysfunction, sexual abuse, physical abuse, substance use, psychiatric problems, child protective services involvement, intimate partner violence, and LGBTQ status.[3]

Mental health considerations

While acute medical problems of a potential victim must be addressed, psychosocial concerns and mental health symptoms cannot be overlooked. It is well established that there is a high prevalence of mental health problems among victims of ST, including depression, anxiety, and PTSD.[14-18] It is unclear what percentage of mental health problems precedes the ST experience, and what percentage occurs as a result of being trafficked, but nonetheless, appropriate mental health evaluation and management is critical to improving patient outcomes.[18] A recent systematic review of the prevalence and risk of mental health problems among trafficked people reinforced that depression, anxiety, and PTSD are among the most commonly reported mental health disorders.[16,17] For that reason, healthcare providers must be familiar with the diagnosis and management of these serious mental health sequelae.

Outside of the context of trafficking, it has been established that depression is a common mental health problem and a major contributor to morbidity and mortality, as well as disability and/or decreased quality of life.[19] According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), depressive disorders include major depressive disorder, persistent depressive disorder, disruptive mood dysregulation disorder, substance or medication-induced depressive disorder, and depressive disorder due to another condition.[20] Screening for depressive disorders can be completed formally by using standardized tools, such as the Patient Health Questionnaire (PHQ-9).[21] Symptoms can also be elicited through subjective history and the primary care provider's observations or a mental status exam.[22] Because those currently experiencing or with a history of experiencing ST may be at risk for suicide, standardized suicide screenings, such as use of the Columbia-Suicide Severity Rating Scale (C-SSRS), may be useful, with special attention given to safety planning, as indicated.[23,24] Though referral to mental health specialists is often prudent in cases of severe or persistent depression, the condition can be managed in the primary care setting, specifically in the context of ST survivors. As discussed, these patients are often vulnerable and may prefer to remain in the care of a single, trusted provider, rather than reiterate their experiences and reestablish connections.[25] In primary care, uncomplicated depression can be managed by nonpharmacologic or pharmacologic modalities, with the first-line medication class of choice being selective serotonin reuptake inhibitors (SSRIs).[26,27] It is important that primary care providers be familiar with the boxed warning for increased suicidality in children, adolescents, and young adults who are prescribed SSRIs, and that they provide necessary patient education with use of a safety plan.[28] The Guidelines for Adolescent Depression in Primary Care (GLAD-PC) were developed based on synthesis of expert consensus and serve as an excellent resource for managing depression in adolescents in the primary care setting.[27,29]

According to the DSM-5, generalized anxiety disorder is considered, "Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)."[20] PTSD is defined as either direct or witnessed exposure to some type of traumatic event, including death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. Additionally, for a diagnosis of PTSD to be made, the patient must be experiencing intrusion symptoms, avoidance symptoms, negative alterations in cognition or mood, and alterations in

arousal and reactivity.[20] As in the case of depression, anxiety and PTSD can be screened for using formally validated tools, or through evaluation of a patient with synthesis from subjective history and the primary care provider's observations or mental status exam.

Also similar to depression, both anxiety and PTSD can be treated with nonpharmacologic methods, pharmacologic modalities, or a combination of the two. As mentioned above, SSRIs can be useful for the treatment of depression, but can also be used to treat anxiety and PTSD. While no SSRIs are FDA-approved to treat PTSD or generalized anxiety in children or adolescents, most, aside from paroxetine, can be used off-label in this population.[30]

As is the case with any advanced medical or specialized complaint, primary healthcare providers need to be cognizant of when to escalate the level of care provided to the patient. Many victims of ST will be in need of intensive mental health treatment, and should be connected to mental health resources as soon as possible.[3] If the victim is most comfortable working only with their primary care provider, or if the mental health concerns are minor, it is appropriate to continue managing their symptoms in the primary care setting. It is also important to acknowledge the significant disparity in the availability of mental health providers in the US. For this reason, primary care providers must be competent at managing these mental health concerns in order to bridge the gap between referral and treatment by mental health professionals. Additionally, because those who are currently being trafficked are at higher risk for loss to follow-up, it may be prudent to initiate treatment expediently.

Trauma-informed care

Another key tenet of treating individuals diagnosed with a history of trauma or adverse experiences is the application of trauma-informed care. Important principles of trauma-informed care include determining ways to ask permission, offer control, and find support for the patient so that they feel comfortable and supported.[31]

Trauma-informed care is critical to promote continued engagement in treatment for those with a history of ST. Foremost, the provision of trauma-informed care seeks to empower patients and diverges from traditional, authoritarian, medical models of clinical practice.[32,33] Patient autonomy is paramount, and harm reduction approaches are critical. Because many who have experienced or are experiencing ST may be at risk for homelessness and substance use, motivational interviewing approaches can be utilized within the harm reduction framework to promote best outcomes. In utilizing such an approach, healthcare providers can assure care continuity and consistency, which can help in developing and maintaining trust. Furthermore, those with a history of ST may be at heightened risk for retraumatization within the context of medical examinations or medical decision-making. All physical exam techniques or diagnostic procedures should be explained carefully to the patient, with consent and assent occurring throughout the intervention or procedure, in an effort to make the individual feel more comfortable and at ease.[34,35] Especially for those with a history of physical or sexual abuse, retraumatization can be problematic. Similarly, revictimization can occur when individuals are stripped of their autonomy.[33] Therefore, it is imperative that interactions are patient-centered.

Conclusions

ST among youth is an increasing problem in the US.[3] Additionally, youth who are victims of ST are highly likely to experience depression, anxiety, and PTSD. Unfortunately, due to lack of knowledge, education, and standardized screening tools, many healthcare providers are currently ill-equipped to handle the growing problem of ST. Therefore, it is essential that all healthcare providers who have regular contact with pediatric patients educate themselves on risk factors and signs of possible victims of ST, in addition to working toward creating a standardized screening tool to help identify these youth. NP

REFERENCES

1. International Labour Organization. Global estimates of modern slavery: forced labour and forced marriage. 2017. www.ilo.org/global/publications/books/WCMS_575479/lang--en/index.htm.
2. Trafficking Victims Protection Act of 2000.
3. Greenbaum J, Crawford-Jakubiak JE, Committee on Child Abuse and Neglect. Child sex trafficking and commercial sexual exploitation: health care needs of victims. *Pediatrics*. 2015;135(3):566-574. doi:10.1542/peds.2014-4138.
4. Goldberg A, Moore J. Domestic minor sex trafficking. *Child Adolesc Psychiatr Clin N Am*. 2018;27(1):77-92.
5. Frey LM, Middleton J, Gattis MN, Fulginiti A. Suicidal ideation and behavior among youth victims of sex trafficking in Kentuckiana. *Crisis*. 2019;40(4):240-248.
6. Greenbaum VJ. Child sex trafficking in the United States: challenges for the healthcare provider. *PLoS Med*. 2017;14(11):1-8. doi:10.1371/journal.pmed.1002439.
7. Hornor G. Domestic minor sex trafficking: what the PNP needs to know. *J Pediatr Health care*. 2015;29(1):88-94. doi:10.1016/j.pedhc.2014.08.016.
8. Osian N, Miller E. Homelessness, unstable housing, and the adolescent patient. In: *Medical Perspectives on Human Trafficking in Adolescents*. Cham: Springer; 2020:197-206.
9. Mostajabian S, Santa Maria D, Wiemann C, Newlin E, Bocchini C. Identifying sexual and labor exploitation among sheltered youth experiencing homelessness: a comparison of screening methods. *Int J Environ Res Public Health*. 2019;16(3):363.

10. Dank M, Yu L, Vasquez-Noriega C, Gelatt J, Pergamit M. Pretesting a human trafficking screening tool in the child welfare and runaway and homeless youth systems. 2017. www.urban.org/research/publication/pretesting-human-trafficking-screeningtool-child-welfare-and-runaway-and-homeless-youth-systems.
11. Xian K, Chock S, Dwiggins D. LGBTQ youth and vulnerability to sex trafficking. In: *Human Trafficking is a Public Health Issue*. Cham: Springer; 2017:141-152.
12. Barnert E, Iqbal Z, Bruce J, Anoshiravani A, Kolhatkar G, Greenbaum J. Commercial sexual exploitation and sex trafficking of children and adolescents: a narrative review. *Acad Pediatr*. 2017;17(8):825-829.
13. Sprang G, Cole J. Familial sex trafficking of minors: trafficking conditions, clinical presentation, and system involvement. *J Fam Violence*. 2018;33(3):185-195.
14. Cary M, Oram S, Howard LM, Trevillion K, Byford S. Human trafficking and severe mental illness: an economic analysis of survivors' use of psychiatric services. *BMC Health Serv Res*. 2016;16:284. doi:10.1186/s12913-016-1541-0.
15. Levine JA. Mental health issues in survivors of sex trafficking. *Cogent Med*. 2017;4:1-13. doi:10.1080/2331205X.2017.1278841.
16. Ottisova L, Hemmings S, Howard LM, Zimmerman C, Oram S. Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: an updated systematic review. *Epidemiol Psychiatr Sci*. 2016;25(4):317-341. doi:10.1017/S2045796016000135.
17. Ottisova L, Smith P, Shetty H, Stahl D, Downs J, Oram S. Psychological consequences of child trafficking: an historical cohort study of trafficked children in contact with secondary mental health services. *PLoS One*. 2018;13(3):1-14.
18. Stevens S, Acker S, Green K, et al. Understanding the mental health impact of human trafficking. *J Am Assoc Nurse Pract*. 2019;31(12):699-704. doi:10.1097/JXX.0000000000000225.
19. Waitzfelder B, Stewart C, Coleman KJ, et al. Treatment initiation for new episodes of depression in primary care settings. *J Gen Intern Med*. 2018;33(8):1283-1291.
20. American Psychiatric Association [APA]. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Publishing; 2013.
21. Spitzer RL. *Patient Health Questionnaire: PHQ*. New York, NY: New York State Psychiatric Institute; 1999.
22. Norris D, Clark MS, Shipley S. The mental status examination. *Am Fam Physician*. 2016;94(8):635-641.
23. Sarzetto A, Delmonte D, Seghi F, et al. Suicide in depressed patients: identifying a clinical risk profile. *Eur Psychiatry*. 2017;41(suppl):S891-S892.
24. Posner K, Brent D, Lucas C, et al. *Columbia-Suicide Severity Rating Scale (C-SSRS)*. New York, NY: Columbia University Medical Center; 2008.
25. Domoney J, Howard LM, Abas M, Broadbent M, Oram S. Mental health service responses to human trafficking: a qualitative study of professionals' experiences of providing care. *BMC Psychiatry*. 2015;15:289.
26. Rushton JL, Clark SJ, Freed GL. Pediatrician and family physician prescription of selective serotonin reuptake inhibitors. *Pediatrics*. 2000;105(6):E82.
27. Cheung AH, Zuckerbrot RA, Jensen PS, Laraque D, Stein REK, GLAD-PC Steering Group. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and ongoing management. *Pediatrics*. 2018;141(3).
28. Spielmans GI, Spence-Sing T, Parry P. Duty to warn: antidepressant black box suicidality warning is empirically justified. *Front Psychiatry*. 2020;11:18.
29. Zuckerbrot RA, Cheung A, Jensen PS, Stein REK, Laraque D, GLAD-PC Steering Group. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice preparation, identification, assessment, and initial management. *Pediatrics*. 2018;141(3).
30. Walter HJ, Bukstein OG, Abright AR, et al. Clinical practice guideline for the assessment and treatment of children and adolescents with anxiety disorders. *J Am Acad Child Adolesc Psychiatry*. 2020;59(10):1107-1124. doi:10.1016/j.jaac.2020.05.005.
31. Rollins R, Gribble A, Barrett SE, Powell C. Who is in your waiting room? Health care professionals as culturally responsive and trauma-informed first responders to human trafficking. *AMA J Ethics*. 2017;19(1):63-71.
32. Roberts SJ, Chandler GE, Kalmakis K. A model for trauma-informed primary care. *J Am Assoc Nurse Pract*. 2019;31(2):139-144.
33. Hamberger LK, Barry C, Franco Z. Implementing trauma-informed care in primary medical settings: evidence-based rationale and approaches. *J Aggress Maltreat Trauma*. 2019;28(4):425-444.
34. Selwyn CN, Lathan E. Helping primary care patients heal holistically via trauma-informed care. *J Nurse Pract*. 2020. In press.
35. Rich K. Trauma-informed police responses to rape victims. *J Aggress Maltreat Trauma*. 2019;28(4):463-480.

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