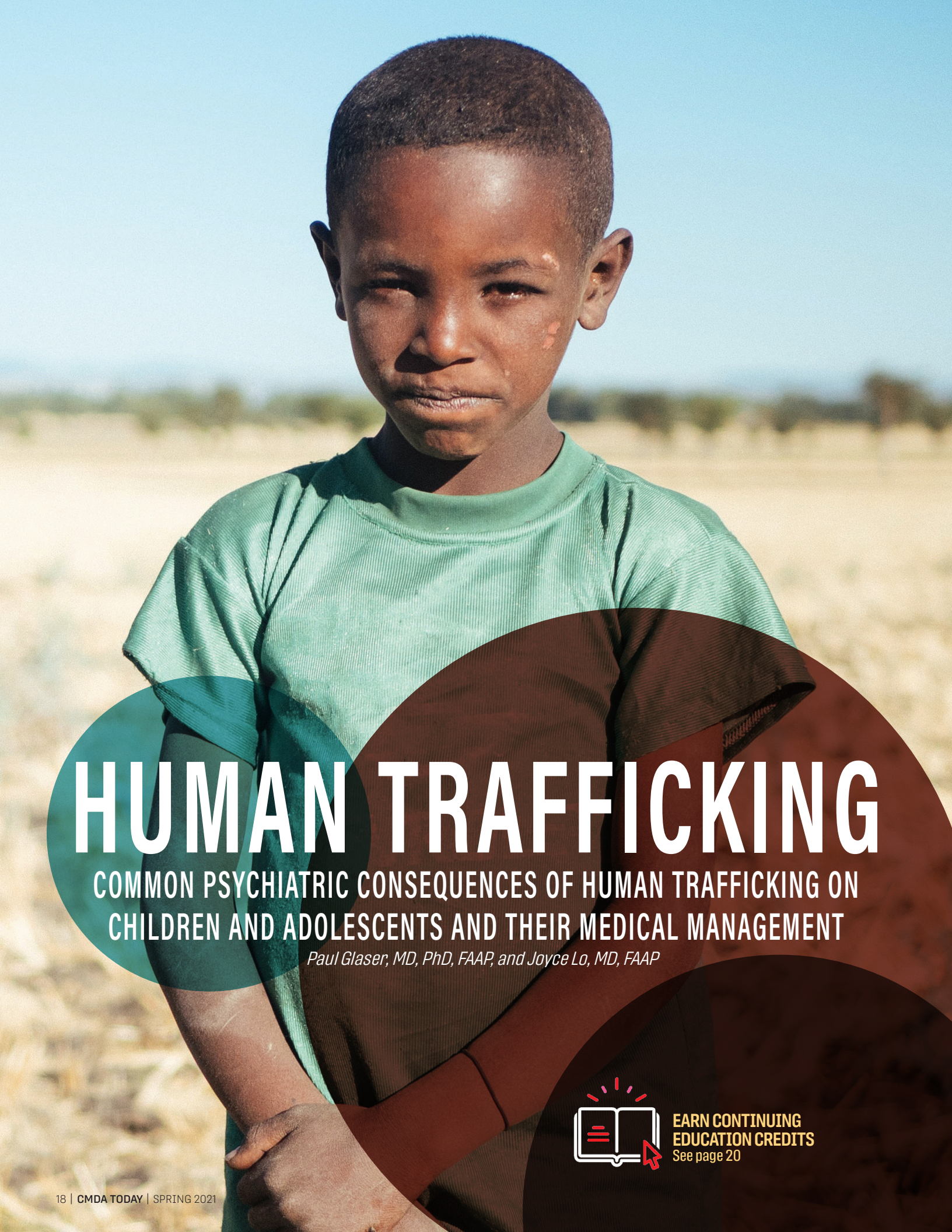

HUMAN TRAFFICKING

COMMON PSYCHIATRIC CONSEQUENCES OF HUMAN TRAFFICKING ON CHILDREN AND ADOLESCENTS AND THEIR MEDICAL MANAGEMENT

Paul Glaser, MD, PhD, FAAP, and Joyce Lo, MD, FAAP

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Slavery still exists. In fact, modern-day slavery, also known as human trafficking, is more prolific than it has ever been. Trafficking in persons is the recruitment, harboring, transporting, provision and obtaining of human beings for the purpose of commercial sex or labor exploitation. On any given day worldwide, it is estimated that 24.9 million people are victims of human trafficking, 25 percent of which are children.[1] In the U.S., it is thought that 400,000 people are currently living in slavery.[2] In 2018, 51.6 percent of active criminal human trafficking cases in the U.S. were sex trafficking cases involving only children.[3] Obtaining reliable statistics on human trafficking is difficult due to numerous factors, and while we may have some statistics on children in the sex industry, we have little statistical information on minors being exploited in labor. What we do know is that the trafficking of our children happens more often than we may have considered, with many of these children having suffered some years of abuse or trauma before being trafficked.

Victims of human trafficking suffer from repeated physical, emotional and psychological trauma, often for years, and sometimes beginning at a young age. Some experience abuse before their trafficking years, which compounds the duration of their mental illness even once they are free of trafficking. Not surprisingly, this causes a plethora of mental health issues. While an emerging body of literature is addressing the mental health outcomes of trafficking, many of these do not account for differences between adults and children. From the studies that are available, it is clear that minors who are trafficked are at high risk for developing post-traumatic stress disorder (PTSD), anxiety and depression. One study researching children in a mental health facility in London reported the most common diagnoses in trafficked children are PTSD (22 percent) and affective disorders (22 percent). The presence of physical violence and sexual violence while being trafficked increased the incidence of substance abuse, suicidal ideation and self-harm. In addition, they found that trafficked children spent a 56 percent longer duration of time in psychological services than their non-trafficked cohorts.[4] Other studies have reiterated the high prevalence of PTSD (22 to 27 percent), depression (56 to 57 percent) and anxiety (32 to 33 percent) in children who are survivors of trafficking.[5,6,7] One of these studies goes further to describe that 16 percent have suicidal ideation and 9 percent display self-injurious behavior. A notable 12 percent of the children in their study had attempted suicide within the one month before their interview.[7] In addition, the presence of physical violence and/or sexual violence increased their risks for developing PTSD and depression; threats increased their risk for anxiety.[5] Despite these risks, some children will be resilient and show little or no direct mental health consequences after being rescued.

Despite the numerous mental health diagnoses that result from human trafficking, treatment of psychiatric diagnoses is not a primary concern. Patients that are newly discovered to be

part of human trafficking will need several basic needs taken care of first. Concerns such as whether a safe placement can be found, proper nutrition, medical needs (sexually transmitted infections, withdrawal) and even if the patient is able to establish a normal sleep pattern will be important to address first. Some patients will defend their abuser or fear retribution if they left their abusive situations. It will still be important to document a mental status exam during the first appointment in order to address any acute psychiatric needs, such as suicidal thoughts or even indifference to rescue.

Once the patient is stabilized, then a more thorough assessment of mental health symptoms can be made. Cultural sensitivity will be needed here to understand how the patient will understand their own anxiety, trauma and depressive symptoms. For example, some cultures have learned to express emotional issues with physical health symptoms, such as seeking help for headaches or gastrointestinal problems. Some cultures may have no concept for children and adolescents even having mental health disorders. Screening tests can be used at this stage to assist (see Table 1). If psychiatric diagnoses are uncovered, then referral can be made to mental health services, such as counseling and psychiatric management if they are available in your area of practice. Faith-based services can be engaged at this point if the patient is amenable. The Christian doctrines of forgiveness and a loving God can be essential parts of recovery. In most areas around the world, specialty mental health services are sparse or non-existent. Primary care professionals then may have to utilize whatever counseling services they have in their own clinic, or simply engage and listen, taking care of psychiatric medication needs as they are comfortable.

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EDUCATIONAL OBJECTIVES

- Describe the scope of human trafficking in children and adolescents.
- Discuss the range of mental health disorders that are commonly found in trafficked people that present in medical settings.
- Strategize how to treat trafficked people that is relevant to their clinical setting.

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Although a large database of evidence-based studies does not exist for therapy treatments for children and adolescents who have been through human trafficking, numerous types of therapy have been studied for children with PTSD.[8] Trauma Focused – Cognitive Behavioral Therapy (TF-CBT) has a large database for use especially in children. This utilizes a play therapy style that taps into the main way children communicate their emotions—through play. Adolescents respond well to Interpersonal Therapy since they depend on relationships with peers for their emotional well-being. Patients with PTSD may benefit from Eye Movement Desensitization and Reprocessing (EMDR) in which repetitive movements and fluctuating lights are used to help reprogram the brain

while discussing their trauma. Dialectical Behavioral Therapy can be useful if the patient is showing traits of Borderline Personality Disorder (although technically one needs to be 18 years old for an official diagnosis) or non-suicidal self-injury (such as cutting). Since all these therapies take special training to perform, areas of low resources should use basic supportive therapy, utilizing listening, connecting and empathizing as core features. Finally, we need to realize that some patients may destabilize when engaging in trauma-based care, so sensitivity will be needed in deciding when to temporarily stop therapies.

In most cases, therapy should be enough to help the patient in their slow recovery from trauma. However, in cases of severe trauma, or when mental illness is prominent in the patient's genetic background, medications may be helpful. In areas of limited resources, the primary care professional may be the only one who can prescribe medications for the mental health needs of children and adolescents who have been through human trafficking. Most used are the Selective Serotonin Reuptake Inhibitors (SSRIs). Although off-label for most indications in this age group, SSRIs have a long track record of safety and efficacy. They are first line for treatment of anxiety, depression and PTSD for children and adolescents. The main caution is the black box warning for increases in suicidal thoughts, although, thankfully, this is not a common side effect and should not stop professionals from prescribing them. The use of benzodiazepines for anxiety or acute trauma is usually discouraged by child psychiatrists due to the lack of efficacy in long-term use. Insomnia may be treated with melatonin and diphenhydramine. Trazodone is a popular non-addictive sleep aid in teen inpatient units. More recently, prazosin has emerged as a first line therapy for flashback-type nightmares. Suboxone is considered appropriate treatment for some patients who begin to withdraw from opioid abuse after removal from trafficking. A general rule of thumb with all psychiatric medications in children is to start low and go up slowly. A list of helpful medications is given in Table 2. Medications for disruptive mood dysregulation disorder, bipolar disorder and schizophrenia are beyond the scope of this article and usually should be prescribed by a specialist.

Various barriers can arise in treating children and adolescents of human trafficking with mental health disorders. Patients may be resistant to therapy for fear of retribution from their traffickers. If attachment issues (such as symptoms of Reactive Attachment Disorder) are prominent in your patient, they may seemingly respond well to interventions early on, but as staff and professionals continue to care for them, the patient subconsciously will act out or sabotage treatment, perhaps because they remember being hurt in the past by anyone else who proclaimed they loved them or were trying to help them. Some cultures may be uncomfortable with therapy techniques. Language barriers can also make things difficult. Some patients may be so used to altering the truth to survive that it will be hard for them to tell the truth about trauma. They may invent trauma that did not actually happen in a need to be taken care of and receive attention. Finally, the mental health of your staff and healthcare professionals can present a barrier due to the strain and burnout that come with working with such challenging patients.

In conclusion, with human trafficking being prevalent in most countries of the world, healthcare professionals are likely to encounter children and adolescents with mental health issues related to their trauma. Knowing the common diagnoses specific to children and adolescents will help you prepare strategies to implement screening and treatment algorithms for your clinical setting. Use

of therapy and medications will depend on the resources in your area. Those with limited resources must consider implementing at least the therapy and medications for which they are comfortable. By addressing these critical mental health needs, healthcare professionals can make sure that progress is made in recovery and re-integration. Hopefully with early recognition and treatment, the mental impact of modern-day slavery can be reduced.

Table 1

Suggested Mental Health Screenings for Primary Care Settings
Depression - Patient Health Questionnaire (PHQ-9)
PTSD - PC–PTSD (Primary Care-PTSD)
Anxiety - GAD-7
Trauma - Abbreviated PCL-C
Bipolar - The Mood Disorder Questionnaire
Substance Use Disorders - DAST-10 (Drug Abuse Screen Test)
Suicide Risk - SAFE-T (Suicide Assessment Five-Step Evaluation and Triage)

Table 2

Medications for Children and Adolescents (Most are off-label but commonly used by child psychiatrists)	
Depression/Anxiety, PTSD	
SSRIs	**SNRIs**
• Fluoxetine (10-40mg daily) • Sertraline (12.5-150mg daily) • Citalopram (10-40mg daily) • Escitalopram (5020mg daily)	• Venlafaxine SR/XR (37.5-150mg daily)
Acute Anxiety	
Buspirone (5-15mg bid prn)	
Hydroxyzine (12.5-25mg tid prn)	
Benzodiazepines (usually discouraged except for inpatient settings)	
Insomnia	
Melatonin (1-10mg qhs)	
Diphenhydramine (12.5-50mg qhs)	
Trazodone (25-150mg qhs)	
PTSD Nightmares	
Prazosin at bedtime (1-4mg)	
Serious Opioid Addiction	
Suboxone (currently requires certification training in the US)	

Endnotes

1 Global Estimates of Modern Slavery. (2017). International Labor Office, Geneva.

2 National Center for Missing and Exploited Children. https://www.missingkids.org/theissues/trafficking

3 Costa, A. M. UNODC United Nations\Office on Drugs and Crime. Global Report On Trafficking In Persons February 2009 UN. GIFT Global Initiative to Fight Human Trafficking.

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Joyce Lo, MD, FAAP, graduated from George Washington University School of Medicine and completed her pediatric residency at the Children's National Medical Center in Washington, D.C. She first learned about human trafficking while on a mission trip in Nicaragua. Since then, she has been dedicated to anti-trafficking work and is passionate in educating the medical community about human trafficking. She works with Reclaim13, an anti-trafficking organization specializing in minors who have been sexually exploited. In addition, she participates in the Cook County Human Trafficking Task Force, Healthcare Subcommittee, and she has created the Amazing Grace Human Trafficking Ministry in her church. Most recently, she joined CMDA's Human Trafficking Commission.