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EDITORIAL

Human Trafficking and Psychiatric Education: A Call to Action

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> Many and sharp the num'rous ills
> Inwoven with our frame!
> More pointed still we make ourselves,
> Regret, remorse, and shame!
> And man, whose heav'n-erected face
> The smiles of love adorn, −
> Man's inhumanity to man
> Makes countless thousands mourn!

—Excerpt from "Man Was Made to Mourn: A Dirge," Robert Burns (1759–1796)

Human trafficking, including labor and sex trafficking, is an enormous global health problem involving severe forms of abuse and human rights violations. Human trafficking is defined as "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power …. for the purpose of exploitation" ([1], p. 42). Exploitation includes "the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery" ([1], p. 42). The illegal worldwide profits of forced labor amount to an estimated $150 billion per year [2]. Although determining the numbers of victims is methodologically challenging, by one estimate, 35.8 million people are victims [3]. In the USA alone, an estimated 60,000 victims [3] can be found in cities, suburbs, and rural areas in all 50 states [4].

Enslavement of individuals occurs through the use of a combination of psychological tactics including isolation, manipulation of perception, induced disability and exhaustion, threats, occasional indulgences, demonstration of omnipotence, degradation, and enforcing trivial demands [5]. Although anyone can become a trafficking victim, approximately half of all detected trafficking victims are adult women [6], and women comprise the vast majority of detected victims who were trafficked for sexual exploitation [6]. Globally, children now comprise nearly one third of all trafficking victims [6], and runaway children are particularly vulnerable to becoming trafficked [4]. The complex interplay of poverty, gender, education, age, and relevant policy deeply affect the vulnerability of women and children to trafficking [7]. Common adverse psychological consequences of trafficking include anxiety, posttraumatic stress disorder, and depression [8–11]. Psychiatrists therefore have an especially important opportunity to identify and help victims as well as to prevent vulnerable persons from becoming victims of trafficking. Recognizing victims is challenging because many may not avail themselves of services when prevented by the traffickers from doing so [5] or when fearful or ashamed [5].

We could not find, however, any formal requirements for psychiatrists to educate on human trafficking. Nor has *Academic Psychiatry* previously addressed this topic area. Nor are we aware of any published survey of psychiatric training programs that informs about what or how topics related to human trafficking are taught. At the same time, there is a need for medical students, residents, and health care providers across disciplines to be informed about human trafficking.

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One proposal was to provide at least a 1-h lecture for both medical students and residents [12].

Consequently, our primary goal for this editorial was to identify curricula on human trafficking that might assist in an effort to educate psychiatric professionals and trainees. We sought to locate articles that describe curricula for educating trainee or practicing psychiatrists on labor or sex trafficking. We wanted to learn and describe what topics were taught and how they were taught as well as the outcomes of teaching. Through this editorial, we hope to assist program directors and psychiatric educators in developing this topic area for psychiatric training in particular.

Model Teaching Programs

We searched PubMed and MedEd Portal databases for all English-language manuscripts using search terms including *psychiatry*, *education* and *human*, *labor*, or *sex trafficking* until August 2015. We also searched the citations of relevant articles to identify additional articles. We included any article describing an educational intervention for psychiatric trainees or clinicians.

Because of a paucity of information about teaching these groups, however, we extended the search to include educational interventions with outcome data targeting other health care providers. We excluded articles that educated about multiple types of violence which were not specific to trafficking [13] or that provided online information and resources or training for physicians or psychotherapists without evaluating educational outcomes [14, 15]. We sought to describe the characteristics of individual educational programs (country of origin, nature of learners, number of teaching sessions, topics and skills taught) and the methods and outcomes of teaching.

We did not find any articles that described a trafficking-focused curriculum for psychiatrists or psychiatry residents. We found only two articles that met the wider inclusion criteria of targeting any health care provider group and examined their outcomes [16, 17]. As shown in Table 1, one program provided brief electronic slide presentations targeting emergency department heath care providers in the San Francisco Bay area [16] and the other provided 2-day training courses for a range of health professionals in the Middle East, the Caribbean, and Central America who were described as likely to encounter a trafficked person [17].

Whereas both programs evaluated outcomes, only one did so by randomizing groups to an immediate- versus delayed-intervention group [16]. Its strengths were developing materials in partnership with police, pilot testing the survey, randomizing using research randomizer software, describing the characteristics of participants in the immediate- and the delayed-intervention comparison group, and assessing accuracy of survey data entry. Weaknesses included lack of information provided about the process of concealment of allocation to groups, lack of blinding of research subjects, low numbers (particularly in the comparison group), and the self-report nature of the outcome data. The strengths of the second study [17] included adapting training materials for local contexts, using a multinational sample, and few dropouts occurring at the time of administering the post-training questionnaire. Its weaknesses were lack of a separate comparison group and of assessment of changes in attitudes or knowledge between the pre- and post-assessments because the post-course questions mainly solicited feedback on the training. Neither study assessed behavioral or skill-based outcomes.

Curriculum Development

Context evaluation concerns the process of defining the environment of the proposed curriculum before implementation and determining the unmet needs of learners. By this process, curriculum goals and objectives can be validated [18]. One study of Canadian medical students suggested that the vast majority were not familiar with signs and symptoms of trafficked persons, and most thought that they should be taught more about this issue during their medical training [19]. A study of a convenience sample of medical students, residents, and physicians throughout the USA found that most respondents had never suspected a patient was trafficked, were inadequately informed about the scope of the problem, and did not know whom to call [20]. Self-reported knowledge about human trafficking and whom to call for a potential victim was low among emergency department health care providers in the San Francisco area before the administration of the educational intervention [16]. Similarly, in a survey of physicians, physician assistants, nurses, social workers, and advocates of patients and families in multiple hospitals and medical clinics in Wisconsin, the majority of respondents reported that they had never received training on how to identify victims of sex trafficking [21]. This survey found associations between having received training and self-reported confidence in the ability to identify victims and having encountered a victim within their practice [21]. Though not generalizable, these results underscore the potential value of educating about trafficking.

Psychiatrists, as physicians with special responsibility for the care of vulnerable and victimized individuals, should have sophisticated and comprehensive understanding of the physical and mental health consequences of human trafficking. Identifying victims is critical to helping them extricate themselves from their circumstances, to preventing re-victimization, and to linking these individuals with appropriate medical, psychiatric, social, and legal services. In this issue of *Academic Psychiatry*, Bespalova, Morgan, and Coverdale [22] systematically reviewed screening tools to identify

Table 1 Characteristics of human trafficking curricula

Authors	Learners	Method of instruction	Topics taught	Study design	Method of evaluation	Outcomes
Grace et al. [16]	Physicians, nurses, and social workers in emergency departments in San Francisco Bay area	Electronic slide presentation delivered between 25 and 60 min	Education on human trafficking, clinical signs in victims, and referral options	Randomized controlled trial (immediate- and delayed-intervention groups; 141 and 20 subjects, respectively)	Four knowledge and attitude items	Intervention group had significantly greater pre- to posttest gains in self-rated general knowledge, knowledge as to how to refer, and suspicion that a patient was a victim of human trafficking than comparison group
Viergever et al. [17]	Health care workers, including nurses, social workers, physicians, and others in the Middle East, the Caribbean, and Central America	2-day training utilizing an adaptation of a handbook on caring for trafficked persons	Caring for trafficked victims; definitions, concepts, and health consequences of human trafficking, and other topics	Pre- and post-intervention questionnaire	A post-intervention questionnaire of 17 questions that solicited feedback on training	Topics rated most useful were role of health care providers in caring for trafficked persons, basic definitions and concepts, and health consequences of trafficking; least useful were mental health and trafficking, children and adolescents, and culturally sensitive care

trafficking victims and described their key features and psychometric properties. Of the nine tools identified, none were found to have been validated in health care settings and there was also little consensus in content, length, and format. Nevertheless, this range of tools and screening questions provides a rich resource for educating health care professionals including psychiatrists and their trainees.

Psychiatrists will also benefit from learning about treatment strategies. The treatment of the psychologically distressing consequences of trafficking shares common elements with the treatment of mood and anxiety disorders, including posttraumatic stress disorder and concomitant alcohol and substance use disorders. Further, treatment must include additional psychosocial factors in the history, including the vulnerability of a population to seduction and emotional manipulation and the consequences of previous sexual abuse, trauma, domestic violence, and poverty. Exploring constructive potential social supports and evaluating sources of resilience are also essential to develop a true understanding of the patient and arrive at a therapeutic plan with likely benefit. Moreover, although we welcome the inclusion of reliable and valid diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, the dynamics of sexual trafficking, much like the dynamics of chronic battering and self-destructive behavior, require an appreciation of the narratives of victims in order to develop an accurate diagnosis and care strategy.

It is important that psychiatrists and psychiatrists in training appreciate that the trauma of trafficking involves multiple interpersonal traumas over the life span [23]. Treatment necessitates an understanding of the trauma and trauma-related issues [24] and is targeted to individual symptom clusters that focus on emotional regulation and the processing of trauma memories and cognitive structures [23, 25]. Trauma-informed care provides a framework for accommodating the vulnerability of trauma victims that enables the provision of long-term, comprehensive, and culturally competent care [24]. We know little, however, about specifically applying psychiatric treatment to trafficking victims.

A wide variety of resources are available for educating and training health care professionals, including psychiatrists. One well-conducted review has identified educational resources in each of the domains of the definition, scope, and health consequences of trafficking, victim identification and appropriate treatment, referral to services, legal issues, security, and prevention [26]. Many online resources also can contribute to educating the workforce [1–4, 6, 24, 27–30]. Victims should be considered for reporting to the National Human Trafficking Resource Center Hotline [28], and they should be referred to safe houses or local domestic violence centers. Consideration also should be given to reporting potential child and adolescent victims to child protective services, or to adult protective services in the case of adult victims, with the support of legal services when indicated. Great care should be taken in maintaining trust, confidentiality, and therapeutic alliance with the patient while also fulfilling legal responsibilities, to victims and society.

Teaching on trafficking should be integrated with teaching on sexuality and sexual history taking, especially in relation to diminishing discomfort and barriers to screening. In addition, it should be incorporated into histories of trauma, abuse and/or neglect, interpersonal coercion, and domestic violence. Teaching on trafficking requires a sensitivity to how uncovering trauma histories is distressing work—potentially

re-traumatizing victims and generating secondary trauma among learners, especially for those learners who themselves experienced trauma. The potentially strong emotional responses for clinicians associated with treating trauma victims or marginalized or stigmatized groups such as sex workers, many of whom are trafficked, can subvert the provision of optimal care and necessitate attention to the virtues of compassion, self-sacrifice, and self-effacement in training and clinical practice. Teaching on trafficking should also be integrated with teaching on global mental health, school health, and prison and forensic psychiatry, because many trafficked victims become incarcerated or criminalized [31]; women's and men's mental health, because many males become victims too [6]; lesbian, gay, bisexual, and transgender (LGBT) health, because many LGBT persons experience discrimination and are vulnerable to human trafficking [32]; and child and adolescent psychiatry.

Looking forward, we suggest that programs can be developed in conjunction with law enforcement officials, psychologists, social workers, school counselors, and relevant political entities to augment the curriculum. Further, providers need to separate and distinguish their moral, religious, and ethical biases in the evaluation and care of sex workers. Much like for the treatment of people who are the victims of domestic violence and people with substance use disorders, clinicians must learn to appreciate their value judgments and hold them in abeyance when taking care of these patients. In caring for trafficking victims, health professionals confront many of the hardest aspects of the human condition. It is hard not to defend against this experience, and yet these defenses may diminish empathy and undermine the therapeutic aims of the relationship. Our role as physicians and healers, further, should not inhibit us from providing information to victims to assist them in reporting illegal behaviors when they feel ready and able to do so.

A focus on teaching of the social determinants that facilitate trafficking can inform preventive interventions [7] and advocacy for the provision of preventive services. A review of resources provided minimal if any guidance related to the potential role for health professionals in preventing human trafficking [26]. Patients with major mental disorders, especially those in fragile economic circumstances, may constitute a particularly vulnerable population to becoming trafficked. Perhaps enhancing access to psychiatric and social services, including referrals for financial and occupational services and support and the provision of housing for those who are homeless, will help prevent some victimization.

For the curriculum to have an adequate and realistic scope, we counsel that a 1-h lecture, as previously proposed for medical training and residence education [12], will not be sufficient by itself. Perhaps the curriculum for psychiatry residents should begin early in training, because residents might encounter victims in any psychiatric setting. Emergency settings are particularly important for identifying victims of trafficking. The curriculum should be properly sequenced with appropriate repetition of content and skill-based teaching at increased levels of complexity across years of training. We emphasize the importance of evaluating the curriculum especially because of a paucity of information to date on outcomes of curricula on trauma-related topics [33]. At the same time, we recognize that to adopt this emphasis may deter some from getting started. This is not our intention—any effort to teach is better than none. We suggest that we, as psychiatric educators, can do more in attending to the care of this highly vulnerable population of exploited people.

In conclusion, this call to action was predicated on data that demonstrate the major global health problems of human labor and sex trafficking. Although this review is limited by its methods, we found only two curricula with outcomes that focused on human trafficking. Neither of these in fact was targeted directly to the psychiatric profession. The lack of formal published curricula on human trafficking across heath care provider groups including psychiatry constitutes evidence that little is being done. Members of our profession, however, are especially likely to encounter victims, and we have a particularly important role in screening, treatment, and prevention. We should seize this outstanding opportunity to develop and evaluate model educational programs on human trafficking. Outrage at "Man's inhumanity to man" should compel us to do so.

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References

1. United Nations Office on Drugs and Crime. United Nations Convention Against Transnational Organized Crime and the Protocols Thereto. Annex II: Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the United Nations convention against Transnational Organized Crime. United Nations, New York, 2004. Available at https://www.unodc.org/documents/middleeastandnorthafrica/organised-crime/UNITED_NATIONS_CONVENTION_AGAINST_TRANSNATIONAL_ORGANIZED_CRIME_AND_THE_PROTOCOLS_THERETO.pdf. Accessed 10/05/2015.
2. International Labor Organization. Profits and poverty; the economics of forced labor. International Labor Office, Geneva: ILO, 2014. Available at www.ilo.org. Accessed 08/30/2015.
3. The Walk Free Foundation Ltd. The global slavery index 2014. Available at www.globalslaveryindex.org. Accessed 08/30/2015.
4. Polaris. Human trafficking: the victims. Available at http://www.polarisproject.org/human-trafficking/overview. Accessed 10/05/2015.
5. Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in health care settings. Health Hum Rights. 2011;13:E36–49.

6. United Nations Office on Drugs and Crime. Global report on trafficking persons 2014. New York, United Nations, 2013. Available at http://www.unodc.org/unodc/data-and-analysis/glotip.html. Accessed 08/30/2015.
7. Perry KM, McEwing L. How do social determinants affect human trafficking in Southeast Asia and what can we do about it? A systematic review. Health Hum Rights. 2013;15:138–59.
8. Zimmerman C, Hossain M, Yun K, Gajdadziev V, Guzun N, Tchomarova M, et al. The health of trafficked women: a survey of women entering post trafficking services in Europe. Am J Public Health. 2008;98:55–9.
9. Hossain M, Zimmerman C, Abas M, Light M, Watts C. The relationship of trauma to mental disorders among trafficked and sexually exploited girls and women. Am J Public Health. 2010;100:2442–9.
10. Oram S, Stöckl H, Busza J, Howard LM, Zimmerman C. Prevalence and risk of violence and the physical and sexual health problems associated with human trafficking: systematic review. PLoS Med. 2012;9:e1001224.
11. Kiss L, Pocock NS, Naisanguansri V, Suos S, Dickson B, Thuy D, et al. Health of men, women and children in post-trafficking services in Cambodia, Thailand and Vietnam: an observational cross-sectional study. Lancet Glob Health. 2015;3:e154–61.
12. Grace AM, Ahn R, Macias Konstantopoulos W. Integrating curricula on human trafficking into medical education and residency training. JAMA Pediatr. 2014;168:793–4.
13. Runyan CW, Gunther-Mohr C, Orton S, Umble K, Martin SL, Coyne-Beasley T. PREVENT: a program of the national training initiative on injury and violence prevention. Am J Prev Med. 2005;29(5 Suppl 2):252–8.
14. Chisolm-Straker M. Human trafficking: information and resources for emergency health care providers. Available at www.humantraffickinged.com. Accessed 09/13/2015.
15. Zur Institute. Human trafficking: resources and updates. Available at www.zurinstitute.com/human_trafficking_course.html. Accessed 09/13/2015.
16. Grace AM, Lippert S, Collins K, Pineda N, Tolani A, Walker R, et al. Educating health care professionals on human trafficking. Pediatr Emerg Care. 2014;30:856–61.
17. Viergever RF, West H, Borland R, Zimmerman C. Health care providers and human trafficking: what do they know, what do they need to know? Findings from the Middle East, the Caribbean, and Central America. Front Public Health. 2015;3:6.
18. Oliva PF. Developing the curriculum. 5th ed. NY: Longman; 2001.
19. Wong JC, Hong J, Leung P, Yin P, Stewart DE. Human trafficking: an evaluation of Canadian medical students' awareness and attitudes. Educ Health (Abingdon). 2011;24:501.
20. Titchen KE, Loo D, Berdan E, Rysavy MB, Ng JJ, Sharif I. Domestic sex trafficking of minors: medical student and physician awareness. J Pediatr Adolesc Gynecol. 2015. doi:10.1016/j.jpag.2015.05.006.
21. Beck ME, Lineer MM, Melzer-Lange M, Simpson P, Nugent M, Rabbitt A. Medical providers' understanding of sex trafficking and their experience with at-risk patients. Pediatrics. 2015;135:e895–902.
22. Bespalova N, Morgan J, Coverdale J. A pathway to freedom: an evaluation of screening tools for the identification of trafficking victims. Acad Psychiatry. 2014.
23. Briere J, Scott C. Complex trauma in adolescents and adults: effects and treatment. Psychiatr Clin North Am. 2015;38:515–27.
24. Williamson E, Dutch NM, Clawson HJ. Evidence-based mental health treatment for victims of human trafficking. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2008. Available at http://aspe.hhs.gov/sites/default/files/pdf/76116/index.pdf. Accessed 10/05/2015.
25. Cloitre M, Courtois C, Charuvastra A, Carapezza R, Stolbach BC, Green BL. Treatment of complex PTSD: results of the ISTSS expert clinician survey on best practices. J Trauma Stress. 2011;24:615–27.
26. Ahn R, Alpert EJ, Purcell G, Konstantopoulos WM, McGahan A, Cafferty E, et al. Human trafficking: review of educational resources for health professionals. Am J Prev Med. 2013;44:283–9.
27. Polaris. What we do. Available at http://www.polarisproject.org/what-we-do. Accessed 10/05/2015.
28. National Human Trafficking Resource Center. Available at www.traffickingresourcecenter.org. Accessed 08/30/2015.
29. Academy of Educational Development. A web resource for combating human trafficking. Available at www.humantrafficking.org. Accessed 09/26/2015.
30. United States Committee for Refugees and Immigrants. Available at www.refugees.org. Accessed 09/26/2015.
31. Human Rights Project for Girls, Georgetown Law Center on Poverty and Inequality, Ms. Foundation for Women. The sexual abuse to prison pipeline: the girls' story. 2015. Available at http://www.law.georgetown.edu/academics/centers-institutes/poverty-inequality/upload/2015_cop_sexual-abuse_layout_web-2.pdf. Accessed 10/05/2015.
32. U.S. Department of State. Trafficking in persons report 2014. Available at http://www.state.gov/j/tip/rls/tiprpt/2014/. Accessed 10/05/2015.
33. Ferrell NJ, Melton B, Banu S, Coverdale J, Valdez MR. The development and evaluation of a trauma curriculum for psychiatry residents. Acad Psychiatry. 2014;38:611–4.