

# Understanding the psychological effects of sex trafficking to inform service delivery

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**Those providing assistance to survivors of trafficking should focus not only on the delivery of services but also on building survivors' capacity to engage in treatment and support.**

When trafficked for sexual exploitation, women are subjected to extraordinary physical, sexual and psychological violence which puts them acutely at risk for developing not just short-term physical ailments but also lasting mental illness that can profoundly alter their ability to navigate effectively in the social world. Survivors may be dealing with HIV infections, experience gynaecological issues, succumb to substance and alcohol abuse, and suffer the prolonged effects of physical injury. The impacts on their mental health include anxiety, depression, self-harm and post-traumatic stress disorder (PTSD).

Violent exploitation may also result in survivors developing a mistrust of caregiving individuals and systems, which can severely hinder service delivery. Sex trafficking disrupts caregiving by hijacking the victim's relationship with trust and security. Victims rely on their traffickers to provide them with food and shelter but to obtain these victims must work, and that work involves sexual violence and coercion. The hand that feeds and gives shelter and promises a path to safety is therefore also the hand that leads to injury and persecution.

This severe rupturing of attachment relationships can have a significant impact on survivors – disrupting their sense of self and affecting their ability to leave exploitative situations, rebuild themselves emotionally and engage with services. After periods of imposed isolation, a loss of autonomy and forced servitude, survivors report feeling helpless and hopeless, struggling to feel competent with life skills, ashamed about their past victimisation, and angry about missed education and job training. Many feel lost in their personal search for identity and meaning. Regulating difficult emotions and interpersonal relationships can be challenging. All told, the effects of sex trafficking are wide-reaching, profound and often not well understood. Signs and symptoms of psychological distress may also fall outside diagnostic categories and manifest in cultural idioms of distress. Systems of care that adequately account for these experiences have a far greater chance of success.<sup>1</sup>

## **The road map of complex PTSD**

The traditional reliance on PTSD as a diagnostic means of describing distress and

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then subsequently guiding treatment falls short of capturing the long-term effects of such debilitating trauma. Instead, 'complex PTSD' was developed as a framework for understanding the effects of complex trauma – trauma that is prolonged, repeated and interpersonal in nature, and from which escape is not possible due to physical, psychological, maturational, environmental or social constraints. Well-accepted examples of complex trauma include child abuse, domestic violence, sex trafficking and other forms of modern slavery, situations of genocide or organised torture campaigns. Complex PTSD includes the core defining symptoms of PTSD (re-experiencing, avoidance or numbing, and hyper-arousal) as well as disturbances to the regulation of emotion, interpersonal relationships, conception of self, consciousness and systems of meaning.<sup>2</sup> Complex PTSD has been suggested as the most accurate way to describe the deep disruptions to psychological functioning that are experienced by survivors of sex trafficking.<sup>3</sup>

### **Incorporating a complex-trauma informed approach**

By incorporating an understanding of complex trauma into their approach, clinicians and humanitarian aid workers can build their capacities to bridge the divide between need and engagement. Several steps could help in doing this:

**Recognise that providing for a survivor's unmet needs sets the stage for their recovery:** Attending to physical safety, nutrition and general health-care needs sets the stage for psychological healing.

**Incorporate elements of evidence-based treatment:** Integrating ideas from the cognitive model of PTSD may enhance service delivery. This approach is anchored in the idea that appraisals of self and one's place in the world play important roles in the maintenance or remission of trauma symptoms. For example, attributing blame to oneself for negative life events has been shown to impede recovery. Psycho-

education about the effects of sexual violence – particularly the strategies that perpetrators deploy to create isolation and decrease victims' sense of self-worth – can be interwoven into programming. Also consider incorporating Interpersonal Psychotherapy (IPT), an evidence-based treatment focused on linking life events – grief, interpersonal conflict, role transitions and/or social isolation – with symptoms of distress. IPT helps individuals build skills that fight helplessness and hopelessness even in situations of extreme adversity.<sup>4</sup> The treatment is recommended in the World Health Organization/UNHCR *mhGAP Humanitarian Intervention Guide* as an effective first-line treatment for depression that can be delivered by trained and supervised non-mental health community workers in low- and middle- income countries.<sup>5</sup>

### **Develop awareness of triggering interactions and incorporate opportunities for choice and autonomy:**

A relationship might become fraught when a well-intentioned clinical provider introduces a legal or programmatic framework that is perceived as controlling or disenfranchising. For example, conversations about safe, effective parenting may backfire if they are undertaken with a punitive or overly authoritative tone. Similarly, interventions addressing 'harm to self' or 'harm to others' can be especially difficult. A trusted relationship can suddenly collapse if a service provider triggers memories of a trafficker by restricting freedom and autonomy. In these circumstances, providers should remember that loss of will and the ensuing feelings of fear may trigger anxiety and even dissociation in survivors, because in the past similar situations have signalled impending harm or assault.

**Realise that rejecting treatment may be a way of communicating distress:** Moments in which we, as providers, feel ineffective, or in which a survivor disengages or rejects agreed-upon goals or work, are the very moments when we need to pause and reflect on what is happening. Ask yourself

if you can understand the interaction in light of the survivor's trauma history. It can also help to ask a colleague for their insights. For example, from a programmatic perspective, a certain housing plan or educational requirement might feel logical and even necessary. But for a survivor of sexual exploitation, it may feel like they are becoming ensnared in something with which they do not agree. Perhaps a survivor is resisting attending educational classes or job training. Consider the possibility that these situations might activate feelings of disappointment, irritability and self-blame related to lost time and opportunity as a result of being trafficked. Take the time to bring empathy into the relationship and solve problems collaboratively in order to support survivors in taking the steps needed to engage in services.

#### **Increase opportunities for social support:**

The strategic abuse and forced isolation imposed by traffickers result in shame, learned helplessness and mistrust. The effects of participating in survivor support groups cannot be overestimated. The validation, emotional connection and practical support provided by fellow survivors and group leaders encourage women to explore relying on others and building attachments. Parenting groups enable survivors to experience support from other mothers, to share feelings in a safe space, and gain information and guidance. Parenting group leaders can pay particular attention to processing 'flashpoints' – moments when interactions with children trigger feelings of vulnerability or set off a cascade of re-experiencing symptoms. By working through these moments in the group, mothers may feel better understood, better equipped to manage their parenting responsibilities, and possibly more confident in moments of intimate connection with their children.

**Address vicarious traumatization:** The isolating and paralyzing effects of trauma can transfer to care providers. Service providers should implement group consultation and provide staff with adequate

supervision. They should also consider establishing co-leadership of support groups. This allows for staff reflection and peer supervision while decreasing the burnout that comes from working independently and holding the weight of stories alone.

#### **Consider the WHO/UNHCR recommendation to include mental health in primary care:**

The *mhGAP Humanitarian Intervention Guide* calls upon humanitarian actors to routinely include mental health programming in primary care settings.<sup>6</sup> Service providers should consider placing mental health practitioners in primary care or maternity clinics. Despite their need for gynecological and obstetrical care, survivors of sexual exploitation may avoid routine gynaecological or antenatal visits because examinations are a source of distress. Clinicians working in this area are in a unique position to help survivors build positive associations with medical care, and maternal health clinics are ideal venues for parenting groups.

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