



# Human Trafficking, Mental Illness, and Addiction: Avoiding Diagnostic Overshadowing

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## ETHICS CASE

### Human Trafficking, Mental Illness, and Addiction: Avoiding Diagnostic Overshadowing

Commentary by Hanni Stoklosa, MD, MPH, Marti MacGibbon, CADC-II, ACRPS, and Joseph Stoklosa, MD

#### Abstract

This article reviews an emergency department-based clinical vignette of a trafficked patient with co-occurring pregnancy-related, mental health, and substance use disorder issues. The authors, including a survivor of human trafficking, draw on their backgrounds in addiction care, human trafficking, emergency medicine, and psychiatry to review the literature on relevant general health and mental health consequences of trafficking and propose an approach to the clinical complexities this case presents. In their discussion, the authors explicate the deleterious role of implicit bias and diagnostic overshadowing in trafficked patients with co-occurring addiction and mental illness. Finally, the authors propose a trauma-informed, multidisciplinary response to potentially trafficked patients.

#### Case

Dr. Shah, an emergency department (ED) resident in New York City, entered the room of a young pregnant patient who was bleeding and visibly frightened. The patient, who only spoke Spanish, was accompanied by her brother, who translated. He explained that the patient suffered from schizophrenia and had been refusing her medications for the last couple of weeks. He added that she'd had a few episodes of aggressive behavior, directed at others and herself. While the patient's brother was talking, Dr. Shah noticed a few bruises and puncture marks with associated ecchymosis (subcutaneous bleeding similar to a bruise) on the patient's arm. The brother saw that Dr. Shah had noticed these marks and explained that the patient sells herself for drugs.

Dr. Shah began to suspect that the patient's brother might not be trustworthy, so she requested a certified clinical interpreter. Through the interpreter, the patient conveyed that she was miscarrying and asserted that she does not have schizophrenia, although she admitted feeling depressed sometimes. The patient's tone became increasingly desperate and she explained, through the interpreter, that the man claiming to be her brother was holding her captive. She stated she was brought to the US as his fiancée,

and, upon arrival, he confiscated her passport, forced her to have sex with him, and introduced her to drugs.

At this point, the man explained that his sister had long had delusions of persecution. He also disclosed that she had required temporary restraints the day before after threatening family members while she was high. He suggested that perhaps this episode had fueled the current delusion.

Dr. Shah had recently read about a case in which a 14-year-old girl had been to the emergency department for treatment and had told the staff she was being sex trafficked. The man accompanying the girl had also claimed she had schizophrenia. The clinicians believed the man and discharged the girl to his care; he was later found to be trafficking girls into commercial sex. The girl was not rescued until police found her bound in a closet during a drug raid weeks later.

Dr. Shah wondered what to do.

### **Commentary**

The clinical scenario described above might seem far-fetched or extreme. However, Dr. Shah's dilemma mirrors many human trafficking clinical encounters in which patients present with medical, mental health, and substance use disorder needs. The health needs of this patient might very well suggest that she is being trafficked and should not be dismissed merely because the "brother" has identified the patient as having a mental illness or substance use disorder. This paper will discuss the implications of the patient's presenting symptoms, the role of implicit bias and diagnostic overshadowing in trafficked patients with co-occurring addiction and mental illness, and the importance of providing trauma-informed care to patients who could be trafficking victims.

### **Terminology**

The article authors define human trafficking according to United States law. Federal law defines "severe forms of trafficking in persons" as:

- (A) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or
- (B) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery [1].

Note that trafficking does not necessarily involve movement and does not necessarily involve physical captivity. Vulnerable people are lured and trapped via myriad means

including economic abuse, psychological coercion, threats against family, drug addiction, physical abuse, and sexual abuse [2]. Vulnerability to trafficking exists on societal, community, and individual levels, and might be a result of society's demand for cheap goods, disruption of a community through humanitarian crisis, or childhood sexual abuse [3].

The authors also specifically use the term "survivor" to refer to those who currently are or previously have been trafficked. "Survivor" is used rather than "victim," as it is an empowering term that has been embraced by anti-trafficking organizations [4-6] to capture the strength it takes to face extensive trauma.

### **Health Implications of Being Trafficked**

Physical consequences of being trafficked include a range of health problems resulting from occupational, trauma, and living condition-related risk exposures [7].

*Pregnancy complications.* One category of medical sequelae of being trafficked is pregnancy-related complications. Pregnancy resulting from sexual assault during labor or sex trafficking can be used as a means to coerce a trafficked female, keeping her emotionally bound to her trafficker and further reliant on the trafficker to meet her own and her child's needs [8]. In a survey of sex trafficking survivors in the United States, 71.2 percent of 66 respondents reported at least one unwanted pregnancy during the period of their exploitation, and 21.2 percent reported five or more pregnancies [9]. The same survey found that 55.2 percent of the 67 female survivors reported at least one abortion, and 29.9 percent reported multiple abortions, with half of those who had had an abortion indicating that they were forced to have at least one of the abortions [9]. Similarly, 54.7 percent of 64 respondents reported at least one miscarriage and 29.7 percent had more than one miscarriage. In addition to enduring abortions and miscarriages with little, if any, clinical attention, trafficking survivors might not have adequate access to prenatal health care and can suffer from pregnancy-complicating sexually transmitted infections, such as HIV [8, 10]. Not surprisingly, a study from the United Kingdom showed that the health professional group most likely to encounter trafficked persons is maternity services professionals [11]. And a US-based study of trafficked persons found that approximately one quarter of labor and sex trafficked persons reported that they saw obstetricians during their period of exploitation [12]. So, the patient in this case presenting as pregnant and miscarrying should be regarded as a warning sign for Dr. Shah and as an opportunity for her to intervene.

*Addiction.* The patient in this scenario has physical stigmata of intravenous drug use in the form of track marks. [Addiction](#) has a complex relationship with human trafficking: it can exacerbate a trafficked person's vulnerability, be part of a captor's means of coercing a captive person to submit, be part of a captor's means of incentivizing a captive person to remain captive, and be used by the captive person as a mechanism of coping with the

physical and mental traumas of being trafficked [9, 13]. The first explanation appears to be the most common, although research is limited. For example, an anti-trafficking service provider in Maine found that 66 percent of its clients reported that substance use led to their being trafficked while only 4.5 percent reported that it arose after their being trafficked [13]. A broader survey of US survivors of sex trafficking found that 84.3 percent used substances during their trafficking exploitation. Alcohol, marijuana, and cocaine were each used by more than 50 percent of respondents and nearly a quarter (22.3 percent) used heroin [9].

Opioids in particular are an effective coercion tool for traffickers because they numb both emotional and physical pain; clinicians have noted clear links between the current US opioid epidemic and trafficking [14]. Some traffickers recruit directly from substance use disorder treatment facilities [15]. Moreover, high rates of opioid-overdose death underscore the potentially lethal consequences of an opioid addiction for trafficked persons [16]. Therefore, as in this case, [opioid addiction](#) in and of itself may be a red flag for clinicians to screen for trafficking.

The power of addiction in trafficking has been recognized by the criminal justice system as well. In 2014, a man in Florida was convicted of sex trafficking based on his use of drug addiction to coerce his victims [17]. One of the survivors he exploited was quoted as saying, "He made me believe that he cared and that he loved me and he was going help get me off the streets.... Instead he got me addicted.... [The drugs] were all bought illegally for the purpose of addicting me and controlling me" [17]. Given the well-documented nature of addiction's links to trafficking, in our case example, even if the "brother" is telling the truth about the patient's substance use problem, it should be yet another component of a physician's index of suspicion that the patient is trafficked.

*Mental health.* The "brother" in this scenario claims that the patient is suffering from delusions, possibly as a result of schizophrenia or her drug use. While labeling the patient delusional could be a ploy to undermine her agency and negate the veracity of her claims, clinicians should be aware that mental illness can be an indicator that a patient is being trafficked and should raise a clinician's index of suspicion that she's being exploited. Studies have shown that people with a known major mental illness like schizophrenia are more likely to be victimized physically than those without mental illness [18]. Moreover, intense, complex trauma—such as could develop in a person who is trafficked—is strongly associated with a patient's development of psychosis, including [schizophrenia](#) [19, 20]. Not surprisingly, 15 percent of trafficked persons in contact with mental health services in South London between 2006 and 2012 met criteria for schizophrenia and related disorders in the *International Statistical Classification of Diseases and Related Health Problems* [21]. Trafficked persons with psychotic disorders and experiences of violence prior to being trafficked are likely to require more therapeutic support than patients with nonpsychotic disorders or those suffering from psychological distress [22]. Research

conducted in many countries demonstrates that, in addition to psychosis, survivors of labor and sex trafficking experience high rates of depression, anxiety, and posttraumatic stress disorder (PTSD), self-harm, and attempted suicide [23–25].

### **Responding to a Potentially Trafficked Person with Mental Illness and Addiction**

*Trauma-informed approach to care.* Any patient encounter involves obtaining and analyzing subjective and objective data with varying degrees of uncertainty and using this information to formulate a care plan. However, in cases of potential human trafficking, like this one, the stakes are particularly high, underlining the need for a protocol, and a multidisciplinary approach that is survivor-centered, culturally relevant, evidence-based, gender-sensitive, and [trauma-informed](#) [26]. A summary of recommendations for how to approach potentially trafficked patients, compiled from survivors and international experts, is outlined in the table below. Protocols for identifying, assessing, and caring for trafficked persons can also be found on the HEAL Trafficking website [27]; these models can be adapted to particular practice settings, as exemplified by the National Human Trafficking Resource Center’s “Framework for a Human Trafficking Protocol in Healthcare Settings” [28]. Health care professionals should familiarize themselves with state-specific mandatory reporting requirements. The overarching goal of the clinical encounter is not rescue but rather improving health and safety. It is important to respect all patients’ assessment of their situation and risks to their safety. The core components of the general approach to a potentially trafficked patient include meeting basic needs, building trust and rapport, being conscious of language, remaining sensitive to power dynamics, and avoiding retraumatization [29, 30]. The patient should be interviewed alone, with an interpreter as needed.

**Table 1.** Expert and survivor-informed tenets: caring for a trafficked person [29, 30]

<b>General approach</b>
<p>Do no harm.</p> <p>Remember that the goal is not rescue, but improving health and safety.</p> <p>Prioritize the safety of trafficked persons, yourself, and other staff.</p> <p>Provide respectful, equitable, non-discriminatory care.</p> <p>Approach interactions with the victim or survivor with respect and kindness.</p> <p>Be empathetic, but not sympathetic, or appearing to pity.</p> <p>Recognize that the victim is a human being that has been abused, exploited, and traumatized far beyond what most people can imagine.</p> <p>Be aware of nonverbal communication: do not show shock or disgust.</p> <p>Be nonjudgmental.</p> <p>Know the basics of the patient’s cultural and religious background in</p>

<p>order to understand his/ her worldview and to avoid potential offenses.</p> <p>Use same-sex staff when possible.</p> <p>Provide a private, warm, quiet, and comfortable place for the interview and exam.</p>
<p><b>History-taking</b></p>
<p>Interview the patient alone.</p> <p>Adequately select and prepare interpreters and co-workers.</p> <p>Sit, don't stand or hover. Take your time, don't multitask; avoid writing while the patient is talking.</p> <p>Avoid asking the same question more than once, which may cause frustration or distrust on the part of the patient.</p> <p>Communicate effectively with other members of the care team to avoid repeated interviews with the victim, which may result in retraumatization.</p> <p>Listen to and respect each patient's assessment of their situation and risks to their safety.</p>
<p><b>Physical exam</b></p>
<p>Allow the patient to lead or set the pace of the exam.</p> <p>Provide assurance that he/she is in control of the exam.</p> <p>Ask permission each time you touch the patient.</p> <p>Explain exactly what you are going to do.</p> <p>If it is going to hurt, say it is going to hurt.</p> <p>Be gentle, but don't "sugar coat."</p>
<p><b>Response</b></p>
<p>Collaborate with multidisciplinary health care team to formulate plan; include patient advocate and social worker where possible.</p> <p>Provide information in a way that is understood.</p> <p>Obtain informed consent before sharing information about patients or beginning procedures to diagnose, treat, or make referrals.</p> <p>Be prepared with referral information and contact details for trusted individuals and organizations that can provide support.</p> <p>Never promise more than you can deliver.</p> <p>Ensure the confidentiality and privacy of trafficked persons and their families.</p> <p>Respect the rights, choices, and dignity of each person by encouraging independent decision making.</p> <p>Include the patient in conversations about him/her when present.</p>

In particular, it is critical to approach all patients with a trauma-informed care perspective [26], which prioritizes a safe environment for the clinical encounter, helping the patient to regain a sense of agency and autonomy during the clinical encounter. Victims of interpersonal violence, including violence stemming from human trafficking, can experience sexual, physical, verbal, or psychological assault on a daily or even hourly basis. Any or all of these ongoing traumas, combined with social stigma, can result in the exploited person feeling less than, or other than, human. In the experience of one of the authors (MM), those who live with the stigma and pain of a diagnosis and experience mental illness and/or addiction can also have feelings of extreme social degradation. A trauma-informed approach to care enables clinicians to recognize that many patients have experienced abuse in their past, that many routine aspects of providing health care—such as asking a patient to undress or performing a gynecological exam—might be unintentionally retraumatizing, and that structural and personnel level changes might be needed. When a health care professional interacts with a potentially trafficked patient in a nonjudgmental manner and treats that patient with human dignity by asking permission before examining patients and reassuring them that they are in control of the exam, these actions alone can be interventions. Trauma-informed care is an approach that entire health systems should adopt for all patients. Training all staff, including receptionists and security staff on trauma-informed principles; not requiring patients to tell their clinical story multiple times during a clinical visit; and providing multidisciplinary, team-based care for survivors of interpersonal violence are all possible systems-level changes that may improve care for trafficking survivors [31].

*Mental illness and addiction.* An especially challenging component of this clinical vignette is the possibility that the trafficking exploitation reported by the young woman could be a delusion rather than reality. Mental health clinicians have expressed that it is often difficult to obtain histories from trafficking survivors [32]. To further obfuscate the clinical picture, patients with psychoses who have been sexually abused or bullied can have hallucinations in which the actual content or the themes of content is similar to that of their trauma, making it difficult to separate the two [33].

In approaching patients with co-occurring addiction and mental illness, clinicians must be particularly aware of their own biases and potential “diagnostic overshadowing” [34]. Diagnostic overshadowing refers to a well-described clinically and ethically problematic phenomenon in which clinicians ignore patients’ general health concerns because of that patient’s mental illness [35–38]. At the core of diagnostic overshadowing is a clinical reasoning error; that is, some clinicians unconsciously tend to express negative bias when diagnosing patients who have co-occurring mental health and general health problems, such that legitimate general health problems are misattributed as originating from a patient’s mental illness [36]. For example, a clinician might assume the patient



with schizophrenia complaining of chest pain is just “crazy” or anxious, rather than accounting for a higher risk for heart disease among those with schizophrenia [36, 39].

Clinicians should be particularly vigilant to avoid diagnostic overshadowing, given that persons with chronic mental illness are not only at increased risk for all forms of interpersonal violence [18], but also more likely to suffer subsequent ill general health and to disclose the violence exclusively to health professionals [34, 40]. It is important to maintain a high index of suspicion for true interpersonal violence or exploitation, thoughtfully evaluating each concern expressed by a patient, knowing that even delusions can have kernels of truth and important places in a patient’s story of what she or he has experienced. Also, just because a patient has a known delusion, clinicians should not assume that the patient’s other concerns are not valid or do not deserve their attention.

### **Conclusion**

Because each interaction with a potentially trafficked person is complex and critical, health systems should have trauma-informed interpersonal violence protocols in place that involve a multidisciplinary response team and respond to the critical needs of trafficking survivors. Dr. Shah should be mindful of the sway of implicit bias and diagnostic overshadowing, applying core principles in response to trafficking coupled with the use of a multidisciplinary team in her encounter with this woman and her “brother.” A response team should include social workers, emergency clinicians, behavioral health professionals, substance use disorder specialists, and obstetrics and gynecology colleagues [29, 41, 42].

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