Human Trafficking and the Trauma-Informed Physical Exam

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1 Trauma Definitions

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma can be described by the "Three E's": Events, Experiences, and Effects. Trauma results from an event, a series of events, or a set of circumstances that is "experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" [1]. Trauma assumes multiple forms, including psychological abuse, physical assault, war, death/loss, poverty, community violence, pandemics such as the COVID-19 pandemic, natural disasters, neglect, generational trauma, racism, homophobia, transphobia, misogyny, and others. Notably, how the event is experienced may vary from person to person, and it is the individual's experience of the event that will determine whether it has long-lasting traumatic effects. These experiences may be influenced by cultural factors (e.g., gender, race, ethnicity, sexual orientation, etc.), as well as by protective factors that are lacking or present (e.g., supportive family, sense of community, economic stability, and others) [2]. Certain populations are at greater risk for trauma than others. These include children who have experienced foster care; impoverished children; refugees and immigrants; LGBTQIA youth (lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual); underrepresented racial, ethnic, and religious groups; children of military families; neurodiverse children; individuals with complex medical needs and chronic conditions; and even overweight and obese youth who many experience microaggressions (seemingly small and sometimes unintentional slights, insults, and biases that accumulate over

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time) [3]. Certainly, people who have experienced human trafficking will be at high risk for trauma, and typically multiple types of trauma.

A pair of “ACEs” contributes to toxic stress and trauma and points to a need for a population health approach to resolving trauma. These ACEs include adverse childhood experiences such as divorce, maternal depression, emotional and sexual abuse, physical and emotional neglect, substance use disorder, mental illness, homelessness, domestic violence, and incarceration as well as adverse community environments such as poverty, discrimination, violence, community disruption, poor housing quality and affordability, and lack of opportunity, economic mobility, and social capital [4] This same pair of ACEs is correlated to human trafficking [5] and increasingly, human trafficking is recognized as a public health issue [6–9].

2 Trauma Statistics

While environment and population characteristics influence the frequency of toxic stress and trauma, simply put, trauma is common, not just among trafficked persons but among the general population, where 89% of people report at least one traumatic event in their lifetime [10]. Youth are susceptible to trauma, with 46% of all youth experiencing at least one traumatic event by 17 years of age [11], and 37% of youth experiencing a physical assault during a 1-year period [12]. Exposure to traumatic events is even more common, with 82% of children entering a Childhood Mental Health Initiative System of Care program having experienced at least 1 trauma exposure, such as witnessing crimes, fires, and physical/sexual assault [13].

3 Effects of Trauma

Health effects of trauma include chronic disease such as asthma and diabetes, cardiovascular disease, mental illness, and chronic pain syndromes [14]. Unsurprisingly, victims of human trafficking experience physical and mental health symptoms, as well as chronic medical problems [15–17]. Signs of trauma witnessed in patients by the medical professional may include avoidance of procedures such as a Pap smear, colonoscopy, or routine dental care; vague, generalized symptoms such as chronic headache or pelvic pain; appearing nervous or distracted or antagonistic during a clinical encounter; and/or nonadherence to medical treatment plans and, therefore, repeated presentations with acute exacerbations of chronic disease such as diabetic ketoacidosis, asthmatic respiratory distress, thyroid storm, and even late transplant graft failure due to immunosuppressive medication nonadherence [18, 19].

4 Trauma Is Treatable

4.1 Prevention and Growing Resilience

Qualitative data suggest that efforts to build community resilience to trauma should be grounded in quality improvement projects through data-driven decision-making and program development [20]. The Centers for Disease Control (CDC) advocates for an approach to stop violence and trauma before they begin. The CDC Social-Ecological Model identifies the connection between four factors that influence violence and trauma: individual (biological, age, personal history) relational (family, intimate partner, and attachment to caregivers), community (schools, workplaces, and neighborhoods), and societal (cultural norms, socioeconomic, and policy-driven) [21, 22].

SAMHSA's Children's Mental Health Initiative (CMHI) promotes treatment and support for children, youth, and young adults with serious mental health disorders—most of whom have experienced at least one traumatic event. Analysis of data gathered from 2009 through 2016 revealed that children and youth with traumatic experiences who received services through the CMHI for 12 months showed reductions in aggression or "externalizing problems," as well as anxiety or depression (often called "internalizing problems") compared to their baseline. Moreover, the benefits extended far beyond their mood and behavioral issues; these children also exhibited improved strengths, improved functioning, and improved problems with substance use and abuse 12 months after the start of treatment. They demonstrated significant improvements in school functioning, with reduction in days absent from school, improvement in school performance, and improved competence in school and classroom tasks, as reported by parents [13]. The bottom line is that trauma is treatable.

4.2 Trauma-Hyphenated Terms

If trauma is treatable, then how do we as medical and healthcare professionals work with traumatized individuals in a manner that avoids re-traumatization and promotes their healing? The term trauma-informed care is thrown around often, but what does this mean? And how does trauma-informed care differ from some of the other trauma-hyphenated phrases being used?

"Trauma-focused" or "trauma-specific" therapies include evidence-based therapies that directly address the source of mental and psychological trauma and seek to treat post-traumatic stress disorder, anxiety, depression, and even substance abuse that might result from trauma. Trauma-focused cognitive behavioral therapy (CBT), psychotherapy, and eye-movement desensitization and reprocessing (EMDR) are examples.

The term "trauma-sensitive" was first introduced into educational literature to describe schools or places of learning in which all students feel safe, supported, and empowered to participate in learning activities. Such environments are free from

racism, misogyny, and other systematic forms of oppression and inequity and instead promote a sense of belonging [23]. Trauma-sensitive clinical practice, as explained by Schacter et al., involves nine principles to promote survivor health: within the clinical encounter, trauma-sensitive care calls for respect, patience, rapport, sharing of information, sharing of control, respecting boundaries, fostering mutual learning, understanding that healing is nonlinear, and demonstrating awareness and knowledge of interpersonal violence [24].

According to SAMHSA, an approach that is trauma-informed [25]:

- Realizes the widespread impact of trauma and understands potential paths for recovery.
- Recognizes signs and symptoms of trauma in patients, families, staff, and others involved in the system.
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices.
- Seeks to actively resist re-traumatization.

The individual physician, nurse, or other clinician will incorporate a trauma-informed approach to their work with patients. In doing so, the CDC recommends six guiding principles to this approach. Namely, these require attention to [26]:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment and choice
6. Cultural, historical, and gender issues

A "trauma-responsive" system of care (such as a hospital, criminal justice, or child welfare network) provides an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. The system emphasizes physical, psychological, and emotional safety for providers as well as patients/clients. Language is oriented toward rebuilding a sense of control and empowerment, collaboration, and the establishment of trust. Screening for trauma takes place universally at all encounters and in all settings. Further, there are protocols already in place that anticipate crises and prepare staff to address these crises in a manner that reflects trauma-informed values and with trauma-informed resources [27, 28].

Trauma-responsive care involves a paradigm shift from "What is wrong with you?" and even "What happened to you?" to "Where do you want to go, and how may I help you get there?"

Trauma-responsive care involves healing-centered engagement through the building of positive relationships, through the focus on agency and well-being, and through engagement with the surrounding communities culturally, spiritually and through collaborative civic action and healing [29]. Part of this engagement with

communities involves listening to and hearing the voices of survivors of human trafficking. Survivors have requested that health professionals avoid judgmental comments, listen empathically, offer resources and information (regardless of disclosure), and avoid pushing for disclosure [30].

5 Case Study

Let's walk through a case.

"Leah" is a 15-year-old girl presenting to your care for contraceptive counseling and acne. She was discharged from the inpatient children's psychiatry unit 6 months ago when she threatened suicide after being "rescued from a hotel with several young adult men." It is noted in the electronic medical record that she is a "victim of rape" and was "introduced to methamphetamine, cocaine, acid, mushrooms, benzos, and marijuana, with likely gang involvement." (Police noted a young man with firearms within the group at the hotel). Prior to being detained by law enforcement, she was living with her dad but frequently ran away.

On her social history, it is noted that she was a straight-A student and basketball player until recently.

Her mother pulls you aside before you enter the room, tells you that her daughter is a victim of human trafficking, and asks you to address this in your visit today.

Her PHQ-9 score is 0.

You enter the clinic room with mom and find your patient sitting in a chair staring blankly at the wall. She doesn't look up when you enter, and she rolls her eyes when you greet her.

How do you begin?

In fact, you've already begun. You are reading her body language and facial expression and are noting signs of withdrawal, perhaps denial, and certainly a lack of willingness to engage with you. Noting her lack of engagement, you proceed cautiously, quietly, and directly.

She has already sized you up: your age, your gender, your race, the expression on your face (Nervous? Nonchalant? Compassionate? Curious? Uninterested?), the clothes you're wearing, your posture, and more. She is already observing how her mom interacts with you, whether she defers to you or challenges you or maybe is even currying favor with you.

You share with the patient and her mother that you have reviewed the electronic medical record and understand that she was recently discharged from the psychiatric unit and experienced significant trauma. You inquire about what follow-up had been obtained for human trafficking.

Leah again rolls her eyes, shoots a dirty look at her mother, and declares, "Oh my GOD!" and turns her back to you and her mom. Her mother looks desperate and looks to you to engage her daughter.

It's quite possible your patient now feels that you and her mother have teamed up "against" her. How do you re-engage your patient?

You shift the conversation back to the patient's reason for seeking medical care: acne.

You note facial acne, and Leah was previously on Accutane and minocycline and tried multiple topical medications before those treatments. She previously had taken combined oral contraceptive pills for acne and dysmenorrhea, but she could never remember to take the birth control pills consistently and, therefore, experienced frequent breakthrough bleeding.

You ask Leah about her skin, and she immediately engages and asks you, "Can you fix it?"

You share with her alternate contraceptive methods that could help with acne, and she appears somewhat engaged but hesitant.

What might you be able to do to further engage Leah and provide her with a safe space to share with you?

You share with Leah and her mom that you need to have some time alone with Leah to discuss "teen issues" such as sex, drugs, and "rock 'n roll"—your shorthand for feelings such as depression and anxiety and even thoughts of suicide. You share that when you're alone with teen patients, there are some guidelines you follow: "When I meet with you by yourself, I don't perform any physical exam unless there's another adult such as a nurse or medical assistant or your parent in the room. Everything we discuss is private, meaning it stays between you and your health care team, unless I find out that you're in danger—for instance because you're planning to hurt yourself or someone else is hurting or threatening you. In those cases, I would need to get help to protect you."

Her mom leaves the room, and you ask Leah about any questions or concerns she might have. She replies immediately, "Can you give me birth control?" You respond that you can. "For real?" she asks, and she now seems happy and engaged.

You start to move into a Strengths-based HEADDSS assessment—a psychosocial assessment exploring your patient's strengths, home environment, education/employment, activities, depression/drug use, suicidality/sexuality/sexual activity. Leah is now quite open with you, but she responds, "No comment" when asked about drug use. When you ask her, "When was the 1st time you chose to have sex?" She pauses, and replies simply, "This year." When you ask her if she'd like to discuss any coercion or violence, she responds tersely but politely, "No comment, thank you."

What do you do now? Do you probe further to elicit the history about trafficking so that you can provide resources and document her disclosure?

In addition to counseling about the various types of contraception, you ask Leah if you could share with her—as you do with all of your patients—about sexual consent and condom negotiation, as well as some basic information about CSEC (commercial sexual exploitation of children). She agrees to listen, and she remains attentive throughout, asking questions about side effects of medication, asking for online resources about sex, and she asks for information about CSEC "for her friends." She decides on the Nuvaring as her choice of birth control, and—after verifying a negative urine pregnancy, the date of her last menstrual period, normal blood pressure, and no contraindication to estrogen-containing medication—you prescribe her Nuvaring. You share that you will need to do a physical exam and ask

her which she would prefer—her mother or another medical professional in the room? She chooses a nurse as her chaperone. You ask if she has ever had a gynecologic exam, and she shares that in the emergency department "after the 'thing,' they did that and tested me for infections." She shares that she has had unprotected sex since then and consents to a pelvic exam with STI testing, including HIV.

6 Trauma-Informed Clinical Encounters

Knowing that your patient has an extensive history of trauma, how do you conduct the gynecological exam in a trauma-sensitive manner? There are additional parts of the routine clinical encounter that might be triggering for this patient, so keeping some basic trauma-informed approaches in mind is beneficial. See Table 1.

Language matters. During the clinical encounter and history taking, it is important to convey transparency, openness, genuine caring, and curiosity rather than judgmentalism. Body language can speak volumes, so introducing oneself by name and title/role, facing the patient—regardless of the location of the computer screen—sitting, and making eye contact are key. The phrasing of questions—in addition to intonation—could be off-putting to patients. Table 2 provides a sample of survivor-informed phrases that could be used to help people who have experienced human trafficking feel supported rather than judged or pitied.

While most medical students learn to perform the trauma-informed gynecologic exam [32], physical trauma—especially for people who have experienced sex trafficking or sexual abuse or exploitation—often is not limited to one part of the body. Ample research shows that survivors of sex trafficking endure other types of physical abuses, such as choking, beating, slapping, burning, and withholding of nutrition [16]. In light of this, the entire physical exam, in addition to history taking, should be conducted with a trauma-informed lens and in a trauma-sensitive manner. See Table 3.

Table 1 Trauma-informed clinical encounter [31]

1. Introduce yourself and clarify names, pronouns, and titles/relationships
2. Show your ID photo without a mask on
3. Set an agenda: establish time, goals for visit, navigation of History + PE + Tests + Tx Plan. E.g., "We're going to spend about 30 min together today. We'll talk about what's been going on for ___ minutes, and then what to expect in terms of physical exam. Finally, we'll discuss any testing that's needed, possible diagnosis and a treatment\ plan"
4. Use simple, anatomic language. Avoid medicalese and slang
5. Identify any concerns, and reassure the patient you will have a private discussion
6. Engage a chaperone
7. Ask about comfort. Use clothes/drapes to preserve modesty/dignity
8. Reassure the patient that you will stop/pause exam if needed
9. Use standard of care for exam, testing, and treatments
10. Educate/summarize what you find

Table 2 Language matters: survivor feedback[a]

Instead of…	Youth feel…	Try…
"I am so sorry for you!"	Weak, pitied, reminds them about their lack of power	"I see you're struggling. I'm here to see if I can help and support you. Talking to me is your choice"
"I understand the way you feel"	Weak, resentful, angry, depersonalized story, provider just like everyone else who thinks they understand	"I can see that must've been hard. What can I do to support you?"
"Why did you run away?"	Angry, judged, in trouble	(Address basic needs.) "When you're ready, I'm here to listen. I would really like to know what pressured you to leave"
"Why didn't you leave?"	Angry, judged, in trouble	"I'm so happy to see you now. Is there anything on your mind you'd like to talk about?"

[a]From San Diego Youth Services CSEC training with Live Well San Diego

Table 3 Trauma-informed physical exam [31]

Exam	Modifications
General	• Communicate beforehand the reason for the exam, what the exam entails, and how much time it could take. • Stay within eyesight at eye level (e.g., sit if needed) • Request permission to begin the exam. • Remind the patient that you will pause or stop the exam at any point if they are uncomfortable. • Leave it up to the patient to decide which parts of the exam are sensitive to them. Offer a chaperone before the start of a physical exam. • Use simple, anatomic language. • When possible, allow patients to keep their clothes on and simply move the fabric as needed. • Take time to educate about findings of the exam.
Cardiac	• Allow the patient to place the bell diaphragm of the stethoscope on their own chest. • The clinician can instruct the patient by pointing on their own body where the bell diaphragm should be placed and asking the patient to mirror the clinician.
Pulmonary	• Advise the patient that you will need to listen from behind them; stand angled at the side of the patient and extend your bell to access the back with the other hand resting on the patient's shoulder.
Abdominal	• Allow the patient to have their hand placed on top of yours as a guide for both auscultation and palpation. • Undrape in segments, only as needed.
Thyroid	• Offer to perform anterior vs posterior vs angled approach based on comfort/preference. • Allow the patient to have their hands resting on top of yours lightly as you perform exam.

Table 3 (continued)

Exam	Modifications
Gynecologic	• Allow patient to wear all clothing above the waist. • Communicate what you are going to do before you do it. • Check in routinely. • Once the patient feels comfortable with your description, perform the exam at your normal speed: do not risk missing details by rushing, and do not prolong the discomfort by going too slowly. • Offer to perform the bimanual exam from the side with the patient in the lateral decubitus position. • Use the smallest speculum to begin, sizing up only if needed. • Use lubricant instead of water, and reapply between the speculum exam and the bimanual. • Offer the patient the opportunity to insert speculum themselves (like a tampon) if more comfortable. • Be honest if you are having difficulty getting a sample: offer to retry or to stop and reattempt at another time if they would prefer. • Provide tissues and/or pad at the end of the exam.
After the exam	• Express thanks • Discuss results/findings • Welcome questions

7 Case Conclusion

After you perform Leah's physical exam in a trauma-informed manner, you express thanks to her for entrusting you with her care. You share that you will send samples to the lab for testing, and that you expect results in several days. You reassure her that you will call *her* (not her parent) with any abnormal results and confirm her phone number, and you confirm that it's safe to leave a voicemail on her phone if needed. You also request phone numbers for two other trusted people in her life, just in case you have trouble reaching her. You invite questions, and Leah asks when she can come back to see you "just to check in." You confirm your clinic schedule and invite Leah to return in 6 weeks to follow-up for a pregnancy test and to troubleshoot any issues with the Nuvaring or any other concerns, and you inform her that the nurse who served as a chaperone will call her in 2–3 weeks to check in with her, as well. Leah thanks you for your time and leaves the clinic with her mom. She is almost smiling.

8 Conclusions and Future Directions

People who have experienced human trafficking will be at high risk for multiple types of traumas. In general, trauma is common, trauma may assume multiple forms, and the long-lasting health effects of psychological and physical traumas may be observed by the trained health care professional (HCP) during history taking and/or during the physical exam. Therefore, the individual HCP must actively seek to resist re-traumatization, must keep in mind that trauma is treatable, but must also

avoid the “rescue mentality.” When HCPs consider the CDC Social-Ecological Model that identifies the connection between individual, relationship, community, and societal violence and trauma [21, 22], HCPs may find it easier to embrace a trauma-sensitive approach that restores agency to the individual and seeks long-term solutions in addition to or rather than quick fixes. HCPs may even advocate for the creation of trauma-responsive systems emphasizing physical, psychological, and emotional safety for providers as well as for patients/clients.

Trauma-responsive systems build on health professional human trafficking education programs by acknowledging the extensive time and resources needed for patients with complex trauma, such as individuals who have experienced human trafficking. In these cases, the integration of multiple services—medical, psychological, social work, immigration assistance, housing, education/jobs training, substance use rehabilitation, and even theater arts—is used to holistically address the needs of trafficked individuals [33–38].

Preliminary data show that medical safe havens that coordinate with community agencies and nonprofits to provide a nexus for delivery of services to trafficked individuals may help participants increase their completion of community rehabilitation programs and may increase persistence of follow-up within such programs [39]. More study is needed with non-female individuals in various geographic locations and across multiple typologies of human trafficking, but building on the trauma-informed exam by working toward the coordination of resources and the creation of trauma-responsive systems may increase long-term recovery and ultimately help people out of exploitation.

Discussion Questions

- What actions can you put into your own practice today to prevent re-traumatizing your patients/clients? These might pertain to history-taking and/or physical examination.
- What are steps that you can take with your practice group to promote patient-centered, trauma-sensitive care for your patients? These might include the patient check-in process, documentation, medical gowns and undressing, universal education in the form of posters, etc.
- Identify agencies and organizations in your area that may be appropriate for partnership, such as housing organizations, cultural organizations, arts organizations, and child welfare agencies, among others.
- For ideas on building community partnerships and forming trauma-sensitive protocols, go to https://healtrafficking.org/2017/06/protocol-toolkit/.

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