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PSYCHOPATHOLOGICAL EVALUATION OF FEMALE VICTIMS OF HUMAN TRAFFIC FOR SEXUAL EXPLOITATION

Cross-sectoral collaboration at The European project “Psychological
Health Impact of Trafficking in Human Beings on female victims”
(PHIT)

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1. INTRODUCTION

The PHIT aims to increase the knowledge about the *Psychological Health Impact of THB for sexual exploitation on female victims*, to measure the impact of stakeholders' interactions and interventions on the psychological well-being of victims. This will take into account their psychological condition and prevent secondary victimization by this system.

In this framework of study and understanding of the phenomenon, a psychiatric clinical forensic evaluation of the Mental Health of the victims in terms of psychopathology rose up to be a significant need under the PHIT project. During the different phases of the PHIT study there was evidence that some of the victims have had, or still have, a severe impact on their mental health. This impact may have led to the presence of psychopathology in some victims and that should be evaluated. The sequels at the mental health level, consequence of the trauma, of all the lived stressors and the complex life events, all represent risk factors for the development of mental health disorders.

A psychopathological clinical evaluation was necessary to be able to diagnose in a reliable and replicable way the presence of psychopathology. This evaluation presented great challenges because the group of female victims of trafficking is highly complex and psychosocially vulnerable. There is a great cultural diversity with all that it implies in terms of cross-cultural psychiatry evaluation. There is also a high degree of stigma in the collective against mental illness, psychiatric evaluation, which hindered the access of women to conventional health facilities for psychiatric evaluation. The expertise of the Transcultural Psychiatry Program (TPP) of Hospital Vall d'Hebron has been a key point for this culturally adapted evaluation.

In this scenario, collaboration and coordination in a multidisciplinary way among the NGO's hosting the victims in Barcelona and Madrid (SICAR, PROYECTO ESPERANZA, APRAM), the special unit of the City Council of Barcelona (UTEH) that leads the attention to the victims in the city and the project

coordinators at UB and the TPP of the psychiatry department at the Hospital has been essential. This has allowed mental health access barriers to be broken, decrease the impact of the cultural and linguistic barriers and to reduce the fear of stigma before a psychiatric evaluation. The final result is that the victims group has been able to access for psychiatric evaluation in a smooth and uncomplicated manner.

2. BIBLIOGRAPHIC REVIEW ABOUT PSYCHOPATHOLGY IN VICITMS OF HUMAN TRAFFIC FOR SEXUAL EXPLOITATION

Violence, abusive living conditions, poverty, crime and restrictions on movement are commonly associated with trafficking, and suppose serious risks to trafficked people's physical health, and especially mental health (Banovic et al., 2012; Diehl et al, 2016; Kimerling et al., 2007).

Health professionals have a privileged position in detecting human exploitation situations, but not having the right knowledge or training, may be a risk for not recognizing those cases. A research conducted in the UK found that up to one in eight mental health professionals working in areas known to have higher numbers of trafficked people had been in contact with a patient they 'knew or suspected had been trafficked' (Ross et al., 2015). Trafficking may be disclosed by the patient or another professional involved in the patient's care, or mental health professionals may detect signs that suggest possible experiences of trafficking. Suspicions may be raised, for example, if patients present signs of physical or psychological trauma and are unable to speak the local language or to provide basic identity documents (Hemmings et al., 2016).

On the other hand, a study made in the United States of America reported that 28% of post-trafficking women had been in contact with a health professional while being exploited. None of this encounters helped women escape their situation due to the lack of information and specialized training of the health professionals (Family Violence Prevention Fund, 2010).

Several studies done with people in contact with post-trafficking support services, mental health assistance services and hospitals, report that women and girls who had been trafficked for sexual exploitation described high levels of physical and sexual violence, which ranged from 33% in a Cambodian case-file review (McCauley et al., 2010) to 90% in a multi-country European survey (Zimmerman et al., 2008). However, these institutions may capture violence that took place before, during or after the trafficking situation (Zimmerman et al., 2003; Di Tommaso et al., 2009; McCauley et al., 2010; Turner-Moss et al., 2014; Kiss et al., 2015). This longitudinal evaluation of violence may give the professionals a more comprehensive point of view of the symptomatology that appears on the survivors.

In a multicenter European study Zimmerman et al., (2008), found that more than half of the women and adolescent girls reported pretrafficking experiences of sexual or physical violence, and 12% had a forced or coerced sexual experience before the age of 15. Nearly all the women and adolescent girls (95%) reported physical or sexual violence while in the trafficking situation; 76% reported physical abuse, and 90% reported sexual abuse. Most of these women tend to normalize violence, may experience shame, guilt, helplessness or fear, which prevents them from reporting violence.

Although evidence on the psychological sequelae of trafficking is limited, studies suggest a high prevalence of physical and sexual abuse, depression, anxiety and post-traumatic stress disorder (PTSD); as well as physical symptoms such as headache, back pain, memory loss; and sexually transmitted infections (STI) and HIV (Oram et al., 2012; Turner-Moss et al., 2014; Kiss et al., 2015).

Research from various countries shows that depression, anxiety, post-traumatic stress disorder (PTSD), and self-harm and attempted suicide are common among survivors in contact with refuge services (Ottisova et al, 2016). Oram et al., (2016) found that symptoms of depression, anxiety and PTSD were reported by 78% of women and 40% of men survivors in England. Similarly, a study of trafficked people in Greater Mekong sub-region found that 61% of men and 67% of women, as well as 57% of children, reported probable depression and

probable PTSD was reported by 46% of men, 44% of women and 27% of children (Kiss et al., 2015).

Oram and colleagues (2012) reviewed data from four studies (Cwikel et al., 2004; Hossain et al., 2010; Ostrovschi et al., 2011; Tsutsumi et al., 2008) of sex trafficked survivors. These studies included checklists, psychological scales, and clinical interviews. Overall, 78% of survivors experienced clinical anxiety (range 48–98%); 52% depression (range 3–100%) and 37% posttraumatic stress disorder (range 8–77%).

Abas et al., (2013), using the Structured Clinical Interview for DSM Disorders (SCID) to diagnose mental disorder among women in contact with post-trafficking services in Moldova, reported that 55% of the sample met diagnostic criteria for a mental disorder at an average of 6 months after return, including PTSD (36%), depression (13%) and anxiety disorder (6%).

Oram et al., (2015), reporting on a sample of 78 trafficked women in contact with secondary mental health services in England, they observed that the most prevalent diagnoses were depression (32%), PTSD, severe stress and adjustment disorders (28%), schizophrenia and related disorders (9%).

Another study conducted by Crawford et al., (2008) examined a cohort of 80 Nepalese women aged 12–19 who were survivors of sex trafficking. They observed higher somatic symptoms than behavioral ones, such as headache, itching, stomach pain, fatigue and pelvic pain.

Beyond formal diagnoses of mental illnesses, survivors of sex-trafficking report many other symptoms (Ijadi-Maghsoodi et al., 2016; Shandro et al., 2016) such as feelings of fear and distrust, being trapped, hopelessness, shame, humiliation, a sense of continuous stress, anger, and irritability. Survivors also often report poor quality sleep, insomnia, and nightmares. They often feel socially stigmatized, whereby they cannot return to their homes and communities because they will be pre-identified as being sex workers.

Zimmerman and colleagues (2008), observed that symptoms associated with depression were most often reported, with 39% of the participants acknowledging having had suicidal thoughts. More than half of the women and

adolescent girls (57%) scored at high at the PTSD Scales, suggesting posttraumatic stress disorder.

Another issue to be taken in mind for the diagnosis and care is trafficked women's complex history of pretrafficking and trafficking-related violence. Existing studies on violence suggest that multiple exposures to trauma of this type can have multiple long-term effects on women's health (Zimmerman et al., 2008).

Hopper et al., (2018), examined psychological symptoms in 131 survivors of sex and labor trafficking in the United States. High rates of depression (71%) and PTSD (61%) were identified. Two thirds of survivors also met criteria for multiple categories of Complex PTSD (C-PTSD), including affect dysregulation and impulsivity; alterations in attention and consciousness; changes in interpersonal relationships; revictimization; somatic dysregulation; and alterations in self-perception. Sex trafficking survivors had higher prevalence rates of pretrafficking childhood abuse and a higher incidence of physical and sexual violence during trafficking. They were also more likely to meet criteria for comorbid PTSD and depression.

None of the diagnose instruments used in the studies had been validated among trafficked women (Cannon et al., 2016), but some have been used in cross-cultural settings and among other traumatized populations (Aroian et al., 1989; Mollica et al.,1992; Silove et al., 1997). Quantitative and qualitative data collection and analysis methods are being used to investigate human trafficking and health. Findings show that the limitations of current methodologies in the studies affect what is known about this topic (Cannon et al.,2006).

Although traumatic experiences while being trafficked may induce or exacerbate mental disorders, poor mental health may also increase vulnerability to trafficking, due to factors directly associated with mental health, such as reduced decision-making capacity or understanding and increased dependence on others. Trafficked individuals' risk of mental disorder appears to be influenced by multiple factors, including: pre-trafficking abuse; childhood sexual abuse; sexual and physical violence, poor living and working conditions,

duration of exploitation; violence and restrictions on movement while trafficked; greater numbers of unmet needs; and lower levels of social support following trafficking (Ottisova et al., 2006; Hossain et al., 2010; Abas et al., 2013; Kiss et al., 2015).

3. METHODOLOGY

Objective:

At the cross-sectoral collaboration the main objective was to identify the presence of psychopathology in female victims of trafficking for the purpose of sexual exploitation in the first 6 months after having abandoned the sexual exploitation network in Spain.

The sample was pre-determinate at 30 female victims to be evaluated during the first 6 months after the abandonment of the exploitation network. The objective was to evaluate the presence of possible psychopathology as a possible mental health sequelae once being supported in a psychosocial wellbeing and safe environment. The expected results is that there will be clinical affectation in terms of mental disorders after going through a very complex and stressful live events that are potentially very traumatic.

For that purpose a *Semi-structured interview designed ad-hoc* (Annex I) was designed for the evaluation protocol. This interview includes a data collection of socio-demographic data, personal history in relation to the trafficking event, and a clinical assessment in mental health history that includes collecting family and personal psychiatric illness history, as well as substance and alcohol use.

The *International Neuropsychiatric Interview (MINI*)* was used for the systematical clinical diagnosis, focusing on the subscales of *Major Depression Episode, Suicide Risk, Panic Anxiety Disorder, Post Traumatic Stress Disorder and Generalized Anxiety Disorder* as those were the most expected disorders based on the state of the art.

Though a systematic approach was taken with the MINI, the evaluations were done by psychiatry clinicians trained on the MINI, so any other disorder that

might have appeared would have been detected and diagnosed out of the research protocol.

**The MINI (Mini International Neuropsychiatric Interview) is a brief and highly structured interview of the main psychiatric disorders of the ICD-10 and DSM-IV for use by psychiatrists and non-psychiatrists after a short training period. The MINI was designed to generate diagnoses of the ICD-10, but also of the DSM-IV. The MINI is a clinical interview, available in 33 languages, structured in format and algorithms, modular by diagnostic categories, reliable (3 studies against CIDI and SCID) and easy to use after a short training course.*

The estimated duration of the protocol interview was one hour and a half, depending on the language barrier and the level of comfort of the woman during the interview. The arrangement of the clinical appointments was coordinated with the professionals from de NGO's hosting the women who did a mediating process for the referral to the evaluation.

There was a 6 month open period for collecting the sample since the incorporation of the victims to the NGO's is constant. Once a new victim entries in the support network the possibility of the psychiatric evaluation is given to her and their participation is totally voluntary and confidential.

A bioethical commitment was established to provide psychiatric treatment options at the outpatient clinics of TPP for those victims of Barcelona who presented psychopathology and who freely decided to continue with the treatment. For the victims of Madrid, a commitment to do a full clinical report in order to refer the victims to the public health system was established.

A statistical analysis was performed to analyze the data obtained from a mental health descriptive epidemiological point of view.

The results are to be presented in the PHIT project through its different meetings, as well to the NGO's. The results are presented with the objective of improving the knowledge of the professionals who work and assist the victims. Also to improve awareness of the impact in terms of mental health and consequently take the appropriate measures for the best mental health care of the victims.

4. RESULTS

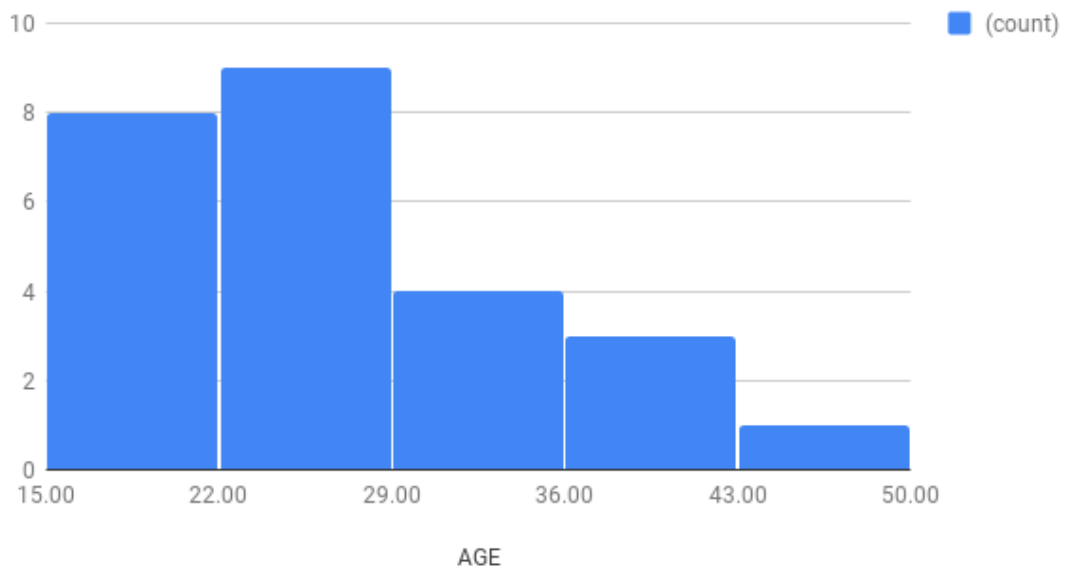
The evaluation was done from February 2018 until July 2018. All the interviews could be done in one session, which lasted minimum one hour and maximum two hours. The evaluations of Barcelona were done in the outpatient clinics of the Vall d'Hebron Hospital and those of Madrid were carried out directly on the devices of the NGO's by the Barcelona team that traveled to Madrid to carry them out.

For communication issues, since most of the victims didn't speak Spanish, the clinical professionals perform most of the interviews in English or French. The psychiatrists were competent in these languages, besides being native in Spanish. This linguistic management option allowed the access to the whole sample without the intervention of third parties except for a victim of Chinese origin who needed professional translation. Summarizing, four different languages were used to do the evaluation of the 30 female victims.

Socio-demographical data:

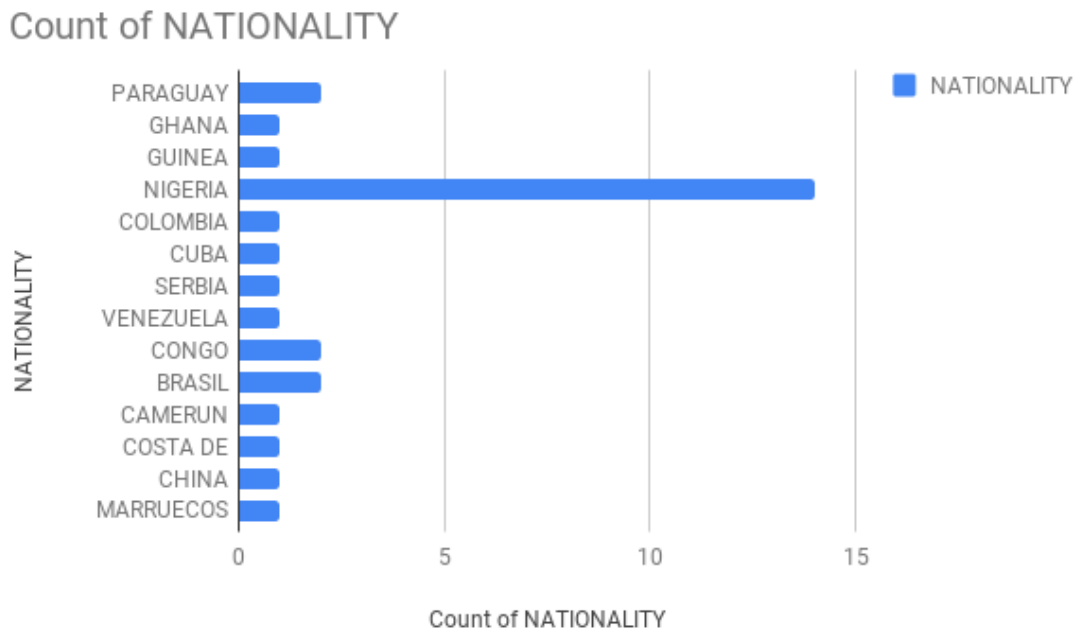
The average age of the victims was 26.6 years-old, having a minimum age of 17 years-old (3 victims where minors). The eldest victim evaluated was 47 years-old, belonging to the Chinese collective.

Histogram of AGE



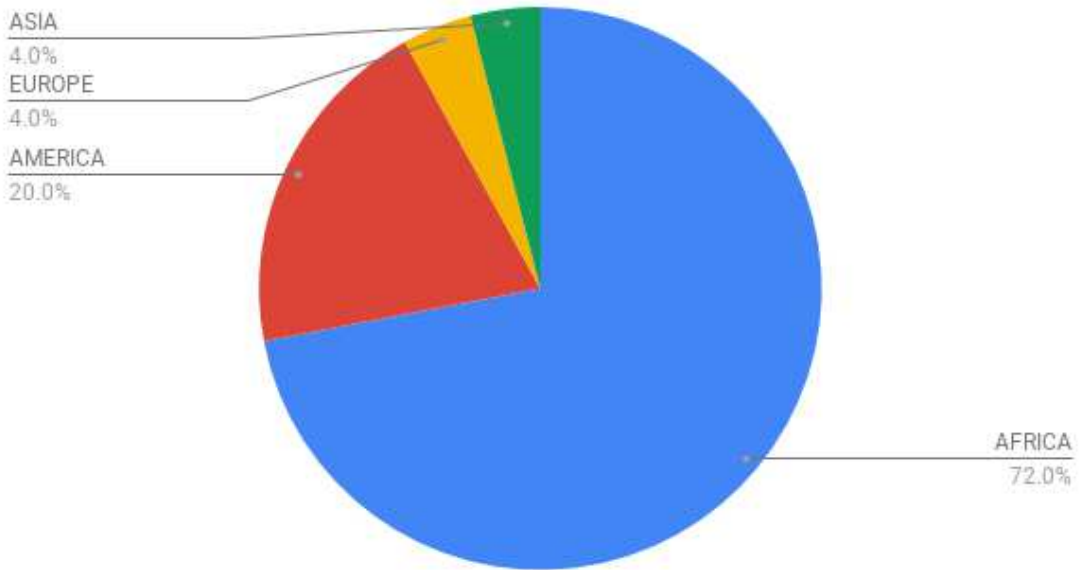
None of the victims had legal residence permit in Spain, and their route of arrival to Spain depended on the country of origin. African victims had all arrived through the illegal migratory routes of the western Mediterranean. While the Latin American victims came to Spain with temporary, tourist visas, which subsequently became invalid. All of the victims had no official incomes and depended totally from the NGO's for their survival in all the basic psychosocial issues.

Regarding place of origin, the victims came from 14 different countries, being the Nigerian victims (46,7%) the most represented in the sample, with great difference with the other countries.



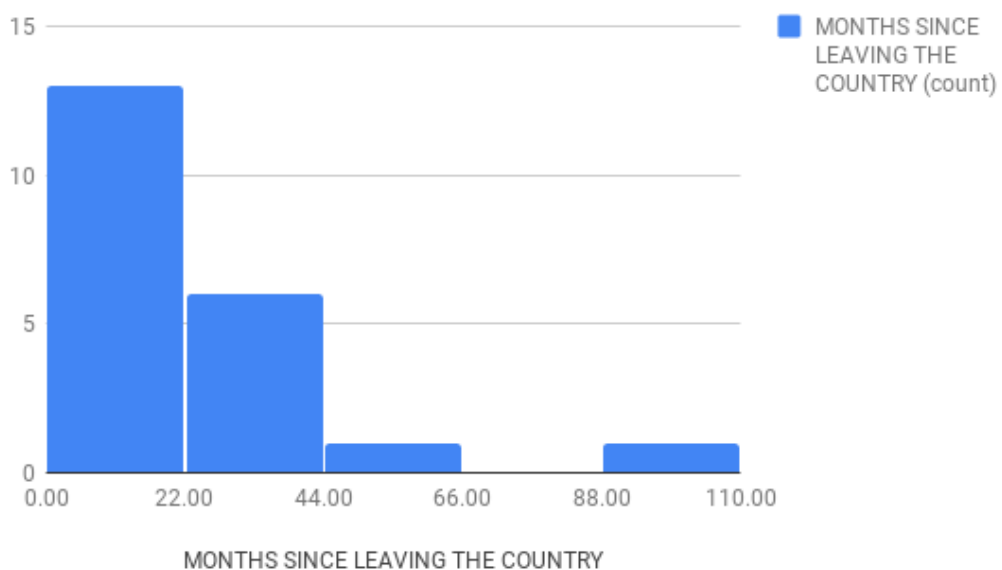
Once dividing the sample for different continents, the African victims are clearly overrepresented in the sample, achieving the 72% of the victims evaluated in the two cities, though most of the Nigerian victims where in Barcelona. All the African victims were able to communicate proficiently either in English or French depending of their country of origin. The whole group of American victims was from “*Latinamerica*”, different countries being represented, but all of them competent on Spanish language.

Count of CONTINENT

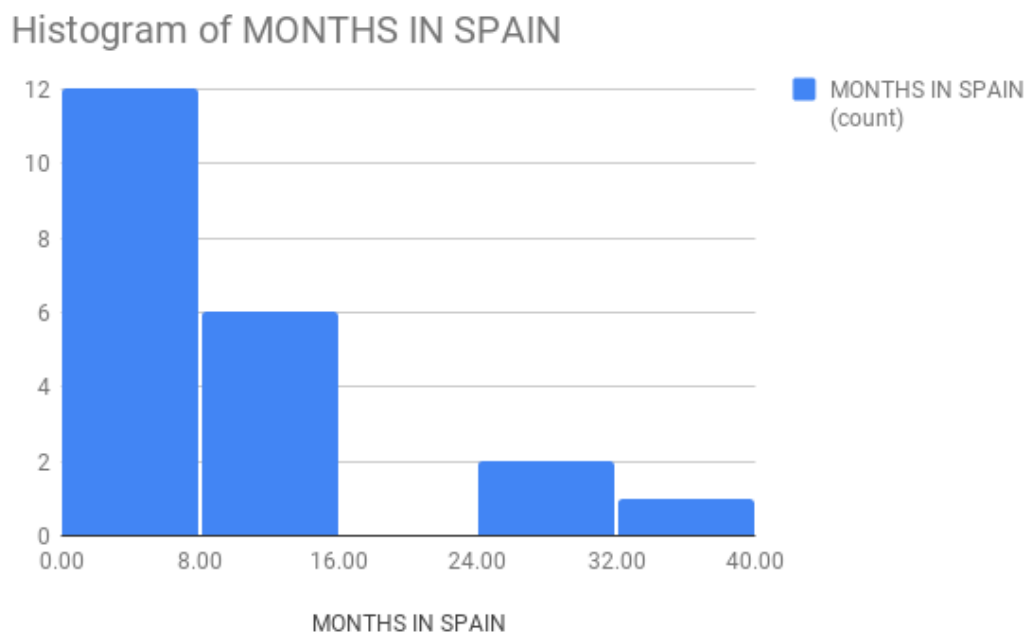


The average months since they have left their country was 21 months (range minimum 1 month and maximum 108 months) before the interview. There was a great variability related with the countries of origin, being very different the exit of the Latin-American ones with fast arrival to Spain through commercial flights in contrast with the long illegal African routes until the Mediterranean.

Histogram of MONTHS SINCE LEAVING THE COUNTRY

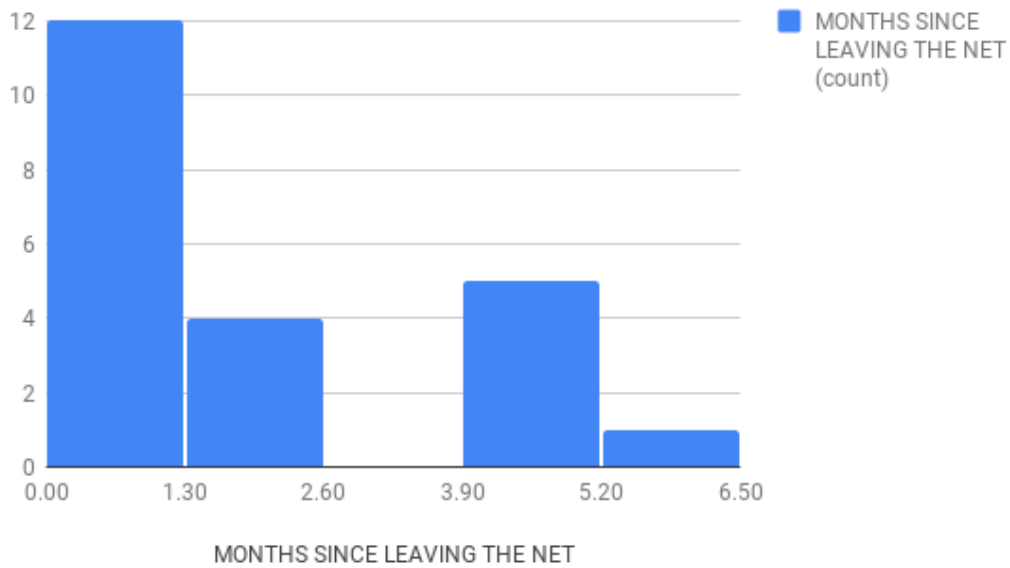


On the sample evaluated the average of time spent in Spain by the victims, therefore “exploited in the net”, before the exit from the extortion nets was 9.6 months (minimum 0.5 months to maximum 36 months).



At the period of the mental health evaluation, the victims had been out of the net and sheltered for 1.94 months average (min 0.25/max 6). The 6-month upper limit was a criterion of inclusion decided for the study to be able to assess, in terms of mental health, the impact after recent exit from trafficking.

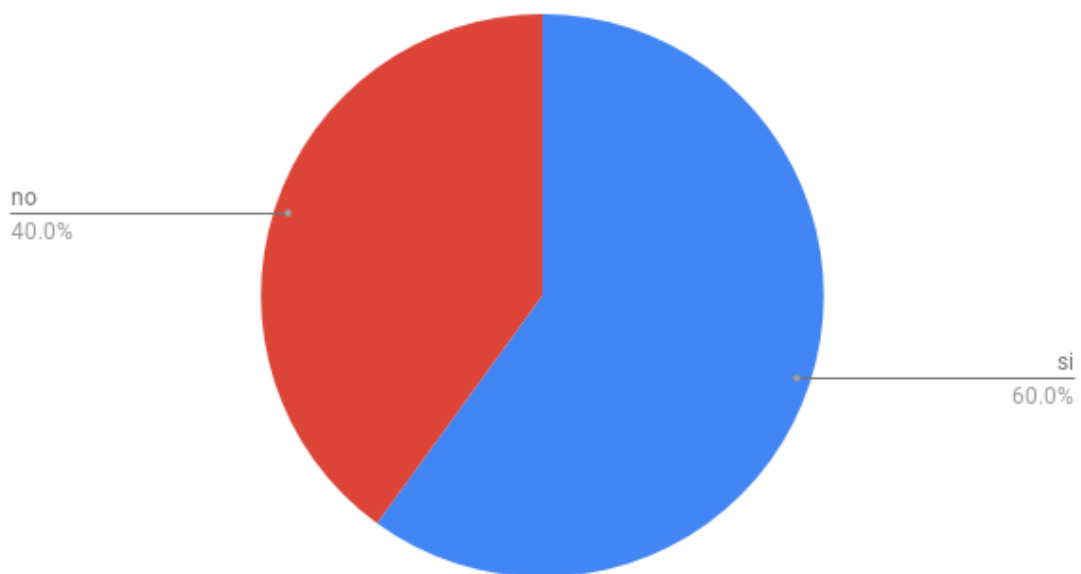
Histogram of MONTHS SINCE LEAVING THE NET



DIAGNOSTIC FINDINGS

60% of the victims evaluated met diagnostic criteria for the disorders evaluated in the MINI (DSM-IV criteria for mental disorders).

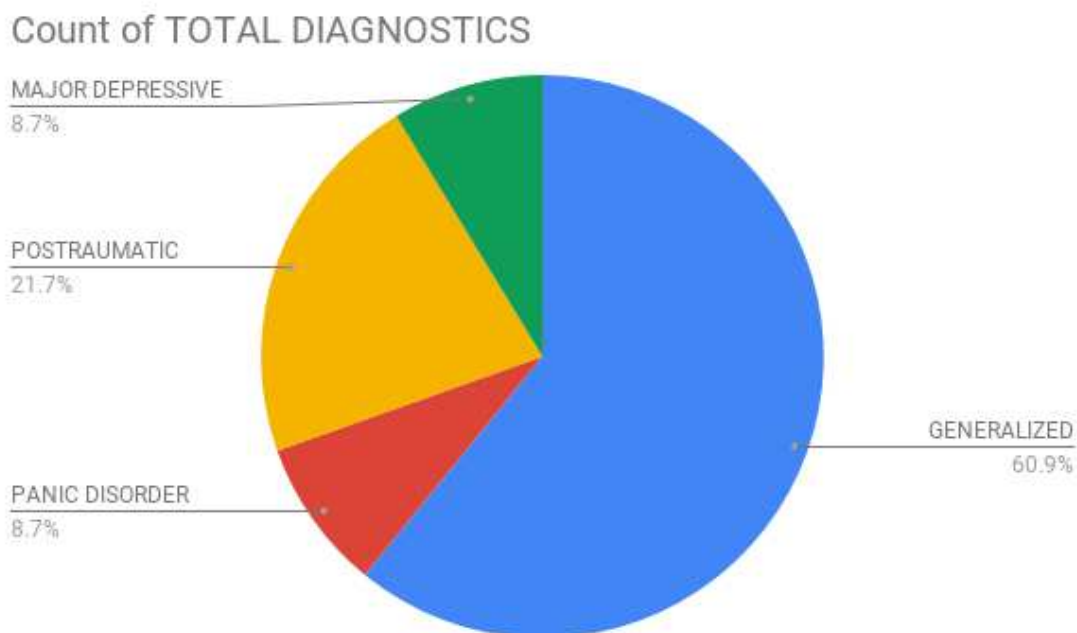
Count of MENTAL HEALTH DISORDER



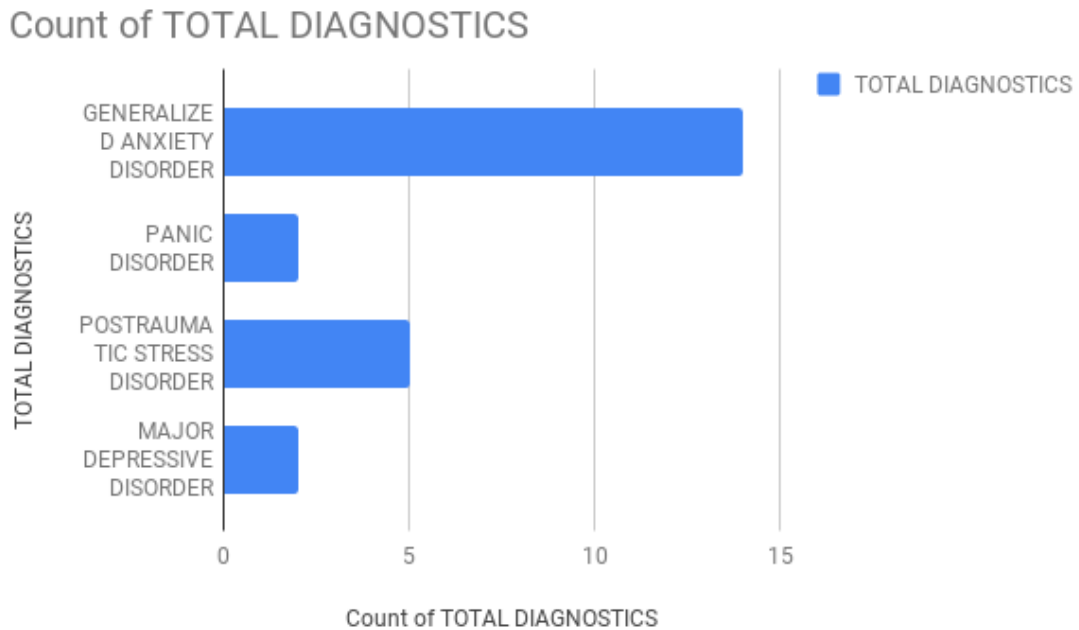
The most prevalent diagnostic was *Generalized Anxiety Disorder (GAD)*, representing more than 60% of the diagnostic disorders. The diagnoses found are among the 4 most present and expected. *Posttraumatic Stress Disorder (PTSD)* as the second most present diagnostic with 21.7%, *Major Depressive Disorder (MDD)* 8.7% and *Panic Disorder (PD)* 8.7%. The final representation of the diagnoses found is in line with the bibliographic review. In DSM-IV, GAD, PTSD and PD are classify in the Anxiety Disorders category, so 91.3% of the disorders found where ***Anxiety Disorders***.

No other disorders were found in this sample. Not any disorder was detected due to substance use, although there were some cases of past abuse of alcohol, but not meeting dependency criteria. No other abuse drugs were reported.

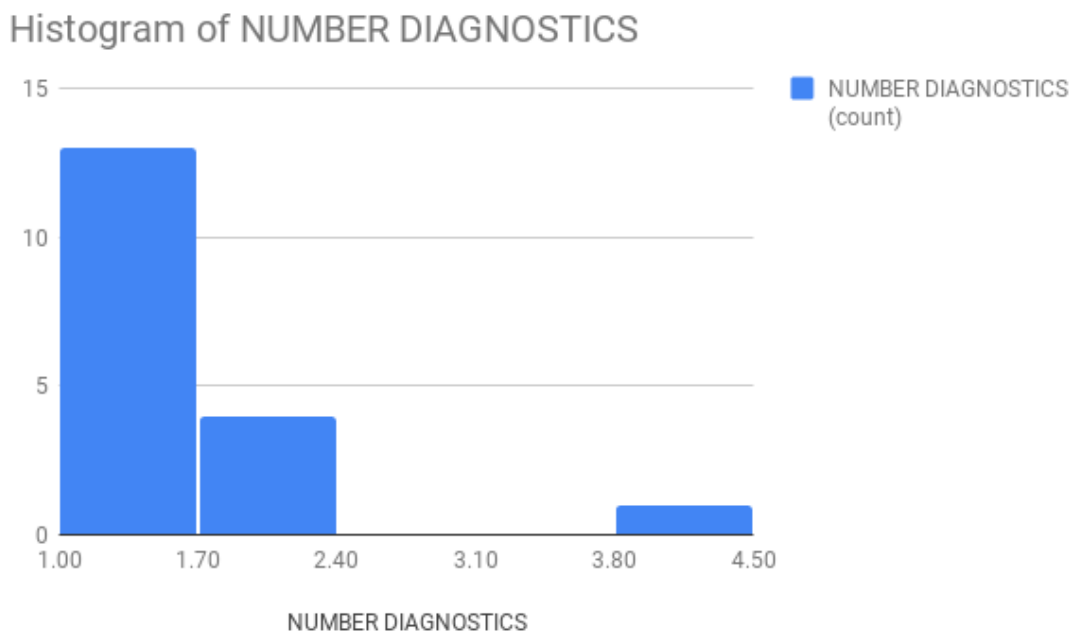
(Annex II DSM-IV Diagnostic Criteria)



In total numbers, GAD was present in 14 victims, followed by PTSD with 5 victims and finally 2 cases of each MDD and PD.



Comorbidity was present in 27.8% of the cases, meaning that those victims had minimum two or more comorbid disorders. For the other 72.2% of cases there was a single diagnostic.



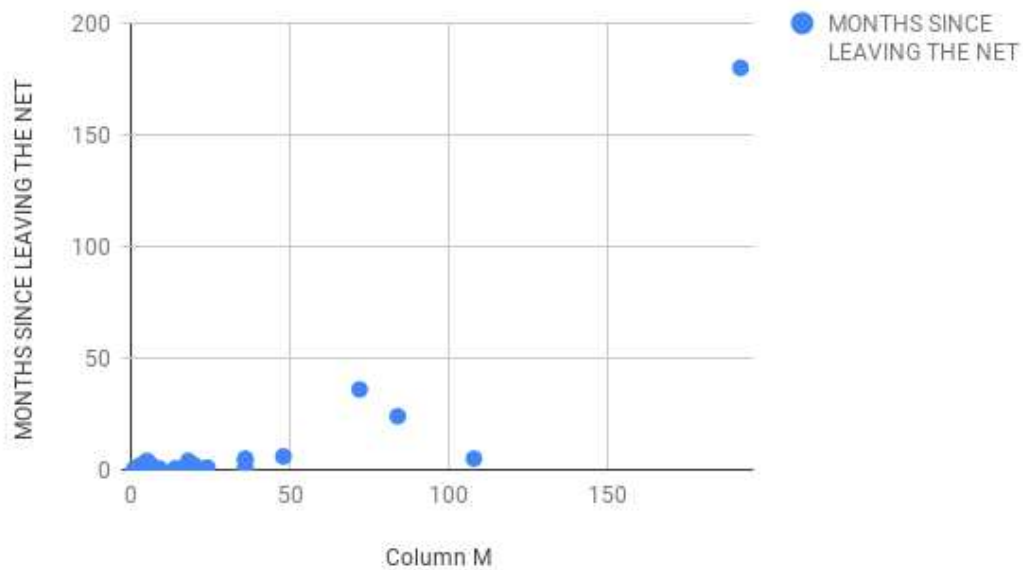
The most frequent presentation was of 2 diagnostic comorbid, though there was a case of one victim who accumulated the 4 different disorders found in the study.

If compared the presence of diagnosis versus non-presence with respect to the time spent by the victims in Spanish territory (in the net), the average number of months in Spain is clearly longer for those victims who have met diagnostic criteria. An average of 11.6 months for those who have pathology versus 6 months for those who do not.

<i>MENTAL HEALTH DISORDER</i>	<i>AVERAGE of MONTHS IN SPAIN</i>
no	6.03125
si	11.61538462
Grand Total	9.488095238

There is also a relationship between the time in months since the victims had gone out from the network and the presentation of the diagnoses. Most of the diagnoses accumulate in those victims who left the network recently when being evaluated.

Correlation of Column M, MONTHS SINCE LEAVING THE NET



And this relationship becomes more precise if we stratify by diagnosis. The victims who presented PTSD are less time out of the network once being evaluated (0.5 months average). On the other hand, the most prevalent diagnosis, that of GAD, occurs more frequently in victims who had left the network more months ago once being evaluated (2 months average).

<i>TOTAL DIAGNOSTICS</i>	AVERAGE of MONTHS SINCE LEAVING THE NET
	3.1
GENERALIZED ANXIETY DISORDER	2.022727273
MAJOR DEPRESSIVE DISORDER	1
PANIC DISORDER	1.25
POSTRAUMATIC STRESS DISORDER	0.5
Grand Total	1.943181818

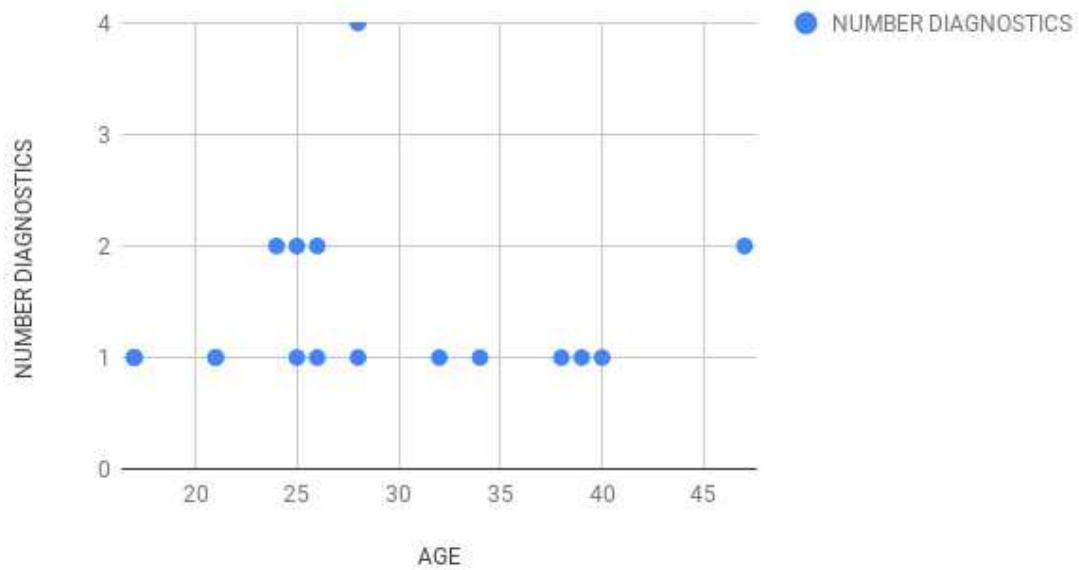
If we go further in time, calculating since the victims left the country of origin, this relationship with the diagnoses is even more evident.

For the cases of PTSD, they are the victims that have left their countries less time ago, with an average of 10 months since they left home. On the other hand, for the other three diagnoses, the average time of appearance is 20 months after departure from origin.

<i>TOTAL DIAGNOSTICS</i>	AVERAGE of MONTHS SINCE LEAVING THE COUNTRY
	35
GENERALIZED ANXIETY DISORDER	20.1
MAJOR DEPRESSIVE DISORDER	24
PANIC DISORDER	19.5
POSTTRAUMATIC STRESS DISORDER	10.33333333
Grand Total	22.38095238

There were no differences based in the age or the origin of the victims and the presence of diagnosis, the diagnoses were distributed in all ages and origins.

Correlation of AGE, NUMBER DIAGNOSTICS



5. DISCUSSION

As the World Health Organization (WHO) reports regarding mental health of women; depression, anxiety, somatic symptoms and high rates of comorbidity are significantly related to interconnected and co-occurrent risk factors such as gender based roles, stressors and negative life experiences and events.

Gender specific risk factors for common mental disorders that disproportionately affect women include gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others.

The high prevalence of sexual violence to which women are exposed and the correspondingly high rate of Post Traumatic Stress Disorder (PTSD) following such violence render women the largest single group of people affected by this disorder.

The mental health impact of long term, cumulative psychosocial adversity has not been adequately investigated.

Sexual Trafficking has serious repercussions on the health of the women who have suffered it. The situations of violence, coercion and exploitation that they have experienced have consequence and damage their physical and mental health. Psychiatric disorders are the main comorbidity in this group.

This type of disorders can be difficult to diagnose since not all victims meet the diagnostic criteria for a psychiatric disorder, but almost all suffer emotional reactions and other psychological symptoms. According to the available literature reviewed and our findings, victims of sexual human trafficking have a high proportion of Depressive Disorders, Anxiety Disorders and Post Traumatic Stress Disorder.

In our study, there is a clear relationship with the presentation of the psychiatric disorders detected and the time exposed to the network and the long and traumatic migratory routes of women. The time factor is related to the "accumulation" of stressors and risk factors for mental health. The "Traumas" are multiple along the way.

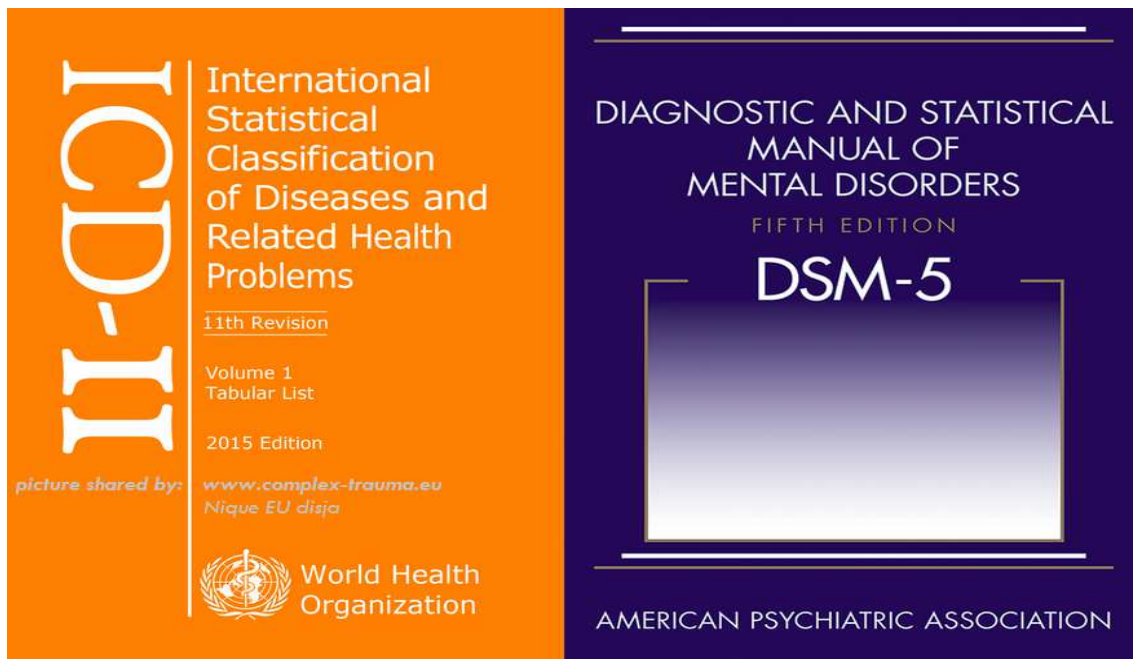
The initial presence of PTSD in the first months after leaving the trafficking decreases longitudinally. The explanation may be in the factors of resilience, in the first psychosocial interventions, and in the very idiosyncrasy of the disorder that is reactive to the traumas experienced and that in most cases will be solved progressively when its direct impact ends even if the memories remain. Then the evolution to the resolution of the disorder as the post-traumatic adaptive time passes in a safe context is the expected one in terms of psychopathology.

But on the other hand, the remarkable presence of GAD in the following months may indicate the chronification of anxiety. It is very relevant that these cases are diagnosed and reported, psychopathology that is not as visible and alarming as PTSD, but generates a very poor quality of life and perceived health for the victims.

Our data do not coincide with those published regarding the percentage of PTSD and MDD detected in other studies, being lower in this sample. Since literature is scarce, there are few studies available in this issue; and the sample is not large; we believe there are several things that might have marked this difference. It might be related to diagnostic process where criteria of the DSM-IV have been strictly applied by psychiatrist with long clinical experience and not only research experience. Also it might be related to culturally marked trends in the exercise of psychiatric practice that diverges in some way between USA and Europe. An example of that cultural bias would be the overrepresentation of PTSD diagnoses promoted largely in the North American and Anglo context. Finally, it is likely that determining that the evaluation should be carried out during the first six months after leaving the network has biased the diagnostics. This could apply for the low prevalence of depression that could increase over time, for example, but not for the lower prevalence of PTSD that should be expected in the first months.

What happens with the PTSD?

In the last few years, the diagnostic criteria of PTSD and its clinical presentation have changed. The diagnostic process has changed with the recent revisions of the DSM-V and the ICD-11 (*Annex III*).

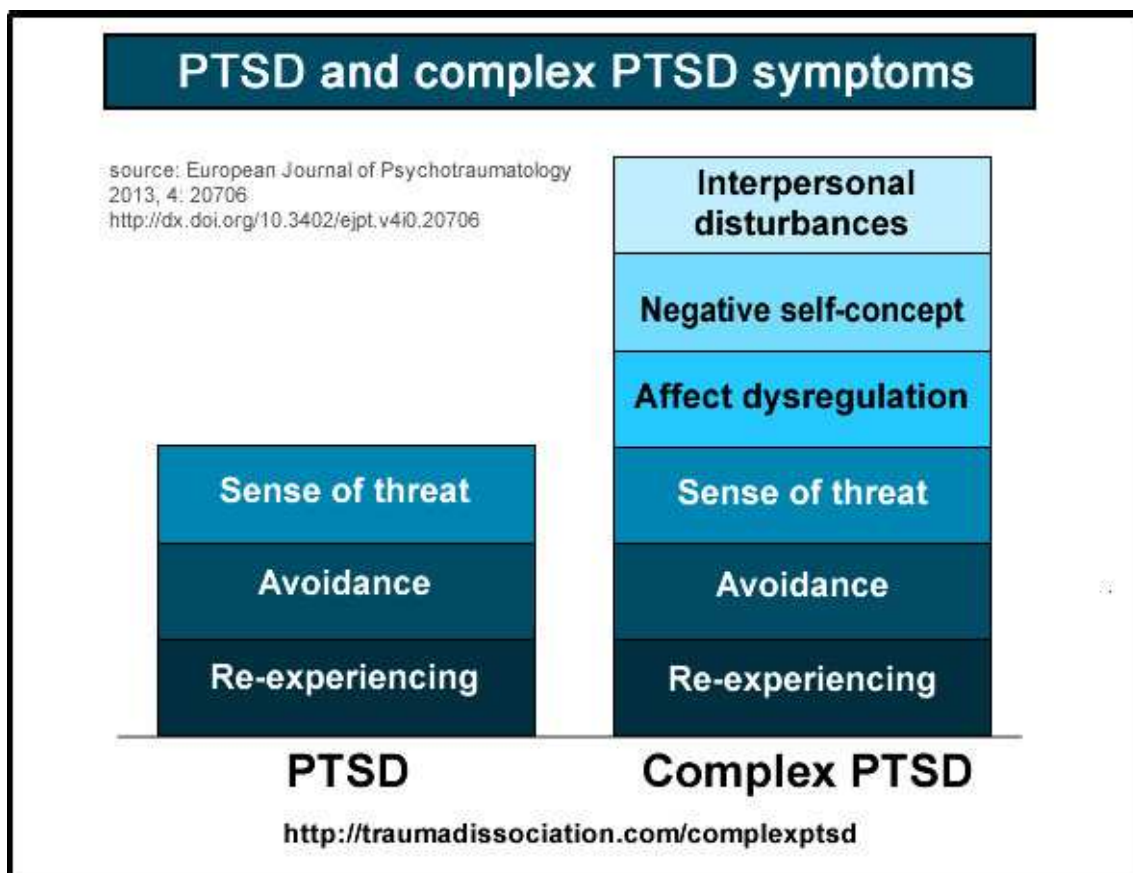


For the PTSD diagnosis, clinically and for research purposes, the DSM_IV criteria have been worldwide used, and currently the DSM-V criteria for its diagnosis will be used. But there are differences between the classification and vision of mental health disorders that are handled from the North American cultural model with the American Psychiatric Society (DSM_V) and the more European and Globalizing tendencies represented by the WHO (ICD-11).

For the victims of sexual traffic, the traumatic event is not only one single and abrupt event; there is an accumulation of stressful and traumatic live events from all the biopsychosocial aspects. For those women crossing all Africa in a dangerous and traumatic route till they reach Europe and the sex traffic starts, the accumulation of highly stressful and traumatic live events has been running for long time before. In many cases, the DSM criteria for PTSD seem to be insufficient, incomplete, to explain the psychiatric impact on some victim's psychological disfunction. The comorbidity within the anxiety disorders, the chronification of some symptoms that persist beyond the first months after adaptation, all this suggests that there should be a different diagnostic category that explains the complexity of these clinical

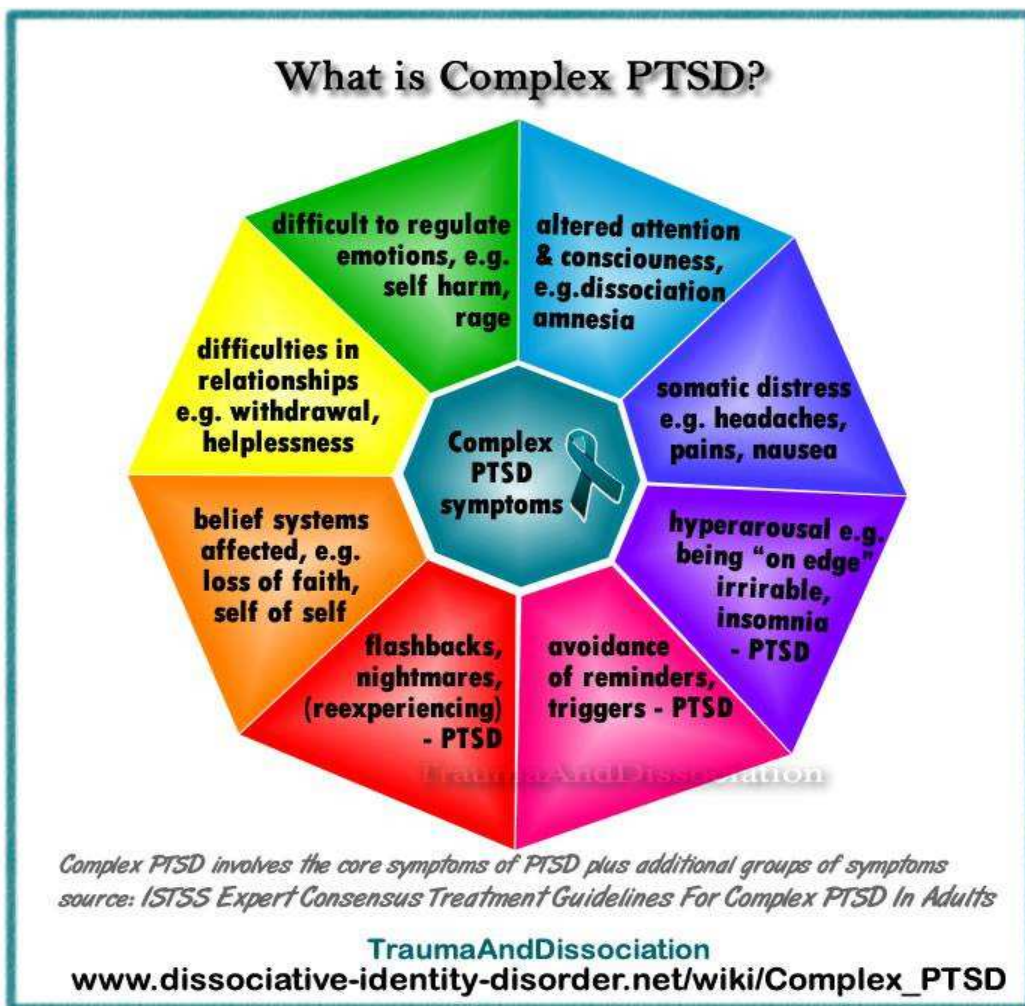
cases, and this option responds better to the model presented by the Complex PTSD from the ICD-11.

The ICD-11 CPTSD identifies a distinct group who have more often experienced multiple and sustained traumas and have greater functional impairment than those with PTSD. The current diagnostic consensus of the Complex PTSD of the ICD-11 (WHO) allows distinguishing between two types of post-traumatic stress disorder, something that DSM does not allow. The core symptoms do not differ, being present and necessary for the diagnosis of both posttraumatic stress disorders. Complex PTSD differs in that it adds other symptoms in the affective, interpersonal and self-concept. These symptoms would be present in the complex but not in the classic one.

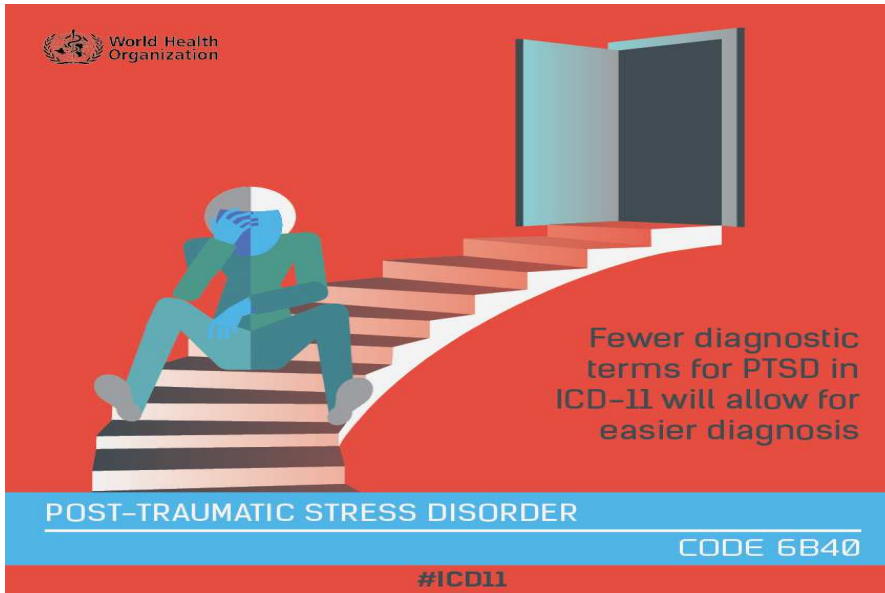


Victims evaluated who met criteria for PTSD DSM version would have met criteria in the ICD11 classification, but others might have gone missing if using ICD-11 category since the complex affective and interpersonal difficulties are not collected or clinically captured in the current diagnosis category of DSM_IV_V. But at the time of the study the ICD_11 had not yet been formally published and there were not structured clinical interviews available following the diagnostic categories in ICD format.

Being able to capture and diagnose Complex PTSD is relevant since the clinical intervention will be more complex in the complex trauma. Further research is needed regarding the psychological and psychopharmacological therapies to understand and improve the clinical management of these patients.



The first steps have been carried out with the publication of ICD-11 (June 2018). This manual should facilitate the clinical assistance of patients by simplifying and improving the diagnosis of the disorder.



6. SUGGESTIONS

Programs to address trafficking in persons must include interventions (such as psychosocial support) to improve the mental health status of the survivors, as well as addressing the areas of general health, occupational health, economic and legal support during the intervention.

Victims of trafficking suffer serious effects on their physical, mental and social health as a result of the exploitation situation to which they have been subjected. And they need, for their recovery, an adequate diagnosis and specific treatment by specialized and sensitized professionals.

The stigma towards mental pathology, both in the victims and in the non-health professionals who care for them, delays the consultation and access to mental health services. It is very important to overcome this stigma so that women who need this mental health care can be treated on the same way they would be in other aspects of health.

Early interventions and referrals to mental health care facilities should be done, thereby reducing the burden of disease accumulated in anxiety disorders, and thus the process of psychosocial insertion. Decreasing and

healing anxiety and PTSD conditions would facilitate the interventions aimed at promoting mechanisms of resilience and psychological well-being that would not be approachable if there is active mental health pathology.

Many women treated have been subjected to physical and psychological violence, so many of the symptoms expressed are of a somatic nature. It is important to do an interrogation focused on the detection of psychological symptoms in order to reach a diagnosis correctly and analyze it in depth to determine where to guide the treatment. As saw in the literature, there are many nonspecific physical and mental symptoms, and perhaps in the first interviews they use to express just somatic distress. Trust needs to be built slowly with victims, as they may not have been able to trust people around them. It is important to be aware that sometimes health professionals failed to discern the unique and variable features of the physical and psychological trauma and the culturally different ways these are experienced or expressed by the victims.

Survivors of sex trafficking can recover physically and psychologically if they are able to access appropriate and culturally sensitive services and resources. Mental health professionals and NGO workers should offer culturally sensitive care to victims. This includes installing them in "safe houses" and improving their access to mental health services. In addition, mental health professionals must be trained to treat the symptoms of traumas and mental illnesses of the victims within a cultural, linguistic and religious context.

The mental health care system should be appropriate within a specific cultural, linguistic and / or religious context. Able to reach the victims (outreach). Ideally prepared to attend from a clinical point of view that includes training and sensitivity in Transcultural Psychiatry, Cultural Competence and attention to mental health of vulnerable groups at risk of social exclusion with a cross-cultural and gender perspective.

It should have an integrative approach, capable of globally satisfying the needs of victims. Focused on reducing the psychological effects of trauma, strengthen resilience and empowerment skills. Physicians should receive

training in working with victims of trauma, especially sexual and interpersonal trauma.

Often victims mistrust people who work in institutions, and this makes that the interventions turn very difficult. A systemic way of responding to victims of trafficking includes all of the systems involved in their contexts, including judicial, law enforcement, health care, education, family, etc. All members of these responding communities need to be trained in the signs and symptoms this population may show, and in the assistance of trafficking victims and survivors.

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8. ANNEXES

ANNEX I

SEPTEMBER 2018

PSYCHOPATHOLOGICAL EVALUATION OF FEMALE VICTIMS OF HUMAN TRAFFIC FOR SEXUAL EXPLOITATION

Cross-sectoral collaboration at The
European project “Psychological Health
Impact of Trafficking in Human Beings on
female victims” (PHIT)

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01/09/201



Introducción

Según las Naciones Unidas, la trata de seres humanos se define como el reclutamiento, transporte, traslado, alojamiento o recepción de personas por medio de amenaza, uso de la fuerza, coacción, rapto, fraude, engaño, del abuso de poder o de una posición de vulnerabilidad, entrega o recepción de pagos o beneficios para lograr el consentimiento de una persona que tiene control sobre otra persona con fines de explotación (ONU, 2000). Las estadísticas sobre este problema son poco confiables, pero la Oficina de las Naciones Unidas contra la Droga y el Delito (UNODC) estima que 21 millones de personas son víctimas de la trata en todo el mundo, 80% son mujeres y el 75% tienen menos de 25 años. Aunque la mayoría de las víctimas de la trata son objeto de explotación sexual (53%), cada vez se detectan con más frecuencia otras formas de explotación. La trata con fines de trabajo forzoso (40%) incluye, por ejemplo, los sectores de fabricación, limpieza, construcción, restauración, trabajo doméstico y producción textil ha aumentado de manera incesante en los últimos años. Se observan diferencias regionales notables en cuanto a las formas de explotación. Mientras que en Europa y Asia Central la trata con fines de explotación sexual es la principal forma detectada, en Asia Oriental y el Pacífico es la explotación con fines de trabajo forzoso. En América se detectan porcentajes casi idénticos de ambos tipos de trata. Además, aproximadamente la mitad de las víctimas de la trata detectadas son mujeres adultas. Aunque esta proporción ha disminuido considerablemente en los últimos años, en parte se ha visto compensada por el aumento del número de niñas identificadas como víctimas (UNODC, 2014).

SALUD MENTAL EN LAS VÍCTIMAS DE TRATA

La trata de seres humanos tiene graves repercusiones en la salud de las personas que la han sufrido. Las situaciones de violencia, coacción y explotación que han vivido tienen como consecuencia trastornos y daños sobre la salud física y mental. Sin embargo, poco sabemos sobre la salud mental de las mujeres víctimas de trata, sin embargo se conoce que los trastornos de psiquiátricos son la principal comorbilidad en este colectivo. Se ha reportado que los grupos de mujeres forzadas a realizar trabajos sexuales tienen mayor riesgo de sufrir trastornos mentales (Tsutsumi et al. 2008). Este tipo de alteraciones pueden ser difíciles de diagnosticar, ya que no todas las víctimas cumplen los criterios diagnósticos para un trastorno psiquiátrico, pero casi todas sufren reacciones emocionales y otros síntomas psicológicos (Williamson et al.).

Las víctimas de trata de personas tienen una alta proporción de depresión, ansiedad y Trastorno por Estrés Posttraumático (TEPT), se ha observado que casi el 40% de quienes presentan síntomas depresivos, también presentan ideación suicida en el último mes (Tsutsumi et al. 2008; Zimmerman et al. 2008; Hossain et al. 2010).

De igual forma, la prevalencia de molestias somáticas en este colectivo es muy alta, manifestando dolor de cabeza, fatigabilidad, mareo, dolor de espalda, dificultades en la memoria, dolor de estómago, dolor pélvico e infecciones ginecológicas recurrentes, así como

tasas más altas de VIH en las víctimas de explotación sexual (Zimmerman et al. 2008; Tsutsumi et al. 2008).

Los resultados de varios estudios sugieren que los programas para atender la trata de personas deben incluir intervenciones (como apoyo psicosocial) para mejorar el estado de salud mental de los supervivientes, además de atender las áreas de salud general, ocupacional, soporte económico y jurídico durante la intervención.

Las víctimas de trata sufren graves efectos en su salud física, mental y social como consecuencia de la situación de explotación a la que han estado sometidas. Y precisan, para su recuperación, un adecuado diagnóstico y tratamiento específico por parte de profesionales especializados y sensibilizados.

Muchas mujeres tratadas han sido sometidas a violencia física y psicológica, por lo que muchos de los síntomas expresados son de carácter somático. Es importante hacer un interrogatorio enfocado en la detección de síntomas psicológicos para poder llegar a un diagnóstico correctamente y analizarlo en profundidad para determinar hacia donde orientar el tratamiento.

OBJETIVO

Identificar la presencia de psicopatología en mujeres víctimas de trata con fines de explotación sexual .

METODOLOGÍA

En la entrevista se recogerán datos sociodemográficos básicos, previendo que la historia personal en relación al evento de trata del cual ha sido víctima la paciente, ya ha sido recogido por personal especializado; así como antecedentes psiquiátricos familiares y personales, así como uso de sustancias y alcohol. Por último, se pasarán las subescalas de la Entrevista Neuropsiquiátrica Internacional (MINI) de Episodio Depresivo Mayor, Riesgo de Suicidio, Trastorno de Angustia, Trastorno por Estrés Postraumático y Trastorno de Ansiedad Generalizada; además de la subescala de somatizaciones del Cuestionario de Salud General de Goldberg (GHQ-28).

INSTRUMENTOS

ENTREVISTA NEUROPSIQUIÁTRICA INTERNACIONAL (MINI). La MINI (Mini Entrevista Neuropsiquiátrica Internacional) es una entrevista breve y altamente estructurada de los

principales trastornos psiquiátricos de la CIE-10 y DSM-IV para ser empleado por psiquiatras y médicos no psiquiatras después de un corto tiempo de entrenamiento. Fue elaborada por Y. Lecrubier y col. de la “Salpêtrière” de París y D. Sheehan y col. de la universidad de Florida en Tampa en los años 1992, 1994 y 1998. La MINI se diseñó para generar diagnósticos de la CIE-10, pero también del DSM-IV. La MINI es una entrevista clínica, disponible en 33 idiomas, estructurada en formato y algoritmos, modular por categorías diagnósticas, con una duración de entre 15 y 20 minutos, fiable (3 estudios frente a CIDI y SCID) y fácil de usar tras un breve curso de formación.

CUESTIONARIO DE SALUD GENERAL DE GOLDBERG (GHQ). Es un cuestionario autoadministrado, creado por Goldberg en 1979, que evalúa el estado de salud general de la persona en dos tipos de fenómenos: la incapacidad para seguir llevando a cabo las funciones saludables normales y la aparición de nuevos fenómenos de malestar psíquico. Su objetivo no es realizar un diagnóstico pero sí detectar trastornos psicológicos en ambientes no psiquiátricos. La versión original tiene 60 ítems, pero existen varias versiones. La versión original consta de un factor general referido a síntomas somáticos y factores específicos (depresión, ansiedad, sueño, somáticos y funcionamiento social). El GHQ-28, contiene 4 subescalas de 7 ítems cada una. Las 4 subescalas miden: subescala A (síntomas somáticos), subescala B (ansiedad e insomnio), subescala C (disfunción social) y subescala D (depresión grave).

ENTREVISTA DE SALUD MENTAL

Fecha

Nombre completo

Edad

1. **Situación Legal** Irregular, sin permiso de residencia
2. Permiso de Residencia sin Trabajo
3. Permiso de Residencia con Trabajo
4. Nacionalidad Española

ID proyecto

Instancia de Referencia

Lugar de nacimiento

Nacionalidad

Lengua materna

Idiomas que habla (español, inglés, francés, especificar).

1. **Situación Documentación** Sin permiso de residencia ni nacionalidad (“sin papeles”)
2. Con permiso de residencia y/o nacionalidad

Tiempo de Acogida/salida de la Red

Tiempo residencia en España (en meses)

Tiempo desde que salió País de Origen (en meses)

Método Migratorio

(Recoger cualitativamente preguntando por mafias, patera, visado...).

Escolarización Estudios Completados:

1. Ninguno
 2. Primarios (hasta 12 años)
 3. Secundarios (de 12 a 16 años)
 4. Bachillerato (16 a 18 años)
 5. Formación Profesional
 6. Titulación Universitaria
1. **Situación laboral actual** Empleada (especificar) _____
 2. Estudiante (especificar) _____
 3. Desempleada
 1. **Ingresos Económicos** Sin ingreso alguno
 2. Prestación económica gobierno (PIRMI; otras)
 3. Ingresos derivados actividad laboral
 4. Paro
 1. **Situación Residencial** Casa de Acogida/Piso acogida
 2. Vive por cuenta propia
 3. Sin domicilio

Número de Hijos

ANTECEDENTES PSIQUIÁTRICOS FAMILIARES

1. ¿Sabes si alguno de tus padres o hermanos tiene alguna enfermedad de los nervios/ mental? Especificar
2. ¿Toma algún medicamento por esta causa?

3. ¿Ha estado hospitalizado por esta causa?
4. ¿Sabes si alguno de tus padres o hermanos tiene algún problema con su consumo de drogas o alcohol? Especificar

1. **ANTECEDENTES PERSONALES PSIQUIÁTRICOS** ¿Tú tienes algún problema de los nervios? ¿Sabes cómo se llama lo que te ocurre?
2. ¿Te ha visto algún médico (psiquiatra o psicólogo) por este motivo? ¿Has estado hospitalizado por este motivo? ¿Cuándo?
3. ¿Has tomado medicinas para esto? Especificar

1. **ANTECEDENTES PERSONALES DE USO DE DROGAS Y ALCOHOL** ¿Durante el último año, estuviste preocupada por tu uso de bebidas alcohólicas, por consumir drogas como marihuana, o tomar medicinas/medicamentos no recetados o más de lo recetado?

- a) Si
- b) No

2. ¿Algunas veces, bebiste alcohol, usaste drogas o medicinas/medicamentos más de lo que habías planeado?

- a) Si
- b) No

3. ¿Sentiste la necesidad de beber más alcohol, de usar más drogas, o de usar más medicinas/medicamentos para obtener el mismo efecto que antes, cuando las usabas menos?

- a) Si
- b) No

4. ¿Durante el último año, algunas veces bebiste alcohol, usaste drogas, o medicinas/medicamentos para tratar de cambiar cómo te sentías?

- a) Si

b) No

5. ¿Intentaste dejar de beber alcohol, dejar de consumir drogas, o medicinas/medicamentos, pero no lo lograste?

a) Si

b) No

6. ¿Has experimentado problemas causados por beber demasiado alcohol, por utilizar drogas o medicinas/ medicamentos recetados y, aún así, seguiste tomándolos o usándolos?

a) Si

b) No

**A. PASAJIÓN DE LA MINI ENTREVISTA NEUROPSIQUIÁTRICA INTERNACIONAL
EPISODIO DEPRESIVO MAYOR**

A1 ¿En las últimas 2 semanas, se ha sentido deprimido o decaído la mayor parte del día, casi todos los días?

NO

SÍ

A2 ¿En las últimas 2 semanas, ha perdido el interés en la mayoría de las cosas o ha disfrutado menos de las cosas que usualmente le agradaban?

NO

SÍ

¿CODIFICÓ SÍ EN A1 O EN A2?

A. Episodio depresivo mayor A3 En las últimas 2 semanas, cuando se sentía deprimido o sin interés en las cosas:

a ¿Disminuyó o aumentó su apetito casi todos los días? ¿Perdió o ganó peso sin intentarlo (p. ej., variaciones en el último mes de \pm 5% de su peso corporal o \pm 8 libras o \pm 3,5 kg, para una

persona de 160 libras/70 kg)?

NO

SÍ

CODIFICAR sí, SI CONTESTÓ SÍ EN ALGUNA

b ¿Tenía dificultad para dormir casi todas las noches (dificultad para quedarse dormido, se despertaba a media noche, se despertaba temprano en la mañana o dormía

excesivamente)?

NO

SÍ

c ¿Casi todos los días, hablaba o se movía usted más lento de lo usual, o estaba inquieto o tenía dificultades para permanecer tranquilo?

NO

SÍ

d ¿Casi todos los días, se sentía la mayor parte del tiempo fatigado o sin energía?

NO

SÍ

e ¿Casi todos los días, se sentía culpable o inútil?

NO

SÍ

f ¿Casi todos los días, tenía dificultad para concentrarse o tomar decisiones?

NO

SÍ

g ¿En varias ocasiones, deseó hacerse daño, se sintió suicida, o deseó estar muerto?

NO

SÍ

C. Riesgo de suicidio Durante este último mes: Puntos:

C1 ¿Ha pensado que estaría mejor muerto, o ha deseado estar muerto?

NO

SÍ 1

C2 ¿Ha querido hacerse daño?

NO

SÍ 2

C3 ¿Ha pensado en el suicidio?

NO

SÍ 6

C4 ¿Ha planeado cómo suicidarse?

NO

SÍ 10

C5 ¿Ha intentado suicidarse?

NO

SÍ 10

A lo largo de su vida:

C6 ¿Alguna vez ha intentado suicidarse?

NO

SÍ 4

¿CODIFICÓ SÍ EN POR LO MENOS 1 RESPUESTA?

¿CODIFICÓ SÍ EN POR LO MENOS 1 RESPUESTA?

SI SÍ, SUME EL NÚMERO TOTAL DE PUNTOS DE LAS RESPUESTAS (C1-C6)

RODEAR CON UN CÍRCULO «SÍ» Y ESPECIFICAR EL NIVEL DE RIESGO

DE SUICIDIO

E. Trastorno de angustia

E1 a ¿En más de una ocasión, tuvo una crisis o ataques en los cuales se sintió súbitamente ansioso, asustado, incómodo o inquieto, incluso en situaciones en la cual la mayoría de las personas no se sentirían así?

NO

SÍ

b ¿Estas crisis o ataques alcanzan su máxima expresión en los primeros 10 minutos?

NO

SÍ

E. Trastorno de angustia E2 ¿Alguna vez estas crisis o ataques o ocurrieron de una manera inesperada o espontánea u ocurrieron de forma impredecible o sin provocación?

NO

SÍ

E3 ¿Ha tenido una de estas crisis seguida por un período de un mes o más en el que temía

que otro episodio recurriera o se preocupaba por las consecuencias de la crisis?

NO

SÍ

E4 Durante la peor crisis que usted puede recordar:

a ¿Sentía que su corazón le daba un vuelco, latía más fuerte o más rápido?

NO

SÍ

b ¿Sudaba o tenía las manos húmedas?

NO

SÍ

c ¿Tenía temblores o sacudidas musculares?

NO

SÍ

d ¿Sentía la falta de aliento o dificultad para respirar?

NO

SÍ

e ¿Tenía sensación de ahogo o un nudo en la garganta?

NO

SÍ

f ¿Notaba dolor o molestia en el pecho?

NO

SÍ

g ¿Tenía náuseas, molestias en el estómago o diarreas repentinas? NO

SÍ

h ¿Se sentía mareado, inestable, aturdido o a punto de desvanecerse?

NO

SÍ

i ¿Le parecía que las cosas a su alrededor eran irreales, extrañas, indiferentes, o no le parecían familiares, o se sintió fuera o separado de su cuerpo o de partes de su cuerpo?

NO

SÍ

j ¿Tenía miedo de perder el control o de volverse loco?

NO

SÍ

k ¿Tenía miedo de que se estuviera muriendo?

NO

SÍ

l ¿Tenía alguna parte de su cuerpo adormecida o con hormigueos? NO

SÍ

m ¿Tenía sofocaciones o escalofríos?

NO

SÍ

E5 ¿CODIFICÓ SÍ EN E3 Y EN POR LO MENOS 4 DE E4? NO SÍ

Trastorno de angustia

de por vida

E6 SI E5 = NO, ¿CODIFICÓ SÍ EN ALGUNA RESPUESTA DE E4?

NO

SÍ

Crisis actual

E7 ¿En el pasado mes, tuvo estas crisis en varias ocasiones (2 o más), seguidas de miedo persistente a tener otra?

NO

SÍ 18

Trastorno de angustia actual

I. Estado por estrés postraumático I1 ¿Ha vivido o ha sido testigo de un acontecimiento extremadamente traumático, en el cual otras personas han muerto y/u otras personas o usted mismo han estado amenazadas de muerte o en su integridad física?

NO

SÍ

EJEMPLOS DE ACONTECIMIENTOS TRAUMÁTICOS: ACCIDENTES GRAVES,
ATRACO, VIOLACIÓN, ATENTADO TERRORISTA, SER TOMADO DE REHÉN,
SECUESTRO, INCENDIO, DESCUBRIR UN CADÁVER, MUERTE SÚBITA
DE ALGUIEN CERCANO A USTED, GUERRA O CATÁSTROFE NATURAL

I2 ¿Durante el pasado mes, ha revivido el evento de una manera angustiada (p. ej., lo ha soñado, ha tenido imágenes vívidas, ha reaccionado físicamente o ha tenido memorias intensas)?

NO

SÍ

I3 En el último mes:

a ¿Ha evitado usted pensar en este acontecimiento, o en todo aquello que se lo pudiese recordar?

NO

SÍ

b ¿Ha tenido dificultad recordando alguna parte del evento?

NO

SÍ

c ¿Ha disminuido su interés en las cosas que le agradaban o en las actividades sociales?

NO

SÍ

d ¿Se ha sentido usted alejado o distante de otros?

NO

SÍ

e ¿Ha notado que sus sentimientos están adormecidos?

NO

SÍ

f ¿Ha tenido la impresión de que su vida se va a acortar debido a este trauma o que va a morir antes que otras personas?

NO

SÍ

¿CODIFICÓ SÍ EN 3 O MÁS RESPUESTAS DE I3?

NO

SÍ

Durante el último mes:

a ¿Ha tenido usted dificultades para dormir?

NO

SÍ

b ¿Ha estado particularmente irritable o le daban arranques de coraje?

NO

SÍ

c ¿Ha tenido dificultad para concentrarse?

NO

SÍ

d ¿Ha estado nervioso o constantemente en alerta?

NO

SÍ

e ¿Se ha sobresaltado fácilmente por cualquier cosa?

NO

SÍ

¿CODIFICÓ SÍ EN 2 O MÁS RESPUESTAS DE I3?

NO

SÍ

I5 ¿En el transcurso de este mes, han interferido estos problemas en su trabajo, en sus actividades sociales o han sido causa de gran ansiedad?

NO

SÍ

O. Trastorno de ansiedad generalizada O1 a ¿Se ha sentido excesivamente preocupado o ansioso debido a varias cosas durante los últimos 6 meses?

NO

SÍ

b ¿Se presentan estas preocupaciones casi todos los días?

NO

SÍ

CODIFICAR SÍ, SI LA ANSIEDAD DEL PACIENTE ES RESTRINGIDA

EXCLUSIVAMENTE, O MEJOR EXPLICADA POR CUALQUIERA

DE LOS TRASTORNOS PREVIAMENTE DISCUTIDOS.

NO

SÍ 3

O2 ¿Le resulta difícil controlar estas preocupaciones o interfieren para concentrarse en lo que hace?

NO

SÍ

O3 CODIFIQUE NO SI LOS SÍNTOMAS SE LIMITAN A RASGOS DE CUALQUIERA DE LOS

TRASTORNOS PREVIAMENTE EXPLORADOS.

En los últimos 6 meses cuando estaba ansioso, casi todo el tiempo:

a ¿Se sentía inquieto, intranquilo o agitado?

NO

SÍ

b ¿Se sentía tenso?

NO

SÍ

c ¿Se sentía cansado, flojo o se agotaba fácilmente?

NO

SÍ

d ¿Tenía dificultad para concentrarse, o notaba que la mente se le quedaba en blanco?

NO

SÍ

e ¿Se sentía irritable?

NO

SÍ

f ¿Tenía dificultad durmiendo (dificultad para quedarse dormido, se despertaba a media noche o demasiado temprano, o dormía en exceso)?

NO

SÍ

¿CODIFICÓ SÍ EN 3 O MÁS RESPUESTAS DE O3?

1. **SUBESCALA DE SOMATIZACIONES DEL GHQ-28** ¿Se ha sentido perfectamente bien de salud y en plena forma?

0 Mejor que lo habitual

1 Peor que lo habitual

2 Igual que lo habitual

3 Mucho peor que lo habitual

2. ¿Ha tenido la sensación de que necesitaba un reconstituyente?

0 No, en absoluto

1 Bastante más que lo habitual

2 No más que lo habitual

3 Mucho más que lo habitual

3. ¿Se ha sentido agotado y sin fuerzas para nada?

0 No, en absoluto

1 Bastante más que lo habitual

2 No más que lo habitual

3 Mucho más que lo habitual

4. ¿Ha tenido la sensación de que estaba enfermo?

0 No, en absoluto

1 Bastante más que lo habitual

2 No más que lo habitual

3 Mucho más que lo habitual

5. ¿Ha padecido dolores de cabeza?

0 No, en absoluto

1 Bastante más que lo habitual

2 No más que lo habitual

3 Mucho más que lo habitual

6. ¿Ha tenido sensación de opresión en la cabeza, o de que la cabeza le va a estallar?

0 No, en absoluto

1 Bastante más que lo habitual

2 No más que lo habitual

3 Mucho más que lo habitual

7. ¿Ha tenido oleadas de calor o escalofríos?

0 No, en absoluto

1 Bastante más que lo habitual

2 No más que lo habitual

3 Mucho más que lo habitual

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ANNEX II

DSM-IV-TR Criteria for Posttraumatic Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
 - (2) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
- (3) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (4) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
 - (5) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience; illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
 - (6) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
 - (7) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (8) Efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (9) Efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (10) Inability to recall an important aspect of the trauma
 - (11) Markedly diminished interest or participation in significant activities
 - (12) Feeling of detachment or estrangement from others
 - (13) Restricted range of affect (e.g., unable to have loving feelings)
 - (14) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal lifespan)
- D. D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) Difficulty falling or staying asleep
 - (2) Irritability or outbursts of anger
 - (3) Difficulty concentrating
 - (4) Hypervigilance
 - (5) Exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

Diagnostic criteria for Generalized anxiety disorders DSM-IV

- A. Excessive anxiety and worry (apprehensive expectation), occurring on more days than not for at least 6 months, about a number of events or activities (such as work or school performance)
- B. The person finds it difficult to control the worry
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note that only one item is required in children
 - 1. Restlessness or feeling keyed up or on edge
 - 2. Being easily fatigued
 - 3. Difficulty concentrating or mind going blank
 - 4. Irritability
 - 5. Muscle tension
 - 6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g. the anxiety or worry is not about having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), being contaminated (as in obsessive–compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during PTSD
- E. The anxiety, worry or physical symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning
- F. The disturbance is not caused by the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder

Diagnostic criteria for Panic Disorder DSM-IV

- A. Both (1) and (2):
 - i. recurrent unexpected panic attacks
 - ii. at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
 - iii. persistent concern about having additional attacks

- iv. worry about the implications of the attack or its consequences (e.g. losing control, having a heart attack, 'going crazy')
- v. a significant change in behaviour related to the attacks
 - B. Absence of agoraphobia/presence of agoraphobia
 - C. The panic attacks are not caused by the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hyperthyroidism)
 - D. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g. occurring on exposure to feared social situations), specific phobia (e.g. exposure to a specific phobic situation), OCD (e.g. on exposure to dirt in someone with an obsession about contamination), PTSD (e.g. in response to stimuli associated with a severe stressor) or separation anxiety disorder (e.g. in response to being away from home or close relatives)

Diagnostic criteria for Major Depressive Disorder DSM-IV

Major Depressive Disorder requires two or more major depressive episodes.

Diagnostic criteria:

Depressed mood and/or loss of interest or pleasure in life activities for at least 2 weeks and at least five of the following symptoms that cause clinically significant impairment in social, work, or other important areas of functioning almost every day

- a. .Depressed mood most of the day.
- b. Diminished interest or pleasure in all or most activities.
- c. Significant unintentional weight loss or gain.
- d. Insomnia or sleeping too much.
- e. Agitation or psychomotor retardation noticed by others.
- f. Fatigue or loss of energy.

- g. Feelings of worthlessness or excessive guilt.
- h. Diminished ability to think or concentrate, or indecisiveness.
- i. Recurrent thoughts of death ([APA, 2000](#), p. 356).

2. ANNEX III

DSM-5 Criteria for PTSD

Full copyrighted criteria are available from the American Psychiatric Association (1). All of the criteria are required for the diagnosis of PTSD. The following text summarizes the diagnostic criteria:

Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B (one required): The traumatic event is persistently re-experienced, in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C (one required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

Criterion D (two required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E (two required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction

- Difficulty concentrating
- Difficulty sleeping

Criterion F (required): Symptoms last for more than 1 month.

Criterion G (required): Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H (required): Symptoms are not due to medication, substance use, or other illness.

Two specifications:

- **Dissociative Specification**. In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
 - Depersonalization. Experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
 - Derealization. Experience of unreality, distance, or distortion (e.g., "things are not real").
- **Delayed Specification**. Full diagnostic criteria are not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

ICD 11

6B41 Complex post traumatic stress disorder

Description

Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterized by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD have been met at some point during the course of the disorder. In addition, Complex PTSD is characterized by 1) severe and pervasive problems in affect regulation; 2) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event; and 3) persistent difficulties in sustaining relationships and in feeling close to others. The disturbance causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Exclusions

- Post traumatic stress disorder ([6B40](#))

6B40 Post traumatic stress disorder

- [Disorders specifically associated with stress](#)

Description

Post-traumatic stress disorder (PTSD) is a syndrome that develops following exposure to an extremely threatening or horrific event or series of events that is characterized by all of the following: 1) re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares, which are typically accompanied by strong and overwhelming emotions such as fear or horror and strong physical sensations, or feelings of being overwhelmed or immersed in the same intense emotions that were experienced during the traumatic event; 2) avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and 3) persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms must persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Inclusions

- Traumatic neurosis

Exclusions

- Acute stress reaction ([QE84](#))
- Complex post traumatic stress disorder ([6B41](#))