A 20-year-old transgender woman presented to a psychiatrist’s office complaining of fatigue. She was accompanied by a man she described as her boyfriend, who looked approximately 20 years older. The patient indicated a desire to have him accompany her during the appointment and both were resistant to suggestions that she be interviewed alone. The boyfriend appeared very interested in all aspects of the conversation; he was generally charming with the psychiatrist, although at times he would answer questions directed to the patient.

The patient appeared withdrawn and fatigued. Her shirt had holes in it and her pants appeared unwashed, but her boyfriend, who held her purse and two cell phones, was well dressed. The patient had a thin body habitus. She was soft-spoken and provided short answers to questions. She described experiencing fatigue and a lack of motivation. She was evasive to questions around sleep and appetite—stating “it’s fine” or “good enough.” She looked to her boyfriend when asked questions about self-harm or suicidal ideation and then denied these symptoms. She denied a history of abuse or trauma. She appeared nervous when asked questions about her line of work, at which point her boyfriend stated, “she’s in school.” During the interview, the boyfriend, although initially very charming and engaging, became annoyed and asked, “how much longer will this take?”

A review of the patient’s chart identified at least one admission to a psychiatric unit after a suicide attempt 2 years prior and notes from emergency department (ED) doctors described scarring on the patient’s thighs consistent with a history of self-harm. Notes indicated that the patient rarely presented to the hospital alone and often left against medical advice. The chart also indicated that staff had been concerned about a history of intimate partner violence, but that the patient had denied it.

The patient’s laboratory tests were consistent with malnutrition and dehydration, with low vitamin B12, iron deficiency, and a slightly elevated creatinine level. Mean corpuscular volume and gamma-glutamyl transferase were elevated in a pattern consistent with recent alcohol use. The results of other blood tests, including thyroid-stimulating hormone, were within normal limits. The patient declined a urine toxicology screen or testing for sexually transmitted infections.
The next week, the patient presented to the ED with a broken jaw. In the ED, staff assessed her for human trafficking using a brief tool after separating her from a woman who had accompanied her. She screened positive for trafficking, resulting in further evaluation by the ED social worker who ultimately called the National Human Trafficking Hotline, which linked the patient to appropriate local resources. While in treatment, the patient was diagnosed with post-traumatic stress disorder (PTSD). She was prescribed sertraline and prazosin, and she began both individual and group therapy. The patient was initially hesitant to cooperate with law enforcement as she expressed feelings of love toward her boyfriend, who was her trafficker, but after some time she understood the extent of the exploitation that she had experienced and decided to work with law enforcement to pursue charges.

**DISCUSSION**

The United States formally criminalized human trafficking in 2000 (Table 1). There are an estimated 40 million people enslaved worldwide, but only 1% of victims have been identified. Many survivors report contact with health care providers during their trafficking experience, but providers generally fail to recognize the impact trafficking has on their patients’ presentations.

**TABLE 1.**

<table>
<thead>
<tr>
<th>Act</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Sex trafficking</td>
<td>“The recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age”¹⁹</td>
</tr>
<tr>
<td>Labor trafficking</td>
<td>“The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjecting to involuntary servitude, peonage, debt bondage, or slavery”¹⁹</td>
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</table>

Victims of sex trafficking may present to a health care provider with signs of malnutrition, evidence of previous physical injuries, poor dentition, and a history of multiple pregnancies, abortions, and/or sexually transmitted infections. Victims may also present with a history of substance use disorders. Psychiatric disorders are common in survivors of sex trafficking and most commonly include depression and PTSD. Rates of self-harm and suicide attempts and ideation are also high.

Victims of sex trafficking may present for clinical attention in the presence of a trafficker or another controlling person who will restrict information exchange and resist leaving the patient alone. Notably, however, traffickers also control their victims through fear and intimidation even when they are not physically present.

Although human trafficking can affect anyone, people with fewer socioeconomic opportunities as well as those with a history of child welfare or juvenile justice system involvement are at particularly high risk for being trafficked; this includes a higher risk for gender and sexual minorities, most notably transgender women, who face increased risk secondary to societal discrimination. Moreover, immigrants, racial and ethnic minorities, and indigenous groups are disproportionately affected.

Survivors of human trafficking have difficulty navigating complex mental health systems. Mental health providers working with this population describe lack of service coordination, unstable social situations, and difficulty engaging patients as some of the main barriers to treating this population.

**CONCLUSION**

Human trafficking often goes unrecognized in psychiatric settings, so it is critical that psychiatric providers receive training in identifying and treating victims in a trauma-informed manner. Such training
can provide guidance in understanding the complexities of human trafficking, how to differentiate it from commercial sex or other forms of exploitation, and how to appropriately collaborate across disciplines to serve survivors’ unique needs. Although pilot studies show that ED screening tools can have relatively high sensitivity and specificity for detecting victims of sex trafficking, the limited scientific body of evidence around trafficking and health care necessitates the identification of evidence-based modalities to help survivors heal after identification. Moreover, it is critical that we collaborate to prevent this form of exploitation, not only by working with people at risk but also by addressing the social, cultural, and economic factors that contribute to vulnerability.

REFERENCES