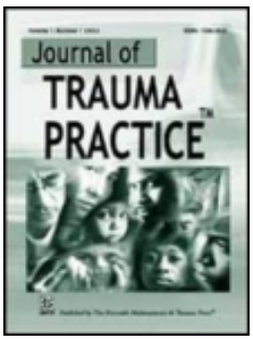

Journal of Trauma Practice

ISSN: 1536-2922 (Print) (Online) Journal homepage: http://www.tandfonline.com/loi/wztp20

Prostitution and Trafficking in Nine Countries

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To cite this article: Melissa Farley PhD , Ann Cotton PsyD , Jacqueline Lynne MSW , Sybille Zumbeck PhD , Frida Spiwak PhD , Maria E. Reyes PhD , Dinorah Alvarez BA & Ufuk Sezgin PhD (2004) Prostitution and Trafficking in Nine Countries, Journal of Trauma Practice, 2:3-4, 33-74, DOI: 10.1300/J189v02n03_03

To link to this article: http://dx.doi.org/10.1300/J189v02n03_03

Published online: 15 Oct 2008.

Prostitution and Trafficking in Nine Countries: An Update on Violence and Posttraumatic Stress Disorder

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SUMMARY. We interviewed 854 people currently or recently in prostitution in 9 countries (Canada, Colombia, Germany, Mexico, South Af-

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The authors express their appreciation to Steven N. Gold, PhD, and to Harvey L. Schwartz, PhD, for their helpful editing suggestions.

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[Haworth co-indexing entry note]: "Prostitution and Trafficking in Nine Countries: An Update on Violence and Posttraumatic Stress Disorder." Farley et al. Co-published simultaneously in *Journal of Trauma Practice* (The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc.) Vol. 2, No. 3/4, 2003, pp. 33-74; and: *Prostitution, Trafficking, and Traumatic Stress* (ed: Melissa Farley) The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc., 2003, pp. 33-74. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: docdelivery@haworthpress.com].

http://www.haworthpress.com/store/product.asp?sku=J189
10.1300/J189v02n03_03

rica, Thailand, Turkey, United States, and Zambia), inquiring about current and lifetime history of sexual and physical violence. We found that prostitution was multitraumatic: 71% were physically assaulted in prostitution; 63% were raped; 89% of these respondents wanted to escape prostitution, but did not have other options for survival. A total of 75% had been homeless at some point in their lives; 68% met criteria for PTSD. Severity of PTSD symptoms was strongly associated with the number of different types of lifetime sexual and physical violence.

Our findings contradict common myths about prostitution: the assumption that street prostitution is the worst type of prostitution, that prostitution of men and boys is different from prostitution of women and girls, that most of those in prostitution freely consent to it, that most people are in prostitution because of drug addiction, that prostitution is qualitatively different from trafficking, and that legalizing or decriminalizing prostitution would decrease its harm.

INTRODUCTION

Commercial sex businesses include street prostitution, massage brothels, escort services, outcall services, strip clubs, lap dancing, phone sex, adult and child pornography (including the sexual assault of children by organized groups of pedophiles as well as non-pedophile rapists), child prostitution, video and Internet pornography, trafficking, and prostitution tourism. Most people who are in prostitution for longer than a few months drift among these various permutations of the commercial sex businesses (Dalla, 2000; Kramer, 2003).

Prostitution dehumanizes, commodifies and fetishizes women, in contrast to non-commercial casual sex where both people act on the basis of sexual desire and both people are free to retract without economic consequence. In prostitution, there is always a power imbalance, where the john[1] has the social and economic power to hire her/him to act like a sexualized puppet. Prostitution excludes any mutuality of privilege or pleasure: its goal is to ensure that one person does *not* use her personal desire to determine which sexual acts do and do not occur–while the other person acts on the basis of his personal desire (Davidson, 1998).

The account of a woman from the United States who prostituted primarily in strip clubs but also in massage, escort, and street prostitution is typical in that it encompasses the following types of violence. In strip club prostitution she was sexually harassed and assaulted. The job required her to tolerate verbal abuse (with a coerced smile), being grabbed and pinched on the legs, buttocks,

breasts, and crotch. Sometimes this resulted in bruises and scratches on her thighs and arms and breasts. Her breasts were squeezed until she was in severe pain. She was humiliated by customers ejaculating on her face. She was physically brutalized, and her hair was pulled as a means of control and torture. She was severely bruised from beatings and frequently had black eyes. She was repeatedly beaten on the head with closed fists, sometimes causing concussions and unconsciousness. From these beatings, her jaw was dislocated and her eardrum was damaged. Many years later her jaw is still dislocated. She was cut with knives. She was burned with cigarettes by customers who smoked while raping her. She was gang raped. She was raped individually by at least twenty men at different times in her life. Rapes by johns and pimps sometimes resulted in internal bleeding.

Seventy percent of women in prostitution in San Francisco, California were raped (Silbert & Pines, 1982). A study in Portland, Oregon found that prostituted women were raped on average once a week (Hunter, 1994). Eighty-five percent of women in Minneapolis, Minnesota had been raped in prostitution (Parriott, 1994). Ninety-four percent of those in street prostitution experienced sexual assault and 75% were raped by one or more johns (Miller, 1995). In the Netherlands (where prostitution is legal) 60% of prostituted women suffered physical assaults; 70% experienced verbal threats of assault, 40% experienced sexual violence and 40% were forced into prostitution and/or sexual abuse by acquaintances (Vanwesenbeeck, de Graaf, van Zessen, Straver, & Visser, 1995; Vanwesenbeeck, 1994).

Prolonged and repeated trauma usually precedes entry into prostitution. From 55% to 90% of prostitutes report a childhood sexual abuse history (James & Meyerding, 1977; Silbert & Pines, 1981; Harlan et al., 1981; Silbert & Pines, 1983; Bagley & Young, 1987; Simons & Whitbeck, 1991; Belton, 1992; Farley & Barkan, 1998). Silbert and Pines (1981, 1983) noted that 70% of their interviewees said that childhood sexual abuse had an influence on their entry into prostitution. A conservative estimate of the average age of recruitment into prostitution in U.S.A. is 13-14 years. (Silbert & Pines, 1982; Weisberg, 1985).

Clearly, violence is the norm for women in prostitution. Incest, sexual harassment, verbal abuse, stalking, rape, battering, and torture–are points on a continuum of violence, all of which occur regularly in prostitution. In fact, prostitution itself is a form of sexual violence that results in economic profit for those who sell women, men, and children. Though often denied or minimized, other types of gender violence (while epidemic) are not sources of mass revenue.

Prostituted women are unrecognized victims of intimate partner violence by pimps as well as johns (Stark & Hodgson, 2003). Although there are little research data available, agencies serving prostituted women observe that a majority of prostitution is pimp-controlled.[2] Giobbe described similar methods of coercion and control used by pimps and non-pimp batterers to control women: minimization and denial of physical violence and abuse, economic exploitation, social isolation, verbal abuse, threats, intimidation, physical violence, sexual assault, and captivity (Giobbe, 1991; Giobbe, 1993; Giobbe, Harrigan, Ryan, & Gamache, 1990). The systematic violence of pimps against prostituted women is aimed not only at control, but also emphasizes the victim's powerlessness, worthlessness and invisibility except in her role as prostitute.

A qualitative distinction between prostitution of children and prostitution of adults is arbitrary and it obscures the lengthy and extensive history of trauma that is commonplace in prostitution. For example the 5-year-old incested by her father and used in child prostitution and pornography may become partially amnesic for these traumas and at adolescence may find herself drifting into prostitution and other savage relationships. The 14-year-old in prostitution eventually turns 18 but she has not suddenly made a new "vocational choice." The abuse and reenactment of abuse simply continue. Women who began prostituting as adolescents may have parts of themselves that are dissociatively compartmentalized into a much younger child's time and place.[3]

Posttraumatic stress disorder (PTSD) can result when people have experienced

> . . . extreme traumatic stressors involving direct personal experience of an event that involves actual or threatened death or serious injury; threat to one's personal integrity; witnessing an event that involves death, injury or a threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. (American Psychiatric Association, 1994)

In fact most prostitution, most of the time includes these traumatic stressors. In response to these events, the person with PTSD experiences fear and powerlessness, oscillating between emotional numbing and emotional/physiologic hyperarousal. PTSD is likely to be especially severe or long lasting when the stressor is planned and implemented by humans (as in war, rape, incest, battering, torture, or prostitution) rather than being a natural catastrophe.

Exposure to paid or unpaid sexual violence may result in symptoms of PTSD. Symptoms are grouped into three categories: (1) traumatic re-experiencing of events, or flashbacks; (2) avoidance of situations which are remi-

niscent of the traumatic events, and a protective emotional numbing of responsiveness; and (3) autonomic nervous system hyperarousal (e.g., jittery irritability, being super-alert, insomnia). The symptoms of PTSD may accumulate over one's lifetime. Many studies report a positive correlation between a history of childhood sexual assault and symptoms of PTSD in adult women (Friedman & Schnurr, 1995; Rodriguez, Ryan, Van de Kemp, & Foy, 1997). Since almost all prostituted women have histories of childhood sexual abuse, this undoubtedly contributes to their symptoms of posttraumatic stress. PTSD is not only related to the overall number of traumatic events, but it is also directly related to the severity of that violence (Houskamp & Foy, 1991). The incidence of PTSD has been investigated among battered women and ranges from 45% to as high as 84% (Houskamp and Foy, 1991; Saunders, 1994; Kemp, Rawlings, & Green 1991). The prevalence of PTSD among prostituted women from 5 countries was 67% (Farley, Baral, Kiremire, & Sezgin, 1998), which is in the same range as that of combat veterans (Weathers, Litz, Herman, Huska, & Keane, 1993).

Following publication of an article which discussed the violence preceding and intrinsic to prostitution, and the symptoms of posttraumatic stress disorder resulting from prostitution in 5 countries–(South Africa, Thailand, Turkey, United States, and Zambia)–the authors were contacted by other researchers and advocates from around the world who were interested in collaborating in further study of prostitution. Consequently, the present study expands the original through the inclusion of four additional countries: Canada, Colombia, Germany, and Mexico.

METHODS

Brief structured interviews of people in prostitution were conducted in Vancouver, Canada; Bogota, Colombia; Hamburg, Germany; Mexico City and Puebla, Mexico; San Francisco, CA, U.S.A.; two cities in Thailand; Lusaka, Zambia; Istanbul, Turkey; Johannesburg and Capetown, South Africa. These countries were included in the study because investigators in those states shared a commitment to documenting the experiences of women in prostitution, and in some instances to providing alternatives to prostitution.

Participants

In Canada, we interviewed 100 women prostituting in or near Vancouver's Downtown Eastside, one of the most economically destitute regions in North America. The effects of colonization of First Nations people were evident

from their overrepresentation in Canadian prostitution. Fifty-two percent were First Nations (in a community where 1.7-7% are the official estimates of the First Nations population), 38% were white European-Canadian, 5% were African Canadian, and 5% left the question blank. The majority of the 52 First Nations women described themselves as Native. Next most often, they described themselves as Metis, a French word that translates to English as "mixed blood" and is used to describe people who are of both First Nations and European ancestries. The two major colonizers of First Nations of Canada were the British and the French; therefore, the majority of those called Metis were First Nations/French or First Nations/British. The First Nations women also categorized themselves as Native Indian, Cree, Cree Native, First Nations, Cree Metis, Ojibwa, Blackfoot/Cree, Aboriginal, and Interior Salish.

In Mexico, we interviewed 123 women prostituting in street, brothel, stripclub and massage prostitution in Mexico City and in Puebla.

Fifty-four women were interviewed in Hamburg, Germany where prostitution is legal. The German women were from a drop-in shelter for drug addicted women, from a program which offered vocational rehabilitation for those prostituted, and were also referred by peers, and by advertisement in a local newspaper. With respect to country of origin, 82% were German and 11% were trafficked into Germany from Thailand or the former Soviet Union. Seven percent were raised in Germany and described themselves as ethnically Polish, Chilean, or Turkish. Two found the experience of answering questions about traumatic events too painful to continue, and a third woman was too intoxicated to participate.

In San Francisco we interviewed 130 respondents on the street who verbally confirmed that they were prostituting. We interviewed respondents in four different areas in San Francisco where people worked as prostitutes. Thirty-nine percent of the 130 interviewees were white European/American, 33% were African American, 18% were Latina, 6% were Asian or Pacific Islander, and 5% described themselves as of mixed race or left the question blank.

In Thailand we interviewed several of the 110 respondents on the street, but found that pimps did not allow the prostitutes to answer our questions. We interviewed some respondents at a beauty parlor that provided a supportive atmosphere. The majority of the Thai respondents were interviewed at an agency in northern Thailand that offered nonjudgmental support and job training.

We interviewed 68 prostituted people in Johannesburg and Capetown, South Africa in brothels, on the street and at a drop-in center for prostitutes. Respondents were racially diverse: 50% were white European; 29% were African or Black; 12% described themselves as Coloured or Brown or of mixed race; 3% were Indian; and 6% left the question blank.

We interviewed 117 current and former prostitutes at TASINTHA in Lusaka, Zambia. TASINTHA is a non-governmental organization that offered food, vocational training, and community to approximately 600 prostituted women a week.

In Turkey some prostitutes work legally in brothels which are privately owned and controlled by local commissions composed of physicians, police, and others who are "in charge of public morality." We were not permitted to interview women in brothels, so we interviewed 50 prostituted women who were brought to a hospital in Istanbul by police for the purpose of STD control.

In Bogota we interviewed 96 women and children at agencies that offered services to them. Prostitution in Colombia starts at a young age, often by adolescence, and is accompanied by unwanted pregnancy (Spiwak & Reyes, 1999; UNICEF, 2000; UNICEF Colombia, 2001; Rodriguez & Cabrera, 1991, Fundación Renacer, 2000, 2001; ICBF, 1999; Cárdenas and Rivera, 2000; DABS, 2002). Spiwak & Reyes (1999) found that 72% of the women and children prostituting in Colombia were from families that had been internally displaced by political violence. Civil wars and internal displacement are known to be risk factors for sexual exploitation (UNICEF Colombia, 2001; Fundacion Renacer, 2000; 2001; Fundación Esperanza, 1998, 2000; CATW, 2002; U.S. Report of Trafficking in Persons, 2001; NCMEC, 1992; ICBF, 2000; Leech, 2001). Prostitution is legal in Colombia, with thousands of brothels in urban areas, as well as in paramilitary and guerilla-controlled rural regions. It is legal to prostitute a 14-year-old girl or boy (Código Penal de Colombia, 2002), although that act of sexual abuse violates the Convention on the Rights of the Child endorsed by Colombia in 1999 (UNICEF, 2000; UNICEF Colombia, 2001; Seitles, 1997; ICBF-UNESCO, 1997; Motta et al., 1998; Morgan & Buitrago, 1992).

In six of the nine countries, we interviewed women and girls. In South Africa we interviewed 10 men (14% of the South African sample) and one transgendered person. In Thailand we interviewed 28 transgendered people (25% of the Thai sample). In the United States we interviewed 18 men (13%) and 15 transgendered people (12%) in addition to women and girls. Transgendered people represent a significant minority of those in prostitution. A previous study (Farley & Barkan, 1998) found that transgendered people (male-to-female) in prostitution experienced the same frequency of physical assaults and rapes as did women.

Mean age, age ranges and mean age of entry into prostitution, percentages under age 18 at time of entry into prostitution, and mean number of years in prostitution by country are shown in Table 1. Across 9 countries, ages of respondents ranged from 12 to 68 with a mean age of 28 years (N = 779, SD = 8) The average age of entry into prostitution was 19 years (SD = 6). Forty-seven

TABLE 1. Age, Age of Entry, and Length of Time in Prostitution

	9 Country Summary (N = 854)	Canada n = 100)	Colombia (n = 96)	Germany (n = 54)	Mexico (n = 123)	South Africa (n = 68)	Thailand (n = 166)	Turkey (n = 50)	USA (n = 130)	Zambia (n = 117)
Mean age (SD)	28 (8)	28 (8)	31 (10)	26 (10)	27 (7)	24 (5)	26 (7)	29	31 (9)	27 (7)
Age range	12-68	13-49	14-58	15-68	18-60	17-38	14-46	16-55	14-61	12-53
Mean age entered prostitution (SD)	19 (6)	18 (6)	17 (4)	19 (6)	20 (4)	20 (5)	21 (5)	Unknown	20 (8)	17 (4)
Years in prostitution (SD)	9 (8)	10 (8)	14 (8)	7 (8)	7 (8)	4 (4)	5 (4)	Unknown	11 (9)	10 (7)
Percent younger than age 18 at entry	47% (353)	54% (54)	59% (56)	41% (22)	32% (38)	40% (27)	32% (28)	Unknown	42% (53)	68% (75)

percent reported that they were under 18 years of age at the time of entry into prostitution. Based on respondents' current age and age of entry into prostitution we calculated the average length of time in prostitution to be 9 years (SD = 8) across countries. This calculation was based on the assumption that from the age at first prostitution to the time of the interview, there was no period of time during which they did not prostitute. Since people seize the opportunity to interrupt or escape from prostitution, this number probably overestimates the amount of time spent in prostitution.

Measures

The Prostitution Questionnaire inquired about lifetime history of physical and sexual violence and the use of or making of pornography during prostitution. We asked whether respondents wished to leave prostitution and what they needed in order to leave. We asked if they had been homeless; if they had physical health problems; and if they used drugs or alcohol or both. Three questions assessed rape: "Have you been raped?" "Who raped you?" and "How many times have you been raped since you were in prostitution?" Some respondents answered "no" when asked if they were raped, but then identified who had raped them and/or how many times they had been raped. Therefore to assess rape in prostitution, if a respondent identified "pimp" or "customer" in response to "Who raped you?" or if the respondent reported one or more rapes since being in prostitution then that respondent was identified as having been raped in prostitution.

Respondents also completed the PTSD Checklist (PCL), a self-report inventory for assessing the 17 DSM-IV symptoms of PTSD (Weathers, Litz, Herman, Huska, & Keane, 1993; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). Respondents were asked to rate symptoms of PTSD on a scale with (1 =) not at all; (2 =) a little bit; (3 =) moderately; (4 =) quite a bit; and (5 =) extremely. PCL test-retest reliability was .96. Internal consistency, as measured by an alpha coefficient was .97. Validity of the scale was reflected in its strong correlations with the Mississippi Scale (.93); the PK scale of the MMPI-2 (.77); and the Impact of Events Scale (.90) (Weathers et al., 1993). The PCL has functioned comparably across ethnic subcultures in U.S.A. (Keane et al., 1996).

We measured symptoms of PTSD in two ways. First, using a procedure established by the scale's authors, we generated a measure of overall PTSD symptom severity by summing respondents' ratings across all 17 items. If a respondent filled out less than half of the PCL (more than 8 blank items) it was not included in the analysis. For those omitting one to eight items, the PCL

sum was estimated by using the respondent's mean PCL score in place of the blank items.

Second, using Weathers' (1993) scoring suggestion, we considered a score of 3 or above on a given PCL item to be a symptom of PTSD. Using those scores, we then noted whether each respondent met criteria for a diagnosis of PTSD. We report the numbers and percentages of respondents who qualified for a diagnosis of PTSD in each country.

In Canada and United States, we administered a Chronic Health Problem Questionnaire that included items developed from responses to an earlier open-ended item which inquired about health problems of women in prostitution. Unanswered items were considered to indicate the absence of the health problem. Therefore, percentages reported below are percentages of the entire sample endorsing that item.

Procedure

In Canada, Colombia, Mexico, South Africa, and United States, if interviewees indicated that they were prostituting, they were asked to fill out the Prostitution Questionnaire (PQ), the Post Traumatic Stress Disorder Checklist (PCL), and the Chronic Health Problem Questionnaire (CHPQ). We interviewed respondents in street, brothel, strip clubs, and massage prostitution. In Germany and Turkey, respondents were administered interviews in medical clinics. In Zambia and in Thailand, most respondents were interviewed in agencies offering services to women in prostitution. The questionnaires were administered in English, German, Spanish, Thai and Turkish. In Zambia, interviewers translated as needed–most participants spoke some English. The authors either administered or directly supervised the administration of all questionnaires. If respondents could not read, the questions were read to them by the researchers.

RESULTS

A range of sexual and other physical violence was reported by a majority of these prostituted people in all nine countries (see Table 2). Listed in the following tables are the percentages of respondents endorsing each item out of the total number of respondents who answered that item. The number of participants endorsing each item is in parentheses.

Across countries, 59% of these interviewees reported that as children they were beaten by a caregiver to the point of injury. Sixty-three percent were sexually abused as children, with an average of four perpetrators against each

TABLE 2. Violence in Prostitution

	9 Country Summary (N = 854)	Canada (n = 100)	Colombia (n = 96)	Germany (n = 54)	Mexico (n = 123)	South Africa (n = 68)	Thailand (n = 166)	Turkey (n = 50)	USA (n = 130)	Zambia (n = 117)
Threatened with a weapon in prostitution	64% (503)	67% (66)	59% (57)	52% (28)	48% (46)	68% (45)	39% (33)	68% (34)	78% (100)	86% (94)
Physically assaulted in prostitution	73% (595)	91% (91)	70% (67)	61% (33)	59% (72)	66% (45)	56% (50)	80% (40)	82% (106)	82% (91)
Raped in prostitution	57% (483)	76% (76)	47% (45)	63% (34)	46% (57)	56% (38)	38% (45)	50% (25)	73% (95)	79% (93)
(Of those raped) raped more than five times in prostitution	59% (286)	67% (51)	64% (29)	50% (17)	44% (25)	58% (22)	56% (25)	36% (9)	59% (56)	52% (48)
Current or past homelessness	75% (571)	86% (84)	76% (73)	74% (40)	55% (65)	73% (49)	57% (53)	58% (29)	84% (108)	89% (99)
As a child, was hit or beaten by caregiver until injured or bruised	59% (448)	73% (72)	66% (63)	48% (26)	57% (69)	56% (38)	39% (35)	56% (28)	49% (37)	71% (80)
Sexually abused as a child	63% (508)	84% (82)	67% (64)	48% (26)	54% (64)	66% (45)	47% (41)	34% (17)	57% (73)	84% (93)
Mean number of childhood sexual abuse perpetrators	4	5	2	17	2	2	1	unknown	2	6
Median number of childhood sexual abuse perpetrators	1	3	1	4	1	1	0	unknown	1	3

child. As adults in prostitution, 64% of these respondents had been threatened with a weapon, 71% had experienced physical assault, and 63% had been raped. Current or past homelessness averaged 75% across countries and ranged from 55% (Mexico) to 89% (Zambia).

From this range of violent events, we categorized four types of violence in these people's lives: (1) childhood sexual abuse, (2) childhood physical abuse, (3) rape in prostitution as an adult and (4) physical assault in prostitution as an adult. Respondents might have experienced none, one, two, three, or all four types of violence (see Table 3). Fifty-one percent of the interviewees had experienced three or four different types of lifetime violence, 36% reported one to two types of lifetime violence, and only 13% had not experienced any of these types of violence. Since those who left items blank were assumed not to have experienced the violence, this is a conservative estimate of lifetime violence. We asked 315 respondents in Canada, Colombia, and Mexico about their experience of verbal abuse in prostitution. Eighty-eight percent reported having been verbally abused.

The responses of our participants suggest that pornography is integral to prostitution. Table 4 shows rates by country of those in prostitution who reported that they were upset by attempts to coerce them into imitating pornography and who had pornography made of them in prostitution. Across countries, 47% were upset by attempts to make them do what others had seen in pornography and 49% reported pornography was made of them.

Posttraumatic Stress Disorder

To meet criteria for a diagnosis of posttraumatic stress disorder (PTSD) a person must have at least one of five symptoms of intrusive re-experiencing of trauma symptoms (criterion B), at least three of six symptoms of numbing and avoidance of trauma (criterion C), and at least two of four symptoms of physiologic hyperarousal (criterion D). Given the extremely high rates of interpersonal violence reported by these respondents (stressors which meet criterion A), we made the assumption that the 13% of respondents who had not directly experienced violence themselves–had witnessed it. Thus we assumed that all respondents met criterion A for a diagnosis of PTSD. Eight hundred twenty-six of our respondents answered at least 8 of the 17 items on the Post Traumatic Disorder Check List (PCL) and were included in the following analysis. Across 9 countries, 68% of these respondents met criteria for a diagnosis of PTSD (see Table 5).

Mean PCL score was 53.5 (SD = 16.2) across the 9 countries, a reflection of the severity of the symptoms of PTSD in this sample (see Table 6). Mean PTSD severities in the 9 countries ranged from 49 (Mexico) to 58

TABLE 3. Number of Types of Lifetime Violence

Number of Types of Lifetime Violence	9 Country Summary (N = 854)	Canada (n = 100)	Colombia (n = 96)	Germany (n = 54)	Mexico (n = 123)	South Africa (n = 68)	Thailand (n = 166)	Turkey (n = 50)	USA (n = 130)	Zambia (n = 117)
No violence reported	13% (110)	2% (2)	12% (11)	6% (3)	22% (27)	12% (8)	28% (33)	20% (10)	6% (8)	7% (8)
1 Type of violence	16% (133)	12% (12)	16% (15)	17% (9)	15% (19)	19% (13)	28% (33)	24% (12)	12% (15)	4% (5)
2 Types of violence	20% (171)	7% (7)	22% (21)	37% (20)	16% (20)	16% (11)	21% (24)	22% (11)	34% (44)	11% (13)
3 Types of violence	26% (222)	24% (24)	16% (15)	33% (18)	25% (31)	19% (13)	17% (20)	34% (17)	34% (44)	34% (40)
4 Types of violence	25% (218)	55% (55)	35% (34)	7% (4)	21% (26)	34% (23)	5% (6)	0% (0)	15% (19)	44% (51)

TABLE 4. Prostitution and Pornography

	9 Country Summary (N = 854)	Canada (n = 100)	Colombia (n = 96)	Germany (n = 54)	Mexico (n = 123)	South Africa (n = 68)	Thailand (n = 166)	Turkey (n = 50)	USA (n = 130)	Zambia (n = 117)
Upset by an attempt to make them do what had been seen in pornography	47% (377)	64% (63)	62% (60)	44% (24)	35% (42)	56% (37)	48% (43)	20% (10)	32% (41)	47% (51)
Pornography made of her in prostitution	49% (371)	67% (64)	50% (48)	52% (28)	44% (53)	40% (26)	45% (39)	N/A	49% (63)	47% (52)

TABLE 5. Posttraumatic Stress Disorder of Prostituted Respondents in 9 Countries

	9 Country Summary (N = 854)	Canada (n = 100)	Colombia (n = 96)	Germany (n = 54)	Mexico (n = 123)	South Africa (n = 68)	Thailand (n = 116)	Turkey (n = 50)	USA (n = 130)	Zambia (n = 117)
PTSD DIAGNOSIS (DSM-IV)	68% (562)	74% (72)	86% (83)	60% (32)	54% (67)	75% (51)	58% (59)	66% (33)	69% (87)	71% (78)

TABLE 6. PTSD Checklist (PCL) Means from Three Studies

	Mean PCLC Sum (SD)
1 Current study	
99 women in prostitution (Canada)	56 (16)
96 women in prostitution (Colombia)	58 (14)
53 women in prostitution (Germany)	51 (16)
123 women in prostitution (Mexico)	49 (18)
68 people in prostitution (South Africa)	55 (16)
111 people in prostitution (Thailand)	51 (18)
50 women in prostitution (Turkey)	53 (16)
128 people in prostitution (USA)	55 (17)
112 women in prostitution (Zambia)	53 (12)
2 Weathers et al. (1993)	
123 Vietnam veterans requesting treatment	51 (20)
1006 Persian Gulf War veterans	35 (16)
3 Farley & Patsalides, (2001)	
(adult women)	
26 controls	24 (7)
25 w/ childhood physical abuse history	31 (10)
27 w/ childhood physical and sexual abuse history	37 (15)

*PTSD sum is an indicator of PTSD severity.

(Columbia). PTSD severity was significantly positively correlated with the number of types of lifetime violence experienced ($r = .33$, $p = .001$). For comparison, Table 6 includes mean PCL scores from two other studies of PTSD severity–Vietnam and Persian Gulf veterans (Weathers et al., 1993) and samples of women from a health maintenance plan who had and had not experienced physical and sexual abuse (Farley & Patsalides, 2001).

We asked interviewees in the 9 countries about their use of drugs and alcohol. Table 7 lists substance use by country. Across countries, 48% of those responding to this item reported drug use, and 52% reported alcohol use. Colombia and Zambia reported the lowest use of drugs. Drugs were probably not available due to the poverty of respondents. We did not inquire specifically about glue sniffing which is common in Colombia. Colombia and Zambia, along with Mexico, had the highest rates of alcohol use (71%-100%). Canada, USA, and Germany reported the highest rates of drug use (70% to 95%).

We asked respondents what they needed by offering them a checklist of options that included an open-ended question for write-in responses (see Table 8). Eighty-nine percent told us that they desired to leave prostitution. A total of 75% needed a home or safe place, 76% needed job training, 61% needed health care, 56% needed individual counseling, 51% needed peer support, 51% needed legal assistance, 47% needed drug/alcohol treatment, 45% wanted

self-defense training, 44% needed childcare, 34% wanted prostitution to be legalized, and 23% wanted physical protection from a pimp.

We asked those we interviewed in six countries (Canada, Colombia, Germany, Mexico, South Africa, and Zambia) whether they thought that legalizing prostitution would make them physically safer. Across countries 46% stated that prostitution would be no safer if it were legalized (see Table 9). It is noteworthy that in Germany where brothel prostitution is legal, 59% of respondents told us that they did not think that legal prostitution made them any safer from rape and physical assault.

In Mexico we were able to compare several different types of prostitution: 54 women in strip clubs, 44 women in brothels and massage parlors, and 25 women who were prostituting on the street. We inquired about age of entry into prostitution, length of time in prostitution, PTSD severity, number of types of lifetime violence and whether or not women in these different types of prostitution wanted to escape from it. Age of entry into prostitution differentiated strip club from other types of prostitution. Compared to brothel, massage and street prostitution, significantly more women in strip clubs entered prostitution when they were younger than 18 ($F = 3.5$; $df = 2,113$; $p = .03$). There were no statistically significant differences between brothel/massage, street, and strip club prostitution with respect to PTSD severity, length of time in prostitution, childhood sexual abuse, childhood physical abuse, rape in prostitution, number of types of lifetime violence experienced, and percentages of respondents who told us that they wanted escape from prostitution.

We investigated differences in PTSD associated with gender and gender identity. In U.S. differences in PTSD incidence among women, men and transgendered prostitutes were not statistically significant. In Thailand, differences between women and transgendered prostitutes were not statistically significant. In South Africa, differences between women and men prostitutes were not significant.

Previously, we found that 61% of those in prostitution in 5 countries reported a current physical health problem, 52% reported alcohol use, and 45% reported drug use (Farley et al., 1998). We are now able to report in more detail the acute and chronic health problems experienced by those in prostitution in 7 of the 9 countries (Colombia, Mexico, South Africa, Thailand, Turkey, USA, and Zambia). Half of these people reported symptoms that were associated with violence, overwhelming stress, poverty, and homelessness.

Common medical problems of these 700 people in prostitution included tuberculosis, HIV, diabetes, cancer, arthritis, tachycardia, syphilis, malaria, asthma, anemia, and hepatitis. Twenty-four percent reported reproductive symptoms including sexually transmitted diseases (STD), uterine infections,

TABLE 7. Use of Drugs and Alcohol Among People in Prostitution in 9 Countries

	9 Country Summary (N = 854)	Canada (n = 100)	Colombia (n = 96)	Germany (n = 54)	Mexico (n = 123)	South Africa (n = 68)	Thailand (n = 166)	Turkey (n = 50)	USA (n = 130)	Zambia (n = 117)
Used drugs	48% (383)	95% (94)	4% (3)	70% (38)	34% (40)	49% (33)	39% (40)	46% (23)	75% (94)	16% (18)
Used alcohol	52% (416)	47% (44)	100% (29)	54% (29)	71% (84)	43% (29)	56% (57)	64% (32)	26% (33)	72% (79)

TABLE 8. Responses to “What Do You Need?” Asked of 854 People in Prostitution

Needs	9 Country Summary (N = 854)	Canada (n = 100)	Colombia (n = 96)	Germany (n = 54)	Mexico (n = 123)	South Africa (n = 68)	Thailand (n = 116)	Turkey (n = 50)	USA (n = 130)	Zambia (n = 117)
Leave prostitution	89% (699)	95% (89)	97% (93)	85% (33)	68% (81)	89% (58)	92% (82)	90% (45)	87% (111)	99% (107)
Home or safe place	75% (618)	66% (63)	74% (71)	61% (33)	87% (107)	72% (46)	59% (64)	60% (30)	78% (99)	94% (105)
Job training	76% (600)	67% (64)	57% (55)	63% (34)	92% (113)	75% (48)	56% (61)	46% (23)	73% (93)	97% (109)
Drug/alcohol treatment	47% (356)	82% (78)	15% (14)	48% (26)	38% (47)	46% (29)	44% (33)	6% (3)	67% (85)	37% (41)
Health care	61% (480)	41% (39)	56% (54)	46% (25)	67% (82)	69% (44)	41% (45)	38% (19)	58% (74)	88% (98)
Peer support	51% (393)	41% (38)	41% (39)	65% (35)	36% (44)	58% (37)	49% (53)	24% (12)	50% (64)	63% (71)
Individual counseling	56% (431)	58% (54)	34% (33)	69% (37)	43% (53)	61% (39)	66% (72)	46% (23)	48% (61)	53% (59)
Self-defense training	45% (340)	49% (47)	29% (28)	46% (25)	35% (43)	60% (39)	59% (64)	12% (6)	49% (62)	41% (46)
Legal assistance	51% (366)	33% (31)	43% (41)	37% (20)	50% (61)	58% (37)	57% (62)	Unknown	42% (54)	54% (60)
Legalize prostitution	34% (251)	32% (30)	20% (19)	35% (19)	51% (62)	37% (24)	27% (30)	4% (2)	44% (56)	8% (9)
Child care	44% (335)	12% (11)	49% (47)	7% (4)	36% (44)	48% (31)	44% (48)	20% (10)	34% (43)	87% (97)
Physical protection from pimp	23% (157)	4% (4)	6% (6)	6% (3)	15% (19)	33% (21)	20% (22)	Unknown	28% (36)	41% (46)

TABLE 9. Respondents Who Stated That Prostitution Would Not Be Safer if Legalized

	6 Country Summary (N = 558)	Canada (n = 100)	Colombia (n = 96)	Germany (n = 54)	Mexico (n = 123)	South Africa (n = 68)	Zambia (n = 117)
Prostitution would be no safer if legalized	46% (226)	26% (25)	44% (22)	59% (27)	15% (13)	59% (40)	73% (79)

menstrual problems, ovarian pain, abortion complications, pregnancy, hepatitis B, hepatitis C, infertility, syphilis, and HIV.

Without specific query about mental health, 17% described severe emotional problems: depression, suicidality, flashbacks of child abuse, anxiety and extreme tension, terror regarding relationships with pimps, extremely low self-esteem, and mood swings. Fifteen percent reported gastrointestinal symptoms such as ulcers, chronic stomachache, diarrhea, and colitis. Fifteen percent reported neurological symptoms such as migraine headaches and non-migraine headaches, memory loss, numbness, seizures, and dizziness. Fourteen percent of these women and children in prostitution reported respiratory problems such as asthma, lung disease, bronchitis, and pneumonia. Fourteen percent reported joint pain, including hip pain, bad knees, backache, arthritis, rheumatism, and nonspecific multiple-site joint pain.

Twelve percent of those who described health problems in prostitution reported injuries that were a direct result of violence. For example, a number of women had their ribs broken by the police in Istanbul, a woman in San Francisco broke her hips jumping out of a car when a john was attempting to kidnap her. Many women had their teeth knocked out by pimps and johns. Miller (1995) cited bruises, broken bones, cuts, and abrasions that resulted from beatings and sexual assaults.

Of the 50 Turkish women, 18% reported mental distress, 16% reported joint or other pain, 10% reported gastrointestinal symptoms, 10% reported gynecological symptoms, 6% had respiratory symptoms, and 6% cardiac symptoms. Almost half of the Turkish women had never been examined by a physician.

In Mexico, 52 of 123 women responded affirmatively to an open-ended question regarding health problems. Twenty-one percent of those who responded to this question reported gastrointestinal symptoms, and 16% reported neurological problems. Other physical health problems included joint pain (12%) and cardiovascular symptoms (12%).

In Thailand, 60 of 116 women responded to an open-ended question about health problems. Thirty percent of these women reported poor health in general, and 30% described reproductive system problems. Twenty-five percent described physical injuries from violence in prostitution, 23% reported neurological symptoms, 17% joint pain, and 15% gastrointestinal symptoms. Twenty-eight percent of the Thai women described serious emotional problems; many told us that they had been lied to, kidnapped, or trafficked into prostitution, which contributed to their distress. Equating prostitution with death, one woman stated: "Why commit suicide? I'll work in prostitution instead." Another woman explained that she felt "spiritually assaulted" in prostitution.

TABLE 10. Chronic Health Problems of Women in Prostitution and Women No Longer in Prostitution*

Chronic Health Problems endorsed more frequently when *not yet out of prostitution*	Canadian women (n = 100)	U.S. women out of prostitution for at least 1.5 years (n = 21)
Muscle aches/pains	78% (74)	71% (15)
Trouble concentrating	66% (63)	62% (13)
Colds or flu symptoms	61% (58)	43% (9)
Joint pain	60% (57)	38% (8)
Shortness of breath	60% (57)	57% (12)
Stomach problems	59% (56)	57% (12)
Headaches/migraines	56% (54)	48% (10)
Constipation/diarrhea	52% (50)	43% (9)
Dizziness	44% (42)	38% (8)
Skin problems	43% (41)	38% (8)
Chest Pain	43% (41)	33% (7)
Nausea	41% (39)	14% (3)
Sweaty Hands	40% (38)	14% (3)
Hearing problems	40% (38)	19% (4)
Jaw or throat pain	38% (36)	24% (5)
Muscle weakness/paralysis	38% (36)	24% (5)
Vomiting	37% (35)	0% (0)
Trembling	35% (33)	10% (2)
Asthma	32% (30)	29% (6)
Poor health in general	30% (28)	10% (2)
Difficulty swallowing	27% (26)	10% (2)
Pelvic pain	21% (20)	19% (4)
Chronic health problems endorsed more frequently *after getting out of prostitution*	**Canadian women (n = 100)**	**U.S. women out of prostitution for at least 1.5 years (n = 21)**
Injury caused by violence	76% (72)	95% (20)
Memory problems	66% (63)	72% (16)
Head injury	53% (50)	95% (20)
Pain/numbness in hands/feet	50% (47)	52% (11)
Vision problems	45% (43)	57% (12)
Trouble with balance or walking	41% (39)	43% (9)
Allergies	35% (33)	38% (8)
Swelling of arms/hands/legs/feet	33% (31)	43% (9)
Rapid or irregular heart beat	33% (31)	38% (8)
Loss of feeling on skin	25% (24)	33% (7)
Painful menstruation	24% (23)	48% (10)
Vaginal pain	24% (23)	38% (8)
Breast pain	23% (22)	24% (5)

*Items from Chronic Health Problems Questionnaire (CHPQ).

In Colombia, the most frequent health complaints were reproductive, cardiovascular and respiratory symptoms, and joint pain.

From these responses, we developed the Chronic Health Problems Questionnaire (CPHQ) which was subsequently given to 100 currently prostituting Canadian women and to a separate sample of 21 women in the U.S. who were no longer in prostitution (see Table 10). Among the Canadian women currently in prostitution, 76% reported injuries from violence in prostitution, with 53% having suffered traumatic head injuries. Once women were out of prostitution, awareness of the severity of the previous violence seemed to increase. For example, 95% of the women already out of prostitution reported violent injuries resulting from prostitution, including a 95% incidence of head injury. Women who were still in prostitution reported these same injuries at 76% (any violence-caused injury) and 53% (head injury). Approximately half of both samples reported headaches or migraines. Some of the cardiovascular, neurological and joint complaints may have been symptoms of substance abuse or withdrawal.

Fourteen of the chronic symptoms we inquired about were *more prevalent* among the 21 women no longer involved in prostitution than among the currently prostituting Canadian women. These symptoms were: any injury caused by violence, report of any medical diagnosis, memory problems, head injury, pain/numbness in hands or feet, vision problems, trouble with balance or walking, allergies, swelling of arms, hands, legs or feet, rapid or irregular heartbeat, loss of feeling on skin, painful menstruation, vaginal pain, and breast pain (see Table 10.) The Canadian respondents still in prostitution endorsed an average of 14 of 32 (SD = 8) symptoms. The U.S. women no longer in prostitution endorsed an average of 12 of 32 (SD = 7) symptoms. There was no significant difference between the two groups in the total number of symptoms endorsed (ANOVA, $F = 3.3$, df. = 1,118, $p = .07$).

In three countries (Canada, Colombia, Mexico) we inquired about verbal abuse in prostitution. Eighty-eight percent of 315 respondents reported having been verbally abused ranging from 84% in Mexico to 91% in Colombia.

DISCUSSION

Our findings from 9 countries on 5 continents indicate that the physical and emotional violence in prostitution is overwhelming. To summarize the findings of this study and other research and clinical literature on different types of prostitution (see Farley & Kelly, 2000; Farley, 2003):

1. 95% of those in prostitution experienced sexual harassment which in the United States would be legally actionable in a different job setting.
2. 65% to 95% of those in prostitution were sexually assaulted as children.
3. 70% to 95% were physically assaulted in prostitution.
4. 60% to 75% were raped in prostitution.[4]
5. 75% of those in prostitution have been homeless at some point in their lives.
6. 89% of 785 people in prostitution from nine countries wanted to escape prostitution.
7. 68% of 827 people in several different types of prostitution in 9 countries met criteria for PTSD. The severity of PTSD symptoms of participants in this study were in the same range as treatment-seeking combat veterans, battered women seeking shelter, rape survivors, and refugees from state-organized torture (Bownes, O'Gormen, & Sayers 1991; Houskamp & Foy, 1991, Kemp et al., 1991; Ramsay, Gorst-Unsworth, & Turner, 1993; Weathers et al., 1993). Severity of symptoms of PTSD was strongly associated with the number of different types of lifetime sexual and physical violence. A Covenant House study of homeless adolescents, many of whom were prostituting, found a similar association between PTSD severity and history of violence (DiPaolo, 1999).
8. 88% of those in prostitution experience verbal abuse and social contempt. Verbal abuse in prostitution has rarely been discussed as one of its harms.

Similar findings suggest that the severity of trauma-related symptoms were related to the intensity of involvement in prostitution. Women who serviced more customers in prostitution reported more severe physical symptoms (Vanwesenbeeck, 1994). The longer women were in prostitution, the more STDs were reported (Parriott, 1994). A number of studies document the greatly increased risk among prostituted women as compared to nonprostituted women, for cervical cancer and chronic hepatitis (Chattopadhyay, Bandyopadhyay, & Duttagupta, 1994; de Sanjose, Palacio, Tafur, Vasquez, Espitia, Vasquez, Roman, Munoz, & Bosch, 1993; Nakashima, Kashiwagi, Hayashi, Urabe, Minami, & Maeda, 1996; Parriott, 1994; Pelzer, Duncan, Tibaux, & Mebari, 1992).

Vanwesenbeeck (1994) noted that poverty and length of time spent in prostitution were each associated with greater violence in prostitution. Like Vanwesenbeeck, we concluded that those women who experienced the most extreme violence in prostitution were not represented in our research. Because of this limitation, it is likely that all of the estimates of violence reported here

are conservative, and that the actual incidence of violence is greater than we found.

Traumatized individuals tend to minimize or deny their experiences, especially when they are in the midst of ongoing trauma, such as war combat or prostitution. This leads to a decreased rate of reporting violent events. Based on a review of previous research and clinical reports, we think that our statistic on the prevalence of child sexual abuse among those prostituting in 9 countries (63%) is much lower than the actual incidence of childhood sexual abuse in this population, which we estimate to be closer to 85% (Silbert & Pines, 1981, 1983; Giobbe, 1991; Hunter, 1994).

Describing the complex connections between childhood sexual abuse, revictimization, prostitution, and health problems, one woman made a decision to prostitute after realizing that she had been sexually abused as a child:

> . . . there was no sense of having a life; the only life I knew of was prostituting . . . I thought I couldn't be hurt no more and I felt that I could do what I want and I could have sex with whoever I wanted because *somebody already gone and messed my system up.* (Morse, Suchman, & Frankel, 1997. [Authors' italics]

In prostitution, the sexual exploitation of children and women is often indistinguishable from incest, intimate partner violence, and rape (Gysels, Pool, & Nnulasiba, 2002). Like adult prostitutes, incested children are bribed into sex acts by adults and offered food, money, or protection for their silence. Use of a child for sex by adults may thus be understood as prostitution of the child, whether the act occurs in or out of the family, and whether it is with or without payment. When a child is incestuously assaulted, the perpetrator's objectification of the child victim and his rationalization and denial are similar to the john's in prostitution. The psychological symptoms resulting from incest and prostitution are similar. One woman described a "prostituting mentality" beginning after sexual abuse by neighbors and family members starting at age nine and continuing to adolescence, when she began prostituting (Carroll & Trull, 1999).

Although this study assessed only PTSD as a psychological consequence of prostitution, additional symptoms of emotional distress are common among prostituted women, including other anxiety disorders, dissociative disorders (Ross, Farley, & Schwartz, 2003), substance abuse, personality disorders, and depression. Depression is almost universal among prostituted women. For example, Raymond, Hughes and Gomez (2001) found that 86% of domestically trafficked and 85% of internationally trafficked women experienced depression.

Another psychological consequence of longterm prostitution is complex PTSD (CPTSD) which results from chronic traumatic stress, captivity, and totalitarian control. Symptoms of CPTSD include difficulty regulating emotions, altered self-perception (in prostitution: a subordinated sexual self), changes in relations with others (a boyfriend may be gradually seen as another john), and shifts in beliefs about the nature of the world (Herman, 1992; Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman 1996). In CPTSD, and in some Axis II personality disorders, the objectification and contempt aimed at those in prostitution can become internalized and solidified, resulting in self-loathing that is long-lasting and resistant to change (Schwartz, 2000). Existing in a state of social death, the prostitute is an outsider who is seen as having no honor or public worth; (Patterson, 1982; Farley, 1997). Those in prostitution, like slaves and concentration camp prisoners, may lose their identities as individuals, becoming primarily what masters, Nazis or customers want them to be. As one woman said about prostitution: "It is internally damaging. You become in your own mind what these people do and say with you" (M. Farley, unpublished interview, 1999).

Sex inequality sets the stage for sexual coercion, intimate partner violence and prostitution, thus contributing to women's likelihood of becoming HIV-infected. Sexual violence has now been recognized as a primary risk factor for HIV in women (Romero-Daza, Weeks, & Singer, 1998). Kalichman and colleagues noted the coincidence of domestic violence and the HIV epidemic in Russia, Rwanda, and in the USA (Kalichman, Kelly, Shaboltas, & Granskaya, 2000; Kalichman, Williams, Cheery, Belcher, & Nachimson, 1998).

Half of new AIDS cases are under age 25, and girls are likely to become infected at a much younger age than boys, in part because of the tolerance of violence against girls and women in most cultures (Piot, 1999). In Africa and Asia, there is still a widespread belief that sex with a girl child cures HIV. In their attempts to escape lives of hunger and poverty, young girls in Africa cannot refuse the sexual assaults of older male teachers who control their educational future (Reilly, 2001). In a review of a number of studies, Sanders-Phillips (2002) observed that prostitution and intravenous drug use are the most common routes of HIV exposure among women of color in the United States. She suggests as does Worth (1989), that women's lack of sexual safety is caused by their subordination by men and by specific other factors that increase their vulnerability such as race/ethnic discrimination and poverty. Aral and Mann (1998) emphasized the importance of addressing human rights issues in conjunction with STDs. They noted that since most women enter prostitution as a result of poverty, rape, infertility, or divorce–public health programs must address the social factors which contribute to STD/HIV. We agree that it is essen-

tial to address the root causes of prostitution: sex inequality, racism and colonialism, poverty, tourism, and economic development that destroys traditional ways of living.

In addition to STD and HIV, prostitution causes a multitude of other physical symptoms. Physical health problems result from physical abuse and neglect in childhood (Radomsky, 1995), from sexual assault (Golding, 1994), battering (Crowell & Burgess, 1996), untreated health problems, overwhelming stress, and violence (Friedman & Yehuda, 1995; Koss & Heslet, 1992; Southwick et al., 1995). Prostituted women frequently suffer from all of the foregoing. Intimate partner violence, especially sexual violence, has been shown to increase gynecological, central nervous system, and stress-related problems by 50% to 70% (Campbell, Jones, Dienemann, Kub, Schollenberger, O'Campo, Gielen & Wynne, 2002; McNutt, Carlson, Persaud, & Posmus, 2002). Among our interviewees in 9 countries, we found many health problems which were the direct result of violence in prostitution, and probably also the result of chronic and overwhelming stress.

For example, 75% of the Canadian women we interviewed suffered injuries from violence that occurred during prostitution. These included stabbings and beatings, concussions, broken bones (broken jaws, ribs, collar bones, fingers, spines, skulls). Half of the Canadian women suffered traumatic head injuries as a result of violent assaults with baseball bats, crowbars or from having their heads slammed against walls or against car dashboards. Not surprisingly, they experienced memory problems, trouble concentrating, headaches, vision problems, dizziness, and trouble with balance or walking. These neurological symptoms are sometimes attributed solely to drug or alcohol toxicity, to PTSD or to personality disorders. However, they may also result from traumatic brain injury (TBI). In one study of prostituted women from three countries, 30% of Filipino women, 33% of Russian women, and 77% of US women reported head injuries (Raymond, D'Cunha, Dzuhaytin, Hynes, Rodriguez, & Santos, 2002).

Unfortunately, physical and psychological symptoms often did not disappear when women escaped prostitution. Instead 38% of the physical problems we inquired about were *more frequently* endorsed by women who no longer prostituted as compared to those who were still prostituting (for example, pain/numbness in hands or feet, vision problems, problems with balance, allergies, irregular heartbeat, and reproductive symptoms). Psychological distress is also persistent. Comparing women who were still prostituting with those who were not, a Canadian study found that "exited respondents were only slightly less likely to experience depression, and more likely to experience anxiety attacks and emotional trauma when compared to their counterparts who were still [in prostitution]" (Benoit & Millar, 2001, p. 71).

More than three-quarters of these people in prostitution from 9 countries stated that they needed secure housing and job training. More than half expressed a need for health care in general and half specifically mentioned a need for individual counseling. These findings are consistent with a study in which prostituting respondents emphasized a need for mental health care, specifically requesting drop-in centers, crisis centers, and a phone hotline (Butters & Erickson, 2003).

CONCLUSION

A Canadian woman told us: "What rape is to others, is normal to us." A Thai woman said, "I hate that I have to have sex with someone I don't like or love." For the vast majority of the world's prostituted women, prostitution and trafficking are experiences of being hunted down, dominated, sexually harassed, and assaulted. Women in prostitution are treated like commodities into which men masturbate, causing immense psychological harm to the person acting as receptacle (Hoigard & Finstad, 1986).

There is widespread misinformation about prostitution, based on propaganda that neutralizes the harms described above and which is disseminated by organizations that present prostitution as legitimate, if unpleasant, labor ("sex work"). We address below myths that: street prostitution is the worst type of prostitution, that prostitution of men and boys is significantly different than prostitution of women and girls, that most of those in prostitution freely consent to it, that most people are in prostitution because of a previous drug addiction, that prostitution is qualitatively different from trafficking, and that legalizing prostitution would decrease its harm.

Prostitution is multitraumatic whether its physical location is in clubs, brothels, hotels/motels/john's homes (also called escort prostitution or high class call girl prostitution), motor vehicles or the streets. Women have told us that they felt safer in street prostitution compared to (legal) Nevada brothels, where they were not permitted to reject any customer. Others commented that on the street they could refuse dangerous-appearing or intoxicated customers and that often a friend would make a show of writing down the john's car license plate number, which they considered a deterrent to violence. Raphael and Shapiro (2002) found that women in Chicago reported the same frequency of rape in escort and in street prostitution. In a previous study, although we found more physical violence in street compared to brothel prostitution in South Africa–we found no difference in the incidence of PTSD in these two types of prostitution, suggesting the intrinsically traumatizing nature of prostitution (Farley et al., 1998).

Ross, Anderson, Heber, and Norton (1990) found that women prostituting in stripclubs had significantly *higher* rates of dissociative and other psychiatric symptoms than those in street prostitution. In the present study we compared stripclub/massage, brothel, and street prostitution in Mexico and found no differences in the incidence of physical assault and rape in prostitution, childhood sexual abuse, or symptoms of PTSD. We also found no differences in the percentages of women in brothel, street, or stripclub/massage prostitution who wanted to escape prostitution.

Comparable findings have been reported in the Netherlands, where, although prostitution is legal, it continues to inflict harm on those in it. For example: 90% of women prostituting mainly in clubs, brothels and windows reported extreme nervousness, a symptom which may reflect the physiologic hyperarousal diagnostic of PTSD. In addition, 75% to 80% of the Dutch women reported distrust, symptoms of depression, irritability, and chronic physical discomfort (Vanwesenbeeck, 1994).

Since the 1980s, the line between prostitution and stripping has been increasingly blurred, and the amount of physical contact between exotic dancers and customers has increased, along with verbal sexual harassment and physical assault of women in strip club prostitution.[2] In most strip clubs, customers can now buy a lap dance where the dancer sits on the customer's lap while she wears few or no clothes and grinds her genitals against his. Although he is clothed, he usually expects ejaculation (Lewis, 1998). Touching, grabbing, pinching, and fingering of dancers removes any boundary which previously existed between dancing, stripping, and prostitution. As in other kinds of prostitution, the verbal, physical, and sexual abuse experienced by women in strip club prostitution includes being grabbed on the breasts, buttocks, and genitals, as well as being kicked, bitten, slapped, spit on, and penetrated vaginally and anally during lap dancing (Holsopple, 1998).

Proponents of prostitution argue that most of the violence and trauma-related symptoms among prostitutes result from street violence or from a drug-related lifestyle rather than from prostitution itself. The following comparisons will hopefully set aside that myth. A study of the health of women street vendors in Johannesburg permits a comparison of the violence against them to violence against our South African respondents. The street vendors were similarly situated women who spent much of their lives on the street in the same dangerous neighborhoods as the women we studied but who were not prostituting (Pick, Ross, & Dada, 2002). The average age of the prostituted women we interviewed was several years younger (24 years) than the street vendors (30 years). Seven percent of the South African street vendors experienced a verbal or physical threat, compared to 68% of the South African prostituted women who had been threatened with a weapon. Six percent of the women street vendors had been physically assaulted, compared to 66% of the prostituted women.

Seven percent of the street vendors reported physical sexual harassment, in contrast to the 56% of our South African interviewees who had been raped in prostitution. Prostitutes thus suffered much greater interpersonal violence than street vendors in the same neighborhood in Johannesburg, South Africa. Since the poverty, proximity to drug dealers, experience of street life and civil war were the same for both the street vendors and prostitutes, the large differences in their experiences of sexual and physical violence can be attributed to the nature of prostitution itself.

A Toronto survey of homeless people can be compared to our Canadian sample of women in prostitution. Crowe and Hardill (1993) found that 40% of homeless people had been assaulted in contrast to the 91% of our Canadian respondents in prostitution who had been assaulted. Although homelessness is associated with violence, prostitution is associated with a greater prevalence of violence.

Several researchers have studied the development of men's attitudes toward prostitution. Investigating men's behavior with prostitutes, Scandinavian researchers suggested that prostitution is an expression of men's sexuality but not women's (Mansson, 2001). Like rape myths, prostitution myths (misperceptions about the nature of prostitution as harmless) are a component of a cluster of attitudes that consider sexual violence to be normal. We found that college students' acceptance of prostitution myths was highly correlated with acceptance of rape myths (Cotton, Farley, & Baron, 2002). Furthermore, the college men who were most accepting of prostitution tended to be those who reported having subjected their partners to coercive sexual behaviors (Schmidt, Cotton, & Farley, 2000).

Although it has sometimes been assumed that prostitution of males is qualitatively different from prostitution of females, we did not find this to be the case (Kendall & Funk, 2003). In USA, South Africa, and in Thailand, we compared women, men, and transgendered prostitutes and found no differences in PTSD. A similar study found that 76% of 100 women, men and transgendered prostitutes in Washington, DC stated that they wanted to leave the sex industry. Ninety-one percent of the male prostitutes wanted to escape prostitution (Valera, Sawyer, & Schiraldi, 2001). These findings are consistent with those of the present study. For men, boys, and the transgendered, the experience of being prostituted is similar to that of women and girls.

Another misconception about prostitution is that a large majority of prostitutes are drug-abusing women who entered prostitution to pay for a drug habit. A number of studies have shown that women increase recreational drug use to the point of addiction *after* entry into prostitution (Dalla, 2002). Lange, Ball, Pfeiffer, Snyder, and Cone (1989) found that 8% of women receiving treatment for addiction reported that their drug abuse preceded prostitution,

whereas 39% reported that prostitution preceded drug abuse. In another study, 60% of a group of Venezuelan women in prostitution began abusing drugs and alcohol only after entry into prostitution (Raymond et al., 2002). Kramer (2003), and Gossop, Powis, Griffiths, and Stang (1994) discuss women's use of drugs and alcohol to deal with the overwhelming emotions experienced while turning tricks. Medrano, Hatch, Zule and Desmond (2003) found that substance abusing African-American women who had a greater severity of childhood emotional abuse, emotional neglect, or physical neglect were at higher risk of prostituting than women who were less severely abused or neglected in childhood. Medrano et al. noted that this association between childhood abuse and prostitution was *unrelated to crack cocaine use*.

A common tactic used by pimps and traffickers to control prostitutes is to coercively addict them to drugs. In a similar way, perpetrators of sexual abuse against children are known to drug children in order to facilitate sexual attacks or to disorient and silence them (Carroll & Trull, 1999; Schwartz, 2000).

Although it is sometimes assumed that legalization would decrease the violence of prostitution, many of our respondents did not feel that they would be safer from physical and sexual assault if prostitution were legal. We found that 46% of people in prostitution in 6 countries felt that they were no safer from physical and sexual assault if prostitution were legal. Fifty percent of 100 prostituting respondents in a separate study in Washington, DC expressed the same views (Valera, Sawyer, & Schiraldi, 2000). In an indictment of legal prostitution, more than half of our German respondents told us that they would be no safer in legal as compared to illegal prostitution.

The triple force of race, sex and class inequality disparately impact indigenous women. Prostitution of Aboriginal women occurs globally, in epidemic numbers, with indigenous women at the bottom of racialized sexual hierarchies in prostitution itself (Scully, 2001). The toxic legacy of colonialism and generations of community trauma are critical factors contributing to the prostitution of indigenous women (Farley & Lynne, 2003). The overrepresentation of First Nations women in prostitution was reflected in the Canadian results reported here. These findings are a consequence of their marginalized and devalued status in Canada, with a concomitant lack of options for economic survival.

Indigenous women are almost always trafficked from rural communities (sometimes reservations) to urban areas. In the process of trafficking–women, men, and children are transported to markets for the purpose of prostitution or they are sold for sweatshop labor, domestic servitude, or servile marriages (also called mail-order brides).[5] Trafficking may occur within or across international borders, thus a person may be either domestically or internationally

trafficked. The harm of prostitution itself is similar whether she crosses an international legal boundary or whether she is moved from, for example, Chiapas to Mexico City, or from Saskatoon to Vancouver. The experience of being uprooted from one's home or community causes distress. Migration itself is frequently a consequence of circumstances of degradation, violence, and dehumanization (deJong, 2000). Migration may also reduce the social support women count on to protect them from sexual violence (Lyons, 1999).

Trafficking cannot occur without an acceptance of prostitution in the receiving country. Governments protect prostitution/trafficking because of the monstrous profits from the business of sexual exploitation. In 1999, Thailand, Vietnam, China, Mexico, Russia, Ukraine, and the Czech Republic were primary source countries for trafficking of women into the United States (Richard, 2000). Source countries vary according to the economic desperation of women, culturally-based gender inequality, the promotion of prostitution and trafficking by corrupt government officials who issue passports and visas, and criminal connections in both the sending and the receiving country such as gang-controlled massage parlors, and the lack of laws to protect immigrating women.

Salgado (2002) described what could be appropriately termed a *trafficking syndrome* resulting from repeated harm and humiliation against a person who is kept isolated and living in prisoner-of-war-like conditions. As in prostitution and domestic trafficking, international trafficking is extremely likely to result in PTSD. Like women domestically trafficked into prostitution, internationally trafficked women experience extreme fear, guilt regarding behaviors which run counter to their religious or cultural beliefs, self-blame, and a sense of betrayal, not only by family and pimps-but by traffickers and governments. In addition, women may fear loss of immigration status if they attempt to leave violent husbands or pimps and they may not know how to access legal or social services. Additional barriers confronted by trafficked immigrant women are absence of services in the language of newcomer groups, discrimination and racism, and models of healthcare that are culturally irrelevant.

In the five years since data from the first five countries of this study were collected (Farley et al., 1998), prostitution has been increasingly normalized in many cultures where, whether legal or not, it is promoted or tolerated as a reasonable job for women. Internet technology has expanded the global reach of sex businesses, which have sometimes been adopted as governments' development strategies. For example, the International Labor Organization (ILO) promoted prostitution as the "sex sector" of Asian economies despite also citing their own surveys which indicated that in Indonesia, for example, 96% of those interviewed wanted to leave prostitution (Lim, 1998). Although they are

clear regarding their desire to get out of prostitution, the voices of these women in the "sex sector" are ignored. The economic motivation for this failure to listen to those in prostitution is evident: 2.4% of the gross domestic product of Indonesia (US $3.3 billion per year) and 14% of the gross domestic product of Thailand (US $27 billion per year) was supplied by legal sex businesses (Lim, 1998).

A woman in Thailand told us, "I want the world to understand that prostitution is not a good job–so that there are other jobs for women. I want the government to look into what's going on." Instead of the question, "Did she voluntarily consent to prostitution?" the more relevant question would be: "Did she have real alternatives to prostitution for survival?" The incidence of homelessness (75%) among our respondents in 9 countries, and their desire to get out of prostitution (89%) reflect their lack of options for escape. It is a clinical, as well as a statistical error, to assume that most women in prostitution consent to it. In prostitution, the conditions which make genuine consent possible are absent: physical safety, equal power with customers, and real alternatives (MacKinnon, 1993; Hernandez, 2001). Until it is understood that prostitution and trafficking can *appear voluntary* but are not in reality a free choice made from a range of options, it will be difficult to garner adequate support to assist the women and children in prostitution who wish to escape but have no other economic choices.

> I feel like I imagine people who were in concentration camps feel when they get out . . . It's a real deep pain, an assault to my mind, my body, my dignity as a human being. I feel like what was taken away from me in prostitution is irretrievable. (Giobbe, 1991, cited by Jeffreys, 1997)

We can no longer assume that the harm perpetrated against prostitutes is in any way accidental. The institution of prostitution is carefully constructed and promoted. Those of us concerned with global human rights must address the social invisibility of prostitution, the massive denial regarding its harms, its normalization as an inevitable social evil that can be moved far from the neighborhoods of nice people, and the failure to educate students of law, psychology, public health, and criminal justice. Prostitution and trafficking can only exist in an atmosphere of public, professional, and academic indifference.

NOTES

1. We use the term "john" throughout to refer to customers of those in prostitution, because that US English terminology is most commonly used by those in prostitution themselves. Women in the US also refer to customers as "tricks" or "dates." The word

"trick" comes from customers' practices of tricking women into doing more than they pay for; the word "date" suggests that prostitution as a normal part of male-female relationships. There are many different words those in prostitution use to describe customers. Women in Johannesburg, for example, called customers "steamers," referring to the steamed-up windows of cars of Dutch settlers who drove into the city from their farms to buy African girls in prostitution.

2. A pimp is the man or woman who procures the prostitute, promotes, and sells her, and profits from prostitution. By this definition, pimps are not only the men on the street, pimps are also strip club owners, bar owners, disc jockeys, taxi drivers, concierges, motel managers, etc.

3. One group of women (over the age of eighteen) who worked in a brothel in Nevada had stuffed "kitties and puppies" in their cubicles, and their favorite foods were Captain Crunch cereal, and Nestle's Quik (Rubenstein, 1998). Similarly, Winick and Kinsie (1971, p. 146) wrote that adult prostitutes' leisure activities included roller skating and playing with dolls. We suggest that these are dissociated child parts of young women who alternate between reenacting abuse in prostitution and seeking soothing and safety in children's food and activities.

4. Many women are confused about the definition of rape. If rape is any unwanted sex act or coerced, then the statistic would be a much higher percentage. Some women in prostitution assume there is no difference between prostitution and rape, and they only call it rape if they were not paid, regardless of the violence of the act. Additionally, many studies, including our own, interviewed women who were currently prostituting. Asking them about rape is like asking someone in a combat zone if they are under fire. The responses to inquiries about rape in prostitution must make the clinical as well as the statistical assumption that a significant percentage of women currently prostituting deny rape and other violence because it would be too stressful to acknowledge the extreme danger posed by johns and pimps.

5. Sweatshop labor, domestic servitude, and servile marriage frequently involve sexual exploitation or prostitution in addition to labor exploitation.

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