Prostitution in Five Countries: Violence and Post-Traumatic Stress Disorder

(South Africa, Thailand, Turkey, USA, Zambia)

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Feminism & Psychology, 1998, Volume 8 (4): 405-426.

Part One of Three

ABSTRACT, INTRODUCTION, METHOD

ABSTRACT

We initiated this research in order to address some of the issues that have arisen in discussions about the nature of prostitution. In particular: is prostitution just a job or is it a violation of human rights? From the authors' perspective, prostitution is an act of violence against women; it is an act which is intrinsically traumatizing to the person being prostituted. We interviewed 475 people (including women, men and the transgendered) currently and recently prostituted in five countries (South Africa, Thailand, Turkey, USA, Zambia). In response to questionnaires which inquired about current and lifetime history of physical and sexual violence, what was needed in order to leave prostitution and current symptoms of post-traumatic stress disorder (PTSD) we found that violence marked the lives of these prostituted people. Across countries, 73 percent reported physical assault in prostitution, 62 percent reported having been raped since entering prostitution, 67 percent met criteria for a diagnosis of PTSD. On average, 92 percent stated that they wanted to leave prostitution. We investigated effects of race, and whether the person was prostituted on the street or in a brothel. Despite limitations of sample selection, these findings suggest that the harm of prostitution is not culture-bound. Prostitution is discussed as violence and human rights violation.

INTRODUCTION

In an effort to document the experiences of women in prostitution, we interviewed and administered psychological tests to 475 people currently and recently prostituted in five countries (South Africa, Thailand, Turkey, USA, Zambia). These people live in social and legal contexts defining them variously as hated and filthy women, criminals and 'sex workers'. We inquired about respondents' histories of violence in childhood, and in adult prostitution. For many, these two historical periods overlapped. Since violence is associated with psychological trauma, we also inquired about the severity of current symptoms of posttraumatic stress disorder (PTSD).

We began this work from the perspective that prostitution itself is violence against women. The authors understand prostitution to be a sequela of childhood sexual

abuse; understand that racism is inextricably connected to sexism in prostitution; understand that prostitution is domestic violence, and in many instances -- slavery or debt bondage; and we also understand the need for asylum and culturally relevant treatment when considering escape or treatment options for those in prostitution. The perspective that prostitution is violence against women and other political perspectives on prostitution have been described and critiqued by Jeffreys (1997).

Another viewpoint considers prostitution to be an issue which primarily involves economic and sexual determination (Bell, 1994). Prostitutes' rights advocates understand prostitution as just another job, a vocation that they should have a choice to make, and as sexual liberation. Alexander (1996) commented on the advantage to the prostitutes' rights movement brought about by the AIDS epidemic. HIV has indirectly facilitated the growth of the commercial sex industry by funding outreach programs which provide sex workers with a safesex education, condoms, union-style organizing and by legitimizing prostitution as commercial sex work. Customers' anxieties about contracting HIV from those in prostitution has further created a vast pool of research and education monies. The contribution of this study to these differing perspectives will be discussed later.

Sexual and other physical violence is the normative experience for women in prostitution. This has been clinically noted by all four authors, and reported by others (Baldwin, 1992; Farley and Barkan, 1998; Hunter, 1994; McKeganey and Barnard, 1996; Silbert and Pines, 1982; Vanwesenbeeck, 1994). Noting 'everpresent' violence against 361 prostituted women in Glasgow, UK, McKeganey and Barnard (1996) described a range of violent behaviors against women in prostitution ranging from name-calling to physical assault, rape and murder. Of the prostituted women interviewed by Hoigard and Finstad (1992) in Norway, 73 percent were exposed to acts of violence -- physical assaults, rapes, confinement and threats of murder. The remaining 27 percent spoke of the extreme violence which had victimized their friends. The Council for Prostitution Alternatives in Portland, Oregon, USA, reported that prostituted women were raped about once a week (Hunter, 1994). A Canadian report on prostitution and pornography found that women and girls in prostitution had a mortality rate 40 times higher than the national average (Baldwin, 1992).

The diagnosis of PTSD describes psychological symptoms which result from violent trauma. In the language of the American Psychiatric Association (1994), 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; or other threat to one's personal integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.

In response to these events, the person with PTSD experiences fear and helplessness.

Exposure to any of these events may lead to the formation of symptoms of PTSD. These symptoms are grouped into three categories: symptoms of traumatic re-

experiencing (items 1-4 in Table 1); efforts to avoid stimuli which are similar to the trauma as well as a general numbing of responsiveness (items 5-11); and symptoms of autonomic nervous system hyperarousal (items 12-17).

TABLE I
Symptoms of post-traumatic stress disorder (PTSD)

1. Repeated, disturbing memories, thoughts or images of past trauma
2. Repeated, disturbing dreams of past trauma
3. Suddenly acting or feeling as if trauma from the past were happening again
   (as if you were reliving it)
4. Feeling very upset when something reminds you of past trauma
5. Avoiding thinking or talking about past trauma or avoiding having feelings related to it
6. Avoiding activities or situations because they remind you of past trauma
7. Trouble remembering important parts of past trauma
8. Loss of interest in activities which you previously enjoyed
9. Feeling distant or cut off from people
10. Feeling emotionally numb or unable to have loving feelings for those close to you
11. Feeling as if your future will be cut short
12. Having physical reactions (such as heart pounding, trouble breathing, sweating)
    when something reminds you of past trauma
13. Trouble falling or staying asleep
14. Feeling irritable or having angry outbursts
15. Difficulty concentrating
15.Difficulty concentrating
16. Being 'superalert' or watchful or on guard
17. Feeling jumpy or easily startled
17. Feeling jumpy or easily startled

Authors of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) comment that PTSD may be especially severe or long-lasting when the stressor is of human design (e.g. torture, rape).

The following are two examples of symptoms of PTSD: many years after escaping from prostitution, an Okinawan woman who was purchased by US military personnel during the Vietnam War became extremely agitated and had flashbacks of sexual assaults on the 15th and 30th of each month -- those days which were US military paydays (Sturdevant and Stoltzfus, 1992). Describing symptoms which were ignored by her counselor, a survivor of prostitution from the USA stated:

> I wonder why I keep going to therapists and telling them I can't sleep, and I have nightmares. They pass right over the fact that I was a prostitute and I was beaten with 2 x 4 boards, I had my fingers and toes broken by a pimp, and I was raped more than 30 times. Why do they ignore that? (Farley and Barkan, 1998).

The symptoms of PTSD may be cumulative over one's lifetime. Several studies report a positive correlation between a history of childhood sexual assault and symptoms of PTSD in adult women (Farley and Keaney, 1994, 1997; Rodriguez et al., 1997). Since almost all prostituted women have histories of childhood sexual abuse, this undoubtedly contributes to their current symptoms of post-traumatic stress.

Prolonged and repeated trauma usually precedes entry into prostitution. From 55 to 90 percent of those in prostitution report a childhood sexual abuse history (Bagley and Young, 1987; Belton, 1992; Farley and Barkan, 1998; Harlan et al., 1981; James and Meyerding, 1977; Silbert and Pines, 1981, 1983; Simons and Whitbeck, 1991). Silbert and Pines (1981, 1983) noted that 70 percent of their sample told them that the earlier sexual abuse had an influence on the later ‚choice' to become a prostitute. A conservative estimate of the average age of recruitment into prostitution in the USA is 13-14 years (Silbert and Pines, 1982; Weisberg, 1985). Any distinction between prostitution of children and prostitution of adults is arbitrary, and obscures this lengthy history of trauma. The 15-year-old in prostitution eventually turns 18, but she has not suddenly made a new vocational choice. She simply continues to be exploited by customers and pimps.

A number of authors (e.g. Barry, 1995; Hoigard and Finstad, 1992; Leidholdt, 1993; Ross et al., 1990; Vanwesenbeeck, 1994) have described the psychological defenses which are necessitated by the experience of prostitution, and which frequently persist: splitting off certain kinds of awareness and memories, disembodiment, dissociation, amnesia, hiding one's real self (often until the nonprostituted self begins to blur), depersonalization, denial. One woman said, 'Only my head belongs to me now. I've left my body on the street' (Hoigard and Finstad, 1992).

Some have criticized the application of any psychiatric terminology to women who have been harmed by the sexism, racism or class prejudice which comprises male supremacy. There is an assumption that the oppression is dismissed once a psychiatric diagnosis is applied. Pejorative terms such as 'masochistic', 'deviant' or 'borderline' have certainly caused pain and sometimes additional harm to women in prostitution.

On the other hand, the concept of PTSD has been important in describing the psychological symptoms suffered by combat veterans, sexual abuse survivors, concentration camp survivors -- and it may also be useful in describing the psychological harm of prostitution. The authors' experience is that when the trauma-related symptoms of PTSD are discussed, survivors of prostitution feel less stigmatized, less 'crazy' and may experience relief at having their symptoms named. Attaching a name to symptoms associated with severe trauma makes it possible for survivors of prostitution to learn about their own and others' experiences. Further, it becomes possible for survivors to organize politically around their own health needs, just as gay men have organized around HIV.

The diagnosis of PTSD is a departure both from the biological viewpoint that psychological symptoms are essentially biochemical in origin and from the psychoanalytic notion that psychological symptoms result from intrapsychic turmoil.

The diagnosis of PTSD requires an external stressor, clearly implying that psychological symptoms result from material conditions that oppress women.

The diagnosis of PTSD alone, however, does not completely articulate the extent of the psychological harm caused by prostitution. Over time, the constant violence of prostitution, the constant humiliation, and the social indignity and misogyny, result in personality changes. Herman (1992) described long-term changes in trauma survivors' emotional regulation, changes in consciousness, changes in self-perception, changes in perception of perpetrator(s), changes in relations with others, and changes in systems of meaning. These personality changes have been called complex PTSD by Herman and others. Describing prostitution, one woman said:

> It's a process. The first year was like a big party, but eventually progressed downward to the emptiest void of hopelessness. I ended up desensitized, completely deadened, not able to have good feelings because I was on 'void' all the time.

Herman saw these symptoms as resulting from a history of subjection to totalitarian control over a prolonged period, and noted that organized sexual exploitation may be one cause of complex PTSD. The violence of pimps is aimed not only at punishment and control of women in prostitution, but at establishing their worthlessness and invisibility (Dworkin, 1997; Patterson, 1982). The hatred and contempt aimed at those in prostitution is ultimately internalized. The resulting self-hatred and lack of self-respect are extremely long-lasting.

Graham et al. (1994) have also described the psychological consequences of being in prostitution. The Stockholm syndrome -- a psychological strategy for survival in captivity -- is useful in explaining the traumatic bonding which occurs between women in prostitution and their pimps/captors. When a person holds life-or-death power over another, small kindnesses are perceived with immense gratitude. In order to survive on a day-to-day basis, it is necessary to deny the extent of harm which pimps and customers are capable of inflicting. Survival of the person in prostitution depends on her ability to predict others' behavior. So she develops a vigilant attention to the pimp's needs and may ultimately identify with his view of the world. This increases her chances for survival, as did Patty Hearst's identification with her captors' ideology. Graham described other behaviors which are typical of the Stockholm syndrome: extreme difficulty leaving one's captor and a long-term fear of retaliation.

Barry (1995) and Giobbe et al. (1990) estimate that at least 90 percent of prostitution is pimp-controlled. Sexual and physical abuse and torture are used by pimps to keep women from escaping prostitution (Barry, 1995; Dworkin, 1997; Hunter, 1994; MacKinnon, 1993). Pimps in Washington, DC, USA, employ ‚catchers' -- thugs who stand guard at the borders of their turf and 'catch' girls trying to escape from prostitution (Michelle J. Anderson, personal communication, 1996).

Houskamp and Foy (199 1) suggested that a primary etiological variable for the development of PTSD in battered women is the extent of violence to which they have been subjected. Giobbe et al. (1990) compared prostitution to other forms of domestic violence. They described methods of coercive control exercised by pimps

and customers over women in prostitution which are identical to the methods used by battering men to control women: isolation, verbal abuse, economic control, threats and physical intimidation, denial of harm and sexual assault used as a means of control.

Although the incidence of PTSD has been investigated among battered women, and ranges from 45 percent to as high as 84 percent (Houskamp and Foy, 1991; Kemp et al., 1991; Saunders, 1994) -- the frequency of the diagnosis has not been investigated among prostituted women, who are exposed to the same violence as battered women.

PTSD has been assessed in people from non-Western cultures, such as Southeast Asian refugees, Latin American disaster survivors, Navajo and Sioux Vietnam veterans (Marsella et al., 1996). A recent review of the PTSD literature noted that its major limitation is that many of the most traumatized populations have not been studied (de Girolamo and McFarlane, 1996; Keane et al., 1996). Our study documents, across several cultures, some of the violence and traumatic stress which result from being prostituted.

METHOD

Brief structured interviews of people in prostitution were conducted in San Francisco, CA, USA; in two cities in Thailand; in Lusaka, Zambia; in Istanbul, Turkey; and in two cities in South Africa. These countries were included in the study in part because of the first author's wish to include a majority of women of color, since globally prostitution exploits vast numbers of women of color. Second, all four authors shared a commitment to the project of documenting the experiences of women in prostitution, and to providing options for escape.

If respondents indicated that they were working as prostitutes, they were asked to respond to a 23-item questionnaire which asked about the following: physical and sexual assault in prostitution; lifetime history of physical and sexual violence; and the use of or making of pornography during prostitution. The questionnaire 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 had a problem with drugs or alcohol or both.

Respondents also completed the PCL, a 17-item scale which assesses DSM-IV symptoms of PTSD (Weathers et al., 1993). Respondents were asked to rate the 17 symptoms of PTSD (see Table 1) on a scale where: I = not at all; 2 = a little bit; 3 = moderately; 4 = quite a bit; and 5 = extremely. Weathers et al. (1993) report PCL test-retest reliability of .96; internal consistency, as measured by an alpha coefficient, was .97 for all 17 items. Validity of the scale is reflected in its strong correlations with the Mississippi Scale (.93); the PK scale of the MMPI-2 (.77); and the Impact of Event Scale (.90). The PCL has functioned comparably across ethnic subcultures in the USA (Keane et al., 1996).

We measured symptoms of PTSD in three ways. First, using a procedure established by the authors of the scale, we generated a measure of *overall PTSD symptom severity* by summing respondents' ratings across all 17 items.

Second, using Weathers et al.'s (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 of 3 or above, we then noted whether each respondent *met criteria for a diagnosis of PTSD.* PTSD consists of three kinds of symptoms: persistent, intrusive re-experiencing of trauma (B symptoms); numbing of responsiveness and persistent avoidance of stimuli associated with trauma (C symptoms); and persistent autonomic hyperarousal (D symptoms). A diagnosis of PTSD requires at least one B symptom, three C symptoms, and two D symptoms. We report the numbers and percentages of respondents who qualified for a diagnosis of PTSD in each country.

Third, we measured partial PTSD, following Houskamp and Foy (1991) who investigated PTSD among battered women. These authors suggested that if a person meets at least two of the three foregoing criteria for PTSD, a significant degree of psychological impairment exists. We report the numbers and percentages of respondents who *qualified for a diagnosis of partial PTSD* in each country.

The two questionnaires were translated into Thai and Turkish. In Zambia, interviewers translated verbally as needed -most participants spoke some English. The authors either administered or directly supervised the administration of all questionnaires.

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.

In Thailand, we interviewed several of the I 10 respondents on the street, but found that pimps did not allow those they controlled to answer our questions. We interviewed some respondents at a beauty parlor which offered 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.

We interviewed 117 women currently and formerly prostituted at TASINTHA in Lusaka, Zambia. TASINTHA is a nongovernmental organization which offers food, vocational training and community to approximately 600 prostituted women a week.

In Turkey, some women 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 venereal disease control.

In two of the five countries, respondents were racially diverse. In the USA, 39 percent (51) of the 130 interviewees were white European/American, 33 percent (43) were African American, 18 percent (24) were Latina, 6 percent (8) were Asian or Pacific Islander and 5 percent (4) described themselves as of mixed race or left the question blank. In South Africa, 50 percent (34) were white European; 29 percent (20)

were African or Black; 12 percent (8) described themselves as Colored or Brown or of mixed race; 3 percent (2) were Indian; 6 percent (4) left the question blank.

We included transgendered people in this study because they represent a significant minority of those in prostitution. A previous study (Farley and Barkan, 1998) found that transgendered persons experienced the same degree of physical assaults and rapes as did women in prostitution. These authors concluded that to be female, or to appear female, was to be targeted for violence in prostitution. In Turkey and Zambia, all respondents were women. Table 2 below describes gender of respondents in South Africa, Thailand, and the USA.

TABLE 2
Gender

	Women	Men	Transgendered
South Africa	*84% (57)*	*14% (10)*	*2% (l)*
Thailand	*75% (82)*		*25% (28)*
USA	*75% (97)*	*13% (18)*	*12% (15)*

Across the five countries, the average age was 28 years, ranging from 12 to 61 years. See Table 3.

TABLE 3
Age

	South Africa	Thailand	Turkey	USA	Zambia
Mean age	*24*	*26*	*29*	*31*	*28*
Age range	*17-38*	*15-46*	*16-55*	*14-61*	*12-53*

Sample Selection Differences and Limitations to Generalizability

The most daunting challenge in cross-cultural research is sample selection. Were the 475 people we interviewed representative of all women in prostitution? We attempted, as McKeganey and Barnard (1996) did in Glasgow, UK, to contact as broad as possible a range of those in prostitution: women of diverse races, cultures, ages, location where working, and including gender differences. However, 'there is quite simply no such thing as a representative sample of women selling sex' (McKeganey and Barnard, 1996). Given the illegality of prostitution in most places, it was necessary to interview those people to whom we had access. In most cases, researchers have access only to people prostituting on the street. We were fortunate that, in South Africa, we were able to interview 25 people in brothel prostitution. Should it become possible to interview those in massage parlors, escort services, stripping, or others who are in brothel prostitution -- the authors would immediately include these people in a future expansion of this work. We will also share our questionnaires with researchers who have access to these groups of people.

There were differences in the ways the samples were selected. In all cases, we interviewed people who were either currently in prostitution or had recently been

prostituted. In the USA and South Africa, all were *currently* prostituting, whereas a higher proportion of respondents in Thailand and Zambia were actively attempting to leave prostitution and find other employment. Respondents in Turkey were interviewed after they were brought to a clinic by police for STD testing. In Istanbul, as elsewhere in this study, women in prostitution were freely offered STD testing, but other acute and chronic health problems were rarely addressed.

Part Two of Three

RESULTS

In most countries, regardless of the legal status of prostitution, interviewing of people in this study was periodically obstructed by others who controlled their lives, whether brothel operators (Turkey) or pimps/boyfriends (USA), or older women hired to guard those in prostitution (Thailand). Thus recruitment was necessarily opportunistic, relying on the discovery and utilization of sites where these prostituted people were away from the supervision of those who pimped them. This opportunistic sampling means that these samples may or may not be representative of the actual populations of those prostituted in each country. Nevertheless, comparisons of the results from the different countries suggest some noteworthy similarities, as well as differences.

Violence marked the lives of these prostituted people from five countries (see Tables 4 and 5). Since not everyone answered every question, the numbers of responses to a given item varied. Averaging across countries, 81 percent reported being physically threatened in prostitution; 73 percent had been physically assaulted in prostitution; and 68 percent had been threatened with a weapon. In Istanbul, 46 percent of these respondents reported physical assaults by police e.g. being kicked, beaten, or hit with a nightstick.

TABLE 4
Violence in prostitution

	South Africa	Thailand	Turkey	USA	Zambia
Physically threatened in prostitution	75% (48)	47% (36)	90% (45)	100% (114)	93% (102)
Threatened with a weapon in prostitution	68% (45)	39% (32)	68% (34)	78% (100)	86% (94)
Physically assaulted in prostitution	66% (45)	55% (47)	80% (40)	82% (106)	82% (91)
Raped in prostitution	57% (39)	57% (47)	50% (25)	68% (88)	78% (88)
(Of those raped) raped more than five times in prostitution	58% (23)	35% (17)	36% (9)	48% (42)	55% (48)
(Of those raped) raped by customers	75% (17)	17% (3)	44% (4)	46% (19)	38% (18)
(Of those raped) raped by noncustomers	64% (11)	44%(1)	NA	36% (7)	40% (7)
Upset by attempt to make them do what had been seen in pornographic videos or magazines	56% (37)	48% (41)	20% (10)	32% (41)	47% (51)
Had pornography made of them in prostitution	40% (26)	47% (39)	NA	49% (63)	47% (52)

TABLE 5
Violence in the lives of people in prostitution

	South Africa	Thailand	Turkey	USA	Zambia
Current or past homelessness	73% (49)	56% (50)	58% (29)	84% (108)	89% (99)
As a child, was hit or beaten by caregiver until injured or bruised	56% (38)	40% (34)	56% (28)	49% (37)	71% (80)
Sexual abuse as a child	66% (45)	48% (39)	34% (17)	57% (73)	84% (93)
Mean no. of sexual abuse perpetrators	3	3	2	3	8
Current physical health problem	46% (31)	71% (78)	60% (30)	50% (65)	76% (89)
Current alcohol problem	43% (29)	56% (62)	64% (32)	27% (35)	72% (84)
Current drug problem	49% (33)	39% (43)	46% (23)	75% (98)	16% (19)

An average of 62 percent of the respondents from five countries told us that they had been raped since entering prostitution. Of those who were raped, 46 percent had been raped more than five times. Of these 475 respondents, 41 percent reported that they had been upset by attempts to coerce them into imitating pornography and 46 percent had pornography made of them while in prostitution.

An average of 54 percent of these interviewees reported that as children they were beaten by a caregiver to the point of injury. And 58 percent reported sexual abuse as children, with an average of four perpetrators.

Of these respondents, 72 percent reported current or past homelessness, with 61 percent reporting a current physical health problem; 52 percent reported a problem with alcohol addiction; and 45 percent reported a problem with drug addiction. In some of the countries, these percentages were much higher (see Table 5).

We found differences in lifetime and current experiences of violence, based on country. There were statistically significant differences in the experience of physical threat in prostitution (chi square = 105.37; d.f. = 4; p = .000); also in the experience of physical assault in prostitution (chi square = 27.30; d.f. = 4; p = .000); and in rape in prostitution (chi square = 17.79; d.f. = 4; p = .001). Similarly, there were significant differences, by country, in report of childhood physical abuse (chi square = 20.73; d.f. = 4; p = .000) and childhood sexual abuse (chi square = 47.43; d.f. = 4; p = .000).

The mean PTSD severities fell in a narrow range from 51 (Thailand) to 56 (South Africa) (see Table 6). Differences between the five countries' mean PTSD severities were not statistically significant (F = 1.33; d.f. = 4, 397; p = .41). Average PTSD severities across the five countries were slightly higher than treatment-seeking US Vietnam veterans (Weathers et al., 1993).

A person must have at least one of the four B symptoms of intrusive reexperiencing of trauma symptoms, at least three of the seven C symptoms of numbing and avoidance of trauma, and at least two D symptoms of physiologic hyperarousal in order to meet criteria for a diagnosis of PTSD (see Table 1). Across the five countries, an average of 67 percent of these 475 respondents met criteria for a diagnosis of PTSD. Of people currently or recently in prostitution, 75 percent in South Africa, 50 percent in Thailand, 66 percent in Turkey, 68 percent in the USA and 76 percent in Zambia met criteria for a diagnosis of PTSD. The differences between these percentages of people in each country with PTSD were statistically significant (chi square = 19.8; d.f. = 4; p = .001). When the Thai respondents, who were administered the questionnaires in a large group, were excluded from the analysis, the differences between the remaining four countries were not significantly different (chi square = 2.66; d.f. = 3; p = .45).

In order to qualify for a diagnosis of partial PTSD, respondents must meet two of the three foregoing criteria for B, C, and D symptoms. Across the five countries, 85 percent of our respondents met criteria for partial PTSD, which suggests a significant degree of psychological distress. Of people currently or recently in prostitution, 87 percent in South Africa, 72 percent in Thailand, 86 percent in Turkey, 83 percent in the USA and 96 percent in Zambia met criteria for a diagnosis of partial PTSD. The differences between these percentages of people in each country with partial PTSD were statistically significant (chi square = 25.7; d.f. = 4; p = .000). When the Thai respondents, who were administered the questionnaires in a large group, were excluded from the analysis, the differences between the remaining four countries were not significant (chi square 4.24; d.f. = 3; p = .24).

TABLE 6
PTSD Checklist (PCL) means from three studies

		SD*
I Current study		
68 people in prostitution (South Africa)	55.8	16.7
110 people in prostitution (Thailand)	51.1	17.3
50 women in prostitution (Turkey)	52.7	15.1
130 people in prostitution (USA)	54.9	17.8
110 women in prostitution (Zambia)	56.0	12.3

2 Weathers et al. (1993) 123 Vietnam veterans requesting treatment 1006 Persian Gulf War veterans	 50.6 34.8	 20.2 16.3
3 Farley, unpublished data (1994) (Random sample of women members of health maintenance organization) 26 control respondents 25 adult women with childhood physical abuse history 27 adult women with physical and sexual abuse history	24.4 30.6 36.8	7.1 10.4 15.0
*SD = Standard deviation: a measure of variability around the mean.		

We investigated differences in PTSD associated with race in South Africa and the USA. There were no differences between racial groups in South Africa (chi square = 1.56; d.f. = 3; p = .67) or in the USA (chi square = 3.98; d.f. = 4; P = .41).

We also investigated differences in PTSD associated with gender. In the USA, differences in PTSD incidence among women, men and the transgendered were not statistically significant (chi square = 2.48; d.f. = 2; p = .29). In Thailand, differences between women and the transgendered were not statistically significant (chi square = 1.31; d.f. = 1; p = .25). In South Africa, differences between women and men were not significant (chi square = .2 1; d.f. = 1; p = .65).

In South Africa, 25 of our respondents prostituted in brothels and 43 prostituted on the street. There was more violence in the lives of those in street prostitution than brothel prostitution. We found significant differences in the incidence of physical assault in brothels as compared with street prostitution (Fisher's Exact Test, p = .000) and rapes in brothels as compared with street prostitution (Fisher's Exact Test, p = .000). There were no differences in histories of childhood physical and sexual abuse, based on whether the person was prostituted in a brothel or on the street. We investigated the relation between PTSD and whether the person was prostituted in a brothel or on the street. There was no statistically significant difference in incidence of PTSD between brothel and street prostitution (Fisher's Exact Test, p = .25).

There were differences in the availability of support services. All of the women at TASINTHA, in Lusaka, Zambia, and most of the women in northern Thailand, were interviewed at agencies which offered support and job training. These agencies not only advocated but actually provided alternatives to prostitution. This level of support and vocational training was not available in San Francisco at the time of this study. Little governmental or nongovernmental funding in the USA is dedicated to services

for those escaping prostitution. In the USA, there is widespread acceptance of the notion that prostitution is a reasonable job choice for women, and there is denial of the extent of prostitution in that country. On the other hand, European NGOs are more actively involved in providing support services for prostituted women in Asia and Africa.

There were also very few services for those in prostitution in South Africa. A drop-in center in Johannesburg, the House, advocated escape from prostitution for drug-addicted teenagers, and provided emergency services. SWEAT was a peer support agency in Capetown which promoted both safe sex and the sex industry.

We asked respondents what they needed (see Table 7). On average, 92 percent stated that they wanted to leave prostitution; 73 percent needed a physical place of asylum; 70 percent needed job training; 59 percent needed health care; 55 percent wanted individual counseling; and 49 percent wanted peer support; 47 percent needed child care; 45 percent wanted self-defense training; 38 percent needed drug or alcohol addiction treatment; 24 percent thought that prostitution should be legalized.

In South Africa and Zambia, we asked whether respondents believed that legalizing prostitution would decrease violence in prostitution.' In reply 62 percent of respondents in South Africa and 73 percent in Zambia stated that they did not believe that legalization of prostitution would decrease violence in prostitution. It should be noted that at the time the question was asked in South Africa (1996), there was a national political movement promoting legalization of prostitution.

TABLE 7
Responses to 'What do You Need?' Asked of 475 people in prostitution

	South Africa	Thailand	Turkey	USA	Zambia
Leave prostitution	89% (61)	94% (103)	90% (45)	88% (114)	99% (116)
Home or safe place	72% (49)	60% (66)	60% (30)	78% (101)	94% (110)
Job training	75% (51)	57% (63)	46% (23)	73% (95)	97% (114)
Drug/alcohol treatment	46% (31)	32% (35)	6% (3)	67% (87)	37% (43)
Health care	69% (47)	43% (47)	38% (19)	58% (75)	88% (103)
Peer support	58% (39)	49% (54)	24% (12)	50% (65)	63% (74)
Personal counseling	61% (42)	68% (75)	46% (23)	48% (62)	53% (62)
Self-defense training	61% (42)	60% (66)	12% (6)	49% (64)	41% (48)
Legal assistance	58% (39)	58% (64)	NA	43% (56)	54% (63)
Legalize prostitution	38% (26)	28% (31)	4% (2)	44% (57)	8% (9)
Child care	48% (33)	45% (50)	20% (10)	34% (44)	87% (102)
Physical protection from pimp	33% (22)	21% (23)	NA	28% (36)	41% (48)

Part Three of Three
DISCUSSION, ACKNOWLEDGMENTS, NOTES, REFERENCES

DISCUSSION

Our data indicate that violence and PTSD are widely prevalent among 475 prostituted people in five countries. Physical assault, rape and homelessness were common. Despite differences in sample selection, and despite major cultural differences, we found no differences in overall PTSD severity in five countries. There was no difference in the incidence of PTSD in four of the five countries. The traumatic experience of prostitution is a more potent variable than race, gender or state where one was born. These findings suggest that the harm of prostitution is not a culture-bound phenomenon.

We found differences in reports of childhood sexual and physical abuse, and also in physical assault and rape in prostitution. In spite of these differences in current and past violence, the experience of prostitution itself caused acute psychological distress and symptoms of PTSD. Our respondents reported a history of childhood sexual abuse on average 58 percent of the time. Based on previous research, we believe that our figure is lower than the actual incidence of childhood sexual abuse. This may be a result of several factors. First, in the midst of ongoing trauma, reviewing childhood abuse was probably too painful. Second, we did not have the time to establish rapport with interviewees. In Zambia, where 83 percent of respondents indicated a history of childhood sexual abuse, interviewers had previously established relationships with interviewees. Thus the Zambian data on child abuse may be more indicative of its actual occurrence than data from other countries.

In figures comparable to those discussed here, Vanwesenbeeck (1994) found that 40 percent of her respondents reported physical or sexual abuse in childhood; 40 percent had been forced into prostitution or had experienced sexual abuse by an acquaintance; 70 percent had been verbally threatened in prostitution; 60 percent had been physically assaulted; and 40 percent had been sexually assaulted in prostitution in the Netherlands. Vanwesenbeeck reported that 90 percent of prostituted respondents in the Netherlands reported 'nervousness', with a slightly lower 75-80 percent reporting depression, aggression, distrust and guilt. Multiple physical complaints were also common.

It is often assumed that street prostitution is qualitatively different from escort or brothel prostitution. Our data shed some light on this assumption. We found significantly more physical violence in street, as opposed to brothel, prostitution. However, there was no difference in the incidence of PTSD in these two types of prostitution. This suggests that psychological trauma is intrinsic to the act of prostitution. Whether the person was being prostituted in a brothel or on the street seemed to make as little difference in incidence of PTSD as the distinction based on the country in which the person lived.

When we asked those interviewed in South Africa and Zambia if they thought that legalizing prostitution would make them physically safer, a significant majority (62 percent in South Africa and 73 percent in Zambia) told us 'no'. They viewed prostitution as an activity which always involved physical and sexual assault -- legal or not.

In addition to prostitution, other factors may have contributed to the incidence and severity of PTSD seen here. The unemployment rate in Zambia was 90 per cent at the time of this study. Many of the women we interviewed, and their children, were

hungry.'

It is likely that the PTSD score elevations from South Africa and the USA are a result of culture-wide violence, as well as from the harm of prostitution. We are in the process of obtaining a nonprostituted sample of people matched for age, race and class in order to compare their responses to those described here.

Some of the lower Thai scores may have resulted from the fact that most of the Thai respondents answered these questions in a large group. (In all countries except Thailand, questionnaires were administered individually.) Although the measures had been translated into Thai, our assistants, who roamed the large room and offered to help read or write, were not able to provide the personal attention offered in the other countries.

There was no difference in the severity of PTSD symptoms across countries, despite sample selection and cultural differences. The 67 percent incidence of 475 respondents meeting criteria for a diagnosis of PTSD may be compared to battered women seeking shelter (45 percent, Houskamp and Foy, 1991; 84 percent, Kemp et a]., 1991); rape victims from Northern Ireland (70 percent, Bownes et al., 1991); and refugees surviving state-organized violence who attended a torture treatment center (51 percent, Ramsay et al., 1993).

Respondents in this study endorsed similar statements when asked what they needed, regardless of country. A vast majority desired to leave prostitution (92 percent), and in order to do that needed asylum (73 percent), job training (70 percent) and health care (59 percent). Like others who have looked at this question, we found that those in prostitution want what everyone else does -- a home, an education, a job, health care, a partner and a community (Hoigard and Finstad, 1992; El-Bassel et al., 1997). The question raised by this study is not 'Should one have the choice to be a prostitute?' rather: 'Does one have the right *not* to be a prostitute?'

Much of the current medical and psychological literature fails to address the physical and emotional harm which is intrinsic to prostitution. In a 1994 literature review, Vanwesenbeeck commented: 'Researchers seem to identify more easily with clients than with prostitutes.' A recent editorial *(Lancet,* 1996) concluded that 'the health risks of street prostitution are likely to remain small'. HIV transmission is the sole 'health risk' discussed in much of the current literature. Pedersen (1994) suggested that an interest in controlling the spread of HIV has motivated a trend toward legitimizing prostitution as just another job.

Legalization or decriminalization of prostitution would normalize prostitution. We do not think that legalization of prostitution -would improve the lives of women in prostitution -- in fact, according to some of our interviewees, legalization makes their lives worse. Legalization of prostitution puts the state in the role of the pimp, and in the role of ensuring that customers are provided with people who are HIV- and STD-free.

Although we advocate depenalization of prostitution for the person being prostituted, we support vigorous prosecution of customers of prostitutes, and pimps, brothel owners and traffickers. Decriminalization of prostitution primarily benefits customers and pimps, not those in prostitution.

Three of the women in the USA had worked in a locale where prostitution is legal. Preferring to work on the streets of San Francisco, they all stated that their lives in legal brothels were unbearable. Hoigard and Finstad (1992) noted that the systematized degradation inflicted on women in brothels is in many ways worse than street prostitution. The women we interviewed who had left brothels stated that they were completely under the control of the brothel's pimp/owners: they were not permitted to refuse customers; they were usually not allowed to leave the brothel for

eight consecutive days; they were not permitted to choose their own physicians -- and were regularly sexually assaulted by physicians who practiced in brothels.

Apologists for prostitution legitimize it as a freely made and glamorous career choice. We are told that people in prostitution choose their customers as well as the type of sex acts in which they engage. Bell (1994) suggested that prostitution is a form of sexual liberation for women. We are also told that 'high-class' prostitution is different, and much safer than street prostitution. Referring to prostitutes in general, Leigh said 'most of us are middle class' (in Bell, 1994).

None of these assertions was supported by this study. Our data show that almost all of those in prostitution are poor. The incidence of homelessness (72 percent) among our respondents, and their desire to get out of prostitution (92 percent) reflects their poverty and lack of options for escape. Globally, very few of those in prostitution are middle class. Prostitution is considered a reasonable job choice for poor women, indigenous women and women of color, instead of being seen as exploitation and human rights violation. Indigenous women are at the bottom of a brutal gender and race hierarchy. They have the fewest options, and are least able to escape the sex industry once in it. For example, it has been estimated that 80 percent of the street prostituted women in Vancouver, Canada, are indigenous women (Lynne, 1998).

The appearance of choice to work as a prostitute is profoundly deceptive. 'If prostitution is a free choice, why are the women with the fewest choices the ones most often found doing it?' (MacKinnon, 1993). In Amsterdam, a woman described prostitution as 'volunteer slavery', clearly articulating both the appearance of choice and the overwhelming coercion behind that choice (Vanwesenbeeck, 1994).

In prostitution, male dominance is disguised as sexuality (Dworkin, 1997). For the vast majority of the world's women, prostitution is the experience of being hunted, being dominated, being sexually assaulted, and being physically and verbally battered. Intrinsic to prostitution are numerous violations of human rights: sexual harassment, economic servitude, educational deprivation, job discrimination, domestic violence, racism, classism (being treated as if you are worthless because you are poor), vulnerability to frequent physical and sexual assault, and being subjected to body invasions which are equivalent to torture. From the perspective of those we interviewed in five countries, prostitution might at best be called a means of survival: if one wants a place to sleep, food to eat and a way to briefly get off the street, one allows oneself to be sexually assaulted. At its worst, prostitution is kidnapping, torture and sale of parts of the person for sex by third parties.

What is needed is public education regarding the intrinsic violence of prostitution to those in it, and programs which offer options for escape to those in prostitution. In order to offer genuine choices, programs must offer more than condoms, unions and safe-sex training. It is necessary to scrutinize the vast array of social conditions in women's lives which eliminate meaningful choices. Psychological treatment is necessary for both acute PTSD resulting from sexual violence and captivity in prostitution, as well as for the long-term harm resulting from childhood abuse and neglect. Drug and alcohol addiction treatment and health care must be integral to programs offered to people escaping prostitution. We must offer asylum and job training to women who are prostituted and who wish to escape prostitution.

We urge feminist researchers to continue to report -- and protest -- the experiences of women in prostitution.

ACKNOWLEDGMENTS

Roma Guy, at the Bay Area Homelessness Program, San Francisco State University, made vital contributions to this project. Her support helped initiate this work.

Zoe Holder was an interviewer in the USA. Norma Hotaling was coresearcher in the USA. Ilse Puaw assisted with interviews in Capetown. Catherine Mubanga, Theresa Kosheni, Mary Mompela, Clara Kabamba and Annie Kashano were interviewers in Lusaka.

The South African data were collected with support and assistance from Adele du Plessis and Jean du Plessis, without whose contribution this project could not have been completed in South Africa.

Tracy Cohen provided invaluable help in South Africa. Shane Petzer (SWEAT) was generous with his time and assistance.

Amporn Leininger translated the questionnaires into Thai, and also assisted with translating responses from Thai to English.

The Thai data could not have been collected without the generous time and energy contributed by Toi Taylor, Joi Taylor and Ellen Keller, and with assistance from Patricia Green. Toi Taylor translated extensively.

Howard Barkan, DrPH provided statistical analysis and consultation, as well as editorial suggestions.

Erica Boddie organized the coding and data entry phase of the project.

Data entry was provided with the generous help of- Mandy Benson, Erica Boddie, Marilyn Davis, Ruth Lankster and Gail McCann.

Michelle J. Anderson, JD and Jonathan Shay, MD, PhD offered editorial suggestions.

The Turkish data were presented at a symposium at International Society for Traumatic Stress Studies, Jerusalem, March 1996.

A paper which described a portion of the USA research was presented by Melissa Farley and Norma Hotaling at the Fourth World Conference on Women, Beijing, China, 1995.

NOTES

I . The item from the prostitution questionnaire: 'Do you think that if prostitution were legal, sex workers would be any safer? (for example, from rape and assault)' was contributed by Tracy Cohen, Johannesburg, South Africa.

2. A discussion of the ways in which different cultures promote prostitution is extremely important but is beyond the scope of this article. Muecke (1992), for example, has written about the complicity of Buddhist ideology with sexist practices which devalue women. In Thailand, it is possible for prostitutes to gain respect (that is, to gain merit with respect to their karmic debts) only if they contribute large sums

of money to organized religion. If they do not contribute generously to their families and temples, they are treated with extreme contempt.

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