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ARTICLE

Prostitution in Vancouver: Violence and the Colonization of First Nations Women

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Abstract We interviewed 100 women prostituting in Vancouver, Canada. We found an extremely high prevalence of lifetime violence and post-traumatic stress disorder (PTSD). Fifty-two percent of our interviewees were women from Canada's First Nations, a significant overrepresentation in prostitution compared with their representation in Vancouver generally (1.7–7%). Eighty-two percent reported a history of childhood sexual abuse, by an average of four perpetrators. Seventy-two percent reported childhood physical abuse, 90% had been physically assaulted in prostitution, 78% had been raped in prostitution. Seventy-two percent met DSM-IV criteria for PTSD. Ninety-five percent said that they wanted to leave prostitution. Eighty-six percent reported current or past homelessness with housing as one of their most urgent needs. Eighty-two percent expressed a need for treatment for drug or alcohol addictions. Findings are discussed in terms of the legacy of colonialism, the intrinsically traumatizing nature of prostitution and prostitution's violations of basic human rights.

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Key words colonization • First Nations • post-traumatic stress disorder • prostitution • sexual assault

Prostitution is a gendered survival strategy that involves the assumption of unreasonable risks by the person in it. A number of authors have documented and analyzed the sexual and physical violence that is the normative experience for women in prostitution (Baldwin, 1993, 1999; Barry, 1979, 1995; Boyer, Chapman, & Marshall, 1993; Dworkin, 1981, 1997; Farley, Baral, Kiremire, & Sezgin, 1998; Giobbe, 1991, 1993; Hoigard & Finstad, 1986; Leidholdt, 1993; MacKinnon, 1993, 2001; McKeganey & Barnard, 1996; Miller, 1995; Silbert & Pines, 1982; Silbert, Pines & Lynch, 1982; Vanwesenbeeck, 1994; Weisberg, 1985). For example, Silbert and Pines (1981, 1982) reported that 70% of women suffered rape in prostitution, with 65% having been physically assaulted by customers, and 66% assaulted by pimps. The foregoing authors include data from Burma, Germany, Mexico, Philippines, the Netherlands, Norway, Scotland, South Africa, Thailand, Turkey, USA and Zambia.

Most of those in prostitution began prostituting as adolescents. Nadon, Koverola, and Schludermann (1998) found that 89% had begun prostitution before the age of 16. Of 60 women prostituting in escort, street, strip club, phone sex,[1] and massage parlors in Seattle, all began prostituting between the ages of 12 and 14 (Boyer et al., 1993). In Canada, as elsewhere, most women and men enter prostitution as adolescents (Lowman, 1993).[2] Fifty-two percent of 183 Vancouver women were first prostituted when they were younger than 16 years, and 70% first prostituted before age 18 (Cunningham & Christensen, 2001). Children typically enter prostitution subsequent to abusive treatment by caregivers (Lowman, 1993) and subsequent to running away from dangerous home environments (Federal/Provincial Territorial Working Group on Prostitution, 1998).

Most people in prostitution were sexually abused as children, usually by several perpetrators. Farley and colleagues (2003) found an average of four perpetrators of childhood sexual abuse against those in prostitution in nine countries. Those in prostitution are often still children (Youth Delegates of Out of the Shadows, 1998). Across nine countries on five continents, 47% of the people in prostitution entered it when they were less than 18 years of age (Farley et al., 2003). One girl prostituting in Seattle said:

> We've all been molested. Over and over, and raped. We were all molested and sexually abused as children, don't you know that? We ran to get away. They didn't want us in the house anymore. We were thrown out, thrown away. We've been on the street since we were 12, 13, 14. (Boyer et al., 1993, p. 16)

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The most relevant paradigm currently available for understanding the harm of prostitution is that of domestic violence. Physical coercion, rape and violence by husband/partner/pimp and john are perpetrated against women in prostitution (Currie, 1994; Lowman, 1993; Lowman & Fraser, 1995; Miller, 1995). Of 854 people in prostitution, 73% reported that they had been physically assaulted in prostitution (Farley et al., 2003). In most instances, women in prostitution are battered women. Giobbe (1993) compared pimps and batterers and found similarities in their use of enforced social isolation, minimization and denial, threats, intimidation, verbal and sexual abuse, attitude of ownership, and extreme physical violence to control women.

One survivor described prostitution as a 'harrowing metamorphosis' that included frequent physical assaults and which ultimately resulted in a 'neutralization of the body' (Jaget, 1980, p. 188) or somatic dissociation. The physical and emotional violence of prostitution leads to somatic dissociation which itself has been regularly associated with chronic health problems (Kirkingen, 2001). In 1858, Sanger asked 2000 prostitutes in New York about their health and concluded that 'premature old age' was the invariable result of prostitution (cited in Benjamin & Masters, 1964). Today we view the chronic ill health of those in prostitution as resulting from physical abuse and neglect in childhood (Radomsky, 1995), sexual assault (Golding, 1994), battering (Crowell & Burgess, 1996), untreated health problems, and overwhelming stress and violence (Friedman & Yehuda, 1995; Koss & Heslet, 1992; Southwick, Yehuda, & Morgan, 1995).

Sanger described conditions of despair, degradation, decline, and early death among women in prostitution who survived, on average only 4 years from entry into prostitution (Benjamin & Masters, 1964). Making the same observation in the parlance of today's global marketplace, an anonymous pimp commented on the 'brief shelf life' of a girl in prostitution. Pheterson (1996) summarized the health problems of women in prostitution: exhaustion, frequent viral illness, sexually transmitted diseases, vaginal infections, backaches, sleeplessness, depression, headaches, stomachaches, and eating disorders. The longer women were in prostitution, the more sexually transmitted diseases they reported (Parriott, 1994). Women who were used by more customers in prostitution reported a range of more severe physical symptoms (Vanwesenbeeck, 1994).

Prostitution can be lethal (Potterat et al., 2004). A Canadian commission found that the death rate of women in prostitution was 40 times higher than that of the general population (Special Committee on Pornography and Prostitution, 1985). A study of Vancouver prostitution reported a 36% incidence of attempted murder (Cler-Cunningham & Christenson, 2001).

Vancouver agencies serving women in prostitution have observed many

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First Nations women in prostitution. We use the words First Nations as a term of respect for people whose ancestors were the first nations of people in North America. We use the term Aboriginal interchangeably with First Nations.[3] In a number of communities across Canada, Aboriginal youth comprise '90% of the visible sex trade' (Save the Children Canada, 2000, p. 7), suggesting the importance of placing prostitution in historical context. Acknowledging the adverse effects of colonialism, Cler-Cunningham and Christenson (2001) observed the 'immense overrepresentation' of Aboriginal women in Vancouver's street-level sex trade.

The Royal Commission on Aboriginal Peoples (RCAP) documented the perilous state of Aboriginal housing: 84% of Aboriginal households on reserves did not have sufficient income to cover housing (RCAP, 1996). Housing instability results in reserve-to-urban migration, leaving young women vulnerable to prostitution, in that homelessness has been established as a primary risk factor for prostitution (Boyer et al., 1993; Louie, Luu, & Tong, 1991; Silbert & Pines, 1983). When women in prostitution are asked what they need, first on their list is housing (Farley et al, 1998).

Colonization and racism result in extensive and insidious trauma that wears away its victims' mental and physical health (Kelm, 1998; Root, 1996). Colonization of First Nations in Canada by the British and the French resulted in well-documented health problems (Waldram, Herring & Young, 2000). The combined effects of poverty, race discrimination and cultural losses profoundly affect First Nations and are likely contributing factors to high rates of interpersonal violence, depression, suicide and substance abuse (Kirmayer, 1994).[4] Canada's Royal Commission on Aboriginal Peoples referred to premature death as one of the consequences of colonization:

> Aboriginal people are more likely [than non-Aboriginal people] to face inadequate nutrition, substandard housing and sanitation, unemployment and poverty, discrimination and racism, violence, inappropriate or absent services, and subsequent high rates of physical, social and emotional illness, injury, disability and premature death. (RCAP, 1996, p. 107)

The suicide rate among First Nations people across Canada was three times that of other Canadians and six times higher for those aged 15–24 years (Bobet, 1990).

The prevalence of violence against Aboriginal women is extremely high. The death rate of First Nations women from homicide is more than four times greater than that of all Canadian women (Health Canada, Medical Services Branch, unpublished tables, 1995, cited in RCAP, 1996, p 153). Nahanee (1993) wrote of 'the almost total victimization of [Aboriginal] women and children' and concluded 'violence against Aboriginal women

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has reached epidemic proportions according to most studies conducted over the past few years. This violence includes the victimization of women and their children, both of whom are seen as property of their men (husbands, lovers, fathers), or of the community in which they live' (Nahanee, 1993, pp. 360–361). Similarly in the United States, 80% of indigenous women seeking health care at one clinic reported having been raped (Old Dog Cross, 1982).

First Nations gay men like First Nations women, are in double jeopardy. Comparing Canadian Aboriginal and non-Aboriginal gay men, researchers found that Aboriginal gay men were significantly more likely to be poor, unstably housed, more depressed, to have been sexually abused as children, to have been raped, and to have been prostituted (Heath et al., 1999).

The diagnosis of post-traumatic stress disorder (PTSD) describes psychological symptoms resulting from overwhelmingly traumatic events such as rape, war, and prostitution. 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' (American Psychiatric Association, 1994). PTSD is characterized by anxiety, depression, insomnia, irritability, flashbacks, emotional numbing, and hyperalertness. Symptoms are more severe and long lasting when the stressor is of human design. PTSD is common among prostituted women. Farley and colleagues (1998) found a PTSD prevalence rate of 67% among those in prostitution in five countries.

Cultural and social factors are known to have a causal role in PTSD symptoms (U.S. Department of Health and Human Services, 2001). Trauma history and PTSD vary by race/ethnicity and national origin with, for example, refugees from South Asian countries experiencing high rates of war-related traumatic events (Mollica et al., 1990) and indigenous peoples in the United States suffering multiple and cumulative trauma when compared with other groups (Robin, Chester, & Goldman, 1996). In a study that included a majority of Alaska Native women, 70% of a sample of pregnant women in substance abuse treatment had experienced childhood physical and sexual abuse (Brems & Namyniuk, 2002).

There are many anecdotal accounts and case studies of prostitution (Farley & Kelly, 2000). We noted the need for quantitative data. This work was an attempt to expand a quantitative database on prostitution, history of violence and PTSD that now includes nine countries (Farley et al., 2003). An analysis of the intersections of race, class and gender is crucial

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to an understanding of prostitution. In reviewing the literature regarding colonialism, cultural alienation, and violence against First Nations, we predicted that First Nations women, compared with non-First Nations women in prostitution, would report increased rates of violence both during prostitution and in their lives prior to prostitution. Given the previous findings of extremely high rates of PTSD among those prostituted, we did not anticipate finding differences in PTSD between First Nations women and white European-Canadian women in prostitution.

Method

Brief structured interviews of 100 prostituting women and children were conducted in Vancouver, Canada. We contacted agencies working with prostitutes and set up collaborative efforts where possible. The second author was a board member of a Vancouver agency that provided services to prostitutes and was familiar with locations where prostitution commonly occurred in Vancouver. She was known to some of our interviewees in her capacity as a social worker. Interviewers were screened for the ability to establish an easygoing rapport on the street and in occasionally dangerous locations.

The women we interviewed were from the Downtown Eastside, Franklin, and Broadway/Fraser prostitution strolls in Vancouver, BC. We attempted to contact any woman known to be prostituting, whether indoor or outdoors. Using a snowball recruitment technique, we asked women to let their friends who were prostituting elsewhere (e.g. in other areas or indoors) know that we would return to a specific location at a specific time the next day. Usually we had access only to people prostituting on the street. Only four women refused to participate; several appeared to be in the process of approaching customers.

Informed consent included a summary of research goals and participants' rights. Respondents' copies of the consent form included names and phone numbers of local agencies that could be contacted for support and assistance and included the authors' phone numbers and email addresses. In all cases we offered to read the items to respondents. Most were able to complete the questionnaire without assistance; however, a few were illiterate.

If respondents indicated that they were prostituting we asked them to fill out three questionnaires. We paid a small stipend ($10 Canadian) to those who responded to the three questionnaires. The Prostitution Questionnaire (PQ), used in similar research in South Africa, Thailand, Turkey, the USA and Zambia, consists of 32 items asking about physical and sexual assault in prostitution, lifetime history of physical and sexual violence, and the use of or making of pornography during prostitution (Farley et al.,

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1998). 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 used drugs or alcohol or both. Because of item heterogeneity, psychometrics on the PQ are not available. Sample items include:

2. Since you've been in prostitution, have you been physically assaulted?
14a. When you were a child, were you ever hit or beaten by a parent or caregiver until you had bruises on your body or were injured in some other way by them?
16. Did you ever have pictures taken of you while you were working in prostitution?
19. Have you ever been homeless?

Respondents also completed the PTSD Checklist (PCL), a 17-item scale that assesses DSM-IV symptoms of PTSD (Weathers, Litz, Herman, Huska, & Keane, 1993). Respondents were asked to rate the 17 symptoms of PTSD (see Table 1) on a 5-point scale with 1 = *not at all*; 2 = *a little bit*; 3 = *moderately*; 4 = *quite a bit*; and 5 = *extremely*. Weathers and colleagues (1993) report PCL test–retest reliability of .96. Internal consistency as measured by Cronbach's alpha was .97 for all 17 items. Validity of the scale is reflected in its strong correlations with the Mississippi PTSD 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, Kaloupek, & Weathers, 1996).

Based on previous responses to open-ended questions about health problems among prostituted women, we constructed a Chronic Health Problems Questionnaire (CHPQ; Farley et al., 1998). The CHPQ is a symptom checklist with dichotomous items. Interviewees were asked whether or not they had symptoms or experienced events commonly reported by women in prostitution. Sample items included joint pain, jaw pain, loss of feeling on skin, pain in breasts and head injury. Scale mean was 17.6, with $SD = 8.6$. Internal consistency as measured by Cronbach's alpha was .92 for 36 items.

Once it was apparent that we were interested in hearing about women's experiences during prostitution, many volunteered information regarding what prostitution was like for them. Some of their observations are included here. Whenever an interviewee wanted to talk with us, we welcomed that and took notes. During this process, referrals were made to substance abuse treatment centers, First Nations community centers and medical clinics.

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Participants

We describe all of the 100 interviewees in this study as women, although one respondent identified as transgendered. This person was included as a woman with the rest of our respondents. Ages ranged from 13 to 49 years, with a mean age of 28 years (SD = 7.8 years).

The youngest age at recruitment into prostitution was 10 years. Respondents spent an average of 10 years in escort, massage, and street prostitution (SD = 7 years). A few respondents had been in prostitution less than a year, with 4 months being the least amount of time any of our interviewees spent in prostitution. One woman had been prostituted for 31 years.

With respect to race/ethnicity, 52% were First Nations, 38% were white European-Canadian, 5% were African-Canadian, and 5% left the question unanswered. Ethnicity was self-reported. The majority of the 52 First Nations women described themselves as Native (n = 24), First Nations (n = 2) or Native Indian (n = 2). Next most often, they described themselves as Metis (n = 10), 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. Historically, the two major colonizers of First Nations of Canada were the British and the French; therefore most of those called Metis were First Nations/French or First Nations/British. In current use in the Downtown Eastside of Vancouver, the word Metis refers to anyone who is biracial or multiracial. We use the term Metis in its broadest sense and not as a term that refers to legal status. The First Nations women also categorized themselves as Cree or Cree Native (n = 3), Cree/French (n = 2), Ojibwa (n = 2), Aboriginal (n = 2), Native/El Salvador (n = 2), Blackfoot/Cree (n = 1), Cree/Metis/Mexican (n = 1), and Interior Salish (n = 1). In order to make statistical comparisons, we collapsed all the foregoing groups into the category 'First Nations.' Fewer than 10 women identified themselves by nation, so we were unable to compare nations in our analyses.

Results

Childhood Violence

Eighty-two percent of our respondents reported a history of childhood sexual abuse, by an average of four perpetrators. This statistic (those assaulted by an average of four perpetrators) did not include those who responded to the question 'If there was unwanted sexual touching or sexual contact between you and an adult, how many people in all?' with 'tons' or 'I can't count that high' or 'I was too young to remember.' Seventy-two percent reported that as children, they had been hit or beaten by a caregiver until they had bruises or were injured.

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Eighty-six percent of these women in Vancouver prostitution reported current or past homelessness.

Physical and Sexual Violence in Prostitution

Ninety percent of these women had been physically assaulted in prostitution. Of those who reported physical assault, 82% of the perpetrators were their customers. Eighty-nine percent had been physically threatened while in prostitution and 67% had been physically threatened with a weapon. Seventy-eight percent had been raped in prostitution, with 67% of those raped having been raped more than five times. Seventy-six percent of those who had been raped had been raped by customers.

Sixty-seven percent of our interviewees reported that pornography was made of them in prostitution; and 64% had been upset by an attempt to force them to perform an act that customers had seen in pornography.

Verbal and Emotional Abuse in Prostitution

Eighty-eight percent of the women responding to our questionnaires reported that they had been verbally abused. One woman commented, 'lots of [customers] are super-nice at first. Then when the sex act starts, they get real verbally abusive.' Another told us that while legal prostitution might make her feel safer from physical assaults, it would not change the verbal abuse and harassment that she knew was intrinsic to prostitution.

Physical Health Problems

Sixty-three percent of these women in prostitution reported health problems. Common symptoms were memory problems (66%), trouble concentrating (66%), headaches (56%), dizziness (44%), vision problems (45%), hearing problems (40%), balance problems (41%), aching muscles (78%), joint pain (60%), jaw pain (38%), and swelling of limbs (33%). Cardiovascular symptoms included chest pain (43%), pain/numbness in hands/feet (49%), irregular heartbeat (33%) and shortness of breath (60%). Sixty-one percent of these respondents had cold/flu symptoms. In addition, 35% reported allergies and 32% reported asthma. Twenty four percent reported both painful menstruation and vaginal pain. Twenty three percent had breast pain. In response to a general query about health, 30% of the women we interviewed reported hepatitis C. Some of the cardiovascular, neurological and joint complaints may have been symptoms of drug withdrawal.

Seventy-five percent of the women reported physical injuries from violence in prostitution. Many reported stabbings and beatings,

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concussions and broken bones (broken jaws, ribs, collar bones, fingers, spinal injuries, and a fractured skull), as well as cuts, black eyes, and 'fat lips.'[5] Fifty percent of these women had head injuries resulting from violent assaults with, for example, baseball bats and crowbars. Many had their heads slammed against walls and against car dashboards. Customers and pimps regularly subjected then to extreme violence when they refused to perform a specific sex act.

Post-Traumatic Stress Disorder

PTSD consists of three types of symptoms: (1) persistent, intrusive re-experiencing of trauma; (2) numbing of responsiveness and persistent avoidance of stimuli associated with trauma; and (3) persistent autonomic hyperarousal. A diagnosis of PTSD requires at least one intrusive symptom, three numbing/avoidance symptoms, and two hyperarousal symptoms, as well as having experienced a traumatic stressor (criterion A). Criterion A requires having experienced or witnessed an event or events involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and reacting with intense fear, helplessness, or horror to these events (American Psychiatric Association, 1994). Attempted rape is commonly accepted as meeting criterion A for diagnosis of PTSD (Avina & O'Donohue, 2002). Ninety percent of our respondents had themselves been physically assaulted in prostitution. Based on previous findings we concluded that all of our respondents met criterion A by having experienced or witnessed serious injury.

We summed respondents' ratings across the 17 items of the PCL, generating an overall measure of PTSD symptom severity that was previously used by the scale's authors. Mean PCL score for our respondents was 55.7 ($SD = 15.6$).

Using Weathers et al.'s (1993) formulation we considered a score of 3 (*moderately*), 4 (*quite a bit*) or 5 (*extremely*) on a PCL item to be a symptom of PTSD. Eighty-nine percent of our respondents endorsed at least one intrusive symptom of PTSD, 81% endorsed at least three numbing and avoidance symptoms of PTSD, and 85% endorsed at least two of the physiologic hyperarousal symptoms of PTSD. The mean scores for these 100 women in prostitution were within the clinically symptomatic range (3 or greater) on two of the five intrusive symptoms, for all seven of the numbing/avoidance symptoms, and all five of the hyperarousal symptoms of PTSD. See Table 1 for mean scores of each of the 17 PCL items. Seventy-two percent of our respondents met criteria for a PTSD diagnosis.

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TABLE 1
PTSD symptoms of 100 Vancouver women in prostitution

PTSD symptom	*Mean*	*SD*	*Percent responding at PTSD symptom level (%)*
Intrusive re-experiencing (B symptoms)			
Memories of trauma from the past	3.1	1.3	64
Dreams of trauma from the past	2.8	1.4	54
Act/feel as if traumatic event were happening again	2.8	1.3	53
Very upset when reminded of trauma from past	3.5	1.2	76
Physical reactions to memories of past trauma	2.6	1.4	52
Numbing and avoidance (C symptoms)			
Avoid thinking or feeling about past trauma	3.5	1.4	76
Avoid activities which remind you of past trauma	3.4	1.4	68
Trouble remembering parts of trauma from past	3.1	1.5	65
Loss of interest in activities you used to enjoy	3.8	1.3	78
Feeling distant or cut off from people	3.7	1.4	72
Emotionally numb; unable to have loving feelings	3.4	1.5	70
Feel as if future will be cut short	3.4	1.5	68
Hyperarousal (D symptoms)			
Trouble falling or staying asleep	3.1	1.4	67
Feeling irritable or having angry outbursts	3.3	1.5	64
Difficulty concentrating	3.3	1.3	72
'Superalert' or watchful or on guard	3.6	1.3	81
Feeling jumpy or easily startled	3.3	1.5	66

History of Violence and PTSD

We investigated four types of lifetime violence experienced by these interviewees: childhood sexual assault, childhood physical assault, rape in adult prostitution, and physical assault in adult prostitution. Eighty-nine percent reported childhood sexual assault, 72% reported childhood physical assault, 92% reported rape in adult prostitution, and 90% reported physical assault in adult prostitution. Four percent of the sample had experienced only one type of lifetime violence, 11% reported two types, 23% reported three types, and 62% reported experiencing all four types of lifetime violence.

PTSD diagnosis and severity were not related to number of types of lifetime violence as would normally be expected. These respondents' extremely high incidence of lifetime violence created a ceiling effect. Because 85% of the sample experienced three or four types of lifetime violence, there were not enough people in the group who experienced only

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one or two forms of lifetime violence (15%) to determine whether there was a relationship between PTSD severity and number of different types of lifetime violence.

Current Needs of Interviewees

Ninety-five percent of these respondents stated that they wanted to leave prostitution. Eighty-two percent expressed a need for drug or alcohol addiction treatment. They voiced a need for job training (67%), a home or safe place (66%), individual counseling (58%), self-defense training (49%), health care (41%) and peer support (41%). Thirty-three percent needed legal assistance, 32% wanted legalized prostitution, 12% needed childcare, and 4% wanted physical protection from pimps.

Differences with Respect to Race/Ethnicity

We compared First Nations women with European-Canadian women in a number of analyses. Table 2 summarizes these comparisons. Childhood sexual abuse was reported significantly more often by interviewees identifying as First Nations than by those describing themselves as European Canadian (χ^2 (1) = 5.2, p = .02). Of those First Nations women reporting sexual abuse, relatives were specified as perpetrators 41% of the time, adult friends or community members were specified as perpetrators 34% of the time, and an older child was specified as perpetrator 25% of the time. Significantly more First Nations women than European-Canadian women reported childhood physical abuse (χ^2 (1) = 5.6, p = .02).

TABLE 2
Comparison of First Nations and European-Canadian women: Childhood physical and sexual abuse, homelessness, and violence in prostitution

	First Nations		*European-Canadian*			
	%	*(n = 52)*	*%*	*(n = 38)*	χ^2	*p*
Childhood physical abuse*	81	(42)	58	(22)	5.6	.02
Childhood sexual abuse*	96	(50)	82	(31)	5.2	.02
Verbal abuse in prostitution	88	(45)	92	(35)	1.0	.30
Physical abuse in prostitution	88	(46)	89	(34)	.02	.88
Raped in prostitution	92	(48)	92	(35)	.00	.97
Threatened with a weapon	63	(33)	66	(25)	.16	.69
Homelessness	83	(43)	87	(33)	.43	.51
Upset by being forced to imitate pornography	69	(36)	58	(22)	1.2	.28
Had pornography made of them	65	(34)	60	(23)	.49	.48

*$p < .05$.

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TABLE 3
Responses to 'What do you need?' asked of women in prostitution

	First Nations		*European-Canadian*			
Need	*%*	*(n = 49)*	*%*	*(n = 36)*	χ^2	*p*
Drug or alcohol treatment	88	(43)	75	(27)	2.3	.13
Job training*	78	(38)	56	(20)	4.6	.03
Individual counseling*	67	(33)	44	(16)	3.9	.05
Self-defense training**	63	(31)	33	(12)	7.4	.006
Home or safe place	61	(30)	75	(27)	1.3	.25
Peer support*	53	(26)	25	(9)	6.3	.01
Medical or health care	41	(20)	36	(13)	.2	.66
Legal assistance	33	(16)	28	(10)	.2	.63
Legalized prostitution	24	(12)	36	(13)	1.3	.24
Childcare	16	(8)	8	(3)	1.2	.28
Physical protection from pimp	4	(2)	3	(1)	.1	.75

Note. Five participants did not respond to these questions.
*$p < .05$; **$p < .01$.

There were ethnic differences in response to a needs assessment. See Table 3. First Nations women indicated a significantly greater need for self-defense training (χ^2 (1) = 7.4, p = .006), a greater need for peer support (χ^2 (1) = 6.3, p = .01), a greater need for job training (χ^2 (1) = 4.6, p = .03), and for individual counseling (χ^2 (1) = 3.9, p = .05).

We found no race/ethnic differences in the frequency of health problems endorsed on the Chronic Health Problems Questionnaire (F(1,82) = .06, p = .81).

First Nations women in the sample were not more likely than European Canadians to qualify for a diagnosis of PTSD (χ^2 (1) = .01, p = .92) nor was there a significant statistical relationship between PTSD severity, as measured by the mean PCL sum score and First Nations heritage (Pearson r = –.02, p = .86).

Discussion

The clinical expression 'hypervigilance' does not adequately describe the physical terror and despair we witnessed in many of these women. Violence seemed to be in the very air they breathed. Our findings document this extreme level of sexual violence. One woman told us that she was continually raped in prostitution, explaining 'what rape is to others, is normal to us.' Another woman, aged 36, described a rape as the 'defining experience' of her life. At age 16 she was raped at knifepoint after which the rapist gave her a gold chain in effect paying her for the rape and defining her as a prostitute.

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Most of our respondents had been physically assaulted (90%) or raped (78%) in prostitution. A fear of men was pervasive. One woman told us that being hit and bruised were 'just your common aggressiveness from men.' In a separate study of Vancouver prostitution, 68% of women had been recently raped, 72% had been kidnapped, and 89% had had customers refuse condoms in the previous year (Cunningham & Christenson, 2001).

For many of our interviewees, accommodation to violence began in childhood. Most women in this study (82%) reported sexual abuse as children, usually with multiple perpetrators. Currie (1994) found a comparable prevalence of childhood sexual abuse (73%) among 600 women prostituting in Vancouver. Benoit and Millar (2001) noted a 55% incidence of childhood sexual abuse among 201 women prostituting in Victoria, BC. A Toronto study noted that many women who were prostituting cited 'persistent abuse' as precipitating their drug use (Butters & Erickson, 2003).

Cler-Cunningham and Christenson (2001) reported that 85% of 183 women in Vancouver prostitution had been verbally or physically harassed more than once in the past year. The verbal abuse in prostitution is socially invisible just as other sexual harassment in prostitution is normalized and invisible. Yet it is pervasive: 88% of our respondents described verbal abuse as intrinsic to prostitution. Customers' verbal assaults in all types of prostitution are likely to cause acute and long-term psychological symptoms. A woman in another study explained this: 'It is internally damaging. You become in your own mind what these people do and say with you. You wonder how could you let yourself do this and why do these people want to do this to you?' (Farley, 2003b). The verbal abuse against prostituted women is reflected in the names that all women are called by violent men during sexual assaults. The epithets seem intended 'to humiliate, to eroticize, and to satisfy an urge for self-justification.' (Baldwin, 1992, p. 60).

The 72% incidence of current PTSD in these women in prostitution is among the highest reported in populations where PTSD has been studied, including battered women, combat veterans, childhood trauma survivors, rape survivors, and torture survivors (Bownes, O'Gorman, & Sayers, 1991; Farley et al., 1998; Feeney, Zoellner, & Foa, 2000; Houskamp & Foy, 1991; Kemp, Rawlings, & Green, 1991; Ramsay, Gorst-Unsworth, & Turner, 1993; Weathers et al., 1993). Rates of PTSD among these prostituted women from Canada did not differ significantly from prostituted women in other countries including South Africa, Thailand, Turkey, the USA and Zambia ($F(5,575) = .95$, $p = .45$). The mean PCL score (56) of these prostituted women was in the same range (51–56) as that of people in prostitution in South Africa, Thailand, Turkey, the USA and Zambia (Farley et al., 1998) and similar to the mean PTSD score (51) of treatment-seeking Vietnam

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veterans (Weathers et al., 1993) and much higher than means in studies of Persian Gulf War veterans (35, Weathers et al., 1993), and women HMO members with and without childhood physical and sexual abuse (24–37, Farley & Patsalides, 2001).

When we compared European-Canadian women with First Nations women we did not find differences in PTSD. The pervasiveness and severity of trauma exposure experienced by these women in prostitution may have obscured differences in PTSD that would otherwise be expected on the basis of race/ethnicity. Our findings are consistent with two studies that failed to find race differences in PTSD symptoms among combat veterans (Beals et al., 2002; Monnier, Elhai, Frueh, Sauvageot, & Magruder, 2002). In these studies, combat (like prostitution) was the overwhelmingly traumatic event that mitigated differences in PTSD based on race.

Our respondents appeared to be in a state of almost constant revictimization. The assaults against these women in prostitution were part of a lifetime surround of exploitation and abuse. Because of this pervasive violence we cannot separate the effects of childhood and adult violence on current PTSD symptoms. It is likely that experiences of violence over the course of one's lifetime have a cumulative effect on PTSD symptoms (Follette, Polusny, Bechtle, & Naugle, 1996). Other research found that a history of sexual assaults is a common precursor to prostitution. West, Williams, and Siegel (2000) found that women were most likely to prostitute if they had experienced *both* sexual abuse as children and were later revictimized by rape as adults. One young woman told Silbert and Pines (1982, p. 488), 'I started turning tricks to show my father what he made me.' Dworkin (1997, p. 143) described incest as 'boot camp' for prostitution.

Fifty-two percent of our respondents were First Nations women, a lower percentage than the 70% of First Nations women in street prostitution in another Vancouver study (Currie, 1994, reported in Federal/Provincial Territorial Working Group, 1998). In population census estimates, 7% of Vancouver's people are First Nations (Vancouver/Richmond Health Board, 1999). The overrepresentation of First Nations women in prostitution, and prostitution's prevalence in an area of Vancouver with a high proportion of First Nations residents reflects not only their poverty, but also their marginalized and devalued status as Canadians. Others report similar findings. For example 15% of women in escort prostitution in Victoria, BC were First Nations although the First Nations population of Victoria has been estimated at 2% (Benoit & Millar, 2001 p. 18).

In New Zealand, Plumridge and Abel (2001) observed that 7% of the Christchurch population were Maori women but 19% of those in Christchurch prostitution were Maori women. Maori in prostitution were significantly more likely than European-ancestry New Zealanders to have

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experienced homelessness and to have entered prostitution as children (Farley, 2003a). As we did in Vancouver, New Zealand researchers sampled from the poorest community in Auckland and reported that twice as many Maori there were in prostitution (40%) compared with their representation in northern New Zealand generally (21%) (Saphira & Herbert, 2003). In the early 1990s, Atayal and other Aboriginal girls comprised 70% of those in Taiwanese debt-bondage prostitution although they were only 1.8% of the total population (Hwang & Bedford, 2003). The researchers noted that pathways into prostitution for Aboriginal Taiwanese adolescents were similar to those pathways elsewhere: globalization of the economy, social and cultural disruption, race/ethnic discrimination, and extremely high levels of family violence.

For women, prostitution is intimately associated with poverty. Its First Nations residents refer to Vancouver's Downtown Eastside, one of the poorest areas in North America, as the 'urban reserve.' Colonization left many First Nations people in extreme poverty that has endured for generations (LaFramboise, Choney, James, & Running Wolf, 1995). Eighty-six percent of our respondents were currently or previously homeless. First Nations youth who leave their home communities for urban areas are particularly vulnerable to sexual exploitation in that they are both homeless and in an unfamiliar cultural environment (Federal/Provincial Working Group, 1998). Although we do not yet have data to confirm this, we suspect that First Nations women are more likely to be overrepresented in the poorest types of prostitution – street and massage – than in strip club, phone sex, and Internet prostitution. The first author observed that in Mexico City, Mayan women were often sold in prostitution for the lowest price and were made available for more violent sex acts, such as anal rapes, that other women refused to perform.

Analyzing the effects of racism is central to an understanding of prostitution. Racism has a profound effect on health (Williams, Lavizzo-Mourey, & Warren, 1994; Turner & Kramer, 1995). For example a U.S. report located more than 175 studies documenting race/ethnic disparities in diagnosis and treatment of medical conditions (Institute of Medicine, 2002). Reflecting poverty, malnutrition, chronic stress and inadequate health care, premature aging is commonplace in the Downtown Eastside where one neighborhood center categorizes anyone over age 40 as a senior. The vulnerabilities of race, class and gender have been recognized as multiplicative risk factors for HIV (Osmond et al., 1993), and we think that they are also multiplicative risk factors for prostitution. In Canada, the triple force of race, class and sex discrimination disparately impacts First Nations women. Prostitution of Aboriginal women occurs globally in epidemic numbers with indigenous women at the bottom of a racialized sexual hierarchy in prostitution itself. This phenomenon has been observed by others

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(Grant, Grabosky, & David, 1999; Ministry of Foreign Affairs and Trade, 2001; UNICEF, 2004).

For many, the experience of prostitution stems from the historical trauma of colonization. Imposing a sexist and racist regime on First Nations women, colonization simultaneously elevated male power within the colonized community (Fiske, 1995). Today, many First Nations women are dominated by a 'newly evolved state of traditional governance' that replaced more egalitarian systems (Brunen, 2000). The cultural destruction of positive roles for First Nations men and their subsequent identification with supremacist attitudes have had disastrous consequences for First Nations women, with astronomical rates of incest, rape and husband violence.

Freire (1994) described the colonial destruction of positive roles for men as resulting in 'adhesion to the oppressor' (p. 27). Dworkin also discussed the harm inflicted on women by colonized men:

> The stigma of the prostitute allows the violent, the angry, the socially and politically impoverished male to nurse a grudge against all women, including prostituted women; this is aggressive bias, made rawer and more dangerous by the need to counter one's own presumed inferiority. (Dworkin, 2000, p. 325)

Sexual violence and other family violence are major social problems in First Nations communities. A Dene woman described communities in which the entire female population had been sexually assaulted by men. She had been threatened with further violence if she spoke out against this (Lynne, 1998, p. 43). Consistent with others' reports, First Nations women in our study were significantly more likely than non-First Nations to report childhood physical and sexual abuse.

There is an urgent need for further exploration of these connections between gender, race/ethnicity, and class in prostitution not only in Canada but elsewhere (Bourgeault, 1989). Prostitution is one specific legacy of colonization although it is infrequently analyzed as such (Lynne, 1998; Scully, 2001). A perspective that understands prostitution to be colonization of First Nations women by both First Nations and non-First Nations men may be helpful in addressing the problem.

The RCAP report suggested that a general health strategy for First Nations should involve equitable access to health services, holistic approaches to treatment, Aboriginal control of services, and diverse approaches that respond to cultural priorities and community needs (RCAP, 1996). These four strategies are applicable to the healing of women escaping prostitution. Models for healing of First Nations women in prostitution would include a decolonizing perspective that analyzes historical trauma, violent crimes, family violence, child abuse and neglect,

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discrimination, unresolved grief and mourning. Cultural moderators of these traumatic experiences that would promote healing include family/community support, traditional spiritual practices and medicine, and a positive indigenous identity (Walters, Simoni, & Evans-Campbell, 2002). A study of the needs of Vancouver prostituted women underscores these recommendations (Benoit, Carroll, & Chaudhry, 2002). A Toronto study of 30 prostituting women emphasized their need for mental health services, including drop-in crisis centers open at night as well as hotlines staffed by peers (Butters & Erickson, 2003). Access to alternative employment that would generate sustainable income is necessary in order to remove the economic motivation for prostitution.

In our opinion, western medical treatment of PTSD is best combined with traditional healing for First Nations women who want to escape prostitution. The Peguis First Nation community in Manitoba found that a combination of traditional and western healing approaches was especially effective for those who suffer from emotional problems, including those related to alcohol and drug abuse, violence and suicide (Cohen, cited in RCAP, 1996).

Women in prostitution self-medicate for depression and PTSD with drugs and alcohol.[6] An urgent need for treatment of drug and alcohol addiction was voiced by 82% of those we interviewed. An approach that simultaneously treats substance abuse and PTSD has proven more effective than treatment that only treats substance abuse and fails to address PTSD (Epstein, Saunders, Kilpatrick, & Resnick, 1998; Najavits, Weiss, Shaw, & Muenz, 1998; Ouimette, Kimerling, Shaw, & Moos, 2000). Women in prostitution who are dealing with addictions are not likely to benefit from treatment in mixed-gender groups. It is unsafe for them to discuss prostitution in the traditional 12-step setting, because men regularly proposition them as soon as the women are known to have prostituted. Furthermore, confidentiality is a concern in communities where everyone is either related or knows one another (Rees, 2001).

Any intervention for those in prostitution must first acknowledge prostitution as a form of violence. As with battered women, physical safety is a critical concern. In order to address the harm of prostitution it is necessary to use education, prevention and intervention strategies similar to those dedicated to other forms of gender-based abuse such as rape and intimate partner violence. This understanding of prostitution as violence against women must then become a part of public policy and it must be structurally implemented in public health care, mental health services, homeless shelters, rape crisis centers and battered women's shelters (Stark & Hodgson, 2003). The healthcare provider must become not only culturally competent regarding differences between nations in culture and language but also acquainted with community services and anti-violence resources

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(Polacca, 2003). In the United States there is the additional complexity of jurisdictional confusion. Tribal courts may lack the means and the will for strong prosecution of perpetrators of violence. Tribal jurisdiction sometimes conflicts with federal law enforcement, and perpetrators may be aware that there are minimal consequences for violence against women (National Sexual Violence Resource Center, 2000; Polacca, 2003).

Caution is warranted in interpreting these results because we ran multiple post-hoc analyses on this data, which has not been statistically corrected for the increased probability of finding significant results when multiple analyses are performed. Nonetheless, we are confident that the trends we have described are accurate and that they warrant further investigation.

Because of the ongoing trauma of prostitution and homelessness it is likely that some of these women minimized childhood violence. To review a history of trauma while in the midst of ongoing abuse was likely to have been too painful for some. Some of these women did not categorize juvenile prostitution as childhood sexual abuse.[7] Others minimized violence they had experienced by comparing it with that suffered by friends. One woman told us that since she had no broken bones and had not been assaulted with a weapon, therefore her rape and strangulation by a john did not count as much. Thus we assume that the reporting of trauma history among our respondents is conservative and that the actual prevalence of traumatic events, health symptoms, and PTSD symptoms is likely to be higher than reported here. Some women we interviewed were obviously intoxicated. This does not decrease our confidence in the accuracy of these results. Along with others we have noted that addicts report life events with as much accuracy as non-addicts do (Bonito, Nurco, & Shaffer, 1976).

No study of prostitution can claim a representative or random sample, given the illegality of prostitution in most locations. 'There is quite simply no such thing as a representative sample of women selling sex' (McKeganey & Barnard, 1996). We interviewed those people to whom we had access. In most cases we and other researchers have access only to people prostituting on the street. That said, we made every attempt to contact any woman known to be prostituting, indoors or outdoors. We did this by asking women to tell friends who were prostituting elsewhere (e.g. in other areas or from their homes or clubs) that we would return to a certain location at a specific time the next day. Interviewees often reported involvement in prostitution across multiple locations, for example, strip club, escort and massage parlors as well as street prostitution.[8]

As shown in these findings, prostitution is a sexually exploitive often-violent economic option most often entered into by those with a lengthy history of sexual, racial and economic victimization. Prostitution is only

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now beginning to be understood as violence against women and children. It has rarely been included in discussions of sexual violence against First Nations.[9] It is crucial to understand the sexual exploitation of First Nations women in prostitution today in a historical context of colonial violence against nations (Frideres, 1993; Ryser, 1995; Waldram, 1997). Today, the continued displacement of women who are poor, rural and indigenous may be understood as *trafficking* in which women are moved from the reserve to the city for the purpose of prostitution (Lynne, 1998).

Just as wife beating was historically viewed as having been provoked by the victim, prostitution is still viewed by some as a job choice to which the victim 'consents.' Ninety-five percent of our interviewees said that they wanted to escape prostitution, while also telling us that they did not feel that they had other options for survival. Another report found that 90% of women in prostitution wanted to leave prostitution but could not (Elizabeth Fry Society of Toronto, 1987). Social scientists have begun to address the harms of incest, rape and family violence. We hope to see more research that examines prostitution as part of the surround of violence against women, specifically including First Nations women. We also hope to see investigations of interventions that promote healing from prostitution.

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Notes

1. In phone sex, a person verbally provides explicit sex talk for pay for a customer who typically masturbates during the call. It can include what in other settings would be verbal sexual harassment, as well as sexist and racist epithets and other verbal abuse. Commonly, women who engage in phone sex, like women in strip clubs, also prostitute in other ways.
2. British Colombia surveys found the average age of entry into prostitution to be 14–15.5 years, and a Vancouver survey found average age of entry into prostitution to be 16.3 for girls and 15.6 for boys (Lowman & Fraser, 1989).
3. Aboriginal and First Nations, are words used to refer to indigenous peoples of Canada. No doubt some will disagree with our choice of terms. We are not using terminology that refers to a person's legal status. Instead, we are attempting to use respectful words as spoken by both insiders and outsiders in the Downtown Eastside community of Vancouver. When an author in a cited work uses the term Aboriginal, we use the word Aboriginal in connection with their work. However, we prefer not to use the term Aboriginal because the Oxford Dictionary currently lists a second descriptor for the word

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Aboriginal as 'primitive.' We use the term First Nations interchangeably with Aboriginal throughout the article, as Brunen does in her 2000 article on the marginalization of Aboriginal women with addictions in the Canadian healthcare system.

4. Similar health consequences of colonialism on indigenous people are seen in health data from the United States. American Indians and Alaska Natives have the second highest infant mortality rate in USA, and the suicide rate of American Indians is 50% higher than the national rate (U.S. Dept of Health and Human Services, 2001, p. 82; U.S. Dept of Health and Human Services, 2001a, p. 17).
5. Other descriptions of violence included:

> [I have a] long history of physical abuse. I was beaten by my mother's boyfriend, ran away from home to a pimp who beat me, I left him for a man who beat me up, and so on. . . .
>
> A 13-year-old told us she had: 'disalignment in my neck, cuts, and scratches, bruises caused by bad dates. Also deafness.'
>
> A stalker hit me with his car on purpose.
>
> Date tried to assault me with steel-toed boots because I wouldn't do something he wanted.
>
> A bad date hit my head on a wall.
>
> I was beaten with stones by a couple of women.
>
> [A pimp] locked me in a room and beat me 30 times with baseball bat.
>
> My boyfriend pushed me downstairs and broke my arm, [I've had] multiple beatings by various boyfriends, broken kneecaps, broken limbs. I'm scared of men.
>
> Two years ago, I was beat and raped for 45 minutes.

6. Wayne Christian, Director of the First Nations Round Lake Treatment Centre in Armstrong noted that most of his clients have used drugs and alcohol to 'deaden' the pain of emotional and physical trauma. 'Up to 95% of clients at Round Lake reported a history of some kind of trauma, personal trauma, whether it was residential school, sexual abuse, physical violence, abandonment – those types of issues . . .' (Rees, 2001).
7. One woman at first answered 'no' to the question, 'before you were 18 years old, did you experience any unwanted sexual touching or any sexual contact between you and a grown up?' Then she thought about it briefly and asked (without interviewer prompt): 'does this question mean for when I was prostituting underage?' After the interviewer said yes, the young woman said 'every time a john touches me, it's unwanted.' She started prostituting at age 12.
8. Although there is a common misconception that street prostitution is the most harmful type of prostitution, there is no research evidence for this. In

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fact, women have told us that they felt safer in street prostitution compared with legal brothels or massage parlors where they were not permitted to reject customers for any reason. Others commented that on the street they could refuse dangerous-appearing or intoxicated customers. Some told us that they considered it a deterrent to violence when a friend made a show of writing down the john's car license plate number. Raphael and Shapiro (2002) noted that women in Chicago reported the same frequency of rape in escort and in street prostitution. Although more physical violence was reported in street compared with brothel prostitution in South Africa – there was no difference in the incidence of PTSD in these two types of prostitution, suggesting that the experience of prostitution is intrinsically traumatizing (Farley et al., 1998). A Canadian study comparing strip club and street prostitution found that women prostituting in strip clubs had significantly *higher* rates of dissociative and other psychiatric symptoms than those in street prostitution (Ross, Anderson, Heber, & Norton, 1990). Strip club/massage, brothel and street prostitution were compared in Mexico. There were no differences in the incidence of physical assault and rape in prostitution, childhood sexual abuse or symptoms of PTSD, and no differences in the percentages of women in brothel, street, or strip club/massage prostitution who wanted to escape prostitution (Farley et al., 2003).

We have begun inquiry about different locations where prostitution occurs. A checklist rather than open-ended questions about location of prostitution is recommended. In a 2003 study, Farley used the following list of categories of prostitution, asking each participant regardless of the location of the current interview, to check off each kind of prostitution she had previously been in. Types of prostitution included: escort, massage, phone sex, street, Internet, brothel, prostitution as a child under age 18, strip club, bar, table dance club, peep show, prostitution associated with a military base, trafficked (moved) from another country to New Zealand for prostitution, trafficked (moved) from one part of New Zealand to another for prostitution, and other. Kramer (2003) found a range of street, escort and strip club prostitution experiences among interviewees in southwestern USA. Across these three types of prostitution, 90% of Kramer's respondents described the experience of prostitution as negative or traumatic. We suggest that any study of prostitution report the length of time in prostitution and the number of customers seen by respondents. These factors, more than the physical location of the prostitution, are correlated with harm (Parriott, 1994; Vanwesenbeeck, 1994).

9. Not only has there been a lack of attention to prostitution as a form of violence against First Nations women, but the RCAP report has been generally criticized for its failure to take into account the viewpoint of Aboriginal women (Frideres, 1996). Frideres in the same article also comments that two-thirds of the presenters at the RCAP hearings were male (Note 18, p. 264).

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