Journal of Forensic Social Work, 1:159–184, 2011
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ISSN: 1936-928X print/1936-9298 online
DOI: 10.1080/1936928X.2011.598843

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Trauma and Substance Abuse Among Women in Prostitution: Implications for a Specialized Diversion Program

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This study was undertaken to inform the implementation of a specialized prostitution diversion program to help women quit prostitution and avoid criminal prosecution. Data on 17 women's experience of trauma and substance abuse and their views on how these experiences affected their involvement in prostitution were gathered in focus groups and face-to-face interviews (including measures of substance abuse, trauma, and PTSD) conducted at a drop-in program in Baltimore, Maryland. The results indicate that the women experienced high levels of trauma and substance abuse interwoven with prostitution. Trauma-informed services and integrated substance abuse and trauma-specific treatment are needed.

Prostitution involves the provision of sexual services in exchange for money or other forms of compensation such as housing, food, or drugs. It is commonly referred to as the "oldest profession" which is indicative of its presence in human civilization for centuries (Evans, 1979). Individuals who engage in prostitution are predominantly girls or women, but boys and men engage in prostitution as well. There are several different types of prostitution ranging from high-end escort/call girl services to street-level services (Harcourt & Donovan, 2005). Prostitution services range from complex enterprises to individuals independently prostituting themselves. In the United

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States, prostitution is illegal except in Nevada where the determination of legality is left to each individual county in the state. While society generally holds a negative view of women in prostitution, those at the lower end of the spectrum, particularly those who engage in street-level prostitution, experience greater social consequences (Weitzer, 2009). They are more likely involved in the criminal justice system than high-end call girls; they routinely experience a revolving door of arrest, brief incarceration, release, re-arrest, and so on. They are known to experience high rates of violence and victimization in the context of prostitution as well as in the context of their families and intimate relationships (Surratt, Inciardi, Kurtz, & Kiley, 2004). They also experience high rates of homelessness and poverty as well as health, mental health, and substance abuse problems (Farley, 2003; Hood-Brown, 1998; Sloss & Harper, 2004).

In Baltimore, Maryland citizens raised concerns about the presence of prostitution in their neighborhoods (Kearney, 2010). A task force comprised of citizens, law enforcement officers, prosecutors, public defenders, social service leaders, and researchers was formed to address the problem. Recognizing that the revolving door of the legal system was having little impact on prostitution in the city and that individuals in prostitution suffered from a number of social and health-related problems, the task force developed an alternative criminal justice response whereby individuals in prostitution could avoid the punishment of incarceration and receive help (Shdaimah, 2010). Initially, the idea of a problem-solving court for prostitution (Shively et al., 2008) that would function similarly to drug courts that are allied with the therapeutic jurisprudence movement (Nolan, 2001; Winick & Wexler, 2003) was entertained. Ultimately, the Specialized Prostitution Diversion program (SPD) was inaugurated in August 2010 (Kearney, 2010). Individuals who are charged with prostitution offenses are offered the option to participate in the 90-day program. The SPD provides individuals with services to facilitate their ability to opt not to re-engage in prostitution. The program is staffed by social workers who provide case management services to clients to identify goals and engage clients in community-based services that would facilitate clients' desistance from prostitution. Clients meet with their social worker weekly over the course of their involvement in the SPD. The SPD clients are also assessed for substance abuse problems by a substance abuse specialist during their intake assessment and are referred for substance abuse treatment as needed. Participants are monitored for changes in their status (i.e., address, re-arrest) by a pre-trial specialist via weekly telephone calls and brief contact on the days that they meet with their social worker. Once they complete the program, their charges are null processed (no prosecutorial action is taken) and may be expunged (Shdaimah, 2010).

This study was designed to understand the experiences of women in prostitution in Baltimore and learn what kinds of services they believed would be needed in a court-based program such as the SPD. We conducted

our research at You are Never Alone (YANA) Place, a drop-in setting for women engaged in prostitution (www.yanaplace.org). Although the SPD serves both male and female defendants, the study focused on the experiences of women engaged in street-level prostitution as they make up a larger portion of those in prostitution who end up in the criminal justice system.[1] Also, they were the people who sought services from the agency where we conducted our research. Our research questions and methods were informed by pre-study conversations with the YANA Place staff and groups of service recipients. Substance abuse and trauma were identified in these conversations and in the research literature as central factors in women's experience of prostitution, which we elaborate below.

Substance Abuse

A commonly held view is that women engage in street-level prostitution to obtain money to buy drugs or in direct exchange for drugs. Indeed, existing research demonstrates a strong association between substance abuse and prostitution (Goldstein, 1979; Gossop, Powis, Griffiths, & Strang, 1994; Nuttbrock, Rosenblum, Magura, Villano, & Wallace, 2004; Roxburgh, Degenhardt, Copeland, & Larance, 2008). The substances that women in prostitution most commonly abuse are heroin, cocaine (crack), marijuana, and alcohol (Gossop et al., 1994; Norton-Hawk, 2001; Nuttbrock et al., 2004; Surratt et al., 2004). The temporal order of substance abuse and prostitution, however, remains an unsettled issue in the research literature. Some researchers report that substance abuse precedes women's engagement in prostitution (Inciardi & Surratt, 2001; Potterat, Rothenberg, Muth, Darrow, & Phillips-Plummer, 1998; Silbert, Pines, & Lynch, 1982), whereas others suggest that substance abuse develops subsequent to initial engagement in prostitution (Dalla, 2000; Kuhns, Heide, & Silverman, 1992). The implication is that those who abuse substances prior to engaging in prostitution do so to fund their need for substances and those who develop substance abuse problems subsequent to their involvement in prostitution use substances in response to the vagaries of prostitution. The effects of alcohol and other drugs appear to make women in prostitution feel more confident and able to manage their interactions with their "customers" as well as provide them with a mechanism for coping with or numbing their negative feelings (Gossop et al., 1994; Young, Boyd, & Hubbell, 2000). Some researchers note that even if women enter prostitution to fund their drug habit, the

[1]Here we use the term *women engaged in prostitution* as this is the description of the criminal offense and because our respondents do not identify as sex workers, which both encompasses a broader range of activities and implies a larger sense of autonomy and choice to engage in sex work. We also use the term engaging in prostitution, rather than prostitutes, as our respondents do not see their prostitution behaviors as constituative of their identity (see Shdaimah & Wiechelt, in press).

degradation and trauma involved in prostitution worsens an existing substance abuse problem (Young et al., 2000). Others note the combination of these possibilities; drug abuse can precede, co-occur with, and/or succeed entry into prostitution (Gossop et al., 1994). It is likely that whatever the etiology, once there, substance abuse and prostitution become mutually reinforcing (Norton-Hawk, 2001).

It is important to note that not all women in prostitution abuse substances and not all women who abuse substances engage in prostitution (Romero-Daza, Weeks, & Singer, 2003). The argument that drug use primarily causes women to enter or remain in prostitution is specious in that it fails to capture the cascade of factors that influences prostitution behaviors among women and essentializes the relationship between these constructs (Ettorre, 2007; Wilson & Widom, 2010). However, the pervasiveness of substance abuse among women in prostitution makes it clear that it is a problem that warrants consideration among the constellation of social, political, and psychological conditions that affect women's entry and continuation in prostitution (see Dalla, 2002).

Trauma

Most women in prostitution experience a range of violent events across the lifespan that are potentially traumatic (Nixon, Tutty, Downe, Gorkoff, & Ursel, 2002). Research indicates that there is an association between various forms of childhood maltreatment (physical abuse, sexual abuse, emotional abuse, and neglect) and subsequent involvement in prostitution (Caputo, 2009; Medrano, Hatch, Zule, & Desmond, 2003; Stolz et al., 2007; Widom & Kuhns, 1996; Wilson & Widom, 2008, 2010). A great deal of the research on childhood maltreatment and prostitution has focused specifically on childhood sexual abuse. It has been reported that as high as 73% of women in prostitution report having experienced childhood sexual abuse (Bagley & Young, 1987). Some researchers suggest that there is a direct link between childhood sexual abuse and prostitution (Bagley & Young, 1987; McClanahan, McClelland, Abram, & Teplin, 1999; Silbert & Pines, 1981, 1983; Vaddiparti et al., 2006). Others argue that the link between childhood sexual abuse and prostitution is not direct but rather occurs across mediated pathways. Several mediating factors have been identified including early sexual initiation (Wilson & Widom, 2010), runaway behavior (Seng, 1989), psychological effects of sexual abuse coupled with the social context of street-life for runaway youth (Tyler, Hoyt, & Whitbeck, 2000), psychological morbidity, and substance abuse (Potterat et al., 1998). The relationship between childhood sexual abuse and prostitution may also be moderated by factors such as family environment, abuse characteristics (e.g., severity, frequency, type, relationship to abuser), race, and educational level (Abramovich, 2005; Kramer & Berg, 2003). Others argue that sexual abuse

in childhood does not increase the risk of engaging in prostitution (Gibbs Van Brunschot & Brannigan, 2002). In any case, it is abundantly clear that there are high rates of childhood sexual abuse among women in prostitution.

High rates of violence and victimization among women in prostitution continue into their adult lives. Intimate partner violence has been associated with prostitution (El-Bassel, Witte, et al., 2001; Raj et al., 2006). Some women flee a relationship where they experience intimate partner violence and end up in a condition of poverty that compels them to engage in prostitution. Others experience intimate partner violence while engaging in prostitution and may even be coerced into prostitution by their intimate partner (Nixon et al., 2002). The distinction between intimate partner and pimp may be difficult to make as the pimp may have started out as a boyfriend or was at least perceived as such and a boyfriend may also be a pimp (Decker & Miller, 2010). Additionally, pimps implement a complex web of violence, protection, and the illusion of love to gain and maintain control of the women they prostitute (whom they view as being their property). The experience of this complex relationship can elicit feelings akin to those elicited in women who experience familial domestic violence, such as conflicted feelings of love and hate, terror, and disempowerment (Williamson & Cluse-Tolar, 2002). Violence in the form of physical assault or rape from customers is commonly experienced by women in prostitution (Farley, 2004; Farley & Barkan, 1998; Nixon et al., 2002) and is sometimes conceptualized as intimate partner violence, albeit in a commercialized partnership (El-Bassel, Witte, et al., 2001).

A subculture of violence that can exist in the context of the streets puts women in street prostitution at risk for violence from others in the vicinity (Surratt et al., 2004). For example, individuals such as drug addicts seeking money, drug dealers, and youth gangs may target them for violence. Police officers may exploit their position of power and commit sexual assault and rape against women in prostitution (Raphael & Shapiro, 2004). The context of the streets in neighborhoods with high rates of crime also increases the likelihood that women in prostitution will witness violence (Romero-Daza et al., 2003). They may see other women in prostitution being physically or sexually assaulted or individuals being stabbed, shot, or beaten related to the drug trade, robberies, or just plain street violence.

Women in prostitution are likely to have experienced violence and victimization across the lifespan. The types of experiences that they are often exposed to (physical and sexual assault, threat of violence, and witnessing violence) have the potential to be traumatic. Traumatic events place individuals at risk for developing posttraumatic stress disorder (PTSD; American Psychiatric Association, 2000), complex-PTSD (also known as disorders of extreme stress not otherwise specified, DESNOS; Herman, 1992) and other related problems such as other anxiety disorders, depressive disorders, and substance use disorders. Indeed, high levels of PTSD, complex-PTSD, anxiety, depression, and substance abuse have been observed among

women in prostitution (Choi, Klein, Shin, & Hoon, 2009; El-Bassel, Cooper, Simoni, Gilbert, & Schilling, 2001; El-Bassel et al., 1997; Farley & Barkan, 1998; Farley et al., 2003; Farley, Lynne, & Cotton, 2005; Jung, Song, Chong, Seo, & Chae, 2008; Roxburgh, Degenhardt, & Copeland, 2006; Valers, Sawyer, & Schiraldi, 2001; Young et al., 2000).

The high rates of substance abuse and trauma and associated effects among women in prostitution suggest that both areas warrant consideration in the development of programs designed to facilitate their departure from prostitution. The current study examines the traumatic experiences and substance use behaviors among women in prostitution in Baltimore City, the community that is served by the SPD. The women's experiences and views on how these experiences affect their lives and their prostitution behaviors will be used to inform the implementation of the court-based SPD and shed light more generally on how to develop and implement interventions with this population.

METHODS

This mixed-methods study was conducted at a drop-in program for women who were currently or formerly engaged in prostitution that is operated by YANA Place located in Baltimore, Maryland. The methods used to gather data in this study were informed by discussions that the researchers held with YANA Place staff and service recipients regarding procedures that would elicit frank responses and avoid being offensive or upsetting. The data were gathered on site with service recipients who volunteered to participate in face-to-face individual interviews and two focus groups. This study was approved by the institutional review boards at each of the author-affiliated universities.

Participants

Some individuals who participated in a focus group ($n = 10$) also participated in an interview ($n = 4$); others participated in an interview ($n = 7$) or focus group ($n = 6$) only. The total sample size was 17. The 11 participants who completed the interview provided background demographic information. They ranged from 22 to 55 years of age ($M = 40.55$, $SD = 10.70$). In terms of years of education, they ranged from 9 to 15 years ($M = 11.64$, $SD = 1.91$); 5 had some high school education, 2 completed high school, 1 obtained a GED, and 3 had some college education. The participants were nearly evenly split on their race/ethnicity with 5 participants identifying themselves as White and 6 as African American. The age that the participants reported first engaging in prostitution ranged from 13 to 36 ($M = 22.27$, $SD = 6.34$).

Measures

The interviews and focus groups were conducted using semi-structured interview guides. Qualitative data were collected in order to elicit "thick description" and nuanced understanding of the women's experiences (Padgett, 2008). Questions on motivations for engaging in prostitution including whether or not their experience with trauma or substance abuse affected their involvement in prostitution as well as their perceived service needs were asked. Given that the interviews were conducted in a drop-in center where individuals may or may not return and that our interview time was short, we used standardized measures to gather specific data on traumatic experiences and trauma-related symptoms. We wanted to gather information on these experiences while minimizing the risk of re-traumatizing participants. We also used standardized measures to gather data on substance use behaviors in order to gather specific detail on potentially complicated substance abuse histories in an efficient and reliable manner. The data from the standardized measures also allowed us to compare the participants' experiences of trauma and substance use to those of the general population and other research on women in prostitution. The four standardized measures that we used are described below.

Stressful life experiences screening

The Stressful Life Experiences Screening (Stamm et al., 1996) is a 20-item self-report measure on experience of stressful events and associated stress levels on a 10-point scale. Internal consistency reliability is strong ($\alpha = .86$). The data gathered using this measure can be used to indicate whether or not an event occurred or scores can be reported.

Trauma symptom checklist–40

The Trauma Symptom Checklist–40 (Briere & Runtz, 1989, 2009) is a 40-item self-report survey that assesses trauma-related symptoms on a 4-point ordered scale ranging from 0 (*never*) to 3 (*often*). The scale has good internal consistency reliability ($\alpha = .90$) and predictive validity is well established.

PTSD checklist—civilian version

The PTSD Checklist—Civilian Version (Weathers, Litz, Herman, Huska, & Keane, 1993) is a 17-item self-report survey designed to measure past month *DSM-IV* PTSD symptoms on a 5-point Likert type scale ranging from 1 (*not at all*) to 5 (*extremely*). Good internal consistency reliability ($\alpha = .86$) and well-established concurrent validity are reported.

Addiction Severity Index—Lite Version

The Addiction Severity Index—Lite Version (McLellan, Luborsky, Woody, & O'Brien, 1980) is widely used to evaluate substance use behaviors and associated problems. Interrater reliability is on average .89, and construct validity is well established. For the purposes of this study only the alcohol/drug use section of the instrument was used. Data on current and lifetime abuse of substances (alcohol, heroin, other opiates/analgesics, barbiturates, sedative hypnotics/tranquilizers, cocaine, amphetamines, cannabis, hallucinogens, and inhalants) were obtained.

Procedures

The two researchers and a research assistant visited YANA Place during drop-in hours between August 2009 and August 2010. Service recipients were informed about the researchers' identity and purpose for being at the agency. In an effort to engage the service recipients, the researchers interacted with them in participatory exchanges. For example, informal discussions about community resources, day-to-day activities, or current events often spontaneously emerged among all those present at the agency. On two occasions, all service recipients who were present at the agency were invited to participate in a focus group. At the end of the focus group and on all other visits to YANA Place, we invited service recipients to participate in an individual interview. The invitation was extended via a general announcement and by directly approaching individuals. Frequently, individuals who had been attending the drop-in center would approach the researchers after a few weeks indicating that they would like to participate in the interview. The researchers' presence and activities at the agency helped potential participants to gain a sense of familiarity and trust with the researchers that contributed to their willingness to participate in the interview. A letter of explanation describing the project, as well as the associated risks, benefits, and participants' rights was provided to all participants prior to their participation in either an individual interview or focus group. A verbal explanation was also provided. Both the focus groups and the individual interviews were conducted at YANA Place and were audio-recorded and transcribed verbatim. The consent process was not documented and participants were instructed to use pseudonyms (of their choosing) rather than their real names in order to keep their participation in the study anonymous. Individuals who participated in either the focus group or individual interview were given a small gift packet of toiletry items for their participation.

The focus groups were designed to establish rapport with the women and gain an understanding of how the women perceived themselves and their experiences. Snacks were provided to the participants. A variety of art materials were made available to the participants, who were asked to

make a collage showing hopes for the future or a strength that they wanted to share. A discussion of the projects was held using a semi-structured guide. Participants were encouraged to freely discuss whatever came to mind regarding their life experiences and their views on the provision of services through the court-related intervention newly implemented in Baltimore City (Peirce, 2008; Shdaimah, 2010). The face-to-face individual interviews lasted from 1 to 1 1/2 hours. In the interviews, we explored women's experiences and views on factors that precipitated and impacted their engagement in prostitution, services they believed would be helpful, and hopes they had for their future. We analyzed the qualitative data and developed coding categories after reviewing and coding the initial interviews independently. We then merged these codes into a unified coding scheme which was applied to all of the interviews, with the assistance of data analysis software (NVivo 8). Quantitative data were analyzed using SPSS 17.

RESULTS

Substance Abuse

Our findings are congruent with the existing literature, which indicates that substance abuse is typically associated with prostitution. All of the women who participated in our study identified substance abuse as being problematic for them prior to or during their experience in prostitution. They identified three pathways, which were not mutually exclusive: (a) addiction led them to prostitution, (b) substance abuse helped them to cope with engaging in prostitution, and (c) addiction made it hard to cease engaging

TABLE 1 Participants Lifetime Substance Use in Years and Percentage Who Used Each Substance.

Substance	Elana	Kara	Maggie	Reba	Lala	Vision	Jo	Nalia	Mouse	%
Alcohol	38	24	10	0	5	40	30	6	15	89
Alcohol Intoxication	4	24	0	0	5	0	20	2	15	67
Heroin	0	20	10	16	5	0	3	0	15	67
Methadone	0	5	1	4	5	0	0	0	2	56
Opiates/Analgesics	15	15	0	0	5	0	15	0	15	56
Barbiturates	0	15	0	0	5	0	0	0	15	33
Sedatives/Hypnotics/ Tranquilizers	5	11	0	0	5	0	10	0	15	56
Cocaine	0	26	0	13	5	4	15	0	15	67
Amphetamines	0	NR	0	0	5	0	0	0	15	22
Cannabis	36	NR	3	0	7	37	10	2	15	78
Hallucinogens	0	NR	0	0	2	0	1	0	15	33
Inhalants	0	NR	0	0	0	0	0	0	15	11
>1 Substance per day	0	NR	3	14	5	0	15	2	15	67

Note. $n = 9$; NR = no response.

in prostitution. Table 1 shows the number of years across the lifetime that the interview participants reported using alcohol and other drugs as well as the percent of women who used each substance. The substances that were most frequently abused across the lifetime of the participants were alcohol, heroin, cocaine, and marijuana. Most of the women reported using more than one substance per day. Current use was less meaningful in our sample as many participants were in substance abuse treatment and had not used substances in the past 30 days; thus current use patterns are not reported here. Two of the face-to-face interview participants did not complete the ASI-Lite, but we know that they also abused substances from their narratives (see Betti and Reen below).

Betti describes how her drug use affected her engagement into prostitution:

> It was when I was a heroin addict. At first I was smoking crack. And I would only do it when I had money. But then as time went on it got worse and worse and then I was addicted to heroin. And then when I was a heroin addict, and it would screw with me and I wasn't about to get sick [from withdrawal]. Then I started getting curious and started asking questions, "what do you do, how do you do it?" And they told me and I did it. I mean, the first time, it was really hard, but then after that, I was numb. I was high, so my body was numb to the situation. I just looked at it like it was a job. I did what I had to do and got out of there.

Although some of our participants such as Reen told us "the only reason" they got into prostitution was "to get money to get high," the narratives of others reveal that substance abuse and trauma were intertwined with their entry, continuation, and experiences in prostitution. The results from the Stressful Life Experiences Screening measure, shown in Table 2, indicate that the 10 women who completed the measure experienced 5 to 14 stressful life events, $M = 10.4$ ($SD = 3.31$). Notably, most experienced physical and sexual violence across the life span. This is higher than the norm for the general population, in which 60.7% of men and 51.2% of women experienced at least one traumatic event; only 10% of the men and 6% of the women who experienced traumatic events reported four or more types of trauma (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Reen declined to complete the measure but told us that she experienced both physical and sexual violence during the course of her life. Although we are unable to quantify the stressful life events that the six focus group-only participants experienced in detail, we can report that all of them told us they had experienced violence and victimization. Taken together, the women's experience of stressful life events and substance abuse problems suggest a more complex relationship between substance abuse, trauma, and prostitution than simply prostituting to get high. Kara and Mouse are both individuals who experienced childhood

TABLE 2 Stressful Life Events Summary

Stressful events	Elana	Betti	Kara	Maggie	Reba	Lala	Vision	Jo	Nalia	Mouse
Natural disaster			X			X				
Human disaster						X				
Serious accident/injury			X	X	X	X	X	X	X	X
Chemical/radiation exposure									X	
Life threatening illness	X	X	X	X	X	X	X	X	X	X
Death of spouse/child			X				X	X		X
Death of close friend/other family member	X	X	X	X	X	X	X	X	X	X
I, friend/family kidnapped taken hostage					X	X			X	
I, friend/family victim terrorist attack torture										
Involved in combat/war										
Seen or handled dead bodies					X	X				X
Felt responsible for serious injury/death of another person	X		X		X			X		X
Witnessed or been attacked with a weapon other that combat or family setting	X		X	X	X	X	X	X		X
As child/teen was hit, spanked, choked hard enough to cause injury	X	X	X		X	X	X		X	X
As adult was hit or choked hard enough to cause injury	X		X		X	X	X	X	X	X
Witnessed other being hit choked, hit, spanked, or pushed hard enough to cause injury	X		X	X	X	X	X	X		X
As child/teen forced to have unwanted sexual contact	X	X	X		X	X	X		X	X
As adult forced to have unwanted sexual contact	X	X	X		X	X	X		X	X
Witnessed someone else being forced to have unwanted sexual contact			X			X	X	X		X
Other stressful event	X						X	X		X
Total	10	5	13	5	12	14	12	10	9	14

and adult violence and victimization as well as substance abuse and health problems. Each of them shared their complicated stories with us that bear presenting at length to shed light on the way that trauma, substance abuse, and prostitution can accumulate and be mutually reinforcing.

Kara and Mouse: Intertwining of Trauma, Substance Abuse, and Prostitution

KARA

Kara was abused and neglected as a child and was coerced into prostitution at an early age. "My mother was drunk with another man in her bed while my father was working . . . it was disgusting. And then she tried to get us, when we were like 11 and 12 to get into engaging in sexual activity for money." By the time Kara was 13 she was prostituting in the streets with the help of her younger sister who would write down the tag numbers of the cars Kara got into. She states "I did it to survive." She developed a heroin addiction which contributed to her need to prostitute herself. "So I was a heroin addict. I didn't care; I worked the streets for $10 . . . whatever I could get." Kara stopped using heroin via a methadone program and refrained from prostitution for 5 years but resumed prostitution when she developed a dependency on other substances: "But then I started using benzos and I got addicted to pills and I was right back out there prostituting again." Kara, who was 48 years old at the time of our interview, told us that after a 10-year break she "turned back to prostitution to try to survive" 2 weeks earlier when her sister threw her out. She told us "I need the [substance abuse] treatment really bad . . . I substituted [alcohol] for heroin, because I didn't want to get back on heroin. And it's worse torture to get off of. I go through seizures, DT's and tremors." Intertwined in Kara's story is repeated physical assault by a violent ex-boyfriend, serious physical health problems including HIV/AIDS and hepatitis, and bouts of homelessness. Kara experienced 13 traumatic stressors across her life span (see Table 2).

MOUSE

Like Kara, Mouse experienced childhood sexual and physical abuse and was initially coerced into prostitution. She described how childhood sexual abuse perpetrated by her father when she was a child impacted her sexuality:

> My dad was molesting me from the age of 5 until 15 . . . I told my mother, but she wouldn't believe me and then at that point, my dad hit her and she hit her head on the kitchen table . . . I think that if he hadn't been touching me [pause] you know he woke up some things. They talk about not waking up things before they're ready. I think that when people molest children, they wake up desires that they're not supposed to have because we don't know how to manage them. We don't know what to do with them. Then, when we do get an idea of what sexual relations is, then we go all out and do that. Because, they've imparted our desires into us. It's like a baby with colic, you can't put it to sleep.

Mouse experienced other kinds of victimization at the hands of her mother. She told us "my mother set the house on fire and left me in it to burn" and "I had a mother that told me that 'if you didn't trick to make money that you couldn't live in her house' ". As an adult, Mouse experienced 14 traumatic stressors over the course of her lifetime, including being diagnosed with HIV/AIDS and learning about the murder of her daughter (see Table 2).

Mouse told us she got into prostitution for two reasons: (a) to feel loved ("You know, even if its only for 5 minutes, you were in the company that you hoped would express more than you would have gotten from family"), and (b) money ("I had an addiction. I was selling drugs at first, but then it escalated to prostitution, because I didn't feel like stealing and I didn't want to sell drugs. And, it seemed like the people who were prostituting were making more money. It wasn't being judgmental and all that. It didn't expose you to crowds of people when you were doing it, so it made it easier.")

Mouse, who has been drug-free and out of prostitution for 18 years, went on to describe the draw of drugs and prostitution during her unsuccessful attempts to stop in the past:

> Yea, I would try to take breaks and I would put signs on my door. I had a place to live that was legal. I was actually paying rent for it. I would put signs on the door that would say, "I'm not doing anything or taking drugs." But then, the withdrawals kicked in. I would try and stop but then you would experience withdrawal from not prostituting. So, even if I'm not drugging, there's a withdrawal and a yearning that happens. And, when you see certain people, your body starts going through certain changes because you know that's what it desires. And, so the same bough breaking when you're feet away from getting a drug, it's the same thing that happens when you're feet away from somebody who knows you've tricked. There's certain corners you've been on where you've tricked and you're still craving. You psychologically still crave it and you just try to put it in the back of your mind, but you'll always be reminded of what you did on this corner, or what you did with that person.

While Kara and Mouse provided the most comprehensive picture of their backgrounds and experiences relative to the relationship between traumatic events and prostitution, other participants revealed histories of trauma and violence that further illustrate these complex and intersecting problems. These women experienced multiple forms of traumatic events, often at the hands of family members. They described ongoing experiences of severe violence and victimization that coincided with engaging in prostitution, whether by coercion or what can dubiously be described as choice.

Traumatic Events Preceding Prostitution

Family violence in the forms of childhood physical and sexual abuse and intimate partner violence as a pathway to prostitution was described by many of our participants. Nalia explained her reasons for going into prostitution:

> Well, there are a lot of reasons, but I'm just going to give you three main reasons. Number one, as a child, I went through the sexual assault thing. Two, I didn't feel loved at home and I couldn't talk to anybody about it. So, what did I do, I ran away. Then I thought about prostitution and I see the money coming and I thought, "Okay, well I'll do this."

Lala experienced childhood physical abuse and intimate partner violence and ultimately ended up engaging in street prostitution because she could not see any other way to survive. She shared her story with us:

> I married really young to a guy that was a lot older than me. My father committed suicide when I was younger and I just didn't have anybody and I was tired of dealing with the problems at home. You know, I was tired of getting beat up and slapped around by my mother's boyfriends, and I just wanted to get out. And, my husband provided a way out and I winded up marrying him and then he beat me up.
>
> He pushed all my friends away and would lock me in the house for days at a time. He was pretty crazy. How I wound up leaving for good was that the neighbors heard the banging and the screaming and they called the police. And the police came and they told me that they would take my child if I didn't leave the situation now. So I left. But, I called the police other times. But . . . I was in a small town and I would get responses like, "Oh, Ma'am, it's such and such holiday, we really don't have time to handle domestic disputes." Or, a cop would come out and say, "Oh, well just come on down to the station and fill out a report." And I'm thinking that my husband that is beating me up is not going to put me in the car and let me come on down to the police station so I can file a report against my husband. I winded up leaving the state.

Lala told us she used substances to cope with the abuse from her husband and her flight from her husband led her into the streets. She described meeting people in the streets who posed as her friends and gave her hope by telling her "well, I got a way that you could make some money so that you could go and get something to eat," or, "well, I'll go get you something to eat if you do this favor for me." This is how Lala began engaging in prostitution.

Traumatic Experiences in Prostitution

Qualitative responses

In addition to the traumatic experiences that led to their engagement, our participants told us about the traumatic events that they experienced and witnessed while they were engaged in prostitution. These events range from witnessing violence to being sexually assaulted, raped, beaten, stabbed, and shot at.

Vision reports what she has seen and heard about women who are held hostage:

> They're making them have oral sex with them from morning until night time. And, if they don't do it, then they're beating them. Some women right now are in homes tied up and you'll never see them again, because they're not letting them out the doors. They're just using them like a piece of meat. They come home too and make them do things to them. Every day I see women out there and they're beat up and bruised up.

Many women, like Maggie, told us that violence and forced sex, even for those who are not coercively prostituted, are common:

> I've gotten stabbed by a John. A lot of times, women get into cars and the guys would beat them up, especially if they get into a car with two guys, which I've never done. They get into cars where a guy acts like he's a cop and forces them . . . I have friends of mine who have been forced to give men a blow job or have sex because he said he was a cop.

Nalia indicated that violence was commonplace: "Most females have been through sexual assault. I would say half of them." This was confirmed by Lala, who said that she had "seen a lot of things happen to girls. From almost getting raped, to getting raped, being beaten, shot at . . . you know it's not a pretty thing." Despite the high levels of danger that seem to be common to street-level prostitution, women in our sample continued to engage in it due to a perceived lack of options (see also Shdaimah & Wiechelt, in press). Reba told us that while she engaged in prostitution "I was forced to do stuff I didn't want to do. I almost got killed several times and managed to get out [of that situation]. Cause I needed the money."

Lala described her feelings related to doing "sexual favors for money": Her experience underscores that prostitution itself can be traumatizing and that drug use numbs the pain associated with it.

> At the time, I just felt completely alone without any choices. And, before long, I was numb and I was doing drugs to numb the pain that I was feeling. I mean, who wants to . . . I didn't like having sex with all of those men. I didn't like it. It wasn't something I enjoyed. It was a job.

SURVEY RESPONSES

Results from the standardized instruments that measure the incidence and severity of traumatic experiences that led women to engage in prostitution corroborated women's narratives of extraordinary and excessive trauma. Ten participants completed the surveys related to trauma symptoms and PTSD. The total severity score mean of 56.8 ($SD = 20.25$) obtained on the PTSD Checklist—Civilian Version is well above the scores of 44 and 50, which are considered to be PTSD positive for the general population and military populations, respectively. In terms of the *DSM-IV-TR* PTSD symptom clusters, the participants had an average of 3.4 ($SD = 1.96$) re-experiencing symptoms, 4.2 ($SD = 2.10$) avoidance symptoms, and 3.4 ($SD = 1.58$) arousal symptoms. An analysis of the number and types of PTSD symptoms on each cluster revealed that seven of the 10 participants met *DSM-IV-TR* criterion B (one or more re-experiencing symptoms), criterion C (three or more avoidance symptoms), and criterion D (two or more arousal symptoms) toward a diagnosis of PTSD. Two others nearly met the criteria with one having zero re-experiencing symptoms, three arousal, and three avoidance symptoms and the other having three re-experiencing and arousal symptoms and two avoidance symptoms. (Note that all of these participants had experienced multiple traumatic events as indicated on the Stressful Life Experiences Screening reported above.)

The Trauma Symptom Checklist total score mean of 49.3 ($SD = 30.43$) found in our sample is comparable to the total score means of 47.96–49.86 reported in a study of women in treatment for substance use disorders where sexual and physical abuse histories were known to be high (Ghee, Bolling, & Johnson, 2009) and are much higher than the total mean score of 22.28 reported for a sample of professional women (D. M. Elliot & Briere, 1992).

Service Needs

Our data shore up the literature indicating that trauma and substance abuse play an interactive role in prostitution and demonstrate some of the ways that these are intertwined and mutually reinforcing. Mouse explains that these connections come up often in her work with other women as an HIV/AIDS AIDS counselor. She recommended that the court set up therapy to help get at some of the root concerns that lead women to engage in prostitution and abuse substances. Mouse told us:

> They walk around with this stuff all day and what we see is just a mask for what they are hiding behind that. So, I think that [therapy to address root causes] would be really good. Because I got a woman right now at my age, when we did a role playing and she was talking about being molested, she was still trembling and shaking and crying, and sweating just pouring off of her. Just the idea of imagining this person coming

> to her. Because she said that she was ready to confront her molester because she had gotten drug free. Like I was trying to tell her it takes more time . . . Yea, a lot of times prostitution is just a symptom. But, if we can deal with the root of what caused the woman to go out there and prostitute in the first place.

Betti, who had recently completed an inpatient substance abuse treatment program and was currently enrolled in an outpatient intensive program for substance abuse and mental health treatment, told us that the outpatient program was "not really" helpful as she needed more structure and that she tended to associate with others in the program who were using drugs. She herself had recently used drugs. She described to us how her experience of sexual abuse as a child was still affecting her:

> When I was growing up, I was abused; I was sexually molested by my step-brothers. And it seems like ever since then, that's the only way I felt needed or wanted, was from sex. Like with relationships, I'm having trouble with that now because I think that if someone wants to have sex with me, they love me, and that's not true. They just really want to have sex with me and get their thing off. And, then it's like forget me. I mean, that actually happened, just today before I came here. So I still need to get better with that because I like somebody and I'll do what I want to do just because I like them and that's not good because sex shouldn't just be so easily given away like that.

Even when Betti was not using or "tricking", she traded her body for "love" (as she described above) and to get the things she needed from her "sugar daddy". She told us: "Even when I wasn't using, he would buy me clothes and jewelry and stuff like that . . . Even if I wasn't tricking, because I still might have sex with him because of what he got me . . . so it's still a trick."

Lala, who was also in a treatment program for substance abuse and mental health problems, told us:

> I'm not really getting any help for being a rape victim and as an abused spouse. I've been dealing with those things on my own, but I don't really know where to go to try and deal with those issues. But, I do attend therapy and things like that and I talk about those things there when it's not so painful.

Mouse told us that the way treatment providers talk to women in prostitution is important. She pointed to YANA Places's Executive Director as someone who had the kind of approach she thinks is necessary:

> She gave me her card and talked to me in a straight conversation like I was a human being. Other times people will talk to you like they've

> got rubber gloves on all the time. They even talk to you in a rubber glove conversation. So, it was that she was talking to me from the heart, and I could tell the difference.

Many of our respondents were explicit in their desire to get help with a variety or problems that impacted their engagement in prostitution. Without comprehensively addressing trauma and substance abuse, which were problems for all of our respondents, they expressed doubts about their own, and others', ability to desist from prostitution over time, particularly as new hurdles and challenges arise.

DISCUSSION

Taken together, the results from our study indicate that most of the women in our sample experienced multiple traumatic events of a violent and interpersonal nature across the lifespan and experienced current trauma symptoms as well as PTSD. The rates of stressful events across their lives are higher than the general population and their experience of PTSD symptoms is greater than those found in the general civilian population and military populations. These findings are consistent with Farley and colleagues who found high levels of traumatic events and PTSD among women in prostitution in the United States, Canada, and nine other countries (Farley & Barkan, 1998; Farley et al., 2003; Farley et al., 2005). Similar to the findings of other researchers (Gossop et al., 1994; Norton-Hawk, 2001; Nuttbrock et al., 2004; Surratt et al., 2004), the participants in our study all had substance abuse problems, with alcohol, heroin, cocaine, and marijuana being the most commonly abused substances.

It is well known that there is a relationship between substance use disorders and PTSD (Chilcoat & Menard, 2003). Individuals who experience these disorders (even at subdiagnostic levels) often present with a more severe clinical profile and have poorer treatment outcomes (Najavits, Weiss, & Shaw, 1999; Ouimette, Ahrens, Moos, & Finney, 1997). Additionally, complex-PTSD is particularly problematic among those who have experienced repeated traumatic events of an interpersonal nature over the long term. Herman (2004) noted that "patients who had been used in prostitution . . . were among the most cruelly abused people we had ever treated." She also noted that "The complex trauma syndromes from which they suffer are among the most difficult to understand and the most challenging to treat. They define for us the far edges of the spectrum of trauma disorders, and the frontiers of our current knowledge" (p. 3). Even though it is known that women in prostitution have high rates of severe trauma and substance abuse, they do not typically receive treatment for these problems in an interconnected fashion. In fact, our participants described a lack of attention to their

trauma-related concerns even when they did receive treatment for substance abuse and mental health problems. This is likely in part due to the dearth of integrated services in Baltimore for concomitant substance abuse and trauma and likely elsewhere.

The stigma associated with what society considers as the "criminal behavior" of prostitution as well as with the social stigma associated with women abusing substances may partly explain the insensitivity and lack of responsiveness to their complex treatment needs by care systems. Many of our participants described a desire "to be treated like human beings." Mouse's reference to people talking to her as if they had rubber gloves on illustrates the disdain that women in prostitution perceive that others have for them. Shaming and punitive responses are not helpful for women who have substance abuse problems or trauma symptoms. The association between trauma and substance abuse and the high prevalence of both among women in prostitution suggests that any program designed for them should at least be trauma-informed and that they should receive trauma-specific care along with substance abuse treatment.

Trauma-informed care is an overall approach to service provision that recognizes the contribution of trauma to the development of a variety of problems (health, mental health, substance abuse, criminal justice, etc.; Substance Abuse and Mental Health Services Administration, 2011). The service or program is therefore designed to minimize the risk of exacerbating trauma-related vulnerabilities or re-traumatizing individuals. Every aspect of the program including administrative and therapeutic processes is designed to be trauma-sensitive. This approach requires that all staff members be familiar with the effects of trauma on individuals and ways of supporting recovery. Trauma-informed care views the individual from a holistic perspective. The broad impact of interpersonal violence and victimization on the lives of individuals in terms of identity, health, relationships, emotional regulation, and world view are recognized (D. E. Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005). Care that is trauma-informed uses empowerment approaches such as respecting choice, utilizing relational collaboration, and building skills instead of managing symptoms (Moses, Reed, Mazelis, & D' Ambrosio, 2003). Social workers are well-suited to trauma-informed care as it is consistent with the strengths-based approaches common to social work practice and social work ethics (National Association of Social Workers, 2008).

Trauma-specific care involves interventions that are designed to help individuals heal and recover from the effects of traumatic experiences in their lives. As is the case with women in prostitution, trauma and substance abuse often go hand-in-hand. A great deal of research shows that treatment for both substance abuse and trauma is warranted when both are present. Failure to address trauma symptoms among those attempting to engage in recovery from substance abuse problems places individuals at very high risk for relapse (Brown, 2000; Brown, Stout, & Mueller, 1996). Conversely, failure

to address substance abuse behaviors among those in treatment for other trauma-related problems places them at risk for revictimization and inhibits their ability to work through their trauma.

A variety of interventions have been designed to address co-occurring PTSD and substance abuse (see Hien, 2009; Najavits et al., 2009). These interventions are based in sequential, parallel, or integrated approaches. In the sequential approach, treatment occurs in sequences or stages with treatment for one issue preceding the other (typically, substance abuse problems are treated first). In the parallel approach, treatment for both problems is provided simultaneously by different providers. In the integrated approach, treatment that addresses both substance abuse and trauma is provided by one provider at the same time. In general, research indicates that an integrated approach is most effective for addressing co-occurring PTSD and substance abuse. A recent national multisite study on services to women with co-occurring substance abuse and trauma-related symptoms indicates that an integrated approach to treatment is effective at reducing trauma symptoms, retaining women in treatment, reducing risky sexual behaviors, improving physical and mental health, and enhancing the well-being or their children (Gatz, Brounstein, & Noether, 2007). Although it would be ideal to engage individuals in treatment that is research-based and suitable to their needs, services are often limited to the types of programs that are available in the community.

The experiences of women in our sample demonstrate that women in street-level prostitution experience a great deal of trauma in their lives and may not have ever experienced functional and/or safe environments. Therefore they may have made adaptations to survive in violent environments that do not serve them well in more mainstream contexts, including court appearances, treatment programs, or educational and employment settings. Punitive responses are unlikely to be helpful in reducing prostituting behaviors, providing alternative solutions for coping, or resolving their intersecting substance abuse and trauma issues. Specialized prostitution diversion programs may be a means of providing help rather than punishment to women in prostitution. However, it is apparent that SPDs as well as other programs where women in prostitution receive services should operate from a trauma-informed framework. This means that the structure of the program should be empowering and that trauma screening should routinely be conducted. The provision of services should be provided in a collaborative way that recognizes and fosters women's autonomy and decision making. Referrals to other programs should be made with consideration of their sensitivity to trauma and ability to address concomitant substance abuse and trauma symptoms and, possibly, PTSD.

Social workers are increasingly incorporated into alternative criminal justice responses, such as problem-solving courts (Nolan, 2001). Those involved in the SPD or other court-based programs may find themselves particularly challenged in operating from a trauma-informed framework.

The nature of the court's referral of an individual to the SPD is inherently coercive in that the individual will face legal charges if they either do not opt to participate in or fail to complete the SPD. The SPD is less coercive than a typical problem-solving court in that the individual only faces the original charges if they fail to complete the program rather than having to plead guilty to enter the program and facing more severe legal penalties should they fail to complete. Additionally, the process of the SPD can be collaborative in working with the women to make an informed choice as to whether they wish to enter the program. Social workers should work with the women enrolled in the SPD to identify the types of services that they need and which programs in the community would be most beneficial to them. Case management should focus on the overall needs of the women (health, education, job training, childcare, housing, financial support, mental health, and substance abuse services) rather than on any single problem and strengths should be emphasized. In any case, the trustworthiness of the social worker and others affiliated with the program will be paramount in the provision of these court-associated services. That is, expectations and clear boundaries must be maintained in a consistent and appropriate fashion, limits as to what the program can and cannot should be shared, and interpersonal interactions must be genuine and safe (Harris & Fallot, 2001).

These recommendations are made with the recognition that they may not apply everywhere to all individuals, but rather to the current constellation of street-level prostitution in Baltimore and likely many other urban U.S. locations. Nevertheless, one recommendation that should stand for all time is that women in prostitution should be viewed in the context of their humanity and provided services free of rubber gloves.

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