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What is This?
Implications of Sexuality Counseling With Women Who Have a History of Prostitution

Jessica Perrone Stebbins

Abstract
Prostitution is a dangerous and illegal occupation that has far reaching consequences on the individual. In this article, reasons in which women become involved in prostitution and the effects of prostitution on the individual and her intimate relationships are explored. A guideline for sexuality counseling with this often traumatized population is provided including assessment criteria, treatment interventions, and ethical concerns.

Keywords
sexuality counseling, prostitution, sexual abuse, sexual dysfunction, ethical concerns

Introduction
Prostitution, the performance of sexual acts for compensation such as money, is an ancient concept (Hutto & Faulk, 2000). Many women engage in prostitution due to necessity and others are forced into the occupation (Tyler & Johnson, 2006). No matter the type of prostitution, women experience objectification, physical, sexual, and emotional abuse resulting in lowered self-esteem, depression, posttraumatic stress disorder (PTSD), and many other negative emotions and disorders (Cooper, 2004; Farley, 2003; Hotaling, Bun-is, Johnson, Bird, & Melbye, 2004; Hutto & Faulk, 2000; Kramer, 2003; Valera, Sawyer, Schiraldi, 2001).

Causes and Risk Factors
Many young women lured into prostitution begin while living on the streets after running away from home or foster care (Kramer, 2003). Many of them have histories of child sexual, emotional, and/or physical abuse (Hotaling et al., 2004; Kramer, 2003; Tyler & Johnson, 2006). In fact, some studies show that between 75% and 95% of women in prostitution have experienced sexual abuse (Hotaling et al., 2004). When children are sexually abused, they may associate sex with the acquisition of material items if the perpetrator bribes them to not tell (Long, Burnett, & Thomas, 2006). The young runaways must find a way to support themselves. Some report that it was not their choice to get involved in prostitution but that they were forced by someone in their lives such as a boyfriend (Tyler & Johnson, 2006). Other women find that their substance abuse is draining their finances and they turn to prostitution to fund their drug habit (Kramer, 2003).

Effects of Prostitution
As stated previously, many women experience abuse prior to entering prostitution. These women are constantly being re-traumatized as a result of their prostitution and the numerous assaults on their body (Farley, 2003; Hutto & Faulk, 2000). According to the Council for Prostitution, it is estimated that female prostitutes are raped once a week (Valera et al., 2001). Farley and Barkan (1998) surveyed women in prostitution and found that 88% of the women had been physically assaulted, 83% were physically threatened with a weapon, 68% had been raped, and 49% had pornography made of them. They also found that the women felt exploited due to the power differential between themselves and their clients. Similarly, Kramer (2003) found that 52% of the women reported that engaging in prostitution was physically painful and 76% reported that it was emotionally painful. The high number of prostitutes experiencing sexual and nonsexual traumas and accordingly PTSD is not surprising (Cooper, 2004). In fact, Farley and Barkan (1998) reported that 68% of female prostitutes meet criteria for PTSD. Increasingly disturbing is the fact that many of these women feel responsible for being victimized (Hotaling et al., 2004).

It is important to mention that a small number of prostitutes report that they find prostitution pleasurable. A few women stated that prostituting allowed them to feel excited and desirable (Kramer, 2003). The majority, however, experience negative emotions in regard to their sex work (Hotaling et al., 2004; Kramer, 2003; Valera et al., 2001). Some of the emotions reported include sadness, shame, anger, worthlessness, and anxiety. Prostitutes may also experience mental health problems such as depression, lack of memory, and suicidal ideation (Valera et al., 2001).

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Over 75% experience a decline in their self-esteem and affirm that they would like to leave prostitution (Kramer, 2003).

Women who engage in prostitution also typically engage in other high-risk behaviors. Even if they were not previously using substances, women in prostitution frequently turn to drugs and alcohol to help them cope with their negative emotions. Survey results by Kramer (2003) indicate that at least 70% of the women use substances to detach emotionally or to numb themselves while “turning tricks.” These women also use substances to increase feelings of confidence, control, connectedness, and to decrease guilt, sexual distress, and fear of being physically harmed (Kramer, 2003). With the high number of sexual partners, prostitutes are more likely to become infected with HIV or other sexually transmitted infections (STIs) or sexually transmitted diseases (STDs; Inciardi, Surratt, & Kurtz, 2005; Valera et al., 2001). This is especially true of those who are drug users. Crack, in particular, is associated with a higher risk of STIs due to an inconsistency in condom use, multiple partners, and having sex while intoxicated (Inciardi et al., 2005). In addition, there is a higher risk of unwanted pregnancy with sex workers (Tyler & Johnson, 2006).

Relationships and Sex

Women with a history of prostitution tend to be familiar with exploitative relationships. Therefore, they choose relationships where they are exploited and re-enact much of their previous trauma within their relationships. Due to this history of abuse, the women do not know who to trust, if anyone at all (Hotaling et al., 2004). One former prostitute stated that the first time she decided she wanted to have sex with a man she thought she was in love with him because she was willing to do so without getting paid (Brown, 2006).

Most sex workers experience sexual dysfunction with personal sex partners (Farley, 2003; Kramer, 2003). Kramer (2003) found that 65% of women with histories of prostitution stated that enjoyment of their personal sex lives was greatly diminished after engaging in prostitution. Thirty-three percent of the women in the same study stated that sex with their chosen partner was painful. Many of the prostitutes described a process in which instead of thinking of themselves as a whole person they began to think of themselves as a collection of body parts (Hotaling et al., 2004). Due to the commoditization of the woman’s body, women prostitutes internalize the objectification and therefore see the sexualized parts of the body as separate from the whole. This process can lead to somatic dissociation. In addition to this process, over time female prostitutes sense of fear increases and can cause dissociative disorders as well. The feelings of dissociation that occur during sex acts performed for compensation carry over to those performed during the prostitutes personal life. Therefore, the separation of the personal from the professional life is difficult for women prostitutes (Farley, 2003).

Assessment

Although there is a plethora of research on prostitution in other countries and the correlation between prostitution and HIV/STIs, drug abuse, and child sexual abuse, there is relatively no information on issues pertaining to counseling this population (Carter & Dalla, 2006). However, some assumptions about assessing the therapeutic needs of sex workers can be made by considering the previous information on the causes and effects of prostitution in addition to the assessment procedures of a sexuality counselor. When assessing a couple or individual for sexuality counseling, a sex history should be taken along with other assessment procedures. Included in the sex history should be questions pertaining to child sexual abuse and rape. All clients should be asked about difficulties they are experiencing in their current sexual relationship to determine whether a diagnosable sexual dysfunction is present. In addition, the counselor should ask about the client’s substance use and medical history (Long et al., 2006).

If throughout the assessment process, it becomes apparent that the client has engaged in prostitution, additional areas of sexuality need to be directly assessed. Clients who have a history of prostitution should be referred to HIV and STI assessment. The therapist should be informed of any STI/STD that the client has because these can have an impact on the client’s sexuality development. In addition, the client should be asked about unwanted pregnancies and the outcomes. If the woman experienced an abortion, feelings of self-blame, anger, guilt, anxiety, shame, denial, depression, loss, and helplessness may need to be assessed (Long et al., 2006).

Due to the high prevalence of child sexual abuse and rape among female prostitutes, the client’s experiences with these types of trauma need to be questioned. If the client states that she has experienced either of these two traumas, the counselor should continue in a way that emphasizes reflective listening skills. In addition, of importance is to assess the client’s sexual attitudes. An inventory such as the “Sexual Effects Inventory” created by Maltz (2001) can be used or the counselor can ask open-ended questions regarding the client’s feelings and thoughts toward sex, their feelings toward themselves as a sexual being, and their belief as to the effect the rape or abuse has had on their sexual functioning, among other questions (Long et al., 2006).

Symptoms of desire disorders, arousal disorders, and orgasmic disorders are a critical part of assessment as many women who have been forced or coerced into sexual acts experience these disorders (Long et al., 2006). Other sexual problems common to sexual abuse survivors are avoidance, fear, or lack of sexual contact, thinking of sex as an obligation, negative emotions to touch, intrusive or disturbing sexual thoughts, inappropriate sexual behavior, and vaginal pain and orgasmic difficulties (Maltz, 2002). Other issues that sexual abuse survivors are prone to that can also cause sexual problems include depression, low self-esteem, anxiety, fears, eating disorders, dissociative patterns, somatic concerns, and interpersonal problems (Long et al., 2006).
Of particular importance with prostitution are issues of dissociation, substance use, and PTSD. The client’s tendency to dissociate, especially during sexual acts, as well as symptoms of PTSD, needs to be assessed (Farley & Barkan, 1998). Substance use history also needs an in-depth assessment to determine whether a current or past problem exists. Substance abuse/dependence issues need to be addressed prior to engaging in other treatment as it will be ineffective if the client continues to use (Long et al., 2006). Assessing for suicidal or self-harm behavior and also if there is any threat to their safety by others is also of utmost importance with this population (Courtois, 1997).

**Treatment**

Treatment for women prostitutes is varied. The therapist will need to thoroughly assess their client with a history of prostitution to find areas of concern and experiences that may be having an impact on the client’s sexual functioning. The therapist must use judgment about which of the following therapeutic interventions are necessary for their client by creating goals congruent with the therapist’s approach (Barnes, 1995).

Formal treatment related to the experiences of trauma may begin once the therapist has determined that the client is physically safe and is currently not using substances. The therapist must create a safe environment where the client can explore and heal from the effects of her trauma (Hotaling et al., 2004). Sex is typically a very sensitive topic with people who have been sexually abused, so it is best if the counselor not bring up sex directly during the beginning stages of the therapy to prevent the client from experiencing flashbacks or other negative emotions (Maltz, 2002). Similarly, the counselor should encourage the client to refrain from sexual activity until she is able to cope with the negative emotions currently associated with sex (Long et al., 2006). The counselor should first work on creating a good working relationship with the client and allow the client to establish trust in the counselor (Courtois, 1997; Moxley, 2006). Because women in prostitution have had negative and even abusive relationships with people in authority, it will be necessary to discuss this relationship dynamic in the counseling session (Moxley, 2006). Otherwise, the counselor may be seen as untrustworthy and may be feared, challenged, and tested or could be seen as the good parent they have longed for (Courtois, 1997). Male counselors may have an even more difficult time because most perpetrators the client faced were male. There is also the possibility that the client will behave sexually toward a male counselor. If handled well, however, this can be a corrective experience for the client (Moxley, 2006). Providing positive feedback is a key therapeutic intervention and will assist the client in rebuilding self-esteem (Hotaling et al., 2004).

During the next stage of therapy, the counselor should allow the client to create goals for treatment. Areas that may be covered are sexual healing, understanding the abuse and how it has affected the client’s sexuality, creating a healthy sexual attitude, developing a positive sexual self-view, stopping negative sexual behaviors, learning to cope with negative reactions to touch, and learning new skills for intimacy (Maltz, 2002). The ultimate goal of the therapeutic work should be to help the client stabilize moods, remove distress, and improve functioning. It may be necessary to refer the client to a psychiatrist for medication assessment for the client to be able to work on these emotional issues (Courtois, 1997). Once goals are established, interventions can be applied to help the client reach her goals. During this process, to minimize negative transference, explanation of interventions is warranted in an effort to give the client freedom of choice. To lessen the negative reactions of the client to treatment, the counselor needs to begin with the least anxiety-provoking items and gradually work toward more emotionally intense therapeutic interventions (Maltz, 2002). During the early portion of treatment, it is okay to allow the client to dissociate (Barnes, 1995). The difficult and challenging nature of this work is important for the therapist to anticipate as many clients may drop out or leave therapy (Courtois, 1997).

Psychoeducational work is an important part of therapy with women prostitutes. The therapist can actively teach the client about trauma as well as the cognitive and emotional effects of trauma. Learning how traumatic events shape a client’s worldview helps them to see how future behaviors are affected and can remove self-blame (Courtois, 1997). In addition, education about HIV and other STIs is especially important, particularly for those clients infected (Long et al., 2006).

Next, the client needs to learn how to relax when experiencing negative emotions (Courtois, 1997). Meditation, deep muscle relaxation, and guided imagery are all useful interventions to help the client learn to lower physiological reactions. These techniques will also help clients reconnect with their body, ground themselves in reality, and keep from dissociating (Courtois, 1997; Moxley, 2006). Once the client is able to regulate reactions, the counselor can assist in creating personal boundaries that can be enforced with others. This will hopefully allow feelings of bodily control with a partner and lessen the probability of re-traumatization (Barnes, 1995). The client should also be encouraged to develop a support system outside of therapy. Because the client has mostly experienced abusive relationships, it will be necessary for the counselor to teach the client what a healthy relationship entails (Courtois, 1997).

The client will also need to be taught coping skills to deal with negative reactions regarding the trauma. One technique that can be used is thought stopping which is helpful for intrusive thoughts. Thought stopping involves having the client engage in a behavior such as snapping a rubber band that is around the wrist when thinking about a negative thought, telling herself to stop thinking about it, and replacing the thought with a positive thought (Trauma-Focused Cognitive Behavioral Therapy, 2005).

Once the client has the ability to cope with negative reactions, therapy can focus on processing the emotions associated with the client’s trauma history. At this time, the client can discuss feelings of shame, guilt, self-blame (Courtois, 1997), self-esteem, depression, anger, self-destructive behaviors, and concerns regarding trust (Maltz, 2002). The counselor can use cognitive-behavioral techniques to help the client think of
herself as a survivor instead of a victim and to also work on improving negative sexual attitudes. The client needs to be able to acknowledge that the trauma occurred without feeling guilty or blaming herself and be able to take responsibility for deciding how to express herself sexually (Barnes, 1995).

Once the client has dealt with the emotional repercussions of the abuse, sexuality counseling can focus on improving the sexual relationship. Techniques that can be used include relearning touch techniques, red light–green light, safe nest, sensual massage (Maltz, 2002), initiating and declining sex, learning to communicate openly, and exploring intimacy (Long et al., 2006). The counselor should begin with techniques that do not involve sexual touching first and slowly move to sexual techniques. Red light–green light is a technique where the client writes down what behaviors are okay in the green light column, behaviors that are not okay in a red light column, and behaviors that are unpredictable in a caution light column. The client can share this with her partner to tell him or her which behaviors are safe and which are not. The client can practice initiating and declining sexual advances with her partner to feel in control of the situation and more comfortable declining sex. She should also be taught to communicate effectively with her partner and use “I” statements to avoid blame. To use the safe nest, the client is instructed to create a space where they feel safe to go to when they are feeling insecure. Clients can also be encouraged to pay attention to their thoughts, feelings, behaviors, and beliefs regarding sex and intimacy. Then, clients can relearn to enjoy touch using sensate focus techniques in which the client and her partner began exploring intimate touch with clothes on and not touching genitals and gradually moving to clothes off and genital touching (Long et al., 2006). Sensual massages can be given for the same purpose (Hotaling et al., 2004). Once the client feels ready, she can move to sexual intercourse (Long et al., 2006). The client can eventually continue with sexual activity even when having intrusive thoughts by simply taking a minute to distinguish between the past and reality (Barnes, 1995).

**Ethical Concerns**

All counselors should practice according to their ethical codes. There are certain ethical concerns that are especially important when practicing sexuality counseling with such a traumatized and sexualized population. Boundaries need to be clearly established and strictly followed. The client may need additional support but it is important to encourage them to build their own support network. Having blurred boundaries or dual relationships can be damaging to this population due to the similarities to an abusive relationship. Counselors working with this population also must undergo specialized training, consultation, and supervision. The counselor must also engage in self-care to be able to work with this population without burning out or becoming vicariously traumatized. The counselor needs to constantly be self-aware and able to determine whether they are emotionally capable of taking on such work. Due to the extreme nature of the therapy, it is very important that the counselor get informed consent concerning all interventions and allow the client freedom of choice. Finally, the risks of treatment also need to be thoroughly discussed with the client (Courtois, 1997).

**Conclusion**

Sexuality counseling with women who have a history of prostitution is a complex issue. A woman prostitute’s traumatic experiences contribute to the state of her mental, physical, and sexual health. There are many variables that need to be assessed when attempting to gain an understanding of the client’s specific issues. Therapy will need to focus on healing trauma and reestablishing a positive sense of self within the client. After mental health is restored, it is necessary for this population to establish a positive sexual identity in addition to improving healthy sexual functioning.

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