ResearchGate

See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/264869474

Hidden in Plain Sight: Clinical Observations on Prostitution

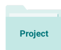
Article *in* Journal of Trauma Practice · January 2012

DOI: 10.1300/J189v02n03_01

CITATIONS
37

READS
1,380

Some of the authors of this publication are also working on these related projects:



Stand alone book review View project

All content following this page was uploaded by Judith L Herman on 08 January 2015.

The user has requested enhancement of the downloaded file.

Hidden in Plain Sight: Clinical Observations on Prostitution

Judith Lewis Herman, M.D.

Published in Melissa Farley, Ph.D. (Ed.), Prostitution, Trafficking and Traumatic Stress.
New York: Haworth Press, 2003, pp. 1-13.

Prostitution is everywhere. Everyone knows this; we just don't particularly want to know (MacKinnon, 2001). Who can bear to think for too long about a worldwide enterprise that condemns millions of women and children to social death (Patterson, 1982), and often to literal death, for the sexual pleasure and profit of men? The choice to avoid knowing operates at the edges of our consciousness; this is how dissociation is practiced as a social norm.

Thirty years ago, rape, domestic violence, and incest were similarly invisible, despite their high prevalence. A mass movement was required to bring these abuses into public awareness. In the social analysis developed by feminists, these crimes were understood as intrinsic features of a system of male dominance. It was recognized that the purpose of these crimes is to impose power, and that the methods used in furtherance of this goal are essentially the same as the methods of torture practiced in political prisons worldwide (Amnesty International, 1973; Russell, 1984).

One question that this analysis left unanswered was how individual batterers and sex offenders came to learn these often quite sophisticated methods of domination. In state-sponsored political violence, the practice of torture is organized within secret police forces and "irregular" military units, who presumably teach these methods to carefully selected new recruits. Knowledge of these methods may be shared among clandestine military units of different countries; indeed, according to declassified documents, such methods have been taught in the US at the notorious School of the Americas (Haugaard, 1997; Nelson-Pallmeyer, 1997). But this mode of transmission can not account for the widespread practice of methods of coercive control in sexual and domestic life. Powerful as they may be, secret military and police units are relatively small in number even within dictatorships, whereas batterers and sex offenders are legion, not only in authoritarian political systems, but also in democratic societies.

It is theoretically possible, of course, that each abuser might spontaneously re-invent the basic methods of coercive control for himself, but this seems quite unlikely, given the constancy

and uniformity of these practices across class and culture. It is more likely that this knowledge is transmitted within all-male groups that promote an ideology of male dominance and contempt for women, what Brownmiller (1975) calls the “men’s house culture.” It is already known that sexual assault is common among young men who belong to groups such as sports teams and fraternities (Koss, 1987). In such groups, the exchange of women or a shared visit to a brothel is often the means by which male bonding and solidarity is affirmed. The ritual display of the power to command sex from women is also a common custom in many business and political enterprises and, of course, in armies worldwide (Johnson, 2000; Goldstein, 2001). It is conceivable, then, that the prostitution industry, which operates in virtually every society, might be a primary vector for socialization in the practices of coercive control, and the pimp might be among world’s most common instructors in the arts of torture.

For helping professionals, it is difficult enough to face the reality of sexual and domestic violence as it operates in a single family, and to engage in a therapeutic relationship with a battered woman or abused child. How much more difficult, then, to face the reality of sexual violence as exercised by an organized criminal enterprise that operates freely in every community, hidden in plain sight, and to engage with victims who have been systematically reduced to the condition of slavery. Even those of us who are seasoned clinicians may find ourselves overcome with feelings of disgust, fascination, or pervasive dread, reactions which interfere with the formation of a successful therapeutic alliance. Like bystanders everywhere, we may choose not to see, hear, or speak about what in fact we already know.

Recently, when preparing a lecture for a conference on trauma, I proposed to address the subject of prostitution. The conference organizer was not pleased with my suggestion. Most of the program was devoted to the response to terrorist attacks and the formation of a national center for traumatic stress in children. Here was plenty of “clean” trauma, with many innocent victims whose plight aroused general sympathy. Prostitution, by contrast, was

embarrassing, shameful, in a word, dirty. Did it even make sense to speak of victims? Wasn't prostitution, after all, a "victimless crime?"

I noted that our staff at the Victims of Violence Program (Department of Psychiatry, The Cambridge Hospital, Cambridge, MA) were seeing a remarkable number of patients who had been used in prostitution, and that these were among the most cruelly abused people we had ever treated. My colleague acknowledged that he, too, had seen such cases, but surely they were unusual. I suggested as an empirical test that we poll the audience at the conference. If few of the participants had seen such cases, I promised not to pursue the subject any further.

At the start of my lecture, with about 600 people in attendance, I asked how many had treated or were currently treating patients who had been used in prostitution. By my rough visual estimate, 450 people (75%) raised their hands. It was a moment of surprise, not only for my colleague, the conference organizer, but for those in the audience as well. Here was a common experience that by common, unspoken consent was simply not discussed in public, not even by a group of mental health professionals who had already amply proved their willingness to bear witness to terrible stories. It was also a moment of illumination and relief, as members of the audience looked around and realized they had lots of company. With the acknowledgement and support of colleagues, perhaps we clinicians could overcome our own resistance to engagement with victims who are generally viewed as neither "clean" nor "innocent."

We have a great deal to learn from these patients. The complex traumatic 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 traumatic disorders, and the frontiers of our current knowledge.

Secrecy is the first and most serious obstacle to forming a therapeutic alliance. People engaged in prostitution, if they seek treatment at all, are likely to conceal or minimize their involvement in prostitution. The shame and stigma attached to prostitution are so severe that

most people will go to great lengths to hide this aspect of their experience, even in a confidential therapy relationship that depends for its success on frank and full disclosure (Baldwin, this volume). Given the widespread prevalence of prostitution, it would seem advisable for clinicians to learn to incorporate questions regarding this experience into routine history-taking (for examples see Stark & Hodgson, this volume). Clinicians working with trauma populations should be especially alert to this possibility, given the vulnerability of childhood abuse survivors to revictimization in general (Coid, et. al., 2001), and to recruitment for pornography and prostitution in particular (Russell 1986).

People in prostitution also commonly suffer from serious neurobiological and personality disorders that hinder the formation of a cooperative working relationship. Moreover, the realities of their daily lives are often so precarious and dangerous that without sustained and well-organized social intervention, ordinary therapeutic measures are unlikely to have any meaningful effect. Some of the problems encountered in treating this group of patients are illustrated by the following case vignettes, drawn from the records of the Victims of Violence Program. Details that might permit identification of individuals have been omitted or disguised.

Neurobiological Problems

These include very complex and confusing ego states (Ross & Farley, this volume), and severe forms of emotional and bodily dysregulation. While somatic and affective dysregulation are commonly seen in complex PTSD (van der Kolk et. al., 1996), the conditions of prostitution exacerbate this problem. Control of bodily functions is an established method of coercion well known to clandestine police forces and criminal organizations worldwide. It is systematically practiced by pimps and traffickers in the sex industry, not only to intimidate victims and break their resistance, but also to train them for sexual performance.

The ultimate goal in this, as in all systems of domination, is to destroy the autonomy of the victim and induce as far as possible a state of willing submission. This may require the

intentional induction of altered states of consciousness and the development of dissociated ego states in which the enslaved person is given a new name and a new identity as a whore (Stark & Hodgson, this volume). An example can be found in the autobiographical account of Linda Marciano, who describes being first raped and beaten into submission, and then trained with the aid of hypnosis to suppress her gag reflex, in order to perform her role as "Linda Lovelace" in the famous pornographic film Deep Throat (Lovelace & McGrady, 1980). Here the colonization of the body extends to the suppression of the most basic autonomic functions.

Under conditions of prostitution, autonomous self-regulation of any sort is a form of insubordination; it is expressly forbidden and actively suppressed. In the absence of normal self-soothing, substance abuse provides the most accessible route to bodily calm and emotional comfort. Addiction further complicates an already complicated clinical picture. When chemical means of self-regulation fail, self-harming behavior and suicide attempts are often the last resort.

Case example One.

Jenny, a 35-year old single woman, entered outpatient treatment complaining of depression and post-traumatic stress symptoms. She was living alone in a condominium owned by her father and working part time in the office of one of her father's business associates. She complained of feeling controlled and bullied by her father, who had sexually abused her when she was a child, but depended on him for financial support.

The initial treatment plan focused on stabilization of symptoms and development of a workable safety plan. Ostensibly Jenny agreed with this plan and seemed highly motivated to carry it out. However, despite her best efforts and those of her treatment team, apparently well-crafted safety plans were repeatedly and inexplicably breached. Her sense desperation and helplessness deepened, and she became actively suicidal. Her treatment team was puzzled by her deteriorating condition. Clearly, some major piece of information was missing.

Finally, two years into her treatment, it was recognized that “Jenny” was the host personality in a patient with Dissociative Identity Disorder. Our experienced clinicians had previously failed to make the diagnosis, despite their general familiarity with dissociative disorders and a high index of suspicion in this particular case. It became clear that the patient had intentionally concealed her dissociative symptoms. Some of her numerous alters disclosed that they had been actively collaborating with the father, who operated a private sex ring. The patient reported that her father had been pimping her since the age of 14, rewarding her with money and cocaine. He was fully aware of her dissociative disorder and routinely summoned specific alters, who identified themselves as willing prostitutes, to perform the desired sexual activities.

In his original study of 100 cases of Dissociative Identity Disorder, Putnam (1986) noted that the average length of time between entry into the mental health system and correct diagnosis was six years. The two year delay in diagnosing this case, while it might represent an improvement over the norms of 20 years ago, certainly leaves much to be desired. It seems clear in retrospect that the key to the diagnosis in this complex case was recognition of the patient’s ongoing involvement in prostitution. Specific questioning regarding prostitution might have uncovered this essential fact earlier.

Characterological Problems

Victimization does not generally improve a person’s character. Personality disorders are a common feature of the complex traumatic syndrome that results from prolonged and repeated trauma in relationships of coercive control (Herman, 1992). Many survivors develop a stigmatized, negative identity and have difficulty establishing stable, cooperative and mutually rewarding relationships. Identity and relational problems reflect the degree of moral degradation to which the person has been subjected, and the resultant shame, resentment and mistrust

which she brings to any new relationship. It is common for survivors to engage in a pattern of intense, unstable and highly conflictual relationships.

Even when the prostitution secret has been revealed, other forms of dissembling and dishonesty may continue. People who have been used in prostitution are keenly aware of the hypocrisy of the supposedly respectable people who seek out their services. They are further exposed to the ideology of the criminal class that exploits them, in which every sort of immoral behavior is rationalized and even glorified, on the grounds that the whole society is exploitative and corrupt, and the only way to preserve one's dignity is to "beat the system." Relationships, including the therapeutic relationship, are often approached with the assumption that people are generally selfish or perverse, and that only a limited number of roles are possible: one can be a perpetrator, an accomplice, a well-meaning but useless bystander, a victim, or, perhaps, a rescuer. The concept of a freely chosen, honest and fair relationship, in which both parties work hard to fulfill their responsibilities and both parties benefit, may be completely foreign to the patient's world-view or experience.

To counter this cynical and despairing view of human relationships, the rules of engagement in psychotherapy must be clearly explained, and the therapist must make it clear that both parties are accountable for honoring them. Honesty, fairness, and respect are mutual obligations. The patient should be encouraged to voice any complaints she may have about her treatment, especially any behavior that she views as unjust, dishonest or disrespectful. Similarly, the therapist should deal openly with dishonest or disrespectful behavior on the part of the patient, both in and outside of the office. Treating patients with dignity includes the expectation that they take reasonable responsibility for their actions.

In general, clinicians aspire to create a therapeutic climate that is accepting, warm and non-judgmental. Confronting a patient's unacceptable behavior, while maintaining an attitude of caring and respect, is one of the therapist's most difficult and challenging tasks. When working with people in prostitution, clinicians may bend over backward to avoid seeming prudish or

judgmental. In the effort to overcome their own prejudices, clinicians may be tempted to overlook or excuse antisocial behavior. This stance, while well-intentioned, ultimately undermines the therapy relationship. Patients do not appreciate being patronized. On the contrary, patients often express their appreciation for therapists who recognize them as moral beings, using expressions such as “she never let me get over on her,” or “he believed in me.”

Case Example Two:

Katarina is a 24 year old mother of a 2 year old son. In the course of her treatment, she had successfully ended a relationship with a pimp and was living in a small apartment with a new boyfriend, who, like herself, was a recovering addict. She supported herself by providing home daycare for several children. Daily contact with the children reminded her of how profoundly neglected she had been as a child and how deeply she longed for both attention and material possessions. She acknowledged that she missed the extravagant spending that was part of her life in prostitution, even though she recognized that her pimp controlled all the money and that she herself had always been desperately poor.

Just before Christmas, Katarina reported that while in a store with her son she had impulsively stolen a bracelet. Her initial feeling of entitlement and triumph had quickly given way to shame and regret as she realized how seriously she had put herself and her child at risk. She was very relieved that she had not been caught, but getting away with shoplifting didn’t feel right either; now she couldn’t even stand to wear the bracelet.

The therapist was glad Katarina had confided in her, and told her so, but also made it clear that she did not approve of stealing. She asked whether Katarina had considered returning the bracelet. This idea came as a complete surprise to the patient, who had never entertained the possibility that she could make things right. Her eventual choice to return the bracelet gave her a new sense of agency and self-respect.

In this case, the therapist was able to maintain the distinction between moral and therapeutic neutrality. To clarify the distinction: moral neutrality means declining to take a stand on the abstract question whether stealing is right or wrong. Therapeutic neutrality means declining to take a stand regarding the patient's inner conflicts about stealing. Here, the therapist was able to convey a clear moral position against shoplifting, while maintaining a confidential and accepting stance toward the patient. This allowed the patient to explore her conflicted feelings about what she had done and come to her own resolution of her dilemma. The therapeutic alliance was enhanced, to the mutual satisfaction of patient and therapist, and the therapy progressed well.

In other cases, however, where crimes against persons rather than property crimes are at issue, neutrality of any sort may be impossible to maintain. If the patient's behavior is putting others at risk, the therapist may be morally or even legally obligated to take a stand, even at the cost of violating confidentiality or jeopardizing the therapy relationship.

Case example Three

Nicole, a 22 year old single mother, came to the clinic seeking medication to help her panic attacks and counseling to help her cope with the behavior of her 5 year old daughter. She had recently moved into the home of a wealthy, divorced older man whom she had met at the nightclub where she worked as a stripper. She saw this move as a great improvement in her life. She was estranged both from her abusive parents and from the father of her child, who had beaten her and had never provided any financial support. Her new boyfriend treated her "like a queen." The only problem was her daughter, who had turned into a "brat." The child had become alternately clingy and defiant, had started wetting the bed, and was refusing to accept her new "daddy." Over time Nicole disclosed that this man had a prior conviction for rape and was currently under permanent court order to have no contact with his two teenage daughters, who had accused him of incest. Nicole believed his assurances that in both cases he had been

falsely accused by conniving women who were after his money. She frequently left her daughter alone in his care, despite the child's protests.

The therapist expressed his concern about the situation. He attempted to engage Nicole's protective feelings for her daughter and to raise her awareness regarding the possibility of abuse, but Nicole adamantly refused to entertain the idea that her child could be in any danger. The therapist shared his dilemma with the patient. He explained that he did not want to take action without her consent, but he could not remain a passive bystander when he suspected that the child might be at risk. He reminded Nicole how much she had longed for someone to intervene when she herself was being abused as a child. In this case, he explained, there were clear warning signals, and he would be negligent if he failed to pay attention. Furthermore, as a mandated reporter he was required by law to bring his concern about the child's safety to the attention of protective services. Enraged, Nicole called the therapist a "fucking pig" and stormed out of the office. An investigation by the state Department of Social Services confirmed sexual abuse, and the child was placed in foster care.

In this case, despite the therapist's best efforts, it was not possible to engage the patient in the project of establishing safety. The treatment alliance failed, and the therapist was obliged to act unilaterally. Though the intervention was necessary, the outcome was tragic for both the patient and her daughter. It was also painful for therapist, who was placed in an untenable position, forced to choose between passive complicity in the ongoing abuse of a child and drastic action that invoked the intervention of the state. In general, because violence and exploitation are an intrinsic part of the daily lives of people in prostitution, therapists who work with them may often be placed in the uncomfortable position of a bystander and faced with similar moral dilemmas regarding intervention.

Social Problems

The numerous social problems encountered by people in prostitution are reviewed by several authors in this volume (Carter; Hedin & Manson; Hotaling et al; Rabinovitch). Of particular concern are the dangers and practical difficulties of leaving prostitution. Like battered women, prostituted women can expect an escalation of violence should they attempt to escape from their abusers, and may need a great deal of assistance to obtain shelter and rudimentary physical safety. Several attempts may be necessary to before safety is achieved. Caregivers who assist women attempting to leave prostitution may feel frustrated and overwhelmed by the complexity of the task; they may also occasionally feel threatened and endangered along with their patients.

Case example Four

Yvette, a 28 year old woman with a 15 year history of prostitution and drug addiction, finally made a decision to leave her pimp. Support for this decision required intensive involvement and sustained cooperation among numerous agencies. She was hospitalized on several occasions, first for detoxification and then for severe depression. She was eventually granted disability on the basis of psychiatric impairment and was assigned a case manager. Supervised housing was arranged through the state Department of Mental Health. A victim advocate assisted her in seeking a court order to prevent the pimp from pursuing her in her new location.

For several months after the court order was granted, Yvette had no contact with her pimp and was consistently abstinent from drugs and alcohol for the first time since early adolescence. Safety was maintained until she was discharged (against her therapist's advice) from the halfway house where she had been living and moved to an unsupervised apartment in an unfamiliar community. Within two weeks she relapsed and called one of the pimp's associates, looking for drugs. Shortly thereafter she was found by the police wandering on the street at night, dazed and bleeding, and brought to the local emergency room. She initially

stated that her pimp had tracked her down and beaten her, but soon retracted her story and refused to cooperate further with law enforcement.

When she recovered from her injuries, Yvette was discharged from the hospital to a secure residential placement. She is currently sober and to the best of our knowledge has had no further contact with her pimp. In therapy she acknowledges that was indeed the pimp who attacked her, but she is afraid that he might kill her if she ever dared to press criminal charges against him. Her therapist considers this to be a reasonable fear.

Consultation was sought with the victim witness advocacy service in the district attorney's office, regarding potential danger to the therapist as well as the patient. In the advocate's judgment, the pimp appeared to be a rational criminal entrepreneur who was unlikely to risk attacking a person with professional status and a strong social support network. Nevertheless, the therapist has taken additional security precautions to protect herself and her family.

The investment of service resources in this case was extraordinary. The financial and emotional costs of this one case were very high, and while significant progress has been made, the patient's recovery is still quite fragile. Premature attempts to move the patient to a less intensive (and less costly) care environment resulted in relapse and placed her in serious danger. Though this case may represent an extreme, some comparable degree of resource mobilization may be necessary for many people in prostitution. Effective recovery programs are likely to require coordination of many types of service, including health, mental health and addiction services, disability or other forms of public assistance (Baldwin, this volume), housing support, and victim advocacy. Any social policy approach to this problem must include a realistic appraisal of the cost and cost-effectiveness of rehabilitation services.

This case also raises philosophical and legal questions regarding responsibility, and choice. Should a criminal case could be brought against the pimp, despite the patient's refusal

to cooperate, based on her initial "excited utterance" in the emergency room and her documented injuries? Would such an "evidence-based" prosecution be in her best interest, or would it further disempower or endanger her? Given the extreme degree of coercive control exercised by pimps, and the general reluctance of their victims to testify against them, is such paternalistic intervention ever warranted (Buzawa & Buzawa, 2003; Epstein, 1999; Mills, 1998)?

Finally, most people who attempt to leave prostitution are also very poor and lack basic education or the rudimentary job skills that might enable them to support themselves independently. They also frequently lack the social skills required for participation in ordinary, non-exploitative relationships. The code of "getting over," although it might conceivably be adaptive within highly stigmatized social groups, is completely maladaptive for a person attempting to enter into the "straight" world. A structured peer support group may offer the most meaningful opportunity for the survivor to develop a new identity as a valued and responsible member of a community (see, for example, Carter, this volume; Rabinovitch, this volume; Hotaling et. al., this volume).

Case Example Five

Kevin, a 21 year old man, had escaped from his abusive family at the age of 17 by running away to live with an older man whom he met in an internet chat room. At first, the relationship seemed very romantic, and Kevin was "happier than I had ever been in my life." Gradually, however, he became disillusioned, as his partner began to pressure him into prostitution, threatening to throw him out of the house if he refused. Kevin became increasingly frightened as his the men his partner brought home insisted on increasingly risky and painful sexual practices. Finally, feeling lost and betrayed, he fled to a homeless shelter and sought psychiatric treatment.

In the course of his recovery, Kevin moved into a rooming house, got a job at a fast-food restaurant, and entered a program to get his high school diploma. Though he had succeeded in

getting safe, he complained that he was lonely and bored and acknowledged that he was strongly tempted to return to"tricking." He reported a dream in which he escaped from a swamp filled with dangerous creatures, only to find himself all alone in a cold, antiseptic swimming pool. It became apparent that Kevin had no idea how to make friends with people his own age, let alone how to form an intimate relationship. He felt that he didn't belong anywhere.

With his therapist's encouragement, Kevin joined a group for male survivors of sexual abuse. In this group he experienced a sense of belonging and felt understood by his peers, and he was able to explore complicated issues such as confusion about his sexual orientation. He also gained self-respect from the experience of being supportive to others. After some time in the group, he began volunteering at an animal shelter, where he found that he could bond with others who shared his concern for abandoned and mistreated animals.

These case vignettes suggest that the basic principles of trauma treatment-- establishing safety, working through the trauma, reconnecting with a community--are potentially useful and effective for survivors of prostitution. Many of the issues illustrated in these case examples are already familiar to clinicians working with trauma survivors. Themes of secrecy, social alienation and stigma are common to victims of many types of oppression, particularly those forms that are socially condoned. Even seasoned clinicians, however, may be shocked to discover the extent of prostitution in their own communities and horrified by the extreme violence and degradation to which people in prostitution are subjected. The contagion of trauma produces a range of predictable countertransference reactions that mirror the symptoms of the posttraumatic disorders. Hyperarousal reactions may include heightened anxiety, embarrassment, fascination, or even sexual excitement. Numbing reactions may include denial, disgust, aversion and avoidance. These intense countertransference reactions have slowed recognition of the problem of prostitution within the trauma field. Furthermore, clinicians are not

immune to the prejudices of the larger community. The dishonor attached to prostitution is so profound that it affects all social interactions, including the therapy relationship.

This special issue of JTS is designed to raise awareness of prostitution among clinicians and to foster public conversation on a subject that has hitherto largely been avoided. For the three out of four clinicians who have already worked with survivors of prostitution, but have done their work in isolation, this special issue is designed to build support and community. For the one out of four who has not yet (knowingly) treated a patient with a history of prostitution, this special issue is designed as preparation for an encounter that is very likely to happen sooner or later. Clinicians who work with traumatized people have borne witness to many kinds of atrocity; we are capable of facing this one, too, as long as we do not have to face it alone.

References:

Amnesty International (1973). Report on Torture. New York: Farrar, Straus & Giroux.

Baldwin, MA (2003). Living in longing: Prostitution, trauma recovery, and public assistance. Journal of Trauma Practice (in press).

Brownmiller, S (1975). Against Our Will: Men, Women, and Rape. New York: Simon & Schuster.

Buzawa, ES & Buzawa, CG (2003). Domestic Violence: The Criminal Justice Response (Third Edition). Thousand Oaks, CA: Sage.

Carter V (2003). Providing services to African-American prostituted women. Journal of Trauma Practice (in press).

Coid J, Petruckevitch A, Feder G, Chung W-S, Richardson J, Moorey S (2001). Relation between childhood sexual and physical abuse and risk of revictimisation in women: A cross-sectional survey. The Lancet: 358; 450-454.

Epstein, D (1999). Effective intervention in domestic violence cases: Rethinking the role of prosecutors, judges, and the court system. Yale Journal of Law and Feminism: 11; 3-50.

Goldstein, J. (2001). War and Gender: How Gender Shapes the War System and Vice Versa. New York: Cambridge University Press.

Haugaard, L (1997). Declassified Army and CIA Manuals Used in Latin America: An Analysis of Their Content. Washington, D.C.: Latin America Working Group.

Hedin U-C & Manson SA(2003). The importance of supportive relationships among women leaving prostitution. Journal of Trauma Practice (in press).

Herman JL (1992). Trauma and Recovery. New York: Basic Books.

Hotaling N, Burris A, Johnson J, Bird YM (2003). Been there done that: A peer leadership model among prostitution survivors. Journal of Trauma Practice (in press).

Johnson, C (2000). Blowback: The Costs and Consequences of American Empire. New York: Metropolitan Books.

Koss, M (1987). Hidden rape: Sexual aggression and victimization in a national sample of students of higher education. In AW Burgess (Ed): Rape and Sexual Assault, vol. 2. New York: Garland; 3-26.

Lovelace L & McGrady, M (1980). Ordeal. Secaucus, NJ: Citadel.

MacKinnon, CA (2001). Sex Equality. NY: Foundation Press. Chapter 10.

Mills, L (1998). The Heart of Intimate Abuse: New Interventions in Child Welfare, Criminal Justice, and Health Settings. New York: Springer.

Nelson-Pallmeyer, J (1997). School of Assassins: The Case for Closing the School of the Americas and for Fundamentally Changing U.S. Foreign Policy. Maryknoll, NY: Orbis Books.

Patterson, O (1982). Slavery and Social Death: A Comparative Study. Cambridge, MA: Harvard University Press.

Putnam FW, Guroff JJ, Silberman EK et.al.(1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. Journal of Clinical Psychiatry 47; 285-293.

Rabinovitch, J (2003). PEERS: The prostitutes empowerment, education and resource society. Journal of Trauma Practice (in press).

Ross C & Farley M (2003). Dissociation among women in prostitution. Journal of Trauma Practice (in press).

Russell, DEH (1984). Sexual Exploitation. Beverly Hills, CA: Sage.

Russell, DEH (1986). The Secret Trauma: Incest in the Lives of Girls and Women. New York: Basic Books.

Stark C & Hodgson C (2003). Sister oppressions: A comparison of wife-battering and prostitution. Journal of Trauma Practice (in press).

van der Kolk BA, Pelcovitz D, Roth S, Mandel F, McFarlane A, Herman JL (1996). Dissociation, affect dysregulation and somatization: The complexity of adaptation to trauma. American Journal of Psychiatry; 153 (Festschrift Supplement): 83-93.

View publication stats