

THE PROSTITUTION AND TRAFFICKING OF AMERICAN INDIAN/ALASKA NATIVE WOMEN IN MINNESOTA

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Abstract: We examined social and physical violence experienced by American Indian/Alaska Native (AI/AN) women in prostitution and their impacts on the mental and physical health of 105 women (81% Anishinaabe, mean age = 35 years) recruited through service agencies in three Minnesota cities. In childhood, abuse, foster care, arrests, and prostitution were typical. Homelessness, rape, assault, racism, and pimping were common. The women's most prevalent physical symptoms included muscle pain, impaired memory or concentration, and headaches. Symptoms of post-traumatic stress disorder and dissociation were common, with more severe psychological symptoms associated with worse health. Most of the women wanted to leave prostitution and they most often identified counseling and peer support as necessary to accomplish this. Most saw colonization and prostitution of AI/AN women as connected.

There is increasing awareness about violence perpetrated against American Indian and Alaska Native (AI/AN) women (LaPointe, 2008; Smith, 2005; Tjaden & Thoennes, 2000). AI/AN women today are vulnerable to sexual exploitation as a result of post-colonial homelessness, poverty, health problems (including mental disorders), and a lack of basic services to address these conditions. Like other women in military conflict zones, AI/AN women were at extreme risk for rape, prostitution, physical abuse, and racist verbal abuse during colonization (Hyman, 2009; Pretty Sounding Flute, 2000; Smith, 2005). During the boarding school era, an effort to force assimilation (Adams, 1997), U.S. policy required most AI/AN children to live in off-reservation boarding schools where physical and sexual abuse were common (Deer, 2004a; Perry, 2002). Colonial abuse aimed at destroying AI/AN cultures persisted throughout the 20th century and continues today.

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As a result, many AI/AN people live in adverse social and physical environments that place them at high risk of exposure to traumatic events with rates of violent victimization more than twice the national average (Manson, Beals, Klein, & Croy, 2005). High rates of poverty, homelessness, and chronic health problems in AI/AN communities (Palacios & Portillo, 2009; Perry, 2008) create vulnerability to prostitution and trafficking among AI/AN women by increasing economic stress and decreasing the ability to resist predators (Bortel, Ellingen, Ellison, & Thomas, 2008; Deer, 2010). AI/AN women are subject to high rates of childhood sexual assaults, domestic violence, and rape both on and off reservations (Bachman, Zaykowski, Lanier, Poteyeva, & Kallmyer, 2010; Chenault, 2011; Clark & Johnson, 2008; Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Saylor & Daliparthi, 2012). The vast majority of prostituted women were sexually assaulted as children, usually by multiple perpetrators, and were revictimized as adults in prostitution as they experienced being hunted, dominated, harassed, pimped, assaulted, battered, and sometimes murdered by sex buyers, pimps, and traffickers (Farley, Franzblau, & Kennedy, 2014).

We use the word *prostitution* to refer to the exchange of sex acts for money, food, shelter, and other needs; outcall/escort/cell phone prostitution; Internet prostitution; massage parlor and brothel prostitution; child and adult pornography; strip club prostitution; sauna- or nail parlor- based prostitution; live sex shows; street prostitution; peep shows; phone sex; servile marriages/“mail-order brides”; and prostitution tourism. *Trafficking* is prostitution under pimp control and can be domestic or international. As noted above, homelessness is linked to the sexual abuse of prostitution and trafficking (Farley et al., 2003) and is a primary risk factor for prostitution (Boyer, Chapman, & Marshall, 1993; Louie, Luu, & Tong, 1991; Simons & Whitbeck, 1991). When state and private agencies fail to offer women and children shelter, pimps provide housing in exchange for prostitution. AI/AN people are overrepresented in the homeless population in the U.S. (Zerger, 2004). Housing instability on reservations sometimes results in migration to urban areas, leaving young women vulnerable to prostitution. Although AI/AN people constitute only 1% of adults and 2% of youth in Minnesota, they constitute 11% of homeless adults and 20% of homeless youth (Koepplinger, 2009; Minnesota Coalition for the Homeless, 2008; Wilder Research Foundation, 2010). Prostitution is, unfortunately, excluded from some reports on violence against AI/AN women. Although both reports addressed sexual violence against AI/AN women, neither a 2007 Amnesty International report nor a 2010 article by Bachman et al. addressed prostitution or sex trafficking. AI/AN women and children are disproportionately represented in U.S. and Canadian

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prostitution (Farley, Lynne & Cotton, 2005; Kingsley & Mark, 2000; McKeown, Reid, & Orr, 2004), just as Māori youth in New Zealand (Plumridge & Abel, 2001) and Atayal youth in Taiwan (Hwang & Bedford, 2003) are overrepresented in prostitution. Most often entered into by those with a history of sexual, ethnic, and economic victimization, prostitution is a sexually exploitive, usually violent survival option that rarely has been included in discussions of sexual violence against Native women. Because Native women are at high risk for poverty, homelessness, and childhood sexual violence, which are risk factors for prostitution, and because prostituted women are at high risk for violence and emotional trauma, our goal was to learn more about the lives of Native women prostituted in Minnesota, a group of people whose experiences of violence, physical and emotional health, opinions about prostitution in a historical context of colonialism, and stated needs in order to exit prostitution have not been adequately studied in psychological research.

METHOD

Participants

We interviewed 105 AI/AN women in prostitution who were in contact with supportive agencies in Minneapolis, Duluth, and Bemidji, Minnesota. Based on the empirical data in this study and others, the authors do not consider prostitution to be work in its positive meaning as legitimate commerce (Farley et al., 2005; Potterat et al., 2004; Silbert & Pines, 1983; Stark & Hodgson, 2003; Widom & Kuhns, 1996). We have come to understand prostitution as a form of violence against women and as a human rights violation; therefore, we avoid using the term “sex worker,” which conceals and mainstreams these violations. Although referring to women as “sex workers” may be an attempt to dignify prostitution, after many interviews with prostituted women, we

conclude that the expression fails to lend dignity to activities that are dehumanizing and degrading. Instead, we use the terms “woman in prostitution,” “prostituting woman,” or “prostituted woman,” avoiding the transformation of women into the very harms perpetrated against them. In professional practice settings such as clinics or shelters, we use words that the women themselves use for prostitution, such as “in the life” or “dating.” In conferences, staff meetings, or articles, we use the terms suggested above.¹ The women volunteered for the study after seeing announcements posted at agencies or via snowball or chain referral sampling. We asked agencies that are members of the Minnesota Indian Women’s Sexual Assault Coalition to help us identify women in their communities who might want to participate in this research project. Advocates at these agencies posted flyers at

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food shelves, homeless shelters, and other locations in the community. We have conducted comparable research in nine other countries; in all locations, we sought at least 100 respondents because that number made it possible to conduct meaningful analyses and arrive at reasonable conclusions. A smaller number would not have permitted this. We interviewed 105 women because we anticipated having to discard some data, or that some data would be missing. Fortunately, this did not occur for most questionnaire items.

Procedure

We conducted research interviews consisting of six questionnaires that included both quantitative items and structured open-ended questions. The following questionnaires were read aloud to the women, and notes were taken on paper or on a computer because audio recording of illegal activity (prostitution) would likely have jeopardized rapport with the interviewees and resulted in less candid responses.

The Prostitution Questionnaire has been used previously in nine countries (Farley et al., 2003) and includes questions about age of entry into prostitution, number of sex buyers; experiences of sexual and physical violence in childhood and adulthood; use of pornography in prostitution; history of homelessness, physical health problems, alcohol and drug use; whether respondents wish to leave prostitution, and what they need in order to do so. Most of the questions are close-ended (requiring a response of *yes* or *no*, or using response categories specific to the question; e.g., *last week*, *last month*, or *last year*) and a few are open-ended (e.g., “Where were you born?”).

We included six items from the Dissociation subscale of Briere’s Trauma Symptom Checklist (TSC-40; Elliott & Briere, 1992), which was developed to assess trauma symptoms in survivors of childhood sexual abuse. On a Likert scale of 0 (*never*) to 3 (*often*), scores of 2 or 3 indicate a clinically significant frequency of dissociative symptoms. TSC-40 total scores yield an alpha of .90, and the mean internal consistency for the subscales is .69 (Elliott & Briere, 1992). Differences in dissociative symptoms among adults with different child abuse histories have been obtained with the TSC-40 (Briere & Runtz, 1990).

The women also completed the Post-traumatic Stress Disorder Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993), a self-report research inventory for assessing the symptoms of post-traumatic stress disorder (PTSD), which are grouped into three categories: 1) traumatic re-experiencing of events or flashbacks; 2) avoidance of situations which are reminiscent of the traumatic events, and a protective emotional

numbering of responsiveness; and 3) autonomic nervous system hyperarousal (such as jittery irritability, super-alertness, or

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insomnia; American Psychiatric Association [APA], 2000). Respondents were asked to rate these symptoms on a 17-item, Likert-scored scale (1 = *not at all*, 5 = *extremely*) with test-retest reliability of .96. Internal consistency as measured by Cronbach's α was .97. Validity of the scale is reflected in its strong correlations with the Mississippi Scale (.93), the Post-traumatic Stress Disorder-Keane scale of the Minnesota Multiphasic Personality Inventory-2 (.77), and the Impact of Events Scale (.90; Weathers et al., 1993). The PCL has functioned comparably across different ethnic cultures in the U.S. (Keane, Kaloupek, & Weathers, 1996). We measured symptoms of PTSD in two ways. First, using Weathers and colleagues' (1993) scoring suggestion, we considered a score of 3 or above on a given PCL item to be a symptom of PTSD. Scored in this way, these symptoms were used to estimate the presence or absence of a diagnosis of PTSD for each woman. Using DSM-IV criteria (APA, 2000), women who scored 3 or higher on at least one symptom of re-experiencing, three symptoms of avoidance, and two symptoms of hyperarousal met criteria for a diagnosis of PTSD. Second, using a procedure established by the authors of the scale, we generated a measure of overall PTSD symptom severity by summing respondents' ratings across all 17 items.

General health was measured using self-rating on a scale of 1 = *poor* to 5 = *excellent*. The validity of this method has been established through correlations with physician-assessed health and mortality (Idler & Angel, 1990; Kaplan & Camacho, 1983; Mossey & Shapiro, 1982). We also administered a Chronic Health Problems Questionnaire (Farley et al., 2005) that included items scored *true* or *false* and was developed from an earlier study of 854 people in prostitution in nine countries, which used an open-ended item to inquire about health problems (Farley et al., 2003). The most frequently mentioned health problems in that study were used as checklist items in the Chronic Health Problems Questionnaire for the present study; reliability data are not available. We created a new questionnaire, the Native American Prostitution Questionnaire, to inquire about interviewees' understanding of prostitution in relation to their cultures, historical trauma, boarding school, foster care, adoption, tribal identity, and sexual violence, among other factors. The questionnaire contained open-ended questions to which verbatim responses were recorded. For example, questions included "What Nation/Tribe are you from?" and "Please explain how colonization of Native people and prostitution and trafficking of Native women are connected, in your own words." The latter question was asked only when the interviewee responded, "yes" to a previous question about whether she saw such a connection. The questionnaire also included close-ended questions (e.g., "Did any of your family members attend boarding schools?" which was coded *yes*, *no*, or *don't know*, and "Were you ever in foster care?" which was coded *yes* or *no*).

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The study protocol was reviewed by Prostitution Research & Education's Ethics Review Committee. The interviews were conducted by 5 interviewers who had experience in sexual assault and domestic violence advocacy and were trained in interview techniques and questionnaire administration, including observed and practice interviews. Interviews lasted 1-2 hours. Advocates at Minnesota Indian Women's Sexual Assault Coalition

member agencies took calls and scheduled interviews; provided transportation, sexual assault advocacy, and support during and after interviews; and provided interview space in their offices.² Each woman signed an informed consent form and received a \$75 gift card in appreciation of her time.

RESULTS

Demographic Characteristics

The mean age of the women was 35 years (range = 18-60 years, *SD* = 11). Ninety-eight percent of the women were currently or previously homeless.

National and Tribal Identities³

The Bureau of Indian Affairs, operating as an arm of the U.S. government, defines “who is an Indian” in approximately 12 different ways for the purpose of determining eligibility for services. Yet identity among AI/AN people does not generally follow the federal government's model (Haozous, Strickland, Palacios, & Solomon, 2014). Most AI/ANs provide an identity connected to their reservation instead of their family ancestry identity. Many have multiple heritages and also have two or more reservation identities. It is possible, for example, for an AI/AN person to live on a reservation but not share the tribal identity of the majority on that reservation. In this study, we have done our best to stay as close as possible to the women's own categorizations, which are sometimes tribes or nations and sometimes reservations. The women were likely to self-identify based on which people in their family or community taught them about their ancestry.

A significant majority (81%, *n* = 85) of women identified as Anishinaabe, also known as Ojibwe or Chippewa. Of these women, 94% (*n* = 80) identified Anishinaabe as their only tribal affiliation, and 6% also identified with another nation. The remaining 19% (*n* = 16) of the women identified as coming from one or more other nations (e.g., Lakota/Dakota, Apache, Oneida, Menominee, Ho-Chunk, Blackfoot, Cherokee, Choctaw, Ponca, Cree, Sioux), or occasionally identified as Native American and did not specify national or tribal affiliation.

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Of the 90 women who told us where they had grown up, the vast majority (91%, *n* = 82) had grown up in Minnesota. Nine percent (*n* = 8) had grown up in other states within the U.S., and 1% (*n* = 1) had grown up overseas. Of the 89 women who told us that they had grown up in the U.S., 44% (*n* = 39) indicated that they had grown up on a reservation. At the time of the interview, most of the women lived in Duluth (49%) or Minneapolis (27%). Six percent currently lived on either Leech Lake or Fond du Lac reservation. The remaining 19% lived in other Minnesota cities.

Antecedents to Prostitution in the Lives of AI/AN Women

Boarding School

Nine percent of the women we interviewed had attended boarding school. More than two thirds (69%, *n* = 63) of the 105 women had family members who had attended boarding school. The relatives who attended boarding school were grandmothers (42%), mothers (35%), grandfathers (26%), sisters (17%), fathers (17%), or cousins (17%). Other relatives included brothers, great grandmothers, great grandfathers, aunts, uncles, and daughters. Boarding schools were located in a variety of states⁴ and in Canada.

Of relatives who had attended boarding school, more than two thirds (69%) were known by the women to have been abused there. All of those relatives were verbally or mentally abused; most (94%) were spiritually, culturally, or physically abused; and 27% were

sexually abused. The abuse was perpetrated by teachers, church officials, and government officials.

Foster Care and Adoption

Forty-six percent ($n = 48$) of the women we interviewed had been in foster care, in an average of 5 foster homes (range = 1-20, median = 3, $SD = 4.8$). Before the age of 5 years, 34% of those who had been in foster care had been placed in an average of 3.7 foster homes (range = 1-10, median = 3, $SD = 3.3$). Between the ages of 6 and 10 years, 53% had been placed in an average of 3.4 foster homes (range = 0-14, median = 2, $SD = 4.1$). Between the ages of 11 and 18 years, 73% had been in an average of 2.8 foster homes (range = 0-16, median = 1, $SD = 3.5$). As children, the women were placed in AI/AN foster homes 36% of the time. Twenty percent of the women were living on reservations prior to being placed in foster care. The 87 foster care locations were most often in Duluth, St. Paul, or Minneapolis (38), other Minnesota locations (30), and less frequently on Minnesota or South Dakota reservations (8).

Minnesota included Leech Lake, White Earth, Red Lake, Fond du Lac, Mille Lacs, Grand Portage, and Bois Forte. Reservations located outside Minnesota were in South Dakota (Pine

Reservations in

Ridge, Rosebud, and Cheyenne River), Wisconsin (Menominee), and Oklahoma (Ponca).

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Several women spoke to interviewers about the reasons for their foster care placement. They were children of alcoholics or drug addicts and frequently ran away from home, almost always attempting to escape abuse from male relatives or neglect/abandonment. Some cared for mothers who were emotionally incapacitated, homeless, or addicted.

Several were placed in foster care upon the death of grandparents.

Almost half (46%) of the women who had been in foster care had been abused in foster families, most often verbally (86%), spiritually (81%), culturally (76%), physically (67%), and/or sexually (38%). The abuser was most often the foster mother (57%), foster brother (52%), foster father (45%), foster sister (29%), or other person (29%). The five interviewees who were adopted reported similar abuse patterns.

One woman's story was illuminating. Violet (name changed) had been raised in several foster homes. In one, missionary foster parents called Violet and her sisters "little savages" and reminded them that they should be grateful to have a home. Violet was sexually abused as a child by adult male relatives and family friends. Kidnapped at age 12 and trafficked to a Midwest city, she was beaten, raped, forcibly addicted to drugs, and sold into prostitution. Until she found peer support and health care, she was not able to escape prostitution. She now connects her prostitution with a multigenerational history of injustice and abuse, including her mother's abuse in a boarding school and family members' alcoholism and prostitution. Finding her cultural identity, Violet explained, was part of the path of her escape from prostitution.

Arrests as Children and as Adults

Police and social service agencies have only recently begun to understand prostitution of children as sexual assault against a child rather than a crime committed by a child. More than half (52%) of the women we interviewed were arrested during childhood on average 8 times (range = 1-60 times, median = 3, $SD = 12$). Several had been arrested for prostitution when they were children; other arrests were for assault and battery (17%),

underage drinking (15%), truancy (14%), and theft (9%). Most of these juvenile arrests (84%) resulted in convictions.

Eighty-eight percent ($n = 92$) of the women had been arrested as adults. They had been arrested an average of 4 times during adulthood (range = 1-39, median = 2, $SD = 6$), most commonly for drunk driving (14%), prostitution (12%), theft (10%), and assault and battery (8%). Most of the women's arrests (84%) resulted in convictions.

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History and Characteristics of Prostitution

Extent and Types of Prostitution

The women had been in prostitution, on average, 14 years (range = 0-43, $SD = 11$), and had begun prostituting, on average, at age 21 (range = 4-50 years, median = 18 years; $SD = 8$). Thirty-nine percent ($n = 41$) had been sold for sex when they were minors, i.e., younger than 18 years of age (see Table 1).

Table 1

Age, Age of Entry, and Length of Time in Prostitution of AI/AN Women Prostituted in Minnesota Compared to Prostituted Women in Nine Countries

Mean age (SD)

Age range

Mean age of entry to prostitution (SD)

Years in prostitution (SD)

Percent younger than 18 when entered prostitution

AI/AN Women Prostituted in Minnesota ($N = 105$)^a

35 (11) 18-60 21 (8) 14 (11) 39%

Prostituted Women in Nine Countries ($N = 854$)^b

28 (8) 12-68 19 (6)

9 (8) 47% (353)

^aSample size varies somewhat depending on how many women answered a given question. ^b

Reported in Farley et al., 2003.

One fourth (27%, $n = 28$) of the women had been used in prostitution by more than 500 men. Eleven percent ($n = 12$) had been used by 500-1,000 men; 16% ($n = 17$) of the women had been used in prostitution by more than 1,000 men.

A large majority (75%) of interviewees had engaged in prostitution in exchange for food, shelter, or drugs. Most (77%) had been prostituted in multiple locations in urban areas (see Table 2). The most common locations were street prostitution (85%); private residences (83%); private parties, hotels, or nightclubs (69%); and bars (68%).

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Table 2

Locations where 105 Minnesota AI/AN Women Were Prostituted and Knew of Others

Prostituting^a

Location where prostituted

Street

Private Home or Apartment Private Parties/Hotels/Nightclubs Bar

Outcall/Escort

Internet or Live Video Chat Phone Sex Line

Reservation

Strip Club

Casino

Sauna

Massage Parlor

Pornography

Peep Show
Brothel
Farm
Church
Cult
Ship in Duluth Harbor

Self

85% (89) 83% (87) 69% (72) 68% (71) 36% (38) 26% (27) 26% (27) 21% (22) 20% (21) 19% (20)
16% (17) 14% (15) 10% (11) 8% (8) 8% (8) 8% (8) 2% (2) 1% (1) 1% (1)

Others

77% (58) 77% (58) 73% (55) 67% (50) 59% (44) 48% (36) 43% (32) 36% (27) 60% (45) 35% (26)
37% (28) 35% (26) 29% (22) 28% (21) 31% (23) 13% (10) 1% (1) 1% (1)

-

^a Sample size varies somewhat depending on how a given question.

The Role of Families

many women answered

Of the 105 women we interviewed, 57% ($n = 60$) had family members also involved in prostitution, including

Fifty-eight percent of the women's families knew about their prostitution, and, in 43% of those instances, had tried to help them get out of prostitution.

cousins, sisters, mothers, aunts, nieces, and daughters. Brothers and fathers, possibly involved in pimping, also were mentioned.

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Trafficking

Forty-five percent of the women had been trafficked for the purpose of prostitution. Although they often assumed that trafficking occurred only if they were transported by pimps from one location to another, under the William Wilberforce Trafficking Victims Protection Reauthorization Act (TVPRA; 2008), no transportation is required to have been trafficked. Additionally, the TVPRA defines any child under the age of 18 years who is used in prostitution as a trafficking victim.

Prostitution often meets the legal definition of human trafficking, in that pimping or third-party control of a prostituted person cannot be distinguished from trafficking (Huda, 2006). Under many laws, consent is irrelevant in determining whether trafficking has occurred (United Nations, 2000). Eighty-six percent of interviewees believed that most women do not know what prostitution is really like when they begin prostituting. They reported that deception or trickery, which are critical elements in most definitions of trafficking, are almost always involved in prostitution.

Almost half (49%) of interviewees turned over most of their money from prostitution to pimps. Forty-two percent of the time, the woman's boyfriend or pimp was gang affiliated, and many women named the gangs with which their pimps were involved.⁵ The women's mothers, children, and other family members were also named as recipients of prostitution monies 27% of the time. Pimps' recruitment tactics included enticement at schools or bars or via the Internet, recruitment as dancers, hitchhiking, and gang coercion. "I wouldn't say there are pimps anymore," explained one woman we interviewed. "Now, they're all boyfriends." The women were often domestically trafficked under brutal pimp control. One woman told us,

My dad was very abusive to my mother and I ended up running away to Chicago. When I was 17 I was stranded in Chicago and had to get home to Wisconsin. I went to a party, there were lots of drugs, I got left there, and I was roaming around. A pimp was nice to me, he gave me this, gave me that. Then he took me to someone's place and he said this guy—age 40—he's interested in you. Then he started hitting me after I said no. I was so scared I just did it. After that I kept doing it because I was afraid to get hit.

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Another woman described being prostituted and trafficked in Las Vegas by her pimp: "The men just kept coming and coming and I never slept or ate, I just had sex all the time. My pimp used the back of the van." Another woman described her prostitution on ships out of the port of Duluth, in international waters.

Many of the women we interviewed (74%) noted where trafficking of others for prostitution had occurred. The most common locations they mentioned were street prostitution (77%); private homes or apartments (77%); private parties, hotels, or nightclubs (73%); bars (67%); and strip clubs (60%).

While most of the women were transported for prostitution from Minneapolis/St. Paul or Duluth, they also were moved from the White Earth and Menominee reservations and from Chicago and Albuquerque. The women mentioned 32 states where they were transported for prostitution.

We asked the women about the ethnicity of the sex buyers. A majority of the men were European American (78%) or African American (65%), but also Latino (44%), AI/AN (24%), and, less frequently, Asian (9%). These percentages are consistent with other research on sexual violence against AI/AN women, documenting that a majority of perpetrators are not AI/AN (Perry, 2004).

Other Violence in the Lives of AI/AN Women in Prostitution

We asked the women about their experiences of four types of lifetime violence: childhood sexual abuse, childhood physical abuse, rape as adults, and physical assault as adults (see Table 3). Seventy-six percent of the women had experienced three or four of these types of violence (see Table 4).

Seventy-nine percent of the women had been sexually assaulted as children, by an average of 4 perpetrators (range = 1-40, median = 2, *SD* = 6.3). Childhood sexual abuse was a critical factor in these women's later prostitution; in some women's lives, this early abuse was prostitution or pimping by family members. "My dad sold us to his friends when I was younger," said one woman. Another woman's father offered her up for sexual abuse when she was 4 years old in exchange for his receiving a tattoo. As children, more than half of respondents (56%) had been physically abused by caregivers.

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Table 3

Violence Perpetrated Against AI/AN Women Prostituted in Minnesota Compared to Violence Against Women Prostituted in Nine Countries

Threatened with a weapon in prostitution

Physically assaulted in prostitution

Raped in prostitution

(Of those raped) raped more than five times in prostitution Current or past homelessness

As a child, was hit or beaten by caregiver until injured or bruised Sexual abuse as a child

Mean number of childhood sexual abuse perpetrators

Median number of childhood sexual abuse perpetrators

AI/AN Women Prostituted in Minnesota (N = 105)^a

78% (73) 84% (85) 92% (92) 68% (50) 98% (97) 56% (55) 79% (78) 4
2

Prostituted Women in Nine Countries (N = 854)^b

64% (503) 73% (595) 57% (483) 59% (286) 75% (571) 59% (448) 63% (508) 4
1

^a Sample size varies somewhat depending on how many women answered a given question. ^b
Reported in Farley et al., 2003.

Table 4

Number of Types of Lifetime Violence Among AI/AN Women Prostituted in Minnesota Compared to Women Prostituted in Nine Countries

Number of types of Lifetime Violence

None

1 Type of Violence 2 Types of Violence 3 Types of Violence 4 Types of Violence

AI/AN Women Prostituted in Minnesota (N = 101)^a

2% (2)
4% (4) 29% (19) 36% (36) 40% (40)

Prostituted Women in Nine Countries (N = 854)^b

13% (110) 16% (133) 20% (171) 26% (222) 25% (218)

^a Sample size varies somewhat depending on how many women answered a given question. ^b
Reported in Farley et al., 2003.

Ninety-two percent (*n* = 92) of the women had been raped in prostitution. More than half (53%, *n* = 56) had been raped five to 10 times, and 15% had been raped more than 20 times in prostitution. Rape as adults contributed to the women’s entry into prostitution.

After one

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respondent was raped, she acceded to prostitution: “I figured why not get paid for acting out, it’s being taken anyway.” Another interviewee explained that being sexually assaulted numbed her to prostitution: “It was easier to prostitute after the sexual assault.” Eighty-four percent (*n* = 88) of the women had been physically assaulted while prostituting. Most often the person who assaulted them was a man who bought sex (44%, *n* = 46), but the batterers also were pimps (15%) or someone else who was neither sex buyer nor pimp (27%). More than half (52%) of the women had been physically threatened in the month prior to our interviewing them. Of those, 87% had been threatened with a gun, knife, or other weapon.

Physical Health Problems

When asked about chronic health problems (see Table 5), more than half of the women reported muscle aches or pains (72%), memory problems (69%), trouble concentrating (69%), headaches or migraines (57%), vision problems (55%), and joint pain (52%). Many of the women experienced stomach pain or bloating (48%), neck pain (44%), shortness of breath (39%), allergies (38%), nausea (35%), pain or numbness in hands or feet (33%), asthma (32%), and dizziness (30%).

Table 5

Chronic Health Problems of 105 AI/AN Women Prostituted in Minnesota

Chronic Health Problem

Muscle aches or pains Memory problems Trouble concentrating Headaches or Migraine Vision problems

Joint pain

Stomach ache or upset stomach or bloating Neck pain

Shortness of breath

Allergies
Nausea
Pain or numbness in hands or feet
Asthma
Dizziness

Continued on next page

Percent (n) 72% (76) 69% (72) 69% (72) 57% (60) 55% (58) 52% (52) 48% (50) 44% (44) 39% (41) 38% (40) 36% (36) 33% (34) 32% (33) 30% (31)

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Table 5, Continued

Chronic Health Problems of 105 AI/AN Women Prostituted in Minnesota

Chronic Health Problem

Constipation or diarrhea

Rapid or irregular heart beat Trouble with balance or walking Swelling of arms, hands, legs, or feet

Carpal tunnel

Painful menstruation

Muscle weakness or paralysis

Chest pain

Vomiting

Hearing problems

Trembling

Sweaty hands

Skin problems

Jaw or throat pain

Cold or flu-like symptoms

Vaginal pain

Loss of feeling on skin

Pain in breasts

Pelvic pain

Difficulty swallowing

Percent (n) 28% (29)

28% (29) 27% (28) 27% (28) 27% (26) 25% (26) 25% (25) 24% (25) 24% (25) 23% (24) 22% (23)

22% (23) 20% (21) 19% (20) 19% (20) 13% (14) 13% (14) 12% (13) 10% (10) 6% (6)

Almost three fourths of the women (72%) had suffered traumatic brain injury. Assaults to the head included the following symptoms and sequelae:

One woman said, "I had a broken nose from being beaten by a pimp. [I experienced] sexual torture from my boyfriend so I have problems in my left hip. How do you tell a doctor about this?"

More than half (51%) of the women we interviewed had been diagnosed with a physical health problem, most frequently diabetes (13%), asthma (7%) or high blood pressure (7%). They also reported back injuries; hepatitis A and hepatitis C; heart disease; fibromyalgia; kidney disease; incontinence; pancreatitis; and neck, knee, and heel injuries.

missing teeth, punched lips, black eyes, blood clots in the head, hearing loss, memory loss,

broken jaws, fractured cheekbones,

headaches, and neck problems. Other violent injuries suffered by the women included flesh

wounds; broken bones; arm/shoulder injuries; scars or bruises; knee/ankle injuries; and being

raped, kicked, strangled, burned, or shot.

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Medication Use

Fifty-six percent of the women were taking medications at the time of their interviews. Of these women, 80% were prescribed medication to manage a psychological condition. Fourteen percent took sleeping pills regularly, and 11% were medicated for chronic pain. Medications for chronic disease such as diabetes or high blood pressure were used by 61% of respondents.

Mental Health Problems

Sixty-five percent of the women had been diagnosed with a mental health problem. The most common diagnoses were depression (78%) and anxiety disorders (71%). The latter included generalized anxiety, panic attacks, phobias, PTSD (28%), and obsessive compulsive disorder. Another 33% had been diagnosed with bipolar disorder. Less common, but also reported, were attention-deficit/hyperactivity disorder, learning disorders, sleep problems, schizophrenia, and dissociative identity disorder. Forty percent of the women had been psychiatrically hospitalized, and 49% had family members who had been psychiatrically hospitalized.

PTSD

Most prostitution includes the kinds of traumatic stressors that are required for a diagnosis of PTSD, such as witnessing violent abuse and experiencing fear, horror, and powerlessness in response. PTSD is characterized by an oscillation between re-experiencing the event (flashbacks and autonomic nervous system hyperarousal) and emotional numbing (avoidance and numbing symptoms). In this study, 70% of the women met criteria for flashbacks, 61% met criteria for avoidance and numbing, and 74% met criteria for autonomic nervous system hyperarousal. Fifty-two percent met all criteria for a diagnosis of PTSD; their mean PTSD severity score was 51 ($SD = 19$). We estimated the association of PTSD with the women's physical health using the Pearson correlation coefficient. The more severe the interviewees' symptoms of PTSD, the poorer their health ratings, $r = .22$, $p = .024$, $N = 101$. Women with PTSD were more likely to report poor or fair health, and much less likely to report very good or excellent health, than women without PTSD, $\chi^2(2, N = 103) = 8.244$, $p = .016$ (see Table 6). When we separately explored the individual components of PTSD, re-experiencing traumatic memories/flashbacks was not significantly associated with self-rated health. However, women with avoidance symptoms were more likely to report poor/fair health, and less likely to report good/excellent

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health, than women without PTSD, $\chi^2(2, N = 103) = 6.508$, $p = .039$. Women who reported autonomic nervous system hyperarousal were more likely to report poor/fair health, and less likely to report good/excellent health, than women without PTSD, $\chi^2(2, N = 103) = 7.362$, $p = .025$.

Table 6

Post-traumatic Stress Disorder Diagnosis and Self-Rated Health of AI/AN Women Prostituted in Minnesota

Health Rating

Poor/Fair

Good

Very good/Excellent

Dissociation

Women with PTSD (n = 54)^a

48% 39% 13%

Women without PTSD (n = 49)

31% 33% 37%

Dissociation is an escape and avoidance strategy in which deliberate human cruelty results in fragmentation of the mind into different parts of the self that observe, experience, and react, as well as parts that do not know about the harm (Ross, Farley, & Schwartz, 2003). The primary functions of dissociation are to handle overwhelming fear and pain and to help one deal with the experience of traumatic abuse. Table 7 indicates the percentages of women who had clinically significant symptoms of dissociation according to the Dissociation subscale of the TSC-40. Almost three fourths (71%) experienced “spacing out,” a colloquial description of dissociation. “After you get into prostitution, you get used to it. It’s like using the bathroom. You don’t think about it after a while.” More than two thirds of the women reported memory problems (68%), which are normative among those with symptoms of dissociation (APA, 2000). More than half of the women reported flashbacks (64%) and derealization (59%), which is the feeling that the world has changed, that one is observing herself from outside the body and/or that things in the world are not real. Half of the women felt that they were not in their bodies. Twenty-eight percent reported clinically significant dizziness.

The more severe the women’s dissociative symptoms, the more likely they were to report fair or poor health, $r = .35, p = .0003, N = 102$. Some of the women explained how dissociation helped them survive prostitution. “It’s a way of blocking memories...leading a double life within.” “When the johns were sexually assaulting me,” said another woman, “I could be in England or somewhere else until they were done.” Several women spoke of learning to dissociate during sexual assaults when they were children. When she was “9 years old and being raped,” one of the interviewees disclosed, “my mind left my body and was looking down from

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the ceiling. I don’t want to be that person on the streets worrying about where the next hit is coming from, losing my kids, hurting them...”

^a

**Table 7
Symptoms of Dissociation in 102 AI/AN Women Prostituted in Minnesota**

Symptom

Flashbacks Spacing Out Dizziness

Memory Problems Derealization

Not in Your Body

Mean SD 1.8 1.0

2.0 1.0 0.9 1.0 1.9 1.1 1.7 1.0 1.4 1.1

Range

0-3 0-3 0-3 0-3 0-3 0-3

Percentage (n) Rating Symptom at Clinical Level

65% (65) 71% (72) 28% (29) 68% (69) 59% (60) 50% (51)

^aSample size varies somewhat depending question.

Substance Abuse

on how many women answered a given

Three fourths (77%) of the respondents used drugs or alcohol, with 67% reporting alcohol use and 59% reporting drug use. The women had used drugs or alcohol, on average, for 18 years (range = 2-57 years, median = 15, *SD* = 12). Crack/cocaine was the drug of choice for 35% of the women, and marijuana was drug of choice for 28%. Methamphetamine/speed was used by 9% of the women, and pain pills/Vicodin/Lortab by 7%. Heroin, OxyContin, MDMA (ecstasy), LSD, morphine, PCP, Xanax, downers, nicotine, and methadone also were mentioned as preferred drugs.

A majority of the women who used drugs or alcohol (61%) described the need to “chemically dissociate” from the physical and emotional pain during prostitution. One woman explained that she used drugs “so it can numb me, so I can do what they want me to do.” Another stated “...That’s why I did a lot of drugs—to numb myself—so I didn’t know what was going on and I could just leave my body.” Many women (43%) used drugs or alcohol after prostituting in order to block traumatic flashbacks or memories of prostitution. “I guess I use drugs to make my body not care so much about what I did.” Some women described how drugs and alcohol helped them cope with other traumatic events in their lives, such as loss of child custody, loss of a relationship, and physical and sexual violence. Others began using drugs or alcohol in childhood.

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Several interviewees stated that substance abuse affected their psychosocial development; for example, one woman noted, “My thought process really came to a halt at the age I started using. I started smoking marijuana at age 10, and started cocaine at age 15.” More than half (61%) of the women had been introduced to drugs and alcohol by family members. Sometimes parents gave them drugs or alcohol as entertainment or as a sedative. Substance abuse sometimes was considered a normal part of family life. “My grandfather gave me Crown Royal when I was two.” More than one fourth (27%) of interviewees had been deliberately addicted by a pimp, boyfriend, or husband in order to coerce them into prostitution.

The Emotional Reality of Prostitution

“It’s like incest—no one wants to talk about it.”

“As far as I’m concerned, all prostitution is rape.”

The Prostitution Questionnaire asked interviewees to list five words that described their feelings during prostitution. Of the 456 responses, 90% (412) were negative words, 7% (32) were positive, and the remaining 3% (12) were neutral. Some words were more frequently used than others. The word *dirty* was used by more than one third of the women (36%) to indicate how they felt during prostitution. Other commonly used words were *sad*, *lonely*, *scared*, *disgusted*, *angry*, *numb*, *ashamed*, *guilty*, *nasty*, *ugly*, *depressed*, and *used*.

Racism

Race and ethnic prejudice is integral to prostitution. Most sex buyers employ ethnic stereotypes—in this study, stereotypes about AI/AN women (Dworkin, 1997). As one of the interviewees explained, “When a man looks at a prostitute and a Native woman, he looks at them the same: ‘dirty.’” For some women, the prejudicial words caused greater

pain than the physical assaults and rapes, and they explained that damage lasts longer. “You can get over the hit, the pain, but the words keep lingering on.”

Forty-two percent of the women had been racially insulted by sex buyers or pimps. The racist verbal abuse (e.g., savage, squaw) was linked to sexist verbal abuse (e.g., whore, slut) when sex buyers used both types of words in the same phrase as part of the abuse. Racist generalizations about alcohol abuse were common. Hatred of the women’s skin color was reflected in comments such as “Why don’t you go back to the rez—go wash the brown off you.” Other racist remarks by sex buyers were homicidal: “I thought we killed all of you.” Some of the racist verbal attacks were unprintable. For some sex buyers, the racist degradation was sexually arousing and was integral to their sexual use of AI/AN women. The women were expected to

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tolerate racism and sexism: “You don’t get paid if you talk back.” AI/AN women were fetishized as exotic others. In some cases, sex buyers demanded that the women role-play colonist and colonized as part of prostitution: “He likes my hair down and sometimes he calls me Pocahontas. He likes to role-play like that. He wants me to call him John.” Several women also experienced racism within their own communities. For example, some communities rejected women because they were “mixed race” and not full-blooded AI/AN. One woman who sought help on her reservation was rejected because her daughter appeared “too White.” A woman whose family included both AI/AN and African American ancestors explained her sense of disempowerment in the community. “I’m just as much this part as that part, even though I’m separated out as African or Black. Don’t cut me up and divide me in half.”

Connecting Colonization and Prostitution

A majority of the women we interviewed (62%, $n = 65$) saw connections between colonization and prostitution of AI/AN women. Some observed the profound inequality of both institutions. One way of understanding colonization is that it removed AI/AN peoples’ options. “I’m doing what I can to survive, just the way Native Americans did what they could to survive with what was given to them by the government: disease, alcohol, violence.” Others described the common losses of basic human rights resulting from colonization and from prostitution: loss of traditional ways of living, loss of social status, and loss of self-respect. “The living conditions. I see a connection to poverty and public housing. I’m put down anyway, so why not prostitution? I’m called a ‘squaw’, so why not?” The devaluation of women in prostitution was often seen by these interviewees as identical to devaluation of colonized AI/AN people. “Back then they treated us like nothing. And when I was out there [prostituting] I felt like nothing.” Several women explained that the concepts of sexism and prostitution were unfamiliar to AI/AN people until contact with colonists. For example, “Our Native people weren’t aware of anything about prostitution until the British came and started raping our Native women and had them as slaves and using them for sex.” Another woman saw the sexism of colonists toward their own women and compared it to prostitution. “The way that the White people treated their women is the same way that pimps treat their hoes. And then Native men started treating us like that.” Expanding the colonist/pimp analogy, another woman said that the U.S. “was the pimp to the Indians.”

Others saw the commonality between colonization and prostitution of AI/AN women in the desire to subordinate another person. “It’s how they treat you. Like cowboys and

Indians. They'd rape the women and take them and sell them. Just like Black people and slavery. We're

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not supposed to have anything. Not supposed to say anything. Not supposed to look them in the eye or be disrespectful." Another woman saw that both colonists and sex buyers "have to have somebody to make feel inferior. To make themselves feel better." The process of colonization, one woman said, reduced AI/AN women to commodities.

Connections and Disconnections with Cultural Identities

Many women felt disconnected from Native cultures, sometimes as a result of feeling shame. One woman explained, "I'm such an embarrassment to my race. A lot of people know what I do, so I stay away." Several women were denied enrollment in their communities. One sought help from her tribe but was rejected because, she said, "people from the reservation don't support people like me."

Many of the women spoke of a desire to connect or reconnect with their cultures. "I'm still trying to find myself...being more connected to my cultural identity would help me find my path." Some women felt that being more connected with their cultures would help them discover ways of healing from prostitution. Indeed, others credited their survival to their cultural identity. One third (32%) of the women described specific AI/AN cultural or spiritual practices, including sweats, smudging, pow wows, dancing, using tobacco, and praying, as an important part of their identities. One woman incorporated cultural practices into substance abuse treatment that ultimately helped her escape prostitution: "When I got into treatment I went through a pipe ceremony and sought to find myself again ... From the treatment center, I entered my first sweat lodge. That's what opened my eyes. I made it all the way through. I knew I wasn't alone." Another woman explained, "My spirituality helped me survive. If I didn't have that I wouldn't have had anything to fall on to keep me sane and give me hope that tomorrow is going to be a better day."

Connections with their own cultural identities and connections with and support from other AI/AN people were often cited as ways of surviving prostitution. "Pray together, burn sage, pray. Confide in one another and embrace each other." Others spoke of the importance of having AI/AN people that they could look up to and from whom they could seek advice: "Just knowing that there's healthy Native ladies out here that I can talk to." "I see a Native therapist and she helps me." "I've had to go to medicine men to get doctored because the White field cannot help you. Because they cannot see it." Some women told us how important it was for them to share history and strength with other AI/AN people. "Just believing, and knowing that our people had made it before, through everything."

Need

Individual Counseling

Peer Support

Vocational Training

Home or Safe Place Substance Abuse Treatment Self-Defense Training Health Care

Legal Assistance

Physical Protection From a Pimp Child Care

Legalized Prostitution

AI/AN Women Prostituted in Minnesota (N = 106)^a

75% (79) 73% (77) 68% (72) 67% (71) 58% (62) 50% (53) 48% (51) 34% (36) 26% (28) 26% (28)

10% (11)

Women Prostituted in Nine Countries (N = 854)^b

56%(431) 51%(393) 76% (600) 75%(618) 47%(356) 45%(340) 61%(480) 51%(366) 23%(157)
44%(335) 34%(251)

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Urgent Needs of AI/AN Women Who Seek to Escape Prostitution

Ninety-two percent of the interviewees wanted to escape prostitution. We asked the women what they needed in order to accomplish this (see Table 8). They mentioned individual counseling (endorsed by 75%) and peer support (73%) most frequently. Other frequently mentioned needs were vocational training (68%), housing (67%), substance abuse treatment (58%), and self-defense training (50%). They also expressed a need for health care (48%), legal assistance (34%), physical protection from a pimp (26%), and child care (26%).

Table 8

Needs of AI/AN Women Prostituted in Minnesota Compared to Women Prostituted in Nine Countries

^a Sample size varies somewhat depending on how many women answered a given question. ^b

Reported in Farley et al., 2003.

Because it is sometimes assumed that legalizing prostitution would decrease its violence, we asked the women about this. Only 17% of the 105 women thought that legal prostitution would increase their safety.

A number of the women said that if they were out of prostitution, they would like to work in a helping profession such as nursing or social work. Many wanted to help other women get out of prostitution; for example, one woman said, "At the hotel there were other women in prostitution. A vice officer who knew my younger daughter said, 'You are so much better than this'. I told him I was in it for my kids. He didn't arrest me, he referred me to Breaking Free. I would love to go with the police when they go to bust these girls and talk to them about a better way."

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DISCUSSION

The unique contribution of this article lies in its documentation of the relationships among prostitution, violence, traumatic stress, and a plethora of resulting adverse symptoms in a population of AI/AN women in Minnesota. Sexual violence against AI/AN women, including prostitution and trafficking, is a deeply rooted phenomenon. To better understand this violence and its consequences, we interviewed 105 AI/AN (primarily Anishinaabe) women in prostitution about their lives, using both standardized and open-ended questionnaires. Through these interviews, we identified important aspects of the women's experiences of prostitution, the contexts that led to it, their experiences of violence and traumatic stress, and their survival skills.

Experiences of Prostitution

The women's descriptions of prostitution were overwhelmingly negative. Many of the words they used to describe these experiences are the same words used by incest and rape survivors (Herman, 1992). More than one third of the women used the word *dirty* to describe how they felt during prostitution, which reflects their internalization of the toxic sexism and racism of those paying for sex toward the women they buy (Poupart, 2003). Some viewed their oppression as AI/AN women in and of itself as a primary reason they were targeted by sexually predatory johns, pimps, and traffickers. The racist and sexist

verbal abuse described here confirms this violent predation of AI/AN women as hated/eroticized objects.

Given the prevalence of violence and these negative descriptions, it is not surprising that almost all of the women we interviewed wanted to escape prostitution. Despite their poverty, lack of stable housing, and need for medical care (including substance abuse treatment), they most frequently endorsed needs for individual counseling and peer support, indicative of the importance of relationship to them. Family members attempted to interrupt the women's prostitution in a variety of ways—urging them to quit, offering housing, moving them out of town, providing money, and encouraging them to break up with pimps/boyfriends. They also took the women to sweats and sought out supportive women's groups and agencies offering addiction treatment.

Context of Prostitution

The women entered prostitution with a background of cultural, family, and personal trauma. The almost universal history of homelessness among them (98%) provides compelling evidence for their lack of alternatives for survival, and also for the association between

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prostitution and poverty. Many of the women's parents or grandparents had been removed from their families and placed in boarding schools. Most of these relatives were known by the women to have been abused there. The majority of the women had family members who also were involved in prostitution. A fourth-generation survivor of prostitution spoke about the rapes of women in her family and her resignation to the sexual violence in her community. Nearly half

We suggest that a history of colonization increases the vulnerability of AI/AN women to poverty, prostitution, and other sexual violence.

The women we interviewed often had had multiple arrests, starting in childhood. These arrests reflect their lack of security and alternatives to prostitution, their homelessness, and their substance abuse. The women had committed almost as many crimes in childhood as in adulthood, suggesting that early in their lives they may have lacked access to adult protection, housing, and health care. Several of the women had been convicted of crimes that were probably committed while they were under the control of a pimp or dominant partner. The multiple arrests of these women prevented their escape from prostitution, because a criminal record was a barrier to obtaining affordable housing, employment, and frequently even essential social services.

The common assumption that women prostitute *either* indoors or outdoors is inaccurate. The women in this study had been prostituted in multiple settings: on the street, in private homes, hotels, nightclubs, bars, escort agencies, reservations, strip clubs and casinos. This and other studies find that women prostitute wherever sex buyers are located. Interviews with sex buyers confirm this (Farley, 2005; Farley, MacLeod, Anderson, & Golding, 2011; Kramer, 2003). Meaningful outreach to AI/AN prostituted women must consider these multiple locations where men pay for sex, which also are where the women are located.

Organized criminals play a significant role in the trafficking of AI/AN women both on and off reservations (Freng, Davis, McCord, & Roussell, 2012; Koeplinger, 2009; Pierce, 2009). Nearly half of the women we interviewed had been trafficked for the

purpose of prostitution, and half surrendered most of their money from prostitution to pimps, of whom nearly half were gang affiliated. Pimps make it extremely dangerous for women to escape prostitution. Death threats are common. As a consequence of this danger, outreach to these women must be cautious and creative; for example, phone numbers for help could be placed on billboards and in restaurants where the women take breaks.

the women had been in foster care, and of those, nearly half had been abused in care.

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History of Trauma and its Consequences

Frequent and extreme violence was committed against these AI/AN women over the course of their lives. Surrounded by predators, three fourths had been sexually abused as children by an average of four perpetrators. A history of sexual assault preceding prostitution has been noted by others. One young woman told Silbert and Pines (1982, p. 488), "I started turning tricks to show my father what he made me." Dworkin (1997, p. 143) described incest as "boot camp" for prostitution.

Our interviewees were in an almost constant state of revictimization. The assaults against them were part of a lifetime of exploitation and abuse. The vast majority of the women had been raped in prostitution, typically multiple times, and most had been physically abused in adulthood, most often by a man who paid for sex. Half had been threatened, usually with a weapon, during the month before we interviewed them. Stable housing and protection from domestic and sexual violence are crucial for the women we interviewed. Most of the women also expressed a need for individual counseling and peer support, reflecting a desire for their unique experiences as AI/AN women in prostitution to be heard and seen by people who care about them. Other frequently mentioned needs were vocational training, housing, substance abuse treatment, and self-defense training, which was likely a result of the frequent violent assaults in prostitution.

Health Problems

A history of violent victimization is associated with physical health problems (Golding, 1999b), which were common among these women. More than half reported physical pain, vision problems, or cognitive problems. Almost three fourths had experienced a traumatic brain injury, which has been associated with chronic illness (Langlois, Rutland-Brown, & Wald, 2006), other disabilities (Langlois et al., 2006), unemployment (Doctor et al., 2005), and early death (Langlois et al., 2006; Vaaramo, Puljula, Tetri, Juvela, & Hillbom, 2015), including death specifically caused by traumatic events (Vaaramo et al., 2015). We recommend a medical evaluation for women in or escaping prostitution. Readers may contact the first author regarding use of questionnaires for assessing adverse health consequences of prostitution in this study.

PTSD

Rape and other sexual violence—whether paid for or not—may result in symptoms of PTSD. Given the prevalence of trauma in their lives, it is not surprising that 52% of the women in this study met diagnostic criteria for PTSD (Robin, Chester, & Goldman, 1996). This rate compares to an 8% prevalence rate in the general U.S. population (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), and to the 54-86% prevalence seen among prostituted people from

nine countries (Farley et al., 2003). The prevalence of PTSD in battered women ranges from 31% to 84% (Golding, 1999a) and in combat veterans PTSD ranges from 2% to 17% (Richardson, Frueh, & Acierno, 2010).

Experiences of violence over the course of one's lifetime, as well as intergenerational trauma, have a cumulative effect on PTSD symptoms (Follette, Polusny, Bechtel, & Naugle, 1996). Historical trauma as experienced by AI/AN peoples—both in the form of prostitution and more generally as colonization—has caused PTSD and other mental disorders such as depression (Cole, 2006). The insidious trauma of racism as documented in these interviews is another cause of emotional distress and disorders (Root, 1996). The high prevalence of PTSD in the women we interviewed is consistent with past research that found that AI/AN children and adolescents who experience sexual trauma and multiple traumas are likely to be at high risk for developing PTSD (Gnanadesikan, Novins, & Beals, 2005). We recommend culturally appropriate treatment that specifically includes a decolonizing perspective (Goodman & Gorski, 2015; Marsella, Friedman, Gerrity, & Scurfield, 1996).

Dissociation

Previous research has established a strong association between trauma history and dissociation (Mulder, Beautrais, Joyce, & Fergusson, 1998). We found high rates of dissociation among the women we interviewed, who told us that it was essential to their survival during prostitution. The same dissociative response that women develop to survive the trauma of rapes in childhood and adulthood is used to survive the paid rapes of prostitution. Consistent with others' findings (Dobie et al., 2004; Schnurr & Green, 2004; Zatzick et al., 1997), both PTSD and dissociation were associated with poorer general health among the women we interviewed. On the other hand, dissociative phenomena that result from interaction between psychological and culturally based social processes, such as shamanism, can be positive (Kirmayer, 1994). The voluntary use of dissociation can enhance artistic creativity (Ross, 1991). Among the interviewees in this study, some experiences of dissociation promoted spiritual healing. For example, one woman explained that when she dissociated, she went to the spirit world, where healing occurred (Pierce, 2009).

Symptoms from recent traumatic experiences may not only cause distress in and of themselves, but may amplify symptoms from earlier violence and abuse (Follette et al., 1996). Numbing symptoms typical of both PTSD and dissociation increase the risk of revictimization (Ullman, Najdowski, & Filipas, 2009) because more adaptive survival responses are not

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employed by the victim of violence. Because AI/AN survivors of prostitution have high rates of dissociation, it is important for health care and social service workers to assess carefully for any history of revictimization when clients seek services.

Three fourths of the women we interviewed used drugs or alcohol, which is common in traumatized populations, including combat veterans and survivors of sexual and domestic violence (McFarlane, 2001; Norris, Foster & Weishaar, 2002; Stewart, Ouimette, & Brown, 2002). The majority of these women described their substance use as a form of chemical dissociation. More than half of those we interviewed voiced a need for alcohol and drug addiction treatment. The literature on drug and alcohol treatment for traumatized populations suggests an integrated treatment protocol for those with both

substance abuse and PTSD, such as the cognitive-behavioral approach developed by Najavits (2001; Najavits & Johnson, 2014). Given the high risk for PTSD in this population, mitigation of traumatic stress (e.g., by providing secure housing, protection from pimps, food, and health care), coupled with appropriate treatments for PTSD, is highly recommended (see below).

Recommendations for Policy, Treatment, and Research

Policy

To address the harms of prostitution, it is necessary to use education, prevention, and intervention strategies similar to those dedicated to other forms of gender-based abuse such as rape and domestic violence. This understanding of prostitution as violence against women must then become a part of public policy and must be structurally implemented in health care, mental health services, substance abuse treatment, homeless shelters, rape crisis centers, and battered women's shelters (Stark & Hodgson, 2003). Health care practitioners must become acquainted with community services, antiviolence resources, and agencies dedicated to offering services to women in prostitution (Polacca, 2003). As with battered women, physical safety is a critical concern. It is essential that health care practitioners and victim advocates receive specialized training in both traditional and Western approaches, and that they understand women in prostitution as victims of violence, not as criminals. Program development and implementation by survivors of prostitution, both AI/AN and non-Native, are essential. Two-thirds of the women we interviewed expressed a need for vocational training, which requires specialized programs. Vocational training or rehabilitation must address prostitution survivors' extensive trauma history and also their history of domination and abuse. For example, Baldwin (2003, pp. 313- 314) suggested that survivors of prostitution should not be required to work in service

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occupations that require the display of female submission, citing a case in which a survivor refused a job that required her to clean beds in the same hotels where she had prostituted for many years. Yet this refusal jeopardized her receipt of public assistance benefits.

Most of the women we interviewed would benefit from legal services, including family law (divorce and child custody), criminal record expungement, disability law, and benefits law. Policy reform recommendations, such as decriminalizing victims of prostitution so they do not have to fear arrest, would ensure that AI/AN women who have been domestically trafficked receive the same access to services as do international victims of trafficking (Johnson, 2012). Tribal officials should be trained to recognize domestic trafficking and pimping as a first step in overcoming silence and denial regarding these issues. Jurisdictional disputes with respect to tribal, state, and federal laws regarding arrests of sex buyers and pimps on tribal lands have hindered policy reforms that would support AI/AN women in prostitution. Cross-deputization agreements among tribal, state, and federal law enforcement agents that would allow them to respond to crimes outside their jurisdictions would increase arrests and prosecutions of pimps and traffickers, as well as rapists (Deer, 2004b; Johnson, 2012).

Treatment

A general health strategy for AI/AN women should involve equitable access to health services, AI/AN control of services, and diverse approaches that respond to cultural

priorities and community needs (Denham, 2008; Royal Commission on Aboriginal Peoples, 1996). Models for healing of AI/AN women in prostitution would include a decolonizing perspective that acknowledges and analyzes historical trauma, violent crimes, family violence, child abuse and neglect, discrimination, and unresolved grief and mourning. Cultural moderators of these traumatic experiences that would promote healing include family/community support, traditional spiritual practices and medicine, and a positive AI/AN identity (Walters, Simoni, & Evans- Campbell, 2002).

Cultural competence in mental health care of AI/AN people includes recognition of a) the asymmetrical power relationship between counselor and client; b) the ways that Eurocentric professional values may conflict with the needs of AI/AN people seeking mental health treatment; c) differences in symptom expression, symptom language, and symptomatic patterns in AI/AN people with mental illness or emotional disturbance; and d) differences in thresholds of individual and social distress (i.e., differences between AI/AN individuals/groups and European Americans with respect to what upsets them, based on culture and history, and also differences in tolerance of symptoms by support systems (Goodman & Gorski, 2015; Western Interstate Commission for Higher Education, 1998). Health care practitioners, especially those in the field

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of mental health, as well as advocates in related fields, need to apply a holistic healing approach to AI/AN women that embraces traditional healing (Fadiman, 1997; Hodge, Limb, & Cross, 2009). Native cultural and spiritual traditions should be made available to AI/AN women in prostitution by nonjudgmental people who are educated about prostitution's devastating impact. A study of the needs of Vancouver prostituted women underscores these recommendations (Benoit, Carroll, & Chaudhry, 2003). Willmon-Haque and Bigfoot (2008) and Gone (2004) describe several culturally relevant trauma treatment programs for AI/ANs that are based on Native perspectives about wellness, and that also include the decolonizing and culturally relevant factors mentioned above. The Peguis AI/AN community in Manitoba, for example, found that a combination of traditional and Western healing approaches was especially effective for people who suffer from emotional problems, including those related to alcohol and drug abuse, violence, and suicide (Cohen, cited in Royal Commission on Aboriginal Peoples, 1996). In our opinion, Western medical treatment of PTSD and dissociation is best combined with traditional healing for AI/AN women who want to escape prostitution. Western-trained practitioners and advocates often are not prepared to provide culturally competent services for AI/AN people that respect their belief systems and history (Grandbois, 2005). For example, several women we interviewed had struggled to use traditional spiritual healing practices for their mental health problems, but their physicians had objected to these practices. "I was in the hospital. I was unstable— depression. It was a bad spirit. I wanted to smudge and was not allowed to." Another woman told her physicians that she suffered from bad dreams and was subsequently diagnosed with schizophrenia. Her doctor prescribed medicine to stop the bad dreams, she said, but "I know that our dreams mean something so I don't take the meds. I need those dreams."

Although most women in this study wanted the opportunity to use traditional healing methods, some women did not. Practitioners should respect both preferences. It is extremely important that no woman be pressured to participate in any spiritual practice if she is uncomfortable. Women in prostitution have been manipulated, coerced, and

betrayed by johns and pimps, sometimes by government agencies and health care practitioners. They must be fully accepted as AI/AN women whose choice not to participate in traditional cultural practices is honored.

Limitations and Future Research

This study was limited to AI/AN women currently living in Minnesota. There is a great need for research on the prostitution and trafficking of Indigenous women in other regions and for careful study of what kinds of interventions help them to exit prostitution. Research in New Zealand, Australia, Canada, and Taiwan has found that Indigenous women are at highest risk for

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prostitution because of their history of oppression and colonization, poverty, and sexual violence (Sethi, 2007). The triple force of race, sex, and class inequality disparately impacts Indigenous women. Another limitation of this study was sampling strategy. Given the illegality of prostitution, researchers have found that a representative sample of women sold for sex is not possible (McKeganey & Barnard, 1996). We interviewed those people to whom we had access and who themselves had access to some social supports. Because the women were recruited through their contacts with service agencies, they may not be representative of prostituted AI/AN women who do not contact service agencies for support. Other studies of traumatized people have found that survivors minimize the intensity and the extent of sexual violence and other abuse (e.g., Van der Kolk & McFarlane, 2006); therefore, we estimate that, as high as some of the numbers are in this study, the trauma and resulting symptoms of distress are in reality likely to be even more prevalent and severe. The use of some open-ended questions occasionally reduced the clarity of the data. However, this limitation was balanced by the use of standardized measures to assess attributes such as PTSD, dissociation, and general health, as well as the use of close-ended questions about a range of experiences in prostitution. Despite these limitations, we are confident that this study of the experiences of prostituting AI/AN women contributes significant new information.

It is crucial to understand the sexual exploitation of AI/AN women in prostitution today in the historical context of colonial violence against nations (Frideres, 1996; Ryser, 1995; Waldram, 1997). Women who are marginalized because of colonialism's devastating historical impact, because of their lack of opportunities and education, because of racial and ethnic discrimination, poverty, previous physical and emotional harm, and abandonment *are* the people bought in prostitution. Women who have the fewest real choices available to them are those who are in prostitution. The critical question to ask with respect to the women we interviewed is not "Did she consent?" but "Has she been offered the choice to exist *without* prostituting?"

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ENDNOTES

¹ For further analysis regarding use of the terms "sex work" and "sex worker" please see *Letter to David Minthorn, Stylebook Editor of The Associated Press*, October 31, 2014, with 301 signatories at <http://catwinternational.org/Home/Article/587-over-300-human-rights-groups-and-antitrafficking-advocates-worldwide-weigh-in-on-sex-work-terminology-in-media>. See also Robert Brannon (2013) *Women and Girls Used in Prostitution are Not "Sex-Workers"* (unpublished paper, on file with first author). See also *Prostitution is not 'sex work'* by Coalition Against Trafficking in Women at <http://www.catwinternational.org/Content/Images/Article/253/attachment.pdf>.

² In Duluth, we worked with Mending the Sacred Hoop Coalition, Domestic Abuse Intervention Project, American Indian Community Housing Organization, Dabinoo'igan Shelter, Min-No-

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Aya-Win Human Services, a Fond Du Lac sexual assault advocate, and Program for Aid to Victims of Sexual Assault (PAVSA). In Duluth, American Indian Community Housing Organization reached out to the community to let them know about the research, posting flyers at food shelves, homeless shelters, and other locations. Mending the Sacred Hoop provided interview rooms and a welcoming atmosphere with refreshments and a smudge bowl for interviewees and interviewers. Dabinoo'igan Shelter provided transportation for the women and also were available to the women post-interview if they needed support. PAVSA and Min-No- Aya-Win offered sexual assault advocacy. The Domestic Abuse Intervention Project provided an advocate who was available to the women during the interviews and as a support resource after the interviews. In Minneapolis, we reached out

to Breaking Free and Minnesota Indian Women's Resource Center. Some of our interviewees participated in Breaking Free's support programs. In the Bemidji area, an advocate at the Anishinaabe Equay program put up flyers in the community, received calls from women who wished to participate in the research, and scheduled the interviews. She also served as a resource for the women in the event of emotional distress and provided ongoing support to several of the women. We also worked with the Anishinaabe Equay program of the Sexual Assault Program of Beltrami, Cass & Hubbard Counties and the Nokimagiizis Program of the Northwoods Coalition for Family Safety. Each organization provided interview space in their offices.

³ Rudolph Ryser, Center for World Indigenous Studies (www.cwis.org) contributed this description of how Native people self-identify based on family versus reservation heritage.

⁴ Boarding schools were located in South Dakota (Flandreau Industrial School, Marty Mission, St. Francis, Stephan), Minnesota (Mission School, Red Lake School, Shattuck), Oklahoma (Riverside, Oaks Mission School, Chilocco Indian School, River), North Dakota (Wahpeton), California (Sherman), Kansas (Haskell Indian Junior College), Arizona (GMA), in Idaho, and in Wisconsin. ⁵

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Frequently mentioned were Gangster Disciples, Black Gangsters, Four Corner Hustlers, Stone Gang, and Vice Lords (all Chicago-based gangs), as well as Bloods, Sureños, and Native Mob.

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(MIWSAC) and other groups who provide services and referrals to victims of violence assisted in recruitment of participants. These agencies and groups include Breaking Free, Minnesota Indian Women's Resource Center, Mending the Sacred Hoop Coalition, Domestic Abuse Intervention Project, American Indian Community Housing Organization, Dabinoo'igan Shelter, Min-No-Aya-Win Human Services, Fond Du Lac sexual assault advocate, and Program for Aid to Victims of Sexual Assault (PAVSA). The Anishinaabe Equay program of the Sexual Assault Program of Beltrami, Cass, and Hubbard Counties and the Nokimagiizis Program of the Northwoods Coalition for Family Safety provided space for the research interviews. An advocate at Anishinaabe Equay coordinated the research in the Bemidji area and offered post-interview resources to the women. Prostitution Research & Education staff members Angel Daniels and Emily Inouye Butler made important contributions to this research, as did William Mitchell College of Law students Sara Marie Campbell and Heather Monasky. Vednita Carter of Breaking Free helped with the first interviewees. Alice Vachss provided valuable consultation regarding the crimes committed by the women. Sarah Curtiss and Paula Morton at Mending the Sacred Hoop in Duluth helped to make the interviews possible in that city. Miriam Sosa, Katrina Crenshaw, Jo Wang, Olivia Hanning, Sister

John Paul at PRE and Elizabeth Fuerst at Native American Youth and Family Center entered data and transcribed narrative questions.

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