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Prostitution

SUMMARY

A review of the literature discloses that prostitutes are distinguishable into distinct classes, each with distinct clinical implications. The spectre of AIDS suggests that we review the implications of the health risks associated with this profession. This article discusses the potential causes, health problems, and treatment of prostitutes. (*Can Fam Physician* 1987; 33:1876–80.)

RÉSUMÉ

Une revue de la littérature révèle qu'il est possible de classifier distinctement les prostituées, chaque classe comportant ses propres implications cliniques. Le spectre du SIDA suggère une révision des implications quant aux risques pour la santé associés à cette profession. L'auteur discute les causes potentielles de la prostitution, les problèmes de santé et le traitement des prostituées.

Key words: prostitution, AIDS

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PROSTITUTION may be the world's oldest profession, but, with the spectre of AIDS, society must reconsider its methods of handling this problem. Not only are prostitutes themselves at risk, but they present a potential reservoir for transmission of this disease.

In reviewing the literature, I found that few studies of prostitutes used controls. Moreover, by far the greater number do not distinguish classes of prostitutes, thus leaving the impression that all prostitutes are similar to the more disturbed groups.

Classes of Prostitutes

Prostitutes have been divided into five classes.[1] Class 1 is the call girl. She does not use pimps, and she tends to be more attractive than street walkers and to command a higher fee. Call girls are also usually better educated and more intelligent. Most of them come from middle- and upper-middle-class backgrounds. Class 2 are in-house prostitutes. They work in brothels, massage parlours, or photo studios. Class 3 are street walkers. They use a permissive hotel or a group pad. Class 4 are commuter housewives. They work an average of two days per week to supplement the family income. They do not use pimps. Class 5 are street-walker addicts. They are usually from lower-class backgrounds and use prostitution to get drugs.

A controlled study of the psychological health of Classes 1 and 2 prostitutes found no evidence to suggest psychopathology. It indicated that prostitutes were probably as mature and well adjusted as demographically similar females engaging in other occupations. Class 1 prostitutes are often intelligent, well educated, sophisticated young women who may view prostitution as an acceptable and lucrative business.[3]

Although members of Class 3 were less mature and more dependent[1] than those of Classes 1 and 2, they were not necessarily pathological. As a group, they were more naïve and self-centred, less well organized, somewhat more rebellious, and probably had less control over their emotions than did either their matched non-prostitute controls or full-time prostitutes, who are higher on the intra-occupational scale. Rather than being seen as pathological, they may be described as less mature and more dependent.

Classes 4 and 5 showed evidence of more psychopathology than the others. Class 4 prostitutes have been found the most pathological. Many show classic signs of schizophrenia.[1]

Class 5 is described as a sad group, destructive of themselves and others. Rorschach tests show Class 5 prostitutes as weak in reality testing, subject to ideational confusion, having limited emotional controls, and lacking in organization of their resources.

In contrast to most of the literature, one controlled study of 95 prostitutes found little difference in family structure and sexual history among women in each of the five classes and the controls.[1]

Underlying Factors of Prostitution

Family-generated factors

Family problems and broken homes have been noted as a factor in the lives of prostitutes. Greenwald reported[4] that the majority of prostitutes

came from broken homes and that all reported discord between their parents. A study made in Lebanon found[5] that 28% of the prostitutes investigated had a death in the family, 15% reported parental rejection, neglect and cruelty, and 9.2% had experienced a divorce in the family of socialization. In reporting on the family of procreation, 21% stated that husband deception and cruelty had occurred, 20% recalled their parents' marriage as unhappy, and 5.4% stated that the death of a husband had occurred. A study of homosexual male prostitutes found[6] that those who disclosed their orientation to their families were rejected and persecuted rather than accepted and supported.

The vaccum created by parental withdrawal through divorce, mothers working, or fathers holding two jobs) creates a dependency on peers at every age level.[7] This age-mate attachment is caused by lack of attention and concern at home.[7] Delinquency is a contingency of deficient family relationships which have a greater effect on females than on males.[8]

In a study of 67 prostitutes, 71% reported verbal abuse by their fathers, as compared to 42% of controls.[9] In this study, prostitution was strongly related to self-description as the "family scapegoat". It has been suggested that the family, through identification with a rejecting parent, helps to instill and foster a negative self-image which later becomes a deviant self-image and a self-fulfilling prophecy.[10] The daughter, it is suggested, may be caught in an unbearable position because of being made a scapegoat and being rejected by the father. The father's influence is especially significant because the father is often the source of norms.

Early Sexual Experience

Sexual abuse is a factor that has been linked to prostitution. In a study of 138 juvenile females involved in prostitution, 37% had been molested, 51% had been raped, and 63% reported that they had suffered physical abuse.[6] Studies made in the United States suggest that at least 60% of juvenile prostitutes have been sexually abused prior to becoming prostitutes.[11] It has been suggested that intra-familial sexual contact may result in the girl running away, becoming delinquent, and turning to prostitution.[12] The report's data show that 27.4% of the boys and 30% of the girls who later became prostitutes had their first sexual experience with a family member or with a person in a situation of trust.[11] Only 23% of those girls who became prostitutes had their first sexual experience with a close-in-age peer.[13]

The first sexual experience of boys who later became homosexual prostitutes was homosexual in 43% of cases as compared to a 4% national sample in United States.[11] Sixty-three per cent of female prostitutes, as compared to 1.7% of a national sample, had experienced intercourse by the age of 13. In another study,[14] 77% of prostitutes reported having had intercourse by the age of fifteen.

Other studies reported that there was a period of time before the participants turned to prostitution when they engaged in promiscuous sexual relations that were rewarded with favours.[5]

James and Meyerding[15] state that 65% of adolescent prostitutes involved in his study had been coerced into sexual activities. A Minnesota study of prostitutes under the age of 20 showed that 65% of the participants reported having been raped, and 30% admitted to sexual abuse within the family.[16] In the James and Meyerding study incest was reported in 15%–36% of cases.[15]

The Bagely[1] report[11] suggests that the decision to enter prostitution is not a voluntary one, but rather reflects a pattern of pre-teen and young teenage children trying to escape emotionally, physically, or sexually abusive homes by running the streets, where they are lured into lifestyles involving drugs. There they are coerced into prostitution by poverty, homelessness, and relationships with street figures, including pimps.

Other Factors

Running away from home is another factor associated with the drift into prostitution. It has been estimated[7] that there are 600,000 youngsters on the run each year in the United States, over 400,000 of these being female. Because most cities lack emergency shelters, the female runaway must turn to the streets for support almost immediately.[7] A carried out study in Canada showed that two-thirds of the children who became prostitutes were hardly present at all in their homes after the age of 12.[17] Wooden notes that pimps and their associates often wait for transient teenagers in transportation depots in order to lure them into prostitution.[14]

Educational values are rejected before the women take up prostitution.[4] This usually follows repeated failure to adjust to the educational system. The absence of connections with the family and the educational system reflect a weak or broken bond with society. Social control theory[4] suggests that this situation leads to deviant or delinquent behaviour as it also entails a growing indifference to the opinion of others, a loss of fear of the consequences of breaking rules, and overall a loss of belief in the rules of society.[4] This turn of mind may remove inhibitions about committing delinquent acts, since these women see themselves as having nothing to lose from a negative evaluation by parents or conventional members of society.

Once these women have been rejected by those around them, the stage is set for them, as alienated persons, to be labelled deviant and, in turn, to reject society. Typically, a prostitute's isolation, withdrawal from society, and separation from people, social institutions, and agencies outside her nuclear family increase the girl's perception of herself as powerless and hence vulnerable to social stigma.[12] Her first encounter with the authorities sets in motion a process of definition that marks her as different from law-abiding folk. This experience enlarges the gap of alienation and leads the girl to depend on others who are in a similar position.[17] The gang of peers forms a new social world or subculture, in which the legitimacy of delinquent conduct is strongly reinforced. The girl who has been branded a member of such a group may actualize this image. Negative attributions and labelling may lock a young woman into a deviant role.[6]

The use of drugs has also been cited as a factor in initiating prostitution. In a study of 200 street-walking prostitutes, 27% stated that they began the practice because of drugs.[18] Fifty-nine per cent stated they were using drugs at the time of the study. Twenty-five per cent stated that they had been turned onto drugs by their

families. All the members of this group declared that they wanted to get off drugs, and 13% saw their addiction as the main obstacle to their succeeding in giving up prostitution. Fifty-eight per cent of this group had parents who were alcohol abusers, and 19% had other family members who were alcoholic.

Financial gain may be a factor in inducing some women to enter prostitution,[14, 7] but this is not a consistant finding.[19]

Another possible factor in influencing a woman to enter prostitution is knowing a prostitute on a fairly intimate basis.[19] Having delinquent friends has also been associated with a girl's turning to prostitution.[7]

Background of Prostitutes

The Minnesota study referred to above[16] noted a consistant lack of sex education in the families of prostitutes. Even after years on the street, these women remained ignorant about the functioning of their bodies. Lack of understanding about venereal disease and birth control has also been documented.[17]

Sexual-role confusion has also been noted. Difficulty in choosing either parent as a role model in severely emotionally deprived women is postulated as a reason for this.[19]

In a previously mentioned study of 20 prostitutes,[19] the women disclosed that they felt lonely and unworthy. It is suggested that a lack of trust in others—a lack founded in inadequacy in early psychosocial development—leads to an inability to form lasting relationships.[14] Prostitutes often internalize the stigma, blaming themselves for their circumstances. As a result, they commonly abuse drugs and contemplate and attempt suicide.[16]

A study of 20 prostitutes established that because of their poor perception of reality, these women had difficulty in distinguishing between the behaviour of individuals they knew in their early experiences and people they met in their adult life.[19] This may partially account for some of the difficulties which physicians may find in working with some members of this group. Street youth often approach medical facilities and physicians with great hesitation. They perceive medical personnel as authority figures representing general societal values which conflict with their personal characteristics and experiences on the streets. They often fail to disclose lifestyle issues and medical concerns because of embarassment, shame, or fear of blame.[6] Non-compliance with instructions about medication and failure to keep return medical appointments were also noted in this study.[6] At the same time, the authors of the study point out that most prostitutes seek health care, and this may be their only contact with health or social service agencies.

The authors of a study of 20 prostitutes observed that in interpersonal relations the girls shifted constantly between an obviously surface type of integrating behaviour and a deeply hostile, aggressive behaviour.[19] Fourteen of the 20 girls expressed hostility to men, while only six reported that they liked men. A lack of impulse control was also noted in this group.

The Family

Teenage prostitutes have been described as having poor relationships with their parents. Lack of adequate supervision, lack of intimacy in communication patterns, and consistent failure of the parents to provide positive social reinforcement in the form of attention, affection, or effective communication have been noted.[4] In a study of 20 prostitutes, there was not one example of a permanent, satisfactory marital relationship between the parents. Three-quarters of these girls experienced broken homes. Even the five girls who did not come from a broken home had never seen evidence of sympathy or affection between their parents. The absence of warmth and permanence between the parents made it difficult for them to form any kind of attachment to their family.[19] Nineteen of 20 reported that they had been rejected by both parents, an experience which gave them a feeling of worthlessness that was a characteristic of the entire group. At times their blind expression of hatred for their parents and their belief that their parents wished to manipulate them made it difficult, if not impossible, for them to incorporate parental images as sources of self-identification or internal control.[19] Jackman's study[20] reported a universal hostility among the participants toward the father. In a study of 63 prostitutes, 23 of the participants considered that their parents were very strict in their religious practice.[21]

Prostitution and Sexually Transmitted Diseases

Syphillis is becoming a very uncommon disease, even in houses of prostitution.[22] Conditions commonly seen include pelvic inflammatory disease (PID), Herpes genitalis, vulvovaginitis, non-gonococcal genital infections, trichomonas, condyloma accuminata, and infestations.[22] Chlamydia Trichomatis is now the most common major pathogen isolated from female patients; it is two to three times as prevalent as Neiserial Gonorrhea.[22] A study of juvenile prostitution found that one-third of the participants had contracted gonococcus, 12% had syphillis, and 50% had some kind of venereal disease.[11]

A screening program used in an Australian study showed that 10% of the prostitutes developed a fresh Neiserial Gonorrhea infection each week.[23] In another study 44% of the participants had acquired gonorrhea within the first month of prostitution. As many as 60% of the women infected with gonorrhea have no symptoms for months, and in a few cases, for years. Up to 10% of men may also be asymptomatic carriers of the gonococcus.[24]

The herpes virus is suspected of playing an important part in the development of cancer of the cervix.[25] Early coital activity is the most important factor in the development of cancer of the cervix. An individual must be sexually active before the age of 17 to be high risk.[20] Prostitutes may have a risk of cancer of the cervix that is 4.7 times that of controls of comparable socioeconomic status.[26]

Sero-postivity to HTLV-III has been reported among 5%–40% of prostitutes in some areas of Europe and the United States, many of whom are parenteral drug users.[27] Thirty-one per cent of 3206 women in a drug-abuse treatment program were involved in prostitution. Parenteral drug abuse likely accounts for much of the seropositivity among prostitutes, but the possible influence of sexual exposure alone should be considered as well.[26] In some people who are antibody positive the only likely risk factors are promiscuity and sexual contact with prostitutes.[27] African prostitutes have shown sero-prevelance rates ranging from 50% to 88%, and these persons seem to be a serious source of infection.[24] HTLV-III antibodies have been

found more commonly in male customers of prostitutes than in controls.[28] HTLV-III may be transmitted directly through heterosexual contact.[28] Prostitutes, and probably their male customers, should be regarded as high-risk groups, at least among the Central African population,[28] and as potentially high-risk groups in Canadian populations. Those who also use IV drugs are, of course, high risk, as well.

The prostitute is also at risk of customers' sadistic behaviour which can be complemented by strong elements of guilt and masochism in the prostitute.[29]

The Physical Examination

The physical examination of the prostitute should include inspection of the mouth, pharynx, perianal region, perineum, vulva, introitus, and urethra.[24] The lower abdomen, inguinal nodes, and Bartholins glands should be evaluated. Urethral secretions may be milked by passing a finger along the anterior vaginal wall, and a urethral swab should be taken. Swabs for gonorrhea should be taken from the endocervix. If there is a history of rectal intercourse, a proctoscope should be passed and specimens collected. Investigations should also include a hepatitis screen, an HTLV test (with confidentiality and appropriate counselling), a chlamydia culture, and a VDRL. Of 20 ex-prostitutes tested in our Family Medicine Teaching Centre, all were sero-negative. The genogram is a useful tool for assessing the prostitute's psychosocial status.[30]

Treatment

The first step in treating a prostitute is to remove him or her from the situation and, if possible, to remove the opportunity to engage in prostitution.[19] This may be accomplished by referral to a half-way house. It is recommended that a psychological examination be done early, and that an early intake conference be held to plan for the optimum use of the facilities and to ascertain what goals the ex-prostitutes should try to reach.[13] Conference planning should occur at various intervals in the program. Material and psychological conditions must be such as to help the patient develop a sense of belonging, and of experiencing emotional support and undergoing reality testing in a sheltered environment. The socializing process of community living with group activities are essential. Residents (prostitutes experiencing a rehabilitation process) must also learn to develop spare-time pursuits.

Education is an essential component of rehabilitation. Remedial education in sex education and values clarification relating to female sexuality are important, as well as teaching the former prostitute how to relate to men in non-sexual ways.[7] Assertiveness training and systematic desensitization may be helpful. Positive role models, such as Big Sisters, may be beneficial. The fostering of self-image is an important step toward transfering dependency to the therapeutic milieu. Relief of boredom must be addressed.

Counselling is an important aspect of rehabilitation. The Teen Challenge Paradigm has been effective; after seven years its rate of recidivism is a low 14%.[16] Therapy for drug dependence, as well as individual and family therapy, are important.[17] Other important aspects will be preparing for employment through assessment guidance and placement. Help in arranging suitable accommodation after leaving the half-way house is important. A 'leaving' conference helps to ensure that everything is in place, and that someone will be monitoring the woman after her discharge. The final step in rehabilitation—and often a trap for the health professional—is not just to substitute one dependency relationship for another, but to encourage the adolescent to develop individuality.

Conclusions

The literature often attributes to the prostitute failures in personality and psychosocial development. Prostitutes are in many ways victims of society. Future controlled research will help to clarify what may be an over-generalization that suggests that all prostitutes are severely disturbed in their psychosocial development.

Prostitution and the AIDS epidemic raise some difficult bioethical questions. Some of these are well described by Macklin, and I summarize them here.[31] Macklin suggests that the state may interfere with an individual's behaviour when it is necessary to do so to prevent harm or the reasonable risk of harm to others. Could society then isolate those who are "dangerous"? Who *is* "dangerous"? Persons with AIDS or AIDS-related complex? All persons positive for HTLV-III antibodies? High-risk groups? Macklin rejects the notion that high-risk groups are dangerous, as they are not co-extensive with the class of individuals transmitting AIDS. Universal screening is morally repugnant and prohibitive in cost. Present technology does not permit accurate prediction of who is dangerous to others (as behaviour is a component of this danger, and testing is not yet accurate enough to permit identification). Incarceration for anything but a crime is also morally repugnant. Isolation becomes more acceptable the more serious a disease is, the more difficult it is to treat, the greater its degree of contagiousness, the wider its range of transmissibility, the less effective the modes of prevention, and the shorter the time span in which contacts remain infectious. The contagiousness of AIDS is still unclear. Its range of transmission is narrow, allowing greater opportunity for voluntary control. Voluntary measures include use of condoms, disclosing sero-positive status, and using sterile IV needles. Persons who are sero-positive become dangerous when they engage in behaviour that produces a risk of harm to others. There are, however, no reliable means of predicting or identifying recalcitrant offenders. Isolation could be justified for recalcitrant prisoners. Prostitutes could be encouraged to have their blood tested, and those who test positive could be counselled to require their patrons to use condoms. Any more impositions than these would constitute an invasion of privacy conducted in a totalitarian manner that would threaten the fabric of our society. Comprehensive and concerted education is therefore essential at this time. Unfortunately, the young, drug-using, street-walking prostitute is at the highest risk of behaving irresponsibly. It is likely to be very difficult to exercise preventive intervention within this group. ◉

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