PSYCHOTHERAPY ROUNDS

Psychotherapy with Women Who Have Worked in the "Sex Industry"

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ABSTRACT

Psychotherapy is effective for a myriad of mental health symptoms, with the clinical situation dictating the most applicable method. For episodes of severe stress including acute depression and anxiety, supportive mechanisms (crisis interventions and shoring up existing coping skills and strategies) may be the best fit. During periods of relatively milder symptomatology a psychodynamic approach may be utilized with the same patient (focusing on self-reflection and a more in-depth exploration). This article focuses on the use of psychotherapy with women working in the sex industry, whether indoor (such as strip clubs and cabarets) or outdoor (such as prostitution and escort services). These women frequently experience violence in various forms, and most report multiple traumatic experiences, both during their developmental years and while working in the industry. A composite case is included that illustrates some of the supportive and psychodynamic psychotherapy techniques that can be applied when treating these individuals.

INTRODUCTION

Women involved in the adult sex industry (e.g., exotic dancers and prostitutes) who have experienced trauma often feel shattered and hopeless.[1,2] Some escape the lifestyle, yet with limited resources many find themselves "trapped" in the business.[1,3] Many have been attacked, exploited, and humiliated, and mind-altering substances often are sought to temporarily mollify the physical and emotional pain.[3] The most prevalent mental health symptoms are in the mood and anxiety spectrums, but are often coupled with addiction to substances.[1–4] Many of these women who use substances state they are anesthetizing themselves to be able to work in the sex industry.[1,2,4] Posttraumatic stress disorder (PTSD) is widespread in this subset of the population and usually is attributed to childhood abuse and/or sex industry-related trauma.[1–4] A substantial number of these women are homeless single mothers of multiple children, under-educated, and medically uninsured; have a high rate of untreated health-related problems; and often have legal problems.[1–4] Table 1 lists important statistics regarding the sex trade industry.

There has been little research on violence against women in the sex industry until recently. Many in society have assumed that women who work in the industry do so willingly and somehow are shielded from sexual and physical harm or that their participation is fully volitional.[1,2] More recently, studies show that both indoor (e.g., strip clubs, cabarets) and outdoor (e.g., prostitution, escort

TABLE 1. Important statistics about the sex industry[1,2,4]

- The sex industry is a $57 billion worldwide business annually.
- The United States has more strip clubs than any other country in the world.
- There are more than 3,800 adult clubs nationwide, which employ over 500,000 people.
- Currently, more women are employed in the sex industry than in any other point in time.
- Between 66–90% of women in the sex industry were sexually abused as children.
- Relative to the general population, women in the sex industry experience higher rates of substance abuse, sexually transmitted diseases, domestic violence, depression, violent assault, rape and posttraumatic stress disorder.
- The sex industry is estimated to be a $15 billion industry annually in the United States.

services) sex work heighten the risk of being assaulted.[1,2,4] Farley and Kelly[1] found that 82 percent of women who were engaged in the outdoor sex industry (prostitution) reported having been physically assaulted and 68 percent reported having been raped.

Raphael and Shapiro[2] found that the high prevalence of violence against women included both the indoor and outdoor sex industries. The perpetrators most commonly were identified as customers, pimps, managers, and intimate partners. More than half of the exotic dancers reported that they had been threatened with a weapon. Violence occurred in all venues of the sex industry, but severity and frequency and type of violence varied depending on indoor versus outdoor venues. The women working in the outdoor setting reported higher prevalence of generalized physical violence; however, the indoor setting was associated with more sexual violence and threats involving weapons.[2]

Raphael and Shapiro[2] also reviewed more than 25 research studies quantifying the level of violence in street prostitution. Eighty-two percent of the respondents reported physical violence and 68 percent reported rape. A staggering 68 percent of these prostitutes also met criteria for PTSD. Similarly, Walls[3] reported those who engaged in survival sex (a consequence of poverty and minimal opportunity for improvement) carried a far greater risk of developing depression, were more often psychiatrically hospitalized, and 4.5 times more likely to attempt suicide.

Holsopple[4] studied exotic dancers. One-hundred percent of the dancers reported that they had been physically assaulted during work-related activities at least once. The prevalence or assaults ranged from 3 to 15 times during the time of employment in the sex industry, with a mean occurrence of eight incidents. The types of offenses included physical assault (100%), attempted vaginal penetration with fingers (61%) or objects (33%), and attempted vaginal rape (17%). Forty-four percent of the women interviewed in that study reported that they had been verbally threatened, with a range of 3 to 150 threats for those who reported threats.[4]

These findings were substantiated by Maticka-Tyndale et al[5] who found similar results. A greater prevalence of physical assaults and unwanted sexual contact occurred in indoor settings (e.g., lap dancing, private booths, and back rooms).

Church et al[6] conducted a comparative study on violence in both indoor and outdoor prostitution in the United Kingdom and found that there was significantly more violence (81% versus 48%) in the outdoor sex industry. The outdoor workers reported being slapped, punched, and kicked in contrast to the indoor workers who reported attempted rape more frequently. Benoit and Millar's study[7] of 201 prostitutes found 67 percent had received medical treatment for physical injuries and 36 percent had been hospitalized for related injuries. Wesley[8] found that dancers accepted as commonplace these physical violations of their bodies.

Complicating the problem of documenting the prevalence of violence against sex workers is their reluctance to disclose it for fear of incriminating themselves or making themselves targets of additional verbal, physical, and sexual abuse.[5–7] Reporting of violence may also hold implications for family relationships, custody of children, legal consequences, credit, and "straight" job applications among other consequences.[7,8] Given these deterrents, it is likely the aforementioned statistics are an under-representation of actual cases. Navigating the secrecy of working in the sex industry coupled with societal stigmatization also often results in social isolation, further complicating reporting, mental health, and subsequent treatment options.[6–8]

CLINICAL VIGNETTE 1

Ms. M was a divorced 32-year-old woman who was a former exotic dancer and escort. She resided in a homeless shelter and only had temporary employment. Her initial complaints included symptoms of PTSD and depression, and she voiced intentions of "getting my life back on track." She was referred to the clinic by a friend.

Ms. M had been seen by a different psychiatrist at the clinic the previous year and followed through in therapy with biweekly to monthly appointments during that time. When scheduling the current appointment, she was surprised to learn her initial psychiatrist had left the clinic and she would need to reinitiate treatment with a new psychiatrist.

PRACTICE POINT: CLEAR COMMUNICATION ABOUT TRANSITIONS IS VERY IMPORTANT

Staff turnover in mental health clinics is inevitable, and this must be clearly explained to the patient. A clear line of communication is essential as this may represent an inconsequential shift for staff, but an

irreparable loss for the vulnerable patient. This is of special importance to the individual who has endured repeated betrayals and rejections to prevent this from being interpreted as yet another episode of abandonment. Through their time in the "field," sex workers typically cultivate a keen sense of reading others.[16,17] Almost as a means of survival, they are compelled to develop a proficiency in deciphering body language and verbal cues.[16,17] The new psychiatrist should try to exude confidence, yet empathic acceptance, especially during the initial encounter.

CLINICAL VIGNETTE 1, CONTINUED

Ms. M arrived early for the re-evaluation; her worn-looking apparel consisted of a faded gray zip-down sweatshirt, torn jeans, and old tennis shoes. Her hygiene was mediocre. She seemed to carry a bit of shame in her appearance; this was unspoken, but it was clear self-confidence was lacking. Old scars were visible on her face and arms, each one depicting a harrowing tale. The deep ridges and multiple creases in her skin revealed a deteriorated woman appearing much older than her chronological age. Her speech was spontaneous and intentional and there was no interruption in eye contact. Overall, her mood was euthymic and affect was full range and easily accessible. Ms. M became dramatically blunted in affect when she recounted the horrific trauma of her past in a mechanical way. She nonchalantly commented, "You just get over it and move on." Yet, she became seemingly distant and almost disconnected from the interviewer.

She readily opened the session depicting interpersonal discord and her current psychosocial stressors, including being unemployed, financially strapped, and in an unstable living environment. At first, the conversation flowed seamlessly without much break. Upon the first major pause, there fell a silence, leaving her visibly apprehensive.

Patient: I don't understand how I'm going to come up with my portion of the rent, plus my car needs work. And how am I supposed to feed my children?"

Doctor: [nods head in acknowledgment]

Patient: I just don't know what to do. [frustrated]

Doctor: [remains quiet]

Patient: Did you hear anything I just said?! [notably frustrated]

The psychiatrist reinitiated the conversation after a pause and offered words of encouragement to proceed.

PRACTICE POINT: PERIODS OF SILENCE

Moments of silence during the psychotherapy hour can communicate important psychodynamic information as well as serve to foster the therapeutic relationship. It is an opportunity for the patient to convey emotional and relational messages of need and meaning. The psychiatrist could use silence to provide safety, understanding, and containment. Nonetheless, if this technique is not adeptly and considerately employed, such a patient could interpret the psychiatrist's silence as indifference, disengagement, or disapproval. Early in the treatment, it is prudent to avoid prolonged absences of speech for the sake of the patient's comfort and tolerability.

CLINICAL VIGNETTE 2

Ms. R was a 23-year-old single woman working as an escort at a location just off the main road of a popular tourist resort. She presented to the mental health clinic after she was allegedly sexually assaulted at work in a commonly frequented motel two weeks prior. She reported the onset of acute anxiety and fearfulness after her most recent attack, and these feelings re-emerged as she described the attack to the psychiatrist. She quickly transitioned into the events of her youth. Notably detached from her graphic depictions, she described her earlier experiences. She began to chronologically relate incidents starting at the age of five when she was first sexually violated. She was aware that her mother had used alcohol and street drugs while pregnant and that this caused her to have learning disabilities and developmental delay. As a toddler, she would have at most a single meal daily and frequently was locked in a dark closet. She was placed in multiple foster and group homes. Being the youngest of three siblings, she told a story of manipulation, negligence, public humiliation, and betrayal.

By the age of 15, Ms. R became pregnant and decided to have her child, although the father's identity was unknown to her. Jobless and with limited means, she discovered the lucrative world of "gentleman's entertainment." She learned how to utilize her body and physical appearance for her own survival. This allowed easy access to some money and afforded her a sense of importance and desirability.

The allure of instant acceptance and adoration was captivating and kept her immersed in the sex business for several years. Unfortunately, she sustained attacks both physical and sexual in nature, plus ruthless disparagement and humiliation by the intoxicated patrons. Eventually, she acquired employment in retail and attempted to exit the profession. The departure was short-lived because she lost the job, and she turned to "escorting" to make ends meet. After being cut, beaten, robbed, gang raped and sodomized, tied up, and left to bleed to death, she again tried to dissolve all ties to the industry and sought help.

After her second visit with the psychiatrist (a male), staff noticed her transformation, which involved an overly enthusiastic demeanor and enhanced appearance (jewelry and makeup plus more stylish and seductive attire) when presenting for appointments. At one point, she mentioned how difficult it would be to

communicate such intimate details of her life with such "an attractive young doctor." Though no boundary violations or crossing had transgressed, the clinic director decided to transfer the patient to another psychiatrist (a female) without informing the treating psychiatrist or the patient, and the patient discontinued treatment for an extended period.

Patient: It's hard to talk about this stuff…especially with a new doctor. I was just getting used to Dr. X.

New Doctor (a female): What do you feel makes it difficult to discuss?

Patient: Well, you're my new doctor and it's hard to say certain things.

New Doctor: Remember, here in therapy, you don't have to discuss anything you don't want to. You make the decisions about what we discuss.

PRACTICE POINT: DEALING WITH THE EMERGENCE OF TRANSFERENCES BY THE TREATMENT TEAM

It is important for members of the treatment team to communicate their observations to the treating psychiatrist and that staff on the team, including the doctor, not be changed abruptly without notice. The psychiatrist should discuss with the staff possible behavioral changes that may occur, and endorse the importance of understanding how transference, countertransference, and concern about professional boundaries can affect such complicated situations. Relationships with members of the treatment team may be the patient's only source of stability and consistency, so it is imperative that this communication be established and maintained during the course of treatment, and changes made judiciously. In this case, when the psychiatrist was changed, the patient did not return for a long time.

CLINICAL VIGNETTE 2, CONTINUED

Upon the patient's return, the new psychiatrist cautiously broached the topic of the patient's six-month absence (which the patient downplayed) and proposed several precipitant factors, including lack of transportation among other innocuous reasons.

Patient: It's been a while, huh?

New Doctor: [nods head in agreement]

Patient: I really couldn't work it into my schedule with starting a new job and not having any consistent transportation.

New Doctor: You found it important to come back today?

Patient: Yeah, I called off work and took the bus to get here because I know I did much better while I was in treatment.

New Doctor: I wonder how the termination with the previous doctor might have affected your feelings about returning?

Patient: Oh, I didn't really care that he left….[gazes away for a moment and turns bitter] I was pissed, he just left me out to dry…

TRANSFERENCE AND COUNTERTRANSFERENCE

Transference is the process of the patient unconsciously attributing aspects of important past relationships, especially those of early caregivers, onto the psychiatrist. The residue of the past experience leads to the "transfer" of either positive or negative feelings onto the present relationship. Dismissal or complete avoidance of the possibility of erotic transference issues especially with this population would be a therapeutic misstep; rather, transference should be confronted and worked through.

Countertransference is the process where a psychiatrist unconsciously ascribes motives or qualities to a patient that are derived from the psychiatrist's past experiences rather than from material from the patient, or also the act of dismissing or not hearing important material that the patient is bringing into the session. For example, although sex workers are over-represented among female murder victims,[9] sex workers often are viewed culturally as voluntarily bringing on the increased risk for violence themselves or are somehow impervious to such risk. This cultural viewpoint should at least be recognized by the psychiatrist (who has, after all, been exposed to the culture) so that avoidable dangers to the patient are not overlooked by the psychiatrist and the patient's worth is validated. The patient may not keep herself safe because she does not know how to do so or does not think she has value. The patient who has been victimized deserves validation, and it should be articulated that she has value and is deserving of the same rights and protections as every other person. The sex worker is subject to multiple and repeated trauma, often has few options for assistance, and often keeps her experiences secret. If the first disclosure is not well received or results in a negative or unsupportive response, it greatly impacts subsequent disclosures. If there is a perceived or actual lack of support, it may significantly limit opportunities or willingness to access social support and resources.[10] Roxburgh et al[11] found that a significant percentage of the sex workers who had suffered sexual assault experienced depression and suicidal ideation, and 50 percent attempted suicide. However, of this study group, only 40 percent had any interface with mental health services. When a group of women who had suffered a trauma history were separated into those working in the sex industry and those not, it was found that only 25 percent of sex workers sought mental health treatment while 45 percent of the other traumatized women did so.[11]

CLINICAL VIGNETTE 3

Ms. L was a 35-year-old sex worker with no prior mental health treatment who was seen for weekly psychotherapy for treatment of depressive symptoms. The patient had divulged her trauma history to the male psychiatrist in the prior session. She felt vulnerable after sharing these agonizing events of her developmental years and she hesitated to proceed in the subsequent session, stating "you probably won't understand." The disclosure of past abuse was complicated by current experiences of humiliation and abuse from her most current boyfriend. Her ambivalence toward men was apparent. She felt dependent on them for economic survival and affirmation of her external appearance, yet concurrently loathed and distrusted "every last one of them." She was not sure what to expect from the psychiatrist, but the psychotherapy relationship could be her first opportunity to have a connection with a man and not be abused or violated or have it sexualized in some manner.

Patient: Men are scum. They treat you so nice at first, only to manipulate and take advantage of you.

Doctor (a male): It must make it hard for you to trust men?

Patient: Hell yeah, they're all bad, I know it's not fair…but that's the way I feel.

Doctor: Now having a male psychiatrist must make it equally as challenging?

PRACTICE POINT: BOUNDARY SETTINGS AND MAINTAINING THE FRAME

Psychotherapy is structured around a "frame" composed of a set of professional boundaries, including location and duration of session, limited personal self-disclosure by psychotherapist, acting in a reliable and consistent manner, absence of physical contact, confidentiality, and avoidance of establishing dual relationships outside the psychotherapy (e.g., interacting on a social level) among others. These basic guidelines encourage the patient to explore her feelings, perceptions, thoughts, and memories in a "safe" environment (Table 2).[12]

TABLE 2. Major boundary issues contributing to the formation of a coherent treatment frame

BOUNDARY ISSUE	FUNCTION AND PURPOSE	IMPLICIT MESSAGE TO THE PATIENT
Stability	Consistency with time, place, parties involved, treatment method	"Therapist is reliable. This treatment can contain my irrationality"
Neutrality and promoting patient autonomy	Avoiding abuse of power and promoting the patient's independence	"Therapist values my ideas and encourages me to exercise choices"
Noncollusive compensation	Scrupulous and forthright terms of remuneration for the clinician	"Aside from payment, I don't have to gratify my doctor."
Confidentiality	To protect the patient's privilege of keeping his or her communications secret	"My thoughts and feelings belong to me, not the doctor."
Anonymity	Avoids seductiveness and role reversal	"This is a place to bring my issues, not a forum for the doctor's personal problems."
Preserving the clinician's safety and self-respect	Discourages the patient's destructive behavior, sets a good role model for establishing healthy self-esteem	"It is possible to have close relationships without someone getting hurt."

Adapted from Tasman A, Kay J, Lieberman J (eds). *Psychiatry, Volume 1, Second Edition.* West Sussex, UK: Wiley-Blackwell Press; 2003:69.

Many female and male patients have difficulty articulating their sense of injury to male psychiatrists.[16,17] Behavior of the doctor may be incorrectly perceived by the patient as exploitation similar to that experienced in prior pathological interactions, and therefore jeopardize a normal therapeutic relationship. Clearly, these patients are very vulnerable when there are boundary transgressions by the psychiatrist. For instance, patients who were sexually abused during developmental years are more likely to acquiesce to an amorous advance by a male psychiatrist and to avoid complaining about the feeling of being used, because they fear the threat of the psychiatrist's rejection and possibility of fictitious repercussions.[12,13] The fact that the psychiatrist may be viewed as an authority figure further obscures the issue (Table 3).[13]

SUPPORTIVE VERSUS PSYCHODYNAMIC PSYCHOTHERAPY

Psychodynamic psychotherapy uses self-reflection and self-evaluation. This is made possible in part by the therapeutic alliance and

TABLE 3. Boundary crossings and violations

BOUNDARY CROSSINGS	BOUNDARY VIOLATIONS
Are benign and even helpful breaks in the frame	Are exploitive breaks in the frame
Are minor and attenuated in most cases	Are egregious and often extreme (e.g., sexual misconduct)
Are discussable in therapy	Therapist generally discourages discussion in therapy
Ultimately do not cause harm to patient	Typically cause harm to the patient and/or the therapy

Adapted from Gabbard G. Long-term psychodynamic psychotherapy. In: Levy R, Lieberman SJ (eds). *Handbook of Evidence-Based Psychodynamic Psychotherapy*. Washington, DC: Springer; 2004:50.

TABLE 4. Basic principles of psychodynamic psychotherapy

- Much of mental life is unconscious.
- Childhood experiences in concert with genetic factors shape the adult.
- The patient's transference to the therapist is a primary source of understanding.
- The therapist's countertransference provides valuable understanding about what the patient induces in others.
- The patient's resistance to the therapy process is a major focus of the therapy.
- Symptoms and behaviors serve multiple functions and are determined by complex and often unconscious forces.

Adapted from Gabbard G. Long-term psychodynamic psychotherapy. In: Levy R, Lieberman SJ (eds). *Handbook of Evidence-Based Psychodynamic Psychotherapy*. Washington, DC: Springer; 2004:3.

inter-relationship with the psychiatrist. The patient explores coping strategies and relationship patterns. The psychiatrist attempts to reveal any unconscious components of maladaptive functioning, and addresses resistances as they reveal themselves. Change is accomplished over time via a trusting alliance, where resistance is managed and deeper understanding has developed (Table 4).[13]

Similar to the psychodynamic type, supportive psychotherapy also relies on a trusting and secure relationship with the psychiatrist; however, supportive psychotherapy is more suitable for a patient in crisis.[14] The chief objective is to bolster the patient's healthy and adaptive patterns of thought and behavior with the goal of reduction in mental health symptoms. Through reinforcement of coping strategies, encouraging emotional expression, and enhancement of self-esteem, the supportive mode of psychotherapy can assist in guiding the patient through the crisis at hand. In general, a deeper examination and inquiry into one's underlying motivations is avoided in supportive psychotherapy (Table 5).[14]

Finally, an additional component of supportive psychotherapy is that it addresses and institutes features of sound patient care that follow best practices.[12,13] Patients who have experienced trauma and boundary violations in relationships may find this professional relationship to be their only source of stability. The patient needs to be able to trust that the psychiatrist will reliably be there for emotional support. The staff should ensure frequent contact with the patient (especially if the patient is actively working in the sex industry) since the patient's life may be chaotic and constantly changing (e.g., phone numbers, place of residence).

CLINICAL VIGNETTE 3, CONTINUED

Ms. L questioned the psychiatrist's motivation for accepting her for treatment and inquired about the reason for serving women in the sex industry.

Patient: There are lots of jobs for psychiatrists, what made you come over here?

Doctor: After learning about this opportunity, I felt I'd be able to make a difference and really help guide individuals going through some of the hardships you have experienced.

Patient: Well, thank you. It's really appreciated that you're here.

PRACTICE POINT: WHEN TO ANSWER DIRECT QUESTIONS

Rather than responding with a question or trying to interpret the patient's query, at times a forthcoming and genuine response works best. Honesty is crucial as the patient likely has been lied to and manipulated her entire life. The professional relationship with the psychiatrist affords the patient the opportunity not to be a victim or object, but an actual human being worthy to safely impart her story and emotions.

TABLE 5. Basic principles of supportive psychotherapy

- It has roots in virtually every therapy that recognizes the ameliorative effects of emotional support and a stable caring atmosphere
- Greater etiological emphasis is placed on external rather than intrapsychic events, particularly on stressful environmental and interpersonal influences
- Major goal is to suppress or control symptomatology and to stabilize the patient in a protective reassuring benign atmosphere that militates against overwhelming external and internal pressures.
- Ultimate goal is to maximize the integrative or adaptive capacities so that the patient increases the ability to cope, while decreasing vulnerability by reinforcing assets and strengthening defenses.

Adapted from Saddock BJ, Saddock VA. *Concise Textbook of Clinical Psychiatry, Third Edition.* Philadelphia, PA: Lippincott Williams and Wilkins; 2004:448.

CONCLUSION

Women working in both indoor and outdoor sex industries are frequently exposed to violence in many forms.[2,15] High levels of violence likely influence decision making in the present with regard to rearing children, transportation, family relationships, and housing conditions; at least as important, it likely influences the ability for planning and future thinking. The effects of violence alter the needs of women in the sex industry and affect their ability to exit the sex industry safely and successfully.[2,7,15] This underserved subset of women typically has numerous psychosocial stressors, limited resources, and all too common physical and sexual abuse histories.[2,4,6] Anxiety, depression, symptoms of PTSD, and use of substances are prevalent,[4,7,15] implying a clear role for mental health involvement. The treating psychiatrist must be aware of transference and countertransference issues that may be involved when working with this population and proficiently know how and when to address these factors within the psychotherapeutic structure. A strong and reliable therapeutic alliance is indispensible in re-establishing trust and security. Through the work of psychotherapy, including a solid rapport and timely interventions, these women can begin to enjoy more fulfilling lives.

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