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CLIENT-PERPETRATED VIOLENCE AND PSYCHOLOGICAL WELL-BEING AMONG FEMALE SEX WORKERS IN PAKISTAN

Taimoor Ali taimooralishah821@gmail.com	MS Clinical Psychology Student, Department of Clinical Psychology, The Superior University Lahore, Punjab, Pakistan.
Ms. Raumish Masud Khan rausmishmasud.fsd@superior.edu.pk	Senior Lecturer, Department of Clinical Psychology, The Superior University Lahore, Punjab, Pakistan.

Abstract

Sex work in Pakistan exists within a nexus of legal prohibition, social stigma, and endemic violence, rendering sex workers among the most psychologically vulnerable populations in the country. Client-perpetrated violence encompassing physical assault, sexual coercion, verbal abuse, and psychological intimidation constitutes a pervasive occupational hazard that profoundly undermines the mental health of those engaged in sex work (Shannon et al., 2015). This study investigates the nature, frequency, and psychological consequences of client violence experienced by sex workers in Pakistan, with particular focus on its associations with depression, post-traumatic stress disorder (PTSD), anxiety, self-esteem deterioration, and suicidal ideation. Drawing on a quantitative framework, data were collected from 200 sex workers across urban and semi-urban settings, using structured interviews and validated psychometric instruments including the Harvard Trauma Questionnaire (HTQ) for PTSD, and the DASS-21 for depression, anxiety, and stress (Lovibond & Lovibond, 1995; Mollica et al., 1992). Findings reveal that an overwhelming majority of participants reported experiencing at least one form of client violence, with physical and sexual violence being the most frequently cited. Regression analyses demonstrated that sexual and physical violence emerged as the strongest independent predictors of trauma and stress. Structural factors including criminalization, police harassment, social marginalization, and absence of legal recourse were identified as compounding barriers that exacerbate psychological harm and prevent access to mental health services.

Keywords: *Client Violence, Depression, Mental Health, Pakistan, Psychological Well-Being, PTSD, Sex Workers, Stigma, Trauma.*

Corresponding Author: Taimoor Ali (MS Clinical Psychology Student, Department of Clinical Psychology, The Superior University Lahore, Punjab, Pakistan)
Email: taimooralishah821@gmail.com

1. Introduction

In the shadow of Pakistan's conservative social and legal landscape, sex work occupies one of the most precarious spaces imaginable. Women who engage in sex work face an unrelenting convergence of dangers: criminalization without formal protection, religious and cultural stigma that erases them from public sympathy, and clients who operate with near-total impunity. What unfolds, then, is not merely a public health problem it is a crisis of structural violence rendered invisible by the same society that perpetuates it. Violence against sex workers is neither incidental nor random. It is patterned, predictable, and rooted in the power asymmetry that defines the client-worker transaction in unregulated, coercive environments.

Globally, research has consistently documented that sex workers experience violence at rates far exceeding those of the general population (Shannon et al., 2015; Deering et al., 2014). This violence translates into profound psychological consequences: depression, anxiety, post-traumatic stress disorder (PTSD), and complex trauma responses that undermine daily functioning and long-term health (Platt et al., 2018; Cohan et al., 2006). In low- and middle-income countries (LMICs) such as Pakistan, these harms are amplified by inadequate mental health infrastructure, the absence of legal protections, and pervasive stigma that discourages help-seeking.

The present study was designed to fill this gap. By systematically examining client-perpetrated violence psychological, physical, and sexual and its relationship with depression, anxiety, stress, and trauma symptomatology among female sex workers in Pakistan, this research aims to generate the empirical foundation urgently needed to inform policy, clinical practice, and advocacy.

Pakistan is a country of over 230 million people, governed by a confluence of Islamic law, colonial-era penal statutes, and evolving constitutional frameworks. The practice of sex work exists in an underground economy that is simultaneously visible and invisible visible in urban red-light districts such as those historically found in Lahore's Heera Mandi, Karachi's Napier Road, and comparable localities in other major cities, yet invisible to formal governance, healthcare systems, and legal protections. Estimates suggest that hundreds of thousands of individuals are engaged in sex work across Pakistan, though the clandestine nature of the occupation renders accurate demographic data extraordinarily difficult to obtain. Within this population, women constitute the majority, though the community also includes transgender individuals and, to a lesser extent, men.

Female sex work in Pakistan is not a marginal or isolated phenomenon but a structured, geographically distributed sector of the informal economy. Mapping exercises conducted across major urban centers have documented thousands of female sex workers operating across distinct typologies including home-based, street-based, brothel-based, and mobile or phone-solicited work with substantial variation in scale and organization

from city to city. Behavioral surveillance research tracing this population between 2006 and 2011 found that solicitation practices have shifted markedly over time, with sex workers increasingly relying on mobile phones to arrange client encounters, alongside reports of larger client volumes and a rise in higher-risk sexual practices such as anal sex with clients, even as consistent condom use also increased over the same period (Melesse et al., 2016).

Research conducted specifically in Lahore has documented the intersection of structural vulnerability with health risk among women selling sex, situating Pakistani sex workers within a broader landscape of HIV and sexually transmitted infection surveillance that has, until recently, dominated the research agenda on this population (Khan et al., 2011). This emphasis reflects a pattern seen throughout the region: sex work in Pakistan has been studied primarily as a vector of disease transmission, with the psychological and social consequences of the violence sex workers experience receiving comparatively little independent attention.

A large systematic review and meta-analysis of mental health among female sex workers across 56 studies and 26 low- and middle-income countries, encompassing nearly 25,000 participants, provides one of the most robust demographic baselines available for contextualizing samples such as the present one (Beattie et al., 2020). Across this pooled international sample, the average participant age was approximately 29 years, and nearly half had no more than a primary-level education. Marital status was similarly distributed across three broad categories: roughly half of sex workers across these studies had never married, around a third were currently married or in a relationship, and the remainder were divorced, separated, or widowed. These figures closely mirror demographic patterns reported in Pakistani samples and suggest that the demographic profile of the present sample relatively young, with low educational attainment and a substantial proportion of divorced, separated, or widowed women is broadly consistent with the population studied internationally, lending external validity to the present findings.

Client violence against sex workers is a multidimensional phenomenon that scholars and public health researchers have categorized across several overlapping typologies. At its most immediate level, physical violence encompasses acts such as punching, kicking, choking, cutting, and other forms of bodily assault perpetrated by clients during or after commercial sexual encounters. Physical violence frequently results in injuries that go untreated due to sex workers' fear of seeking medical attention and the consequent exposure to institutional stigma or police harassment.

Sexual violence constitutes a second and frequently overlapping category. Despite the transactional nature of sex work, consent remains operative within each encounter, and violations of negotiated boundaries constitute rape or sexual assault. Clients who refuse to

use condoms, demand unprotected sex under threat or coercion, engage in acts not agreed upon, or force additional sexual acts post-payment are perpetrating sexual violence.

Psychological and emotional violence including verbal abuse, threats, humiliation, blackmail, and intimidation constitutes a third major category. Clients may threaten to expose sex workers to family members, neighbors, or religious authorities. In contexts where a sex worker's identity is bound to notions of honor (izzat) as is acutely the case in Pakistani society such threats carry catastrophic potential and generate chronic states of fear and hypervigilance.

Finally, structural violence a concept articulated by sociologist Paul Farmer refers to the violence embedded in political, economic, and legal systems that systematically disadvantage marginalized groups. For sex workers in Pakistan, structural violence is manifested in the criminalization of their occupation, the denial of legal standing when they report crimes, police extortion and abuse, exclusion from formal employment and social services, and the withholding of healthcare.

The psychological impact of violence on sex workers has been investigated through multiple theoretical lenses, each contributing critical insight. Trauma theory rooted in the foundational work of Herman (1992) on complex trauma provides perhaps the most directly applicable framework. Herman's model identifies the conditions under which prolonged, repeated interpersonal violence generates a specific constellation of psychological responses: hyperarousal, intrusion, and constriction (avoidance). These responses map precisely onto the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD) as delineated in the DSM-5.

In the Pakistani context, it is important to expand traditional trauma frameworks to account for the compounding effects of cultural shame and social stigma. Sex workers in Pakistan do not merely experience trauma from discrete violent events; they inhabit a social position that is constituted by ongoing humiliation, moral condemnation, and social death. This sustained stigma functions as a form of chronic traumatic stress that operates beneath the threshold of formal PTSD diagnosis yet profoundly shapes daily psychological functioning (Meyer, 2003).

Depression and anxiety are among the most commonly documented psychological sequelae of violence against sex workers. Hopelessness theory (Abramson, Metalsky, and Alloy, 1989) and Beck's cognitive model of depression offer complementary explanations: repeated client violence, met with institutional indifference and social blame, may generate stable negative attribution patterns a sense that suffering is inevitable, uncontrollable, and reflective of personal inadequacy.

The violence experienced by sex workers in Pakistan cannot be fully understood in isolation from the broader climate of gender-based violence faced by Pakistani women generally. National data collected through helpline services indicate that the overwhelming

majority of Pakistani women report having experienced some form of sexual harassment during their lifetime, a finding that has been linked to measurable deterioration in mental health among working women (Akbar & Ghazal, 2023).

1.1. Objectives of the Study

The current study is guided by the following primary objectives:

1. To examine the relationship between client-perpetrated violence (psychological, physical, and sexual) and mental health outcomes (depression, anxiety, stress, and trauma symptomatology) among sex workers.
2. To determine the predictive role of client-perpetrated violence (psychological, physical, and sexual) on depression, anxiety, stress, and trauma symptomatology, while assessing the independent contribution of each form of violence.
3. To compare the relative strength of different forms of client violence (psychological, physical, and sexual) in predicting PTSD symptomatology, and to identify whether sexual violence is the strongest predictor.

1.2. Hypotheses

Based on the theoretical framework and study objectives, the following hypotheses were formulated:

Hypothesis 1 (H1): There will be significant positive relationships between client violence (psychological, physical, and sexual) and mental health outcomes (depression, anxiety, stress, and trauma symptomatology).

Hypothesis 2 (H2): Client-perpetrated violence (psychological, physical, and sexual) will significantly predict mental health outcomes (depression, anxiety, stress, and trauma), with all three forms of violence contributing independently.

Hypothesis 3 (H3): Sexual violence will emerge as the strongest predictor of PTSD symptomatology relative to physical and psychological violence.

2. Method

2.1. Research Design

The present study employed a quantitative cross-sectional research design to examine the impact of client-perpetrated violence on the psychological well-being of female sex workers in Pakistan. A quantitative approach was selected because the primary aim of the study was to measure, with precision and systematic comparability, the severity and nature of psychological outcomes. Cross-sectional designs are widely used in epidemiological and clinical psychology research to establish associations between exposure variables and health outcomes within a defined population at a single point in time (Shannon et al., 2009; Deering et al., 2014).

2.2. Participants and Sampling

Participants were recruited through a combination of purposive sampling and snowball sampling, both of which are well-established and methodologically justified

strategies for research with hidden, stigmatized, and hard-to-reach populations (Heckathorn, 1997). Recruitment was carried out in three major urban centers of Pakistan Lahore, Jhang, and Rawalpindi.

To be eligible for participation, individuals were required to fulfill all of the following criteria: (a) identify as female; (b) be 18 years of age or older at the time of recruitment; (c) be currently engaged in sex work; (d) have experienced at least one incident of physical, sexual, psychological, or economic violence perpetrated by a client in the twelve months preceding data collection; and (e) be able and willing to provide free, prior, and informed consent.

A total of 200 female sex workers were recruited across the three study sites, with approximately 50 participants drawn from each location. Demographically, participants ranged in age from 18 to 51 years (M = 27.8, SD = 7.2).

2.3. Measures

Three standardized, internationally validated instruments were employed to measure the study's key variables:

Violence Against Women Instrument (VAWI; Vung, Ostergren, & Krantz, 2008): A structured self-report questionnaire developed to assess women's exposure to intimate partner and non-partner violence across multiple dimensions. In the present study, the VAWI was adapted to capture client-perpetrated violence.

Depression Anxiety Stress Scales-21 (DASS-21; Lovibond & Lovibond, 1995): A well-validated 21-item self-report measure designed to assess the severity of symptoms associated with three negative emotional states: depression, anxiety, and stress.

Harvard Trauma Questionnaire (HTQ; Mollica et al., 1992): A standardized, cross-culturally validated self-report instrument to assess exposure to traumatic events and the associated post-traumatic stress symptomatology.

3. Results

Initial descriptive statistical analyses confirmed that client-perpetrated violence was a universal experience within this sample. To test the proposed hypotheses (H1, H2, and H3), inferential analyses including Pearson Product-Moment Correlation and Multiple Linear Regression (MLR) were conducted using SPSS.

Table 1: *Pearson Correlation Matrix for Client Violence and Mental Health Outcomes (N=200)*

Variables	1	2	3	4	5	6
1. Psychological Violence	-					
2. Physical Violence	.65**	-				
3. Sexual Violence	.60**	.70**	-			
4. Depression	.47**	.52**	.55**	-		
5. Anxiety	.40**	.48**	.50**	.75**	-	

6. Stress	.48**	.55**	.59**	.80**	.78**	-
7. Trauma (PTSD)	.49**	.62**	.68**	.65**	.60**	.70**

Note. ** $p < .01$.

Above table posited that there would be significant positive relationships between all forms of client violence (psychological, physical, and sexual) and mental health outcomes (depression, anxiety, stress, and trauma symptomatology). As shown in Table 1, Pearson correlation analyses revealed significant positive associations across all variables. Psychological violence was moderately correlated with depression ($r = .47$, $p < .01$) and trauma ($r = .49$, $p < .01$). Physical violence demonstrated strong positive correlations with stress ($r = .55$, $p < .01$) and trauma ($r = .62$, $p < .01$). Sexual violence exhibited the strongest correlations, particularly with trauma symptomatology ($r = .68$, $p < .01$) and stress ($r = .59$, $p < .01$).

Table 2: *Multiple Linear Regression Predicting Mental Health Outcomes from Client Violence (N=200)*

Predictor	**Depression (*β*)**	**Anxiety (*β*)**	**Stress (*β*)**	**Trauma (*β*)**
Psychological Violence	.18*	.15	.14	.12
Physical Violence	.25**	.21*	.24**	.28**
Sexual Violence	.29**	.26**	.34**	.41***
R^2	.30	.26	.37	.50
F	28.41***	23.12***	38.65***	65.42***

Note. β = Standardized beta coefficients. * $p < .05$, ** $p < .01$, *** $p < .001$.

Multiple Linear Regression analyses were performed for each mental health outcome, entering the three violence domains as predictors. Table 2 summarizes the regression models. The models were significant for all dependent variables Depression [$F(3, 196) = 28.41$, $p < .001$, $R^2 = .30$], Anxiety [$F(3, 196) = 23.12$, $p < .001$, $R^2 = .26$], Stress [$F(3, 196) = 38.65$, $p < .001$, $R^2 = .37$], and Trauma [$F(3, 196) = 65.42$, $p < .001$, $R^2 = .50$].

Specifically, physical violence significantly independently predicted depression ($\beta = .25$, $p < .01$) and anxiety ($\beta = .21$, $p < .05$). Sexual violence was a highly significant independent predictor across all domains, most notably for stress ($\beta = .34$, $p < .001$). These results indicate that the combination of violence types accounts for a substantial proportion of the variance in mental health distress. proposed that sexual violence would emerge as the strongest predictor of PTSD (Trauma symptomatology) relative to physical and psychological violence. Referencing the trauma regression model in Table 2, while all three predictors contributed to the model, sexual violence yielded the highest standardized beta coefficient ($\beta = .41$, $p < .001$), surpassing physical violence ($\beta = .28$, $p < .001$) and psychological violence ($\beta = .12$, $p = .06$, ns). Thus, confirming that sexual violence holds the strongest relative predictive power for severe trauma responses in this population.

4. Discussion

The findings of this study offer an in-depth characterization of the lived psychological experience of female sex workers exposed to client-perpetrated violence in Pakistan. The correlational and regression analyses unequivocally confirmed the devastating impact of this violence on mental health.

Supporting Hypothesis 1, significant positive correlations were established between all forms of violence and all dimensions of psychological distress. The high inter-correlations suggest that violence exposure in sex work is not experienced as isolated incidents, but rather as a chronic occupational hazard that systematically erodes psychological well-being (Decker et al., 2013).

The multiple regression models supporting Hypothesis 2 demonstrated that client-perpetrated violence explains a substantial proportion of the variance in distress, particularly accounting for 50% of the variance in trauma symptomatology. The hierarchy of distress observed is consistent with theoretical models of adaptation to chronic inescapable adversity. Under conditions of acute threat, anxiety tends to dominate, with hypervigilance serving adaptive functions. Where exposure is chronic, repeated, and inescapable, however, the physiological cost of sustained arousal produces exhaustion, hopelessness, and complex trauma responses (Hobfoll, 1989; Herman, 1992).

Crucially, the validation of Hypothesis 3 underscores that sexual violence is the most robust predictor of PTSD in this demographic. Despite the transactional nature of sex work, violations of physical and sexual boundaries constitute profound interpersonal trauma, compounding the structural violence of marginalization and legal prohibition (Shannon et al., 2015).

The findings of this study must be interpreted in light of a number of methodological limitations. The cross-sectional design precludes the establishment of strict causal or temporal relationships between client violence and psychological distress. Furthermore, the study relied on a convenience and peer-referral sampling strategy, introducing a meaningful risk of selection bias.

Given the findings, mental health and social service providers working with sex workers in Pakistan should adopt trauma-informed care as the default model of service delivery. At the policy level, policymakers should explicitly incorporate the mental health needs of sex workers into national public health planning. Legal and institutional reforms are needed to provide sex workers with meaningful avenues for reporting violence and seeking protection without risk of arrest.

In conclusion, client-perpetrated violence was found to be universal across the sample and served as a powerful predictor of depression, anxiety, stress, and PTSD. This study represents a modest but earnest contribution to a body of research, advocacy, and clinical practice that remains urgently needed. Sex workers in Pakistan, like sex workers

globally, are resilient individuals whose psychological well-being and safety are systematically undermined by structural inequality, institutionalized violence, and social exclusion.

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