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THE MENTAL HEALTH MANAGEMENT OF INDIVIDUALS IN SEX WORK

by
Bianca Tocci, M.A.

A Dissertation submitted to the Faculty of the Graduate School,
Marquette University,
in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy

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ABSTRACT
THE MENTAL HEALTH MANAGEMENT OF INDIVIDUALS IN SEX WORK

Bianca Tocci, M.A.

Marquette University, 2024

This dissertation examines the mental health implications and experiences of individuals engaged in sex work, employing a constructivist grounded theory approach to explore the nuanced realities of this marginalized population. Through in-depth interviews with sex workers, this study reveals the complex interplay of positive aspects (enjoyment and empowerment), and the negative (severe risks faced by individuals in this field, including verbal abuse, physical violence, and sexual assault). The findings underscore the critical need for a holistic and nuanced understanding of sex work, challenging prevalent stereotypes and emphasizing the importance of ongoing consent, communication, and respect for sex workers' boundaries.

Participants in this study represented a diverse group of individuals in sex work. Gender identities for participants included cisgender women, transgender woman, and agender. Participants engaged in a range of forms of sex work including prostitution, phone sex services, exotic dancing/stripping, among other forms. 90% of participants identified as black/African American with 10% identifying as white/Caucasian. In accordance with grounded theory, participants had the opportunity to review transcripts, and make additions if needed. The transcripts were then analyzed by the dissertation team via initial coding, focused coding, and theoretical coding. Constant comparative methods and memo-writing were employed by the dissertation team.

The implications for practice and policy are shared, including suggestions that mental health practitioners should adopt a trauma-informed approach and that policymakers should prioritize the decriminalization of sex work. The integration of sexuality courses in mental health graduate programs is also proposed to enhance understanding and support for this population. Future research directions are identified, emphasizing the need for longitudinal studies on mental health outcomes, resilience factors, and the impact of legal and cultural contexts on sex workers' well-being.

This dissertation contributes to the burgeoning discourse on sex work and mental health, advocating for comprehensive, inclusive, and culturally competent approaches to support the well-being, agency, and rights of sex workers. It calls for a reevaluation of societal, legal, and healthcare practices to better accommodate the needs of individuals engaged in sex work, urging a shift towards more equitable and inclusive mental health support systems.

DEDICATION

This is for my participants. Thank you for trusting me with your narratives and allowing me to guide a larger audience to your platforms. Your words matter, your stories matter, your experiences matter, your perspectives matter, and your lives matter. Let this be a drop in the wave of change that fuels the reconstruction of the mental health care you deserve. Thank you for everything.

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Bianca Tocci, M.A.

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To my siblings, Francesca, Noah, & Seve- I would not be who I am today without you all. Thank you for listening to me tirelessly, encouraging me, and being the best cheer squad always. Your support helps me to continue working in areas of the field that are not always tread and to shed light on topics we do not often discuss. You all are the best.

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Chapter One: Introduction

“Everyone seemed to think that violence was an acceptable risk and a forgone conclusion for prostitutes, call girls, and streetwalkers alike. There was almost an air of, well what did she expect? What did she expect, indeed? To be allowed to live?”

– Jeanette De Beauvoir

Sex work is an occupation that is fraught with scrutiny, stigma, and risk. Consideration for the wellness of those who work within sex work is lacking throughout society. It is undeniable that some forms of sex work pose great risk to physical safety and security (Lowman & Fraser, 1995; Potterat et al., 2004; Ward et al., 1999). As De Beauvoir’s quote highlights, society often views this risk as a work hazard. This notion has been reverberated throughout research and has contributed to the stigma often associated with individuals in sex work known as “whore stigma” (Anesu et al., 2019; Benoit, 2020; Brody et al., 2005; Carr, 1995; Ditmore, 2016; Rayson & Alba, 2019). The quote also highlights an important component often forgotten in the discussion of risks associated with sex work- at what point did society accept the risk of harm to individuals in sex work and subsequently disregard the notion that individuals in sex work deserve to survive a day at work?

Defining Sex Work

While the history of “sex work” is extensive, there appears to be a lack of clarity as to what the term *sex work* truly means. The term “sex work” was coined by Carol Leigh, a sex-work activist, to best describe the labor she and other workers in commercial sex industries performed (Berg, 2014). This term currently remains as the standard in value-neutral language. Similarly, in an effort to use person-centered language, the term individual(s) in sex work will be used throughout this study.

For the purpose of this study, and in an effort to ensure clarity and inclusivity regarding the individuals who are discussed in the literature and their careers, resources provided by the Sex Workers Outreach Project (SWOP) have been compiled to generate a comprehensive definition of *sex work*. “Sex work” is a general term used to encapsulate any type of labor in which the explicit goal is to produce a sexual or erotic response in the client for compensation such as, but not limited to, monetary payment or goods that is agreed upon by all parties involved (SWOP, 2019).

Pertinent Issues in Sex Work

Sex work, and those involved in sex work, has had a tumultuous history (Ditmore, 2011; 2006). Sex work has been documented within primitive society and flourished across cultures including Ancient Egypt and Greece (Ditmore, 2011; 2006). Individuals in sex work were largely regarded as contributors to music, dance, literature, and societal projects (e.g., building monuments; Ditmore, 2011; 2006). However, there was an apparent shift in societal view of sex work and individuals in sex work during the 16th century (Ditmore, 2011; 2006). At this time, the concern of morality, fueled by religion, infiltrated societal view (Ditmore, 2011; 2006). The depiction of sex work contradicting morality only continued to grow through the 19th century when government systems began developing policies to criminalize sex work (Ditmore, 2011; 2006). Currently, the stains of the 16th to 19th century remain as individuals in sex work continue to be cast out from society via legal policy and societal views on morality (Allman & Ditmore, 2016; Brents & Hausbeck, 2005; Ditmore, 2011; Ditmore, 2006; Fellows et al., 2020).

The harms of casting individuals out from society via policy and societal view are profound. The stigma now associated with individuals in sex work is known as “whore stigma” (Benoit, 2020). This stigma classifies individuals in sex work as being immoral, deviant, and

lacking decency (Benoit, 2020; Benoit et al., 2018; Pheterson, 1996; Rayson & Alba, 2019). Sex workers are often believed to have a history of trauma, be dependent on drugs and illicit substances, and even inviting harm done to them (Anesu et al., 2019; Benoit, 2020; Brody et al., 2005; Carr, 1995; Ditmore, 2016; Rayson & Alba, 2019).

These perceptions have influenced individuals in sex work dramatically. Specifically, cisgender females in sex work are as high as 120 times more likely to be murdered than cisgender females in the general population (Lowman & Fraser, 1995; Potterat et al., 2004; Ward et al., 1999). The fear of enduring stigma and potential discrimination has been shown to lead to burn-out and fatigue among individuals in sex work (Morris & Feldman, 1996; Patterson et al., 2009; Vanwesenbeeck, 2005). If individuals in sex work wanted to access support or care either because of what they have experienced or as is their right as citizens of society, they are faced with barriers; individuals in sex work experience high rates of abuse and discrimination from those largely designed to help them (i.e., medical professionals, mental health clinicians, and law enforcement officials; Aral et al., 2003; Benoit, 2020; Benoit et al., 2018; Chakrapani et al., 2009; Ghimire et al., 2011; Gorry et al., 2010; Mtetwa et al., 2013; Ngo et al., 2007; Peers, 2021; Phrasisombath et al., 2012; Scorgie et al., 2013; Stadler & Delany, 2006). These abuses come in the forms of refusing care, withholding comprehensive care, pathologizing sex work and allowing this to influence mental health diagnoses, physically and verbally abusing individuals in sex work, and wrongfully arresting individuals in sex work (Allen, et al., 2015; Anesu et al., 2019; Benoit, 2020; Benoit et al., 2018; Chakrapani et al., 2009; Gould & Fick, 2008; Herek, 2004; Pettifor et al., 2000; Pauw & Brenner, 2003; Shahmanesh et al., 2008; Singer et al., 2020).

It may not be surprising, then, that there is an inherent distrust in societal systems among individuals in sex work (Anesu et al., 2019; Human Rights Watch, 2012; Michels, 2009; Singer

et al., 2020). This fear of abuse, maltreatment, and discrimination has had a resounding effect on the help-seeking behaviors of individuals in sex work (Rayson & Alba, 2019; Zehnder et al., 2019). Individuals in sex work, a predominantly neglected and vulnerable population, have found it better to not seek help because they feel that the care they would receive would do more harm to them as individuals than it would good (Benoit et al., 2018; Biradavolu et al., 2009; Blakenship & Koester, 2002; Mtetwa et al., 2013; Rayson & Alba, 2019; Scambler & Paoli, 2008; Spittal et al., 2003; Zehnder et al., 2019).

Rationale for the Current Study

I have conducted this study because I want to learn about the experiences of sex workers with mental health and mental health services to inform the field's response and service for this population. This study has been designed to involve individuals in sex work directly and ethically. I aim to stem away from the trend of focusing on sexual health when conducting research with individuals in sex work. This is not to say that the sexual health of the sex work community is not important; rather, I aim to avoid oversampling and research fatigue by exploring a largely untouched area of interest within the community of sex work- mental health management (Ashley, 2021; Price et al., 2020). Research supports the notion that individuals in sex work are less likely than the general population to work with mental health clinicians, even if they may be suitable for attaining mental health services (Rayson & Alba, 2019; Zehnder et al., 2019). What is not understood is what individuals in sex work do to address their mental health concerns. Thus, this study is designed to explore and understand how individuals in sex work navigate, or work through, their own mental health concerns when they arise. It will explore any resources individuals may have used, individuals they have relied on or felt helped them with their mental health concerns, and/or things they may have done on their own to address their

mental health concerns. Understanding the experiences and processes of individuals in sex work regarding mental health management would help fuel our understanding of the community of sex work and the mental health field to better address their needs.

Purpose of the Current Study

Mental health professionals, though they have a duty to serve clients in all lines of work, may not serve all clients with equity. Specifically, mental health professionals may perpetuate bias toward individuals in sex work that negatively impacts their help-seeking behaviors (Rayson & Alba, 2019). While this study is not intended to investigate the reasons for engagement in sex work, it is geared toward addressing how mental health resources may strengthen their support and provide comprehensive and quality care to individuals in sex work. Pushing up against the stigma and bias asserted by mental health professionals is essential. By asking individuals in sex work how they navigated their mental health experiences, what they found helpful, what they did not find helpful, and how mental health professionals may have played a role in their experience will only help further inform the field of directions we must move to provide comprehensive care and how we may be contributing to the current management of mental health care for individuals in sex work, for better or worse.

Research involving individuals in sex work has predominantly focused on their sexual health (Benoit, 2020; Benoit et al., 2018; Ditmore, 2016; Ditmore, 2011). In combination with this focus and subsequent academic reduction of an entire population, researchers have contributed to unethical and biased portrayals of this population and/or relied heavily on the researchers' voice to express the experiences of individuals in sex work (Brody et al., 2005; Farley et al., 1998; Weathers et al., 1993). The purpose of this study is, therefore, to explore the lived experience of individuals in sex work of managing their mental health concerns and to

generate a theoretical model for mental health care providers to use when serving this population. This study has a goal to produce ethical research that honors the voices of each participant in an effort to gain insight into how individuals in sex work manage their mental health concerns and how the mental health field can provide accessible and equitable service to these individuals.

Research Questions

The proposed study sought to explore how individuals in sex work have navigated their mental health concerns and create a model for how they can be better served by the mental health profession. This explored participants' mental health concerns, the types of resources they had accessible to them, what resources they engaged in, and the potential influences of decision making throughout their experience of mental health concerns. This inquiry is in an effort to understand what individuals in sex work have found helpful in navigating their mental health concerns and what they found to be unhelpful, in an effort to guide future resources and care services that align with the insight provided by individuals in sex work.

That in mind, the specific research questions were as follows:

- What is the lived experience of individuals in sex work with addressing their mental health concerns and their mental health wellness?
- What experiences with help seeking behavior (whether through professional mental health providers or their own networks) were helpful and what experiences were not helpful?
- What suggestions would sex workers have for safe, accessible, and quality mental health care?

Rationale for Qualitative Method

Considering the history of individuals in sex work and the nature of the research questions, I have selected to use Constructivist Grounded Theory (CGT; Charmaz, 2014; Glaser & Strauss, 1967), as my method for the proposed study. CGT has its roots in grounded theory and stresses the importance of immersing yourself in the research, having a collaborative nature to allow for the truths of each participant to emerge from their words and form the subsequent theory (Charmaz, 2014). CGT stresses the importance of hearing and remaining true to the voice of the participants (Charmaz, 2014). Given the historic silencing of individuals in sex work and assertion of researchers' opinions on this population via research, I believe it is important that I choose a methodology that holds a value to combat the bias put forth via research.

CGT implements constant comparative analysis of data and has a systemic process of coding and categorizing said data (Charmaz, 2014). Guidelines are also set forth by CGT scholars on how researchers are to address their own biases with consistent reflection and discussion on reactions and other influences on the researchers that may impact the uncovered truths in the data (Charmaz, 2014). Given the bias toward individuals in sex work, having a methodology that prioritizes addressing biases of the researchers is imperative. While this study may not be without bias entirely, actively working through the biases and experiences of researchers openly as we work in collaboration with the participants is essential and largely missing from the research conducted with this population. With that said, there are critiques of CGT that are important to address.

CGT has been largely criticized for its dependence on the researcher (Fassinger, 2005). Specifically, critics have noted a seeming lack of standardization because of this reliance, and potential overreliance, on the researcher's skills (Fassinger, 2005). Additionally, CGT has been

criticized for the labor-intensive data analysis process (Fassinger, 2005). The process is notably time consuming and is often thought to exceed the time dedicated to other qualitative methodologies (Fassinger, 2005). However, CGT continues to be seen as a strong tool for generating research and theory when working with individuals and populations that have largely been silenced (Charmaz, 2014; Charmaz & Belgrave 2018). Despite the limitations of the method, CGT has been selected given its apparent fit with the research question, rationale, and purpose of this study.

Overview of Study Methods

The study used semi-structured interviews with participants. Interviews were conducted in person with the option for them to do be done over the phone if that was preferred by the participant. All interviews were audio recorded and subsequently transcribed by the primary investigator (PI). The primary data for this study was the participants' own expression of their experiences and participants were recruited via flyer distribution and community outreach. Participants were eligible for the study if they were over the age of 18, had engaged in sex work while over the age of 18 in the United States, and have lief experiences with managing their mental health while engaged in sex work. In accordance with CGT scholars, theoretical sampling and data saturation were used in determining the specific sample size of this study (Charmaz, 2014; Thompson, 2011). Applying both theoretical sampling and data saturation to this study yielded a sample size of 10 participants (Thompson, 2011). A full explanation of the methodology, research process, research team, and criteria for the sample is provided in chapter three with subsequent appendices following the reference section.

Chapter Two: Literature Review

Definition of Sex Work

As previously noted, Carol, Leigh coined the term “sex work.” (Berg, 2014). In this wording, Leigh hoped for unity amongst workers and to provide an alternative to stigmatized language by means of “acknowledge[ing] the work we do rather than defin[e] us by our status,” (Leigh, p. 203, 1997). This term currently remains as the standard in value-neutral language. Similarly, in an effort to use person-centered language, the term individual(s) in sex work will be used throughout this proposal.

While the history of sex work is extensive, there appears to be a lack of clarity as to what the term *sex work* truly means. Sex work’s historic prominence has led individuals to acknowledge the term as common knowledge. Often, researchers will justify this reality by utilizing the term “sex work” within their research without further defining it (Allman & Ditmore, 2016; Berg, 2014; Brents & Hausbeck, 2005; Niccolai et al., 2012). However, the few definitions provided in research demonstrate clear variation in understanding (Allman & Ditmore, 2016; Jackson 2016).

In a study conducted by Begum, et al. (2013), researchers adapted the definition of *sex work* provided by Quadara (2008) claiming sex work is: “the exchange of sexual services for money or other reward” (p. 85). This definition is concerning because it does not clarify what “sexual services” entails. “Sexual services” may make the assumption of physical contact. However, *sex work* does not require physical proximity as technology has provided additional platforms (i.e., the internet, video calls, telephone calls, and streaming services) for “sexual services” to be provided. Thus, Quadara’s definition is not inclusive nor is it specific enough to constitute a proper definition of sex work.

Navani-Vazirani et al. (2015) defined sex work as “exchanging sexually related practices for goods, services and/or money” (p. 225). “Sexually related practices” allows for the flexibility in understanding of location and interaction that “sexual services” from Quadara’s definition may not. However, the nuances of sex work, specifically the urgency and business components involved for individuals in sex work, are still lacking from these definitions. Specifically, this definition excludes the notion of consent and agreement on services between the individual in sex work and their patron(s). Without clarifying the mutual consent and agreement involved in sex work, Navani-Vazirani et al. (2015) continue to deny need for contractual agreement in services. Without acknowledging consent and contractual agreement, this definition allows for coercion and abuse of services to be considered within the scope of sex work.

These variations in definition illustrate a lack of consistency in understanding what sex work truly is. There is a lack of distinction between willingness, intent, and action. Without a clear understanding of what sex work is, we are unable to know who could be considered an individual in sex work. This inability to clearly understand who is involved in sex work eliminates our ability to understand the experiences of those in sex work. The lack of clarity and inconsistency in defining sex work has stemmed from researchers who have not engaged in sex work themselves, as previously illustrated. To limit confusion and discrepancy with the term *sex work*, I turn to a definition composed by experts in sex work- individuals in the field themselves.

The Sex Worker Outreach Project (SWOP) is an organization composed of current and past individuals in sex work who provide resources to the sex work community. Their definition of *sex work* comes from those actively engaging within it or who previously have engaged and continue to interact with the community. In an effort to ensure clarity and inclusivity regarding the individuals who are discussed in the literature and their careers, I compiled resources

provided by SWOP to generate a comprehensive definition of *sex work*. “Sex work” is a general term used to encapsulate any type of labor in which the explicit goal is to produce a sexual or erotic response in the client for compensation such as, but not limited to, monetary payment or goods that is agreed upon by all parties involved (Sex Workers Outreach Project [SWOP], 2019). This definition is not only articulated by the sex work community rather than researchers interested in the community, but it also notes that physical contact is not necessary for sex work although consent and communication between parties are. This helps expand the narrow scope that is often placed on sex work (i.e., sex work being prostitution solely) and helps create a boundary between what is considered a part of sex work and what is considered to be an abuse of contract or services. Without consent on services, individuals in sex work may be forced to engage in acts they do not agree to and, or, be taken advantage of. If consent is not included in the definition, sexual violence may be considered a part of sex work rather than a violation of individuals in sex work. Thus, it is imperative that consent and agreement to services are included in the definition. This definition, further, creates space to acknowledge the impact and influence technology has had on sex work. As technology has evolved, so has the field of sex work. Technology has provided a platform for sex work that eliminates the need for physical proximity. I felt it was imperative to include a definition of sex work that allowed for all current forms of sex work to be included. Additionally, it felt important to have a clear definition of sex work to identify other forms of labor that may involve sexual actions but not be included under the scope of sex work (i.e., sex trafficking; Berg, 2014).

Differentiating Sex Trafficking from Sex Work

Given the difficulty in clearly defining sex work seen throughout research on the topic, it may not be surprising that sex trafficking has historically been conflated with sex work. Those

involved within sex trafficking are often misidentified as individuals in sex work, and vice versa. To eliminate further confusion and establish how sex trafficking is different than sex work, it is important to understand what sex trafficking is.

Sex trafficking is one element of human trafficking. Human trafficking is a human rights violation in which the threat or use of coercion is utilized for the purpose of exploitation, including sexual exploitation (Open Society Foundations, 2021; SWOP, 2019). While often misidentified as victims of sexual exploitation, individuals in sex work engage in a consensual transaction between adults where human rights violations are not inherently involved (Open Society Foundations, 2021; SWOP, 2019).

Victims of sex trafficking are often thought to need assistance in escaping and are discussed under the bigger realm of contemporary human rights abuse (Bromfield, 2016). Therefore, human rights activists and political acts have shown they are eager to put forth policy, attention, and funding, to right this human right violation. In fact, there have been global efforts to combat sex trafficking and provide resources for individuals in sex trafficking. The first legally binding global attempt to dismantle/address human trafficking was the United Nations (2000) Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (The Palermo Protocol) on December 25, 2003 (Hodge, 2014). The Palermo Protocol created an internationally used definition of human trafficking while simultaneously criminalizing all trafficking efforts (Hodge, 2014). The Palermo Protocol defines human trafficking, including sex trafficking as:

The act of recruitment, transportation, transfer, harboring or receipt of persons, by *means* of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of

payments or benefits to achieve the consent of a person having control over another person, for the *purpose* of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs. [italics added] (p. 2, Art. 3a).

This definition provides clarity and distinguishes sex trafficking from sex work as force and coercion are necessary to be considered sex trafficking. Sex trafficking is a clear societal concern. Given the illicit nature of sex trafficking, it is difficult to estimate the number of victims of sex trafficking (Hodge, 2014; Jackson, 2016). Within cases that have been identified as human trafficking, 58% are sex trafficking cases (Hodge, 2014); Because of this, media attention, push for policy change, and resources for victims of sex trafficking are incredibly important.

However, individuals in sex work do not have the same societal push for support. The idea of injustice ignites researchers, policy makers, and helping professions to focus on victims of trafficking more so than individuals in sex work. Women engaging in sex work are dehumanized and thought to be poor decision makers because society continues to struggle with the idea that choice is involved in sex work (Ditmore, 2011; Jackson 2016). Society's conflation of sex work with trafficking and its general condemnation will be further discussed in future sections. It is, however, important to note that individuals in sex work are seen as the pariahs rather than those in the most need of resources and help- unlike victims of sex trafficking. While we recognize that research is needed to stop the practice of sex trafficking and protect its victims, this study focuses on those in sex work as they continue to be ignored and less of a focus than victims of sex trafficking within the literature.

We have now defined sex work as well as sex trafficking and provided a rationale for differentiating the two. The current study's focus is specific to sex work, one defining characteristic being its consensual nature as a chosen profession. Having defined sex trafficking as a separate topic, we now turn to the types of sex work in which professionals may engage.

Types of Sex Work

Understanding what sex work is, and what it is not, is vital in being able to comprehend the nuances within. As the definition of sex work indicates, there are a great deal of professions, or types of work, that fall under the category of sex work. One of the most obvious and historically tied to the term *sex work* is prostitution (Allman & Ditmore, 2016; Ditmore, 2006, 2011). As previously mentioned, prostitution has historically been assumed to be the sole definition of sex work (Ditmore, 2006); however, prostitution is a specific type of sex work in which an individual engages in agreed upon physical, sexual relations with other individual(s) for monetary value or goods (Ditmore, 2006). In other words, prostitution required physical contact between patrons and the individual in sex work.

Other professions include stripping and exotic dancing. These professions include dancing or moving either on a stage, within a club (e.g., gentlemen's club, strip club), private party, or private room. These two professions are often seen as the same, however, some would argue that stripping reinforces derogatory connotations of the profession whereas exotic dancing is believed to command more respect with the focus being on the act of dancing rather than taking off clothes (Ditmore, 2016). Unlike prostitution, neither physical contact nor physical, sexual relations are inherent in exotic dancing. Individuals who engage in exotic dancing dance in seductive clothing (e.g. fishnet stockings, lace or sheer gowns) or remove their clothing while

they dance (Ditmore, 2016). Patrons observe the dancers and often provide financial compensation for their performance via tips.

Escorting is another form of sex work in which an individual may accompany a client for an evening. Typically, this is done through an escort service, although some escorts, or “call girls,” work independently (Ditmore, 2016). This role does not inherently involve sexual or erotic responses, as some escorts solely provide companionship and conversation. However, others may include sexual services or services that target sexual or erotic responses as part of their available services in escorting (Ditmore, 2016) so not all individuals who escort are considered individuals in sex work. It is the individuals that include sexual services or services that target sexual or erotic responses in their escorting business that are included in the definition of sex work.

Camming, or being a cam (shortened for web camera) model, is another form of sex work that has recently gained more traction with the increase in interest and accessibility of technology (Jones, 2020). Camming has been equated to “virtual peep shows” (Ditmore, 2016; Jones, 2020) as it is when individuals, or Cam Models, perform various acts on a webcam that is livestreamed to an audience of internet viewers in an effort to incite an erotic or sexual response from the individuals in the audience (Ditmore, 2016). This position removes the physical proximity other individuals in sex work share with their clients and is most closely aligned with the porn industry.

Porn and the porn industry do fit under the definition of sex work. However, porn, those involved in porn, and the production of porn are all considered to be a part of an industry (Ditmore, 2016). The industrial inclusion of porn is important to note as we consider the effects of stigma and overall experience of those in sex work. This industrial inclusion points to a higher

level of acceptance or, at the very least, the ability for lobbying safer workplace environments, practices, and wages that other individuals in sex work lack (Ditmore, 2016). Without the power of an industry behind them, other individuals in sex work are unable to unionize or address workplace concerns in a comprehensive way. The porn industry is highly profitable and more powerful in a capitalist society (Ditmore, 2016). Capitalism puts porn and individuals in porn at the pinnacle of the hierarchy of sex work with individuals in prostitution at the nadir (Ditmore, 2006; Rubin, 1992). This is not to say that individuals in porn do not endure stigma associated with sex work, nor does this mean that individuals in porn are not marginalized. However, the focus of this literature review is on those at the nadir of sex work- The fields of sex work that include those at the nadir are those involved in exotic dancing and prostitution. These professionals often work with the least amount of support and are thought to be put at the most risk, lacking the worker benefits that are seen within the porn industry. Sex workers in exotic dancing and prostitution will, therefore, be the participants in this study.

Brief History of Sex work

Sex work has been viewed as the “oldest profession” with evidence stemming from both archaeological discovery and written word documentation in history. Anthropologists have demonstrated that sex work, namely prostitution, has been demonstrated in even primitive society (Ditmore, 2006, 2011). Ancient Egypt and Ancient Greece have also well documented presence of sex work (Ditmore, 2011; 2006). Individuals in sex work, historically referred to as *Courtesans*, were linked to high society and culture until the Middle Ages (Ditmore, 2011; Ditmore, 2006). Their work has been associated with funding the pyramids of Egypt; inspired operas, ballets, Chinese and French literature, while also starring in these great works of art

themselves. Many individuals in sex work were, in fact, regarded as “cultural treasures” due to their contributions and training in music and dance (Ditmore, 2006, p. xxvi).

Influence of Religion and Morality on Sexuality

Global recognition of cultural importance of sex work and its contribution to society drastically shifted during the Middle Ages. At the beginning of the 16th century, both the Renaissance and the Protestant Reformation fueled the condemnation of individuals in sex work (Ditmore, 2011; Ditmore, 2006). As Carr (1995) argues, Western ideas of morality and sex are rooted in religion, leading to a societal emphasis and increased focus on morality, fear of being considered depraved, and religious principles, prompted an increase in condemning promiscuity, sexual interactions, and a specific increase in societal restriction of female autonomy- perceiving moral and proper women to remain close to home, under the ownership and guide of men in society (Ditmore, 2011; Ditmore, 2006). However, government and policy were largely uninvolved until the 19th century (Ditmore, 2011; Ditmore, 2006; Fellows et al., 2020).

Impact of Morality on Policy Surrounding Sexuality

During the 19th century, it was common for cities within the United States to have designated areas for sex work to occur, also known as Red Light Districts (Ditmore, 2006, 2011; Fellows et al., 2020; Smith et al., 2020). However, approaching the turn of the 20th century, the Comstock Act was introduced (Ditmore, 2006, 2011; Fellows et al., 2020; Smith et al., 2020). The Comstock Act was often regarded as the “Chastity Laws” as they limited production of sexual health related educational materials and restricted certain information regarding sexual health to be distributed and taught (Burnette, 2019; Ditmore, 2006, 2011; Fellows et al., 2020). Furthermore, they proclaimed contraceptives as “obscene and illicit,” making it a federal offense to distribute contraceptives even if written as a prescription by a physician (Burnette, 2019;

Ditmore, 2006, 2011; Fellows et al., 2020; Smith et al., 2020). These laws hindered access to contraceptives, disproportionately impacting individuals in sex work given their pressing need for contraceptives comparatively (Ditmore, 2006, 2011; Fellows et al., 2020; Wall, 2005). This limitation on sexual health information and resources was predominantly pushed by conservative Anglo-Saxon individuals throughout the country, especially in leadership roles (Ditmore, 2006, 2011; Fellows et al., 2020; Wall, 2005; Smith, et al., 2020). This rise in power among conservative Anglo-Saxon individuals in the United States ties directly to the hindrance and social out-casting of individuals in sex work.

Bromfield (2016) argued that the condemnation of individuals in sex work largely marked the turn of the 19th century. At the turn of the 19th century, the United States government became involved in sex work policy for the very first time. Many anti-sex work activists connected sex work with social disorder and violence (Brents & Hausbeck, 2005; Ditmore, 2011; Ditmore, 2006; Fellows et al., 2020).

Sex Work's Conflation with Sex Trafficking

Specifically, Anti-sex work activists claimed sex trafficking was an issue of immigration and instilled the notion that sex work was an attack, or forced slavery, of white women by immigrant men (Bromfield, 2016; Ditmore, 2006, 2011; Fellows et al., 2020). Their claims directly ignored that sex work involved choice. Instead, claiming force and or coercion, sex work became synonymous with sex trafficking across the United States. Their claims directly ignored that sex work involved choice. Instead, claiming force and or coercion, sex work became synonymous with sex trafficking across the United States. Thus, women who were engaging in sex work, even if temporarily due to circumstances requiring additional income for their family- a common motivation for sex work at this point in history (Ditmore, 2006, 2011; Fellows et al., 2020;

Smith, et al., 2020)- were viewed as victims to a horrific crime rather than working individuals of their own volition.

The argument put forth by the anti-sex work activists also built on the fear of immigrants that was rampant in the United States at the time (Brents & Hausbeck, 2005; Ditmore, 2006, 2011). Policy pushed to abolish sex trafficking due to its immorality and heinous crimes against women by foreign men (Brents & Hausbeck, 2005; Ditmore, 2006, 2011; Fellows et al., 2020). However, this also meant there was a major push in policy to abolish sex work, given that sex work was viewed under the scope of sex trafficking (Brents & Hausbeck, 2005; Ditmore, 2006, 2011; Fellows et al., 2020). This policy further condemned sex work as immoral and criminal as increased efforts to eliminate sex trafficking as a whole began. By building on this fear and having influence among individuals in power, the anti-sex work movement largely influenced the conservative policies eliminating legal sex work within the United States (Brents & Hausbeck, 2005; Ditmore, 2006, 2011). A further examination of this movement's influence on policy will be addressed in future sections.

Sex Work in the 20th Century

The wars of the 20th century and political damnation of immigration further fueled the fears of United States Citizens as much of the world was seeking refuge due to these wars (Brents & Hausbeck, 2005; Ditmore, 2011; Ditmore, 2006; Fellows et al., 2020). By viewing sex trafficking as an attack on white women by foreign men continued into the 20th century, traction for condemning sex trafficking, and thus, sex work, increased tremendously (Ditmore, 2011; Ditmore, 2006; Fellows et al., 2020). At this time, a new argument also arose- sex work *allowed* for sex trafficking to occur (Brents & Hausbeck, 2005; Ditmore, 2011; Ditmore, 2006; Fellows

et al., 2020). In the continued effort to abolish sex trafficking, repressive laws banning sex work were enacted throughout the United States (Benoit, et al., 2019; Vanwesenbeeck, 2018).

The targeting of sex work as socially damning coincided with the eugenics movement. Individuals in sex work increasingly became a part of the involuntary sterilization occurring at asylums and institutions, given the view that they were seen as socially unfit and immoral (Bretns & Hausbeck, 2005; Ditmore, 2011; Ditmore, 2006; Fellows et al., 2020). Individuals in sex work became increasingly ostracized from society and put at higher risk for violence and abuse to occur as laws forced riskier opportunities to pursue their work.

The damnation of individuals in sex work rose tremendously into the 1980s when the United States was confronted with the HIV and AIDS pandemic (Allman & Ditmore, 2016 Ditmore, 2011; Ditmore, 2006;). During this time, individuals in sex work were viewed as the root of the HIV and AIDS pandemic alongside gay men (Allman & Ditmore, 2016 Ditmore, 2011; Ditmore, 2006;). Given their engagement in *illicit behavior* and potentially having sex with multiple partners, American society viewed individuals in sex work as vehicles for HIV and AIDS rather than being individuals at higher risk for contracting the virus and disease (Allman & Ditmore, 2016; Ditmore, 2011; Ditmore, 2006;). This connotation further drove the notion that individuals in sex work were *diseased* and at the root of others' demise, adding fuel to their stigmatization (Allman & Ditmore, 2016; Ditmore, 2011; Ditmore, 2006; Fellows et al., 2020). It was this very stigmatization that gave rise to the *Culture, Health, & Sexuality* journal as a select few researchers strove to promote research on individuals in health work under a more holistic lens to combat this societal stigma starting in 1999 (Allman & Ditmore, 2016). Further discussion on the stigma experienced by individuals in sex work will be discussed in later sections. However, seeing the rise of holistic research in regard to individuals in sex work is important, as the

humanity of individuals in sex work and disruption of moral damnation in academia has only recently become more common. Discussions related to social and systemic barriers for individuals in sex work in academia are on the rise with an emphasis on demonstrating how societal barriers fuel risk and harm for individuals in sex work (Allman & Ditmore, 2016).

Unfortunately, perceptions of safety and danger have continued to fuel policy currently in the United States while fueling the pariah image of individuals in sex work (Allman & Ditmore, 2016; Brents & Hausbeck, 2005; Ditmore, 2011; Ditmore, 2006; Fellows et al., 2020). Law and policy within the United States will be addressed further in future sections. However, to understand the concerns with legality, it is important to know the different types of sex work to then understand legal nuances pertaining to sex work as a whole.

Sex Work Today

Population Statistics

Accurate demographic statistics of individuals in sex work are difficult to obtain. Unlike other professions in the United States, many forms of sex work are not included in the professions for which the United States Bureau of Labor collects demographic data for, such as exotic dancing and prostitution (U.S. Bureau of Labor Statistics, 2021). Furthermore, the various definitions of sex work further complicate estimations of the number of individuals engaged in sex work (Foundation SCÉLLES, 2016). Difficulty in making population estimations has been largely tied to the lack of research in this area (Allman & Ditmore, 2016; Berg, 2014; Brents & Hausbeck, 2005; McCarthy et al., 2012; Niccolai et al., 2012). A lack of expressed research interest and a dearth of opportunities for funding to investigate this population has made it difficult to understand how many people are within the field of sex work and how they identify

meaning? (Allman & Ditmore, 2016; Berg, 2014; Brents & Hausbeck, 2005; McCarthy et al., 2012; Niccolai et al., 2012).

Attempts to acquire estimates of individuals in sex work have largely relied on arrest reports. However, not all forms of sex work are illegal; this will be discussed further in future sections. The estimates largely refer to individuals in prostitution (Havoscope, 2015; Foundation SCELLES, 2016). However, there is a disproportionate rate at which marginalized individuals and individuals from non-dominant cultures are arrested (Federal Bureau of Investigation, 2017). Therefore, if we are to only rely on arrest reports, demographic information related to individuals in sex work may discuss the higher rates of individuals from non-dominant cultures being involved in sex work when that is not a truly accurate representation of those involved. Estimations from police reports and societal desire to distance white women from sex work, as described previously, has promoted the notion that sex work predominantly involves non-dominant cultures (Doezema, 1998; Harcourt & Donovan, 2005; Sumner, 1847; Roe, 1911). Thus, it is important to note that while the proportion of individuals from non-dominant cultures compared to dominant cultures within sex work is not well established, data do demonstrate that all cultural backgrounds, including race, ethnicity, and socioeconomic status, are represented within the population of individuals in sex work (Benoit et al., 2018; Katsulis et al., 2010). The demographic information regarding individuals in sex work is abysmal and, when estimated, the context of data sampling must be considered (McCarthy et al., 2012; Benoit et al., 2018; Shaver, 2012; Weitzer, 2009).

Additionally, many estimates of individuals in sex work are based on data collection from HIV clinics (Benoit et al., 2012; Shaver, 2012; Weitzer, 2009). This, unfortunately, ties to the stereotype often affiliated with individuals in sex work- that they are all diseased and carry

sexually transmitted infections (STIs) (Benoit et al., 2018; Ditmore, 2011; Ditmore, 2016).

Further discussion on this stereotype and its contribution to the stigma affiliated with individuals in sex work will be discussed in later sections. However, here, it is important to note that STIs, specifically HIV, are not a universal diagnosis among individuals in sex work, nor would attending a clinic be something all individuals in sex work are inclined to do given fear of enacted stigma (Benoit et al., 2018; Biradavolu et al., 2009; Blakenship & Koester, 2002; Mtetwa et al., 2013; Scambler & Paoli, 2008; Spittal et al., 2003).

Thus, it is with an abundance of caution that the following data are provided on the population of individuals in sex work. The National Task Force on Prostitution (2013) suggests around one percent of American women are working in prostitution. The Foundation Scelles (2016) noted that 80 percent of individuals in sex work, namely prostitution, are female. Furthermore, Havoscope reported that over 10 million women are engaged in prostitution worldwide- one million women in the United States- although this number includes those who have been sex trafficked (Havoscope, 2015). Via national arrest records in the United States, over 100,000 women were arrested for crimes of prostitution, pointing to the potential minimum number of individuals in sex work (Sex Workers Education Network, 2013). The predominant reports on women in sex work do not mean that men and nonbinary individuals do not engage in sex work. Rather, less information is known about the proportion of men and nonbinary people engaged in sex work. However, McCarthy and colleagues (2012) have estimated that about 25% of individuals in sex work are men and nonbinary persons. Given this notion, and that of the demographic information indicating that the majority of those involved in sex work appear to be women, the research within the literature review largely portrays this.

Motivations for Sex Work

Many individuals have posed that people are motivated to engage in sex work solely due to desperation, lack of resources, poverty, abandonment, abuse, and discrimination (Farley, 2006; Krumrei-Mancuso, 2017). Reports from the Open Society Foundations (2021) noted while some individuals engage in sex work due to struggles with poverty and need for income, other individuals engage in sex work due to earn better pay and have a more flexible work schedule than other jobs. However, reasons to engage in sex work such as attaining better pay and a flexible work schedule are largely ignored (Farley, 2006; Krumrei-Mancuso, 2017; Open Society Foundations, 2021). There is a disproportionate focus on motivations that may be rooted in trauma or hopelessness. This focus furthers the narrative that individuals in sex work are struggling or had limited options regarding their career choices. This undermines the independent circumstances of individuals in sex work and ignores more positive motivations for engagement in sex work.

The harm of this disproportionate focus has led to individuals in sex work being predominantly thought of as substance users or are poor decision makers, who now have to resort to working in the sex industry (Cwikel, Ilan, & Chudakov, 2003). However, research supports there is no one sole reason for why an individual engages in sex work. In 2003, Cwikel, Ilan, and Chudakov examined the working conditions, reported morbidity, and symptoms of post-traumatic stress syndrome and depression as they relate to an index of occupational health risks among 55 women working in brothels. The researchers utilized structured interviews and an occupational risk scale (unspecified). They found multiple reasons for why the sample of women entered sex work. The main motivation was economic, as many women found working in a brothel to be a way to make consistent money and support themselves as well as their families

(Cwikel, Ilan, & Chudakov, 2003). While some individuals did engage in drug use, their motivation for working in the brothel was not due to a need to support their drug use. Also, none of the individuals in the study reported having a current drug abuse concern. This does not mean that all individuals in sex work are substance free, but it does highlight that there are multiple reasons for why individuals engage in sex work, and that it is likely most individuals do not also have drug abuse concerns.

Seeking economic gain has been reiterated as the main motivating factor for individuals in sex work to engage in sex work (Arnold, et al., 2020; Vanwesenbeek, 2001). This motivation for engaging in sex work was seen as especially true among college level students who engage in sex work, due to the steady increase in tuition fees (Payne et al., 2013; Roberts et al., 2010; Roberts et al., 2013). Among a college student sample of individuals in sex work, Sagar et al. (2016) investigated motivations for sex work. Participants represented multiple professions within sex work (i.e., involved in prostitution, camming, dancing, and escorting). Participants were asked their personal motivations to engage in sex work by ranking the listed motivations provided as important or not important. The list of motivations they could select from included financial reasons (i.e., fund their lifestyle, fund higher education, cover basic living costs, avoid debt, reduce debt), intrinsic reasons (i.e., perceived the work to be enjoyable, curiosity about sex work, wanting to work in the sex industry, sexual pleasure, gain experience and skills, maintain contact working world), practical reasons (i.e., hours suited their class schedule, could not attain another job, friends worked in the industry), and force (i.e., “I felt forced to” – a one item category). Economic considerations, job flexibility, anticipated enjoyment, funding education, and curiosity were the primary motivating factors for individuals to engage in sex work from this study (Sagar et al., 2016). Additionally, the motivators of sexual pleasure and schedule flexibility

were more often endorsed by the students engaged in direct selling of sexual services than those involved in camming and dancing (Sagar et al., 2016). Furthermore, Krumrei-Mancuso (2017) and Rossler et al., (2010) found that 25-40% of women sampled in their own studies engaged in sex work, namely prostitution, because it was fun, exciting, and they enjoyed the work.

Indeed, there are a variety of reasons why an individual in sex work may engage in this trade. With social perception often looking to force, lack of options, poverty, and inability to attain other areas of work, these other factors (i.e., enjoying the work, flexibility in work schedule, higher financial compensation compared to other forms of work, funding education, gaining experience, and comradery) are not as often considered. However, regardless of reason or personal circumstance, the motivator for engaging in sex work that is consistently noted across research is for financial gain (Arnold, et al., 2020; Krumrei-Mancus, 2017; Payne et al., 2013; Roberts et al., 2010; Roberts et al., 2013; Rossler et al., 2010, Sagar et al., 2016; Vanwesenbeek, 2001). Other components such as enjoyment, flexibility of schedule, and funding education are starting to become more recognized, although they are only recently becoming areas of focus in research (Sagar et al., 2016). With that said, the world of research is not alone in having a complex and tumultuous relationship with the sex work community.

Current Laws and Regulations

The United States has had a complex history regarding the regulation and criminalization of sex work. Globally, prostitution and additional forms of sex work were viewed as governable and taxable commercial activities through the Middle Ages (Bromfield, 2016; Lucas, 2005; Shah, 2011). This view was largely held into the colonization of the United States up to the 1800s. However, this view shifted in the United States during the Progressive Era during the 19th century. This era depicted individuals in sex work as victims of sex trafficking for the first time.

Specifically, individuals in sex work were seen as white, rural American women trafficked by Eastern European Jewish individuals, immigrants from China and Italy, and African American men (Harcourt & Donovan, 2005; Joslin, 2002; Sloan & Wahab, 2000; Smolak, 2013). This narrative is described as the “white slave narrative”- promoting the notion that innocent white women were being tricked and imprisoned by men from non-dominant cultures. The white slave narrative was first used by Charles Sumner when he described the discrimination and slavery of Christians throughout the Ottoman Empire (Sumner, 1847). Sumner specifically noted the forced sexual labor of white Christian women in legal brothels within his description of “white slavery” (Sumner, 1847). Christian white women were largely viewed as extensions of the dominant culture both in Europe and in the United States. He tied the forced sexual labor to immorality, directly contradicting the expectations and values of a *good Christian*. Framing white slavery as a threat to Christian values and an infringement upon the power of dominant culture, Sumner attracted the attention of many individuals in power and fueled dominant culture fears. He prompted the idea that there is a direct attack on women who are both white and Christian by those who were not. His narrative associated victimhood with whiteness and Christianity and the oppressor as those from non-dominant cultures. This was a direct threat to the power of the dominant culture both within the United States and Europe. Unsurprisingly, individuals in power in the United States, who all identified as both white and Christian, noted this threat and grew concerned.

This increase in fear is evident in the power that was thrown to “eliminating white slavery” at this time. Clifford Roe, a prosecutor in Chicago, used Sumner’s claim of white slavery and the inherent infringement on the dominant culture of the United States to campaign against forced prostitution and sexual slavery of women in legal Chicago brothels. He reiterated

the message of Sumner, and proclaimed sex work was sinful, an evil put on white people by those less *civilized* (Roe, 1911). This threat to whiteness has largely been described as further evidence of systemic racism within our history because of how society's fear of differences, specifically ethnic and racial differences, became heightened (Addams, 1912; Doezema, 1998; Harcourt & Donovan, 2005). Efforts to abolish white slavery became foundations for political campaigns (Addams, 1912; Doezema, 1998; Harcourt & Donovan, 2005; Sumner, 1847; Roe, 1911).

However, this narrative of white slavery contradicts the voluntary notion of sex work. This movement would have conceivably lost some traction if it did not hold the view that engagement in sex work was forced. Additionally, Sumner catapulted the notion that sex work is immoral because it contradicts the Christian values of sexual conservation (Sumner, 1847). Thus, white women choosing to disregard Christian values and be viewed as sinful would also directly threaten the notions of white superiority. Sex work involving choice became a direct threat to whiteness in the United States.

To rectify this threat and uphold the superiority of whiteness, the “innocent” vs. “fallen” woman narrative emerged (Addams, 1912; Doezema, 1998; Harcourt & Donovan, 2005). The “innocent” vs. “fallen” women narrative establishes that women, largely, are pure in status within the United States although they may become tainted by engaging in sexual labor – voluntarily or not (Bromfield, 2016; Doezema, 1998). However, a woman may regain her innocence, or recover from “falling,” if the engagement in sex work was involuntary (i.e., the woman was trafficked) (Bromfield, 2016; Doezema, 1998). Individuals in power were able to hold onto the idea of white supremacy by claiming victimhood when engagement in sex work was involuntary while dismissing those who engage voluntarily as *exceptions to the rule*. The

“fallen” women narrative provided an opportunity for individuals to view choice in sex work as immoral and the work of bad Christians. However, those who were forced into sex work needed rescuing because they are not to blame for their behavior. In what appears to be an effort of preserving white power within society and Christian values, *restoring* white women and condemning immorality became a major push within policy (Bromfield, 2016; Doezema, 1998).

The notion of restoration of the “innocent” while condemning the “fallen” is most recently evident with the Victims of Trafficking and Violence Protection Act (TVPA) in 2000 (Jackson, 2016). This act both asserted an anti-sex trafficking movement, and that prostitution was responsible for sex trafficking (Jackson, 2016). This blames those who choose sex work as a profession for the victimization and violation of others rather than the traffickers and contributors to the illegal sex trade. Eliminating, or abolishing, both sex work and individuals in sex work actually may be greater opportunity for sex trafficking to flourish in an effort to meet the demand (Benoit et al., 2015; Blakenship & Koester, 2002; Brents & Hausbeck, 2005; Day & Ward, 2007; Dewey & St. Germain, 2014). When sex work becomes harder to achieve, while the demand is still intact, the possibility for illegal, and even violent, means to fulfill the demand remains (Benoit et al., 2015; Day & Ward, 2007; Shaver, 2012). There is the argument that criminalizing or abolishing sex work would temporarily reduce sex work activity; however, it has also shown to drive sex work activity into covert forms. Thus, the ability for sex trafficking to flourish is enhanced (Benoit et al., 2015; Blakenship & Koester, 2002; Brents & Hausbeck, 2005; Day & Ward, 2007; Dewey & St. Germain, 2014; Shaver, 2012).

Additionally, TVPA perpetuates the idea that those who are victimized can be saved while others (i.e., those who choose sex work) are criminals (Gerasi, 2015). Under TVPA, an individual engaging in sex work has the option of either identifying a trafficker who coerced

them into sex work, or they will be arrested for prostitution (Gerasi, 2015). There only option is to choose victimization or criminalization. There is no option of freedom without either victimization or criminalization a direct parallel to the “innocent” vs. “fallen” women narrative. TVPA legally marks individuals in sex work as one or the other- innocent or fallen, victim or criminal.

Federal vs. State Laws

The previously described notion of the “fallen” and vilification of individuals in sex work is promoted currently in both state and federal laws. The persecution of individuals in sex work varies by state, with an overarching federal law that views sex work in the form of prostitution as illegal. This next section will summarize both federal and state laws and punishments of individuals in sex work.

As mentioned, there are elements of sex work that are illegal in the United States. At the federal level, exotic dancing is legal whereas prostitution is illegal with both customers and individuals in sex work subject to arrest (Lennon, 2020). For first-time offenses, engaging in prostitution (i.e., individual in sex work, customer or client, manager of individuals in prostitution, owning an establishment where prostitution occurs) is considered a misdemeanor with the potential consequence of imprisonment and/or a fine (Lennon, 2020).

However, as is seen with drug policy, there are discrepancies between federal law and state law. While exotic dancing is federally legal, there are independent state policies regulating the circumstances in which exotic dancing, or dancing establishments, may arise and occur. Regulations for exotic dancing across the states include the amount of space exotic dancing may occupy in an establishment, the areas in which exotic dancing establishments may be placed, the amount and type of clothing that can be removed or must remain on while dancing, the distance

between clientele and dancers throughout the establishment, and the types of contact that can be made between dancers and clientele. However, each state's specific regulations for exotic dancing vary drastically from one another. Similarly, the punishments for breaking these laws and regulations vary across state lines. Thus, providing an in-depth analysis of state policies related to this form of sex work is beyond the scope of this proposal. However, understanding that the laws regarding exotic dancing are complicated and variable is important to note. Understanding the law and regulations for any activity, career, or behavior, is essential to understand what is legal and illegal. With exotic dancing, policy allows for individuals to understand their rights and responsibilities as patrons, law enforcement officials, and dancers. However, rights and responsibilities, what is legal vs. illegal, becomes more difficult to clearly understand the more complex policy becomes. This raises concern for potential violation of rights of dancers. Without understanding of policy, individuals may be violated, or violate, others. Specifically, it may be difficult for dancers to understand what their rights are, for patrons to understand when they violate those rights, and for law enforcement to uphold appropriate policy and consequences when rights are violated. This is a potential risk of the complex policies surrounding exotic dancing.

However, prostitution policy appears slightly more streamlined than exotic dancing. While most states fully criminalize prostitution, meaning that all persons involved in the sale of sexual activity are subject to prosecution, there are ten counties in Nevada where prostitution is legalized, meaning engaging in prostitution is considered legal when following specific regulations (Britannica Group, 2020; Lennon, 2020). However, there are further regulations limiting the ways in which individuals may legally engage in prostitution. In order to engage lawfully, individuals in prostitution must work within a "licensed house of prostitution," also

known as a brothel (Lennon, 2020; NRS 201.354). Brothels have often been argued to provide the best option for individuals to conduct their sex work when considering safety and hygiene (Bell, 1994; Best, 1998; Brentz & Hausbeck, 2005; Gilfoyle, 1992; Walkowitz, 1980). Brothels have regulations they follow to ensure safe and hygienic grounds for individuals in sex work to engage in their work. Furthermore, it provides a designated workplace for patrons to enter, giving ownership of the space to the individual in sex work (Bell, 1994; Best, 1998; Brentz & Hausbeck, 2005; Gilfoyle, 1992; Walkowitz, 1980). However, a license can be obtained only if the building is within a county of fewer than 700,000 people [NRS 244.345] and if the building passes an investigation by the county's license board (NRS 201.354; Lennon, 2020).

Additionally, Nevada state law requires individuals who legally engage in prostitution to use condoms [NAC 441A.805] and be tested for sexually transmitted diseases (STDs) weekly including a monthly HIV test [NAC 441A.800]. The legalization of sex work, namely prostitution allows for policies and laws to enforce the safety and health of individuals in sex work. This combination of decriminalization and, to a further extent, legalization of sex work and health policy for individuals in sex work is congruent with other countries such as: where either decriminalization or legalization occur (Krumrei-Mancuso, 2017).

While congruent with other countries globally, Nevada's state laws surrounding prostitution largely differ from the remaining 49 states. Penalties for prostitution, whether an individual engages in sex work or is a customer, are categorized as misdemeanors for first-time offenders (Britannica Group, 2020). While specific punishment differs in each state, 39 of the 50 states provide equal punishment for the individual in sex work and the customer (Britannica Group, 2020). However, nine states provide harsher punishment for the customer where two states have harsher penalties (i.e., fines and imprisonment) for the individual in sex work. The

two states with harsher penalties for the individual in sex work are Delaware and Minnesota. There penalties will be discussed and are illustrated in Table 1 below. In Delaware, the customer can receive a maximum of 30 days imprisonment and a \$500 fine, where the individual in sex work can receive a maximum of 6 months imprisonment and a \$1,150 fine. In Minnesota, the first offense for a customer can result in a minimum of \$500 fine and/or community service. A second offense for a customer may result in a minimum of \$1,500 and 20 hours of community service. However, an individual in sex work has more severe punishment across offenses. In Minnesota, the first offense for an individual in sex work can receive up to 90 days imprisonment and/or a fine up to \$1,000. The second offense of an individual in sex work can result in up to one year imprisonment and/or up to a \$3,000 fine (Britannica Group, 2020).

Table 1
Sex Work Penalties in Delaware and Minnesota

	Delaware	Minnesota
Patrons' First Offense	30-day imprisonment; \$500 fine	\$500 fine; community service
Patrons' Second Offense	30-day imprisonment; \$500 fine	\$1,500 fine & 20 hours of community service
Individuals in sex work First Offense	6 months imprisonment; \$1,150 fine	90 days imprisonment; \$1,000 fine
Individuals in sex work Second Offense	6 months imprisonment; \$1,150 fine	One year imprisonment; \$3,000 fine

Note. This table was created using the information provided above for clarity.

The laws surrounding sex work vary widely by state. The intricacies of law by state are complex and difficult to understand by pulling from available resources. The difficulty in finding policy for someone trained in acquiring information points to the potential difficulty for other individuals without this privilege and training (e.g., some individuals in sex work, some police personnel) to both find and understand the regulations surrounding sex work, opening a window of further vulnerability for individuals in sex work as iterated previously when discussing the complex policies about exotic dancing. Having an understanding about policy, and acknowledging its complexity, is imperative to understand the legal layer involved in sex work. The influence legal policy has on the stigma associated with individuals in sex work will be explored further in this next section.

Stigma

Stigma derives from socially given judgements put onto a person that marks or separates them from others (Goffman, 1963). These markings may derive from a piece of someone's identity (e.g., race, religion, ethnicity, profession), but often permeate all avenues of an individual's life, discrediting them or tainting them in the process (Benoit, Jansson, Smith, & Flagg, 2018). Link and Phelan (2001) put forth five elements of stigma: Labeling, Stereotyping, Separation, Status Loss, and Discrimination within the context of Power Differential. Labeling refers to distinguishing and highlighting differences (i.e., red apple vs. green apple, apple vs. orange, able bodied vs. disabled, individual in sex work vs. victim of sex trafficking) (Link & Phelan, 2001). Stereotyping is assigning negative connotations to those highlighted differences (i.e., individuals in sex work are immoral, dirty, poor decision makers, have substance use disorders) (Link & Phelan, 2001). Status Loss and Discrimination are when the stigma associated with individuals prevents them from being able to contribute and engage in both the social and

economic life of their community (i.e., excluded from social gatherings, both private and public clubs, organizations, being denied resources, establishing a business, etc. due to stigma associated with an individual) (Green et al., 2005; Link & Phelan, 2001). The power differential refers to having interactions between individuals with the stigma and those without the stigma associated. Those with the stigma do not have the social support and additional benefits of those who do not have the stigma. Stigmatized individuals do not have the same level of power as those without the stigma when interacting with one another (Green et al., 2005; Link & Phelan, 2001).

Across a variety of stigmatized groups, research has demonstrated the negative impact of stigma. Specifically, when an individual internalizes stigma, or begins to view themselves in the biased ways the dominant culture does, they experience lower levels of self-worth, efficacy, and self-esteem compared to individuals who do not endure the same stigma (Chronister et al., 2013; Livingston & Boyd, 2010). Research also supports the notion that stigma has negative impacts on one's self-concept and identity formation, is negatively associated with quality-of-life measures, and negatively impacts both physical and mental health (Green et al., 2005; Goldberg, 2021; Turan et al., 2019).

In 2005, Green and colleagues examined the impact of stigma amongst individuals with disabilities. They analyzed the data for themes resembling stigma (i.e., labeling, stereotyping, separation, status loss, and discrimination) from 15 individuals whose lives had been impacted by disability. They found that individuals endorsed negative psychosocial impacts of stigma (i.e., quality of life, self-efficacy; Green et al., 2005). These findings were paralleled in a study looking to address the impact of stigma for individuals with spinal cord injuries (Monden et al., 2021). Among 225 participants with spinal cord injuries, experiencing stigma was negatively

associated with quality of life and self-efficacy, and was positively associated with symptoms of depression, perception of their disability, and engagement in abilities (i.e., mobility and physical independence) (Monden et al., 2021).

Stigma, and the differential treatment imbedded in it, has been found to have an impact on individuals' biological, social, and psychological functioning (Chronister et al., 2013; Goldberg, 2021; Green et al., 2005; Livingston & Boyd, 2010; Monden et al., 2021; Turan et al., 2019). However, as previously mentioned, there are multiple stigmatized groups within the United States. While each group may be stigmatized given distinguished differences from the majority of society, their lived experiences, interactions with society, and stereotypes differ substantially (Link & Phelan, 2001). General research on stigma does not provide enough context to the experiences of individuals in sex work and the stigma associated with them.

Whore Stigma

Individuals in sex work experience stigma and the name for stigma placed on these individuals is often called "whore stigma" (Benoit, 2020). The word *whore* has been defined as "indulging in unlawful or immoral sexual intercourse; lacking in purity, virginity, decency, restraint, and simplicity; defiled," (Pheterson, 1996, p. 94). The phrase purposefully uses the derogatory word "whore" because it is often associated with individuals in sex work. This term, unfortunately, is also used in the media, policies, and by health care professionals (Benoit et al., 2018; Benoit, 2020). Thus, for individuals in sex work, there are multiple levels of society reinforcing the stigma they carry. The stigma signifies that individuals in sex work are the deviant other- that they are a problematic element to society (Rayson & Alba, 2019). The marks of *whore stigma* include viewing individuals in sex work as dirty, immoral, vectors of disease, traumatized, deviant, inept, mentally unstable, drug-dependent, and even inviting their own

demise (Anesu et al., 2019; Bodenhausen & Richeson, 2010; Benoit, 2020; Brody et al., 2005; Carr, 1995; Ditmore, 2016; Rayson & Alba, 2019). On the whole, United States society stigmatizes the profession to this day. The impact of this stigmatization results in increased dangerous consequences for those who engage in sex work. For example, statistics show cis-gender females in sex work are anywhere from 12 to 120 times more likely to be murdered than cis-gender females in the general population (Lowman & Fraser, 1995; Potterat et al., 2004; Ward et al., 1999).

Impact of Whore Stigma

Unsurprisingly, many individuals in sex work keep their work a secret. However, the consistent energy necessary to keep this secret, compounded with the anxiety and fear of being discovered as an individual in sex work, has shown to be emotionally taxing for many individuals in sex work (Koken, 2012; Sanders, 2004).

Koken (2012) investigated the tendencies of individuals in sex work, specifically escorting, to disclose their work to their support networks, how they receive social support, and how individuals in sex work minimize their exposure to and impact of stigma. Thirty women engaged in semi-structured interviews addressing these areas of interest. They then completed a brief questionnaire to gather demographic information and their access to health care, housing, counseling, and legal services. From their data analysis, four major themes arose: *Fear of being identified as a prostitute, living in the closet, selective disclosure, and coming out as a sex worker.*

Fear of being identified as a prostitute largely influenced the behavior of the participants. Many women noted they were concerned about being revealed as an individual in sex work when they spent money specifically (Koken, 2012). They noted concern that their additional

identities and stigma associated with them (i.e., gender, race, economic status), would lead others to question how they made money if others were to see them in possession of money (Koken, 2012). They feared the compounding stigma of their additional identities and financial gains from sex work would be enough for others to identify them as individuals in sex work despite them keeping their work a secret (Koken, 2012). There was a consensus that higher pay compared to other jobs was a main motivator to engage in sex work; having more financial means than may be expected of them felt threatening to the secrecy of their involvement in sex work (Koken, 2012). Due to this, many women would limit their spending for fear of their work being exposed (Koken, 2012). The participants also reported that exposure as an individual in sex work may hinder their ability to attain additional work (Koken, 2012). They expressed concern that other places of work would not want to hire them if the other places became aware of their sex work due to the stigma associated with it (Koken, 2012). Participants restricted spending behavior and put forth a great deal of effort to conceal their sex work (Koken, 2012).

For many, this secret has led to living what is often referred to as a *double life* (Koken, 2012). Additional research supports this same notion that many individuals in sex work feel compelled to lie about their involvement in sex work, occupy multiple jobs, and separate their life where they are involved in sex work from their life in which they enjoy their friends, family, and social events (Benoit et al., 2017). This separation and consistent hypervigilance some individuals in sex work engage in has shown to increase their social isolation- a marked risk factor for loneliness and symptoms related to depression (Koken, 2012).

The women also endorsed engaging in separation and pushing themselves away from others due to fear of anticipated stigma. In an effort to avoid the potential harm from stigma, individuals would not be open about their work and would close themselves off from support

systems to avoid revealing their work. They were found to engage in avoidance coping- closing off opportunities for support due to fear of enduring stigma by said support. This was done in an effort to protect them from the harms that come from a loss of social status affiliated with being stigmatized (Koken, 2012; Link & Phelan, 2001). The desire to avoid judgement and loss limited individuals' abilities to be open and honest with people in their lives (Koken, 2012). By feeling this need to live in the closet, implementing selective disclosure, and avoiding coming out as a sex worker, individuals in sex work feel compelled to sacrifice social connection and potential access to resources. However, the results from this study also indicated complex results about coming out as an individual in sex work.

Having a select few individuals to be open with about their work yielded mixed results. Some women endorsed feeling safe being able to speak to the select few about their work, while others endorsed having individuals attempt to persuade them to stop or treat them differently when they disclosed (i.e., enacting stigma) (Koken, 2012). Lastly, very few women endorsed being completely open with their social networks about their work. While one woman endorsed feeling liberated and having a positive experience being open about her work, she noted an active effort is required to resist stigma and continue exposure to others' reactions. She identified that her feeling liberated does not exempt her from other's discrimination of her nor does it rid her of the necessity to protect herself against the dangers that stigma poses (Koken, 2012). Despite this, the few women in this study who did endorse being open and honest about their work with others not their openness helped prevent feelings of burnout and internal distress. These feelings of burnout and internal distress were diminished because these women no longer needed to question how their support networks would react to their involvement in sex work. They found relief in being open because it allowed them to know exactly how their support networks would react to

their involvement- they no longer needed to wrestle with how they could react because they witnessed how they did react (Koken, 2012).

Furthermore, the intensity of *whore stigma* has been linked to “burn-out” among individuals in sex work. Vanwesenbeeck (2005) found individuals in sex work are prone to *burn-out* due to the emotional labor involved in sex work. Vanwesenbeeck (2005) found that individuals in sex work often attend to the emotional needs of their patrons- providing emotional support, validation, and care. Other research has echoed this finding given the need for individuals in sex work to navigate their own emotions and those of their patrons while working (Hochschild, 1983; Shumka & Benoit, 2018). As often discussed in the mental health realm, providing emotional support to individuals can influence our own emotional states. It is imperative that individuals providing emotional support address the ways in which they may be impacted. If the impact of providing emotional support is not addressed, the result for individuals in sex work, specifically, is similar to what we see among mental health professionals: emotional exhaustion as well as depersonalization (Morris & Feldman, 1996; Vanwesenbeeck, 2005). The health of individuals in sex work is linked to the health of their clients; sex workers are also at risk of physical exhaustion given the physical nature of sex work (Morris & Feldman, 1996; Patterson et al., 2009; Vanwesenbeeck, 2005). Individuals in sex work are at risk of both mind and body exhaustion if their needs are not addressed. Furthermore, the highest rates of *burn-out* are associated with individuals in sex work who experience significant stigma and stigma-related experiences (i.e., negative reactions related to their work from family, friends, and the general public, experiencing role conflict, enduring violence, and lacking worker-supportive organizational context) (Vanwesenbeeck, 2005). Thus, individuals in sex work are faced with

multiple components of their work that influence potential exhaustion and burn-out on both physically and mentally.

Health and Wellness of Individuals in Sex Work

It should be stressed that despite these risks (i.e., exhaustion, burn-out, violence), many view themselves to be in excellent health- both physically and mentally (Raphael, 2004). A trend throughout the literature regarding health-related concerns among individuals in sex work is, much like the general population, varied (Raphael, 2004). Mental health implications, specifically, may differ in accordance with degrees of freedom, exposure to violence, economic and social conditions, which are all influenced by sociocultural and legal contexts where sex work occurs (Krumrei-Mancuso, 2017). Furthermore, reflecting the reality of the general population, individuals in sex work are subjected to genetic inheritance, lifestyle, and social determinants of health (Raphael, 2004). Raphael notes these components “shape the health of individuals, communities, and jurisdictions as a whole. Social determinants of health [...] are about the quantity and quality of a variety of resources that a society makes available to its members,” (Raphael, 2004, p. 2). Many potential health concerns for individuals in sex work are not necessarily in their control, as is the case with the general population, so it is important to explore the resources open to individuals in sex work, such as mental health care, physical health care, and the judicial system, combined with an individuals’ access to said services to further understand potential health concerns and barriers to care if any.

Mental Health of Individuals in Sex Work

Individuals in sex work are at increased risk for serious consequences if they were to disclose their profession to others, which results in many individuals keeping their engagement in sex work secretive (Koken, 2012; Lowman & Fraser, 1995; Potterat et al., 2004; Ward et al.,

1999). However, this coping behavior of keeping their work secretive also comes with substantial risks such as negative impacts to their own health and lack of engagement in social services (Koken, 2012). This is not to blame individuals in sex work for their coping behavior. Rather, it is important to understand why this coping strategy is necessary and how their interactions with stigma across professional fields may perpetuate the imbalance of power and risks to their overall health and safety.

Assumptions by Mental Health Professionals

Individuals in sex work are at high risk for enduring violence while at work (Church, et al., 2001; Lowman & Fraser, 1995; Potterat et al., 2004; Ward et al., 1999). However, there is another side to the stigma placed on individuals in sex work. If an individual is in sex work, it is often perceived that they have a history of trauma prior to engaging in sex work or have even been sex trafficked (Ross, Anderson, Heber, & Norton, 1990; Jackson, 2016). A great deal of research has looked to examine the amount of trauma experienced by those in sex work; however, they often do not distinguish between those who have been sex trafficked and individuals in sex work (Cwikel, Ilan, & Chudakov, 2003; Jackson, 2016; Krumeri-Mancuso, 2017). Without this distinction, it is possible that the rates of trauma experienced by individuals in sex work are over reported given the nature of sex trafficking. Sex trafficking, as previously described, is a human rights violation. Conflating sex trafficking and sex work assumes shared experiences by those who choose to engage in sex work and those who are victims of human rights violations. Associating the trauma experiences from human rights violations under the scope of sex work does not provide a clear understanding of trauma experienced by those in sex work. This is not to discredit any report of experienced trauma by an individual in sex work, but

more so to highlight that claiming research indicates individuals in sex work have extensive trauma histories is flawed and does not accurately depict individuals in sex work.

Influence of Bias in Mental Health Literature

This issue is represented in a study conducted by Farley and colleagues (1998) who sought to address the debate if prostitution is “just a job” or “a violation of human rights” (Farley, et al., 1998). All researchers endorsed believing prostitution is “an act of violence against women” and proceeded to interview 475 individuals in five countries who were “currently or recently prostituted,” (Farley, et al., 1998). Researchers conducted structured interviews and used a 23-item response questionnaire regarding physical and sexual assault while in prostitution, lifetime history of physical and sexual violence, and creating pornography while in prostitution. Psychometric properties of the item response questionnaire were not provided. Participants also completed the PTSD Check List (PCL; Weathers et al., 199). Research on the PCL’s psychometric properties indicates a wide range of values for item correlations ($\alpha = 0.386-0.788$; Blanchard et al., 1996) demonstrating some weakness within the internal consistency of the measure. However, the PCL rendered strong concurrent validity when compared to the Clinician Administered PTSD Scale (CAPS; 0.929 correlation value; Blanchard et al., 1996). Questions regarding physical health, substance use, homelessness, and needs for escaping prostitution were assessed. Researchers concluded that violence and psychological trauma were inherently a part of prostitution with 73% of participants reporting physical assault in prostitution, 62% of participants reported rape while in prostitution, 67% of participants met criteria for PTSD, and 92% of participants wanted to leave prostitution (Farley, et al., 1998).

This study has been critiqued substantially due to its inherent bias and methodological flaws (Ditmore, 2011). Further criticisms of this article include using data from qualitative

research to generalize across all individuals in sex work when qualitative data is not supposed generalized. Rather, qualitative data is to be viewed within the specific context of the research. Additionally, the researchers approached each interview as an opportunity to save individuals in sex work as they, “shared a commitment to the project of documenting the experiences of women in prostitution, and to providing options for escape,” (Farley, et al., 1998, p. 410). Researchers also credited lower reported rates of childhood sexual abuse among participants to lack of rapport between interviewee and interviewer and the difficult nature in discussing this topic (Farley et al., 1998). Additionally, researchers concluded that those in prostitution had PTSD via two scores from the PCL (Weathers et al., 1993). Ethical standards for diagnosing individuals include the need for variable sources of information rather than a sole checklist. To that individuals possess a diagnosis without further investigation or assessment is unethical (American Psychological Association, 2017). Additionally, the PCL was not normed on populations outside of the United States. However, the researchers had the checklist translated and applied the PCL to all individuals across the five countries sampled (Farley, et al., 1998) contributing to severe methodological flaws to this study.

The authors also perpetuate the narrative of bias that individuals in sex work, namely prostitution, have a history of childhood sexual abuse. The authors state this without citing empirical evidence. Farley et al., continues on and state, “Since almost all prostituted women have histories of childhood sexual abuse, this undoubtedly contributes to their current symptoms of post-traumatic stress,” (Farley et al., 1998, p. 408). Once again, the authors do not cite or reference any empirical evidence for this claim. Furthermore, these statements demonstrate continued conflation of sex trafficking and sex work as they use prostitution in verb form- demonstrating an action being done to someone rather than a choice an individual makes. Their

statements also note their tendency to view all individuals in sex work as sharing the same experiences as they generalize all individuals in sex work to experience post-traumatic stress (Farley et al., 1998).

While the criticisms of this study are vast, it is not unique in its assumptions made. While it is not appropriate to assume causality, it is important to address the influence biased literature, such as this study, has had on the view of individuals in sex work among mental health professionals. Near publication of this study and additional flawed literature, individuals in sex work remarked on the increase in mental health professionals looking to diagnose them with PTSD (Ditmore, 2011). Researchers in the study claimed their findings indicated “psychological trauma is intrinsic to the act of prostitution,” (Farley et al., 1998, p. 419). Unfortunately, similar bold claims have been published despite glaring flaws. An overall over-diagnosis of PTSD has since been noted as an integral piece in pathologizing sex work, despite individuals in sex work looking to address other concerns unrelated to their job and experiences therein (Ditmore, 2011).

Another example of biased mental health literature is demonstrated by Brody et al. (2005). Brody et al. (2005) took data from a previous study that assessed the causes of death of 1,969 women over a 30-year period. The purpose of this study was to link personality and psychopathological characteristic to the mortality rates among women in prostitution. However, the article was conceptual rather than empirical. The researchers attempted to use the previous data as a way to leverage their claims. The researchers argued that women in prostitution often invite their own death or murder due to the personality characteristics they possess. The researchers believed the notion that an individual attracts like-minded individuals, and the women in prostitution are interacting with individuals that are similar to themselves. If women in prostitution were getting murdered or dying at higher rates than the average woman, it must be,

they argue, because the women are hanging around with individuals that are dangerous or more inclined to antisocial personality disorder.

Brody and his colleagues go on to connote women in prostitution exhibit behavior that is diagnosable for antisocial and borderline personality disorder. However, Brody and his colleagues fail to provide any evidence for their claims. Rather, Brody and his colleagues assert that the women were dangerous, erratic, and exhibited behavior aligned with antisocial and borderline personality disorder solely because some women died in violent ways (i.e., homicide). The researchers defend this argument by claiming individuals engage with people similar to themselves and invite harm onto them (Brody et al., 2005). No other evidence is provided. The researchers did not interview the women before their death to understand them as individuals, know what their behavior was, or what their experiences were in day-to-day life.

While studies have shown individuals in sex work have higher rates of mortality and experiences of workplace violence than individuals not engaged in sex work, there have not been any studies to suggest the individuals in sex work invite this behavior (Cwikel, Ilan, Chudakov, 2003; Krumeri-Mancuso, 2017). Rather, biased research that promotes this notion actually may reinforce individuals' beliefs that they can be degrading and cruel toward individuals in sex work (Jackson, 2016; Krumeri-Mancuso, 2017; Anesu, Calvin, Agnes, Johanna, Prudence, Koketso, Namoonga, Frank, Ilonga, & Winnie, 2019; Anasti, 2020).

The research described illustrates the ethical limitations in studies that have been conducted regarding mental health concerns of individuals in sex work. Biased literature is dominating our understanding of the mental health concerns for individuals in sex work. This domination hinders helping professionals' abilities to turn to research to accurately understand trends for this population. Thus, the quality of services, care, and potential help-seeking

behaviors of individuals in sex work are impacted. However, a search of the literature regarding mental health and sex workers does yield a limited example of research that strives to be unbiased against this population.

Unbiased Research within Mental Health

In an effort to combat the biased literature as presented previously and influence the field of psychology in a way that is more holistic and inclusive of individuals in sex work, some researchers have sought to understand the mental health concerns of those involved in sex work.

Krumrei-Mancuso (2017) examined the mental health correlates of prostitution in the Netherlands- a country that has legalized this form of sex work. Additionally, the researcher looked to provide information about how levels of depression and post-traumatic stress relate to various characteristics of prostitution and quality-of-life factors. This was done by utilizing the Brief Personal Meaning Profile (PMP-B; Wong, 1998) for quality-of-life factors, 10-item Center for Epidemiologic Studies Depression Scale (CES-D10; Radloff, 1977) for depressive symptoms experienced in the past week, and 17 of the 22-item Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997) to assess post-traumatic stress experienced. Psychometric properties of the PMP-B have demonstrated strong internal consistency reliability (0.957), split-half reliability (0.936), and test-retest reliability (0.852; Xiao & Lai, 2018). Psychometric properties of the CES-D10 demonstrate acceptable internal consistency across samples ($\alpha = 0.69-0.89$), and adequate concurrent validity, when compared to the PHQ-9 and WHODAS (Baron et al., 2017). Lastly, evaluations of the psychometric properties of the IES-R indicate adequate internal consistency for each subscale ($\alpha = 0.71-0.86$) and adequate concurrent and discriminant validity ($\alpha = 0.59-0.84$; Beck et al., 2008). By implementing these measures, Krumrei-Mancuso (2017) found when self-acceptance was low, desire to leave prostitution was high as was post-traumatic stress. When

self-acceptance was high, desire to leave prostitution was low as was post-traumatic stress experienced.

Additionally, the researcher found those who engage in sex work in a combination of places, including outdoors, experience more post-traumatic stress while those who engaged in prostitution for financial reasons only exhibited significant levels of depression (53.49% of the sample scoring at or above the cutoff). This further informs when individuals in sex work may be at higher risk for post-traumatic stress and depression rather than continue to generalize mental health concerns across all forms of sex work. Furthermore, the researcher found participants who experienced violence reported significantly higher levels of intrusion symptoms than those who had not. Additionally, a focus on achievement and sense of fair treatment in life predicted fewer depressive symptoms, self-transcendence predicted more depressive symptoms, and self-acceptance predicted less post-traumatic stress. However, the findings of this study should be considered with caution given the weak alpha of the self-acceptance scale to begin with ($\alpha=.55$).

PTSD is present within the population of individuals in sex work; however, it is not a ubiquitous diagnosis nor is it the only presented concern. As the previous study indicates, depression is experienced within the population at varying degrees (Krumrei-Mancuso, 2017). Indeed, additional research have noted the presence of symptoms related to depression, anxiety, psychosis, and eating disorders by individuals in sex work (Day & Ward, 2007; Sanders, 2004).

Impact of Stigma on Help Seeking Behaviors and Accessing Resources for Mental Health

The difference presented between common diagnoses given by mental health professionals and the presenting concerns of individuals in sex work raises ethical concerns for effective treatment, quality of care, and risk of harm to individuals in sex work (American

Psychological Association, 2017). This is not to say that mental health professionals and clients will always agree on diagnoses, rather that there is a clear demonstration of bias historically addressed within the mental health field regarding clients in sex work (Cwikel, Ilan, Chudakov, 2003; Ditmore, 2011; Jackson, 2016; Krumrei-Mancuso, 2017; Zehnder, 2019). Indeed, research has demonstrated that mental health professionals are enacting bias and negatively impacting the mental health of individuals in sex work by using their own assumptions about sex rather than data from their clients to influence the focus and care they provide to individuals in sex work (Geymonat et al., 2017; Koken, 2012; Rayson & Alba, 2019; Zehnder et al., 2019).

In an attempt to further understand the direct relationship between mental health professionals, whore stigma, and individuals in sex work, Zehnder et al. (2019) conducted a study examining predictors of utilizing mental health services by individuals in sex work. The sample consisted of 60 female sex workers in Switzerland recruited through an information center located within the Red-Light district in Zurich. The Red-Light district is a designated zone within a city or town that has brothels, sex shows, and/or erotic oriented venues (Martin, 2021). The information center itself offers numerous services to individuals in sex work, including legal assistance and health and prevention resources. Each participant completed the Barriers to Access to Care Evaluation scale (BACE) (Clement et al., 2012). The BACE is a 30-item questionnaire that assesses stigma-related (e.g., feeling embarrassed or ashamed) and non-stigma related barriers (e.g., appointments are inconvenient/take too much time) to care (Clement et al., 2012) with acceptable test-retest reliability and good internal consistency (weighted kappa values from 0.61 to 0.80; treatment stigma subscale: $\rho = 0.816$ and Chronbach's $\alpha = 0.89$; Clement et al., 2021). Additionally, the treatment stigma subscale has both strong convergent and construct validity. A significant positive correlation between the BACE treatment stigma

subscale and the SSRPH was supported ($r = 0.30$, $p = 0.001$), as was the relationship between the BACE treatment stigma subscale and the Internalised Stigma of Mental Illness Scale ($r = 0.40$, $p < 0.001$; Clement et al., 2012). The researchers also had individuals complete two subscales from the Self-Appraisal of Illness Questionnaire- a six-item Perceived Need for Treatment subscale and a four-item Presence of Illness subscale. Participants also completed a measure assessing their use of mental health services (i.e., if services were utilized, the duration of treatment, and the form of treatment utilized in the past six months). The final two measures utilized assessed psychopathology- the Symptom Check List-Revised (Derogatis, 1992) and the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998). Research on the psychometric properties of the Symptom Check List-Revised indicate strong reliability with a Cronbach's alpha score ranging from 0.81 to 0.98 and factorial validity being acceptable according to the parameters set by RMSEA (< 0.06 and CFI, TLI > 0.95 ; Sereda & Dembitskyi, 2016). Research on the psychometric properties for the MINI have yielded rates as high as 95% sensitivity and 84% specificity to diagnose and grade the severity of depression (Pettersson et al., 2015). This is considered an acceptable measure with strong sensitivity and specificity.

The combination of these questionnaires allowed for a comprehensive look at participants' perceptions of their need for care, what their experiences of care have been, and the current state of their mental health. Results from these questionnaires showed that the majority of the sample (67%) had not utilized mental health care in the past six months. Among participants with at least one psychiatric diagnosis, the majority of them (56%) had not utilized mental health care for the past six months.

To understand why this may be the case, Zehnder et al., (2019) conducted a multiple logistic regression that adjusted for symptoms. The results demonstrated a connection between

the enacted bias by mental health professionals on individuals in sex work's tendency to attain services. They found that use of mental health service was predicted by a lower level of stigma-related barriers to care. In other words, the less individuals in sex work were made to feel embarrassed or ashamed while working with mental health professionals, the more likely they were to access services (Zehnder et al., 2019). Additionally, perceived need for treatment, perceived presence of illness, and age also predicted utilization of mental health services.

The relationship between lower level of stigma-related barriers and accessing mental health care is important. These results suggest perceived bias by mental health professionals affects help-seeking for mental health services in sex workers. While mental health and seeking mental health treatment itself is stigmatized, it is important to note that the objective of this research study was to assess the stigma related to the individuals in sex work rather than the stigma of mental health (Zehnder et al., 2019). This is not to say that the stigma of mental health and seeking care are not relevant to individuals in sex work. Rather, these results indicate that the level of sex work stigma-related barriers to care further help predict accessing mental health treatment (Zehnder et al., 2019).

These results were echoed in a similar study conducted by Rayson and Alba in 2019. Rayson and Alba (2019) aimed to assess the levels of stigma and discrimination enacted on individuals in sex work by mental health professionals and how that may impact individuals in sex work's help-seeking behaviors. The sample for their study consisted of 189 individuals in sex work. Each participant completed the Perceived Devaluation and Discrimination Scale (PDD; Link, 1987) which had been adapted for individuals in sex work. Given the adaptation of the PDD it is unclear if the original psychometric properties withstand. Despite this limitation, Participants reported on the frequency of experienced stigma and discrimination from

professionals including mental health professionals, the frequency of seeking mental health support from psychologists and/or psychiatrists, and how their previous experiences of stigma and discrimination from mental health professionals impacted the future likelihood of seeking services from mental health professionals.

From the sample, 64.4% of individuals who engaged with a mental health professional reported that they had either sometimes, often, or always experienced stigma and negative treatment by those professionals because of their profession. Only 22.4% of participants stated they had never experienced stigma or discrimination from mental health professionals, with the remaining portion of the participants stating they had experienced stigma from mental health professionals at least once. Researchers also found that 78.8% of the entire sample, regardless of how often they experienced stigma from mental health professionals, reported they would be very unlikely to seek mental health support in future because of their past experience. This research shows that every opportunity or instance where mental health professionals engage with individuals in sex work matter. If the goal is to provide comprehensive services for those in need and establishing safe spaces to do so, mental health professionals have yet to meet that goal specifically when it comes to individuals in sex work. In fact, it is apparent that mental health practitioners are contributing to the marginalization of individuals in sex work. However, stigma impacting access to resources and quality care is not unique to mental health resources for individuals in sex work.

Coping Strategies in Mental Health

Individuals in sex work are not immune to the stresses of the human experience. As individuals navigate the diverse landscapes of personal and professional challenges, their ability to navigate stressors becomes a critical determinant of mental well-being. Coping strategies, the

adaptive mechanisms individuals employ to manage stress, emerge as focal points in the quest for psychological resilience and balance.

The field of coping research recognizes a fundamental dichotomy between active and passive coping strategies. At the heart of this dichotomy lies the distinction between proactive engagement with stressors and more indirect, emotionally focused responses. Active coping involves direct efforts to address and mitigate stressors, emphasizing problem-solving, seeking social support, efficient time management, and embracing physical exercise (Lazarus & Folkman, 1984). In contrast, passive coping strategies often involve avoidance, distraction, denial, and self-blame, where individuals may employ mechanisms that provide temporary emotional relief without necessarily addressing the underlying issues (Folkman & Moskowitz, 2004; Carver & Connor-Smith, 2010). The significance of coping strategies in maintaining mental well-being cannot be overstated. As individuals navigate the complexities of life, the choices they make in responding to stressors profoundly impact their mental health outcomes. Having a base understanding of active and passive coping strategies, shedding light on the mechanisms that underpin these approaches, is crucial when investigating how individuals in sex work manage their own mental health.

Active Coping Strategies

Active coping, as conceptualized by Lazarus and Folkman (1984), emphasizes the proactive engagement with stressors through problem-solving. This strategic approach involves a systematic assessment of stressors, followed by the identification and implementation of viable solutions. Problem-solving is not merely a cognitive process; it is a dynamic interplay of cognitive and behavioral efforts aimed at addressing the root causes of stressors.

Another cornerstone of active coping is the deliberate seeking of social support. Lazarus and Folkman (1984) underscore the role of interpersonal connections in the coping process. Beyond the emotional catharsis derived from sharing one's feelings, seeking social support provides a practical avenue for garnering advice, resources, and alternative perspectives. The communal nature of social support fosters a sense of belonging and resilience.

Efficient time management is a skillful active coping strategy that transcends the mere organization of tasks. It involves a deliberate allocation of time to activities that promote well-being and contribute to stress reduction. The structured approach to time management advocated by Lazarus and Folkman (1984) empowers individuals to maintain a sense of order in their lives, alleviating the overwhelming impact of stressors.

Physical exercise emerges as a multifaceted active coping mechanism, as highlighted by Lazarus and Folkman (1984). The physiological benefits of exercise are complemented by its profound effects on mood regulation and cognitive function. Regular physical activity becomes a holistic strategy that not only addresses the immediate symptoms of stress but also promotes overall mental health.

Passive Coping Strategies

In contrast to the directness of active coping, passive coping strategies often involve avoidance. Folkman and Moskowitz (2004) note that avoidance is a common response wherein individuals consciously distance themselves from stressors. While avoidance may offer immediate relief by reducing exposure to stressors, it does not contribute to their resolution. The long-term consequences of avoidance may include the perpetuation of distress and missed opportunities for growth.

Distraction, as a passive coping mechanism, manifests as an attempt to redirect attention away from stressors temporarily. While this strategy provides a respite from immediate emotional distress, Folkman and Moskowitz (2004) caution that overreliance on distraction without addressing the root causes of stressors may impede long-term coping efforts.

Denial, the refusal to acknowledge the existence of a stressor, is identified as another passive coping strategy. Folkman and Moskowitz (2004) describe denial as a psychological defense mechanism that shields individuals from the discomfort associated with confronting stressors. However, the downside lies in the potential inhibition of adaptive coping mechanisms and the delayed recognition of reality.

Self-blame, as expounded by Carver and Connor-Smith (2010), involves individuals attributing excessive personal responsibility to themselves for a stressor. This passive coping strategy often leads to heightened feelings of guilt and inadequacy. By internalizing the stressor, individuals may inadvertently exacerbate emotional distress without addressing the root causes.

Integration of Coping Strategies

Research suggests that effective coping is not a dichotomy between active and passive strategies but rather a dynamic integration based on the nature of the stressor (Carver & Connor-Smith, 2010). Striking a balance between active and passive coping approaches emerges as a nuanced and adaptive strategy for comprehensive mental health management. The intricate interplay of these strategies necessitates a personalized approach that recognizes the diversity of individual coping preferences and the unique characteristics of stressors.

This section has provided an intricate examination of active and passive coping strategies in mental health. From problem-solving and seeking social support to avoidance and self-blame, each strategy contributes to the complexity of coping responses. The integration of these

strategies emerges as a key theme, inviting further exploration into the personalized nature of mental health interventions and sheds light on how all individuals, including those in sex work, may navigate the human experience.

Current Understanding of Coping among Individuals in Sex Work

Research on how individuals in sex work utilize coping strategies, both active and passive, is a complex and evolving field. Coping mechanisms in sex work often arise as responses to the multifaceted challenges associated with the profession. Understanding these strategies is crucial for developing support systems and interventions. A discussion of the literature exploring how individuals in sex work employ both passive and active coping strategies can help us understand how providers might facilitate healthy coping among this population.

Active Coping Strategies

One of the keyways individuals in sex work are seen as using active coping strategies is by way of seeking community support and solidarity. Sex workers often actively seek support within their communities, known as active engagement. Literature by Sanders (2007) and Krusi et al. (2010) emphasizes the importance of forming strong social bonds with peers. This active engagement creates a sense of solidarity and shared experiences, providing emotional support and a platform for collective action against discrimination.

Additional active coping is used when addressing safety planning and risk reduction. To address safety concerns, sex workers may adopt active coping strategies. Research by Shannon et al. (2009) and Decker et al. (2013) indicates that some engage in safety planning, working in pairs, using communication networks, or utilizing online platforms for client screening. These proactive measures aim to mitigate risks associated with violence and enhance personal safety.

Thirdly, individuals in sex work are seen using active coping strategies by protecting themselves through the law and empowering themselves via information. Literature by Ditmore et al. (2011) and Bruckert and Law (2013) suggests that some sex workers actively seek legal knowledge, engage in advocacy efforts, and collaborate with legal support networks. This active approach empowers them to navigate the legal complexities associated with sex work.

Passive Coping Strategies

One of the most major uses of passive coping among individuals in sex work involves the avoidance of stigmatization. Sex workers may employ passive coping strategies, such as avoidance, to protect themselves from stigmatization, also known as self-preservation. Literature by Goffman (1963) and Benoit et al. (2017) indicates that some sex workers may strategically choose to avoid disclosing their profession to mitigate the negative impact of societal judgment.

Further, Individuals in sex work may adopt passive coping mechanisms to navigate the emotional toll of their profession. Research by Krusi et al. (2010) and Ditmore et al. (2011) suggests that some sex workers engage in distraction and disassociation as a way to temporarily disconnect from the emotional challenges associated with their work.

In some instances, sex workers may adopt a passive coping strategy of acceptance or resignation. Research by Pitcher (2016) and Cabezas (2004) notes that individuals may come to terms with certain challenges, such as economic instability, and develop a passive acceptance as a means of navigating these difficulties.

Integration of Coping Strategies

Research, including studies by Benoit et al. (2017) and Scambler and Paoli (2008), suggests that individuals in sex work often employ a combination of both active and passive

coping strategies. The integration of these strategies reflects the dynamic and adaptive nature of coping in response to the diverse challenges inherent in sex work.

In summary, the literature on coping mechanisms among individuals in sex work portrays a diverse array of strategies that are both active and passive in nature. Understanding these coping mechanisms is critical for developing support systems that acknowledge the agency of sex workers and address the complexities of their lived experiences. Ongoing research continues to shed light on the nuanced ways individuals in sex work navigate the challenges they encounter. However, research in this area is limited and further exploration especially within the context of the United States remains needed. Thus, this study aims to bridge this gap and further inform how individuals in sex work may cope.

Physical Health of Individuals in Sex Work

Having comprehensive quality health care is imperative for those in the sex work profession. However, the research looking to address the physical health concerns of individuals in sex work is minimal (Peers, 2021). Furthermore, a common trend across the literature has been to investigate the sexual health of individuals in sex work. As previously noted, a major stereotype that is encompassed within whore stigma is that individuals in sex work harbor sexually transmitted infections (STIs). However, also as described previously, not all individuals in sex work engage in sexual contact with another person. Regardless, this stereotype is often enacted across the hierarchy of sex work (Ditmore, 2016; Ditmore, 2011; Benoit, 2020; Benoit et al., 2018). This is mainly due to the focus of both medical professionals and the general public on the sexual health of individuals in sex work (peers, 2021).

Medical professionals largely address HIV/STI concerns when investigating the health of individuals in sex work (Chien, 2021; Glick et al., 2020; Seib et al., 2009; Shannon & Csete,

2010). While sex health is important for many individuals in sex work, Sanders (2004) found that this is not the only reason why an individual may engage with physical health professionals, nor is it the primary physical health focus of individuals in sex work. However, investigating reasons for engaging with physical health professionals has not been prioritized in the literature.

Treatment by Medical Professionals

Research looking to address the interactions between medical professionals and individuals in sex work is, unfortunately, minimal. However, Chakrapani et al., (2009) found that health care providers appear ambivalent about treating individuals in sex work. However, they will do so begrudgingly because their ethical codes promote they are obligated to provide nonjudgmental services (Chakrapani et al., 2009). Furthermore, Ganju & Saggurti (2017) and Scorgie et al., (2013) demonstrated health care providers often deny care of individuals in sex work once they become aware that their patient engages in sex work. Furthermore, individuals in sex work have noted that their disclosure of being engaged in sex work has resulted in abusive language directed toward them, insensitive remarks made, being disrespected and humiliated in public health spaces, experiencing marginalization within their appointments, experiencing breaches of confidentiality, and being denied care by medical professionals (Aral et al., 2003; Chakrapani et al., 2009; Ghimire et al., 2011; Gorry et al., 2010; Mtetwa et al., 2013; Ngo et al., 2007; Phrasisombath et al., 2012; Scorgie et al., 2013; Stadler & Delany, 2006). When individuals in sex work have been able to receive care from medical professionals, research has demonstrated their disclosure of sex work often results in a lower quality of care (Chakrapani et al., 2009; Ghimire et al., 2011; Ghimire et al., 2011; Ghimire & Van Teijlingen, 2009; Logie et al., 2011).

A comprehensive look into how medical professionals treat some individuals in sex work comes from a study by Allen and colleagues (2015). This addressed the apparent gap in the literature surrounding women in sex work with chronic pain and their experiences with medical personnel. The sample consisted of 11 women who either currently, or formerly, engaged in sex work and had previously disclosed their challenges with chronic pain to a Providing Alternatives, Counseling and Education (PACE) society support staff. While the methodology was not explicitly stated, Allen et al. (2015), described an exploratory qualitative methodology utilizing semi-structured interviews following structured domains: Experiences and expressions of chronic pain; Therapies/Treatments; and Medical Community.

The results indicated five key themes from the women in sex work's experiences of chronic pain: communication, cures and addictions, barriers, stressors, and support systems. Within each of these themes, there was a trend toward the inability to connect and attain support from medical staff. Within the communication theme, a subtheme arose of communicating with others. Specifically, individuals acknowledged barriers to communicating with medical professionals that resulted in them feeling unheard, "ignored," and "rejected," ultimately leading women to disengage from medical attention, even in emergency situations, for fear of enduring similar experiences. Within the theme of cure, attaining medicinal treatment for chronic pain was found to be quite difficult. Women did not know that medicinal treatment was a possibility while others were denied medicinal treatment. While some individuals did have an experience of substance abuse in the past, others found it "very defeating" (Allen, et al., 2015, p. 4) given the perception that their denial of medication was based on their job history and the discriminatory stereotype that all individuals in sex work engage in substance abuse. This inability to attain medicinal treatment also directed women toward attaining substances illegally.

Regarding systemic barriers, the notion of unattainable treatment plans arose. Women found that medical staff would recommend physical therapy and lifestyle changes that they could not afford. This is not to say that the recommended treatments are unhelpful, rather they are inaccessible. The treatment recommendations the women receive do not coincide with their financial circumstances nor their housing circumstances. Thus, finding accessible resources falls upon the women themselves rather than medical personnel collaborating with the women to seek affordable and accessible treatment. Their lack of accessible treatment transcends into the fourth theme of stressors. Multiple women within the study noted the stress of managing and enduring their chronic pain. Without treatment, their pain persists and adds to other stressors such as unstable relationships, grief from loss, sexual assault, and additional traumas. Therefore, it may not be surprising to find the theme of support indicated individuals in sex work rarely received support from medical professionals.

The stigma personified by medical professionals and lack of adaptability in treatment modalities lead women to perceive medical professionals as unhelpful. However, in the few moments where women in sex work had a positive experience with either medical personnel or counselors, the support and experiences were described as “lifesaving” (Allen, et al., 2015, p. 5). This notion is profound. Medical personnel have the ability to provide support in a way that can alter the course of an individual’s lived experience when stigma is not present. However, the interactions of individuals in sex work with medical personnel appears to be riddled with stigma and marked by discrimination.

In 2016, Duff et al., examined the correlates of pap testing among individuals in prostitution. Researchers used data from An Evaluation of Sex Workers’ Health Access (AESHA). AESHA was a collection of data on individuals in both prostitution and off-street sex

work. Specifically, researchers in this study identified the dependent variable as annual pap testing. Researchers also assessed explanatory variables: individual and biological factors (I.e., age, HIV status, injection drug use, and Aboriginal ancestry), interpersonal factors (I.e., intimate partner violence), workplace locations (I.e., formal indoor settings [brothels, massage parlors], informal indoor settings [hotels, clients' homes], or public settings [streets, parks]), education attained (I.e., graduating high school vs. Not), immigration status, experiences of homelessness, experiences of barriers to health care, and accessing outreach Pap testing services. The researchers identified barriers to health care as limited hours of operations, long wait times, language barriers, inability to see a doctor of preferred gender, and poor treatment by health care professionals.

Via bivariate generalized estimating equations (GEE) to measure the independent associations of explanatory variables with annual pap testing. Their results indicated only ten percent of the 611 sample of female individuals in sex work were HIV positive. Additionally, they found one third of the sample received annual pap testing with those who are HIV-positive being more likely to receive pap testing than those without HIV. Additionally, individuals were more likely to receive annual pap testing if they accessed outreach pap testing. Finally, they also found, like Allen et al., (2015), experiencing a barrier to health care service in the past six months decreased the likelihood of individuals receiving annual pap testing.

This study demonstrated how individuals in sex work largely are not accessing pap testing regularly. However, the study did include individuals in sex work as young as 14 years old and routine pap testing is not recommended by doctors until an individual is 21 years old (National Cancer Institute, 2020). Something not discussed in the article is that a potential barrier to accessing pap testing could be due to perceived importance and appropriateness given the age

of the individual. With that said, accessing routine pap testing remains limited among individuals in sex work. While this study showed a minimal correlation between experiencing a barrier to health care services and being less likely to receive annual pap testing, the correlation was still significant and provides further evidence that barriers to health care service, such as poor treatment by health care professional, has a significant impact on the overall health of individuals in sex work (Allen et al., 2015; Duff et al., 2016).

The impact of barriers to health care service is further explored by Singer et al., (2021). Singer et al., (2021) conducted interviews with 21 individuals in sex work in Chicago to explore experiences with health care. Via interview analysis, seven themes emerged: stigmatization and cultural safety; dismissal, disregard and distrust; financial barriers to accessing services; openness and shared understanding; acceptance of intersectional identities; alternatives to formal healthcare; and the power of community (Singer et al., 2021).

Of the 21 participants, 16 endorsed experiencing stigmatization in the healthcare setting (Singer et al., 2021). This stigmatization hindered their ability to receive comprehensive care as some were discouraged from re-engaging with health care providers, felt they could not share their background in sex work for further stigmatization, and, for those who did share their background, they noticed changes in both demeanor and attitude of their providers (Singer et al., 2021). Many noted that the stigmatization experienced, whether being open about their engagement in sex work or not, hindered any additional disclosure and overall limited open communication with care providers (Singer et al., 2021). Researchers argue that this limitation in open communication and decrease in self-disclosure highlights the systemic issue preventing culturally safe care for individuals in sex work (Singer et al., 2021).

Additionally, participants reported experiencing condescension, disbelief, and disregard by health care professionals, hence the theme of dismissal, disregard and distrust (Singer et al., 2021). Specifically, the lack of trust individuals in sex work have in health care professionals led many to not engage in health care services or engage in conversation with providers about their expertise and decisions in what researchers called *critical moments* (Singer et al., 2021).

An important finding within this theme was that distrust of medical professionals was additionally fueled by participants experiences of racism and discrimination given their intersectional identities (Singer et al., 2021). Non-white participants endorsed hesitancy about accessing care from a medical system that has routinely failed to protect non-white individuals (specifically noting the Tuskegee Syphilis Experiment and Henrietta Lacks; Singer et al., 2021). Furthermore, transgender participants in this study noted a trend across their care experiences- medical providers focused more on their identity as transgender and/or as an individual in sex work rather than the concern of the participant (Singer et al., 2021). Having their identities be the focus of care providers rather than the participants' concerns impacted their willingness to access care and be open about their identities in a health care setting (Singer et al., 2021).

Singer et al., (2021) also found that costs of services largely influenced access to care given that most services (I.e., physical and mental health treatment, medications) were incredibly expensive and difficult to cover even with health insurance. With many individuals feeling motivated to bypass formal healthcare services due to these barriers, many participants endorsed engagement in alternative ways to practice wellness (I.e., yoga, exercise, strength training, and meditation; Singer et al., 2021). Individuals in this study turned to these alternative ways to practice wellness because they were looking for more accepting, accessible, and emotionally safe

environments- environments unlike the ones they had experienced with healthcare providers (Singer et al., 2021)

It may be unsurprising that participants who endorsed had experiences with health care providers reported feeling validated and understood by their providers prompting them to feel more comfortable and open to sharing with their providers (Singer et al., 2021). Additionally, participants noted patient-centered care was essential to positive experiences as they felt their provider exhibited cultural competence and recognized the intersectionality of the participants identity and sex work (Singer et al., 2021).

This qualitative research study provides insight into the experiences of individuals in sex work in the Chicago area. Specifically, participation in this study was limited to those who had access to internet and communication devices due to the restrictions of the COVID-19 pandemic. The experiences of these participants highlight the impact that medical professionals' attitudes and actions have on the overall well-being and health of individuals in sex work, though the reach of the study was limited. Given the qualitative nature of this study, it is not ethical to generalize the findings of this one study to all individuals in sex work. However, as described previously, these findings are not unique to this study (Allen et al., 2015; Duff et al., 2016). So, this study may not be generalized, but the experiences and implications of these findings on this specific sample in Chicago are in fact reverberated throughout the literature on individuals in sex work and their engagement with health care. Indeed, there is a trend in the literature showing medical professionals are largely perpetuating bias when working with individuals in sex work and hindering their overall health (Allen et al., 2015; Duff et al., 2016; Singer et al., 2021).

Impact of Stigma on Help-Seeking Behaviors and Accessing Resources for Physical Health

Since the 1990s, research has been conducted to assess the impact of stigma on access to health services (Vanwesenbeeck, 2001). These studies specifically looked to see if occupational stigma, or stigma associated with an individual's job title, functioned as a barrier, or preventative component, to accessing comprehensive and quality health services. This research found that stigma associated with an individual's job title did in fact function as a barrier to accessing comprehensive and quality health care due to fear of discrimination and receiving discrimination when engaging with health service providers (Vanwesenbeeck, 2001).

However, it was not until 2012 when Lazarus et al., conducted a study utilizing multivariable analysis which suggested that whore stigma was independently associated with a higher likelihood of experiencing barriers to health access than other occupational stigmas. The "barriers" related to accessing health services were described as *not liking, not trusting, and/or even fearing health professionals*. These barriers, as described by Lazarus and colleagues, stem from perceived stigma experienced by individuals in sex work from health care providers (Lazarus, et al., 2012).

Benoit, Ouellet, and Janson (2016) further assessed access to care and found that individuals in sex work were nearly three times more likely to experience unmet health needs when compared to their counterparts in the general population. Anticipation of negative treatment and being turned away by helping professionals were additional barriers found in a study conducted by the Australian Institute of Family Studies (AIFS) in 2008. Individuals in sex work largely are not accessing resources due to the expectation of bias and poor treatment. These results corroborated the findings of King et al., (2013) who found that individuals in sex work, although in need of receiving medical attention, have not done so because they expect the doctors to treat them poorly.

Impact of Societal Systems on Individuals' Lived Experiences

Role of Law Enforcement

Multiple researchers have argued that criminalization, targeted policing, and limiting individuals in sex work's sense of agency impacts their ability to practice harm reduction and engage in wellness behaviors (Benoit et al., 2019; Herek, 2004; Shahmanesh et al., 2008; Singer et al., 2020; World Health Organization, 2014). As previously described, individuals in sex work, mainly prostitution, work under policy and law that dictates punishment for involvement in sex work and makes individuals in sex work vulnerable to sexual violence. Being arrested, incurring fines for their work, and experiencing sexual violence are often viewed as occupational hazards (Anesu et al., 2019; Benoit et al., 2019; Herek, 2004; Shahmanesh et al., 2008; Singer et al., 2020).

These occupational hazards put individuals in sex work at substantial risk to experience police violations. These violations include arbitrary arrests, physical abuse, and sexual abuse (Pettifor et al., 2000; Pauw & Brenner, 2003; Gould & Fick, 2008). The Open Society Institute (2006) noted that individuals in sex work, even legal forms of sex work, often have limited or abysmal labor rights or defense under the law. Further research has reinforced this notion and has described how the justice system discriminates against individuals in sex work by treating them as unworthy of defense and protection (Benoit et al., 2018; Parent et al., 2013; Wojcicki & Malala, 2001). This vulnerability and overt power of police officers make it difficult for individuals to fight back when injustices are brought upon them (Scourgie et al., 2011). Research has demonstrated that police exerting their power over individuals in sex work is not as rare as one may hope. Rather, police officers have been noted to extort bribes from individuals in sex

work or demand sex in exchange for avoiding arrest or being released from jail (Human Rights Watch, 2012; Scourgie et al., 2011).

A major violation of police power is in connection with carrying condoms. In 2012, the Human Rights Watch, an organization of researchers across the globe investigating abuses of human rights, interviewed 200 individuals in sex work within New York, Washington, DC, Los Angeles, and San Francisco. Their investigative report identified that individuals in sex work are often stopped, searched, and arrested by police officers (Human Rights Watch, 2012). Many endured degrading treatments, abuse, being coerced to have sex with police officers, or being faced with the choice between engaging in sex work with the police officer or facing detention. While this is parallel with previous findings, what the Human Rights Watch researchers found was that the carrying of condoms was, in fact, used as evidence against individuals in sex work to support police officer's charges of prostitution. Police officers would even instruct individuals to dispose of their condoms because police officers viewed condoms as contraband (Human Rights Watch, 2012). Furthermore, these stops and arrests for carrying condoms were reported to occur via profiling rather than based on observed breaches in law, as many individuals were stopped and searched while they were not working (Human Rights Watch, 2012). However, there is no rule or law against the carrying of condoms nor a law pertaining to the number of condoms that one is allowed to carry (Human Rights Watch, 2012). Evidence of contraceptives does not mean evidence of sex work. Despite this fact, police using condoms as evidence for sex work was seen as a practice across all four major cities.

Indeed, multiple studies have confirmed this report that individuals in sex work often continue to be harassed, humiliated, and subjected to police interference within their communities even when not working (Benoit et al., 2018; Bernstein, 2007; Biradavolu et al.,

2009; Blankenship & Koester, 2002; Miller, 2002; Rhodes et al., 2008; Van Der Meulen et al., 2013). Furthermore, the continued harassment combined with fear of individuals in sex work being insulted, ignored, or arrested has led to many either being hesitant to engage with law enforcement and/or refuse to engage in law enforcement despite victimization (Benoit et al., 2018; Blankenship & Koester, 2002; Boittin, 2013; Dewey & St. Germain, 2014; Jeffrey & MacDonald, 2006; Sallmann, 2010, Wong et al., 2011).

Impact on Trust and Help Seeking Behavior in Society

The police harassment and abuses via searching for condoms contradicts the public health initiatives promoting condom use as integral for safe sex practices (Human Rights Watch, 2012). Per the investigative report, most women would then either refuse to carry condoms for fear of consequences or only carry a small number of condoms (Human Rights Watch, 2012). However, this has put individuals in sex work at substantial risk for STIs if they only carried a small number of condoms given that it may not be enough to cover all their patrons (Human Rights Watch, 2012). This led some individuals in sex work to seek alternative methods for contraceptives (i.e., plastic bags). These actions by police officers have left individuals in sex work to select paths of harm- either harassment, detention, and abuse by the hands of police officers or unprotected sex with patrons.

These interactions with police officers have led to increases in fear for individuals in sex work (Human Rights Watch, 2012). Furthermore, very few women interviewed went on to file complaints about the abuses they endured. Many noted their fear of further abuse and loss of faith in fair responses from law enforcement fueled their decision to not report (Human Rights Watch, 2012). Not only are the actions of police officers enacting abuse and further putting individuals at risk for serious health consequences, but they are also impacting the help-seeking

behaviors of individuals in sex work. While this investigation did not discuss the methodology intensely, nor did it distinguish the process of data analysis, these same results regarding individuals' interactions with police have been consistent across the literature (Anesu et al., 2019).

A qualitative study using an explorative research approach by Anesu and colleagues (2019) looked to explore the sexual violations committed to individuals in sex work who use substances. Individuals in this study reported experiencing sexual violence occurs often when they interact with police and law enforcement officials. The participants identified these occurrences as normal due to the rate at which they occur. Furthermore, researchers found that these individuals also did not report their abuses due to mistrust of officers, fear of future abuse, and lack of faith in having the system treat them fairly and see their claims as viable (Anesu et al., 2019). The findings from this study reiterate the common perception among law enforcement officials that individuals in sex work cannot experience rape or sexual assault due to their line of work (Anesu et al., 2019). While these are qualitative data, and not to be generalized, it is additional evidence to the stigma, fear, harassment and harm many individuals in sex work face when interacting with law enforcement.

Role of the Court

Filing charges against an individual who has physically or sexually harmed someone is a well understood notion with more recent social movements, such as the "Me Too" Movement, further shedding light on the issues of sexual assault. Incidents of sexual assault are still largely thought to be underreported (Michels, 2009). Individuals in sex work are not an exception to this rule (Anesu et al., 2019; Human Rights Watch, 2012).

The stigma and fear of discrimination by law enforcement as previously described, largely fuels this lack of reporting (Human Rights Watch, 2012, Anesu et al., 2019). However, it is important to note the message that has been administered by court officials themselves. Few cases of sexual assault among individuals in sex work are received in court, making the impact of the cases' verdict that do occur profound.

In 2007, an individual in sex work pressed sexual assault charges against Dominique Gindraw (Michels, 2009). The individual in sex work had agreed to have sex with Gindraw and one friend of his for money. However, Gindraw refused to pay the individual, held her at gunpoint, and proceeded to force her to have sex with several men. Municipal Judge Teresa Carr Deni was ruling in this case. She dismissed the rape and sexual assault charges and charged Gindraw with armed robbery for theft of services (Michels, 2009). The dismissal of rape and sexual assault charges was enough to aggravate allies of individuals in sex work as well as fellow board-certified attorneys resulting in 40 complaints sent to the local bar association per executive director Ken Shear (Michels, 2009). However, it was Judge Carr Deni's statements in an interview post-verdict that provided further evidence for where stigma perpetuated in the court system. Judge Carr Deni stated to a newspaper reporting that charging Gindraw for rape "minimizes true rape cases and demeans women who are really raped" (Michels, 2009). She claimed further to the *Philadelphia Daily News* that the individual in sex work "consented and she didn't get paid. [...] I thought it was a robbery" (Michels, 2009). In an unprecedented response, the bar association chancellor Jane Dalton pointed out that this ruling and subsequent comments by Judge Carr Deni further brutalized the individual in sex work and that the state's rape laws were misapplied. Jane Dalton speaks to Judge Carr Deni's decision directly and states:

“Her decision in this case was based on a pre-existing bias as to when sex can be consented to, and as to when that consent can be withdrawn, and reflects [...] clear disregard of the legal definition of rape and the rule of law.”

This ruling by Judge Carr Deni demonstrates the enactment of whore stigma at one of the highest levels of power within our country. The idea that individuals in sex work cannot be raped or experience sexual assault given the nature of their work described previously transcends law enforcement and is replicated here (Anesu et al., 2019). While this is one case, as previously noted, the judge ruling in this way helps establish precedent and, unfortunately, continues the discrimination of individuals in sex work at one of the highest judicial levels.

Impact of the COVID-19 Pandemic

Currently, as the COVID-19 pandemic continues, individuals in sex work are faced with navigating a global health crisis. Given that the health of individuals in sex work is put at risk by police officers confiscating condoms as evidence and perpetuating acts of violence, individuals in sex work health may be further compromised by the current pandemic. There is limited research on how the pandemic has impacted the health of individuals in sex work, Singer et al., (2020) attempted to bridge this gap in the literature.

In this study, researchers looked to inform public health researchers, clinicians, and health educators about individuals in sex work during the pandemic. They conducted interviews during the first phase of Illinois shelter-in-place order that closed all schools and non-essential businesses. Their preliminary analysis showed that individuals in sex work continued to work during this phase but noted a decrease in the amount of money they earned due to a decrease in regular clientele. With trusted clientele largely inaccessible, individuals in sex work endorsed engaging with new clientele. However, their need for money largely determined if an individual

in sex work would engage with new clientele rather than rely on a vetting system they would typically implement. Individuals in sex work endorsed that this shift in decision making made it difficult for them to feel protected from COVID-19. Some participants endorsed that engaging in their work at this time puts them at greater risk of contracting COVID-19.

Rather than condemning the actions of individuals in sex work, Singer et al., (2020) view this increased risk of COVID-19 exposure among the individuals in sex work as a call to disseminate safe sex practices during COVID-19 in a free and accessible manner. Having specific information and resources in place to help guide safe sex practices for individuals in sex work during this time may further protect them from COVID-19 exposure and allow for individuals in sex work to continue their work.

However, this research is preliminary, and the methodology of this study is largely not articulated by the researchers. An in-depth critique about this study is difficult given the lack of explanation in methodology. However, it is important to note that lack of resources currently available for individuals in sex work to safely conduct their work. Many are facing the choice between potential exposure to COVID-19 or not receiving an income. This current predicament highlights a new societal hindrance and vulnerability for individuals in sex work.

Critical Gaps in the Literature

Furthermore, there remains a gap in the literature as it relates to comprehensive care for individuals in sex work within the mental health field. Research has largely focused on the impacts sex work has on an individual's mental health, their experiences of stigma, with less albeit some, research on how individuals cope with said stigma. However, there does not appear to be any research investigating effective treatment modalities or how best to serve individuals in sex work within the mental health field. It is understood that mental health professionals are

contributing to the stigma of individuals in sex work, often turning individuals in sex work away from seeking help when needed (Cwikel, Ilan, Chudakov, 2003; Ditmore, 2011; Jackson, 2016; Krumrei-Mancuso, 2017; Zehnder, 2019). There is little research demonstrating effective ways to combat this, although some research has noted the importance of addressing the bias among helping professionals (Benoit et al., 2020; Benoit et al., 2018; Benoit et al., 2017; Cwikel, Ilan, Chudakov, 2003; Ditmore, 2011; Jackson, 2016; Krumrei-Mancuso, 2017; Zehnder, 2019).

Finally, there is minimal research looking to assess the wellness of individuals in sex work. Benoit et al., (2017) and Koken (2012) did start to investigate coping strategies of individuals in sex work, targeting how individuals navigate and manage their mental health. While these are great starts to understanding elements of wellness, the literature is not comprehensive.

Additionally, medical literature does look to assess the physical health of individuals in sex work, which is often tied to overall health and wellness. However, this is another single entity of health and wellness. There has been a lack of research to establish a more holistic and comprehensive understanding of wellness among individuals in sex work. In fact, Kisting (2015) noted that assessing wellness of individuals in sex work in this way is lacking and that the present literature on wellness equates sex work with forfeiting aspects of their wellness or need restoring wellness. If wellness literature for this population by researchers was prioritized, we may help combat societal views of individuals in sex work's wellness and increase the efforts for establishing resources necessary for this population.

Conclusion

The historical representation of individuals in sex work transcends all societies (Ditmore, 2011; Ditmore, 2016). The societal view of individuals in sex work stemming from the 19th century Progressive Era unfortunately has fueled much of the research regarding individuals in

sex work and set the trend for biased literature (Brody et al., 2005; Ditmore, 2016; Ditmore, 2011; Farley et al., 1998; Fellows et al., 2020). Despite the impact biased literature may have on societal view and the limited research on this population, major strides have been made to ethically create understanding of the experiences of individuals in this population. Despite this lack of information, researchers have noted all individuals within the population are represented, in some capacity, within sex work.

What has been established so far points to the specific stigma experienced by individuals in sex work- *whore stigma*. Researchers have identified that this stigma is not only enacted by their social supports. Stigma is also enacted by helping professionals- especially mental health, medical, and law enforcement professionals. The literature is clear that negative experiences put forth due to this stigma harm individuals in sex work, both physically and mentally.

Experiencing physical harm, violence, being hypervigilant, enduring verbal harassment, off-handed comments, and internalizing their own concerns appear to be common occurrences. The risks of this work are well-documented and explored. The risks of engaging in sex work largely involve being harmed by individuals not in sex work, including helping professionals.

Understanding the risks and experiences via ethical, unbiased research helps inform the social perceptions of individuals in sex work. The more research produced, the more the stereotypes fueling the stigma of individuals in sex work are being challenged.

It seems clear that continuing this area of research is imperative for helping challenge the stigma associated with individual experiences. Doing so provides a unique opportunity to assist in shifting society's view of individuals in sex work. Furthermore, this may allow for the positive experiences of individuals in sex work to grow, including growth in the number of safe places

available with helping professionals. In an effort to work ethically, safely, and in an inclusive manner, prioritizing work in this field, especially for mental health professionals is imperative.

Chapter Three: Methodology

Constructivist Grounded Theory

Research on individuals in sex work has largely involved researchers making assumptions from data, and or invoking their own values on to the population of individuals in sex work. In an effort to combat this and to better understand how individuals in sex work manage their mental health, the present study used the qualitative research methodology of Constructivist Grounded Theory (CGT; Charmaz, 2000, 2014).

CGT is one form of grounded theory research which, as a whole, originated from inductive qualitative inquiry in sociology (Charmaz, 2014). In the 1940s, inductive qualitative inquiry had not yet been theorized and its methodology was largely inaccessible, as field methods were not described by those engaging in this research (Charmaz, 2014). By 1967, Barney Glaser and Anselm Strauss attempted to refocus inductive qualitative inquiry and focus on the methods of analysis- thus, theorizing methodology and allowing for replication (Charmaz, 2014; Glaser & Strauss, 1965, 1968; Strauss & Glaser, 1970). Glaser and Strauss' refocus was formerly called grounded theory and they published their methodology in 1967 as *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Together, Glaser and Strauss stressed the notion that qualitative analysis could construct theory to explain specific social processes (Charmaz, 2014; Glaser & Strauss, 1967; Glaser, 1978; Strauss, 1987). In order to accomplish theory in this way, Glaser and Strauss established tenants of grounded theory research:

Simultaneous involvement in data collection and analysis; constructing analytic codes and categories from data, not from preconceived logically deducted hypotheses; using the constant comparison method, which involves making comparisons during each stage of

the analysis; advancing theory development during each step of data collection and analysis; memo-writing to elaborative categories, specify their properties, define relationships between categories, and identify gaps; sampling aimed toward theory construction (theoretical sampling), not for population representativeness; conducting the literature review after developing an independent analysis (Charmaz, 2014, p.7-8).

While this shift in qualitative analysis was groundbreaking and fundamental for the legitimization of qualitative research (Charmaz, 2014), it has not been free of criticism. Many have thought grounded theory to be outdated as they view this theory to align with modernist epistemology (Charmaz, 2014; Conrad, 1990; Richardson, 1993). Specifically, critics have taken issue with how they view the theory fragmentizes participants' stories, enforces the notion of a single truth, and relies too heavily on the voice of the researcher (Charmaz, 2014; Conrad, 1990; Richardson, 1993).

Charmaz built on the foundation of grounded theory set by Glaser and Strauss in response to many of these criticisms (Charmaz, 2014). Constructivist grounded theory explicitly added the notion that research is, itself, a construction that occurs within a specific context and under specific conditions (Charmaz, 2000, 2014). The researchers and the participants are involved in this construction as are the different components they each bring to the research (Charmaz, 2014; Clarke, 2005, 2006, 2007, 2012). There is no neutral observer nor expert and those researchers involved must thoroughly examine their privileges, beliefs, and potential bias that may influence their work (Charmaz, 2014).

This analysis of researcher positionality and bias is stressed and addressed in the action of memo-writing. This will be talked about further in subsequent sections but is an essential component in the way CGT is often viewed as fostering social consciousness development and a

methodology that conducts social justice research (Charmaz, 2017). Not only that, CGT also allows for theorization of action which is a value of myself and aligns with my hope of the future of this work (Charmaz, 2017).

Ethical Consideration for the Current Study

In selecting the methodology for the present study, ethical considerations were made. In accordance with the APA ethical guidelines, I am to conduct research within the scope of my “education, training, supervised experience consultation, study, or professional experience” (APA, 2017, 2.01). While I have had course training on qualitative research methods, I have had explicit training in CGT. This training was achieved by being involved in two separate dissertation teams that used CGT. The training in both the classroom and as a part of the dissertation teams has enhanced my ability to conduct CGT. However, I had not been the primary investigator on a CGT study prior to this study and am continuing to learn the more I engage with CGT.

With that said, I have learned from strong examples on the ways to conduct CGT. Pulling from the examples of the primary investigators I have worked with, I adhered to CGT guidelines and protocols throughout my study and committed to engaging in ethical research. Furthermore, the research project in discussion was geared toward hearing from the population directly to develop theory of experience and how individuals in sex work manage their mental health concerns. Having a methodology that aligns with this direction was, thus, imperative. CGT methodology is not only aligned with this objective, but the data generated from CGT studies, “allow us to learn from the stories of those left out and permits research participants to break silences” (Charmaz & Belgrave, 2018, p. 743).

This notion is essential as another ethical consideration for this study was the use of human subjects. Specifically, the proposed research study looked to hear from and collaborate with individuals in sex work. This population of individuals endure the stigma associated with their work, are often considered a part of the outgroup of society, and when they are the focus of research, have often been subjected to biased work with a heavy emphasis on their sexual health solely. Expanding the narrative of this population and providing opportunity for members of this population to contribute to this is imperative to help shift the narrative often associated with this population. Furthermore, having an alternative focus in the research conducted with this population, such as this study, is an important ethical consideration as well given the potential fatigue felt by individuals in sex work with research involvement given the repetitiveness of research questions. While this study did have a different focus than those studies often involving individuals in sex work, it was still essential for myself and the research team to be conscious of the ethical dilemmas of research conducted with individuals in sex work in the past. Furthermore, we wanted to encourage participation but be conscious of the potential fatigue in participants. Thus, adhering to limits and addressing the rights of participants was vital.

The rights of participants and explanation of the nature of the study was explicitly addressed in an informed consent form. While more will be said about the informed consent form in future sections, including informed consent aligns with the American Psychological Association's (APA) ethical guidelines for research in psychology (APA, 2017). All handling of the data, including recording, data analysis, and providing unique identifiers to all data, was aligned with APA ethical guidelines and also under the guidance of the Marquette University Institutional Review Board (IRB). The adherence to ethical guidelines set by both the APA and

Marquette University's IRB is in an effort to ethically produce research and protect the participants of the study from any harm that may arise from unethical research.

Research Team

The research team for this study included a primary investigator, two team members, and one auditor. The primary investigator (PI) was myself and I am the author of this study. The two other team members were current doctoral students in the counseling psychology doctoral program at Marquette University. Both team members had previous experience working on CGT projects, but neither had experience working with individuals in Sex Work. The auditor for this study was my faculty advisor whose work largely focuses on sexuality and wellness.

I, the PI of this study, am a white cisgender female with experience working with individuals in sex work and survivors of sex trafficking in the clinical arena. I volunteered with the Sister's Program, providing services to both individuals in sex work and survivors of sex trafficking that target their basic needs (i.e., food, clothing, housing). Additionally, my training and practice included trauma informed care provided as part of a hospital-based Trauma and Acute Surgery team as well as working a Trauma Psychology outpatient Clinic. This training and practice influence the trauma informed approach found throughout my work and within the current research study.

The team members for this study were selected because of their interest in qualitative research and the topic of this study. Both team members have served on research teams and have training in trauma-informed care. To ensure understanding of CGT, both team members were instructed to read vital articles and materials and current CGT research. The auditor was a white cisgender woman with extensive research experience and an expertise in sexuality and the

impact of sexual self-concept on wellbeing. She teaches sexuality education to youth and adults in Milwaukee and is involved in research projects assessing intersectionality of identities.

Memo-Writing Expectations

Given CGT's acknowledgement of research as a construction of theory from data, and the impact of the researchers' positionality and values on what is seen as the truth (Charmaz, 2014), all researchers on the research team participated in reflexive practice. Prior to engaging with the data, each researcher on the team reflected and wrote on their positionality. This was in an effort to address the influences on the data and coding process. This transparency in practice is essential to the practice of CGT as it openly reinforces the subjectivity of the research content (Charmaz, 2014).

A sole moment to reflect on positionality, however, is not substantial enough, reflection not being a stagnant process. Rather, having reflective practice throughout the process of research was vital. Reflecting on positionality in the beginning of the study was only the beginning of the process. A core component of CGT is the practice of memo-writing (Charmaz, 2014). This process is viewed as the step between data collection and writing the findings of the data as it informs the data analysis process (Charmaz 2014). The purpose of memo writing is to provide opportunity for the researchers to reflect on their experiences while immersed in the data (Charmaz, 2014). Researchers were expected to be intentional in their reflections and foster additional analysis of the findings as they emerged (Charmaz, 2014). Documenting these reflections was essential as they informed the emerging codes, inspired new ideas, and informed gaps in the study itself and/or allowed for researchers to address bias or concerns that arose as they were noted (Charmaz, 2014). All members of the research team followed Charmaz's recommendation of keeping a methodological journal so that they could document reflections

and memos throughout the process (Charmaz, 2014). Memos and reflections were discussed with the team as coding was conducted to foster transparency of positionality and ensure all potential influence was shared in an effort to enhance the findings.

Data Collection Procedures

Participants

Recruitment Methods

Recruitment for this study was carried out using a combination of purposive sampling methods, snowball, and theoretical sampling. First, I distributed my flyer to organizations working with individuals in sex work and local community establishments. The flyer contained information about eligibility for the study and the general nature of the study. Please see Appendix A for recruitment materials. I recruited participants exclusively in the United States. The focus of participants from the United States was essential given the lack of examination and understanding of individuals in sex work within the context of the United States.

Participants had my contact information from the flyer to reach out to me if they were interested in participating. Many participants reached out via their supports at local resource centers to alert me of their interest. Participants were given the option of having the interviews be done in-person, over the phone, or via computer. All participants elected to do in-person interviews in a private room within a local resource center for their privacy and safety. Interviews were conducted between February and May 2023, scheduled based on participants' availability, typically coinciding with their planned presence at the resource center or when they could allocate 60 to 90 minutes for the interview.

Sample Size

As previously mentioned, I used theoretical sampling in my sampling methods. CGT suggests the continuation of data collection if there is a need for clarity among codes and/or if there is any pertinent information lacking from the emergent findings (Charmaz, 2014). The process of sampling from the population to expand upon the emergent findings is known as theoretical sampling (Charmaz, 2014; Glaser & Strauss, 1967). This is imperative here as it has the potential to influence the sample size for this study.

Furthermore, CGT has a strong emphasis on data saturation (Charmaz, 2014; Glaser & Strauss, 1967; Hood, 2007). Data saturation is the point in data collection where no additional categories or codes are established- when all additional information does not provide new insight to the emerged codes (Charmaz, 2014; Glaser & Strauss, 1967). There is no distinct sample size explicitly stated for CGT; rather, the expectation is to cease data collection once data saturation has been reached (Charmaz, 2014; Glaser & Strauss, 1967).

However, experts in the realm of CGT have provided guidelines for sample size (Charmaz, 2014; Thompson, 2011). Scholars have considered the need for data saturation and use of theoretical sampling and have recommended that the sample size for CGT research ranges from 10 to 15 participants (Thompson, 2011). This range in size is believed to be necessary for theory to emerge and be established (Thompson, 2011). This study yielded 10 participants using theoretical sampling and reaching data saturation. This sample size fits within the expert appointed guidelines and was achieved by following CGT methodologies.

Eligibility Criteria

Predetermined inclusion of criteria is essential in CGT to define who is best able to participate in a study (Charmaz, 2014). The following criteria were developed for the current study:

1. Live in the United States
2. Be at least 18 years old.
3. Self-identify as an individual in *sex work* (either in the past or currently)
 - a. *Sex Work* is defined as a general term used to encapsulate any type of labor in which the explicit goal is to produce a sexual or erotic response in the client for compensation such as, but not limited to, monetary payment or goods that is agreed upon by all parties involved
4. Have experienced mental health concerns or had difficulties with mental health concerns while they were engaged in sex work
5. Be able to communicate in spoken English or American Sign Language (ASL) with access to a telecommunication device for the deaf (TDD).

Pre-Study Measures

Screening form

The screening form was used as a means to review participants for eligibility. The screening form contained all eligibility criteria for the current study and required participants to confirm their eligibility after review (see Appendix B). This was done in person as a precursor to the formal interview process. Once participants were confirmed as eligible for this study, I

provided the participants with an informed consent form (see Appendix D) and demographic form (see Appendix C) so they may be completed prior to the interview.

Informed Consent Form

The APA ethics on research stress the importance of informed consent (APA, 2017). The informed consent form was designed to abide by the APA expectations of informed consent. The informed consent form included the purpose and nature of the study, the potential risks and benefits, the limits of confidentiality, the participants' right to decline participating, and compensation for their time and contributions (APA, 2017, Section 8). Participants were compensated with a monetary award of \$15.00. Participants had the option of receiving their compensation in the form of an Amazon or Walmart gift card. Participants received the informed consent form after eligibility for the study was established. Participants were instructed to review and verbally acknowledge their understanding of the form before continuing to the demographic form and formal interview. Verbal acknowledgement was approved as a safety measure for participants. By verbally acknowledging their understanding, participants were not further risking safety by signing their name on any form of paperwork. The informed consent form was reviewed during the interview appointment time to allow for participants to ask questions and confirm understanding between researcher and participant about participant rights and the nature of the study as a whole. Please see Appendix D for the informed consent form.

After completion of the informed consent and demographic form, a formal interview was conducted in person. All completion of forms and interviews was done in person to protect participants. Participants had the option of completing paperwork and interviews via alternate forms of media (e.g., email for forms and Microsoft teams for interviews), however all participants opted to complete screening, informed consent, and the formal interview in person.

Study Measures

Demographic Form

The demographic form functioned as a means to confirm participant eligibility and provide descriptive data regarding the sample of the study. However, the demographic form did not include explicit identifying information in an effort to preserve confidentiality of participants. Demographic forms had a unique code assigned to them that linked to the participants' de-identified interview transcripts. Given the study focus, the form requested information regarding gender identity, nationality, race, ethnicity, current country of residence, if participants are currently engaged in sex work, forms of sex work participants have engaged in and/or currently engaged in, and experienced mental health concerns. Please see appendix C for the demographic form.

Interview Protocol

The interview protocol was designed as a preliminary means to begin data collection via semi-structured interviews. The use of semi-structured interview protocol in this study was to guide the interview while allowing researchers to explore the content provided by participants deeper and allow participants to use their own language to express their experiences. Charmaz (2014) addressed the importance of using broad, open-ended questions to ensure participants may share their experiences in their own language rather than be unintentionally forced into preconceived categories by way of pointed questions. To further address CGT guidance, the majority of the questions included in the interview protocol were open-ended questions (Charmaz, 2014; See Appendix E for the interview protocol). The developed interview protocol was tested with one to two colleagues so the language, wording, appropriateness, and clarity of

each question could be assessed. By first pilot testing the protocol, I then was able to revise and strengthen the protocol before interviews with study participants began. Additional follow-up questions were added as the research process progressed. In following with CGT, emergent findings were intended to inform further data collection (Charmaz, 2014) and follow-up prompts were added when necessary for clarification.

Interview

Interviews in research allow for collaboration of data construction between the participant and the researcher (Charmaz, 2014). Even more so, they are commonly used in qualitative research as a recognized means to facilitate strong data generation (Ponterotto, 2013). While the interview is constructed around the developed protocol, there may also be additional factors that influence the interview experience. Notably, the interview may be impacted by factors related to the participant, researcher, technology, and the larger societal context in which the interview occurs. These factors may include fatigue, nervousness, defensiveness, and technological difficulties. Despite these considerations that may impact the quality of interviews, a semi-structured interview was used in this study to allow for the voice of the participants to be shared and combat the historic exclusion of their voices in research.

Participants engaged in a semi-structured interview after they had been vetted via the screen form and then filled out the demographic form. The interview process began after informed consent was reviewed between the participant and the researcher and the participant verbally acknowledged their understanding of the risks, their rights, and willingness to participate. The interviews themselves were conducted in person. Participants were offered the choice of doing the interview over the phone, over Microsoft Teams, or in person but all participants elected to complete the interview in person. The interviews were audio-recorded

with two recording devices to ensure content from the interview was captured. The interviews ranged from 45 to 90 minutes in length. At the conclusion of the interview, all participants were asked about their openness to being contacted in the future if any follow-up questions arise. While all participants were open to future follow-up, no follow-up was required.

Transcripts & Trustworthiness

The interviews were then transcribed verbatim by the research team. As previously described, all transcripts were deidentified to eliminate any explicit identifying information of the participants. Transcripts were then assigned a participant identifier code that was linked to the screening form and demographic form. All recordings of the interviews, forms, and transcriptions were securely stored by me and shared solely with the research team for analysis as needed.

To ensure trustworthiness of the data, an essential component of qualitative research (Connelly, 2016), all participants had the opportunity to review their transcripts. The goal of this triangulation process was to ensure that the participants were confident in the representation of their narratives. This process allowed for the collaboration between researchers and participants to flourish while also reinforcing the value of having participants' voices heard in their words. Participants then confirmed their review to the researchers and any additional notes they may have had. However, in assessing the methodology of this research, it should be noted that a part of their triangulation process did not include participant review of the transcripts. While participants were offered the opportunity to review their transcript, all participants denied wanting to. These themes arose without participants' approval of how their words were perceived, dismantling an element of trustworthiness that is paramount in qualitative research.

This also reiterates a major ethical consideration regarding inclusion of individuals in sex work within research that will be explored in the ethical considerations section.

Data Analysis Procedures

As described above, this study was aligned with the methodology put forth by Charmaz known as CGT. The data analysis process put forth by Charmaz involves a systemic coding method to identify and organize the data into specific categories, or codes (Charmaz, 2014). Throughout the coding process, comparison among data is conducted consistently as a form of analysis (Charmaz, 2014). The coding process is designated by three distinct stages of coding- initial coding, focused coding, and theoretical coding (Charmaz, 2014).

The Coding Process

Initial Coding

Initial coding is the first stage of coding in CGT (Charmaz, 2014). Initial coding is done by reviewing the data, one line at a time and parsing it into individual components (Charmaz, 2014). Per Charmaz's (2014) recommendations, this form of coding was done beside the transcribed text in its own column. Charmaz (2014) also recommends using gerunds and action-oriented language in this stage of coding. This is recommended because coding in this way allows for a more dynamic and immersive experience for the researcher and the data (Charmaz, 2014). The proposed study focused and developed initial codes in this way.

Focused Coding

Once initial coding had been completed on data, the next stage, known as focused coding, began. This stage focuses on the initial codes and tracing those that occur frequently. The goal in

this stage of coding is to develop larger components of the data revealing patterns (Charmaz, 2014). This stage has an emphasis on refinement of the data as codes are assigned and either further developed or discarded as comparison continues with the additional data (Charmaz, 2014). CGT does hold the value of flexibility as well (Charmaz, 2014). Focused codes are essential as they may influence future data collection (Charmaz, 2014).

Theoretical Coding

The final stage of coding in CGT is theoretical coding (Charmaz, 2014). This stage of coding is where the entire picture from the data comes together- the bigger picture of the data is realized (Charmaz, 2014; Glaser, 1978). This story, or theory, that emerges from the data should arise directly from the data itself rather than be forced onto the data (Charmaz, 2014). The research team in this proposed study thoroughly adhered to the principles and expectations of the coding process in each stage in an effort to establish a comprehensive theory by the theoretical coding stage.

Conceptual Mapping

The theory that emerges from CGT research is also accompanied by a visual representation of the theory (Charmaz, 2014). This visual representation is known as conceptual mapping (Charmaz, 2014). Concept maps are a visual representation of the relationship between the codes that resulted in the theory put forth (Charmaz, 2014). This visual representation allows for the more visual learners to access the information provided by the theory. It also allows for further critical analysis of the strength and weaknesses of certain relationships represented in the data (Charmaz, 2014). I strongly value having research be accessible for all persons and the

notion that critical analysis of research and theory is essential to enhancing our work. I created a conceptual map in accordance with the theory produced via the coding process.

Group Process and Auditor

As mentioned, the research team consisted of myself, two additional research members from the counseling psychology doctoral program at Marquette University, two transcribers from the clinical mental health counseling master's program at Marquette University, and one external auditor. In addition to the memo-writing and triangulation of data, I wanted to ensure I adhered to the principles of trustworthiness via creating a research team as described. Additionally, I wanted the process of data analysis to also adhere to the principles of trustworthiness.

Initial coding was facilitated through two research team members and myself, working together on the first several transcripts. This allowed for the team as a whole to become familiar with the process and encourage immersion in the data as a team. After the first several transcripts were initially coded in this way, I conducted initial coding on the remaining transcripts on my own. I then requested review by my team members to ensure the initial codes I produced were scrutinized and audited. This process aligns with the recommendations by GT scholars to enhance familiarity with data analysis procedures, foster inclusion among the research team, balance individual work and group work within the research team and maintain consistent communication within the team (Hall et al., 2005).

The auditor of this study provided additional insight on codes established by the team. The auditor position also addressed the concern of researcher bias and provided additional assurance of remaining true to the narratives provided by each participant. The auditor's work

for the study lasted throughout the study with final review of the emerging theory and conceptual mapping process included.

As noted, the research methodology of Constructivist Grounded Theory (CGT) was employed to investigate the experiences of individuals in sex work and their management of mental health concerns. This methodological approach was chosen to address the limitations of previous research, which often imposed assumptions and values onto this population. CGT, as developed by Charmaz (2000, 2014), emphasizes the iterative and inductive nature of qualitative inquiry, allowing theory to emerge from the data itself. CGT builds upon the foundational principles of grounded theory while addressing criticisms regarding its alignment with modernist epistemology. By incorporating the notion of constructionism, CGT recognizes research as a subjective endeavor influenced by the context and perspectives of both researchers and participants. This methodology fosters reflexivity and encourages researchers to critically examine their own biases throughout the research process. Ethical considerations were paramount in the design and implementation of this study. Efforts were made to ensure participant confidentiality, informed consent, and protection from harm. Recruitment strategies prioritized the voices of individuals in sex work, aiming to provide a platform for their narratives while respecting their autonomy and rights as research participants.

Data collection procedures involved semi-structured interviews, which allowed for a collaborative exploration of participants' experiences. Through rigorous transcription and analysis procedures, trustworthiness of the data was maintained. The coding process, consisting of initial, focused, and theoretical coding stages, facilitated the emergence of themes and patterns from the data. Additionally, the creation of a conceptual map visually represented the theoretical framework derived from the analysis. A collaborative research team, including the external

auditor, contributed to the rigor and trustworthiness of the study. Memo-writing and ongoing reflexivity practices further enhanced the transparency and depth of the analysis. By adhering to the principles of CGT and ethical guidelines, this study aimed to provide a nuanced understanding of the mental health experiences of individuals in sex work.

Chapter 4: Results

Introduction

This chapter will present the study results through the lens of Constructivist Grounded Theory, explore the themes and patterns that emerged from the data, and shed light on the complex interplay between mental health and experiences in sex work. By grounding the findings in the rich narratives of participants, this study seeks to contribute to a deeper understanding of this often-marginalized population and inform future research and interventions in the field.

Constructivist Grounded Theory (CGT), originating from the work of Charmaz (2000, 2014), facilitated an inductive and iterative exploration of participants' narratives, allowing theory to organically emerge from the data itself. Employing semi-structured interviews and meticulous transcription procedures, we amassed a wealth of qualitative data, capturing the intricacies and nuances of participants' experiences. The rigorous data analysis methods facilitated the identification of key themes and patterns within the data, offering a holistic understanding of participants' perspectives on mental health and sex work. The selection of this qualitative research methodology aimed to address the deficiencies of previous research and enable a profound exploration of the lived experiences of individuals in sex work. Embracing CGT, our research team immersed themselves within the data, acknowledging personal biases and promoting reflexivity throughout the research journey. These findings depict a vibrant tapestry of experiences, illuminating the intricate interplay between mental health and engagement in sex work.

The results presented in this chapter provide invaluable insights into the coping mechanisms, challenges, and resilience strategies utilized by individuals in sex work to navigate

their mental health. By centering the voices of participants and grounding the analysis in their lived experiences, this study contributes to a more holistic understanding of this often-marginalized population.

Subsequent sections of this chapter will delve into the emergent themes and sub-themes derived from the data. Most themes will be accompanied by illustrative quotes from participants, offering a glimpse into their lived realities. Participant quotes were selected when they further expressed the findings of the study in a way that could not be done without the quote present. Thus, while all themes have been constructed based on participants' voices, not all themes will contain participant quotes. Through this exploration, we endeavor to amplify the voices of individuals in sex work, challenge stigmatizing narratives, and inform future research and interventions in the realm of mental health and sex work.

Description of Participants

This section offers a comprehensive overview of the demographic profile of the study participants, a critical aspect for contextualizing their identities and experiences within the developed theory. All participants were situated in the Midwestern region of the United States throughout the study duration. The demographic questionnaire employed in this study encompassed a spectrum of variables, including preferred pronouns, gender identity, race and ethnicity, tenure in sex work, types of sex work engagements, current involvement in sex work, mental health challenges encountered during sex work, and formal mental health diagnoses.

70% of participants indicated their preferred pronouns as She/Her, while 10% identified with They/Them pronouns, and the remaining 20% either did not specify a preference or refrained from using pronouns. Regarding gender identity, 90% of participants identified as

women, among whom 22% identified as transgender, and 10% as agender. Racial and ethnic diversity among participants was represented by 90% identifying as Black/African American and 10% as White/Non-Hispanic. See Table 2 for a full listing of demographic data.

Table 2
Participants' Demographic Data

Participant	Preferred Pronouns	Race/Ethnicity	Gender Identity
P1	She/Her	Black/African American	Cisgender Woman
P2	-	Black/African American	Cisgender Woman
P3	She/Her	Black/African American	Cisgender Woman
P4	She/Her	Black/African American	Cisgender Woman
P5	She/Her	Black/African American	Cisgender Woman
P6	-	Black/African American	Transgender Woman
P7	She/Her	Black/African American	Cisgender Woman
P8	She/Her	Black/African American	Transgender Woman
P9	She/Her	Black/African American	Cisgender Woman
P10	They/Them	White/Non-Hispanic	Agender

Note. This table was created using the information provided above for clarity.

The duration individuals were engaged in sex work ranged from nine months to 35 years, underscoring the breadth of experience among participants. At the time of the study, 60% of participants are actively engaged in sex work, while 40% are not, indicating a diverse range of current involvement.

All participants in this study engaged in more than one form of sex work while working, showcasing the multifaceted nature of their experiences. Specifically, the range of forms of sex

work encompassed two to five distinct categories. Predominantly, 90% of participants engaged in prostitution, illustrating its prevalence among the cohort. Additionally, 50% were involved in phone sex services, 40% in exotic dancing/stripping, 40% in dominatrix/submissive work, 40% in sugaring, 30% in escorting, 20% in camming, and 10% in erotic massage. See table 3 for a full listing of participants' backgrounds in sex work.

Table 3
Participants' Background in Sex Work

Participant	Years in Sex Work	Currently Engaged In Sex Work	Forms of Sex Work
P1	10	Yes	Prostitution, Phone Sex Services
P2	30	No	Prostitution, Exotic Dancing/Stripping
P3	25	Yes	Prostitution, Erotic Massage, Sugaring, Dominatrix/Submissive Work, Escorting
P4	35	Yes	Prostitution, Phone Sex Services, Dominatrix/Submissive Work
P5	15-20	No	Prostitution, Exotic Dancing/Stripping, Sugaring, Phone Sex Services
P6	20+	Yes	Prostitution, Phone Sex Services, Dominatrix/Submissive Work, Escorting
P7	11	Yes	Prostitution, Phone Sex Services, Dominatrix/Submissive Work
P8	20	Yes	Prostitution, Exotic Dancing/Stripping, Sugaring
P9	20+	No	Prostitution, Exotic

Dancing/Stripping, Camming, Phone
Sex Services, Escorting

P10 9 months No Sugaring, Camming

Note. This table was created using the information provided above for clarity.

Regarding mental health concerns and emotional experiences while engaged in sex work, participants reported a range of challenges. Ninety percent expressed feelings of fear, 70% reported feelings of depression and anxiety, 60% experienced anger and sleep disturbances, and 60% had concerns about their safety or perceived life threat. Additionally, 50% had a history of suicidality, 40% reported concerns related to eating and substance use, while 20% dealt with identity concerns, and 10% experienced guilt and disappointment.

Furthermore, formal mental health diagnoses were reviewed, with Major Depressive Disorder (MDD) being the most common, affecting 60% of participants. Generalized Anxiety Disorder (GAD) and Bipolar Disorder (BD) were the next most common diagnoses, each affecting 40% of participants. Other formal diagnoses included Schizophrenia (30%), Attention Deficit/Hyperactivity Disorder (ADHD) (10%), and Persistent Depressive Disorder (PDD) (10%). Notably, 20% of participants had never received a formal mental health diagnosis. See table 4 for a full listing of participants' mental health and emotional experiences while in sex work.

Table 4
Participants' Mental Health and Emotional Experiences

Participant	Mental Health Concerns/Emotional Experiences	Formal Diagnoses
P1	Anger, Guilt, Disappointed	None
P2	Fear, Perceived Life Threat, Suicidality,	None

	Substance Use	
P3	Fear, Sleep, Eating, Depression, Anxiety, Anger, Identity	Major Depressive Disorder
P4	Fear, Sleep, Depression, Anxiety	Major Depressive Disorder & Bipolar Disorder
P5	Fear, Sleep, Perceived Life Threat, Depression, Anxiety, Anger	Major Depressive Disorder, Generalized Anxiety Disorder, Bipolar Disorder, & Schizophrenia
P6	Fear, Sleep, Perceived Life Threat, Depression, Anxiety, Suicidality, Anger, Substance Use	Bipolar Disorder
P7	Fear, Sleep, Perceived Life Threat, Eating, Depression, Anxiety, Suicidality, Anger, Identity	Major Depressive Disorder, Generalized Anxiety Disorder, Bipolar Disorder, Schizophrenia, and Attention Deficit/Hyperactive Disorder
P8	Fear, Perceived Life Threat, Suicidality, Anger, Substance Use	Schizophrenia
P9	Fear, Sleep, Perceived Life Threat, Eating, Depression, Anxiety, Anger, Substance Use, Auditory Hallucinations	Major Depressive Disorder, Generalized Anxiety Disorder
P10	Fear, Eating, Depression, Anxiety, Suicidality	Major Depressive Disorder, Generalized Anxiety Disorder, & Persistent Depressive Disorder

Note. This table was created using the information provided above for clarity.

This demographic overview underscores the intricate interplay between individual experiences, societal contexts, and the multifaceted nature of sex work. Through an exhaustive examination of participant demographics, encompassing preferred pronouns, gender identity, race and ethnicity, tenure in sex work, types of sex work engagements, current involvement,

mental health challenges, and formal diagnoses, a rich collection of narratives emerges, illuminating the diversity of lived experiences within this study.

The contextual understanding provided by the demographic information is pivotal for comprehending the subsequent constructivist grounded theory results. By clarifying the diverse identities, experiences, and challenges faced by participants in the realm of sex work, this demographic overview lays the groundwork for interpreting the emergent themes and conceptual frameworks uncovered through the constructivist grounded theory approach. The nuances captured in the demographic data inform the lenses through which participants engage with and navigate their lived realities, thus enriching the depth and breadth of the ensuing analysis. As such, a nuanced understanding of participant demographics serves as a critical lens through which to interpret and contextualize the constructivist grounded theory results, facilitating a more comprehensive and insightful exploration of the complexities inherent in the phenomenon under study.

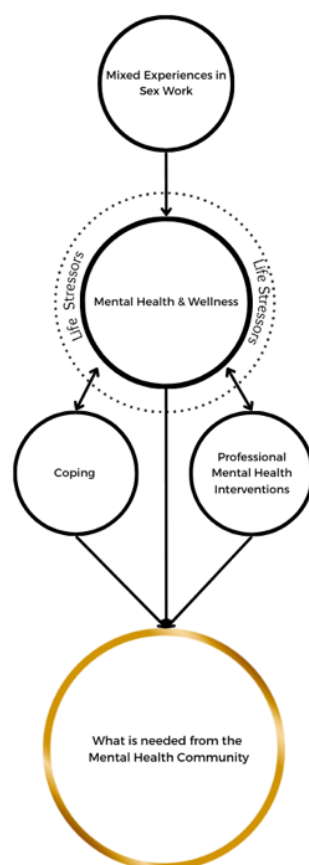
Results

The results section of this constructivist grounded theory (CGT) dissertation delves into the rich array of coping strategies and mental health care utilization among individuals engaged in sex work. Grounded in the lived experiences and perspectives of participants, this section illuminates the multifaceted ways in which individuals navigate the complex intersection of sex work and mental health within the greater context of their life and additional stressors. Through thematic analysis, we uncover the diverse array of coping mechanisms employed by participants to manage the challenges and stressors inherent in their profession, as well as the barriers they encounter in accessing and engaging with mental health care services. By delving into these themes, we gain deeper insights into the lived realities of individuals in sex work and the broader

sociocultural factors that shape their experiences. This exploration not only enhances our understanding of the coping strategies utilized within this population but also informs the development of more tailored and effective interventions to support their mental health and well-being. In accordance with CGT, an image has been generated to display the theoretical framework of these results (Figure 1). The visual representation is created to further understand how the main themes interact and connect with one another within the greater context of participants' lives.

Figure 1

Visual Representation of Grounded Theory: Coping and Mental Health Interventions for the Life and Work Stressors of Sex Workers



Main Themes

Figure 1 illustrates the developed theory grounded in the experiences of this study participants and the variety of experiences they had within sex work, and also as individuals in life. These experiences ultimately impact their mental health for better or worse. However, their experiences are not the only impacts on individuals' mental health. Rather, these experiences are simply another variable that influences individuals' mental health as general life outside of sex work also impacts participants mental health. For example, multiple participants illustrated concerns with their physical health, feeling worried or concerned about family members, having other tasks and activities to try to accomplish outside of work to fulfill life and community obligations. Thus, viewing the data within a larger framework of life, noting that sex work is a fraction of their experience, is essential. Further, participants employed both coping strategies and professional mental health. These interventions came about to manage their mental health and ultimately influenced their overall mental health and wellness. It is the participants' experiences with coping, professional mental health interventions, and ultimately their overall mental health and wellness that brings about their suggestions and requested needs from the Mental Health community at large. The following sections will dissect and elaborate on these themes further.

Mixed Experiences in Sex Work

Central to the narratives shared by participants in this study is the theme of having a mix of neutral, positive, and negative experiences while in sex work. This is important to highlight as this theme resembles life experience similar to many other careers, a blend of highs and lows, challenges, and successes, throughout. Most notable, participants highlighted the theme of sex work being fun and also having endured real threats to their overall well-being and life.

Sex Work is Fun

Within the theme of having mixed experiences in sex work, participants noted the idea that sex work can be fun. Multiple participants noted the beginning of sex work was particularly fun. P10 described her reason for engagement in sex work was due to the fun she thought she could have and initially experienced: “I also wanted to do it for fun. And you’re just like ‘you know, why the fuck not? This IS fun!’” Participants expanded that beyond their initial excitement and fun in sex work, they selected certain forms of sex work to engage in because of the enjoyment they experienced doing that specific form of it. P1 described stripping as one form she engaged in because it was fun and allowed her to play. “I did it for playing, I mean, yeah for fun. I’ve dressed in some dumb shit and did it for fun, yeah.” This quote highlights the way integrating fun and play guided P1’s experience in sex work; she described her experience with her clients as being rooted in fun to the point that does not feel like a chore or work:

I don’t know how to describe it but, it’s not like I’, selling them sex, but I know I’m going for the money. But I make it fun. You know what I’m saying... we have fun sex, you know, using whipped cream, milk, body wash, shea butter, all kinds of shit.

Even though this is her job, P1, is able to have fun with it, incorporates a level of play, and gets to try new ways to work with her clients.

However, this is not to say that we now ignore the other parts contributing to the mixed experiences of participants. Other participants noted that they enjoyed their experience in sex work and/or at least had fun and enjoyment at the start of their work. Specifically, P8 noted that sex work used to be fun for her. However, just as the overarching theme of participants having mixed experiences highlights, P8’s experience in sex work changed. P10 elaborated further on

P8's notion by stating, "Although fun, [sex work] was, you know- not black and white." This quote highlights the varied nature of sex work; it provides the context that while it can be a chosen profession, enjoyable and fun for those who chose it, it also carries certain threats.

Experiencing Violations & Threats

The range of threats participants experienced was vast and included name calling, having clients violate the original work agreement, physical violence, sexual abuse, and/or threats on the participants' lives.

Multiple participants described being called degrading names while in sex work. When talking about being called different names P3 stated, "Yeah, I had been talked about. You know, like during my prostitution days. Just called me all kinds of names like whore and slut and stuff like that. Really, it used to bother me."

Additional threats experienced by participants included clients violating original agreements of service. All participants reported explicitly discussing with their clients what services they offer and would mutually agree on what services they would provide their clients before engaging. However, multiple participants reported having clients violate the original contract without seeking consent of the participant. These violations included clients not paying the full amount of money that was originally agreed upon, recording participants and distributing said recording without their consent, and sexually assaulting and/or raping participants. P7 specifically noted an experience with a client where her consent was not obtained and her pleas for the client to stop did not suffice:

I was scared because he wanted to wrap a belt around my neck and you know, I didn't know he was gonna do that. He came from the back and went like this [shows someone

grabbing her neck]. I'm like, what are you doing? [He's] like nothing, I'm just holding you from the back. I'm like, oh, and he slid up and his hands were like this. But his arms went off, and then I felt like a pressure. So I was like, what are you doing? Like, let me go, it's tight, I can't breathe. And he was just holding the belt. So I took my phone off mute. And I'm like, I can't breathe. You squeezing it so tight, let me go. And the whole time he's doing it, he's laughing. And then I'm like please stop and then I stopped talking for a couple seconds and then he let go and I started gasping for air.

P7's experience highlights the critical importance of ongoing consent and communication in sex work interactions. Despite initially consenting to physical contact, P7's boundaries were violated when her client introduced a belt without her consent and disregarded her pleas to stop. This highlights the need for clients to seek explicit consent before engaging in any new or potentially harmful activities, and for sex workers to have agency and control over the services they provide. Moreover, P7's account sheds light on the pervasive risk of clients as individuals in sex work may face coercion, violence, and non-consensual behavior at the hands of clients aligning with existing research documenting the prevalence of such threats within the industry (Smith et al., 2019; Monto & Milrod, 2014). By sharing her experience, P7 contributes to a broader understanding of the complex and often hazardous realities of harmful clients that individuals in sex work may face. Other participants reported instances of rape and being lied to about sexually transmitted disease status by clients. These threats were further compounded by clients threatening the physical wellbeing and lives of participants.

Multiple participants noted experiencing physical violence by clients and/or having their physical safety threatened by clients. P2 described saying “no” to a client about performing a specific service the client requested but had not originally agreed to. P2 stated the client's

response was “if you ain’t doing it, you can get the fuck up out my car or Imma kill your ass.” While this client did not enact physical harm on P2, many other participants noted similar threats of being killed if they would not cooperate. Two participants, P6 and P8, described having clients pull out guns on them. While P8 described the client pulling a gun on her as “a regular day,” she described the situation further escalating as the client tried to push her out of the car while on the highway with the gun pointed at her. P6 described the efforts she took to protect herself when she was in a car with a client and turned to find a gun pointed in her face.

So, I was trying to put my side of the passenger seat down back and when I turned my head towards the door of the car, and I looked back at him, there was a big gun in my face. I managed to get it out of my face and knock it out of his hand, and I jumped out of the car. By the time I got to the end of the alley, it was “pow,” and it hit my arm.

Thus, some participants endured physical violence despite actively defending themselves and taking safety precautions while working.

Mental Health & Wellness

Similar to the mixed experiences in sex work among participants, participants’ mental health and wellness also varied. This study investigated the mental health and wellness of individuals while they were in sex work. However, that is not to say that individuals’ mental health and wellness was entirely dependent on their involvement in sex work. While sex work may involve certain threats as previously described, there are also additional benefits. Similar to other careers, sex work is one element of individuals’ lives and those engaged in sex work enter their careers with their own set of circumstances, premorbid mental health conditions, and interpersonal dynamics at play. While noted previously in the demographic section, participants elaborated further on their emotional experiences while in sex work.

Participants largely described grappling with various emotional challenges that included anxiety and depression. While some reported experiencing anxiety as improving with age and described their sleep patterns as relatively stable, others expressed ongoing struggles with bad anxiety, particularly when faced with the uncertainty of interactions with clients. Additionally, participants often described depression as overshadowing their experiences, with some noting that it felt more manageable than their anxiety but still significantly impacted their well-being.

Fear emerged as a dominant theme, permeating participants' narratives about their experiences in sex work. The fear of potential threats from clients, such as violence or exposure to sexually transmitted infections, was a constant concern. This fear extended to the streets themselves, with participants expressing discomfort and vulnerability while working in these environments. The fear of unknown dangers, particularly when getting into cars with clients, underscored the pervasive sense of risk and insecurity that characterized their experiences.

Despite the challenges they faced, participants also highlighted moments of empowerment and resilience in their narratives. Engaging in sex work, for some, provided a sense of control and agency over their lives, offering financial independence and a means of survival. Participants described developing coping mechanisms to navigate the complexities of their circumstances, such as compartmentalizing emotions and focusing on survival. However, these coping strategies often coexisted with feelings of self-hate, shame, and isolation, reflecting the nuanced and multifaceted nature of their experiences.

The narratives shared by participants in this study offer a nuanced understanding of the emotional landscape experienced by individuals engaged in sex work. Anxiety and depression emerged as prevalent challenges, echoing findings from previous research (Goffman, 1963; Weitzer, 2010). While some participants reported improvements over time, others faced ongoing

struggles, underscoring the heterogeneous nature of mental health experiences within this population (Dalla, 2000; Lazarus & Folkman, 1984). The pervasive theme of fear, encompassing concerns about client violence and street-based vulnerabilities, aligns with existing literature on the risks associated with sex work (Sanders, 2005; Monto & Milrod, 2014). Despite these challenges, narratives of empowerment and resilience mirror findings that highlight the agency and coping strategies adopted by individuals in sex work (Phoenix & Oerton, 2010; Dewey et al., 2018). However, the coexistence of coping mechanisms with feelings of self-hate and isolation suggests a complex interplay between empowerment and emotional distress (Giobbe, 1993; Vanwesenbeeck, 2001). Thus, a further understanding of how individuals do cope and navigate these experiences is warranted.

Coping Strategies

Participants in this study endorsed a variety of coping strategies for the lived experiences and mental health while engaged in sex work. As earlier noted, participants described coping with the challenges of sex work itself in addition to preexisting mental health challenges and life stressors outside of work. The coping strategies discussed align with both active and passive coping strategies as described previously. Thus, the coping strategies have been organized in this way due to organic alignment.

Active Coping

Establishing Boundaries and Assertiveness. A main way participants engaged in active coping was by communicating clearly what their expectations were to clients regarding payment, services, and appropriate behavior. This communication reinforced the nature of the relationship they would be having and set a clear understanding of the rules of engagement. By simply

asserting and enforcing prices to reflect the value of services provided, participants reinforced that this was in fact a service that had value. These boundaries served as a way to protect participants financially, emotionally, and physically. Staying true to these boundaries as much as was within their power proved essential and a high value among participants as they would even refuse clients who did not meet financial requirements or exhibit disrespectful behavior despite the guarantee of income. Safety was a clear top priority and participants would actively take proactive measures to ensure safety, such as not working in certain areas or refusing clients who try to underpay for services.

Self-Protection and Safety Measures. Participants also used active coping through enforced safety measures within the rules of engagement by refusing to engage in certain services, assess for sexually transmitted diseases, refuse unprotected sexual activity, and refusing clients that were demanding or pushing these boundaries. Some participants reported vetting clients ahead of time either through other individuals in the field or via personal assessment the first time they interact with a client. All participants noted that they needed to achieve a sense of trust with their clients before engaging with them or providing any kind of services to them. Many participants described having great relationships with clients that have lasted for years. P5 noted she has been working with some clients for nearly 25 years and P1 described her clients as “my friends” who she has a great deal of love and respect for.

They my guys, you know- they my friends now [...] They don't hurt me. I could call them right now and get money from them, call and get a ride, call and get something to eat. I like, I love them. I love both of them- they just cool. Yeah, real cool. They friendly to me, they nice to me, they don't treat me bad or nothing.

Additional safety measures taken by participants included utilizing physical actions to remove oneself from uncomfortable or threatening situations and carrying their protection, to minimize risks. One participant noted how they would have their phone on at all times while engaging in sex work to ensure that someone knew where they were and if anything went wrong:

[My cousin] always wanted, like, when I do things- he wanted me to have him on the phone. [He'd say] 'put your mute off and speaker on so I can hear everything. Share your location so I know where you at' and I said 'okay.' So, that's what made me actually feel comfortable and so I was okay with doing it.

Seeking Community and Self Advocacy. Some participants noted seeking and engaging with a network or community has been especially helpful for their mental health management. Specifically, some participants noted their own religious faith, spirituality, and prayer helped manage both stress and intrusive thoughts. However, spirituality and religious environments were not endorsed by all participants of being safe spaces. Largely, participants noted that they would resist societal stigma and negative perceptions of sex work through their own self-advocacy and by engaging with trusted people or communities that were supportive.

Specifically, participants noted that social support itself acted as a form of protection. P7 noted her cousin would always have her back and looked out for her. As noted previously, P7 had a threatening situation occur when a client violated her trust and assaulted her with a belt. She had her phone on during this interaction with her cousin on the line. She had muted herself throughout this interaction but managed to unmute herself so her cousin could hear her pleading for her life. She went on to say, "my cousin came through the door. It felt so good to see his face. And he was like 'You almost killed her- who the fuck is you?' [to the client]. [And then] he took me to the hospital to make sure that [the client] didn't mess up anything in me." Additional

participants felt similar protection from close relatives and friends and God. Some noted simply having people they could talk to about their experiences, especially before and after working for the day, helped them debrief their experiences and alleviate any stress or tension.

However, the benefits of these social supports largely hinged on the beliefs of the people in participants' lives. Some noted that they would not receive support from friends and family unless the participant adjusted the frequency that they worked in sex work. P3 reported that her relationship with her friends and family has improved now that she is not engaging in sex work as frequently. Specifically, P3 noted "they treat me better, give me more respect." P1 also noted that she started cutting back on sex work because of the reaction her mother had when she found out that P1 was engaging in sex work:

Oh yeah, my Mother was hurtful [when she first found out]. When my mom found out- I told her the truth [...] When my mother found out- instead of me going every day, every day, every day, it'd just be two guys. So she's still not okay with it, but she feels better that it's two rather than 200.

Her mother's perception of her work altered P1's behavior so that she could receive more support from her mother- drastically adjusting the number of clients she interacted with. Thus, social support is powerful as it allows participants to feel safe and supported but also can hinder on the approval and/or expectations this support has on the ways participants engage in sex work.

Given the participants' report of social support being transactional and dependent on whether or not they were engaging in sex work, many participants noted that they did not actually have social support at all. This lack of social support was a result of more stereotypical supports, such as friends and family, projecting bias and judgment. P8 noted that she was labeled

as the black sheep of her family and facing judgement due to her work. P9 reported that she actively tried to receive validation and support from her family and develop strong relationships with them but found that her involvement in sex work fueled her family's attempts at deeming her incompetent, casting her aside, and not addressing any of her needs even when she felt at her lowest mentally.

This time around I really am just winging [the management of my mental health] because I have the issues with my family, my girls. It's really wearin' and tearin' on me [...] They're trying to say I'm incompetent. You know? In what they do, how they treat me. That isn't what I need. That's not it [...] I'm not looking for instant gratification, I just need [my family] to say, "okay," I need you to answer your phone. Simple things. I need people to be there. Period.

When social support was present, it could drastically help participants manage their mental health and wellness. However, the often times conditional nature of social support and loved ones' opinions about sex work often led to reducing frequency of work to achieve approval of friends and family. Others would often not have support due to the bias and stigma asserted by their friends and family. This highlights the desire on the part of sex workers for social support to not only be available, but to be unconditional as well. Mental health practitioners can help sex workers by exhibiting a non-judgmental and supportive opinion and care that is not conditional to the details of participants' work or supporting them when family members are not able to provide this type of support.

Participants would navigate the varied opinions of those in their lives and the conditional social supports by engaging in selective disclosure about their work. Selective disclosure refers to participants actively assessing and sharing their work with a select few individuals whom they

believe they can trust. Most participants noted that their engagement in sex work was largely kept a secret. P4 described keeping sex work as a secret is relatively easy and it prevented her from experiencing stigma. However, P4 did not she would let some of her doctors know she engaged in sex work because she felt that she could trust them. Alternatively, P3 and P10 described having therapists that they have worked with and even felt a sense of trust with whom they never disclosed their work to. P10 elaborated further:

Even the therapist that I have had since junior year of high school still doesn't know I have done this [...] I'm so scared that if I tell her that she's gonna be like 'ooo.' But at the same time, logically, I know she would be, you know, it's been a few years first of all. She could, she would be like, 'okay.' But I can't see myself anytime soon telling her.

This fear of how trusted people would react that P10 shared here was endorsed by multiple participants in this study.

P7, P8, and P9 all expressed having family members and loved ones respond negatively when they disclosed their involvement in sex work. Specifically, these participants reported their family and loved ones would often express their disappointment in the participant for engaging in sex work, judge participants for their work, want the participants to stop engaging in sex work, and openly discuss their dislike for participants' work. Participants would then be selective in what they shared to the people whom they wanted to trust to avoid negative interactions with support systems. This included limiting the details they disclosed, not discussing threats experienced while working, and or not disclosing entirely so that participants would avoid judgement, discrimination, and lose support from those they loved and cared about.

Mental Health Skill interventions. A third method through which participants used active coping to manage their mental health and wellness involved the application of specific coping skills commonly discussed in therapy and the mental health field. Notably, participants mentioned engaging in therapy, receiving psychotropic support as needed, and utilizing skills specific to Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT). These included relaxation techniques, positive self-talk, emotion regulation skills, self-soothing strategies, interpersonal effectiveness through maintaining personal boundaries, and addressing basic needs to mitigate vulnerability factors such as sleep hygiene practices and grooming. Emphasizing these skills is essential as previous assessments of this population often overlook or fail to explore how individuals in sex work employ these specific coping mechanisms discussed in psychology and counseling. While not all participants accessed psychotherapy, as will be elaborated upon later, many still acquired and applied comprehensive coping strategies derived from DBT and CBT. This underscores the adaptive nature of individuals in sex work, who draw from their experiences, interactions, and self-awareness to identify effective coping mechanisms and incorporate them into their lives with resilience and determination.

The participants largely demonstrated a proactive and empowered approach to coping with the challenges and stressors associated with sex work, emphasizing the importance of assertiveness, self-protection, and self-care in maintaining well-being and safety. Additionally, participants also employed passive coping strategies including some avoidance strategies.

Passive Coping

Individuals engaged in sex work also employ avoidance strategies to navigate potentially harmful or undesirable situations. This passive coping mechanism is evident in various aspects of their experiences. Participants in this study described physically removing themselves from

threatening or uncomfortable environments, such as leaving interactions with clients when faced with hostility or violence (P3, P4, P5). Additionally, avoiding confrontations or conflicts with clients or peers is a common strategy, as seen in participants' decisions to not engage in arguments over payment or respond to derogatory remarks (P5, P6). These strategies helped the participants to avoid harm and retain a sense of safety. P5 described how why she actively walks away from clients even if they did not pay her or would get angry with her:

I'm not gonna argue my life anymore. My life is more important than, you know, money [...] I would just take slow, deep breaths, ask for a cigarette. I don't know- I really didn't have a temper when I was out there. I didn't wanna run into no bad encounters.

Participants also used avoidance to deal with difficult feelings and experiences in sex work and in their lives in general. Some demonstrated a tendency to withdraw or isolate themselves emotionally when feeling overwhelmed or unsupported, choosing to keep their thoughts and feelings to themselves rather than seeking social support (P7, P8). Furthermore, substance use emerged as a coping mechanism for avoiding negative emotions or experiences, with individuals turning to drugs or alcohol to numb their feelings or escape from distressing situations (P8, P9). Overall, the avoidance of negative situations serves as a protective mechanism for individuals in sex work, allowing them to minimize their exposure to harm and maintain a sense of control over their circumstances.

The biggest issue- it was hell working the streets, man- being in [sex work] and not on my medication I had to put up with some things, you know? I used it as a substitute- getting high. You know what I mean? I had to, I went off my medication, I knew that the drugs was the only thing that would give me that quick release [...] I could do drugs and

get [the job] done. The risks wasn't a big problem then, you know? Because I was getting high, and I had a job to do.

Another way in which participants used passive coping to avoid uncomfortable feelings was the use of distraction and dissociation. It is not uncommon for individuals engaged in sex work to manage distressing situations or emotions in this way (Smith et al., 2020). Participants described various ways in which they engage in activities or behaviors to divert their attention from negative experiences. For instance, some individuals mentioned using substances, such as drugs or alcohol, as a means of distraction from their mental health concerns or the challenges of sex work (P8, P9). Additionally, engaging in risky or thrilling behaviors served as a form of distraction from underlying feelings of depression or anxiety, providing a temporary escape from emotional distress (P10). Dissociative experiences were also reported, with participants describing instances where they mentally disconnected from their surroundings or emotions to cope with overwhelming situations. This dissociation often manifested as a detachment from reality or a numbing of emotions, allowing individuals to temporarily distance themselves from distressing experiences (P2, P8). P8 went on to specifically explain how she copes with her boyfriend not supporting her work:

Like yesterday, I didn't feel like I was wanted. I didn't feel too good about myself [...] I just deal with it most of the time- it's like a pain [...] I isolate myself; I cope with it myself; I deal with it- with my pain. I shut everything down I shut myself down. I just sit down and zone out. Don't let anybody know nothing about me.

Forms of Mental Health Care

In addition to coping strategies, participants illuminated their experiences with formal mental health care. This theme of note uncovered the use of mental health care among the participants

engaged or having engaged in sex work. Participants in this study highlighted the use of three major forms of mental health care: inpatient treatment and hospitalization, outpatient treatment and therapy, and medication management. Participants noted that accessing mental health care often was the result of them experiencing their hardest moments emotionally and mentally. Specifically, some participants pointed out that their ability to access psychiatry and psychology services was only possible while in jail or by voluntary hospitalization. Participants further elaborated that engagement in psychological care was often discontinued upon release from jail and/or discharge from the hospital itself. P2 specifically described the access to mental health care and her experience with it while in jail:

Because I was in jail, this person came to talk to me in jail and she said I have a mental problem and blah blah blah. But I never- you know, when they let me out of jail, I never seen the lady and she never came around no more. So actually, I was kind of [like]- well that's weird.

Thus, P2's access to her mental health professional was dependent on her being incarcerated. P2 denied any additional referrals being made or resources provided for her mental health care upon her release.

Some participants engaged in mental health care in an outpatient setting. For those participants who used outpatient treatment and therapy, the use of psychotherapy was to discuss the ups and downs participants experienced and their daily life stresses. P3 explicitly noted that her engagement with Mental Health Professionals was not to speak about sex and sex work:

You know, it wasn't based upon sex. You know, I dealt with it in the past [...] I wasn't thinking about it. [I went to therapy because] of a lot of stress. Lost my mother, lost my

baby in the same year. Just going through ups and downs and lot of other things- arguing with my kids' father and getting jumped on, beaten on, a whole lotta abuse, a whole lotta other things besides sex.

In fact, most individuals in the study who engaged in outpatient psychotherapy did not disclose their work to mental health professionals. P3's statement provides insight as to why this is the case beyond fear of stigma and discrimination. As P3 noted, there are other things that felt more pressing and important for her to address in therapy. This further highlights the notion that someone's job, common among all jobs including sex work, is only one part of an individual's life. Their treatment may include addressing the impact of work on their lives, but that may likely not be the sole reason for engagement in treatment, nor may it be the sole focus of treatment. Participants noted that the most helpful piece of treatment were to have people that would listen to them without judgment, gave them a safe space to talk about whatever they wanted to discuss, and provided coping strategies for navigating life stressors, emotional distress, frustration tolerance and interpersonal effectiveness.

Not all participants accessed mental health care, however; some did not engage in any form of mental health care because of the concern that they would be expected to quit sex work as a part of treatment. P1 noted that in order to engage in treatment that was offered to her, quitting sex work was deemed as a requirement, much like abstinence from substance use in certain treatment facilities. Thus, despite potential benefits of accessing resources, individuals in sex work have multiple barriers that may be limiting their ability to engage and accessing comprehensive equitable care.

Barriers to Mental Health Resources

One of the most significant barriers to accessing mental health care was a general lack of awareness among participants of what mental health resources were available. P3 noted that she had been attending a resource center that provided food and clothing but had no idea that they also provided mental health care despite attending for years. P6 also highlighted an additional practical barrier: having limited flexibility and/or time constraints due to the nature of sex work.

However, some, regardless of knowing what resources are available to them, thought accessing mental health care was either unnecessary or had the potential to be unhelpful. Some participants noted that it did not feel necessary for them because they did not have reason to engage in treatment at this time. Some participants felt that, if they did have issues to address, they had the ability to resolve them independently. Others noted feeling that therapy would be futile because the mental health professional (MHP) might try to convince the individual to stop sex work, which they are not willing to do, especially without the offer of any other meaningful assistance. P1 demonstrated further resistance to seeking mental health care due to the perception that talking to professionals would make them feel like they are asking for help, which the individual resists. P5 further noted that engaging in therapy would feel like her privacy was invaded as she would be expected to share personal information she does not want to share.

Many participants described feeling that therapy has been unhelpful or ineffective, leading to disinterest in seeking further treatment. One of the biggest contributors to this belief was the negative experiences participants had and/or hearing about the negative experiences other individuals in sex work had with mental health professionals.

Negative Experiences with Mental Health Professionals

The exploration of negative experiences with mental health care providers among individuals engaged in sex work reveals a complex interplay of factors that hinder effective support. Participants articulated a profound sense of disillusionment with mental health facilitators, attributing their dissatisfaction to a lack of authenticity, integrity, and empathy in their interactions. This sentiment was particularly pronounced in instances where facilitators were perceived as engaging in behaviors incongruent with their professional role, such as drug use, or when participants felt that treatment modalities were driven more by profit motives than genuine concern for their well-being (P1). Moreover, participants described discomfort and judgment during discussions about their involvement in sex work, often resulting in feelings of alienation and inadequacy (P4, P5, P10). P4 described how all the doctors on her care team have felt comfortable talking with her about sex work except for her psychology provider. “He just sits there and looks at me and starts laughing. I know he’s not comfortable when I am talking, I can tell.” P4 further described how her psychology provider’s body language informed her of his discomfort as he would move around a lot in his chair and would try to move her along and out of his office when they met. This ineffectiveness of mental health care services extended beyond interpersonal dynamics to encompass broader systemic issues, such as a lack of comprehensive support and a failure to address the unique challenges faced by individuals in sex work (P6, P7, P8). P7 endorsed having multiple people in her life that do not take her concerns seriously, with mental health professional being a large part of that, despite her asking for help. These findings show the urgent need for mental health care providers to cultivate trust, demonstrate genuine empathy, and develop a nuanced understanding of the multifaceted experiences of individuals in sex work. Such efforts are essential to fostering a therapeutic environment that is inclusive, supportive, and conducive to the well-being of this marginalized population.

Participants in this study highlighted various barriers to accessing mental health resources, including a lack of awareness of available services, time constraints due to the nature of sex work, and concerns about the effectiveness and potential consequences of therapy (P1, P3, P5, P6). Negative experiences with mental health professionals further compounded these barriers, with participants expressing disillusionment with the lack of authenticity, empathy, and understanding displayed by some practitioners (P4, P7, P8). Such experiences not only hinder effective support but also contribute to feelings of alienation and inadequacy among individuals in sex work.

The urgency of addressing these issues is emphasized by the profound impact they have on the well-being of this marginalized population. While assumptions may be made on how mental health care providers can improve and/or what they must implement to provide equitable care to individuals in sex work from this section alone, participants in this study named direct and specific recommendations for the mental health field.

In summary, the findings from this study continue to emphasize the critical need for comprehensive and equitable mental health care services for individuals engaged in sex work. By addressing barriers to care and improving the quality of support provided, mental health professionals can play a pivotal role in promoting the mental health and well-being of this marginalized population. How mental health professionals may address these concerns, reduce discrimination amongst this population, and provide equitable care is explored in depth in the following section.

Suggestions for the Mental Health Field

An important subtheme articulated by participants, in this final area of mental health care utilization, was that individuals in sex work needed access to mental health care. As described briefly above, some participants are not aware of what resources are even available to them currently, with others finding it difficult to engage due to work restrictions. However, multiple participants noted the need for developing mental health resources and or adjusting current mental health resources to allow for individuals in sex work to have access to them. Largely, participants noted that there are not many, if any, mental health professionals or resource centers that clearly address the needs of individuals in sex work. Thus, if they are available, participants were not aware of them, but more so noted the lack of clarity regarding how resources may support them specifically considering they are engaged in sex work.

Additionally, nearly every participant reported the need for mental health care providers to be able to talk about both sex and sex work. When asked directly how mental health professionals can improve, P1 stated “probably address [sex work] more. They don’t really go into it, so they need more talk on that.” P10 had a similar notion stating it would be helpful if she had a therapist:

And just generally have it be more of an open discussion when it comes to better professionals in general- not just [a discussion between] medical professionals and client, but [between] medical professionals with medical professions. Let’s say you’re in a conference room or something with all doctors or whoever the fuck. Let’s talk about it! The client’s not here, but let’s talk about sex work. Let’s talk about how we can approach if someone may or may not be doing sex work, let’s bring it in. Let’s have criteria of questions we have to ask our clients, no matter what. They don’t wanna answer, that’s fine- but at least we said it out loud.

Despite the lack of participants who shared their experiences in sex work or disclosed their profession to mental health care providers, many participants built off of P10's statement, reflecting that it would be wonderful to have a mental health care provider who had knowledge about sex work, assessed for it as they do other areas of a person's life, and had the ability to openly communicate with the provider about their full experiences in life which includes sex work (P1, P2, P3, P8, P9).

Additionally, participants noted a major way for mental health providers to improve in their work and service to individuals in sex work included implementing basic counseling skills. Notably, the first skill noted was for mental health professionals to take their time and demonstrate active listening skills. When asked how mental health professionals could improve, P4 stated:

Listen to you. Really listen to [the individual in sex work]. See where they're coming from. Cause some of them can't explain themselves all the way out. Some of them can't do certain stuff. You got to really listen to them. It might confuse you. But you'll get it together. Just listen to them 'cause they feel like you are not listening to them.

Further, P9 stated, "I'm gonna say the truth no matter how it looks, you need to slow down and listen to me" reiterating the notion that mental health professionals need to slow down, take their time, and also be knowledgeable and prepared for the honest experiences individuals want to share with them.

An additional counseling skill desired by participants was for mental health professionals to be genuine. Many participants noted they would like to see a mental health professional that was going to be themselves (P1, P4, P6, P9). Many participants expressed an ability to

understand when people were not being authentic and/or when people were uncomfortable around them which inherently makes participants feel uncomfortable and that they cannot be honest about their full experience. Specifically, P4 stated:

I let them know right off the bat [if] I don't feel comfortable with you. Just be yourself [...] Not putting on a show, a professional show. Just be yourself. I'm gonna keep it 100. You keep it real with me, and I'll keep it real with you.

Participants also suggested that mental health professionals would be of stronger service if they were able to 'meet the individual where they are at'. Meeting a client where they are at means taking the time to get to know them, to understand where they are coming from, what experiences they are grounded in, and why they are coming into treatment. Additionally, taking a nonjudgmental stance, using person-centered language, and checking their own biases before and during engagement with individuals in sex work. P10 noted that these skills "feel kind of obvious, but for some people it's totally not." She further concluded her interview and perspective by noting that implementing these skills demonstrates respect to individuals in sex work and clients at large. Her final message is to mental health professionals is one that largely echoes the thoughts and beliefs of majority of the participants in this study:

Maintaining respect, knowing that the person's a human no matter what. I mean, almost everybody on this planet has sex, generally. And just because you have sex doesn't make you a dirty person. And just because you don't have sex doesn't make you this pure being, you know? You're just a person living your life. And if it means doing [sex work], making extra money for fun, or, you know, whatever, just respect- respect the work.

The findings from this study shed light on the critical need for accessible and tailored mental health care services for individuals engaged in sex work. The theme of mental health care utilization and the subtheme of addressing barriers underscores the importance of addressing the systemic barriers that hinder access to mental health resources for this population. Participants expressed a pressing need for mental health professionals and resource centers that specifically cater to the needs of individuals in sex work, highlighting a significant gap in current service provision (Smith et al., 2020). Additionally, participants emphasized the necessity for mental health care providers to engage in open and informed discussions about sex work throughout training, integrating it into their practice and actively addressing it as part of their assessments and treatment plans (Smith et al., 2019).

Moreover, participants articulated the importance of mental health professionals possessing fundamental counseling skills, such as active listening, genuineness, and meeting individuals where they are at (Surratt et al., 2012). These skills are essential for fostering trust and creating a therapeutic environment where individuals feel comfortable sharing their experiences and seeking support (Smith et al., 2020). Importantly, participants emphasized the need for mental health professionals to adopt a nonjudgmental stance and to check their biases, ensuring that individuals in sex work are treated with dignity and respect (Smith et al., 2019).

Conclusion

The findings from this study provide a comprehensive understanding of the coping strategies and mental health care utilization among the study participants—individuals engaged in sex work, shedding light on their unique experiences and needs within the context of their profession. Abiding by the tenants of CGT data analysis, several salient themes emerged,

illuminating the diverse array of coping mechanisms employed by participants to navigate the challenges and stressors inherent in sex work.

The examination of coping strategies revealed a nuanced interplay between active and passive mechanisms, underscoring the adaptive nature of individuals' responses to distressing situations. Active coping strategies, such as seeking social support and engaging in self-care practices, were identified as crucial components of resilience and well-being among participants (Smith et al., 2020). Conversely, passive coping strategies, including avoidance and dissociation, were also prevalent, highlighting the complex ways in which individuals manage their emotional experiences within the context of sex work (Surratt et al., 2012).

Exploration of mental health care utilization among the participants unveiled significant barriers to access and dissatisfaction with available services. Participants reported limited awareness of mental health resources, logistical challenges in seeking care, and concerns about stigma and judgment from providers much aligned with additional research findings (Smith et al., 2019). Negative experiences with mental health professionals, including perceived lack of authenticity, empathy, and cultural competence, further compounded these barriers, highlighting the need for education among mental health care providers and both tailored and culturally sensitive approaches to care (Surratt et al., 2012).

Importantly, the findings show the importance of addressing systemic issues and implementing evidence-based practices to enhance mental health support for individuals engaged in sex work. Strategies aimed at increasing awareness of available resources, reducing stigma, and providing flexible and nonjudgmental services are essential for improving access to care and reducing disparities in mental health outcomes (Smith et al., 2020), strong implications for future practice.

Finally, this study contributes to the growing body of literature on the intersection of sex work and mental health, providing valuable insights that can inform policy, practice, and future research endeavors in this field. By acknowledging and addressing the complex challenges faced by individuals engaged in sex work, we can strive towards a more just and inclusive society where everyone has access to the care and support, they need to thrive.

Chapter 5

“Most of those who look down on people who sell their bodies look up to some of those who sell their souls.”

- *Mokokoma Mokhonoana*

Discussion

Individuals in sex work are often discriminated against simply due to their occupation. These individuals are often rendered down to their job title and experience a great deal of stigma and barriers to care with both the physical and mental health field. Both fields treat individuals in sex work based on assumptions of individuals' occupation without consideration for their ability to attain, and overall right, to wellness. The current qualitative grounded theory study delves into the nuanced experiences of individuals involved in sex work, revealing a complex interplay of enjoyment and hazard. This exploration underlines the necessity for a comprehensive understanding of this field, aligning with current literature that recognizes the diverse experiences within sex work, and the changes needed to be made by mental health professionals, including counseling psychologists, to no longer contribute to the discrimination of this marginalized community (Sanders, 2005; Vanwesenbeeck, 2001; Weitzer, 2009; Sullivan, 2007).

This study revealed a theoretical framework for professionals and individuals to further understand the complexity and impacts of experience in sex work. Sex work is a fraction of a participant's life that impacts their mental health and wellness similar to additional aspects or stressors of participants' overall lives. The state of their mental health and wellness largely led participants to engage in both active and passive coping strategies and possibly engage with mental health professionals. The engagement with mental health professionals and coping strategies impact participants' mental health as well. It is from their experiences with coping,

mental health professionals, and overall mental health and wellness that influences their insights and recommendations for the mental health field at large.

Acknowledging that some participants find aspects of sex work enjoyable or fulfilling challenges stereotypes and misconceptions about the nature of sex work (Sullivan, 2007; Weitzer, 2009). This recognition helps to humanize individuals engaged in sex work and counter stigmatizing narratives that often portray them solely as victimized or oppressed (Weitzer, 2009). By highlighting the diversity within this population and the varied experiences individuals have with sex work, we receive a more nuanced understanding of their lived realities (Sanders, 2005; Vanwesenbeeck, 2001). Understanding that individuals may find aspects of sex work enjoyable also provides context for their mental health experiences, allowing for a more holistic examination of the factors influencing mental well-being within this population (Smith et al., 2020; Scambler, 2007). Moreover, by respecting the agency and autonomy of participants in choosing sex work, it validates their perspectives and lived experiences, rather than imposing external judgments or assumptions (Pheterson, 2001; Doezema, 2002). Finally, recognizing the positive aspects of sex work can inform the development of more effective interventions and support services tailored to the needs and preferences of this population (Lazarus et al., 2012; Cunningham et al., 2019).

This recognition is done in conjunction with recognizing the diversity of threats disclosed by participants in this study. These disclosed threats underscores the urgent need for the mental health field to grasp the nuanced experiences of individuals engaged in sex work. From verbal degradation to physical violence and threats on their lives, these narratives shed light on the multifaceted risks encountered within this marginalized community (Smith et al., 2019; Monto & Milrod, 2014). Particularly notable is the narrative shared by P7, emphasizing the critical

importance of continuous communication and consent in sex work interactions. While acknowledging the challenges and vulnerabilities inherent in sex work due to client behavior, it is imperative to balance the discourse by recognizing the agency and positives individuals may derive from their work (Bowen & Bungay, 2016). Indeed, for some, sex work serves as a means of autonomy, empowerment, and financial independence. By acknowledging both the risks and benefits, mental health professionals can provide more comprehensive support and interventions tailored to the unique needs of individuals in the sex work industry. Moreover, these narratives emphasize the urgent need for policies and interventions that prioritize the safety and well-being of sex workers, addressing client behavior and mitigating risks associated with sex work encounters (Shannon et al., 2015). Through a nuanced understanding of these experiences, the mental health field can foster a more inclusive and supportive environment for individuals engaged in sex work, promoting their mental health and overall well-being. However, it is also imperative that we examine the impressions these experiences have left on the participants rather than make assumptions. Overall understanding the mental health and wellness of individuals in sex work that expands further than the demographic questionnaire with help illuminate the impact of participants' lived experiences.

The juxtaposition of enjoyment with experiences of threats in the field of sex work and as shown through the participant experiences in this study, highlights the urgent need for a holistic approach to support individuals in this industry while simultaneously combatting the stigma of individuals in sex work given the expression of fun and enjoyment in work. These findings emphasize the importance of ensuring ongoing consent and communication within sex work interactions, echoing broader discussions on safety, respect for sex workers' boundaries, and

conceptualization of experience and impact in the realm of sex work (Smith et al., 2019; Monto & Milrod, 2014; Bowen & Bungay, 2016; Shannon et al., 2015).

The in-depth examination of mental health and wellness within this study illuminates the profound challenges faced by individuals engaged in sex work, drawing attention to the significant emotional and psychological burdens they bear. Participants vividly detailed how societal pressures—stemming from stigma, discrimination, and the criminalization of their profession—exert a deleterious impact on their mental health. This narrative aligns with existing research that highlights the heightened vulnerability of sex workers to mental health issues, a vulnerability that is often aggravated by the marginalization they experience and by legal systems that inadequately safeguard their rights and dignity (Sanders & Campbell, 2007; Platt et al., 2018). The testimonies of participants underscore the pervasive nature of these societal challenges, revealing how external perceptions and regulatory environments contribute to a landscape where stress, anxiety, and depression are prevalent.

Yet, within these accounts of hardship, a compelling narrative of resilience and empowerment emerges. Participants shared stories of overcoming adversity, employing a variety of coping mechanisms that serve not just as survival strategies but as means to reclaim their autonomy and assert their agency. This aspect of their experience challenges common misconceptions and pathologizing views of sex work, showcasing instead the capacity of individuals in this sector to harness their inner strength and resourcefulness. Strategies highlighted include the development of supportive networks, the implementation of self-care routines, and the strategic navigation of work-related challenges, all of which enable them to mitigate the impact of their work on their mental health and to carve out spaces of empowerment within the constraints of their profession (Koken, 2010; Dewey & Zheng, 2013).

The findings of this study shed light on the intricate coping strategies employed by individuals in sex work, revealing both active and passive approaches to managing the challenges encountered in their professional and personal lives. Active coping strategies, identified by participants, include setting clear professional boundaries and actively seeking out social and emotional support. These strategies underscore the importance of autonomy and self-determination within the context of sex work. For instance, establishing firm boundaries can serve as a critical mechanism for controlling work conditions and interactions with clients, thereby reducing exposure to potentially harmful situations (Sanders, 2005; Monto & Milrod, 2014). Further, active engagement with supportive social networks has the potential to significantly benefit individuals' overall well-being and mental health management (Pitpitan et al., 2013; Scorgie et al., 2013). Moreover, the act of seeking support—whether through professional networks, community organizations, or personal relationships—highlights the value of solidarity and communal resilience among sex workers (Pitpitan et al., 2013; Scorgie et al., 2013). These active coping mechanisms not only enable individuals to navigate the complexities of their work but also foster a sense of empowerment and control over their professional lives.

Conversely, the study also reveals the adoption of passive coping strategies by some participants. Strategies such as selective disclosure of their work to avoid stigma and judgment, or the use of substances to temporarily alleviate stress and emotional discomfort, reflect the nuanced ways in which individuals navigate the societal marginalization of sex work (Krüsi et al., 2014; Shannon et al., 2009; Surratt et al., 2012). Further, as noted previously, these forms of passive coping strategies from participants are not uncommon for individuals engaged in sex work to manage their emotions or distressing situations (Smith et al., 2020). These passive strategies, while offering short-term relief or a means of managing societal perceptions,

underscore the pervasive impact of stigma and discrimination on the lives of sex workers. Furthermore, these short-term strategies reflect individuals' resourcefulness in managing challenging circumstances (Smith et al., 2019; Surratt et al., 2012). The reliance on such strategies highlights the need for a broader societal shift towards acceptance and understanding, reducing the stigma that necessitates these coping mechanisms in the first place.

Understanding the array of coping mechanisms, including both active and passive strategies, utilized by individuals engaged in sex work is pivotal for mental health professionals. This comprehensive understanding allows for a nuanced perspective on how individuals navigate the multifaceted challenges inherent in their profession (Smith et al., 2020; Monto & Milrod, 2014). By recognizing the diverse coping strategies employed, professionals can tailor interventions to address the unique needs of this population, whether they lean towards seeking social support or utilize avoidance and distraction techniques (Smith et al., 2019; Surratt et al., 2012). Moreover, acknowledging the use of both active and passive coping strategies contributes to reducing stigma surrounding sex work and mental health, challenging stereotypes, and promoting empathy (Church et al., 2017; Scambler & Paoli, 2008). This understanding also facilitates the development of resilience-building interventions, as professionals can help individuals build adaptive coping skills that promote resilience and overall well-being (Cheng et al., 2020; Surratt et al., 2016). In sum, recognizing the diversity of coping strategies employed by individuals in sex work enriches our understanding of their mental health experiences and informs the development of more effective and inclusive support systems.

The types of mental health support accessed by the participants in this study offer valuable insights into the efficacy of coping strategies and the overall well-being of this population (Smith et al., 2020). Delving into the broader context of mental health care allows for a deeper

exploration of the resources available to individuals in sex work and the extent to which these resources address their unique needs (Surratt et al., 2012). Moreover, by examining the intersection between coping strategies and mental health care utilization, we can identify potential gaps in support and areas for improvement in service delivery (Smith et al., 2019). This comprehensive approach enables researchers and mental health professionals to develop more targeted interventions that are tailored to the specific challenges faced by individuals in sex work, ultimately promoting their mental health and well-being.

Complimentary to understanding coping strategies, understanding the diverse forms of mental health support accessed by individuals engaged in sex work is crucial for enhancing their overall well-being and promoting effective coping strategies (Smith et al., 2020). By exploring the intersection between coping strategies and mental health care utilization, we can identify gaps in support and areas for improvement in service delivery, ultimately leading to more targeted interventions tailored to the specific challenges faced by this population (Smith et al., 2019). Additionally, delving into the broader context of mental health care allows for a deeper exploration of available resources and their effectiveness in addressing the unique needs of individuals in sex work (Surratt et al., 2012).

However, these results would be wasted if the field of mental health professionals did not look at integrating these findings into daily practice. By integrating these findings into mental health care practice, providers can enhance the quality of care and promote the well-being of individuals in sex work. It is imperative that mental health professionals receive training and education on the unique needs and experiences of this population, enabling them to provide effective and culturally competent support (Surratt et al., 2012). Ultimately, by addressing these issues and implementing evidence-based practices, mental health care providers can play a vital

role in reducing stigma, promoting inclusivity, and improving the overall mental health outcomes of individuals engaged in sex work.

To address these complexities, targeted mental health interventions are essential, addressing both individual and structural determinants of mental health in sex work. This includes stigma reduction, legal reforms, and the provision of non-judgmental health services (Cunningham et al., 2019; Lazarus et al., 2012; Orchard et al., 2019). Participants suggested several key recommendations for the mental health field, emphasizing the importance of mental health care providers engaging in open and informed discussions about sex work throughout their training and practice (Smith et al., 2019). Additionally, they highlighted the need for mental health professionals to possess fundamental counseling skills, such as active listening, genuineness, and meeting individuals where they are at (Surratt et al., 2012). However, barriers to accessing care persist, highlighting the need for more inclusive and culturally competent mental health services (Scambler & Paoli, 2008; Monto & Milrod, 2014; Church et al., 2017).

Counseling psychology, nestled within the expansive domain of mental health work, has historically championed the cause of social justice (Sue & Sue, 2016). This historical grounding not only delineates the ethical framework but also accentuates the necessity for the subfield to embrace current best practices and evolving understandings. In alignment with the ethos of social justice, it becomes incumbent for counseling psychology programs to incorporate innovative strategies to address neglected yet pivotal aspects of mental health. Specifically, the integration of sexuality courses and enhanced practicum opportunities within counseling psychology programs emerge as essential avenues for nurturing a holistic understanding of mental wellness (Smith, 2020). By exposing students to diverse perspectives and experiences, their competence is

fortified but an environment is created that is conducive to challenging biases and promoting inclusivity (Ratts et al., 2015).

Moreover, the creation of safe and welcoming spaces within counseling psychology practice emerges as a critical endeavor. The insights shared by the current study's participants emphasize the pivotal role of basic coping skills in fostering therapeutic rapport and efficacy (Lambert & Barley, 2001). However, it is imperative to extend the purview beyond clinical interventions and contemplate the holistic experience of clients from the moment they engage with the counseling environment. Integrating inclusive wellness assessments into intake procedures represents a proactive step toward affirming the space's commitment to addressing diverse needs, including those related to sexuality and sex work (Jenkins & Williamson, 2019). By normalizing discussions around sensitive topics and signaling support for marginalized communities through symbolic gestures such as signage, counseling psychologists can engender an environment characterized by acceptance and inclusivity (Cook & Cusack, 2016).

The advocacy role of counseling psychologists extends beyond individual therapeutic encounters to encompass broader systemic changes. The entrenched stigma, societal prejudices, and safety concerns surrounding sex work necessitate concerted efforts toward policy reform and resource allocation (Hofer et al., 2019). By leveraging their expertise and influence, counseling psychologists can advocate for policies that safeguard the rights and well-being of individuals engaged in sex work. This proactive engagement not only amplifies the voices of marginalized communities but also aligns with the foundational tenets of social justice espoused by counseling psychology (Hays & Erford, 2014).

In essence, the integration of sexuality education, the creation of inclusive spaces, and advocacy for policy changes represent pivotal avenues through which counseling psychology can

uphold its commitment to social justice. By embracing these recommendations, counseling psychologists can transcend the confines of traditional therapeutic paradigms and actively contribute to fostering a more equitable and inclusive society.

In future practice with this population, collaborative efforts among mental health professionals, policymakers, and stakeholders are needed to develop comprehensive and inclusive approaches to mental health care that meet the unique needs of individuals in sex work. By centering the voices and experiences of this marginalized population, we can work towards a more equitable and compassionate mental health system that promotes resilience, empowerment, and holistic well-being for all (Surratt et al., 2012).

In summary, the study's comprehensive exploration of the experiences, challenges, coping strategies, and suggestions for the mental health field made by participants shows the critical need for accessible, tailored, and culturally competent mental health care services for individuals engaged in sex work. By addressing systemic barriers and integrating participants' recommendations into mental health practice, stakeholders can better support the well-being of sex workers and work towards creating a more equitable and inclusive society.

Additional Considerations

This study draws upon intersectional feminist theories (Crenshaw, 1989) and empowerment frameworks (Zimmerman, 1995) to examine the multifaceted experiences of individuals engaged in sex work. Intersectionality theory allows for an understanding of how various social identities intersect to shape individuals' experiences, while empowerment theory provides a lens through which to explore agency, resilience, and coping strategies within the context of sex work.

The intersectionality of identities such as gender, race, ethnicity, and socioeconomic status significantly influences the experiences of individuals in sex work (Hankivsky et al., 2014). For example, women of color and transgender individuals often face compounded marginalization and heightened risks due to intersecting forms of discrimination and stigma (Haley, 2018; Reisner et al., 2016). Exploring these intersections can deepen our understanding of how structural inequalities exacerbate vulnerabilities and shape coping mechanisms within sex work communities. While this study included gender diversity amongst the population, how the individuals' identities may have impacted their lived experiences further was not fully explored. While having diverse samples can further our understanding of the varied experiences in sex work, it is important to for future studies to consider intersectionality more explicitly to better inform the data that emerges.

Ethical considerations in researching sex work are paramount, given the stigma and legal ambiguities surrounding the industry. Safeguarding participant confidentiality, ensuring voluntary participation, and minimizing potential harm are crucial (Bernard, 2012). This study adhered to ethical guidelines by obtaining informed consent, protecting participant anonymity, and employing trauma-informed research practices to mitigate potential harm (Draucker et al., 2013).

Limitations

Constructivist grounded theory acknowledges the subjectivity inherent in qualitative research, recognizing that researchers' interpretations and biases can influence the data collection and analysis process (Charmaz, 2006). Despite efforts to remain reflexive and transparent about the researcher's positionality, it's essential to acknowledge that the findings are inherently shaped by the researcher's perspective and interactions with participants.

Constructivist grounded theory prioritizes the depth of understanding over broad generalizability, focusing on constructing theory from the data rather than confirming pre-existing hypotheses (Charmaz, 2006). As such, the findings may not be easily transferable to other contexts or populations beyond the scope of the study. The emphasis on context specificity means that the findings may not be universally applicable but rather offer insights into the particular social and cultural context in which the research was conducted.

The iterative nature of constructivist grounded theory involves constant revisiting and refining of data, categories, and concepts. While this iterative process enhances the richness and depth of the analysis, it also opens the door to interpretive bias. Researchers' preconceptions, theoretical orientations, and analytical decisions may influence the construction of categories and the interpretation of data (Charmaz, 2006). Engaging in reflexive practices and peer debriefing can help mitigate interpretive bias, but it remains an inherent limitation of the methodology.

Constructivist grounded theory is situated within a specific temporal and contextual framework, emphasizing the importance of understanding phenomena within their socio-historical context (Charmaz, 2006). However, this contextualization also means that the findings may not capture the dynamic nature of experiences over time or across different social and cultural contexts. Additionally, the study's findings may be relevant primarily within the specific context in which the research was conducted- the midwestern region of the United States- limiting their applicability to broader contexts or future time periods. This context creates another limitation to the study as the participants felt safe enough to voluntarily participate in the study interviews as well as not feel the need to read and respond to the written transcripts of what they had said. This poses a two-fold limitation: 1. Given the setting in which the study interviews were conducted, the study results cannot be generalized to a larger population of those in the sex

work industry. 2. The participants denied the opportunity to read through and correct the transcripts of their interviews which meant themes arose without participant's additional approval. This limitation may have caused less accuracy of results as well as an element of trustworthiness important in CGT research.

In this study, participants were not explicitly questioned about the motivations behind their engagement in sex work. While some participants volunteered insights into this aspect during their interviews, it was not systematically addressed as a formal inquiry. This decision was made considering the extensive body of literature already dedicated to exploring the reasons for individuals' involvement in sex work (Platt et al., 2018). However, it is important to acknowledge that this omission represents a limitation of the study. The literature reveals a notable gap in research focusing on how individuals manage their mental health while engaged in sex work (Katsulis et al., 2010). Therefore, while the primary focus of this study was on understanding the mental health experiences of individuals engaged in sex work, the absence of data regarding their initial motivations constrains the depth of the findings. Future research endeavors should strive to address this gap, thereby enhancing the comprehensiveness and applicability of findings in this domain.

While constructivist grounded theory prioritizes participant perspectives and voices, ethical considerations such as ensuring informed consent, protecting participant confidentiality, and minimizing potential harm remain paramount (Charmaz, 2006). However, despite efforts to adhere to ethical guidelines, challenges related to power dynamics, stigma, and confidentiality may still arise, potentially impacting participants' willingness to disclose sensitive information or engage fully in the research process.

Constructivist grounded theory requires researchers to engage in reflexive practices, acknowledging their own biases, assumptions, and preconceptions throughout the research process (Charmaz, 2006). While reflexivity enhances the transparency and rigor of the study, it also introduces complexities related to the researcher's positionality and subjectivity. Researchers must navigate their role as both an observer and interpreter of data, continually reflecting on how their background, experiences, and perspectives shape the research process and findings. While researchers did their utmost to be reflexive in their roles, one final limitation may be the areas in which they may not have been as reflexive or missed something within the data due to personal bias.

Future Directions

Training & Policy

The findings of this study have several implications for both mental health practice and policy initiatives. The four implications of note that will be discussed here are the need for trauma informed care, the bridge to social support through accepting spaces in therapy, the need for targeted training including sexuality and sexual health topics for clinicians in training programs, and, finally, policy changes. First, mental health practitioners should adopt a trauma-informed approach that recognizes the complex needs of individuals engaged in sex work (Hien & First, 2018). This approach entails understanding the pervasive impact of trauma, including experiences of violence, discrimination, and societal stigma, on the mental health and well-being of sex workers. Thus, clinicians would be able aligned with an approach that addresses the potential of any traumatic experiences that occur while in sex work, any potential trauma that predates individuals' entry in sex work, and traumas that individuals may experience through life in general outside of work. It is important to note here that this trauma-informed approach is not

because all individuals in sex work need trauma work but rather in acknowledgement that individuals in sex work are at greater risk for experiencing discrimination and trauma as a result of the stigma attached to their work. Sex work itself, as described previously, may or may not involve trauma. However, stigma and the actions of others, cannot be controlled nor predicted. By recognizing and addressing any underlying trauma and societal stigma, practitioners can provide more effective and empathetic care that respects the agency and autonomy of sex workers.

In line with effective care, practitioners can foster an open and accepting environment for clients who are sex workers as a bridge to social support. The narratives shared by participants illustrate the crucial role of seeking social support in managing mental health challenges associated with sex work. However, participants revealed that the fear of bias, discrimination, and loss of support often acts as a barrier to seeking and sharing support from trusted individuals (Krüsi et al., 2014; Shannon et al., 2009). This fear may even extend to withholding experiences from long-term supporters who have previously exhibited trust and acceptance. Nevertheless, when social support is nonjudgmental, supportive, and nurturing of individuals' overall well-being, their impact on mental health management can be profound (Reed et al., 2018; Sanders et al., 2019). Therefore, empowering clients to create safe and accepting spaces within social networks can facilitate meaningful support exchanges and enhance individuals' ability to cope effectively with the challenges of sex work.

The last implication for practice falls under training. Training in sexual health topics for practitioners would allow them to better serve this underserved population. To further enhance the competence of mental health practitioners in addressing the needs of individuals engaged in sex work, it is imperative to integrate sexuality courses into mental health graduate programs

(Yeh & Inman, 2007). These courses would provide students with comprehensive training on issues related to sexuality, including sex work, sexual health, and sexual diversity. By equipping mental health professionals with a deeper understanding of sexuality and its intersections with mental health, these courses can better prepare them to provide affirming and inclusive care to sex workers.

Finally, policymakers play a crucial role in shaping the socio-legal landscape in which sex work operates. The study findings also hold implications for policy makers and advocates. Given the challenges identified in this study, policymakers should prioritize the decriminalization of sex work as a means of promoting the health, safety, and human rights of sex workers (Platt et al., 2018). Decriminalization can reduce the stigma and discrimination faced by sex workers, enhance their access to essential services, and facilitate their engagement with mental health care. Additionally, policymakers should allocate resources for tailored mental health services specifically designed to address the unique challenges and needs of sex workers, including trauma-informed care, harm reduction approaches, and culturally competent interventions.

Future Research Directions

Future research should delve into the long-term mental health outcomes of individuals engaged in sex work, focusing on factors contributing to resilience and trajectories of coping over time (Deering et al., 2014). Longitudinal studies can provide insights into the dynamic nature of mental health among sex workers, exploring how various factors, such as social support networks, access to resources, and changes in work conditions, influence mental health outcomes. Additionally, comparative studies across different legal and cultural contexts are essential for understanding the impact of policy frameworks on sex workers' well-being. By

examining variations in mental health outcomes and coping strategies across diverse contexts, researchers can identify effective interventions and policy measures to support sex workers' mental health and overall well-being.

Engaging sex work communities in research design, implementation, and dissemination is crucial for ensuring the relevance, validity, and impact of research findings (Rhodes et al., 2008). Community-based participatory research approaches that center the voices and priorities of sex workers can lead to more meaningful research outcomes and inform the development of community-led interventions. By actively involving sex work communities in all stages of the research process, including identifying research questions, collecting data, and interpreting findings, researchers can build trust, foster collaboration, and generate knowledge that resonates with the lived experiences of sex workers.

In conclusion, this study highlights the urgent need for comprehensive and inclusive approaches to addressing the mental health needs of individuals engaged in sex work. By adopting trauma-informed practices, integrating sexuality courses into mental health graduate programs, advocating for decriminalization, allocating resources for tailored mental health services, conducting longitudinal and comparative research, and engaging sex work communities in research and intervention efforts, stakeholders can advance policies and practices that promote the well-being, agency, and rights of sex workers.

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Appendix A: Recruitment Material

Flyer

Text Communication to Potential Participants

Dear _____,

My name is Bianca Tocci and I am a fourth-year doctoral candidate in counseling psychology at Marquette University. I am seeking volunteers to contribute to my dissertation research that explores how individuals in sex work have managed their mental health concerns. I am specifically looking to interview individuals in sex work who have had mental health concerns and learn how they navigated those concerns.

In this study, sex work refers to any type of labor in which the explicit goal is to produce a sexual or erotic response in the client for compensation such as, but not limited to, monetary payment or goods that is agreed upon by all parties involved (Sex Workers Outreach Project [SWOP], 2019). An individual in sex work is someone who engages in any form of work that is applicable to this definition. In order to contribute to this research, individuals must be 18 years or older, have engaged in sex work, and have had experience with mental health concerns while engaging in sex work. Please note that the mental health concerns of the participants do not need to be due to their engagement in sex work. Rather, I am looking to assess how mental health concerns were navigated while individuals were actively involved in sex work. Individuals who volunteer to participate in this study will be asked to complete a 60 – 90-minute interview via telephone, in addition to a brief follow up via phone. Individuals who participate will receive a \$15 gift card to keep, or they may elect to donate to an organization supporting individuals in sex work of their choice.

If you are interested in learning more and/or potentially participating in this study, please contact me, Bianca, via email at bianca.tocci@marquette.edu or by phone at (781) 308-4566. If you know individuals who may be interested in this study, I would be grateful if you would be willing to relay this information on to them.

Appendix B: Screening Form

Instructions: Thank you for your interest in this research on navigating mental health concerns among individuals in sex work. To determine if you are eligible to participate, you will be asked the following statements. Please respond with the response that is most true for you. Please let the researcher (Bianca Tocci) know if you have any questions regarding the statements below.

	Yes	No
Are you at least 18 years of age?		
Are you currently, or have you ever, engaged in sex work in the United States?		
Where you 18 when you engaged in sex work in the United States?		
While you engaged in sex work, did you experience any mental health concerns?		

Appendix C: Demographic Form

Pronouns: _____ Gender: _____ Nationality: _____

Race: _____ Ethnicity: _____

Current Country of Residence: _____

How long have you worked in sex work: _____

Forms of Sex Work you have engaged in:

- Prostitution
 - Street work
 - Brothel work
 - Window work
 - Private work
- Exotic Dancing/Stripping
- Erotic Massage
- Sugaring
- Camming
- Phone sex services
- Dominatrix/Sub work
- Escorting
- Pornography
- Other: _____

Are you currently engaged in sex work?: Yes: _____ No: _____

Mental Health concerns you had while engaged in sex work?:

- Fear
 - Sleep
 - Perceived Life Threat
 - Eating
 - Depression
 - Anxiety
 - Suicidality
 - Anger
 - Eating
 - Identity
 - Substance Use
 - Formal Mental Health
- Diagnoses: _____

Other: _____

Participant Code (For researcher only): _____

Appendix D: Informed Consent Form

MARQUETTE UNIVERSITY
AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS
Mental Health Management for Individuals in Sex Work
Bianca Tocci, MA,
Department of Counselor Education and Counseling Psychology

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate.

PURPOSE:

- The purpose of this research study is to investigate how individuals in sex work have managed their mental health concerns.
- You will be one of approximately 10-15 participants in this research study.

PROCEDURES:

- You will be asked to participate in a phone interview during which you will be asked a series of questions related to the mental health concerns you experienced, your experiences navigating mental health concerns, what resources you may or may not have used, and what you found most helpful during that time.
- You will be contacted for an additional one to two brief phone interviews during which you will be asked to confirm, clarify, and/ or elaborate on your answers in the initial interview.
- You will be audio recorded during the interview portion of the study to ensure accuracy. The tapes will later be transcribed and destroyed after 5 years beyond the completion of the study. For confidentiality purposes, your name will not be recorded and will be removed during transcription.

DURATION:

- Participation will involve an initial telephone interview lasting approximately 60-90 minutes in length, and one to two follow up interviews lasting approximately 10 minutes in length.

RISKS:

- The risks associated with participation in this study are no greater than you would experience in everyday life.
- Although your privacy is very important, if you talk about actual or suspected abuse, neglect, or exploitation of a child or elder, or if you talk about hurting yourself or others, the researcher or other study team member must and will report this to the Bureau of Milwaukee Child Welfare, the Wisconsin Department of Children and Families Services, or law enforcement agency.

BENEFITS:

- There are no direct benefits to you for participating in this study. This research may benefit society by contributing to the advancement of mental health care and community resources for individuals in sex work.

CONFIDENTIALITY:

- Data collected in this study will be kept anonymous.
- All your data will be assigned an arbitrary code number rather than using your name or other information that could identify you as an individual. A key linking names to ID numbers will be stored in a locked location in the principal investigator's office.
- The data collected in this study will not be used or distributed for future research even if they have been deidentified.
- Audio recordings will be secured and stored on the password protected laptop computer of the principal investigator.
- When the results of the study are published, you will not be identified by name. Direct quotes collected during your interview may be used in the publication of study findings.
- The data will be destroyed by shredding paper documents and deleting electronic files within 5 after the completion of the study.
- Your research records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

COMPENSATION:

- You will receive a \$15.00 Visa electronic gift card. While you must begin the interview to receive the gift card, you do not have to complete the interview to receive the gift card.

VOLUNTARY NATURE OF PARTICIPATION:

- Participating in this study is completely voluntary and you may withdraw from the study and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.
- If you chose to withdrawal from the study, your data will be destroyed and discarded.
- You may skip any questions you do not wish to answer.
- Your decision to participant or not will not impact your relationship with the investigators or Marquette University.

ALTERNATVES TO PARTICIPATION:

- There are no known alternatives other than to not participate in this study.

CONTACT INFORMATION:

- If you have any questions about this research project, you can contact the principal investigator, Bianca Tocci via email: bianca.tocci@marquette.edu or by phone: (781) 308-4566, or her dissertation chair and faculty advisor, Dr. Allie Kriofske Mainella via email: Alexandra.kriofskemainella@marquette.edu.

- If you have questions or concerns about your rights as a research participant, you can contact Marquette University's Office of Research Compliance at (414) 288-7570.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

(Printed Name of Participant)

(Signature of Participant)

Date

(Printed Name of Individual Obtaining Consent)

(Signature of Individual Obtaining Consent)

Date

Appendix E: Interview Protocol

Thank you for your interest in this study on the lived experience of individuals in sex work with navigating mental health concerns and mental health wellness. I am so grateful for your willingness to support this investigation by sharing your own experience. I'll start by asking you some basic demographic questions, then questions about your experience in sex work. Then I'll ask you about your experience with mental health and wellness during your time in sex work. Finally, I will ask about your thoughts and ideas regarding how mental health professionals could best/better serve you or other sex workers.

Interview Questions

1. Please tell me a little bit about yourself and what motivated you to participate in this study?
2. Please tell me generally about your experience with sex work?
 - a. Prompt: *Please describe the type of sex work you have engaged in*
3. Tell me about your experience with the stigma of sex work
 - a. Prompt: *What coping skills have you used to deal with sex work stigma?*
4. Please tell me about your experience with your mental health and wellness while engaged in sex work?
 - a. *What steps have you taken to care for your own mental health?*
 - b. *What steps have you taken to get professional help for your own mental health*
 - i. Prompt: *If no steps toward seeking professional help were taken, tell me why (further prompts: barriers? Reasons why not?)*
 - ii. Prompt: *If steps toward seeking professional help were taken, tell me about them.*
5. Have you noticed any differences or changes to your mental health care while engaged in sex work compared to when you were or are not? If so, please tell me about those changes
6. In your care for your own mental health, whether personally taken care of or professionally, what resources have been helpful to you?
 - a. Prompt: *Why or what made them helpful?*
7. What resources have been unhelpful to you?
 - a. Prompt: *Why weren't they helpful or what was unhelpful about them?*
8. We would love to know your thoughts on how the mental health profession could better serve people in sex work (more safely, more equitably, more accessibly, etc.)
 - a. Prompt: *What would you change about your experience?*
 - b. Prompt: *How could your experience have been improved?*
 - c. Prompt: *How can mental health professionals improve in providing care?*
9. Is there anything else you would like to add, or you would like us to know about providing mental health care for people in the sex work profession?