Social Science & Medicine 268 (2021) 113468

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: http://www.elsevier.com/locate/socscimed

Rethinking the relationship between sex work, mental health and stigma: a qualitative study of sex workers in Australia

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ARTICLE INFO

Keywords:
Mental health
Sex work
Stigma
Resilience

ABSTRACT

Aims: Sex workers may experience stigma both related to their occupation as well as to mental health issues that they face. There is limited research on the lived experience of sex workers managing mental health and stigma. This study examined the experiences of sex workers in Australia in relation to stigma surrounding sex work, and sex workers' mental health, including self-management and experiences of accessing mental health services.
Method: Six focus groups and two interviews were conducted with 31 sex workers. Data collection was co-moderated by a sex worker and a university-based researcher. Analysis was informed by an approach which positioned sex workers as agential and capable, and which drew attention to structural aspects of stigma.
Results: Sex workers identified that the stigma surrounding their profession had a significant impact on their mental health. The need to manage risks through selective disclosure of sex work was a pervasive experience. Management of mental health and the stigma associated with sex work was described as a responsibility primarily of the individual through self-care activities and occasional access to mental health services. Participants reported poor treatment from mental health practitioners who saw sex workers as victims lacking agency, imposed beliefs that sex work was the pathological root cause of mental health issues, or approached the issue with fascination or voyeurism. Other presenting issues (especially mental health) were lost or obscured in therapeutic encounters resulting in suboptimal care.
Conclusion: The threat of stigma is pervasive and has mental health implications for sex workers. Our findings point to the need for increased training and capacity development for mental health practitioners, funding for peer support services to ameliorate internalised stigma, and action from governments to introduce enabling legal environments, stigma reduction programs and structural protections from sex work stigma.

Author credit

Carla Treloar: Conceptualization, Methodology, Investigation, Writing - original draft, Funding acquisition, Supervision. Zahra Stardust: Conceptualization, Methodology, Investigation, Data curation, Writing - review & editing. Elena Cama: Conceptualization, Methodology, Data curation, Writing - review & editing, Project administration. Jules Kim: Conceptualization, Methodology, Investigation, Writing - review & editing, Supervision

1. Introduction

Sex work and mental health have a vexed relationship in academic literature. Some high-profile studies into sex worker mental health have documented post-traumatic stress disorder, childhood sexual abuse and experiences of threats and sexual assault among sex workers, focusing on sex workers' desire to 'escape' (Farley and Barkan, 1998) and arguing that sex work itself is 'Bad for the Body, Bad for the Heart' (Farley, 2004). The study of mental health issues among sex workers has focused on experiences of trauma and violence either prior to or during sex work (Krumrei-Mancuso, 2017). Such research attempts to draw causal links between sex work, trauma and abuse, imply either that people turn to sex work because of histories of trauma, or that sex work itself is traumatic or inherently violent (Dworkin, 1981).

Higher rates of mental health issues (particularly, depression and PTSD) have been described among sex workers who report social and economic disadvantages (Chudakov et al., 2002; Seib et al., 2009; Suresh et al., 2009; Tsutsumi et al., 2008). However, this literature needs

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https://doi.org/10.1016/j.socscimed.2020.113468
Received in revised form 7 October 2020; Accepted 19 October 2020
Available online 22 October 2020

to be read carefully and with awareness of critiques regarding the use of convenience samples of street-based or incarcerated sex workers (Rayson and Alba, 2019), failing to distinguish the context in which sex work is done (Seib et al., 2009) or for ideological stances which seek to pathologise sex workers (Benoit et al., 2017). That is, pathological approaches study sex work through the lenses of injury, victimhood and presumed lack of agency, resulting in methodologies that are heavily skewed (Weitzer, 2005). In turn, this can affect the attitudes of mental health service providers, who may view sex work as the "master" or essentialising identity of the individual (Benoit et al., 2018) and see sex work as the cause of mental health issues and encourage sex workers to exit the industry, posing barriers for sex workers seeking to access mental health services. The growth of a 'rescue industry' (Agustín, 2007) has facilitated the delivery of 'exit programs' by NGOs, government-funded health and support services and faith based organisations. These are subject to critique from sex workers, who argue that while the availability of programs for sex workers who wish to leave the industry is important, the realisation of these programs often violates ethical standards, such as by including criminal justice intervention (Ham and Gilmour, 2017; Wahab and Panichelli, 2013). Scoular and O'Neill (2007), p764) argue that the move towards "welfare-based" responses designed to exit women from sex work are a form of "social control under the rhetoric of inclusion, through techniques of risk and responsibilization." This can have a deterrent effect for sex workers. Research into sex workers' mental health help-seeking indicates that sex workers' perceived experiences of stigma and discrimination significantly impact upon their intentions to seek mental health support in future (Rayson and Alba, 2019).

Sex workers themselves have argued that research has difficulty moving beyond the sex in sex work and often forgets the daily challenges facing them including "managing money, juggling family and other intimate relationships, dealing with legal restrictions and policing, confronting social stigma, and challenges to them organizing collectively" (Levy and Willman, 2010, p1). A broader view of sex work and mental health has called for understanding of mental health among sex workers as differing "in accordance with factors such as women's degree of freedom, exposure to violence, and economic and social conditions, all of which are influenced by the sociocultural and legal contexts" in which sex work takes places (Krumrei-Mancuso, 2017, p 1844). Further, social support, perceived stigma and coping styles have been identified as important aspects to consider in a fuller understanding of mental health among sex workers (Carlson et al., 2017; Sanders et al., 2017).

A key concept that ties together the experience of mental health and sex work is stigma which has been described as "omnipresent in sexual commerce" (p 717) and "typically not problematised as a variable subject to change" (Weitzer, 2018 p725). Goffman's (1963) definition of stigma as "an attribute that is deeply discrediting" and through which an individual possesses a "spoiled identity" is widely cited. However, this focus on individual attributes suggests that the stigmatised individual is both the source and location of stigma, rather than recognising the ways that social, economic, and political power shapes the expression of stigma (Kleinman and Hall-Clifford, 2009; Millar, 2020). Stigma is not inherent to sex work itself (Weitzer, 2018), but rather is a social process of exclusion, which produces and reproduces power relations (Link and Phelan, 2001). In addition to understanding the ways that negative attitudes of a social group can manifest in discrimination towards stigmatised groups of people, taking this approach recognises the ways that structures and institutions can reinforce social, cultural, and economic inequalities.

Other scholars (Benoit et al., 2018) have provided a thorough overview of the literature on stigma as it applies to sex work. These authors highlight various issues important to understanding the experience of sex work including that stigma sits at the boundary of community and individual factors, the totalising properties of stigma, that stigma has multiple sources (at macro, meso and micro levels), that stigma is not only an interpersonal phenomena but is embedded in social power and that stigmatising social messages can be internalised by those who are the targets of these messages in the form of depression (Carlson et al., 2017; Lazarus et al., 2012). We expand on these understanding of sex work stigma using Mary Douglas' work on matter out of place, disorder and risk in which beliefs about pollution are morally based and reinforce social structures (Douglas, 1992, 1994). These concepts have been used previously to examine sex work establishments, such as brothels (Crofts, 2011) which suggests, in part, that people coming into contact with brothels (and sex workers) will be "polluted" by this association. The use of notions of pollution and contagion is used to denigrate those deemed to be "out of place" as well as contain a particular social order (Phillips et al., 2012)..

Sex workers' perceived experiences of stigma and discrimination may adversely impact upon their intentions to seek mental health and other support services in future (Folch et al., 2013; Rayson and Alba, 2019). However, the stigma associated with mental health can be challenged, rejected and reduced (Corrigan et al., 2001; Corrigan et al., 2017; Thornicroft et al., 2016). To consider what may be amenable to change in the relationship between sex work, mental health and stigma, it is necessary to take a critical view of how the existing literature has been framed. A key critique of sex work research is the dominant use of a framework of pathology which renders invisible the "strengths and resilience factors such as [sex workers'] ability to seek and receive both formal (i.e., medical and legal assistance) and information (i.e., emotional support from family and friends) assistance" (Burnes et al., 2012, p 138). A resilience and strengths framework can provide a means to "use a collectivist, community-based perspective looking at ways in which one's community serves as a protective lens rather than focusing the individual's innate pathology" (Burnes et al., 2012, p 138). For example, in research conducted with sex workers in the Netherlands where "voluntary adult prostitution" is recognised as a "normal occupation", Krumrei-Mancuso (2017, (p 1843) explored patterns and associations of mental health drawing on traditional risk factors as well as quality of life measures. While there were factors associated with mental health concerns that have been found previously, (experience of violence in sex work, desiring to leave sex work, etc), other factors were found to be associated with better mental health outcomes including having a sense of fair treatment by others and self-acceptance (Krumrei-Mancuso, 2017).

The notion of "fair treatment by others" is central to the experience of managing stigma and mental health among sex workers. A recent review described the stigmatising attitudes of health workers as a key barrier to seeking health services among sex workers (Ma et al., 2017). This is consistent with stigma scholarship in general in which stigma is demonstrated to be a fundamental cause of population inequalities (Hatzenbuehler et al., 2013) with inequalities produced by a range of mechanisms that dissuade or create barriers to development or use of resources, including access to health care, legal redress and justice. The existing literature has limited representation of the lived experience of sex work and mental health in settings where sex work is decriminalised.

The aim of this study was to examine Australian sex workers' experiences of stigma and mental health. In this study we were interested in exploring how sex workers experience stigma related to their employment and the impacts of such stigma on sex workers' mental health. This included exploration of how sex workers self-manage stigma and mental health, their experiences of accessing mental health services, and whether sex workers' reported ways that stigma can be challenged and rejected in mental health services at micro, meso and macro levels.

2. Method

This project was undertaken as a collaborative project between university-based researchers (CT, EC) and the executive members and staff of national sex worker organisation, Scarlet Alliance, Australian Sex Workers Association (JK, ZS). As Australia's national peak body, Scarlet Alliance represents individual sex workers as well as sex worker

networks, groups, projects and organisations in all states and territories. Some projects have multicultural or culturally and linguistically diverse project workers, migration projects employing multilingual project staff, Aboriginal and Torres Strait Islander working parties and gender and sexuality diverse spokespeople. This membership and these projects (which include outreach and service delivery) afford Scarlet Alliance a very high level of contact with sex workers in Australia. In 2010, Scarlet Alliance's members, networks, groups and projects conducted outreach with over 20,000 distinct individual sex workers in Australia. Each phase of the project (including development of the study rationale, data collection instrument and conduct of focus groups and interviews and analysis) were conducted in partnership.

The framing of the project posits sex work as "work" and sex workers as "workers, migrants and agents" (Kempadoo and Doezema, 1998) rather than taking a blanket perspective of all sex work as coercion and sexual subordination (Weatherall and Priestley, 2001). We adopted a deliberate stance to understand sex work as an occupation with "presumption of willful rationality … and right to self-determination, and that the starting point for any analysis be the respectful attribution of agency" (Whitaker et al., 2011, p 1089). Our research was framed by an acknowledgement of structural aspects of stigma that is beyond the stigma in inter-personal exchanges (Benoit et al., 2018), and the capacities and resilience of sex workers (Burnes et al., 2012).

Recruitment of participants was managed by researchers (JK, ZS) who identify as sex workers and work within Scarlet Alliance. In this way, the researchers were able to assure participants that participation in the project would be a non-judgemental experience in which all perspectives would be valued. Scarlet Alliance advertised this study through its individual membership of sex workers, its organisational membership of state and territory-led peer sex worker organisations and through online networks open to people identifying and verified as sex workers. Potential participants registered with their interest (with their local organisation, ZS or JK) and a series of times for focus groups were arranged. Focus groups were conducted with people residing in the same jurisdiction in order to assess the differences in regulation across jurisdictions, however many sex workers had previously worked in multiple states and territories. The sampling was conducted to ensure representation from different jurisdictions as well as sexual identity and gender diversity.

Four focus groups were conducted by telephone. We have previously published using this method (Tolhurst et al., 2003) and note that it has been described as useful for situations in which it is not possible to bring people together in a common location and when discussing sensitive issues (Cooper et al., 2003). Given the lack of visual cues and physical presence of others, the group moderator/s need to adjust their style to suit the telephone medium. For example, other authors have indicated that the moderator needs to use "frequent verbal comments and reflective listening" and pay "careful attention to paraverbal cues, such as voice inflections, emphases, interjections, and laughter" Allen (2014), (p 573). Two face-to-face groups were held in Sydney: one group involved migrant sex workers and the other non-migrant sex workers. Interviews were offered to potential participants who did not feel comfortable participating in a group discussion or who were not available at the time of focus groups. Two people participated in interviews. All participants were reimbursed AUD$50 for their time and expertise.

At the start of each focus group, participants were asked to introduce themselves so the moderators (and other participants) could become familiar with each person's tone of voice. For each topic of discussion, the moderators checked in with participants by asking if there were other perspectives or experiences to add to the discussion. This was to ensure that participants felt that they could disagree or pose alternative experiences to those which had been discussed and to provide a cue for those who had not yet commented. Occasionally, if a topic had not engaged all participants already, the moderators would ask individual participants who had not yet commented, whether they would like to add to the discussion.

The focus group guide covered a number of topic areas drawn from previous research into the experiences of stigma and discrimination among sex workers in Australia (Scarlet Alliance & Australian Federation of AIDS Organisations, 1999). Researchers from the Centre for Social Research in Heath and Scarlet Alliance discussed the gaps in research and the kinds of research that would benefit sex worker communities. A consultation workshop was also held at an annual national sex worker forum (by ZS) involving more than 100 sex workers from around Australia, where peer researchers shared draft focus group topic areas for feedback and brainstorming by participants. Discussion at this forum was used, along with research, to direct attention to areas that sex workers prioritised as important to them. These included areas of disclosure or concealment of sex work, employment, education, access to healthcare and social services, engaging with institutions (e.g. banking, insurance), engagement with policing and access to legal and justice, portrayals of sex work in the media, families and parenting as well as issues related to general health, drug use and sexual health of sex workers. For each area, the discussion was opened with a question, for example, "how does being a sex worker affect your experience with health care services". The moderators included prompts to ensure that the range of experiences (positive and negative) were canvassed in discussions. This paper concentrates on findings relating to the mental health of sex workers, including access to and experience in mental health services.

Audio recordings of focus groups and interviews were transcribed by a transcriber working under a confidentiality agreement. Transcripts were deidentified and checked for accuracy. A coding scheme was developed by all authors and applied (by ZS) with checks for consistency and clarity of concepts (between ZS and CT). Analysis of the coded data focused on codes covering issues of stigma and mental health. One author (CT) undertook analysis of coded data using key conceptual concerns (resilience, multiple levels of stigma and matter out of place) to guide analysis of the data. Preliminary analyses were discussed with co-authors (who had been involved in data collection) to elaborate and extend interpretation of the data. Data from focus groups were used to show the interactions between participants rather than as proxies for individual interviews (Kitzinger, 1994). Approval was received from the Human Research Ethics Committee of UNSW, Sydney (HC 16880). No demographic data is assigned to individuals (such as age, gender or location) to prevent unintended identification of participants.

3. Results

Sex workers participated in six focus groups (n = 29) and in individual interviews (n = 2). The majority of participants (n = 21) identified as female and 19 were assigned female sex at birth. Table 1 presents additional demographic characteristics of the sample. One participant identified as Aboriginal or Torres Strait Islander. Most participants were born in Australia (n = 15) with nine born in South East and North East Asia. Participants had performed a range of sex work with the most common type of work being private escort or in call (n = 19 each). Participants had worked across a range of jurisdictions, with all Australian states and territories represented. The majority of participants spoke English at work (n = 28).

This study was conducted in Australia where sex work is variously decriminalised, licensed and criminalised in various jurisdictions and some anti-discrimination protections for sex workers exist (for example, in the Australian Capital Territory sex work is protected under a general protection on the basis of 'occupation', while in three other states (Victoria, Queensland, Tasmania) some forms of sex work have limited protections under the category of 'lawful sexual activity'). As participants reported working in a variety of locations and over time, they had experienced a range of legal frameworks relating to their work. While criminal and licensing laws could exacerbate stigma for sex workers, even those working in a decriminalised jurisdiction still reported a consistent and pervasive legacy of stigma that was not simply eliminated

Table 1
Participant demographic characteristics.

N = 31	N
Age	
18-29	7
30-39	9
40-49	10
50 and over	5
Gender[a]	
Female	21
Male	5
Non Binary	7
Sex assigned at birth[b]	
Female	19
Male	11
Sexual identity[a]	
Heterosexual	7
Lesbian or Gay	7
Bisexual	4
Queer	14
Region of birth	
Australia	15
Oceania (New Zealand, Melanesia, Micronesia, Polynesia)	3
Asia	10
Europe	1
Americas	1
Africa	1
Type of sex work[a]	
Private (escort)	19
Private (in call)	19
Escort (agency)	3
Brothel (full service)	15
Street-based	2
Massage parlour	7
BDSM house	2
Different	4
States participant works in[a]	
ACT	2
NSW	23
NT	2
QLD	7
SA	5
TAS	1
VIC	10
WA	6
Languages spoken at work[a]	
English	28
Thai	4
Mandarin	1
Cantonese	2
Other	2

[a] Items were not mutually exclusive.
[b] one participant did not respond to this question.

by a lack of criminalisation. Further, the participants' comments in relation to mental health were consistent across jurisdictions and legal frameworks. . The participants' experiences of sex work stigma were apparent in all domains of life and an ongoing feature of their engagement with mental health services. These patterns were pervasive and participants provided only very few examples in which sex work stigma was not a feature of their lives generally or in the management of mental health. The results are presented in three sections related to the impact of stigma, accessing mental health services and, the benefits of sex work in managing mental health.

3.1. A heavy burden to bear: the impact of sex work stigma upon mental health

The stigma associated with sex work had a significant impact on mental health. Sex workers feared anticipated stigma and negative judgements from most people if they disclosed their work. In all of the domains canvassed in the interview schedule sex work seen to be "out of place". Thus, lying to avoid disclosure of sex work was commonly reported by participants in most aspects of life. Re-framing or omitting details of one's life was an everyday practice for sex workers. This was often a necessary practice in order to avoid the inevitable clash when the supposedly polluting value of sex work came into contact with schools, parents, psychologists or family. The weight of this risk management was heavy and accumulative. Participants described being constantly vigilant in their interactions, trying to remember what they had told to whom, as well as a growing sense of "worthlessness" that their true experiences and stories could not be shared publicly. Participants mused that their mental health would significantly improve if they were able to tell others about their sex work without fears of experiencing stigma and discrimination.

> Participant 9: I don't think it would affect my behaviour, although I would be pleased if my family weren't telling people I was dead. I think it would affect other people's behaviour like being able to tell people about what I did for a living and not be frightened of the result or frustrated about the result.

> Participant 7: Being constantly aware of I think, and everything that comes out of your mouth when you're in an environment …

> Participant 9: Yeah not always having to do that risk balancing.

> Participant 8: I think my mental health would be a hell of a lot better, because it's definitely been the lies that affects mental health rather than the actual job. (Focus group 2)

> Participant 20: …. I think that probably contributes to us perhaps taking on, I'm talking individually, you know a feeling of worthlessness or a sense that we are not valued the same way. Every time you have to lie, you're kind of saying that really. (Focus group 5)

Participants pointed to the role for governments in enacting legal and regulatory protections against discrimination. The lack of such protections drew strong critique amongst participants and exacerbated feelings of internalised stigma by demarcating sex workers as a different class or out of place among the citizenry and unworthy of protection. Even in some parts of Australia where sex work was first decriminalised (in New South Wales), governments still perceive sex work as a liminal occupation or at the boundaries of legitimacy and protection. For example, in 2012, the Queensland government deliberately amended its anti-discrimination legislation in order to permit discrimination against sex workers by accommodation providers, after a sex worker commenced legal proceedings when she was evicted from a motel (Queensland Government, 2012).

> Participant 20: [G]overnments won't protect you, won't enact anti-discrimination legislation to protect you, they are saying "you're not worthy of protection", so that's, you know, an overarching message we get from governments. Very few jurisdictions will protect us on the basis of our occupation and even then, only with conditions in certain circumstances. So the message comes down, "not worthy". (Focus group 5)

The sources of stigma discussed by participants were largely external: not necessarily related to sex work itself but rather to other people's responses to sex work. And yet participants described their internal feelings of responsibility for diminishing this stigma (through daily tasks of hyper-vigilance, selective disclosure, constant risk-mitigation, education or by operating in sex worker-only spaces) without much structural support. They bore the burden of either unpacking or deflecting such stigma, and maintaining hard privacy boundaries that could also distance them from non-sex worker family and friends. The sheer weight and incessancy of stigma was a recurring theme in focus groups, one that participants reported as being heavy and isolating to shoulder. The data above emphasises the importance of peer support in providing spaces of solace for sex workers to debrief, recover and recoup within the safety of sex worker value systems.

3.2. Pathology and voyeurism: experiences of accessing mental health services

Some participants identified that they lived with a pre-existing mental health condition and all described the need to manage the impacts of stigma on their mental health. In the absence of structural protections and with barriers to care related to stigma, the management of mental health and the stigma associated with sex work was described as a responsibility primarily of the individual through self-care activities and occasional access to mental health services. The experience of managing or deflecting stigma associated with sex work was described as episodic and as having an enmeshed relationship with mental health. Increasing mental health symptoms made participants more vulnerable to stigma and less able to manage the demands and burdens of stigma in daily life. These experiences were exacerbated if participants were managing stigma related to multiple aspect of identity.

> Participant 12: I know that when I am experiencing a really bad mental health day, week, month that all the negative narratives around my identity can quite get to me, so the negative narratives around being trans or around being a sex worker or around experiencing homelessness or being a drug user, can really get to me and really get me down, which like normally if I'm okay, if my mental health is stable, it doesn't impact me too much, but once I become vulnerable then all of that gets into my head and makes it an even more toxic place and it just perpetuates the already fucked up bullshit that is going on in there. (Focus group 3)

> Participant 16: [W]e all go along in our lives as, you know, outwardly, strong, confident people and there are private times when that's not how we are and we crumble because of this weight of stigma and it's that kind of … at different points it gets to all of us and I think that's the difference, like I think it just … it's a layer over every single thing we do. Like every engagement you have, and every sex work job you do, and every time somebody treats you like crap and every time you know, every time … every experience you have, it's kind of a layer over the top of it or under it or behind it and I think that's the difference. (Focus group 4)

Typically, the experience of seeking mental health support was negative. Participants described that in these interactions the stigma associated with both mental health and sex work became entangled. In mental health services, being a sex worker with mental health concerns rendered participants non-agential in their choice of work. The framing of sex workers as victims and of sex work as an illegitimate occupation obscured the resilience of participants and their efforts to proactively manage their mental health. Mental health practitioners were described as "essentialising" sex work into all other aspects of experience; that is, in this circumstance seeing sex work as the only cause and the root cause of mental health issues. In this situation, other presenting issues (especially mental health) were lost or obscured in therapeutic encounters because of assumptions by mental health practitioners that sex work was the core problem. Despite decriminalisation in some parts of the country, sex work, sex workers and sex work establishments are out of place, disorderly, polluted and polluting (Douglas, 1992, 1994) as they cross the boundaries of acceptable occupational and social mores. Mental health practitioners may perceive that removal of the anomalous condition (sex work) will restore the individual to order and hence ameliorate mental health symptoms. The drive to remove sex work as an out of place attribute is consistent with the need to rescue sex workers. A final experience of mental health care to note was the voyeuristic response of mental health workers taking an overly detailed history and keeping exchanges focused on sex work.

> Participant 28: I think it's often used to de-legitimize people's choices and that if you have a mental health issue then you are not able to freely choose sex work and so you need to be rescued. (Focus group 6)

> Participant 26: … people perceive that you have less agency or like you have less ability to make your own choices. Like for example, sex work for me is being like something I have found I am able to do because I have a mental illness and I find it to be like an opportunity and not like …, "oh you're a victim because you have mental health issues, that means you find it really difficult to work you know nine-to-five, forty hours a week, so you've resorted to sex work", whereas for me how I perceive it because I'm aware that I have agency and I have choice is that, how I view it, is that I have chosen sex work, because it offers benefits over traditional employment … People have assumed that sex workers all have problems with mental health issues, since like we are unable to choose our occupation, that's what they think and think that if we do sex work, if we have mental health problem, it will only get worse, only we stop doing sex work, then we will have no mental health problem. People get associated with two things together (Focus group 6)

> Participant 19: I just had to sack a very sweet mental health professional who was supposed to be helping me with my mental health, because they were too interested in my life as a sex worker and our sessions were more discussing my history and stuff like that than about helping me and I'm thinking this is a voyeuristic trip and he wouldn't stop it, so I stopped seeing him. (Focus group 5)

In these examples, sex workers report mental health professionals' fixation (and at times, fascination) with sex work, often at the detriment of their care. These experiences of voyeurism, pathology, denial of agency and reliance on rescue frameworks of sex work were often shared by sex workers in peer networks. As a result, sex workers engaged in their own practices of careful engagement and dis-engagement with mental health professionals who did not meet their needs, or simply returned to their own practices of self-management and self-care.

3.3. Flexible workplaces, peer support and resiliency: the benefits of sex work for management of mental health

Very little previous literature has examined the ways in which sex workers self-manage their mental health in the context of their work. Self-management strategies such as planning daily activities in order to manage symptoms and preserve energy and learning how to communicate more effectively with health care professionals are widely cited as positive adaptions in research with samples of people with chronic illness including mental health are widely cited (Stenberg et al., 2016). However, the available literature may have limited utility in application to a context of high occupational stigma and little understanding of the structure of the sex industry. In particular, the flexibility of sex work was described as an asset by participants who needed new strategies to manage their mental health issues. In this way, participants described sex work as relatively safe and accommodating for people living with mental health issues.

> Participant 30: Sex work is something that they can pick up and put down, they don't have to walk into an office and work with people nine-to-five. They find that the people are more sort of amenable to their times of being more unwell than other times and if they need to take time out or they feel they get a bit more support. So those people who live with mental ill health, but sex work is something that they feel has provided for them like no other job could. (Interview 2)

> Participant 12: Sex work is one of the only industries which is actually quite safe for people with a mental illness to work in. Like if I'm just too sad and suicidal to get out of bed, I don't have to like worry about being fired from like sucking cock. It's more the job that is a concern, like if I'm physically incapable of managing to handle

the day, I [don't] have to worry about whether or not my bourgeois fuck-wad of a boss is going to fire me kind of thing. (Focus group 3)

Participant 19: One of the reasons why we do sex work, a lot of us do sex work, is that it fits in with our mental health. You know there was one stage where I probably couldn't do a forty hour week in a nine-to-five job, but I could get myself together enough to do at least one, one-hour job a day and make probably more money than I would have made in a nine-to-five job, so I continue to sex work. (Focus group 5)

The flexibility of sex work, in circumstances where sex workers could determine their own working conditions, was a clear benefit in self-management of mental health. Previous research has noted that the flexibility in one's work environment is important in boosting sex worker's self-confidence, safety and job satisfaction (Hubbard and Prior, 2013). Beyond this, other aspects of sex work provided benefits. The skills of negotiation, boundary-making and self-containment were described as emerging from the experience of sex work and as having positive aspects in other parts of their life, beyond work. For one participant, sex work had provided the impetus to focus on their mental health and the means by which to support this. These aspects of the industry might be less visible to those who take a deliberate stance not to see sex work as a legitimate work choice and obscure aspects of the industry that can support workers to build resilience and acknowledge their existing self-management strategies.

Participant 20: being a sex worker has been one of the most empowering things for my mental health because I had to learn how to say "no" and up until that point I had often been passive aggressive or had taken a backward position without asserting myself, because at some level I didn't think I had perhaps had the right to assert myself, I didn't have a sense of myself that was strong enough to advocate on my own behalf, but having become a sex worker and having learnt how to say "no" very early, that's helped me to become a much stronger person mentally than I think I could have been under any other circumstances.

Participant 23: I think in terms of mental health, because you are so used to getting a negative reaction if you ever say, "I had a bad day at work" when you're a sex worker, you learn how to fix that stuff for yourself, so you are not as reliant sometimes on other people … So I think that you actually learn to put back into yourself and be kind of more self-supporting.

(Focus group 5)

Participant 22: [B]efore I did sex work, mental health was this thing that was foreign to me, you know I didn't associate it with myself and after I became a sex worker, you know developing self-care techniques around sex work, actually made me look after my mental health and I don't think I would have reached that stage if I wasn't a sex worker. It actually made me take that you know, take that responsibility of seeking help in things that I needed and actually financially it's allowing me to do it as well, because I wouldn't have been able to. So had I not been a sex worker, I would have probably never really sat down and looked at this aspect of my well-being and I probably wouldn't have had the means to do, so yeah. (Focus group 5)

Without sex work fully acknowledged as an occupation and being subject to protective regulations, the importance of sex worker organisations as a "movement" to provide support for individuals and in advocacy was highlighted. Participants reflected on the notable gap between patchwork government protection and the invaluable forms of peer support they found among sex worker organisations. These findings are significant in that they demonstrate the unique and vital role of local and global peer support services, networks, community hubs and organisations as sources of strength in ameliorating the impacts of sex work stigma.

Participant 31: The global sex worker rights movement is extraordinary. You know, I can drop into any country in the world pretty much and find support from other sex workers. They would be able to tell me how I can work in their town, they would be able to tell me what the law was, they would be able to tell me about the pitfalls and they'd be able to take me out for dinner and buy me a cup of tea and I think that's just incredible. (Interview 2)

Participant 30: You'll meet a group of sex workers for a few days doing activism stuff or just hanging out or doing whatever, you can sort of … that internalized stigma stuff will lessen, because you're like, "oh wow, they're amazing people, they're so fantastic" but then if you're not in those spaces and you're isolated, I think that that can become … you know, wear you down a bit. (Interview 1)

Participants described how the structure of sex industry work, the nature of sex work itself, and the associated stigma all played a role in how they managed their mental health. The structure of the industry allowed sex workers to identify, manage and take responsibility for their own mental health needs; sex work required them to develop skills in boundary-making, negotiation and saying no; and the stigma itself produced resilience, whereby sex workers developed not only self-protection strategies but also self-reliance and self-care. In the absence of adequate formal supports, other sex workers were another key element in addressing stigma and developing resilience. It was only within peer networks that sex workers were not fundamentally out of place – instead they found a place of belonging.

4. Discussion

Mental health is a concern and a priority for sex workers. What may be under-appreciated in the literature is the degree to which sex work stigma contributes to the experience of mental health symptoms even in countries such as Australia with relatively liberal laws regarding sex work. This suggests that while decriminalisation of sex work should be the first legal and policy step, it will not be sufficient on its own without broader cultural and social change in attitudes. The prevalence and impact of sex work stigma on mental health suggest that mental health services are an imperative site of support for sex workers. However, the pervasive stigma associated with sex work also means that the use of any services can be predominantly an unhelpful (and potentially re-stigmatising) experience for sex workers.

The genesis of sex work stigma lies (at least in part) in the perception that sex work is 'out of place' in the order of acceptable occupations and uses of one's body (Douglas, 1994). The requirement for sex workers to hide their work at multiple occasions, the risky consequences of disclosing one's work, and the social incentives for sex workers to exit the sex industry – which situate sex workers as escaping from trauma rather than exiting 'as a personal or professional strategy' (Ham and Gilmour, 2017) – all compound to ensure that sex work remains closeted. In turn, sex workers readily anticipate stigma, either avoiding disclosure of the nature of their work (Koken, 2012) or accruing fatigue associated with the need to continually educate and defend sex work (Quadara, 2008). The need for constant risk management is fed by the pervasive and harmful stigma attached to sex work in all aspects of life (Weitzer, 2018). Participants used selective disclosure as a self-protection and risk management strategy affording them some control in their efforts to keep stigma at bay in their public and personal worlds. However, the practices of creatively describing one's work or maintaining multiple identities are accompanied by the need for vigilance and isolation. Further, concealing stigmatised aspects of identity can have negative implications for mental health (Pachankis, 2007; Quinn and Earnshaw, 2013), potentially compounding the negative outcomes of anticipating or experiencing stigma and discrimination

related to sex work.

The omnipotence of stigma also shaped participants' experience of seeking mental health support. In these encounters, participants reported that service providers viewed sex work as the universal cause of all issues. This "essentialising" of the sex worker identity has been noted before (Benoit et al., 2018). From scholarship in illicit drug use, we can see parallels to a "master identity" (Lloyd, 2013) where, particularly for those "out of place "or at the margins of society, one attribute or aspect of an individual's life is seen to determine and define all others and is viewed as the cause of all problems in that individual's life. It was the experience of participants that mental health workers typically could not disentangle the sex worker identity from other experiences and roles taken by the individual. That is, sex workers were "out of place" in mental health services as their problems were thought not to stem from accepted origins but from this essentialising notion of sex work.

The burden of warding off stigma is managed by sex workers with little formal support or protections. The absence of these supports and protections are a further source of mental health concern. That is, unlike other workers, sex workers are not considered legitimate and worthy of occupational protections. This can also be seen as structural violence in denying sex workers the rights to meet their basic needs (Farmer, 2004). In criminalised regimes, individual sex workers' ability to seek information, support and health care is "severely limited by the risk of prosecution" (Donovan et al., 2010, p viii). The relationship between occupational legitimacy, criminalisation, stigma and mental health are significant and valid concerns. With the decriminalisaiton of sex work, it becomes possible for sex workers to claim the same rights and responsibilities of other citizens including being able to seek justice and restitution for assault and theft in the workplace as well as more mundane issues such as submitting taxation and income returns as typical businesses.

Management of mental health is an issue for all sections of the community and there is significant work to reduce the stigma associated with mental ill health (Corrigan et al., 2017). There is the need for more nuanced examination of mental health among sex workers, which takes account of the conditions in which sex work is performed. For example, data from other studies has shown high rates of mental health issues, particular in the most vulnerable or marginalised groups of sex workers (Chudakov et al., 2002; Krumrei-Mancuso, 2017). By comparison, mental health issues may be somewhat alleviated among sex workers in situations where their work is decriminalised. To this end, a study of workers in brothels in Sydney NSW (where sex work is largely decriminalised) showed that workers enjoyed levels of mental health that were comparable to the general population (Donovan et al., 2012). However, our research also suggests that while decriminalisation is a necessary first step and may improve sex workers' access to better working conditions and industrial rights, sex workers may still experience a hangover of stigma. While repealing criminal and licensing laws surrounding sex work has potential to reduce risk, anxiety and stigma, thereby leading to improved mental health, it is not sufficient alone to address the prevalence of stigma in social and cultural attitudes. A reduction in sex work stigma may take longer and require additional, specific interventions to achieve as stigma is not a singular product of legal frameworks.

What has received less attention in the literature has been the framing of sex workers' experiences in positive ways. These data show numerous ways in which sex work was seen as a valuable resource for coping with mental illness. These included the flexibility and nature of the industry as well as ways in which the skills learnt during sex work facilitated self-management of mental health symptoms. Some participants had also developed innovative and direct ways to manage engagement with mental health services by anticipating and deflecting essentialising, stigmatising or pathologising responses of health workers. Sex workers' self-advocacy and resistance of a pathology focus in mental health services is important as such a bias may influence the therapeutic process, and sex workers may internalise further negative and deficit-based messages (Burnes et al., 2012).

Challenges to pathologising sex work and to associated stigma can be organised through collective action by sex workers and their allies (Benoit et al., 2018; Lazarus et al., 2012). Participants in this study reflected on the role of sex worker organisations and peer support in minimising internalised stigma and associated isolation. The organisation of this project as a partnership approach is another example of challenging the status quo and accepted conventions within the literature (Jeffreys, 2010). This framing of this research as co-produced between researchers and sex workers and the explicit approaches taken (strengths-based, regard for agency, non-homogenising) reflect political actions in this field and a commitment to the precepts of 'insider research' (Kim and Jeffreys, 2013), the 'nothing about us without us' framework (Canadian HIV/AIDS Legal Network, 2005) developed by HIV activists, and the ethical guidelines develop by sex worker organisations (Wahab and Sloan, 2004).

The participants in this study were recruited from the membership and networks of sex worker organisations. Despite these comprehensive networks, sex workers who remain isolated and socially marginalised may have lesser opportunity to access sex worker organisations or participate in research. Being in contact with a sex worker organisation may have also raised participants' awareness of the issues central to this study in ways that were not available to sex workers in more isolated circumstances.

5. Conclusion

The findings of this study compel us to rethink the relationships between sex work and mental health as they have been previously articulated. This paper troubles assumptions made about causal links between pre-existing trauma or mental illness and sex work, and suggests that sex work stigma has very significant impact on mental health. By framing this paper using the lenses of sex worker agency and resilience and by taking a structural view of stigma, the data suggest that sex work can provide a flexible and adaptive occupational choice for some people with mental health issues. Sex work stigma can exacerbate symptoms of mental ill health, however sex workers use the skills that they have developed through sex work to cope with and manage these risks. What remains missing or fragmented is a professional mental health sector that can see beyond the sex in sex work to engage with clients and their mental health in respectful and helpful ways. The fact that these experiences occurred in Australia, which includes the first jurisdiction in the world to decriminalise sex work, points to the significant work ahead to provide access to culturally competent, appropriate and non-stigmatising mental health care for sex workers. In the absence of structural protections and in light of the enduring impact of sex work stigma, the data indicate the continuing need for funded and resourced sex worker peer support. Such support is necessary at multiple levels: to support individuals who are isolated and cannot find support in other ways; to build awareness and capacity among the mental health workforce; and to conduct high level advocacy for law reform, decriminalisation and anti-discrimination protections.

Acknowledgements

This research was supported by the Australian Government Department of Health.

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