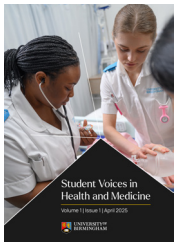
Student Voices in Health and Medicine




# Mental ill health experiences of female sex workers and their perceived risk factors: A systematic review of qualitative studies

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## Abstract

**Aim:** To provide in-depth insights into the lived experience of sex workers' mental ill health. **Background:** Female sex workers globally are vulnerable to significant mental health challenges due to social inequalities, including classism, gender inequality, discrimination and criminalisation, coupled with stigma and violence. Understanding the mental ill health experiences of female sex workers is crucial for developing effective tailored interventions. **Design:** A systematic qualitative literature review. **Methods:** Searches across ten databases, including CINAHL Plus, Cochrane Library, Medline (1949 to current date 2022), ProQuest, PTSDPubs, PsycINFO, EMBASE, Web of Science (Core Collection), AMED, and Google Scholar. Included studies were assessed for quality using the Critical Appraisal Skills Programme (CASP) Qualitative Studies Checklist and subsequently thematically analysed. **Results:** Seventeen studies were included revealing five interconnected themes. Female sex workers frequently experience anxiety, depression and suicidal ideation, at times exacerbated by addiction as a coping mechanism. Stigma from society, family and healthcare providers leads to isolation and hindered access to care. The normalisation of violence both from clients and law enforcement contributes to severe mental health issues including Post Traumatic Stress Disorder (PTSD). Despite these challenges, Female Sex Workers employ various coping mechanisms such as rationalising their work, community mobilisation and strategic risk navigation. **Conclusions:** Female sex workers face multifaceted mental health challenges, significantly influenced by societal stigma and violence. Comprehensive support systems including mental health services, addiction support, and efforts to combat stigma and violence are essential to improving the wellbeing of female sex workers. Addressing these issues can lead to better mental health and overall wellbeing for female sex workers, creating a safer and more supportive environment. Policymakers and healthcare professionals need to collaborate to implement strategies that address these challenges and promote the wellbeing of female sex workers.

**Keywords**: Sex work; Mental health; Qualitative systematic review

# Introduction

The exploration of mental ill health among marginalised populations has garnered significant attention in recent years (World Health Organization, 2022). Among these populations, female sex workers (FSW) are particularly vulnerable to various psychosocial challenges, given the complex interplay between their occupation, social stigma and societal attitudes (World Health Organization, 2022). Having been around since approximately 2400 BCE, the sex industry is often called the oldest profession in the world (Lerner, 1986) and is described as 'the commercial trade of sex and sexually stimulating materials' (Oxford English Dictionary, 2024). Understanding the mental ill health experiences of female sex workers is crucial for the development of effective interventions and support systems tailored to their unique needs.

Female sex workers, individuals who 'offer sexual services in exchange for compensation (i.e., money, goods, or other services)' (Sawicki et al., 2019), face a multitude of adversities, including legal and social stigmatisation, violence, substance abuse, and limited access to healthcare services (World Health Organization, 2022). These challenges can have detrimental effects on their mental wellbeing, contributing to the development and exacerbation of mental ill health disorders. It is important to understand the specific risk factors that sex workers face in relation to mental ill health, while some studies have investigated a single risk factor (Kramer, 2004; Brown 2013), they do not consider how risk factors are likely to be intertwined for many individuals (MIND, 2017).

A recent systematic review explored the relationship between sex work and mental health (Martín-Romo, 2023). Focusing on the quantitative literature, they found that depression was the most commonly reported mental health problem and that sex workers are exposed to many work-related risks including violence and high-risk sexual behaviours. This is an important review, highlighting the high prevalence of mental health issues among sex workers and underscoring the significant barriers they face in accessing healthcare, emphasising the need for targeted interventions to promote their psychological wellbeing. The aim of this current systematic review is to provide in-depth insights into the lived experience of sex workers' mental ill-health, revealing the contextual factors that quantitative data might overlook, thus informing more effective, tailored interventions and policies.

# Methods

## Design

This systematic qualitative literature review is reported according to the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) 2020 checklist (Page et al., 2021). No protocol has been registered, due to the time constraints of the student project.

## Search strategy

The Population, Phenomena of Interest, Context (PICo) framework, as shown in Table 1, was used to identify search terms (Lockwood et al., 2015). Search terms were used in conjunction with subject headings, as well as all common synonyms and truncations being searched alongside Boolean operators. The results were limited to the English language only; no other limits were placed (Drucker et al., 2016).

The following databases were searched in November 2022: EMBASE, CINAHL, AMED, Cochrane Library, ProQuest, PTSDplus, Medline, PsycINFO and Web of Science (Core Collection). An example EMBASE search can be seen in Supplementary Table 1. Results were initially screened by title and abstract by single reviewers to remove irrelevant literature. The remaining results were uploaded to Rayyan, an online software

for organising and managing systematic literature reviews, (Ouzzani et al., 2016), and following duplicate removal, they were independently screened by two reviewers against the eligibility criteria listed in Table 2. Conflicts were discussed until a consensus was reached.

*Table 1. Search terms*

| PICo framework | Search terms |
|---|---|
| Population/Context | Sex worke*; Sex work; Prostitut*; Prostitution; Strippe*; Porn star; Pornographic actress; Commercial sex; Sex trade worker; Transactional sex; Porn stars |
| Phenomenon of Interest | Mental health; Mental disorde*; Mental health care; Mental health treatment; Mental well-being; Psychological health; Psychological wellbeing; Psychological distress; Mental illness; Mental health problems; PTSD; Post traumatic stress disorder; Trauma; Violence; Drug and alcohol abuse; Anxiety; Depression; Suicidal behaviour; Mood disorde*; Experienc*; Occurrenc* |

Google Scholar was searched using 'Publish or Perish' (Harzing, 2016). The search '("Sex worke*" OR "Sex work" OR Prostitut* OR Prostitution) AND ("Mental health" OR "Mental disorde*" OR "Mental health care" OR "Psychological distress" OR "Mental illness" OR "Mental health problems" OR PTSD OR "Post traumatic stress disorder" OR Trauma OR Violence OR Anxiety OR Depression) AND (Experienc*)' was used and limited to 200 results.

*Table 2. Eligibility criteria*

| | Inclusion criteria | Exclusion criteria |
|---|---|---|
| **Population** | Cisgender, female sex workers, aged 18 years or older.<br>The intimate partners of female sex workers. | Under the age of 18.<br>People who have been sex trafficked.<br>Sex workers who identify as transgender or male. |
| **Exposure** | Mental ill health including, but not limited to: post-traumatic stress disorder, (childhood) trauma, substance misuse, anxiety, depression, suicidal behaviour and mood disorders. | N/A |
| **Outcome** | Discussion of participants' personal experiences of mental ill health. | |
| **Types of studies** | Primary, qualitative studies. | Quantitative or mixed methods studies.<br>Studies that do not include direct quotes from participants. |
| **Language** | English language only. | |
| **Date range** | No limits on date of publication. | |

## Data extraction

Data extraction was completed independently by each reviewer. The information extracted included: citation, aim, participant demographics, sample size, setting, geographic location, data collection, results, and additional comments, based on the information from the Cochrane Data Extraction Template for Included Studies (Cochrane Consumers and Communication, 2016). The data extraction tool was piloted using 5 studies.

## Risk of bias

The Critical Appraisal Skills Programme (CASP) qualitative studies checklist (Critical Appraisal Skills Programme, 2022) was used to assess study quality. Alongside the CASP checklist, notes were made to enable an in-depth analysis of the strengths and limitations of the included papers. As the purpose of this review was to present an overview of findings, no studies were excluded based on quality (Butler et al.,

2016).

## Data synthesis

A manual inductive approach to thematic analysis was undertaken, following the framework described by Braun and Clarke (2022). This involved data familiarisation, coding, initial theme generation and theme refining, defining and naming. This process was undertaken by one author (LM), who used a series of spider diagrams to gather data codes into groups before using this to understand, refine and name each data theme. Themes were discussed and agreed upon with the other authors.

# Results

The search across 9 databases yielded 18,072 results (see Figure 1). After title and abstract screening, 416 papers were imported to Rayyan. Deduplication removed 97 papers, leaving 397 papers for full-text screening. A total of 386 papers were excluded, leaving 11 papers to be included. Additionally, three papers from Google Scholar searches were added and three further papers from reference list searching, leaving 17 papers included in this review.

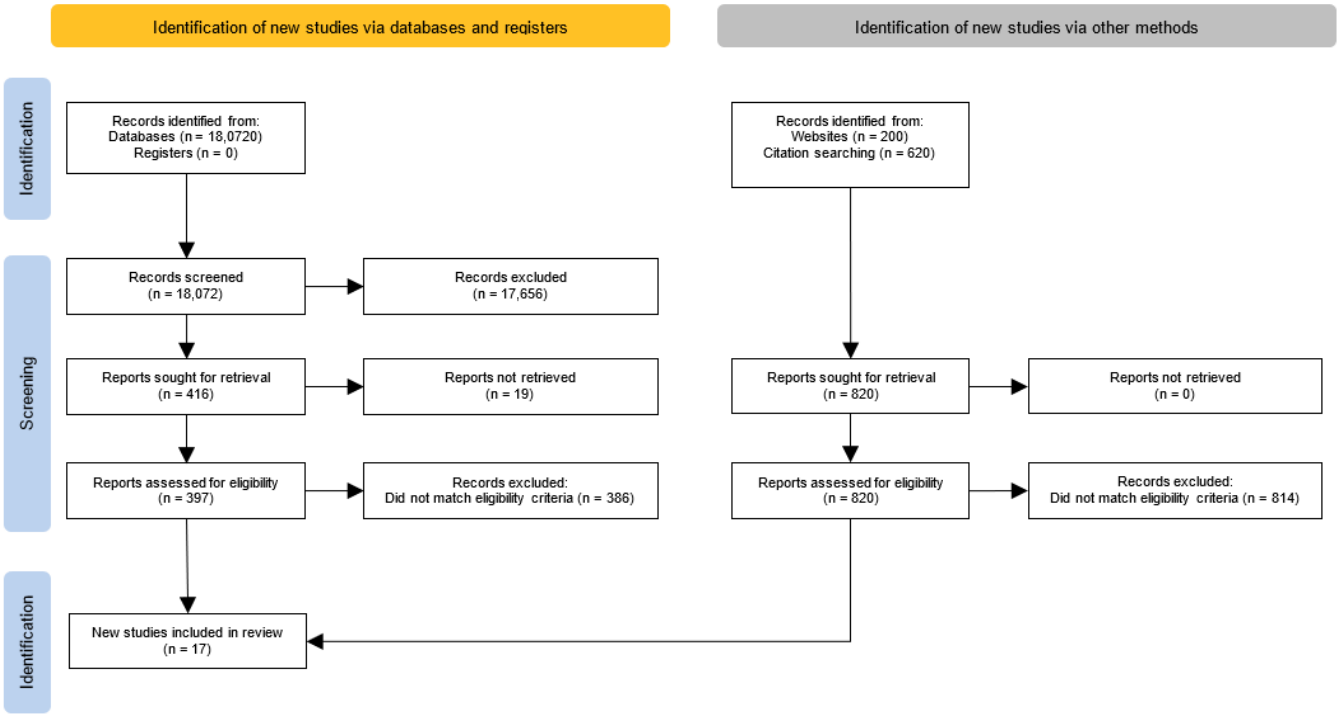


*Figure 1. PRISMA flow diagram*

## Study Characteristics

The sample sizes ranged between 9 and 69 (Table 3). Most studies (n=16) used interviews to collect data, while one used focus group discussions. All studies, bar five, took place in lower-middle-income countries (LMICs) with the non-LMICs being the United States of America (USA; n=3), Canada (n=1) and the UK (n=1). The LMIC countries were Iran (n=3), China (n=2), India (n=2), Nepal (n=2) and one in each of the following: Kenya, Mexico, Nigeria, Tanzania and Zimbabwe.

*Table 3. Study characteristics*

| CITATION COUNTRY | AIM | PARTICIPANT DEMOGRAPHICS | SAMPLE SIZE | DATA COLLECTION AND ANALYSIS | KEY FINDINGS |
|---|---|---|---|---|---|
| Williamson and Folaron, 2003 Unspecified cities across the USA | To explore the experiences of female sex workers working on the street. | Female sex workers aged between 18 and 35 years old. | 21 female sex workers. | In-depth interviews. Analysis used substantive and theoretical coding. | Entry into the SI, daily challenges and getting out of the SI. |
| Jackson et al., 2007 Canada | To explore emotional stressors experienced by female sex workers in their home and work lives. | Female sex workers, 19 to 48 years old. 26 women worked with an escort service, 18 only worked on the streets, 8 only worked as escorts and 16 worked in other settings. | 69 female sex workers were interviewed, but only 68 were coherent so 68 interview results were used for the findings of the study. | Open-ended interviews. Common themes and patterns were identified to find codes and generate themes and sub-themes. | Working in the SI, mental ill health, relationships with co-workers, intimate partners, and families, and being outed that you work in the SI. |
| Choudhury, 2010 Tijuana, Mexico | To explore how sex work impacts health. | Female sex workers, in their early 20s to mid-50s. | 20 female sex workers. | Interviews that lasted 40 to 75 mins. Constant comparative method analysis which used an inductive approach to analyse data. | The effect of services on the sex workers' physical and mental ill health, and their reasons for staying in the SI. |
| Sallmann, 2010 Unspecified states across the USA | To explore female sex workers' experience of stigma due to being a SW and abusing substances. | Female sex workers, between 19 and 48 years old | 14 female sex workers. | Tape-recorded interviews. Hermeneutic analysis to identify emergent themes and then discussions were held to decide on themes. | How female sex workers cope with stigma and their day-to-day experiences of stigma and violence. |
| Mellor and Lovell, 2011 UK | To explore the experiences of life conditions, sex work, health consequences and service accessibility among female sex workers. | Female sex workers aged between 32 and 40 years old. | 9 female sex workers. | Semi-structured interviews with open and closed questions. Thematic analysis was used to generate codes and themes. | The female sex workers' perceptions of their health, homelessness, substance misuse and the violence they face. |
| Mtetwa et al., 2013 Zimbabwe | To explore why women left care after referral to a sex work programme. | Female sex workers between 18 and 48 years old. | 38 female sex workers. | Focus group discussions. Transcripts were analysed using familiarisation of the data, identifying themes and topic areas, and categorising data. | Feelings of shame due to healthcare workers' attitudes, anxiety from this, and implications for practice. |

| CITATION COUNTRY | AIM | PARTICIPANT DEMOGRAPHICS | SAMPLE SIZE | DATA COLLECTION AND ANALYSIS | KEY FINDINGS |
|---|---|---|---|---|---|
| Oselin and Blasyak, 2013 Four different unspecified cities across the USA | To explore female sex workers' responses to violence. | Female sex workers, 20 to 47 years old who accessed support from non-governmental organisations (NGOs). | 17 female sex workers. | Tape-recorded in-depth interviews. Data was coded and major data patterns were identified. | Client perpetrated violence faced by female sex workers and how they defend themselves. |
| Basnyat, 2014 Bhaktapur, Kathmandu, Nepal | To explore the lived experience of female sex workers and their health. | Female sex workers aged between 32 and 45 years old who engage in street-based sex work. | 35 female sex workers. | Interviews. Thematic analysis was used to create codes and themes. | How female sex workers use their work to provide for themselves, financial security and how they deal with the stigma of working in the SI. |
| Yeun et al, 2014 Hong Kong, China | To explore challenges faced by female sex workers, how this impacts their mental ill health, resilience, and how they cope with challenges. | Female sex workers, between 24 and 55 years old. | 23 female sex workers. | Audio-taped interview. Grounded theory took place for data analysis. | The emotional challenges of being a sex worker, resilience when working in the SI and how they cope with challenges. |
| Basnyat, 2017 Kathmandu, Nepal | To explore structural violence experienced by sex workers in Kathmandu, Nepal, and how this reduces their access to healthcare services. | Female sex workers aged between 32 and 45 years old. | 35 female sex workers. | One-to-one semi-structured interviews. After 15 interviews, initial codes were shared with participants to ensure that data represented their experiences. Thematic analysis was then used. | Structural violence in the healthcare that impacts female sex workers, and the implications this should have on healthcare provision. |
| Blanchard et al., 2018 Kannada, India | To explore the experience of intimate partner violence and human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) in female sex workers and their intimate partners. | Female sex workers, over 21 years old. | 38 interviews took place. 10 with couples, interviewed separately, 13 individual female sex workers, and 5 individual male intimate partners. | Semi-structured one-to-one in-depth interviews. Thematic analysis using coding and categorization of data using Nvivo 10 and collaborative data analysis. | The acceptance of violence due to stigma from society, gender norms and other boundaries due to sex work, and the structural violence towards intimate partner violence and condom use. |
| Leddy et al., 2018 Iringa, Tanzania | To explore alcohol consumption, gendered violence, and HIV risk in the SI. | Female sex workers aged between 19 and 47 years old. | 24 female sex workers. | Broad, open-ended interviews. Analysis involved inductive and deductive approaches, as well as the framework approach. | Promotion of alcohol consumption in the SI, the female sex workers' thoughts on this, and their self-protection strategies. |

| CITATION COUNTRY | AIM | PARTICIPANT DEMOGRAPHICS | SAMPLE SIZE | DATA COLLECTION AND ANALYSIS | KEY FINDINGS |
|---|---|---|---|---|---|
| Ma and Loke, 2019 Hong Kong, China | To explore the stigma experienced by female sex workers when they access healthcare services and how they cope with it. | Female sex workers, over 18 years old and not diagnosed with a serious psychological health problem. | 22 female sex workers. | Semi-structured interviews with open-ended and probing questions. Directed content analysis was used. | The stigma female sex workers face in healthcare, how they cope with this and the healthcare needs of female sex workers. |
| Lebni et al., 2020 Tehran, Iran | To explore the challenges Iranian female sex workers experience. | Female sex workers, between 19 and 42 years old. | 22 female sex workers. | Guided questions and semi-structured interviews. Crucial phrases and sentences were identified and turned into codes, codes were then placed into categories and subcategories which were named. | Violence faced by female sex workers, how this impacts their mental, physical and sexual health, the stigma they face from society and how this impacts their lives. |
| Nelson, 2020 Uyo, Nigeria | To explore the lived experience of violence of SWs and how this impacts their health. | Female sex workers aged between 19 and 31 years old. | 27 female sex workers. | Guided interviews. Analysis used three approaches: thematic, inductive, and data-driven. | Client perpetrated, intimate partner and police violence faced by female sex workers, and how they defend themselves. |
| Swathisha and Deb, 2022 Puducherry, India | To explore challenges experienced by female sex workers. | Female sex workers, between 19 and 48 years old. 9 participate in phone-based sex work, 3 in home-based sex work, and 3 in street-based sex work. | 15 female sex workers. | Interviews. Thematic analysis using coding and categorisation of major themes. | Economic and social issues, and mental ill health faced by female sex workers. The study identified that these issues all interlink, and a common theme is a lack of support. |
| Wanjiru et al., 2022 Nairobi, Kenya | To explore how female sex workers use resources to help navigate the consequences of their work. | Female sex workers, 18 to 45 years old. | 40 female sex workers, selected randomly from a pool of 1003 participants of a wider study. | Audio-recorded interview. Thematic coding and analysis using Nvivo 12. | Adverse childhood experiences, intimate partner violence, mental ill health, learning to cope using resilience, ways in which we can support SWs. |

## Risk of bias of included studies

All studies had a clear statement of the aim of the research, clear findings, and discussed the implications for practice and research. Seven studies did not discuss whether their research design was appropriate to address the aims of their research. Only three studies considered the researcher-participant relationship. Furthermore, only seven studies mentioned ethical considerations or ethics approval. See Table 4 for further information.

*Table 4. Critical appraisal*

| Author (year) | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 | Q9 | Q10 | Score |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Williamson and Folaron (2003) | Y | Y | N | Y | Y | N | N | Y | Y | Y | 7/10 |
| Jackson et al. (2007) | Y | Y | N | Y | Y | N | Y | N | Y | Y | 7/10 |
| Choudhury (2010) | Y | Y | Y | Y | Y | N | Y | Y | Y | Y | 9/10 |
| Sallmannn (2010) | Y | Y | Y | Y | Y | N | N | Y | Y | Y | 8/10 |
| Mellor and Lovell (2011) | Y | Y | N | Y | Y | Y | Y | Y | Y | Y | 8/10 |
| Mtetwa et al. (2013) | Y | Y | Y | Y | Y | N | N | Y | Y | Y | 8/10 |
| Oeslin and Blasyak (2013) | Y | N | Y | N | Y | N | N | Y | Y | Y | 6/10 |
| Basnyat (2014) | Y | Y | Y | Y | Y | N | N | Y | Y | Y | 8/10 |
| Yeun et al. (2014) | Y | Y | Y | Y | Y | N | N | Y | Y | Y | 8/10 |
| Basnyat (2017) | Y | Y | N | Y | Y | N | Y | Y | Y | Y | 8/10 |
| Blanchard et al. (2018) | Y | Y | Y | Y | Y | N | N | Y | Y | Y | 8/10 |
| Leddy et al. (2018) | Y | Y | N | Y | Y | N | N | Y | Y | Y | 7/10 |
| Ma and Loke (2019) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | 10/10 |
| Lebni et al. (2020) | Y | Y | Y | Y | Y | N | N | Y | Y | Y | 8/10 |
| Nelson (2020) | Y | Y | N | Y | Y | N | Y | Y | Y | Y | 9/10 |
| Swathisha and Deb (2022) | Y | Y | Y | Y | N | N | Y | N | Y | Y | 7/10 |
| Wanjiru et al. (2022) | Y | N | N | Y | Y | Y | Y | Y | Y | Y | 8/10 |

Q1. Was there a clear statement of the aims of the research?
Q2. Is qualitative methodology appropriate?
Q3. Was the research design appropriate to address the aims of the research?
Q4. Was the recruitment strategy appropriate to the aims of the research?
Q5. Was the data collected in a way that addressed the research issue?
Q6. Has the relationship between researcher and participants been adequately considered?
Q7. Have ethical issues been taken into consideration?
Q8. Was the data analysis sufficiently rigorous?
Q9. Is there a clear statement of findings?
Q10. How valuable is the research?

## Findings

This review identifies several key themes related to the mental health challenges faced by sex workers. First, experiences of mental ill health, including anxiety, depression, and suicidal ideation, highlight the psychological burden of sex work. Next, the theme of addiction reveals how sex workers often turn to substances as coping mechanisms. Stigma was a significant factor, exacerbating mental health issues and hindering access to care. The theme of normalization of violence shows how violence is an expected and pervasive part of their lives. The final theme provides a positive perspective, highlighting the coping mechanisms that FSWs develop to manage their mental health. These interconnected themes provide a comprehensive understanding of the multifaceted challenges impacting the mental wellbeing of FSWs.

### *Experiences of mental ill health*

Many participants reported experiencing anxiety. In a study that aimed to understand their challenges, some sex workers expressed feelings of shame and guilt over their occupation and were worried about people's

perceptions of them once they learned about their jobs (Swathisha and Deb, 2022). This led to increased frustration and hopelessness, 'I have a constant fear of honour, fear of getting caught and fear of losing my husband, (Swathisha and Deb, 2022, p. 264).

Depression and suicidal ideation were expressed by many participants. Some had attempted suicide; they felt as though life would not improve and the best action to take would be to commit suicide, 'Since I got into this job, my life was over. I wish death most of the days. Sometimes I think of suicide' (Lebni et al., 2020, p. 4.).

Our analysis identified little difference between the reports of female sex workers from LMICs and non-LMICs regarding depression. For example, some participants from LMICs believed that everyone who works in the sex industry must be depressed to some extent because of the poor and stressful work environment and socially isolated living conditions (Choudhury, 2010; Lebni et al., 2020). Similarly, Mellor and Lovell (2011), who focused on understanding the wider determinants of health of UK street-based sex workers, found that many participants associated suicidal thoughts with the lifestyle of being a sex worker, 'In this line of work, you could say that we are depressed, because at times the depression just hits you' (Choudhury, 2010, p. 684).

### *Substance (mis)use*

Many participants experienced mental ill health due to their work, which led some to use substances as a coping mechanism. This included smoking tobacco, drinking alcohol, using illegal substances and gambling. Many sex workers reported living in a cycle of their addiction and mental ill health, in which their experiences of mental ill health led to them seeking unhealthy coping mechanisms; the aftermath of this then exacerbated their mental ill health (Williamson and Folaron, 2003; Ma and Loke, 2019; Wanjiru et al., 2022). This highlights the idea that globally, female sex workers experience similar struggles with their mental ill health and perceived risk factors.

Some participants reported that the violence they experienced caused them to turn to illicit substances to help with mental separation between their physical body and their emotions (Oselin and Blasyak, 2013). Using illicit substances made this process easier, helping them alleviate their worries and anxiety about future assaults, with one participant stating that 'the drugs take away the feelings' (Williamson and Folaron, 2003, p. 280). Despite the fear being reduced momentarily, this would only help them cope for a short time (Williamson and Folaron, 2003; Yuen et al., 2014). As one participant said, 'I would put my head into something else [....] my mind was somewhere else. [....] This was easier when I'd be high' (Oselin and Blasyak, 2013, p. 285).

Two studies, one that aimed to explore alcohol consumption in the sex industry (Leddy et al., 2018) and another that aimed to understand how working in the sex industry impacted health (Choudhury, 2010), found that many sex workers expressed drinking alcohol to attract clients. They felt as though it was difficult to take part in sex work if they had not been drinking. Drinking alcohol encouraged them to feel more confident and outgoing.

### *Stigma*

Many participants expressed experiencing stigma from society, including their families, friends, clients, and the public. These women worried about the reactions of their families if they ever found out about their work, so they hid their occupation (Yuen et al., 2014). This caused them to live in isolation, playing a role in their poor mental health, 'After my family knew that I got into this job they never wanted to see me, I lost all my old friends, I'm very alone' (Lebni et al., 2020, p. 4).

Some participants reported that they felt they were often viewed by the public as immoral because their work deviates from societal norms (Wanjiru et al., 2022). This caused prejudices and the opinion they deserve the things happening to them, such as violence and mental ill health (Lebni et al., 2020; Wanjiru et al., 2022). It was reported that labels were often used by society to dehumanise and humiliate sex workers (Sallmann, 2010; Basnyat, 2014). According to a study that recruited sex workers via a sex worker service program in the US, the participants discussed the use of the words 'whores' and 'hookers' (Sallmann, 2010, p. 150) by members of the public as hurtful and a gateway into discrimination: 'You get called vulgar names like 'whore', fingers are pointed at you, people disapprove, you get treated differently' (Basnyat, 2014, p. 1047).

For the women who left work in the sex industry, they found this stigma still follows them (Sallmann, 2010). They felt they could never fully escape the stigma and the effects this has on their mental health throughout their lifetime. Some reported feeling as though they could not seek other employment (Jackson et al., 2007). Living with this stigma had a large effect on their day-to-day lives and impacted the ways they saw themselves and others.

> Like if I get a job, somebody will recognize me and say 'oh my god, you're letting her work here as a prostitute', you know, people shoot you down cause you work the streets. You're nothing but a 'ho', and you always will be, that's their attitude (Jackson et al., 2007, p. 266).

Furthermore, stigma was reported as a significant obstacle to accessing healthcare for many participants. They felt that this stigma led to discriminatory acts such as a reduced quality of care provided by healthcare professionals (Basnyat, 2017). This directly impacted their health, as they felt they were not receiving appropriate care for their conditions (Basnyat, 2017). Some also expressed experiencing humiliation and patronisation from healthcare professionals, while receiving treatment from services, which made them feel shameful and guilty for their work and trying to seek help (Mellor and Lovell, 2011). This made the women anticipate stigma the next time they needed treatment and thus avoided getting help (Mtetwa et al., 2013; Basnyat, 2014, 2017).

> The staff there probably suspected that I was a sex worker, because they were rude and spoke to me in harsh reprimanding voices. I felt humiliated. I definitely won't go there again (Ma and Loke, 2019, p. 8).

Two studies that aimed to understand sex workers' experiences of accessing healthcare services found that most of the participants felt ashamed of their work and were worried about the consequences of being discovered (Mtetwa et al., 2013; Ma and Loke, 2019). This meant they would avoid going to health clinics to reduce the chances of being found out and being treated differently (Basnyat, 2017). As one participant shared, 'I felt ashamed of myself when I visited the social hygiene clinic… They must look down on me' (Ma and Loke, 2019, p. 8).

### *Normalisation of violence*

The women reported expecting violence due to the stigmatisation of working in the sex industry (Sallmann, 2010; Lebni et al., 2020). Because of this stigma, the women expressed that they were dismissed when they reported the violence, and one was told she 'deserved it' (Sallmann, 2010). This normalisation of violence made some of the women fear attacks and death in the future, manifesting as anxiety and PTSD (Jackson et al., 2007; Oselin and Blasyak, 2013). One participant went as far as stating 'In the last couple of years I was out there the murder rate went up 200 percent' (Oselin and Blasyak, 2013, p. 279-280). There was a fear the next person murdered may be themselves or a friend (Jackson et al., 2007; Oselin and Blasyak, 2013), with a

participant stating, 'I thought I was going to die in the life.' (Oselin and Blasyak, 2013, p. 279).

Some women expressed undergoing verbal or physical violence from their intimate partner. The origins of this violence came from stigma, disapproval and distrust (Blanchard et al., 2018). Much like in client-perpetrated violence, stigma led many women and their partners to accept violence (Blanchard et al., 2018; Wanjiru et al., 2022). One woman expressed that 'they have that right to beat us.' (Blanchard et al., 2018, p. 7), highlighting the normalisation of violence in the sex industry. The women viewed this as punishment for their work, resulting in self-blame, distress, and fear (Blanchard et al., 2018; Nelson, 2020).

Sex workers also discussed violent encounters with the police, reporting being arrested, beaten up, verbally assaulted, and demanding that they give sex and money (Sallmann, 2010; Nelson, 2020; Swathisha and Deb, 2022; Wanjiru et al., 2022). This violence left them feeling as though they had nowhere to turn to report other injustice in their lives and reinforced societal discrimination, fear and anxiety (Nelson, 2020). An example of this is when one sex worker who lived in the US, tried to report an incident of violence to the police and she was told she 'deserved it' (Sallmann, 2010, p. 151). This study discussed how stigma from society is linked to sex workers experiencing violence, being dehumanised, and having to withstand prejudice because of their occupation. This idea led some sex workers to accept police violence (Blanchard et al., 2018; Nelson, 2020), 'Maybe it is ok for police to beat prostitutes, but I didn't do them anything' (Nelson, 2020, p. 1023).

Some US participants discussed worries about experiencing physical violence (Oselin and Blasyak, 2013). Due to sex work being unpredictable, and for example, not knowing the mood of the client, their pimp, or their intimate partner, some women expressed feelings of fear for their lives (Oselin and Blasyak, 2013). One participant reported that her anxiety was caused by the violence she experienced while working, which affected her ability to access healthcare (Mellor and Lovell, 2011). She expressed that while seeking support for her anxiety, she faced rejection from healthcare services due to asking for help 'too many times' (Mellor and Lovell, 2011, p. 317).

> I was always too nervous to go… I can't go out on my own, I got attacked in Liverpool [UK]… and I can't go out on my own at night due to my nervousness (Mellor and Lovell, 2011, p. 317).

This idea was additionally prevalent in studies from LMICs where many participants reported experiencing client-perpetrated physical and sexual violence, as well as reporting psychological violence (Blanchard et al., 2018; Lebni et al., 2020; Nelson, 2020; Swathisha and Deb, 2022; Wanjiru et al., 2022,). Psychological violence included being manipulated and called vulgar names, and for some, this caused more harm to their mental ill health than physical or sexual violence (Lebni et al., 2020). Sex workers from a Nigerian study, which explored how experienced violence impacted their health, described how discussing condom use with their clients could trigger arguments, leading to rape, beatings or being threatened, and consequently mental ill health, reduced self-efficacy and internalised stigma (Nelson, 2020).

> They will hit you so that you will just allow them to do what they want. Some will agree to use condom but later remove it… You know they are troublemakers. You don't complain unless you are ready for a fight (Nelson, 2020, p. 1022).

One study spoke about how the violence that participants faced caused PTSD (Oselin and Blasyak, 2013). For one participant, this was due to increased stress and fear from an attack by a client. She expressed that 'the stress was mainly because of the most recent guy that tried to kill me.' (Oselin and Blasyak, 2013, p. 279).

### *Coping mechanisms to manage mental health*

Female sex workers described various coping mechanisms to navigate the challenges of their work and maintain mental well-being. Some rationalised their role by viewing it as a legitimate means of earning a living and maintaining financial independence, thus helping them find dignity and purpose despite societal stigma (Yuen et al., 2014). Additionally, some FSWs normalised their work as a survival strategy and found strength in shared experiences and collective agency, participating in community mobilisation efforts and advocacy groups (Basnyat, 2014). They also developed strategic skills to navigate risks, such as negotiating condom use (Basnyat, 2014; Leddy et al., 2018) and creating support systems within their work environment (Mtetwa et al., 2013; Leddy et al., 2018). Others maintained hope and optimism for a better future, driven by aspirations to leave sex work and improve their lives and their families (Wanjiru et al., 2022). Emotional regulation strategies, such as reframing negative thoughts, seeking temporary distractions, and accepting their situation, helped some to manage stress (Yuen et al., 2014).

To avoid the shame that some women experienced when accessing services, some women expressed a preference for visiting anonymous NGOs to seek support, as this meant they would not have to state their occupation (Ma and Loke, 2019). They felt they received educational and emotional help here, as well as accessing free condoms and healthcare services, 'Because it is a sex worker-friendly organization, I feel safe and be respected there' (Ma and Loke, 2019, p. 9).

For some, building strong support networks with peers offers practical and emotional support, creating a sense of community that buffers against isolation (Yuen et al., 2014; Wanjiru et al., 2022). While some rely on informal health information networks and seek care strategically to manage health-related challenges (Basnyat, 2015), others felt their experiences were brushed off by all support systems, leading to a decline in their mental health (Sallmann, 2010). They then felt the need to learn coping mechanisms on their own and to rely only on themselves (Wanjiru et al., 2022). One participant exemplified this, stating, 'I have no friends. There is nobody I can talk with a little.' (Lebni et al., 2020, p. 4).

## Discussion

This review has synthesised the qualitative research on the mental ill health of FSWs, showing that mental ill health is significantly influenced by societal stigma and discrimination. Moreover, this stigma hinders healthcare access due to fear of judgment. Some FSWs cope through addiction, using tobacco, alcohol and drugs, which further exacerbates their mental health issues. The review highlights the normalisation of violence within the sex industry, with FSWs facing frequent physical, sexual and psychological abuse, leading to severe mental health problems such as PTSD. Additionally, a lack of support systems can leave FSWs isolated, relying on inadequate personal or peer support. Despite these challenges, some FSWs employ coping mechanisms such as rationalising their work, finding strength in community mobilisation, developing strategic skills to navigate risks and maintaining hope for a better future. While the coping mechanisms identified are vital for resilience, access to formal mental health services and systemic interventions are necessary to address the root causes, and the symptoms, of mental ill health.

Building on Martín-Romo et al. (2023), this review provides a deeper understanding of the lived experiences of FSWs, detailing the emotional and psychological impacts of stigma, violence and isolation. It explores the barriers to healthcare access and underscores the importance of both formal and informal support systems. These findings highlight the need for comprehensive, empathetic and holistic interventions tailored to the unique challenges faced by FSWs to improve their mental health and overall wellbeing.

The socio-ecological model (SEM) is a comprehensive framework that examines the interplay between

individual, relationship, community and societal level factors and their influence on behaviours and outcomes and can be used as a framework for holistic interventions; the model is widely recognised in public health and behavioural sciences for its holistic approach to addressing complex issues (Kaufman et al., 2014). Interventions based on the SEM should address all levels when tackling the mental health issues that FSWs encounter. Personal traits such as age, sex, health knowledge, attitudes, and behaviours are considered at the individual level (Kaufman et al., 2014). Social networks and interactions, such as those with family, friends and peers, form the interpersonal/network level and can significantly impact health outcomes and behaviours. The community level concerns the larger social, cultural and physical contexts, including the accessibility of resources and community norms. The institutional/health system level includes the provision of appropriate services, competent and supportive providers, and a culturally competent environment. Finally, broader structural, political and economic systems that influence health-related behaviours and outcomes are included at the societal level.

When tackling the mental health challenges faced by FSWs, interventions based on the SEM should address multiple levels of influence. At the individual level, personal characteristics such as age, sex, health knowledge, attitudes and behaviours are considered (Kaufman et al., 2014). The interpersonal level involves social networks and relationships, including family, friends, and peers, which can significantly impact health behaviours and outcomes. The community level focuses on the broader social, cultural and physical environments, including resource availability and community norms. Finally, the societal level encompasses larger structural, political, and economic systems that shape health behaviours and outcomes. By addressing these multiple dimensions, the socio-ecological model ensures a comprehensive approach to improving mental health care for FSWs, as supported by various studies and applications in public health contexts.

At the individual level, tailored mental health services and addiction support are needed. Services are often inadequate for people who experience mental illness alongside substance misuse, i.e., dual diagnosis, and this inadequacy is exacerbated by the barriers that sex workers face when accessing services (Potter et al., 2022). Integrated services, in community centres and hospitals, should offer information and support on both addiction and mental ill health so those in need are not passed between multiple services, as well as offering post-treatment support (National Institute for Health and Care Excellence, 2016). This is better for those with a dual diagnosis over receiving treatment from multiple centres as support increases (Kelly and Daley, 2013; Iversen et al., 2021). Higher levels of support have been found to reduce the usage of illicit substances and improve mental ill health (Laudet et al., 2007). Advantages include faster access to care under a multidisciplinary team and the ability to discuss health promotion with patients (Kurpas et al., 2021) However, disadvantages include a less specialised team of staff unless teams for each speciality run seamlessly together. Despite disadvantages, integrated care is the gold standard for treating dual diagnoses.

At the interpersonal level, this review shows how family, friends, intimate partners and even clients can influence FSWs' mental health. Stigma and discrimination from these relationships can lead to isolation and a lack of emotional support, worsening mental health issues. Education could be used for destigmatisation at an interpersonal level (Sawicki et al., 2019); Corrigan and Watson (2002) suggest that people who have accessible information regarding mental illness are less likely to experience negative effects from stigma and discrimination. This is because they can use this knowledge to inform their actions towards people and thoughts about mental ill health (Corrigan and Watson, 2002). As female sex workers face stigma, both outside and inside the healthcare system, workshops in hospitals would be a useful implementation to educate and reinforce the need for patient-centred, culturally competent healthcare (Rüsch et al., 2005; Sawicki et al., 2019). However, evidence for the long-term effectiveness of these educational interventions

is limited (Committee on the Science of Changing Behavioral Health Social Norms et al., 2016). That said, while these educational resources would not directly impact the mental ill health of female sex workers, they would have an indirect impact on the stigma and therefore mental ill health problems they face (Corrigan and Watson, 2002; Rüsch et al., 2005; Sawicki et al., 2019). Consequently, it seems to be a feasible option to reduce the stigma and the impact it has.

The community level reveals the pervasive normalisation of violence within the sex industry and the lack of adequate support systems. FSWs frequently face physical, sexual, and psychological violence from clients, intimate partners, and law enforcement, contributing to severe mental health issues like PTSD. The link between violence and mental ill health among sex workers has been consistently demonstrated (Alschech et al., 2020; Beattie et al., 2020; Millan-Alanis et al., 2021). This demonstrates the need for violence prevention strategies, not only to protect the physical health of sex workers but also to protect their psychological and emotional health.

Globally, it is well-documented that sex workers face human rights violations, including physical and sexual violence from police, clients and partners. They also encounter institutional discrimination when trying to access healthcare, welfare services and the criminal justice system (Schwartz et al., 2021). In response to these violations, sex worker-led organisations, such as the South African National Sex Workers' Network (Sisonke) in South Africa, have acted by offering legal advice, crisis counselling and advocacy (Crago, 2008). These efforts have had a significant impact, influencing government recommendations for law reform aimed at reducing discrimination and enhancing harm reduction as part of HIV prevention strategies. Despite these advancements, public health interventions that address violence among sex workers are limited, primarily focusing on HIV outcomes (Schwartz et al., 2021). There are few interventions designed as integrated multi-level approaches that target violence prevention and human rights violations. However, there are some noteworthy initiatives from various LMICs across Asia and Africa (Schwartz et al., 2021) as well as HICs such as the UK.

In India, the Karnataka Health Promotion Trust's programme, a component of the Avahan AIDS Initiative, collaborated with police and sex workers (Beattie et al., 2015). They trained officers and provided community mobilisation, skills-building, and legal empowerment workshops. This initiative led to a decrease in violence reports and improved the way police treat sex workers. In Mongolia, a randomised controlled trial merged HIV sexual risk reduction with a micro-savings intervention (Tsai et al., 2016). This approach reduced client violence against sex workers through skills-building and financial literacy training. The National Key Populations Programme in Kenya adopted a multi-level approach (Bhattacharjee et al., 2018). This involved violence response training for service providers and the creation of 24-hour response teams. As a result, the number of sex workers increased, and access to post-violence services improved. Furthermore, the Kenya Sex Workers Alliance (KESWA) has proposed a multi-level intervention that addresses legal and structural barriers to justice for sex workers who have experienced violence.

While there is limited evidence of the efficacy of interventions aimed at enhancing the health and wellbeing of sex workers (Hallett et al., n.d.), some community-level interventions have been shown to reduce some of the risks that FSWs face and that can increase the risk of mental ill health. For example, the Managed Approach - a coordinated approach to managing on-street sex work in Leeds – established a set of rules that were designed to reduce the likelihood of arrest or other enforcement measures for loitering, soliciting or kerb-crawling (Brown and Sanders, 2017). Over a three-year period of implementation there was a reduction in anti-social behaviour orders and Home Office cautions as well as a shift in police attitudes towards their role, from enforcement to protection.

There is much that could be done at the institutional level to support FSWs, reducing the risk of mental ill health while intervening when mental health deteriorates. Sex workers should be asked to give constructive feedback on their experiences of healthcare services so that organisations can improve policies to increase the likelihood of informed care services (Baldie et al., 2017; Bombard et al., 2018). These changes may include flexibility with appointments, easier access to primary care, trauma- and psychologically-informed staff and offering a variety of information for easier access to resources (Potter et al., 2022). Integrated services offering multifaceted treatments are necessary for those with a dual diagnosis. For example, a 'one-stop shop' for FSWs who use heroin was situated within a general practitioner clinic and provided medical, social and drug treatment services (Litchfield et al., 2010). The evaluation of this service found that the quality of life for FSWs improved, and heroin use reduced, as did self-reported sex work.

Stigma and discrimination greatly impede the uptake of HIV and sexual and reproductive health services (Geibel et al., 2017). Therefore, when minority individuals seek these services, they frequently encounter stigma from healthcare providers. Health care professionals often have both implicit and explicit biases against marginalised groups, including sex workers, LGBTQIA+ individuals, people living with HIV/AIDS, Indigenous and people of colour, refugees and asylum seekers, and the homeless. As a result, marginalised individuals often experience a higher burden of disease compared to their peers in the general population due to healthcare worker biases significantly hindering the care quality these individuals receive, perpetuating health disparities and contributing to poorer health outcomes (Geibel et al., 2017; Morris et al., 2019). Continuing educational interventions targeting healthcare professionals are vital in mitigating these unconscious biases, raising awareness about the violence and stigma faced by these populations, and ultimately improving the quality of care. A 2017 study by Geibel et al. demonstrated training healthcare professionals on sexual and reproductive health rights significantly reduced the belief that individuals with HIV should be ashamed and the perception that members of the LGBTQIA+ community are immoral. This training also increased satisfaction among service users, who felt more positively about the care provided after the professionals received stigma reduction training. Similarly, results from a systematic review, aiming to assess the effectiveness of programs aimed at reducing bias among healthcare students and providers towards LGBTQIA+ patients, found that education about bias was successful in increasing knowledge of problems faced by LGBTQIA+ individuals when accessing healthcare, improved healthcare students comfort of working with LGBTQIA+ patients and created more tolerant attitudes toward these patients (Morris et al., 2019). This work should be used as a foundation for educational interventions for healthcare professionals and students to reduce implicit and explicit bias against marginalised individuals. This is further reinforced by the idea that it is crucial to integrate such training into the curricula of healthcare programmes, ensuring future healthcare professionals are equipped with the knowledge and sensitivity required to deliver compassionate care to all patients, regardless of their background or circumstances.

Bias-oriented education and training are additionally crucial for police to reduce violence against female sex workers and better improve the support provided. Many female sex workers experience implicit biases from police officers, due to them working in high-stress environments in which police officers are likely to rely on automatic processing leading to more bias-based decisions, causing violence against sex workers and mistrust from sex workers (Barrett, 2023; Struyf, 2023). Research from a 2023 study conducted in the USA shows that bias-oriented training can help police officers recognise prejudices, ideally to ensure fair and unbiased treatment of all individuals, however, little changes were made in strategies and attitudes of officers one month after training completion (Lai and Lisnek, 2023). A similar sentiment is made by Worden et al (n.d.) in which police officers within the New York Police Department received bias-orientated education, with little longer-term impact on their approaches to marginalised individuals. This suggests that current training approaches are inadequate, and strides must be made to improve educational interventions

for police education.

At the societal level, broad systemic issues such as legal frameworks, social norms, and public policies significantly impact the mental health of FSWs. Societal stigma, discrimination and criminalisation of sex work hinder access to essential services and perpetuate mental health challenges. Public education campaigns to reduce stigma, legal reforms to protect the rights of FSWs, and policies to integrate mental health and addiction services are critical. Public education is needed to reduce perceived risk factors for mental ill health, e.g., stigma and violence (Rüsch et al., 2005; Sawicki et al., 2019). Educational programmes should aim to change individuals' preconceived perceptions (Corrigan and Watson, 2002). Posters in public spaces and social media campaigns could also be used to target a larger audience, although they may be less beneficial than more interactive educational programs (Latha et al., 2020). Legal challenges can increase risks; for example, in the UK, legal sanctions can be placed on sex workers operating on premises together, despite working together in an indoor setting reducing risks related to violence (Klambauer, 2019). As this review has shown, human rights violations against sex workers are widespread, including violence from police, clients and partners as well as discrimination in accessing services.

### Strengths and limitations

Extensive database searching was conducted across ten databases, thus ensuring sufficient literature searching (Bramer et al., 2017; Bramer et al., 2018). However, the generalisability of this review may be reduced because of the focus on the experiences of cisgender female sex workers; findings should not be extrapolated to male or transgender sex workers. Additionally, the initial title and abstract screening was undertaken by a single reviewer.

A qualitative review is only as good as the studies it reviews, and there were notable omissions in the included papers. For example, only three studies used in this review's analysis considered the researcher-participant relationship. Primary researchers should acknowledge and consider the ethical implications of a research relationship (Eide and Kahn, 2008). When researchers begin to provide more of a therapeutic service, rather than data collection, perspectives may be influenced and reported findings may be altered. The consequence may be that this review's findings and implications for practice may be misinformed due to primary researcher bias, as it cannot be said whether a relationship between the researchers and participants impacted the reported findings.

This review identified some universal themes, despite the included studies being conducted across the globe. The fact that no one country dominated the literature is a notable strength of the review, meaning that a global picture has been obtained.

## Conclusion

The findings of this review underscore the need for more holistic and comprehensive support systems for sex workers, including mental health services, addiction support and efforts to combat stigma and violence. Integrated care services designed to target the complex and intersecting needs of FSWs are essential for supporting those with dual diagnoses. These services are crucial in reducing mental ill-health and improving overall well-being among this population by creating a safer and more supportive environment for them. Policymakers, healthcare professionals and society as a whole need to work together to implement strategies that address these challenges and promote the well-being of sex workers.

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