Narratives of Violence, Pathology, and Empowerment: Mental Health Needs Assessment of Home-Based Female Sex Workers in Rural India

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This study explores the narratives of psychological distress and resilience among a group of female sex workers who use residential spaces to attend to clients in rural India. The narratives reflect the lived experiences of these women. They describe the women's reasons for opting into sex work; guilt, shame, and stigma related to their sex worker status; experiences with intimate partner and domestic violence; health-related problems; communication with their family members about their sex worker status; mental health referral practices among the women; and elements of resilience and strength that they experience within themselves and within their community of fellow sex workers. The article also offers elements of our own experiences of recruiting the women to participate in the focus group, training local outreach workers in conducting focus group discussions, and forging a collaboration with a local community-based organization to highlight important barriers, challenges, and strategies for planning a group-based discussion to explore the mental health needs of home-based sex workers.


Keywords: home-based sex work; qualitative research; global mental health; integrative health belief model

Introduction

Female Sex Workers in India: Background and Context

There are an estimated 3 million female sex workers in India (United Nations on Drugs and Crime, 2010). A female sex worker “is a woman who receives money or goods in exchange for sexual services, and who consciously defines these activities as income generating even if she does not consider sex work as her occupation” (Overs, 2002, p. 2). Home-based sex workers solicit clients primarily from their homes, and contact clients by phone, through word of mouth, or through middlemen (Buzdugan, 2009).

A small number of studies have identified risk factors for mental illness among sex workers in the major cities of India, including lack of educational, economic, and health resources (Shahmanesh et al., 2009). Studies have also reported gender disadvantage, exposure to intimate-partner violence, and problems in the area of sexual and reproductive health as risk factors for common mental disorders such as depression and anxiety (Patel & Kleinman, 2003; Patel, Kirkwood, Pednekar, Weiss, & Mabey, 2006).

In their sample of 326 female sex workers in Goa, India, Shahmanesh et al. (2009) noted that 19% had reported a suicide attempt in the past 3 months. Furthermore, in Bangalore, India, among 100 female sex workers accessing a central hospital, 71% reported depression,

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73% reported social dysfunction, and 42% reported anxiety (Pandiyan, Chandrasekhar, & Madhusudhan, 2012). In the one previous study on the mental health needs of sex workers in rural areas of the country, Hennick and Cunningham (2011) reported that 92% of their sample endorsed clinical depression and 57% reported a past instance of a suicide attempt. The data from these studies, along with the prevalence estimates of mental illness in India (6%–7% of the population), lead to the assumption that there are significant numbers of sex workers in India suffering from or at risk for some form of mental illness.

Worldwide, sex workers are consistently exposed to known risk factors for mental disorders, including exposure to violence and other traumatic life situations (Hossain, Zimmerman, Abas, Light, & Watts, 2010; Kurtz, Surrat, Inciardi, & Kiley, 2004; Mayfield-Schwarz, 2007), sociolegal victimization of women in sex work (Halder & Jaishankar, 2006; Karlebach, 2008), and exposure to and transmission of HIV/AIDS. Gender-based discrimination and violence against women and girls, particularly those living in low- and middle-income countries, increases the vulnerability of female sex workers to depression, self-harm, sexually transmitted diseases, and suicide (Aaron et al., 2004). Despite these multiple stressors, the consistent focus of research in this population has been on HIV/AIDS, for the most part neglecting the study of the psychological impact of sex work on mental health. To the best of our knowledge, this case study represents the first systematic study to explore the mental health needs of home-based female sex workers.

The Quasi-Legal Status of Sex Work in India, Cultural Traditions, and Implications for Accessing Health Care

In recent years, greater attention has been paid to the global issues of human trafficking and sex work, specifically among advocacy and human rights communities. An active dialogue currently surrounds the general categorization of sex workers as an exploited or enslaved population, versus a population that has participated in a legitimate profession and should be afforded the full spectrum of human and labor rights. Our position is to assume that female sex workers come from diverse backgrounds and possess varying degrees of agency yet they all belong to a marginalized, underserved population that experiences a severely elevated vulnerability to mental distress.

The selling of sex for money is not illegal in India, but related activities such as soliciting in a public space or owning or managing a brothel are criminalized under current law (Ramachandran, 2014; Suresh, Furr, & Srikrishnan, 2009). As a marginalized group considered to be engaging in a quasi-legal or illegal profession, sex workers do not fit into the public health framework of occupational health (Rössler et al., 2010). The marginalized position of sex workers in society prevents them from gaining the same protections afforded to other citizens, creating a position of significant vulnerability for this population.

Moreover, certain systems of sex work in India have historical precedents. The devadasi tradition (slave/servant of the god) in India (Evans & Lambert, 1997; Gathia, 1999, Gilada, 1993; Srinivasan, 1983), where young girls “become wives of the deities and perform temple rituals, offer sexual services to male temple attendants, priests and the temple patrons or clients” (Blanchard et al., p. 853), continues to pervade the lives of young girls and women who emerge from lower castes and lower socioeconomic status. The devadasi tradition affects many young girls in the country who are adopted into the trade soon after they attain menarche (Orchard, 2007), although precise estimates of these numbers are not available due to poor access to this invisible population (O’Neil et al., 2004). Additionally, because these devadasis often provide sex services without the use of a condom (Gurav, Lorway, Bradley, & Blanchard, 2013), these girls create an acute health risk of sexually transmitted infections to their children (Orchard, 2007), thereby elevating the risk for intergenerational transmission of trauma and reproductive and mental illnesses.

The narratives presented in this article are drawn from a larger cross-sectional pilot study that was conducted in a rural part of Gujarat State, India, in the summer of 2015. Gujarat is located along the west coast of India with a population of 50.67 million people, 62.33% of whom reside in the rural areas of the state. Among those seeking mental healthcare services, 51% are females. Although 1 in 4 families in India include an individual with a mental health
disorder—14% with a common mental disorder including anxiety and depression; 52% with a severe mental disorder, and 34% with various other mental health disorders (World Health Organization [WHO], 2006)—the government of Gujarat spends less than 1% of the total health budget on mental health services (approximately, $300,000 USD).

These services exist through a network of 53 district hospitals, two specialized hospitals (with psychiatric facilities), and 60 dispensaries (WHO, 2006). There are currently .30 psychiatrists, .17 nurses, .05 psychologists, and .03 social workers per 100,000 individuals in India (WHO, 2011); overall, there are 1.43 human resource individuals working in mental health facilities in Gujarat State per 100,000 people, which includes physicians, nonphysicians, and nursing and nonnursing staff (WHO, 2006). In comparison, the United States has 7.79 psychiatrists and 29.03 psychologists available per 100,000 individuals. Such a wide treatment gap is not unique to India and is a common trend in low- and middle-income countries (Bruckner et al., 2011). Furthermore, the lack of reliable and systematic reporting of mental health prevalence in these countries makes it difficult to determine the extent and nature of the services that are needed.

The Focus of this Study

Sex workers experience pervasive stigma and discrimination in accessing mental and physical health care that is relevant to their needs and environment. There is currently little understanding of the mental health needs among this population in India, including the barriers they experience in their efforts to access healthcare services. They are a difficult population to engage in a research study due to their vulnerable legal and emotional status as well as their potential wariness of exploitation at the hands of outsiders to their community.

This study used a mixed-methods design to explore the mental health needs of female sex workers in a rural section of India, the current health care delivery routes that these women use, and the barriers to their access to mental health care systems. To pilot the study, the Global Mental Health Lab at Teachers College (Columbia University) collaborated with MINDS Foundation, a nonprofit organization focused on providing high-quality mental healthcare in rural India through an existing network of trained community mental health care workers. Purposive sampling was used to recruit 60 home-based female sex workers from Baroda city in Gujarat State to participate in focus group discussions and semistructured key informant interviews aimed at capturing the narratives of psychological distress and the desire for mental health resources among the women. Additionally, a brief health questionnaire and the WHO Quality of Life BREF Scale (WHOQL-BREF; Group, 1994) were used to assess the prevalence of clinical symptoms of common and severe mental illness.

Finally, information about these issues was also obtained from a cadre of 13 health workers who came in direct contact with sex workers in the area. These health workers participated in a focus group discussion and semistructured key informant interviews to gain their perspectives on the mental health needs and barriers to care experienced by female sex workers in the region.

All participants were recruited by outreach workers at a partner community-based organization (CBO) that worked closely with MINDS Foundation and provided health services, including reproductive health and psychological and HIV/AIDS counseling, to female sex workers in the community. The outreach workers used a recruitment script that included information regarding the purpose of the study, which was described as a 1-hour discussion focusing on participants’ health status and the existing health service delivery pathways they were accessing. Additionally, the women were informed of a $10 remuneration that would be given for their time and participation in the study. If the female sex worker expressed interest in the study and agreed to join a focus group session, the female social workers provided further details on date, time, and location of the group. Participation in the study was left open to all interested female sex workers who met the inclusion criteria.

A total of 60 home-based female sex workers participated in seven focus groups, with approximately 6 to 10 new participants in each group. All participants were compensated $10 for their participation in a single 1-hour focus group discussion. After each focus group, participants were asked to complete the WHOQOL-BREF and 28-item general health survey, and volunteers were requested to participate in an individual interview with the Hindi-speaking author.
Participants were not given additional compensation for completing measures or volunteering for an individual interview. All 60 women completed the written measures, and a total of 10 female sex workers participated in an individual interview.

No formal demographic information was collected to maintain the confidentiality of the sex worker participants. A social worker from the partner CBO that was familiar with the members of the study sample suggested an age range of 18–63, and noted that all participants had been married at least once. All 60 participants resided in Baroda city and carried out sex work in either their own residence or the houses that other women in the community rented to the women for the purpose of providing sex services. Six women among the 10 who participated in the focus group were peer educators, meaning they were sex workers who were employed by the CBO to deliver basic health education, including HIV/AIDS counseling, and facilitate condom distribution within their community. None of the participants, including those who participated in the focus groups and completed the measures, had any prior exposure to formal psychotherapy treatment or reported a past or current history of a psychiatric or physical illness.

All focus groups were held in the homes of sex worker participants, or in “hot spots,” which were apartments that sex workers rented together to see clients. This was contrary to the initial approach that we had defined, which was to conduct the focus groups and interviews within a clinic at the CBO already being accessed by the women participants. However, the women suggested that we interact with them in their homes.

Standardized Measures

Each participant was given the WHOQOL-BREF and a general health survey to complete. The WHOQOL-BREF provided information on the effects of social, physical, psychological, and environmental stressors on the routine life of the participants. One of the important goals of the study was to assess participants’ perceptions of the difficulties within their work environment and their understanding of the availability of support services.

While the study design indicated that each participant should complete self-report measures in a private room, time and space constraints led to participants completing the measures in a group setting, with each instructed to face a different direction from those next to them and not look at their neighbors’ responses. Although the WHOQOL-BREF is a self-report inventory, the coauthor facilitating the focus groups and a social worker from MINDS Foundation helped the women complete their responses to the various components of the scale by reading items aloud and clarifying questions. This assistance was necessary because the women disclosed that this was the first time they were being asked about their mental life, and they were unfamiliar with the vocabulary and structure of this measure. Many of the words in the Hindi version of the WHOQOL-BREF felt unclear or overly medical to the participants and they required clarification so they could place the questions within the contexts of their own lives.

Because of the diversity of responses in initial engagement with sex work, it was particularly challenging to ask the women directly about their levels of satisfaction with their work environment. Some of the women were coerced into sex work, while others opted for it as a result of desperate circumstances, and still others no longer engaged in sex work themselves but continued to be the owners and managers of houses that offered safe spaces for other women to attend to clients.

Keeping in mind the primary research question (“What are the mental health needs of home-based female sex workers in rural India?”) and framework of the current study, we supplemented the quality of life questionnaire with a general health survey derived from a standardized General Health Questionnaire (Gautam, Nijhawan, & Kamal, 1987). This survey explored the presence of somatic symptoms, anxiety/depression, and level of social dysfunction among the women within the past 2 weeks. This survey asked women simple questions about their general health and required them to provide binary responses (yes = endorsement of presence of psychological symptom; no = absence of the symptom) indicating the presence of psychological distress. While results from this survey cannot be directly attributed to sex work, it provided a clear endorsement of mental health challenges and high levels of psychological distress among a sample that engages with sex work. There were particularly alarming rates of pervasive suicidal thoughts endorsed by
the study sample: 66.7% endorsed thinking of the possibility of suicide, 80% endorsed wishing they were dead, and 38.3% endorsed that the idea of taking their own life kept coming to mind.

Sex work is a difficult phenomenon to address, especially in the cultural context of India, which is influenced by forces of poverty, patriarchy, and the caste system. Some aspects of the effects of this work on sex workers’ psychosocial world can be accurately gauged via standardized self-report measures. However, other factors affecting their experiences—for example, the difficulty in seeking help and support from enforcement officials, the lack of available crisis-intervention support services, and the nature of sexual servitude within the cultural context of India—are not adequately captured via standardized tools of assessment. To develop a more complex and thorough understanding of these women’s responses, it was important to supplement the information gathered by standardized measures with the narratives provided in the focus groups and interviews.

The following sections provide details, in the form of participant narratives, of a single focus group discussion with 10 home-based female sex workers. The aim of this approach is to illustrate the challenges involved in the recruitment of a “hidden” population, building trust and rapport for disclosure of intimate narratives, and sharing the lived experiences of mental health hazards as a consequence of sex worker status. We also attempt to integrate their experience as “outsiders” invited into the private space of the study participants and reflect on implications for future clinical interventions. All potentially identifying details of the study participants, including their names, have been changed to protect their confidentiality.

**Narratives From a Focus Group**

The women participants of the current focus group reported several factors that contributed to their decision to opt into sex work (e.g., child marriage, poverty, and emotional abuse—in the form of husband’s infidelity). For example, one of the women, Alka, shared that her family forced her into marrying without her will or consent, and that, later, her mother suggested she opt for sex work in the city to sustain the family. Alka disclosed:

I never wanted to get married. I was forced to get married. I got married when I was 13. Then, by the time I was 14, I gave birth to my son. I mean, in my own family, my own mother did this [to me], so it’s hard for me to trust anyone, not knowing what they’ll do [starts to cry].

Further, she reported distress associated with the infidelity of her husband and the subsequent difficulty of raising a child single-handedly:

When I was home and pregnant, I needed him the most, and instead of being with me, he was with someone else! I even caught him red-handed, but I didn’t say anything. I said [to myself], “Let it go. At least I’m at home. I have some respect in the society.” I didn’t say anything. Then, slowly, he started to hit me. He was suspicious of me. He hit me so much when I was pregnant. Before I had my son, I was pregnant once before. Then in the third month, he kicked me in the chest in such a way that I fell on my stomach, and I had to get an abortion right away because the child had died inside.

Her distress worsened due to the lack of support from her own family. She reported a hostile relationship with her mother, and attributed it to her mother’s severe alcoholism: “My mom used to drink, she used to drink a lot. She drinks so much that even if you took her to heaven, she would say, ‘I can’t get a drink here’. She would even refuse heaven!”

During this time, Alka was living with her alcoholic mother and her 1-year-old son in desperate circumstances: “The thing is, at that time, my situation was so bad that we didn’t have enough money to properly eat at home. I would go to people’s houses and wash their dishes just to feed myself.” At this juncture, Alka found support from within the community of sex workers. She
felt close and comforted by the care and nurturing that other women offered to her, when all other means of support had failed her. She felt grateful to the women who provided her food, shelter, and comfort for her then very young child. This support led to her initial interest in pursuing sex work:

When my husband drank a lot, the children were small—my daughter was 7 months old when I got into sex work. When he left, I sought help from another woman in the neighborhood. I watched her go for “work” each day and asked her about her job, and if there could be a similar opportunity for me too. She said, “I have a job,” and I would often say, “Take me to work with you.” So she said, “What I do, you won’t be able to do”—and she refused. But then, I said, “If you do this kind of work, then take me [with you] once.” That is how I came into this line [of work].

It was then that Alka built a sense of reliance on other women sex workers to survive desperate situations, during a time when neither her own family nor her husband cared for her: “After coming here, I talked to the other women (sex workers) and they gave me 10,000 rupees (approximately $150). Nowadays, who would do such a thing for others? They told me, “Whatever you need, keep it.” Another woman resonated with her need to continue in the trade to generate financial support by saying, “I do this work, and I earn, because I’m not educated.”

Alka and other women reported being threatened by police officials, who were both exploitative and corrupt:

They bother us at home, [and] they say, “If you don’t give us the money, then we won’t let you do this work”—that's how they threaten us. I was in jail for 3 years because I was caught bringing girls from Ahmedabad to Baroda and would allow them to attend to their clients from my house.

As researchers, we were stepping into the world of these women with a sense of our own personal safety; we also had the choice to return to a society that created systems for our protection and security. The study participants, on the other hand, were beaten and extorted routinely, without an alternative. Other women in the group, such as Reshma, reported that their husbands forced them into becoming a sex worker:

[I had] to get separated from my husband because he was going to other women and was very violent towards me and forced me into all sorts of sex practices that I was not comfortable with. At some point I decided for myself and for my children to leave my husband's house despite the security that I was getting from him and escaped that and came over to Baroda.

Reshma was married to her first husband for over 25 years, and she described him as an alcoholic who was violent toward her before dying from an illness and leaving her to take care of three young children. She had no means of support and decided to remarry. However, her second husband refused to take care of the children from her first marriage, yet she continued to live with him because the status of being married provided her with a sense of social security and respect in the community. In order to provide for her children, she resorted to sex work. Because this was a choice she had made for herself 10 years earlier, she asserted that there was “no going back” and that she had “come too far.” Responding to a request to describe a routine day, Reshma said,

I am always worried. I cry at home, What will I do! I tell the children to be quiet even when they are quiet. I even fight with the customer. What can I do? Other women are trying to support me now to get out. This is also mental stress. I struggle inside.
A woman in this focus group attributed the stigma and shame associated with being a sex worker to the lack of acceptance that she and her fellow sex workers experience in their society, as well as the fear of exploitation by outsiders to the community of sex workers.

The society shames sex workers. She [a sex worker] remains in distress, poor thing. It’ll stay in her mind, in her psyche. She comes to work and someone needs rent; the person who lends the house for her to attend to her clients just cares about the rent. When she goes inside to attend to the client, she has all this tension of what if someone from outside–some policeman or some media person or some relative–finds out about her sex worker status.

Several factors, including lack of social and medical support and financial debts were reported as factors contributing to their experiences of distress, including suicidal ideation. One woman noted:

Our money is visible. We get very little money and where that little bit goes we barely know. What should I do? The collectors/brokers also harass us. There is a woman in our community who doesn’t even have enough rice to feed her young children. Sometimes she cries a lot, and at other times she sits quietly. Sometimes, she will get angry and drink a lot of alcohol.

Another stated: “For me, it’s like I want to die. Today she [another sex worker] talked about dying, [but] tomorrow she’ll refuse to die. There is no human being in this line of work who doesn’t have mental stress.”

The women also shared that the lack of available safe spaces within which they could disclose their struggle often felt disempowering for them. They would seek relief in prayers and offerings at temples, but such relief was short lived.

In instances where we need mental health support, we talk to each other. And if it feels like there’s no one to listen or understand, then I fight with god in the temple. I argue and fight with god for having given me this life. And I cry sometimes, or I ask god, “Why did you give me a life like this? Why did you bring me to this world?” Once I am done fighting with god, I feel normal and then I calm down.

Women often used phrases in the local language such as “paagal”–a word that in some instances implies going crazy or mad, and at other times connotes symptoms of anxiety and depression. “Sometimes I sit in the corner and cry. Sometimes I get paagal (crazy/mad), like mental. For me, it’s like I want to die.” The word was often associated with screaming, pulling hair, feeling heaviness in one’s body, dizziness, crying bouts, and sitting alone without wanting to talk. Women described their experiences with feeling angry and often resorting to the use of drugs to cope with paagalpan (madness).

Barriers to seeking mental health resources included the perceived stigma of disclosing their sex-worker status to clinicians, inadequacy of mental health services, and their own lack of understanding of mental illness symptomatology. Furthermore, discussions with the health workers indicated that while our female sex worker participants were willing to engage with a medical model that provided HIV/AIDS counseling support and healthcare services related to other venereal diseases, the health system in Gujarat lacked integration of mental health services into the existing network of health service provision. Although the healthcare providers we interviewed were familiar with HIV/AIDS counseling, they were largely untrained with regard to the diagnosis and treatment of mental illness. The female sex worker participants similarly had a limited vocabulary for discussing symptoms of mental illness as a legitimate health condition.

There were two related and somewhat unexpected findings: The urgent need for mental health services that the women expressed to us and the lack of awareness of this need among the health workers directly accessing and providing services to the women. Regarding the first of these findings, despite the pressing needs for financial stability and physical health for a marginalized population in a developing country, many of the sex worker participants were acutely aware of
the need for and absence of mental health services in their lives. As one woman stated, “In a private hospital, they take 4–5 thousand [rupees] in fees . . . and we don’t have as much money, so we can’t go there. There should be treatment like for blood pressure or any other (mental problem) in one place.” Another noted: “For our HIV test, it’s just the HIV person. For the reproductive health, there’s the reproductive health person. But for mental health problems, there is no doctor.”

Regarding the second finding, the health workers who treat female sex workers do not clearly understand their health needs. One of the health workers we interviewed said:

A lot of time is needed to explore the problems that the sex worker is confronting. It requires rapport building and she needs to trust the doctor to even begin disclosing. Usually, doctors don’t have much time. They are overworked and so believe in readily prescribing medicines to relieve symptoms, instead of exploring the root cause of the problems that the sex worker may be willing to share. Some of my colleagues also believe that sex workers have no mental health problems. This is inaccurate. The problem is that the doctors never spend enough time to explore their problems.

Clinical Observations

The study participants demonstrated a sense of safety and comfort with one another and us during the focus group discussions. While some women were more willing to share details of their personal narratives than others, the general feeling in the focus group was one of support and a collective identity. The women reported that one method they relied on to cope with their own distress is to share their experiences with a fellow sex worker, and they find stability in this sense of connectedness. The peer educators in particular are trusted leaders within their community and are frequently the first person a sex worker may turn to if she is in experiencing mental distress.

The women were open to speaking to us about their lives in a way that elicited a great deal of detail and affect. Their willingness to engage in focus group discussions reflected an eagerness for sharing their varying levels of psychological distress, as well as their hope for future resources that will offer them support and mental health treatment. As a further illustration of the women’s interest in speaking about mental health issues within their community, we had asked for up to 10 participants to be personally interviewed after the focus group discussions and 24 women volunteered. Several participants asked to be interviewed but not to have the content they provided to be included in the study; they simply wanted share their story with us as a means of being heard and seen.

The women also displayed a sense of ownership over their participation in the study. For example, while the women ranged considerably in their level of literacy, they all insisted on physically signing their consent forms, despite our emphasis on acquiring verbal consent to protect their confidentiality. We interpreted the insistence on providing a written signature as an expression of ownership over the focus group discussions that followed. Many of the women shared with us that they recognized that the goal of the study was to provide them with a means to share their stories, in their own words, and that this provided them with a sense of comfort in sharing their experiences. Many of the women who had participated in a focus group discussion encouraged their peers to attend a later group, and the result was larger focus groups than the original study design called for and a need to limit the number of participants for this pilot study.

The focus group presented in this article was the sixth group discussion conducted with female sex workers. This focus group was chosen because it represented a shift in the experience that we had with the study participants. It had been challenging to interact with the women to start with—a challenge that we faced at many different levels as outsiders entering this intensely intimate space with a population that tends to be weary of exploitation and abuse.

We were concerned about posing questions about mental health concerns that were not relevant to the women’s experience, and similarly imposing a Western model of inquiry that was
perhaps a poor fit for the context in which we were operating. We found moments that resonated with us as researchers operating from within a Western model of qualitative research, while there were other moments in which we felt alienated and ill-equipped because the language that the women used often did not clearly fit the content of the discussion guides being used. While the semistructured style of the focus group felt at times like a clumsy fit for a group discussion in an unstructured environment, we experienced a sense of synergy with the women and began to find more phrases and words that the women were more comfortable using as the discussion went on.

It was during the sixth focus group that we realized our concerns were in fact secondary to the willingness of the study participants to be involved: They clearly conveyed that they felt they were being listened to for the first time, and that their voices and experiences mattered, regardless of their sex worker status. We had anticipated that these women would reject the notion of psychological services, perhaps out of shame, or indifference to the benefit. We were surprised. The women we spoke to were gratified to be asked about their psychological experiences; they shared with us that this was the first time that they were being asked about their mental life.

As the women shared their stories of trauma and strength with us, we were compelled to deconstruct our own identities as outsiders to this community, and as women who were perceived as privileged and possessing some degree of power and ability to improve the lives of the study participants. Although one of the authors is an Indian female, she was considered an outsider to the community because she was raised in a large urban setting and was well educated. Another of the authors was Caucasian and therefore presented with a more explicit form of outsider status that was further reinforced by language and cultural barriers. We were aware of the preemptive stereotypes that could potentially govern our interactions with the women as well as their perception of outsiders who come for a short duration of time and leave, never to be heard from again.

We attempted to address these potential barriers by communicating a sense of openness to our study participants as individuals, and showing a genuine sense of interest in their experiences and stories. We made an effort to sit on the ground with the participants during focus group discussions as a way of expressing solidarity. We shared tea and meals with the participants and accepted offers to be introduced to their family members. While nontraditional, this level of engagement with participants was prompted by the women themselves and was a culturally normative expression of warmth and appreciation.

The strong sense of connection that was cocreated through focus group discussions and interviews in this study led to worries that the women would feel abandoned once the data collection period of the study ended. The women repeatedly asked us not forget them and to come back and continue the work we had started with them. Peer educator participants were adamant in their desire to acknowledge the level of psychological distress in their community as well as their hope for more high-quality health resources to be made available to the women. The women made it clear that their hope was not for us to return and provide a mental health intervention, but it was for us to return and equip them with the tools and skills necessary for providing an effective intervention. Through this sentiment, the women reinforced our position as outsiders who could use the knowledge we gained from research to empower the community we were studying.

**Clinical Implications**

The content of the focus group discussions and interviews in this study presents a clear demand for mental health interventions that fit the unique needs of the home-based sex worker population in India. When conceptualizing the modality of treatment, there seems to be no clear evidence supporting a preference for interventions that have a group or individual format. On the one hand, many women draw strength from their sense of sisterhood within their community and conveyed their ability to support and comfort one another in a group setting. On the other hand, some women told us that they didn’t feel comfortable sharing intimate details of their narrative with members of their community present for fear of gossip or judgment. They said they felt more comfortable talking to an outsider because there is no fear of their story coming back to their community.
Overall, the women told us that they would benefit from some form of intervention in which they could talk about their more difficult experiences in a safe environment. Many endorsed a high level of severity with regard to psychological distress, and therefore any future intervention would require a trained facilitator to be present to ensure the provision of quality care. Although peer educators within the community of sex workers may be strong candidates to train to deliver basic mental health interventions, the women told us that there was something powerful about being acknowledged by an outsider, someone telling them their issues are “real” and that there are structured tools that exist to help them.

Harm-Reduction Model

A number of different parameters need to be considered when selecting a mental health intervention for use with female sex workers: the setting (e.g., general hospital, community-based general clinic, psychiatric facility); the modality of intervention (i.e., individual or group); the facilitator (e.g., mental health specialist, general health professional, peer counselor); the type of intervention (i.e., evidence-based psychotherapy); the domains addressed (e.g., strengths, difficulties, behaviors, emotions, symptoms, functioning, exposure to past stressors, current experience); and the possibility of multisector collaborations between and among indigenous organizations and outside agencies, including perhaps university-based researchers and students.

A harm-reduction model (Rekart, 2006), including practices of peer education, preventive care, and occupational health and safety, might be considered. Such models are not new and have already been “adopted by health authorities, sex worker organizations, and sex workers themselves” (Rekart, 2006, p. 2123). It is important to note that the harm-reduction model may not be applicable to all cultural and social contexts. In countries where sex work is decriminalized, sex workers may be enabled with human and labor rights, as other citizens are. However, in an impoverished rural demography in India, where sex work is governed by a quasi-legal status, a harm-reduction approach focused on prevention of drug abuse, disease, and violence may more effectively guide interventions.

Further, the success of multisectoral partnerships—involving mental health expert trainers, locally recruited and trained mental health supervisors, and local counselors in low- and middle-income countries—has been well documented (Murray et al., 2011). Because female sex workers are also at an increased risk for mortality, homicide, intimate partner violence, and psychological morbidity and stress (Potterat et al., 2004), systematic approaches that educate the women regarding prevention of risky behavior while building skills to cope with their psychological duress is essential.

In fact, harm-reduction initiatives currently exist in the community of sex workers involved in the study, such as sexual and reproductive health education, condom use campaigns, and the establishment of worker autonomy to choose the type of sex services that a woman might be more comfortable and feel safer offering. However, no evidence of social or behavioral interventions was reported, despite these women’s expressed need for accessing mental health services when faced with extreme trauma, torture, or violence. One of the prominent harm-reduction strategies that might follow from our interactions with the women includes training healthcare professionals to be more sensitive to the status of their sex worker patients, i.e., encouraging and helping them, for example, to access existing health services without (excessive) fear of stigma, shame, and discrimination.

Additionally, because many women reported benefiting more from community-based HIV/AIDS prevention campaigns than from similar services offered by a formal healthcare setting, community-based mental health programs involving peer educators and locally recruited lay counselors may be a means of offering a harm-reduction program in an especially culturally appropriate and sustainable manner.

Conclusion

This study is drawn from a pilot project aimed to better understand the treatment gap for a highly marginalized and vulnerable population: female sex workers practicing in a rural area.
of India. It provides the first direct evaluation of home-based female sex workers’ psychosocial context, mental health needs, and service utilization. It offers an important step in the expansion of research as well as strategies that clinicians could adopt while planning treatment protocols for home-based sex workers. The findings from this study will be used to lay the groundwork for future mental health services and research to improve access to feasible and effective psychotherapy services for female sex workers to help support empowerment in this population. A future mental health intervention that targets the unique experience of psychosocial stressors this population faces must address the effects of risk for HIV/AIDS, effects of routine violence, exposure to drugs, and economic instability in a comprehensive manner.

Further research is also needed to deepen understanding of the obstacles to mental health service access encountered by women sex workers, specifically those who work from their homes, and whose needs are different from other sex workers groups, such as street and brothel-based sex workers. This should include an assessment of structural (e.g., cost, transportation issues, lack of psychological service providers) and attitudinal barriers to service access (e.g., the influence of mental health stigma among sex workers, the inhibition among health workers to cater to or acknowledge the health needs of the sex workers and their communities).

Health workers in our study primarily provided medical support for venereal diseases, and we learned that the women often used their symptoms and the AIDS testing experience to talk about their conditions of sexual servitude. There is no cultural, logistic, or technical infrastructure for providing mental health services to these women; they exist on the margins of a society in which there is virtually no awareness of mental illness. They often managed the adversity they faced with self-medication and routinely resorted to narcotics and alcohol to soothe themselves. Importantly, though, they did rely on each other to speak about their concerns, fostering a sense of community among themselves.

Effective work addressing the health concerns of this population should be conducted in collaboration with organizations that have already gained their trust and emphasize the rights and respect due to sex workers. By collaborating with organizations such as MINDS Foundation and their partner community-based organization, and by leveraging existing outreach and peer support networks that the organization has already created, the current project used existing resources and provides a model to inform a more feasible and sustainable approach for future interventions.

Selected References and Recommended Readings


