Becoming a Mother in the Context of Sex Work:

Women's Experiences of Bonding with their Children

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Abstract

Many females engaged in sex work are mothers, often experiencing poverty, violence, marginalization, and psychological distress, factors also found to affect parental bonds. However, little is known about how this context impacts the bonding process. Given the ubiquity of sex work across geographical territories, understanding the relationship it has with mother-child bonding is an important international consideration in providing health care for sex working mothers and their children. Therefore, in this study we sought to explore women's experiences of bonding with their children in the context of sex work. We interviewed six women in the UK who were sex working during the first two years of their child's life about their bonding experiences and analysed transcripts using Interpretative Phenomenological Analysis. We identified four themes were identified: (1) the complex process of bonding; (2) the role of powerlessness on bonding; (3) the powerful impact of receiving help, and (4) new perspectives of the body and sex work following motherhood. Findings contribute to the research literature on bonding by emphasising the value of supportive care and the importance of social context, indicating specific factors to inform psychological support among sex working women.

Keywords**:** attachment; bonding; qualitative; parenting; prostitution; sex work

The significance of the parent-child relationship is well established in attachment theory and research, where researchers have highlighted its impact on children's biological, emotional and cognitive development (Benoit, 2004; Slade, 2002) and, increasingly, have examined these issues in wider global and cultural contexts (see the collection of work in Crittenden & Claussen, 2000, for example). Difficulties in this relationship can lead to long-term behavioural (Rackett & Holmes, 2010) and mental health problems (Travis & Combs-Orme, 2007) for the child. Accordingly, authors of public policy increasingly recommend provision supporting the development of secure attachments (e.g. Moullin et al., Byrne 2014).

Parental bonding is an important aspect of the parental side of this relationship. Bonding can be defined as the forming of an emotional connection or closeness to a child (Perry, 2001) and has also been described as 'parent-child connectedness' (Brook et al., 1990). It relates to affection, love and warmth felt by a caregiver towards a child (Bouchard, 2011), and behaviours representing such feelings (Shieh & Kravitz, 2006), and importantly is a process, continuing from pregnancy to beyond birth (Slade, 2002). As such it is largely a subjective experience, perceived and felt by those involved. Maternal bonds during and after pregnancy influence confidence in interacting with an infant (Fegran et al., 2008) and are associated with childhood attachment security (Miller et al., 2008). Higher parent-child connectedness may lead to better parent-child relationships overall (Lezin et al., 2004). In contrast, bonding difficulties may contribute to familial hostility (Lezin et al., 2004) as well as parental distress and isolation (Larkin, 2006).

Within the UK, where the present study takes place, estimates suggest approximately 72,800 people sell sex for money (HAC, 2017). These are mostly women, of whom approximately 70% are mothers (The English Collective of Prostitutes, 2004). Despite such figures, little is known about parenting within this context (Beard et al. 2010; Sloss et al., 2004), particularly regarding women's experiences of the mother-child relationship,

indicating a need for research to inform appropriate support. Although this research took place within the UK, the ubiquity of sex work across geographical territories, understanding the relationship it has with mother-child bonding is an important international consideration in providing health care for sex working mothers and their children. For example, recent studies conducted by researchers in this area include antenatal care presentation and engagement for sex worker mothers in South Africa (Parmley et al., 2019), the role of sex work venue for maternal role strain and depressive symptoms in Mexico (Semple et al., 2020), and sexual health communication between sex worker mothers and their children in India (Ali et al., 2021).

In this paper we refer to the selling of sex as 'sex work' rather than 'prostitution' which carries considerable stigma due to its criminal and moralistic connotations (Open Society Foundations, 2019). We define sex work as the exchange of sexual activities for money, goods or other services recognising its varying and multifaceted nature. Where possible we refer to women 'involved in sex work' rather than identifying people as 'sex workers', allowing for varying positions women hold in relation to this work.

In the present study, we focus on women where the context of their work makes them more vulnerable to factors such as drug use (Balfour & Allen, 2014), violence and poverty (Home Affairs Committee, 2017), and separation from their children (Bletzler, 2005). Previous researchers have identified how such factors can pose risks to sex-working women and their children (Duff et al., 2015; McClelland & Newell, 2008). Researchers have also described guilt, stigma, and shame (Dalla, 2003; Sloss et al., 2004), often focussing on difficulty occupying a dual identity (Castañeda et al, 1996; Dodsworth, 2014) and avoidance of prenatal or child care services (Sloss & Harper, 2004). However, women also emphasise they are "mothers first" (Basu & Dutta, 2011, p.118), expressing a strong desire to care and

provide for their children (Bletzer, 2005), which motivates them to work (Castaneda et al., 1996).

Many sex-working women have children removed from their care (Balfour & Allen, 2014). In the UK, where the present research is conducted, in a study involving 333 women researchers found only 21% of children under 16 lived with their mothers (Hester & Westmarland, 2004). Longitudinal outcomes for children in care include emotional and behavioural difficulties (Wilkinson & Bowyer, 2017), poorer educational attainment (Department for Education, 2016), and increased mental health problems (Richardson & Lelliot, 2003). Outcomes for birth parents are less studied (Hunt, 2010), but include psychological distress (Neil et al., 2010) and increased maternal suicide (Oates & Cantwell, 2011). Specific to sex work, researchers have found separation from children increased chaotic drug use and sexual risk taking (Sloss & Harper, 2004; McClelland & Newell, 2008).

The concept of bonding is particularly useful in understanding parenting experiences for mothers involved in sex work. Researchers in existing studies have largely focussed on overall experiences of parenting and the practicalities of managing sex work alongside motherhood and none have yet explored women's experiences of developing a bond with their children within the context of sex work. However, overlaps in literature on both subjects indicate potentially relevant factors. Sex work involvement has been associated with numerous mental health difficulties (Ling et al., 2007), some of which have been shown to affect maternal bonding (Perry et al., 2011). Furthermore, researchers have found as many as 90% of women involved in sex work have experienced childhood physical or sexual abuse (Farley & Kelly, 2000), with childhood trauma potentially impacting on subsequent parenting (Fraiberg et al., 1975; Leckman et al., 2004) including bonding pre-birth (Schwerdtfeger & Goff, 2007). Whilst measures exist that researchers use in an attempt to quantify parental bonds retrospectively from children's accounts (e.g. Parker et al., 1979), in order to better

understand mothers' subjective experiences of parenting, exploring the process and meaning of bonding from their perspective is crucial.

However, much remains unknown about the relationship between sex work and parenting (McClelland & Newell, 2008), specifically workers' relationships with their children (Dodsworth, 2014) and how women perceive this. In the present study we aimed to address this gap in understanding by asking women directly about their experiences of bonding with their children in the context of sex work.

Method

Design

Research design and materials were developed through discussion between the authors and services working with women involved in sex work, and a former service-user. The service-user helped particularly in considering relevant topics and interview questions. We chose a qualitative approach, that of Interpretative Phenomenological Analysis (IPA, Smith et al., 2009), to explore the experience and meaning of bonding for sex working mothers. Formal ethical approval was granted by an NHS Research Ethics Committee and by the Research and Development department of the NHS Trust involved. Additional ethical approval was given by individual services.

Recruitment and Participants

We used purposive sampling to recruit participants through two substance misuse services, two voluntary sex work projects, and one specialist midwifery service. To be included in the study participants had to be female, aged 18 or over, have one or more children, identify themselves as sex working at the time of interview or in the first two years of their child's life, and to have had some contact with the child during first two years of his/her life.

Service staff identified eligible service-users they worked with and informed them about the research, issuing information sheets, and answering any questions. Interviews were arranged through staff members. Travel expenses related to participation were reimbursed and a £10 voucher provided to express appreciation. The final sample comprised of six participants (See Table 1 for details) aged 25-49 (one participant did not provide their age). Four participants were still involved in sex work. All had used drugs in the past and four were current users. Number of children each participant had ranged from one to four. Two participants were pregnant at the time of interview.

[INSERT TABLE 1]

Data collection and analysis

The first author conducted five interviews took place in private rooms within services familiar to participants and one in a refuge where the participant lived. Two participants brought their midwife to the interview. Interviews lasted between 45 and 102 minutes. The interview guide included example questions exploring key areas, such as, "what can you remember about your experience of giving birth and the events surrounding it?", "what would you say your experience of bonding with your child has been and how has this been affected by your involvement in sex work?'; "is there anything else that you think has influenced your bond with your child?". Follow up questions, for example, "could you tell me more?" encouraged elaboration.

Interviews were transcribed verbatim by the first author and pseudonyms applied. The first author took the lead in analysis and collaborated with the last author to produce an audit trail (see Murray & Wilde, 2020). One transcript was chosen to begin the analysis. In keeping with the idiographic philosophy of IPA, the entire text of the transcript was treated as a whole and coded thoroughly. Anything relevant to the research question was highlighted

and notations made in a side column summarising relevant statements or sections. Notations varied between descriptive paraphrasing of participants' accounts (e.g. 'excited preparations for child'), using participants' actual language (e.g. 'his dad was a waste of space'), and interpretative observations of participants' experience (e.g. 'adopting defensive position as parent'). Next, we grouped in clusters that reflected different dimensions of the participant's experiences. We then wrote a narrative summarising each cluster, and expressing its central meaning in relation to the research topic. This process was repeated for all transcripts. The second stage of analysis involved integrating the analysis across all transcripts. Cluster titles across all transcripts were grouped according to thematic relationships. These emerging themes were checked and refined against the original transcripts, ensuring they were grounded in the data. In total, four themes were created. The final analytic stage involved writing a narrative for each theme, evidenced by participant quotations (see Results).

Results

The complex process of bonding

Here we discuss how participants experienced and understood the nature of bonds formed with their babies. Bonding was widely discussed as the emotional closeness or connection women felt towards their child; a sense of togetherness with them. The significance of elements of the process of forging this bond differed across participants, for example experiencing powerful feelings, maintaining physical proximity, providing practical care, or bestowing gifts. Bonding was initially experienced as overwhelmingly positive but did not always occur or continue as hoped due to the complexities surrounding women's lives. Accordingly, women sought ways to make sense of and negotiate bonds over time.

For Kirsty and Jenny, bonding was positive and immediate: "The time I had with me son was beautiful… it was the nicest thing ever" (Kirsty). Such accounts highlighted the

flow of immediate and intense feelings of love towards the new baby, creating an exclusive bond: "You don't have it with no-one else… the bonding is just between you and that child" (Jenny). For Sue, bonding had been more complex. While she largely portrayed this as inevitable, occurring automatically at birth ("…with me two younger ones… *obviously* I got that rush of love with both of them"), she experienced subsequent difficulties in bonding as the responsibilities of motherhood grew:

> I like the novelty of having children and to be fair I didn't really bond with them too well because I had post-natal depression and mastitis…but… when I actually got into the role it just wasn't suited to me… it's taken a long time to realise… and admit that. (Sue)

As bonding was the perceived norm, women sought explanations for deviations from it, here referring to health problems. Furthermore, Sue highlighting her unsuitability as a mother emphasised how bonding was understood as central to motherhood and a resignation that she could not change it. Failure to bond highlighted maternal deficiencies, making it hard to admit due to the shame felt. Sue's contrasting bonding experiences also highlighted different facets of bonding, suggesting initial feelings did not represent or guarantee what was to come. Mothers' bonding experiences ebbed and flowed according to the complexities of their lives. Most participants had experienced intimate partner violence within their relationships which sometimes complicated bonding: "…he [partner] only seemed to… hit me when I had me son in my arms… One time… I had to crouch down hold onto him while he's hitting me on top of my head" (Kirsty). Bonding was costly to Kirsty as it led to increased violence from her partner, threatening both her and her ability to protect her son.

Bonding was most notably challenged during formal separation where bonds acquired new meanings and needed negotiating accordingly. Women responded differently to learning

their child would be removed after birth, for example: “That’s what made me go more away from him… I couldn’t… hold him… when he were first born, they were trying to pass him me and I were like, no, not a chance… get that thing away from me” (Linda). Here, bonding, in the knowledge of eventual separation, was threatening, painful, and to be avoided.

In contrast to the above, Jenny “made a conscious choice… however long I’m gonna get to be in hospital with him I will bond with him but I’ll also know when the time is to let go.” Whilst also protective, Jenny intentionally compartmentalised bonding. After her son entered care, Jenny emotionally retreated from him until she finally had “no bond... I literally just let go of it”, reflecting how women’s psychological investment fluctuated in response to circumstances and their own emotional needs.

In contrast to an understanding of bonds as inevitable and automatic, the above experiences demonstrated they could be resisted or even severed as a result of women’s choices, which were in turn shaped by their circumstances. However, through symbolic gifts to them, Kate sought to maintain the bond with her children post-adoption: “I did life story books for them… I got ‘em lockets with photos in saying mummy loves you, my love always and forever… they’ll have them for when they grow up.”

In summary, whilst bonding was commonly experienced positively, as intense feelings of love and exclusivity, women revealed a dissonance between immediate feelings and maintaining bonds over time. A simplistic view of bonding was challenged by circumstances which complicated its meaning, leading women to negotiate bonds in new ways. Accordingly, bonding was understood as both automatic and something intentionally managed.

The role of powerlessness on bonding

All participants recounted experiences of powerlessness in their children's lives, largely due to the effects of care arrangements, mirroring the powerlessness they reported in relation to drugs, violence and sex work. Every participant had a child involuntarily removed, consistently feeling the decision and process was out of their control. Helen described discovering how her son was adopted:

> I remember sitting in the house and going 'I can't understand how they adopted him …I wouldn't sign no papers.' And [his father] went 'I signed them'. I went 'You what? You sit there and say it like, "Oh I picked up a paper today"… what gives you the fucking right to sign them? I pushed for how many hours… and you signed him away?'

Helen's relationship with her son was ended by decisions beyond her knowledge, desire and control, illustrating a common experience of miscommunication, rendering women ignorant regarding care proceedings.

> When women maintained contact, arrangements often remained beyond their control: I was supposed to have parental rights... [My mum] didn't even invite me to me own daughter's christening... Even though it was court that said that... I just didn't feel I had a leg to stand on. Because… I had just given her up. (Kirsty)

Kirsty distinguished between legal rights and her perceived power in asserting them, the latter compromised by her sense of culpability; she gave her power away alongside her child.

Powerlessness in care arrangements also had a negative psychological impact on bonding through eroding women's sense of their children belonging to them. Women highlighted a sense of belonging as a key component of bonding, frequently referring to their babies as 'theirs', for example stating "that's my baby": (Sue) and "my little bundle" (Kirsty), indicating their joy and pride in creating a new life. However, this experience was

threatened when involvement in children's lives was prevented: "I never felt like my baby was my baby. I felt like my mum had… pushed herself in… like it was her baby not mine" (Kate). Not feeling her daughter belonged to her meant Kate felt redundant as her mother, without an active role in her life.

The maternal role was further undermined through professional surveillance. Women expressed feeling judged by professionals and feared making mistakes leading to their children being removed: "Because I was in a mother and baby unit… they're watching you all the time. Am I feeding him right? Am I cooking it right? Am I doing nappies right?" (Kirsty). Observation led to hypervigilance, reducing Kirsty's confidence in decision-making, relying instead on external approval. Surveillance prevented women enjoying their children, so some described only bonding when alone, for example, Jenny when in hospital: "I wanted to be his mum for them three weeks… It were me that were feeding him… me that were seeing to his nappy, me that were bathing him… with no-one interfering." Jenny reiterated the importance of autonomy in managing the responsibilities and decisions of childcare for bonding to occur.

Accordingly, women found ways of asserting their maternal autonomy through making decisions for their children, most notably when Kate, Kirsty, and Jenny chose to put children into care: "It did take a lot of guts for me to do that and it was really harsh for me but I thought of their needs before mine" (Kate). This choice evidenced sacrificial love as mothers, strengthening their maternal identity. The significance of feeling empowered in this process is striking when comparing Kate's experience here with the time her first child was removed suddenly: "…me head had gone because… I knew that baby weren't coming home with me… so I started using heroin and… going back on the streets… and funding me habit." Despite sadness both times, the autonomy reflected in actively giving up her second child protected Kate from coping through a cycle of drug use and sex work.

In summary, the powerlessness women experienced in relation to their children undermined their sense of belonging with their children and their autonomy as mothers, both impacting bonding. Feeling empowered to participate more fully in decisions and care regarding their child enhanced women's maternal identity, confidence and self-worth.

The powerful impact of receiving help

Participants highlighted the importance of both practical and emotional support to bonding, particularly in relation to the challenge of meeting a baby's needs:

> It's just that feeling when they put that baby in your arms and they're crying and you think, 'God, I've got to protect you for the rest of your life'. (Sue)

> I was only young meself and… my mum… didn't care… so no-one taught me how to look after them emotionally. (Helen)

Here, the baby's vulnerability confronted Sue with demands that provoked fear, perhaps due to feeling inadequate to meet them; while for Helen, difficulty in providing care was related to absence of guidance.

Kirsty highlighted the social isolation most participants experienced, due to complex family relationships leaving them without a wider network of support, and partners who were unsupportive, absent (here, a 'punter') or abusive:

> I'd had a social worker when I was younger so I thought they might be able to help me because I wasn't… talking to me parents. And I thought 'cause I'm on me own, because the dad wasn't interested obviously because he was married… I thought I'm not gonna be able to cope. (Kirsty)

Being alone was repeatedly associated with difficulty in coping, partly relating to practical factors such as no childcare support. Conversely, Sue described the impact of her mother's practical support in providing valuable relief:

> I think being with my mum, that I get that break where I know I can hand them back… just physically knowing I don't have to put up with it.

Helen further emphasised the emotional impact of a lack of social support for parenting:

> Helen: …with Kyle's dad it was hard, it was lonely... My friend got caught pregnant …and her fella came with roses. I got leathered every time I opened the door… He had the scan picture and I remember him going on about it…
>
> Interviewer: Did you have anyone to share any of that with?
>
> Helen: No
>
> Interviewer: So, no family or friends that were really (pause) interested?
>
> Helen: Interested (at same time). No (laughs). That's the word we want – interested…. Nobody was interested. But nobody had been interested about me since I was a kid.

When women's own needs were met, this had a notable impact on their bonding experiences:

> …me ex partner's mum could see I were absolutely drained and she says … 'Go and get yourself in a nice hot bath… don't worry about him crying… just go and get yourself up into that bed and… sleep.' … For about two days solid I slept… I just woke up a different person… I just wanted more to do with him. (Sue)

Somebody recognising and taking care of her needs and worries had a transformative effect on Sue; having her own needs met enabled her to meet her child's.

In the absence of supportive adult relationships, some women's children met their needs for companionship and care, exemplified by Kate's toddler helping her during a traumatic labour:

> I'll always remember she did that for me, for her own mum… it was just special to me… even though she didn't know what we're going on, she were trying to help me and trying to stop the bleeding… that was really… bonding.

Although recognising her daughter's limited understanding, for Kate, her actions communicated love and care. In her isolation, this had a powerful effect on how she perceived herself, as worthy of care. This highlights the importance of reciprocity within women's bonding experiences; the relationship became more meaningful by what it offered to the mother.

In summary, becoming a mother was daunting, its challenges exacerbated by social isolation. Receiving care facilitated giving care by relieving the parenting burden and making women feel valued. In this context, bonding offered a relationship that was reciprocal and rewarding but was difficult to maintain without external support.

New perspectives of the body and sex work following motherhood

The final theme reveals how pregnancy and motherhood marked a shift in women's identity, reflected in the way they saw and used their bodies which often conflicted with sex work.

Upon becoming pregnant, four women stopped sex work immediately, describing this as a natural reaction. This reflected beliefs about the baby's safety: "I thought… it could harm the baby" (Linda). Conversely, Sue described how drug addiction and fear of motherhood meant she did not develop a sense of her baby during pregnancy and so

continued working: “I was in… denial all the way through me pregnancy because I was… just carrying on doing whatever, whenever… I wanted”.

Accordingly, for most participants, not working evidenced maternal love and commitment, as they did not want to “let [THE CHILD] down” (Jenny). Specifically, women began to see their bodies as no longer their own: “I don’t think it’s really right… to sleep with another man when you’ve got another man’s baby in your belly… just a place you don’t go” (Jenny). Her baby and its father had rights to her body; sex with anyone else, regardless of the context, was unfaithful. The pregnancy created new boundaries which could not be crossed, emphasising how women perceived their babies as an extension of their own body: “I had buggies, cots, everything but… he slept with me, usually sat on me hip. Everywhere I went he was with me” (Helen).

Women expressed bonding through sharing their physical space and bodies. Accordingly, when women did work, it felt like a violation with ‘punters’ trespassing the baby’s territory: “I hated anyone sucking on me nipples… I’d feel myself go tense and I’d want to smash their face in ‘cause that’s what fed me child” (Helen). Helen’s anger indicated a sense of intrusion and a need to defend her body. As she was no longer pregnant or breastfeeding, this indicated a permanent change in bodily identity and purpose. It carried memories of the bond formed, which sex work somehow sullied.

The separation of sex work and motherhood was emphasised by several women only returning to work when their children left. Sue and Helen however, needed to return to work whilst caring for their children, resulting in them developing strategies to separate their conflicting identities:

> I can be on the phone… - “hiya everything alright?” I’m mum. As soon as I come off the phone and look in the mirror I’m not mum anymore, I’m whatever name I’m using. And that’s how I cut off… I associate make-up with work. When I go to work

> and put my face on, I am whoever I want to be. But when I'm at home I'm mum… I have to leave it at the door. (Helen)

Helen managed to switch identities on and off. The ritualistic application of make-up created a mask signifying her identity as a sex worker, the mirror a symbolic reminder of her current role.

Women also managed conflicting identities by reinterpreting the meaning of sex work as congruent with motherhood: "when I go out to work it doesn't even bother me no more because… I think to myself, 'Oh, I've got 60 pounds I could spend a little bit on each of my children'" (Sue). Sex work became the means for providing for children, thus enhancing their relationship. Accordingly, Helen defended sex work: "I love my kids just as much as anyone else… if not more, because… I'll do what other people would shun, turn their nose up at, or, flat out refuse to do." Sex work thus became a demonstration of sacrificial love for her children.

In summary, motherhood marked a shift in women's identity reflected in how they perceived their bodies. They no longer saw their body as solely their own but now intimately connected, even belonging to, children and partners, complicating sex work. Consequently, women worked hard to separate the two, primarily by stopping working, but when not possible, by maintaining separate identities, and attributing meanings to sex work more congruent with their desire to love and provide for their children.

Discussion

Our present study is the first to explore bonding experiences of women involved in sex work. Although in many ways their experiences reflected the diversity of bonding experiences held within the general population, they were also significantly influenced by contextual factors surrounding their work.

In contrast to other research reported by other researchers (e.g. Dodsworth, 2011), women here did not identify strongly as sex workers, instead focussing on contextual factors in their lives that impacted bonding, including drug use, financial hardship and problematic relationships (see Perdue et al., 2012). Specifically, powerlessness, reflecting a theme often identified in sex work literature (e.g. Gorry et al., 2010), resulted in women feeling they had no right to actively care for their children as mothers due to care arrangements. Needing to feel entitled to the baby has been identified elsewhere, for example, for parents of babies in a neonatal unit (Fegran et al., 2008) and adoptive parents (Goldberg et al., 2013), suggesting its general importance for bonding, particularly when threatened. Women in this study were not asked specifically about their own early experiences but some did discuss their own childhood trauma. Researchers have repeatedly found large numbers of women who sex work experienced childhood sexual abuse and the majority have experienced sexual or physical assault whilst working (Farley & Barkan, 1998) (although this varies for types of work), resulting in complex trauma being commonplace, particularly among street based workers. Given complex trauma can have a significant impact on parenting experience (Banyard, Williams, & Siegel, 2003) it is an important consideration in interpreting the findings here.

A related finding was the enduring grief after losing custody of a child. Meaningful participation in child protection decisions and procedures was protective and reduced problematic coping strategies. Furthermore, corresponding with literature concerning bereavement after a death (Klass et al., 1996), continuing bonds with separated children was healing for some, confirming findings elsewhere (Bletzler, 2005). Nevertheless, as recognised previously (Hunt, 2010; Neil et al., 2010), care proceedings were largely experienced negatively, potentially increasing concerning behaviours by causing anxiety, reducing confidence, and leading to withdrawal from children, facilitated by drug use. Despite legal requirements for support of birth parents (Department for Children, Schools and

Families, 2010), women described poor communication, judgment, and betrayal, highlighting the impact of the adversarial stance professionals often take (Smeeton & Boxall, 2011). Such a portrayal of professionals may well be influenced by psychological processes on the part of the women seeking to defend themselves from the shame associated with 'failing' as mothers and may be influenced by 'impression management' (Davies & Allen, 2007) in an understandable attempt to prove their capacity as mothers. However, a more compassionate approach by services as well as greater psychological support for mothers is likely to allow for greater collaboration and more positive outcomes.

A final systemic factor affecting bonding was social isolation, with most women managing parenting without the practical or emotional support of partners, family members, or wider community. Elsewhere, social isolation has been identified as a factor in the wellbeing of mothers and children in the general population (Paris & Dubus, 2004; Thomspon et al., 2019). Furthermore, bonding difficulties have been found to increase isolation (Sluckin, 1998) indicating a vicious cycle for women struggling to bond without support. In contrast, we found that positive experiences of practical and emotional care, both professional and personal, transformed women's self-worth and bonding capacity. Attachment helps to explain how social support can affirm a mother's sense of herself as deserving of care and capable of caring (Crockenberg, 1988). Additionally, Suchman et al. (2005) found substance-using mothers' *perceptions* of available support influenced their capacity to care for their children, emphasising the importance of subjective interpretations of support.

Due to sex work involvement, women encountered negative assumptions regarding their parenting abilities, reflected in wider sex work literature (Duff et al., 2014), undermining their confidence. However, importantly, in this study we identified that women's bonding experiences reflected those of non-sex working mothers, for example,

incorporating feelings of love and affection towards the child (Bouchard, 2011) and a desire for proximity and reciprocity (Goulet et al., 1998). Interestingly, participants' experiences in this study mirror qualitative research findings of mothers with a schizophrenia diagnosis (Seeman, 2010), demonstrating a desire to be a good mother yet facing barriers of societal stigma and expectation and lack of support and resources, reflecting the powerful impact of such factors on parenting opportunity and capacity.

We draw on the findings to challenge frequent representations of bonding as secure and stable (e.g. Fegran et al., 2008); rather, bonds may fluctuate over time (Mercer & Ferketich, 1994).

Additionally, bonding itself was problematic for some participants' wellbeing, for example due to the threat of loss of custody or increased violence from partners, an important finding when promoting bonding. The latter example supports previous findings that domestic violence impairs the maternal-infant bond (Zeitlin et al., 1999). Women also conveyed shame and resignation regarding bonding difficulties. Whilst the promotion of parent-child bonding across society rightly highlights the importance of infancy for attachment and child development (Moullin et al., 2014) it can inadvertently lead to undue pressure, unrealistic expectations, and shame on behalf of parents when their experience is difficult or does not match the 'ideal' standard, suggesting the need for more nuanced and sensitive discussion about parenting in public discourse.

Finally, in contrast to previous studies, where researchers have found pregnancy had little impact on women's sex-working lifestyle (Deisher et al., 1989; Dalla, 2002), most women reported stopping working immediately in pregnancy. This specifically related to acknowledging the baby's existence, emphasising the impact of keeping the baby in mind (Slade, 2002). In contrast, ambivalence towards pregnancy and the baby facilitated ongoing drug use, which has been found to restrict pregnant women's mental representations of

motherhood and their child (Söderström, 2012), suggesting a cyclical relationship. Bonding also altered women's self-perceptions; maternal identity superseded their working or sexual selves (Speier, 2001) deeming sex work a necessary means to provide for children, as reported elsewhere (Basu and Dutta, 2011; Duff et al., 2014; Sloss & Harper, 2004).

Clinical implications

Findings here suggest the need for greater recognition of and provision for sex-working mothers due to the value of supporting women in parenting, and to respond to the increased motivation for change that resulted from` the special connection with their child. Given factors complicating bonding and women's common experiences of separation, psychological support may benefit sex-working mothers and their children, increasing the likelihood of them remaining together (Golding, 2007). Evidence-based interventions should be utilised that acknowledge the impact of complex trauma on mother and child, for example, child-infant psychotherapy (Ghosh Ippen et al., 2011) and mentalization-based parenting approaches (Byrne et al, 2019). This is likely to help women to mentalise themselves as mothers, their child, and their relationship (Markin, 2013). Individual therapeutic work could consider factors identified here, including powerlessness, childhood experiences, and shame. Additionally, providing support around loss of custody is vital, through therapy, grief counselling, or organisations connecting mothers separated from their children.

In response to the identified need for supportive and caring relationships, sex-working women may benefit from accessing provisions such as peer support programmes (McLeish & Redshaw, 2017), and specialist sex work projects. Additionally, we use the findings to emphasise the importance of offering empathic non-judgmental support to sex-working mothers. As they may be more likely to attend specialist sex work services (Cooper et al., 2001), psychological provision could be offered, within these services thus maximising the potential for engagement in interventions. Additionally, professionals supporting women

involved in sex work in both specialist and generic services, such as midwifery, could be offered psychologically-informed training regarding the opportunities and risks facing mothers in this context. This could facilitate early identification of women needing support and clarifying pathways to appropriate provision, such as perinatal mental health services.

Finally, recognising the contextual factors affecting bonding, interventions specialising in engaging disadvantaged and excluded communities and working to improve broader social, economic and health outcomes are vital (such as, in the UK, Empowering Parents, Empowering Communities (Cooper

for Parent and Child Support, 2017) and the Family Nurse Partnership (fnp.nhs.uk)). Care must be taken in the way early attachment relationships are discussed in public health material and services. Emphasis on the importance of parent-child relationships needs to also include messages about the divergent experiences during this period so as to not enhance stigma and shame which inadvertently reduce engagement in support for those who may need it the most.

Additionally, in relation to care proceedings, approaches must recognise strengths and hope as well as risks (Featherstone et al., 2014), and approach parents with care, compassion and dignity (Crittendon, 2005; Schofield et al., 2011), by ensuring clear communication and participation. Incorporating psychological formulation into risk management procedures within social services could facilitate this (McGee, 2016), as well as offering psychological supervision for social workers, recognising the impact of managing complex relationships with families on professionals' emotions and empathy (Featherstone & Lutman, 2012). In all of the above, providing opportunity for women's experiences to be heard and shared is crucial in raising awareness, informing relevant support, and reducing stigma.

Limitations and future research

Whilst the research did not aim to explore child custody, it formed a large part of what women wished to talk about and proceedings had a significant impact on their bonding experiences. Further research focussing specifically on this could aid understanding of how this process could be done differently to support and empower women, potentially through researching experiences of women who were able to maintain custody of their children or for whom motherhood acted as a catalyst for positive change as some suggested here.

Recruiting through specialist and substance misuse services meant all participants were drug users or had complex difficulties, and two thirds worked on the streets (thus not reflecting the broad spectrum of sex work (Balfour & Allen, 2014)). Future research could incorporate bonding experiences of women in different types of sex work, particularly including non-drug users and those with greater contact with their children. Indoor work is thought to make up the largest part of the sex industry and online work has seen a considerable increase in recent years, particularly during the COVID-19 pandemic (Moss, 2020). As accessing a wider sex work population can be problematic (Shaver, 2005), this may require innovative methods, for example utilising internet sex work sites. The sampling method may also explain the homogenous racial demographics of participants, not reflecting the large numbers of minority ethnic women involved in sex work and migrant workers in the UK (Home Affairs Committee, 2017) thus potentially missing factors relating to these groups of women.

Alternatively, whilst women who sex work have been underrepresented in research and service provision (McClelland & Newell, 2008), it is possible a focus on sex work obscures the core issues and may not reflect the priorities of the women themselves. The main themes raised here had limited relation to sex work itself and more to do with women's experiences of facing multiple disadvantage (e.g. poverty, domestic abuse, and substance use,

marginalisation, and trauma). Considering parenting experiences of this population through a trauma framework may be relevant and help to inform intervention. Furthermore, making space for peer-led research is vital here in exploring lived experiences and reducing the risk of imposing particular social assumptions onto the research (Sanders, 2006).

Another limitation was that, although interviews focussed on early maternal experiences, participants were generally older and speaking about events in the past. This may have resulted in less detailed accounts or in narratives being 'reconstructed' in the light of later relationships and circumstances and in order to produce self-enhancing accounts, as Smith (1994) found in retrospective pregnancy research. Finally, little is known about children's experiences of having a parent involved in sex work (Beard et al., 2010), which could be explored utilising qualitative methods.

In the present study we focussed on the UK, where thousands of mothers sell sex. Sex working mothers from this study demonstrated that, whilst having strong connection towards and desire to care for their children, multiple systemic factors complicated the process of bonding. Relationships with those in their personal lives as well as professionals and wider society greatly impacted their parenting experiences, highlighting need for greater non-judgmental support for the wellbeing of mothers and their children. We recognise that, in accordance with the idiographic focus of our methodological approach, our sample is small and we do not argue that similar findings would apply to all mothers in similar situations. In particular, further work in other geographical and cultural contexts would be valuable in identifying the degree to which our findings traverse or are modulated by particular settings for sex working mothers.

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Table 1. Summary of participants' descriptive information

Participant	Age	Children (Age and level of contact)	Sex work			Drug use	
			Type	Age when started	Current involvement	Approximate years using	Current use
Kate	30	9 (In care with her mum from birth. Irregular current contact now with aunt) 8 (Lived with shortly as a baby then in care with mum. Irregular current contact now with aunt) 6 (Lived with from birth. Adopted about age 4) 3 (Lived with from birth. Adopted about age1) Pregnant	Street; sex videos	16	Stopped five years ago	10	No
Linda	25	4 (Lived with sister from birth. Contact till nearly age 1 then none since) Pregnant	Exchanging sex for drugs	15	Stopped one year ago	10	Stopped one year ago
Helen	49	29 (Lived with from birth. Adopted age 2. Regular contact since age 14) 15, 10 (Lived with since birth)	Street; parlors	16/17	Recently stopped	30	Yes
Kirsty	-	20 (Lived with for three months. With	Street	Started 16	Stopped one	19	Yes

		parents since. Current contact) 17 (Lived with for 15-18 months then in foster care. Current contact)		years ago	years ago		
Sue	33	4 (Lived with till age 1) 5 (Lived with till age 2) 16 (Lived with till age 5) 17 (Lived with till age 6) All live with her mum. See once/twice month	Mainly street	22	Yes	11	Yes
Jenny	42	23 (Current contact) 22 (Current contact) 13 (Lived with from birth. Adopted age 5) 6 (Fostered from birth. Contact till 18 months then adopted)	Street	32	Yes	25	Yes