Submitted in partial fulfilment of the

Lancaster University Doctorate in Clinical Psychology

October 2017

Doctoral Thesis

A Qualitative Exploration of the Experiences of Women Involved in Sex Work

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Statement of Total Word Count for the Thesis

	Main Text	**Appendices (including references, tables & figures)**	**Total**
Thesis Abstract	278	-	278
Part 1: Literature Review	7977	6045	14022
Part 2: Research Paper	7981	7709	15690
Part 3: Critical Appraisal	3909	-	3909
Part 4: Ethics Section	5171	1912	7083
Total	**25316**	**15666**	**40982**

Thesis Abstract

This thesis explores lived experiences of women involved in sex work and is comprised of three parts: a literature review, research paper, and critical appraisal. The literature review is a meta-synthesis of the ways women involved in sex work cope with the associated stigma. It synthesised findings from 14 existing qualitative studies, identified through systematic searches of six online databases. Using a meta-ethnographic approach, three themes were identified: 1) denial: ‘I do not do sex work’; 2) distancing: ‘I do sex work but it’s not me’, and 3) defending: ‘I do sex work but it’s not that bad’. Findings identify particular strategies used within the sex work context, emphasising the importance of power and resilience in stigma coping.

The research paper explores women’s experiences of bonding with their children in the context of sex work. Six women were interviewed and interpretative phenomenological analysis (IPA) was used to identify four themes accounting for their bonding experiences: 1) the complex process of bonding; 2) ‘I never felt like my baby was my baby’: the impact of powerlessness on bonding; 3) ‘give them the help that they need’: the powerful impact of receiving help, and 4) new perspectives of the body and sex work in the light of motherhood. Findings emphasise the complex nature of bonding within this context, particularly highlighting the importance of empowerment and care. Implications for clinical psychology are discussed in relation to both the literature review and the research paper.

Finally, the critical appraisal elaborates on some of the ethical and practical issues arising throughout the research, leading to a wider consideration of conducting research within the sex industry, particularly of a sensitive nature.

Declaration

This thesis describes research carried out between May 2015 and October 2017 for the Doctorate in Clinical Psychology Programme at the Division of Health Research, Lancaster University. The work presented here is my own, except where due reference is made. This thesis has not been submitted for the award of any higher degree elsewhere.

Name: Ruth Elsdon

Date: 4th October 2017

Acknowledgments

My main thanks go to the women who agreed to sit and share their stories with me and with other researchers whose studies I reviewed. Thank you for your time and honesty and for showing the hope, humour and resilience possible in the face of adversity. I hope I have been faithful to your accounts and that sharing these experiences may benefit others.

I am also very grateful to services and staff members who helped with recruitment. I was inspired by your dedication and passion for the demanding work you carry out.

I would also like to thank several people who have helped me complete this thesis: Dr Craig Murray for your guidance and knowledge; Dr Suzanne Hodge for your valuable input earlier in the process; Dr Ruth O'Shaughnessy for your insight and encouragement and for helping me to stay connected with the research along the way; Dr Vikki Baker for offering a listening ear and the opportunity to reflect and be challenged about the research; Dr Jenny Davies for your general support throughout the DClinPsy and for encouraging me to find and follow my passions, and to my lovely friends who have read drafts and shared advice.

And finally, my little family - Chris, Bonnie and Asher. Thank you for giving me the time to study and for daily reminders of the bonds we share. I am so grateful for you.

Thesis Contents

Section One: Literature Review

Section Two: Research Paper

Section Three: Critical Appraisal

Section Four: Ethics

SECTION ONE

LITERATURE REVIEW

A Meta-synthesis of Women's Accounts of Coping with Sex Work Related Stigma

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Word Count: 7977

(Excluding tables and figures, reference lists and appendices)

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Please refer to Appendix 1-A for manuscript preparation guidelines.

ABSTRACT

Objective: This literature review aimed to integrate existing qualitative findings of women's attempts to cope with sex work related stigma.

Method: A meta-synthesis was conducted based on a meta-ethnographic approach (Noblit and Hare 1988). A systematic search identified 14 articles for review using PyschInfo (1887-present), Academic Search Complete (1984-present), Cinahl (1981-present), Medline (1946-present), Psycarticles (1984-present), and Social Care Online (1980-present). No date restrictions were applied. Quality was assessed and original findings extracted and synthesised.

Results: Three themes incorporating different strategies were identified and presented with supporting quotations, namely, coping through (1) denial, (2) distancing, and (3) defending. Findings highlighted the impact of power and resilience on stigma coping in this setting.

Conclusion: Findings contribute to existing literature by identifying strategies used within the sex work context. The review makes suggestions for therapeutic interventions with sex-working women, emphasising the importance of making services accessible and non-judgmental.

KEYWORDS: Qualitative; literature review; meta-synthesis; sex work; stigma; coping

Introduction

Sex work research has historically focussed on the risks of participation to women's physical health, particularly sexual health difficulties, drug use, and violence (Church et al. 2001; Sanders 2008). In recent years, however, researchers have begun to explore emotional and psychological risks of sex work previously receiving little attention (Stevenson and Petrak 2007), finding associations with mental health problems including depression and post traumatic stress disorder (Rossler et al. 2010). Alongside factors such as trauma experiences (Dodsworth 2011) and the toll of sexual performance (Silcock 2014), stigma has been repeatedly identified as contributing to emotional distress due to workers' experiences of judgment from society that dehumanises and humiliates them (Gorry, Roen, and Reilly 2010; Sanders 2004; Vanwesenbeeck 2001).

Stigma

Stigma has been defined as an attribute so discrediting that the person possessing it is reduced “from a whole and usual person to a tainted and discounted one” (Goffman 1963, 3), prompting discriminatory behaviour towards them. Experiencing stigma and the associated discrimination can lead to multiple difficulties, such as poverty, academic underachievement, and reduced access to housing, education and jobs (Allison 1998; Crocker, Major and Steele 1998; Jackson 1996; Link and Phelan 2001); it has been associated with psychological distress including low self-esteem and rejection anxiety (Kadianaki 2014) and physical health problems such as chronic pain and hypertension (Clark et al 1999; Contrada et al. 2001; Lewis et al. 2003). Difficulties result from enacted stigma (active discrimination) and felt stigma (the knowledge that one occupies a stigmatised identity) (Scambler and Hopkins 1986), the latter incorporating both the fear of enacted stigma and the shame associated with being something considered inferior.

Sex work stigma

Pheterson (1993) argues sex workers are among those society considers most inferior due to “whore stigma”, meaning the dishonour and unworthiness attributed to prostitution. This is often reflected in sex work's legal status as well as the moral scorn shown towards it, strengthened by the implication that sex-working women defy societal norms of femininity (Dodsworth 2012). Accordingly, involvement in sex work tarnishes a woman's overall identity so they have to contend with being damaged and lesser as people, contrasting with male clients who may face criticism for their behaviour but whose identity remains intact.

Based on an exploration of historical approaches to prostitution, Rubin (1992) proposes that such ideology, particularly when accompanied by criminalisation, leads to sex workers being classed as “inferior individuals not worthy of being left in peace” (156), resulting in discrimination, social isolation and a discredited place in society (Goffman, 1968). This leaves women vulnerable to oppression and violence (Basu and Dutta 2009; Davis 2000); reduced job opportunities (Begum et al. 2013); denial of healthcare (Basynat 2017); and particularly where criminalised, lack of legal protection (Baldwin 1992; Chapkis 2003), resulting in numerous negative health outcomes (Lazarus et al. 2012). Accordingly, stigma and the accompanying social isolation may present the most damaging aspects of sex work (Holroyd et al. 2008; Petro 2010; Vanwesenbeeck 2001), causing considerable concern to women involved (Sanders 2004).

Concealable stigma

The nature of sex work stigma is influenced by participation being largely concealable, as opposed to observable stigmas such as ethnicity (Miller and Kaiser 2001; Pachankis 2007). Despite previous assumptions that possessing a visible stigma would cause greater distress due to increased incidents of discrimination (Miller and Kaiser 2001), recent evidence has highlighted particular psychological stressors faced by those with concealable stigmatised identities (Pachankis 2007; Quinn and Ernshaw 2013). These include decisions about disclosure of the identity (Greene et al. 2003); anxious anticipation regarding being ‘found out’ and the potential implications (Quinn and Chaudoir 2009); isolation from others with the identity (Goffman 1963); feelings of dissonance and inauthenticity, and preoccupation and anxiety resulting from efforts to hide the identity (Bockting et al. 2013; Smart and Wegner 1999). Models presenting the impact of concealable stigmas (e.g. Quinn and Earnshaw 2013) incorporate the effect of the stigmatised person’s reactions and efforts to manage their identity, for example by hiding it (Pachankis 2007). This highlights a growing understanding of stigmatisation as a dynamic process influenced by the stigmatised individual’s efforts to cope with, manage, or resist its effects (Kadianaki 2014; Major and O’Brien 2005; Miller and Major 2000). Research regarding stigma coping strategies is therefore vital in understanding how such approaches may increase or reduce the psychological distress stigma causes.

Coping with stigma

Coping has been defined as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus and Folkman 1984, 141); emotional efforts will be incorporated within this definition in the present review. Furthermore, coping can be categorised as problem- versus emotion-focussed and as engagement/approach- versus disengagement/avoidance strategies.

In relation to stigma, research has identified disengagement coping strategies such as denying or minimising prejudice (Ruggeriero and Taylor 1997); avoiding social comparisons with non-stigmatised people (Crocker and Major 1989), or socially withdrawing and avoiding situations where stigma may be enacted (Goffman 1963). Particular to those with a concealable stigma, secrecy and ‘passing’ (pretending to ‘pass’ as a ‘normal’ person) are common disengagement strategies (Koken 2011). Examples of engagement coping include attempts to change stigmatising attitudes through collective action (Wright, Taylor and Moghaddam 1990); acceptance (Miller and Kaiser 2001), and cognitive re-structuring, for example, attributing negative outcomes to prejudice (Crocker and Major 1989).

Stigma coping models often seek to generalise findings across contexts, ignoring divergence between particular stigmas. However, due to the variability in subjective experiences of and responses to stigma, it is important to consider different stigmatised populations in order to better understand their socio-cultural nuances (Kadianaki 2014). Accordingly, generic models may be limited in their application to sex work due to its particular nature, demands and place within society. Research is therefore necessary that explores experiences of stigma within sex work. Focussing on resilience by exploring women's role in coping with stigma is particularly important to avoid traditional polarisation of people sex-working as either passive victims or empowered activists/villains (Weitzer 2009). This dichotomy is increasingly recognised as an over-simplification by research exploring women's lived experiences and how they manage the emotional elements of their work (Sanders 2004). Accordingly, qualitative studies have begun to consider how women navigate their stigma experiences and occupying such a heavily stigmatised identity, deeming the present review both relevant and necessary.

The present review

In the context of understanding women's coping strategies, qualitative methods are particularly important in "taking the perspective of the stigmatised" (Major and O'Brien 2005, 411) so as not to inadvertently reinforce marginalisation through silencing them further. However, qualitative explorations risk being lost if left as a series of disparate research endeavours and not "put together" in any meaningful way (Noblit and Hare 1988, 7), leading to endless duplication of studies at the cost of advancing knowledge in the field (Sandelowski, Docherty, and Emden 1997). Furthermore, this can result in research and clinical practice becoming increasingly distant, with empirical findings seemingly irrelevant to real life (Finfgeld 2003). For the present topic, findings often fall within broader explorations of sex work experiences, accentuating the risk of being lost if not usefully combined. It is therefore essential to find ways of collating such research to develop understanding for clinical application.

In contrast to narrative reviews that summarise existing research in a largely descriptive manner (Dixon-Woods et al. 2006), meta-syntheses seek to synthesise findings from a body of research in order to provide an overall or ‘whole’ picture which goes beyond the findings of original studies (Noblit and Hare 1988). In attending to similarities and differences across studies, they aim to produce novel and in-depth interpretations that provide a coherent account of the subject matter, thus adding to the explanatory power and generalisability of the findings (Britten et al. 2002).

The present meta-synthesis therefore aimed to integrate existing findings concerning women’s strategies to cope with sex work-related stigma. Although one unpublished thesis reviewed identity management among female sex workers (Jones 2014), to the author’s knowledge no existing systematic literature reviews have focussed on how women cope with stigma specifically. The intention is that findings will inform professionals working with sex-working women in both specific (e.g. sex work projects) or generic (e.g. mental health) services about contributory and protective factors relating to their distress, supporting interventions which identify areas for growth and change in women’s lives (Koken 2011). Additionally, it is hoped greater understanding will increase empathy towards sex-working women, leading to more inclusive and accessible services.

Method

Sex work is defined broadly here as the “provision of sexual services for money or goods” (Overs 2002, 2), including all forms, in recognition of the discrimination faced by women throughout the industry (Vanwesenbeeck 2001). Involvement is defined as people using their bodies within sexual activities, as opposed to others working within the industry (e.g. managers).

Approach

The meta-synthesis was based on the meta-ethnographic approach developed by Noblit and Hare (1988). Within this approach, original studies are read to identify ‘first-’ and ‘second-order’ constructs, referring to participants’ spoken accounts and the original authors’ interpretations of these accounts respectively (Malpass et al. 2009; Shaw 2012). Constructs are compared across studies, looking for differences and similarities, leading to the production of ‘third-order constructs’, namely concepts or themes describing the phenomenon under investigation (Paterson et al. 2001). Additionally, attention is given to how findings relate to one another in ways that are reciprocal, whereby they are in agreement; refutational, whereby they are contradictory, or by representing a line of argument, telling an overall story of the phenomenon represented across studies (Shaw 2012).

Search strategy

A systematic literature search was conducted in July 2017. The following databases were used: PyschInfo (1887-present); Academic Search Complete (1984-present); Cinahl (1981-present); Medline (1946-present); Psycarticles (1984-present), and Social Care Online (1980-present). Databases were chosen to be inclusive of a range of literature, for example, accessing literature relating to healthcare and sexual health through Medline and Cinahl and research relating to social work and policy through Social Care Online. A comprehensive list of search terms (Table 1) was generated using the APA thesaurus (Gallagher Tuleya 2007); identifying key terms from relevant articles; using individual database term generators (e.g. ‘related terms’ in Social Care Online), and reviewing terms with the academic supervisor and a library advisor. Search terms were combined using Boolean operators and thesaurus and mesh headings where available. Filters were used for peer-reviewed articles in English. No date restrictions were applied. The methodology filter was used in Psychinfo and Psycarticles to identify qualitative research.

[Insert Table 1]

The initial search retrieved 2934 articles, titles of which were screened for relevance and duplicates removed. Reading abstracts facilitated further screening. Finally, 155 whole papers were reviewed for eligibility according to inclusion and exclusion criteria. References from the 13 remaining papers were read to identify additional studies, leading to 14 papers being included in the meta-synthesis. Figure 1 details the search process.

[Insert Figure 1]

Inclusion and exclusion criteria

Studies were included that: 1) presented findings from qualitative research; 2) had a substantial focus on the ways women attempted to cope with sex work stigma; 3) presented analysis derived from and evidenced by the accounts of female sex workers; 4) were accessible in English, and 5) were published in peer-reviewed journals. Studies with current and former sex-workers were included if analysis concerned stigma related to involvement in the profession. Papers were excluded that: 1) included non-female sex workers; 2) presented combined analyses of the accounts of sex workers and other study participants; 3) focussed on stigma relating to other factors, e.g. HIV; 4) did not separate stigma coping from coping with other aspects of sex work, e.g. violence; 5) presented purely descriptive analyses, and 6) focussed solely on participation with a specific project.

Examples of excluded papers were Abel (2011) which included male workers in the analysis and Weine et al. (2013) which discussed stigma but not coping.

Selected studies

A summary of the final studies is presented in Table 2. Studies mirror the international nature of sex work and the research concerning it (Vanwesenbeeck 2001). Samples included a range of ages and types of sex work, reflecting the diversity within sex work (Weitzer 2009): three included only exotic dancers and strippers; one had an escort as the sole participant; one focussed on dominatrices; three included only street-based workers; two included only bar workers; and the remaining four had mixed samples. As well as individual interviews, some also included: focus groups (3); participant observation (1), and analysis of published memoirs and blogs (1). All studies presented a form of thematic analysis, drawing upon different methods: IPA (2); grounded theory (5); content analysis (2), and undefined (5). Methodologies reflected differing epistemological standpoints. Methodologies thus reflected differing epistemological standpoints. Although some have highlighted this can be problematic (e.g. Jenson & Allen, 1996) because of conflicting theoretical backgrounds and research focus, others argue that findings from studies with differing methodologies can be complimentary (Field & Marck, 1994). Here, divergent studies were included due to the limited number of relevant studies published. They all met inclusion criteria and thus contributed to the research question.

[Insert Table 2]

Quality

Quality of the final articles was appraised using questions 3-10 from the Critical Appraisal Skills Programme (2013) qualitative checklist. The first two questions concern the appropriateness of qualitative methodology for the research aims, essential for all studies included. Utilising Duggleby et al.'s (2010) scoring system, a weak score (1) was allocated to studies providing little justification or explanation, for example, stating interviews were used but not why or how; a medium score (2) was allocated to studies offering some explanation but lacking detail, for example, stating ethical approval was gained with no reference to ethical considerations; and a high score (3) was allocated to studies providing thorough justification and explanation, for example, explaining why a method of analysis was chosen and identifying the steps taken. Scores were totalled, with a maximum of 24 (Table 3). All papers were also quality-assessed by a clinical psychologist unrelated to the research to strengthen the reliability of the process. Scores largely concurred but any differences were discussed and the author allocated final scores. Sandelowski, Barroso, and Voils (2007) highlight difficulties with excluding qualitative studies from reviews due to quality because of variations in assessing it and the fact ‘good’ studies could be rejected because of superficial errors such as incorrect terminology, or details missing due to word limitations. Instead, they advise to consider quality in the comparison of studies. Accordingly, it was not used as an exclusion criteria here. Although studies vary in quality (scores ranging from 11-20) the meta-synthesis’ findings are predicated on the set of papers as a whole and not reliant on the weaker studies.

[Insert Table 3]

Synthesising the data

The synthesis began by repeatedly reading the studies to gain familiarity, and key concepts were noted (Noblit and Hare 1988). Next, all data relating to the review question was extracted from the studies and inserted into a table of key themes, ideas and concepts (second order constructs), alongside supportive quotes from participants (first order constructs). As far as possible, authors’ phrases and words were used. A third column was added to the table where initial interpretations of second order constructs were noted, using phrases and summaries. A brief overall summary was also written in order to consolidate understanding of each study. Individual studies were analysed in chronological order. Thirdly, studies were translated by collating interpretations from stage two in a spreadsheet in order to compare and contrast findings across studies, leading to the identification of 20 initial concepts. Attention was given to how studies related to each other in ways that were either reciprocal or refutational (Noblit and Hare 1988). Particular points of difference between studies were noted. Finally, initial concepts were synthesised in order to represent findings from across studies, which formed a line of argument. This was an iterative process of grouping and re-grouping themes in ways that best represented interpretations from across studies, involving repeated clarification with original studies, facilitated by writing themes out on pieces of paper. Appendices 1-C to 1-F provide examples of data synthesis. Three final themes (presented below) were constructed to present a narrative revealing different ways in which women seek to cope with stigma in the context of sex work. Figure 2 presents themes visually.

[Insert Figure 2]

Results

Theme one: Coping through denial: 'I do not do sex work'

The most common strategy women used to cope with stigma was through denying their involvement in sex work by hiding it from others, lying, avoiding situations or people, and separating their personal and work lives.

Concealment

Women concealed their involvement in sex work through lying, and efforts such as hiding paraphernalia (Levey and Pinsky 2015) or covering work related smells by drinking coffee (Wong, Holroyd and Bingham 2011). Concealment was motivated by a desire to avoid discrimination that would limit opportunities, for example securing employment or accommodation:

> I have to lie to my boss, because, I want a job, right? .... Did I ever tell that I am a whore and get a job? No, I doubt it. (Tomura 2009, 66)

As women experienced being a sex worker as a permanent identity: "You're nothing but a 'ho' and you always will be" (Jackson, Bennet and Sowinski 2007, 266), options for exiting sex work and pursuing other careers felt limited and thus lying became a permanent feature of women's lives.

Women also concealed their work out of fear of “what others will say” (Basnyat 2014, 1048). They were concerned about the impact on their relationships (Basnyat 2014; Phrasisombath et al. 2012), fearing ridicule (Trautner and Collett 2010); assumptions about sexual availability (Trautner and Collett 2010); people thinking badly of them (Basnyat 2014; Phrasisombath et al. 2012; Wong et al. 2011), and complete rejection by their family or community (Ngo et al. 2007; Van Blerk 2011). Although fear of prosecution was also cited as motivating concealment (Ngo et al. 2007; Uddin and Ashrafun 2011), the fear of social rejection was deemed worse. Accordingly, women often avoided situations where disclosure might occur or where the risks would be particularly great, such as in certain jobs, or when attending social gatherings or health clinics:

> We are afraid of who will see us, maybe a family or a friend, and find out about what we do. (Basnyat 2014, 1048)

This fear prevented some from developing relationships:

> I do not dare get acquainted with anyone or show my love with a man. (Ngo et al. 2007, 565)

Some adopted systematic levels of concealment to carefully manage information (Levey and Pinsky 2015; Tomura 2009; Trautner and Collett 2010; Uddin and Ashrafun 2011; Wong et al. 2011), for example, telling nobody, just close friends, or particular ‘safe’ friends, requiring appropriate judgment regarding predicted responses. Alternatively, they chose how much to disclose:

> I couldn’t lie to my mother . . . I broke it to her gently. I didn’t tell her … ‘…I’m fisting some guy, I went all the way up to, you know’ … over the years I revealed more … to her. (Levey and Pinsky 2015, 356)

Wong et al. (2010) attributed differences in concealment to the degree women internalised stigma. Accordingly, some chose not to hide work at all, for example: “I don’t go through pains to hide it from my friends" (Levey and Pinsky 2015, 356), which authors connected with higher self-esteem (Maticka-Tyndale et al. 2000; Ngo et al. 2007); personal views of sex work (Basnyat 2014; Levey and Pinsky 2015); satisfaction with work (Levey and Pinsky 2005; Tomura 2009; Trautner and Collett 2010), or personality (Wong et al. 2011). As a result, some explained they only concealed their involvement when necessary to protect others:

> I think that [it] would really upset my mom and . . . I don't want to have to deal with that. (Trautner and Collett 2010, 270)

Lying protected others' feelings and women's relationships with them. Accordingly, concealment was not necessarily equated with views of sex work but was often a pragmatic strategy to 'get by' and maintain their place in society. However, for others, hiding did infer personal values:

> I don't approve of it [sex work]... It makes me feel bad, I see my own body and I feel bad. Sometimes I start crying, or sometimes I cover myself. (Cox, Casablanca and McAdams 2012, 1472)

Accordingly, Cox et al. (2012) portrayed concealment as a direct consequence of the shame women felt, indicating their desire to hide their work even from themselves.

Keeping worlds apart

To support concealment, women created two separate worlds and identities. However, this was problematic when women lived in their place of work (Campbell 2000; Phrasisombath et al. 2012; Van Blerk 2011). To counter this, women emphasised distance between the present setting and their home villages, preserving their reputations in the latter through performing acceptable roles such as participation in traditional village activities (Phrasisombath et al. 2012; Van Blerk 2011). Additionally, although most were unable to, some created distance within their setting, for example by moving in with boyfriends and working in a different location. Accordingly, the advantages of concealment were made available dependent upon access to resources to successfully separate lives and provide convincing cover stories, for example, creating false careers (Tomura 2009) or relying on alternative roles in their employment history (Trautner and Collett 2010). One participant aptly explained her ability to utilise multiple identities:

> In the publishing world, I'm a writer ass-deep in scholarly S&M research. To my parents, I'm a dutiful daughter and semi-starving artist… to the schoolchildren of three counties…I am Barkley, the Smart Dog. (Levey and Pinsky 2015, 357)

Similarly, some studies highlighted how women could more effectively hide their work when working in private rather than in visible settings (Maticka-Tyndale et al. 2000; Phrasisombath et al. 2012). However, in one study, although the entire community was aware of or involved in sex work, they participated in a corporate denial of the work, for example never mentioning the work and "pretend[ing] we are not selling" when in bars with clients (Campbell 2000, 489). Accordingly, they preserved a sense of dignity and order, demonstrating effective negotiation of stigmatised positions.

Consequences of hiding

Concealing work protected women from the discrimination, maltreatment and judgment threatened by disclosure, enabling them to participate in mainstream society and maintain relationships. However, there were disadvantages. Several studies emphasised the fear and anxiety resulting from women's continual vigilance in guarding themselves against exposure, and their awareness of the fragility of separating worlds (Maticka-Tyndale et al. 2000; Tomura 2009). Additionally, separating worlds prevented full participation in either, and occasionally had costs in work, for example by missing shifts to avoid meeting acquaintances (Trautner and Collett 2010). However, one participant identified advantages of occupying two worlds, in providing perspectives of life from society's centre and margins:

> I … like margins but I like the centre too… I am glad to be in the margins…we are original, unique and special. There is a good part to oppression. You get stronger, you can see things more clearly, and you develop strategies. (Tomura 2009, 75)

Another difficulty concerned lying:

> [My kids] are starting to ask where I go every night... I'm starting to have problems in lying to them because they are starting to understand things better, and one day when they are older [they] might come and say "Mom, why didn't you tell the truth?" (Cox et al. 2012, 1471)

Managing information, environments and relationships to maintain the lie was difficult, as was going against personal values such as trust (Cox et al. 2012; Tomura 2009; Uddin and Ashrafun 2011). Furthermore, avoidance compromised people's physical health (Basnyat 2014; Uddin and Ashrafun 2011); furthered social isolation (Jackson et al. 2007; Ngo et al. 2007; Sallman 2010; Tomura 2009; Uddin and Ashrafun 2011); and led to unwanted life changes, such as leaving college and relocating (Jackson et al. 2007; Trautner and Collett 2010).

Women worked hard to prevent people knowing about their involvement in sex work, with some detrimental consequences. However, despite threats to both physical and mental health, protecting themselves from the perceived risk of exposing their occupation and therefore maintaining a respectable place in wider society, was considered worth it.

Theme two: Coping through distancing: 'I do sex work but it's not me'

Women also coped with stigma by distancing their identities from sex work, emphasising it is something they do, not who they are.

Working out of necessity

Eight studies presented women distancing themselves from sex work through narratives justifying their involvement, thus minimising stigma's impact on them (Basnyat

2014; Campbell 2000; Jackson et al. 2007; Maticka-Tyndale et al. 2000; Ngo et al. 2007; Sallman 2010; Uddin and Ashrafun 2011; Wong et al. 2011). Some explained how they were forced into sex work through sharing accounts of coercion, trickery, and desperation, or highlighting a failure of the police and state to support them. Similarly, many emphasised they worked due to financial need, lack of alternatives, and entrapment:

> Everywhere there is struggle and hardships... You get called vulgar names like "whore", fingers are pointed at you, people disapprove, you get treated differently, but this is all because you have no option. But to survive, you do what you can to survive. (Basnyat 2014, 1047)

Sex work was thus firmly situated within a context of poverty; involvement was indicative of their situation, not them personally.

Furthermore, some women presented sex work as temporary, highlighting plans to return to something more representative of their character in the future, for example:

> I would like to stop this business and have my own work. One day I would like to have my own shop where I sell nice things but I first have to pay my debt. (Van Blerk 2011, 227)

Although hopes of another easier life often seemed idealistic and ambiguous, e.g., "I want to go home but I do not want to go home" (Campbell 2000, 490), framing work as a necessary but temporary occupation enabled women to distance themselves from it, aligning themselves with dominant views of sex work instead. Accordingly, Campbell argued how by deliberately constructing themselves as "victims of fate" (25), women removed accountability for their work. However, it presented difficulties for some regarding the incongruence of doing something of which they disapproved:

> I do this work only to feed my … children ... if I get a safe and sound economic opportunity I shall stop this irreligious work ... Blood of pain is oozing from my heart

> … I can't compensate it by any means ... Oh! Allah, forgive me for the sake of my children. (Uddin and Ashrafun 2011, 28)

Here, even economic necessity was not sufficient to excuse sex work, causing great shame. Shame was possibly accentuated in this study by the strong sense of religiosity held by participants and society, meaning sex work represented a greater violation of their values. Maticka-Tyndale et al. (2000) and Wong et al. (2011) also reported that the adoption of cultural and religious views increased stigma's impact. In contrast, although facing similar hardships, in Basnyat's (2014) study, emphasising the necessity of sex work enabled participants to accept it as a legitimate occupation for which they felt no shame. Accordingly, they rejected society and its stigma to focus on the more important task of surviving, reflecting resistance and taking control of one's life, one reasoning, "Why worry about a society that doesn't worry about you?" (Basnyat 2014, 1047).

Rejecting society enabled others to fully embrace their sex work identity and lifestyle:

> I have no time to think about life, whether I am good or bad…My life is entangled with enjoying ganja, doing sex work and earning money. (Uddin and Ashrafun 2011, 34)

Morality was presented as irrelevant as this participant immersed herself in work and leisure. Her use of drugs however, was perhaps a means to cope with the pain of the work, mirroring findings from Maticka-Tyndale et al.'s (2000) study, whereby women used alcohol to dull the reality of stigma.

Separating 'work me' and the 'real me'

Another means of distancing was by separating 'sex worker' and 'real' selves (Levey and Pinsky 2015; Maticka-Tyndale et al. 2000; Trautner and Collett 2010). Women did so by using various devices such as performing at work; drinking alcohol 'to bring out the other character' (Maticka-Tyndale et al. 2000, 102), and dressing differently:

> I look like a bum when I go to school. I spend a lot of time getting ready for work. I fix my hair, wear lots of makeup, and wear sexy, revealing clothing. (Trautner and Collett 2010, 268)

Women thus developed a separate work persona, often assisted through make-up, wigs, and stage names. This strategy also facilitated switching off from work and concealing their profession, but for some, threatened the integrity of the self:

> I turn into a totally different personality … it's getting to the point that it's really hard to find Jane again. I'm becoming this other person completely. (Maticka-Tyndale et al. 2000, 101)

Differing from narratives of necessity which associated sex work with limited choices, role distancing was employed in studies involving exotic dancers and dominatrices, perhaps reflecting their agency and the performance inherent in their work.

Appealing to alternative identities

Women also emphasised alternative identities offering a truer, more socially acceptable representation of themselves, for example, emphasising the dissonance between sex work and their origins:

> …it is not the education that my mother gave to me. These are not the values she taught me during my childhood, and this is not the life she expected for me. (Cox et al. 2012, 1471)

Additionally, they highlighted their role in providing for their families:

> I have to support my father, I have to support my mother, I have to support my children, I have to support my family. (Basnyat 2014, 1044)

Emphasising motherhood enabled women to meet prescribed female norms and expectations, protecting themselves from the full force of stigma attached to deviant women. Furthermore, demonstrating they chose the “heavy sacrifice” of sex work in order to “remain active mothers to their children" (Cox et al. 2012, 1472) meant their maternal identity subsumed their sex worker identity. Similarly, in one study women drew strongly upon their student role to decrease the salience of their sex worker identity: "school is and always has been my top priority" (Trautner and Collett 2010, 267), made easier by them being less dependent on work and choosing it as an optimum source of additional funds. Accordingly, this strategy was more available to those with access to other roles on which to base their self-worth, demonstrating the impact of privilege on guarding against discrimination.

For many women, asserting that sex work did not represent their true selves preserved their self-esteem by aligning themselves with acceptable views of sex work. However, the dissonance this created was problematic for some women in internalising stigma and creating a disrupted identity.

Theme three: Coping through defending: 'I do sex work but it's not that bad'

Women also attempted to cope through collapsing the dichotomy between sex workers and others, thus including themselves within 'normal' society. They did this by defending sex work to show how it was not as bad as people thought, indicating others were worse that they realised, and highlighting the similarities between them.

Asserting the benefits of sex work

Women often defended sex work by presenting its personal benefits. Specifically, they emphasised financial gains to convince others of its worth (Tomura 2009); to dismiss stigma: "you should laugh at the poor not the prostitute" (Wong et al., 2011, 57), and to demonstrate superiority:

> I will have money or things to show for my efforts… I can wear expensive clothes and use a good mobile phone. Then people will never look down on me. (Phrasisombath et al. 2012, 6)

Personal benefits also included providing motivation to work hard (Trautner and Collett 2010), increasing confidence, and offering enjoyment and freedom:

> I'm happy to trade off on the ignorant public perception that I'm a deviant if it means I can earn a living, provide for my family and have fun while I'm at it. (Levey and Pinsky 2015, 361)

However, such attitudes were rare where sex work was presented as a necessity (e.g. Basnyat 2014).

Furthermore, participants extolled wider virtues of sex work (Levey and Pinsky 2015; Tomura 2009; Wong et al. 2011), asserting emotional and sexual benefits to clients (Tomura 2009); arguing it relieved stress and reduced the likelihood of rape (Wong et al. 2011); presenting it as artistic and beautiful (Levey and Pinsky 2015), and as enabling marginalised people to "explore their fetishes and sexual fantasies" (Levey and Pinsky 2015, 361). Accordingly, aligning sex work with widely accepted values aimed to increase its social credibility.

Comparative judgments

Women also raised their profile by arguing they were not as bad as others. They drew attention to more dishonest means of money-making to gain a sense of comparative morality and respectability:

> Our profession is better than other nasty professions such as pocket picking, kidnapping, killing or murdering. (Uddin and Ashrafun 2011, 33)

Participants in three studies also highlighted their superiority to other sex workers (Levey and Pinsky 2015; Tomura 2009; Trautner and Collett 2010), for example, asserting the difference between a dominatrix and sex worker:

> …quite a lot of them are basically… sex workers with a kink… they're havin' intercourse, everything. . . If you're a dominatrix, it's some sort of … honorable thing that you're not having intercourse. (Levey and Pinsky 2015, 359)

Asserting firm boundaries thus increased confidence through maintaining control and dignity, also found in Van Blerk's (2011) study, and enabled women to align themselves with wider society by distancing themselves from less respectable forms of sex work. As one participant summarised: "Whores have this thing, 'You are more of a whore'" (Tomura 2009, 74). However, in protecting themselves from stigma, women simply enlarged the remit of respectable society to include them, still leaving 'lesser' sex workers in the outer circle, thus reinforcing wider stigma. Additionally, this strategy was only used by women working as escorts or dominatrices, and not others such as street workers, from which this distancing strategy drew their comparison.

A similar comparison related to competition between workers (Campbell 2000, Van Blerk 2011). Some participants, for example, identified being among the elite at work, gaining additional privileges:

> I am a young, beautiful and attractive girl. Clients are very lucky to have sex with me. My owner indulges me because I can attract a lot of well-paying clients. (Ngo et al. 2007, 566)

This elevated position contrasted with their lowly position in society - they were 'big fish in a little pond', thus increasing their confidence and self-esteem.

However, others found comfort and friendship with similar women, creating "micro-communities of respect and support" (Van Blerk 2011, 227). This provided reassurance and a sense of comradery in the context of societal neglect:

> …one person was hospitalised for three months after getting a beating when she was arrested… I went around asking people to chip in … so that we could help her. She is, after all, like me. (Basnyat 2014, 1048)

Such communities provided alternative places of belonging from which to draw acceptance and self-worth, particularly for those with limited options for finding this outside of work due to living at work (Campbell 2000; Van Blerk 2011), or being rejected by friends and family (Basnyat 2014; Uddin and Ashrafun 2011).

Highlighting similarities

Another approach involved demonstrating likeness to non-sex workers, for example:

> I'm a normal person. I go to the movies. If you saw me walking down the street, you'd never imagine… (Levey and Pinsky 2015, 360)

Similarly, women corrected misconceptions about sex work:

> They think I have a huge sex drive … I don't want to fuck just anybody. I am fucking them for money! (Tomura 2009, 73)

Asserting they were not deviant or over-sexualised sought to reduce judgment towards them.

Women also drew parallels between their behaviour and that of socially acceptable others, for example discussing sex within normal relationships:

> … a lot of housewives are prostitutes…they spread their legs when they'd rather not. To keep the peace, to…keep their credit card going…who knows why but they do it too. (Sallman 2010, 155)

Through such arguments, women revealed the fragility of the barriers stigma placed between normal society and sex work, undermining the basis for social rejection and increasing their sense of respectability.

Criticising stigmatising attitudes

Finally, some sought equality through emphasising the flaws of stigmatising others, particularly highlighting the inequality of how female workers, but not male clients, are stigmatised by sex work:

> …it's a double standard…men can go out, get high, and do what they want with women, and it's accepted. But if a woman goes out, gets high, and screws five men to get what she needs … then she a ho. (Sallman 2010, 155)

This strategy enabled women to identify themselves with women generally, sharing experiences of gender discrimination (Sallman, 2010). Similarly, some emphasised the immorality of a society that simultaneously neglects and criticises sex workers:

> I don't understand why some people look at us so harshly…society will not feed me. So people should not hate our work or bother us. (Uddin and Ashrafun 2011, 34)

In critiquing stigmatising attitudes and those propagating them, women resisted their devalued status, discrediting stigma and reducing its internalisation. Defending sex work also demonstrated confidence and intellect, dismissing portrayals of women as passive and ignorant (Tomura 2009). However, one participant admitted how adopting a defensive stance prohibited her from addressing negative aspects of work:

> I know my resistance to talking about pitfalls comes from society saying, "You are bad", so I have to say, "No, I'm not". (Tomura 2009, 71)

Thus, asserting equality potentially prevented help-seeking regarding sex work's challenges.

Discussion

The present review synthesised qualitative findings regarding ways sex-working women cope with its stigma, identifying three types of strategies, whereby they denied, distanced themselves from, or defended their involvement.

As found previously among those with a concealable identity, disengagement strategies involving hiding and avoiding (theme one) often had detrimental consequences, including isolation; anxiety; stress in managing a double life, and healthcare avoidance (Bockting et al 2013; Chambers et al. 2015; Kelly 2005; Koken 2011; Pachankis 2007). Interestingly, though some felt considerable shame, concealment was often purely pragmatic and did not reflect personal views, differing from an understanding that secrecy necessarily infers shame (Lewis 1998).

Despite disadvantages, denying sex work involvement also benefited women by minimising enacted stigma; limiting discrimination, and protecting and maintaining relationships, contrasting with previous findings that emphasise the harm concealment causes (Beals, Peplau and Gable 2009; Link, Mirotznik and Cullen 1991; Pachankis, 2007). Accordingly, consequences were mixed, as found in a review of HIV stigma (Chambers et al. 2015), resulting in women weighing up costs and benefits, and utilising selective concealment (Quinn and Chaudoir 2009) to achieve the best perceived outcome.

Distancing strategies (theme two) correspond largely with wider stigma literature (Crocker 1999; Kadianaki 2014). The protective benefit of emphasising alternative identities affirms claims that the more central a stigmatised identity is to one’s core identity, the greater distress and internalisation of stigma (Quinn and Chaudoir 2009). Additionally, justificatory narratives regarding sex work involvement parallel those used by other groups such as obese individuals (Puhl and Brown 2003). The use of such strategies may provide some explanation for the proliferation of the victim discourse of sex workers generally (Vanwesenbeeck, 2001). However, there is a risk that interpreting personal narratives as “rationalised defences” rather than “real reasons” (Puhl and Brown 2003, 61) may ignore women’s difficulties, leading to them being treated with suspicion.

Attempts to defend sex work (theme three) involved strategies identified elsewhere, including making social comparisons (Kalemi et al. 2017); attributing stigma to negative attitudes (Crocker and Major 1989), and asserting normality (Miller and Kaiser 2001). Another common strategy involves devaluing domains upon which stigma is based, for example academic achievement (Miller and Kaiser 2001), but was not apparent here, possibly due to the centrality of the domains sex work is judged upon, such as morality and sexuality. Women did however emphasise sex work's benefits within more acceptable domains such as financial gain and social contributions, found with other stigmas, such as chronic illness (Park 2010). Additionally, in-group comparisons inadvertently reinforced stigma, as elsewhere (Puhl and Brownell 2003; Thoits 2011), strengthening hierarchical sex work structures (Weitzer 2009).

Despite parallels, findings departed from existing stigma research in the absence of engagement coping strategies such as utilising education and confrontation to challenge stigma beyond immediate friends and family. This may relate to the scientific knowledge available for educating about HIV, for example, in contrast to greater subjectivity regarding sex work. Similarly, women did not mobilise for collective action, contrasting with broader stigma literature whereby people unite to strengthen identity pride and promote social change (Hejnders and Van Der Meij 2006). However, evidence exists of sex workers uniting elsewhere, for example, community mobilisation initiatives to prevent HIV/AIDS (Murray et al. 2010) and organisations such as 'The English Collective for Prostitutes' (prostitutescollective.net). Lack of involvement here may reflect studies' focus on individual coping, or result from limited access to skills and resources necessary for participation, such as the internet; the prioritisation of immediate survival, or the criminalised nature of sex work limiting collective organisation (Sanders 2004).

Also notable was the lack of emotional regulation and expression that features in wider stigma literature (Miller and Kaiser 2001; Mizock and Mueser 2014). Although women reported sadness, shame, anger and anxiety, they did not describe attempts to manage these feelings. Furthermore, alcohol and drug use, widely identified as coping strategies among sex workers (Sanders 2004), were only mentioned twice. This may reflect a lack of emotional coping resources, or indicate they were missed due to a focus on stigma rather than general coping or a recent emphasis on identity management in stigma coping literature (Pachankis 2007).

Power and resilience

An important finding was how specific coping strategies were differentially available to women dependent on power and access to resources. This often related to work setting, for example, those in well managed clubs generally possessed greater power than those on the streets. Women possessing greater power, demonstrated by choice and control within work and receipt of more tangible benefits, were more likely to cope by successfully maintaining separate lives; drawing from alternative identities, or defending their work. Those possessing less power were more likely to justify their involvement or accept stigma. This corresponds with Link and Phelan’s (2001) assertion that stigma is dependent upon access to social, economic or political power. Accordingly, the impact of power identified here highlights a need to move beyond reviewing costs and benefits of individual stigma responses to addressing structural inequalities and the location of power in stigmatisation (Holley, Stromwall and Bashor 2012; Kadianaki 2014).

Importantly, the relationship between power and stigma-coping was not straightforward as some women resisted stigma, acquiring a sense of control despite desperate circumstances, thus highlighting their resilience in terms of ‘internal resources that enhance coping' (Mizock and Mueser 2014). Accordingly, more nuanced explanations of the resources people use despite their disadvantage are needed (Moser 1998).

Further research and limitations

Further research could extend findings by considering the impact of power on sex workers' stigma experiences and how they exert agency within this. Similarly, gaining a better understanding regarding factors influencing collective mobilisation and action could identify women's access to such strategies and their usefulness within this context.

Additionally, investigating emotional management of sex work stigma could further identify related needs and strengths. Finally, women reported a permanence to the sex worker identity, in that they experienced others viewing them as sex-workers even when no longer working. Accordingly, it would be important to explore how women manage stigma's effects post-sex work, including efforts to rebuild relationships; regain acceptance, and strengthen new identities. This could identify means of supporting women who feel unable to exit sex work due to stigma.

A limitation of the review was that by focussing solely on stigma coping, strategies may have been missed that original authors did not identify as such. Similarly, it did not account for women not experiencing sex work stigma nor finding it problematic, potentially providing a skewed account of women's experiences. Additionally, focussing on women excluded the experiences from male or transgender sex workers, potentially facing double stigma due to gender identity or sexuality (Infante, Sosa-Rubi and Cuadra 2009). Accordingly, further reviews might identify and compare coping strategies between these groups. Additionally, studies included reflected considerable cultural heterogeneity. Whilst this demonstrates the international nature of sex work and highlighted the diverse strategies used dependent on factors such as type of work and religious or cultural norms, it limits the generalisability of the findings to the UK setting. Clinical application must therefore take this into consideration and practitioners must be mindful of how cultural factors may impact women's attempts to cope. Finally, studies varied in quality, particularly highlighting a need for greater reflexivity and transparency regarding data analysis in qualitative studies of sex work.

Clinical Implications

An understanding of how women cope with sex work stigma, presented in this review, can benefit clinical psychologists and others working directly with sex workers. Fearing discrimination, women may hide their occupation within generic services or emphasise powerlessness in order to avoid judgment for their work. Furthermore, defending sex work may hide difficulties women for which women need support. Recognising such possibilities and responding sensitively may limit professionals inadvertently reinforcing stigma and enable them to offer appropriate support.

Given the impact of individual resilience, direct interventions must recognise and build upon women's existing resources. Specifically, collaboratively developing coping strategies, such as identifying supportive people to disclose to, may reduce psychological distress (Pachankis 2007). Cognitive Behavioural Therapy has been identified as an effective strategy for dealing with the consequences of self-stigma (Corrigan and Calabrese 2005) and may be beneficial, for example, in understanding how avoidance maintains distress. Additionally, findings indicate a need regarding emotional management. Whilst multiple relevant approaches exist, for example self-help materials or teaching groups, Compassion Focussed Therapy (Gilbert 2009) is particularly relevant, given its emphasis on shame and self-criticism. This may be especially useful for those internalising stigma, perhaps due to cultural factors, or when doubly stigmatised by others within the sex industry.

Experience of discrimination and fears of it occurring present barriers to sex-working women accessing mainstream services, reported here and elsewhere (Sanders 2004;

Stevenson and Petrak 2007). One response to overcome this is to integrate psychological provision within specialist services or sex worker organisations. Additionally, generic services must increase accessibility to sex workers. This can be facilitated through training about sex work, its diversity, and related psychological experiences, led by or involving sex workers. Furthermore, professionals may have “blind spots” regarding discriminatory practices (Crawford and Brown 2002, 358). Enabling recognition of professionals’ prejudicial attitudes and emotional responses towards sex work is therefore essential, for example through clinical supervision. Improving accessibility also involves addressing power, given its impact on coping. One practical means of doing so is power mapping (Hagan and Smail 1997) with sex workers to facilitate transparent conversations about where power lies; consider its impact on services, and support sex workers to increase their power to challenge stigma, individually and collectively.

Conclusion

The present review is the first to synthesise qualitative findings regarding sex work stigma coping, contributing to existing understandings of managing concealable stigmas, and of sex workers’ needs and resources. Its particular strengths were in representing the diversity and international nature of sex work, furthering individual studies’ findings by emphasising the impact of power and resilience in stigma coping. Findings have implications for the content and delivery of psychological support for sex workers, in order to empower women to cope with stigma whilst promoting change that decreases their marginalisation.

References

Abel, G. 2011. Different stage, different performance: The protective strategy of role play on emotional health in sex work. *Social Science & Medicine* 72 (7): 1177-1184.

Allison, K. W. 1998. Stress and oppressed category membership. In *Prejudice: The target's perspective*, ed. by J. K. Swim and C. Stangor, 145–70. San Diego, CA: Academic Press.

Baldwin, M. A. 1992. Split at the root: Prostitution and feminist discourse of law reform. *Yale Journal of Law and Feminism* 5: 47-120.

Basnyat, I. 2014. Lived experiences of street-based female sex workers in Kathmandu: implications for health intervention strategies. *Culture, Health and Sexuality* 16 (9): 1040–1051.

Basu, A., and M. Dutta. 2009. Sex workers and HIV/AIDS: Analyzing participatory culture-centered health communication strategies. *Human Communication Research* 35: 86–114.

Basynat, I. (2017). Structural Violence in Health Care: Lived Experience of Street-Based Female Commercial Sex Workers in Kathmandu. *Qualitative Health Research* 27 (2): 191–203.

Beals, K. P., L. A. Peplau, and S. L. Gable. 2009. Stigma management and well-being: The role of social support, cognitive processing, and suppression. *Personality and Social Psychology Bulletin* 35 (7): 867-879.

Begum, S., J. Hocking, J. Groves, C. Fairley, and L. Keogh. 2013. Sex Workers Talk about Sex Work: Six Contradictory Characteristics of Legalised Sex Work in Melbourne, Australia. *Culture Health and Sexuality* 15 (1): 85–100.

Bockting, W. O., M. H. Miner, R. E. Swinburne Romine, A. Hamilton, and E. Coleman. 2013. Stigma, mental health, and resilience among an online sample of the U.S.

transgender population. *American Journal of Public Health* 103: 943–951.

Britten, N., R. Campbell, C. Pope, J. Donovan, M. Morgan, and R. Pill. 2002. Using meta-ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research & Policy* 7(4): 209-215.

Campbell, C. 2000. Selling sex in the time of AIDS: The psycho-social context of condom use by sex workers on a Southern African mine. *Social science & medicine,* 50 (4): 479-494.

Chambers, L. A., S. Rueda, D. N. Baker, M. G. Wilson, R. Deutsch, E. Raeifar, S. B. Rourke, and The Stigma Review Team. 2015. Stigma, HIV and health: A qualitative synthesis. *BMC Public Health* 15: 1-17.

Chapkis, W. 2003. Trafficking, migration, and the law: P*rotecting innocents, punishing immigrants. Gender and Society* 17 (6): 923-937.

Church, S., M. Henderson, M. Barnard, and G. Hart. 2001. Violence by clients towards female prostitutes in different work settings: Questionnaire survey. *British Medical Journal* 322: 524–5.

Clark, R., N. B. Anderson, V. R. Clark, D. R. Williams. 1999. Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist* 54: 805–16.

Contrada, R.J., R. D. Ashmore, M. L. Gary, E. Coups, J. D. Egeth, A. Sewell, K. Ewell, T. M. Goyal, and V. Chasse. 2001. Measures of ethnicity- related stress: Psychometric properties, ethnic group differences, and associations with well-being. *Journal of Applied Social Psychology* 31: 1775– 820.

Corrigan, P.W., and J. D. Calabrese. 2005. Strategies for assessing and diminishing self-stigma. In *On the stigma of mental illness: Practical strategies for research and social change,* ed. by P.W. Corrigan, 239–256. Washington, DC: American Psychological Association.

Cox, K. S., A. M. Casablanca, and D. P. McAdams. 2013. “There is nothing good about this work”: Identity and unhappiness among Nicaraguan female sex workers. *Journal of Happiness Studies* 14: 1459–1478.

Crawford, P., and B. Brown. 2002. Like a friend going round: Reducing the stigma attached to mental healthcare in rural communities. *Health and Social Care in the Community* 10, 229–238.

Critical Appraisal Skills Programme. 2013. *Qualitative research checklist 2013: 10 questions to help you make sense of qualitative research.* http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf. Accessed July 14th 2017.

Crocker J. 1999. Social stigma and self-esteem: Situational construction of self-worth. *Journal of Experimental Social Psychology* 35: 89–107.

Crocker J., and B. Major. 1989. Social stigma and self-esteem: The self-protective properties of stigma. *Psychology Review* 96: 608–630.

Crocker J., B. Major, and C. Steele. 1998. Social stigma. In *Handbook of Social Psychology*, ed. by S. Fiske, D. Gilbert, and G. Lindzey, vol. 2, 504–53. Boston, MA: McGraw-Hill.

Davis, N. J. 2000. *From victims to survivors: Working with recovering street prostitutes. In Sex for sale: Prostitution, pornography, and the sex industry*, ed. by R. Weitzer, 139-155. New York: Routledge.

Dixon-Woods M., S. Bonas, A. Booth, D. R. Jones, T. Miller, A. J. Sutton, R. L. Shaw, J. A. Smith, and B. Young. 2006. How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research* 6 (1): 27-44.

Dodsworth, J. 2011. Pathways through sex work: Childhood experiences and adult identities. *British Journal of Social Work* 42(3): 1-18.

Dodsworth, J. 2012. Pathways through sex work: childhood experiences and adult identities. *British Journal of Social Work* 42 (3): 519-536.

Duggleby W., L. Holtslander, J. Kylma, V. Duncan, C. Hammond, and A. Williams. 2010. Metasynthesis of the hope experience of family caregivers of persons with chronic illness. *Qualitative Health Research* 20 (2):148-158.

Field, P. A., & Marck, P. B. (1994). *Uncertain motherhood: Negotiating the risks of the childbearing years.* Thousand Oaks, CA: Sage.

Finfgeld, D. 2003. Metasynthesis: The state of the art so far. *Qualitative Health Research* 13: 893–904.

Gallagher Tuleya, L. 2007. *Thesaurus of psychological index terms*. 11th ed. Washington, DC: American Psychological Association.

Gilbert, P. 2009. Introducing compassion-focused therapy. *Advances in Psychiatric Treatment* 15 (3): 199-208.

Goffman, E. (1968). *Stigma: Notes on the management of spoiled identity*. Harmondsworth: Penguin.

Gorry, J., K. Roen, and J. Reilly. 2010. Selling your self? The psychological impact of street sex work and factors affecting support seeking. *Health and Social Care in the Community* 18 (5): 492–499.

Greene, K., V. J. Derlega, G. A. Yep, and S. Petronio. 2003. *Privacy and disclosure of HIV in interpersonal relationships: A sourcebook for researchers and practitioners.* Mahwah, NJ: Erlbaum.

Hagan, T., and D. Smail. 1997. Power-mapping—I: Background and basic methodology. *Journal of Community and Applied Social Psychology* 7: 257–267.

Heijnders, M., and S. Van Der Meij. 2006. The fight against stigma: An overview of stigma-reduction strategies and interventions. *Psychology, Health and Medicine* 11 (3): 353-363.

Holley, L. C., L. K. Stromwall, and K. E. Bashor. 2012. Reconceptualizing stigma: Toward a critical anti-oppression paradigm. *Stigma Research and Action* 2 (2): 51-61.

Holroyd, E., W. C. W. Wong, A. Sr. Gray, and D. C. Ling. 2008. Environmental health and safety of Chinese sex workers: A cross-sectional study. *International Journal of Nursing Studies* 45 (6): 932–41.

Infante, C. S. G. Sosa-Rubi, and M. Cuadra. 2009. Sex work in Mexico: Vulnerability of male, *travesti*, transgender and transsexual sex workers. *Culture, Health and Sexuality* 11 (2): 125-137.

Jackson, L. A. 1996. Female prostitutes in North America: What are their risks of HIV infection? In *AIDS as a gender issue: Psychosocial perspectives*, ed. by L. Sherr, C. Hankins, and L. Bennett, 149-162. Philadelphia, PA, US: Taylor & Francis.

Jackson, L. A., C. G. Bennett, and B. A. Sowinski. 2007. Stress in the sex trade and beyond: Women working in the sex trade talk about the emotional stressors in their working and home lives. *Critical Public Health* 17 (3): 257–271.

Jensen, L. A., & Allen, M. N. (1994). A synthesis of qualitative research on wellness-illness. *Qualitative Health Research, 4,* 349-369.

Jones, L. 2014. *An exploration of coping in sex work*. DClinPsy., Lancaster University.

Kadianaki, I. 2014. The transformative effects of stigma: Coping strategies as meaning-making efforts for immigrants living in Greece. *Journal of Community and Applied Social Psychology* 24: 125–138.

Kalemi, G., S. Gkioka, P. Tsapatsari, G. Tzeferakos, T. Kandri, M. L. Psarra, F. Konstantopoulou, and A. Douzenis. 2017. Stigma and self-esteem: A case of HIV-positive sex-workers. *Psychiatriki* 28: 67–74.

Kelly, B. D. 2005. Structural violence and schizophrenia. *Social Science and Medicine* 61: 721–30.

Koken, J. A. 2012. Independent female escort’s strategies for coping with sex work related stigma. *Sexuality and Culture* 16 (3): 209-229.

Lavin, M. F. 2017. She got herself there: Narrative resistance in the drug discourse of strippers. *Deviant Behavior* 38 (3): 294-305.

Lazarus, L., K. N. Deering, R. Nabess, K. Gibson, M. W. Tyndall, and K. Shannon. 2012. Occupational stigma as a primary barrier to health care for street-based sex workers in Canada. *Culture, Health & Sexuality 14*: 139–150.

Lazarus, R. S., and S. Folkman. 1984. *Stress, appraisal, and coping*. New York: Springer-Verlag.

Lewis, M. 1998. Shame and stigma. In *Shame: Interpersonal behaviour, psychopathology and culture*, ed. by P. Gilbert and B. Andrews, 126-140. Oxford: Oxford University Press.

Lewis, R. J., V. J. Derlega, J. L. Griffin, and A. C. Krowinski. 2003. Stressors for gay men and lesbians: Life stress, gay-related stress, stigma consciousness, and depressive symptoms. *Journal of Social Clinical Psychology* 22: 716–29.

Link, B. G., and J. C. Phelan. 2001. Conceptualizing stigma. *Annual Review of Sociology* 27: 363–85.

Major, B., and L. T. O’Brien. 2005. The social psychology of stigma. *Annual Review of Psychology* 56: 393–421.

Malpass, A., A. Shaw, D. Sharp, F. Walter, G. Feder, M. Ridd, and D. Kessler. 2009. “Medication career” or “moral career”? The two sides of managing antidepressants: A meta-ethnography of patients' experience of antidepressants. *Social Science and Medicine* 68 (1): 154–168.

Maticka-Tyndale, E., J. Lewis, J. P. Clark, J. Zubick, L. L. B., and S. Young. 2000. Exotic dancing and health. *Women and Health* 31 (1): 87-108.

Miller, C. T., and B. Major. 2000. Coping with stigma and prejudice. In *The social psychology of stigma,* ed. by T. F. Heatherton, R. E. Kleck, M. R. Hebl, and J. G. Hull, 243–272. New York: Guilford.

Miller, C. T., and C. R. Kaiser. 2001. A theoretical perspective on coping with stigma. *Journal of Social Issues* 57: 73–92.

Mizock, L., and K. T. Mueser. 2014. Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. *Psychology of Sexual Orientation and Gender Diversity* 1 (2): 146–158.

Moser, C. 1998. The asset vulnerability framework: Reassessing urban poverty reduction strategies. *World Development* 26 (1): 1-19.

Murray, L. R., S. A. Lippman, A. A. Donini, and D. Kerrigan. 2010. "She's a professional like anyone else": Social identity among Brazilian sex workers. *Culture, Health and Sexuality* 12 (3): 293–306.

Ngo, A. D., S. A. McCurdy, M. W. Ross, C. Markham, E. A. Ratliff, and H. T. B. Pham. 2007. The lives of female sex workers in Vietnam: Findings from a qualitative study. *Culture, Health and Sexuality* 9 (6): 555–570.

Noblit, G.W, and R. D. Hare. 1988. *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park: Sage.

Overs, C. 2002. *Sex workers: Part of the solution. An analysis of HIV prevention programming to prevent HIV transmission during commercial sex in developing countries,* 1-41. http://www.who.int/hiv/topics/vct/sw_toolkit/115solution.pdf

Pachankis, J. E. 2007. The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin* 133: 328–345.

Park, C. L. 2010. Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin* 136: 257–301.

Paterson, B. L., S. E. Thorne, C. Canam, and C. Jillings. 2001. *Meta-study of qualitative health research: A practical guide to meta-analysis and metasynthesis*. Thousand Oaks, CA: Sage.

Petro, M. 2010. Selling sex: Women's participation in the sex industry. In *Sex work matters,* ed. by M. H. Ditmore, A. Levy, and A. Willman, 155-169. London: Zed Books.

Pheterson, G. 1993. The whore stigma: Female dishonor and male unworthiness. *Social Text* 37: 39-64.

Phrasisombath, K. E. Faxelid, V. Sychareun, and S. Thomsen, S. 2012. Risks, benefits and survival strategies-views from female sex workers in Savannakhet, Laos. *BMC Public Health* 12: 1-12.

Puhl, R. M., Brownell, K. D. 2003. Ways of coping with obesity stigma: Conceptual review and analysis. *Eating Behaviours* 4: 53–78.

Quinn, D. M, and S. R. Chaudoir. 2009. Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology* 97: 634–651.

Quinn, D. M., and V. A. Ernshaw. 2013. Concealable stigmatized identities and psychological well-being. *Social and Personality Psychology Compass* 7 (1): 40–51.

Rossler, K. U., C. Lauber. A-K. Hass, M. Altwegg, V. Ajdacic-Gross, and K. Landolt. 2010. The mental health of female sex workers. *ACTA Psyciatrica Scandiavica:* 1-10.

Rubin, G. 1992. Thinking sex: Notes for a radical theory of the politics of sexuality. In

Pleasure and danger: Exploring female sexuality, ed. by C. S. Vance, 143-179. London: Pandora.

Ruggiero, K.M., and D. M. Taylor. 1997. Why minority group members perceive or do not perceive the discrimination that confronts them: The role of self-esteem and perceived control. *Journal of Personality and Social Psychology 72*: 373–389.

Sallman, J. 2010. Living with stigma: Women’s experiences of prostitution and substance use. *Journal of Women and Social Work* 25 (2): 146-159.

Sandelowski, M., J. Barroso, and C. I. Voils, C. 2007. Using qualitative metasummary to synthesize qualitative and quantitative descriptive findings. *Research in Nursing and Health* 30 (1): 99–111.

Sandelowski, M., S. Docherty, and C. Emden. 1997. Qualitative metasynthesis: Issues and techniques. *Research of Nursing Health* 20: 365–371.

Sanders, T. 2004. A continuum of risk? The management of health, physical and emotional risks by female sex workers. *Sociology of Health and Illness* 26: 557–74.

Sanders, T. 2008. *Paying for Pleasure: Men Who Buy Sex*. Willan: Devon

Scambler, G., and A. Hopkins. 1986. Being epileptic: Coming to terms with stigma. *Sociology of Health and Illness* 8: 26–43.

Shaw, R. L. 2012. Identifying and synthesising qualitative literature. In *Qualitative research in mental health and psychotherapy*, ed. by D. Harper and A. R. Thompson, 9-22. London: John Wiley & Sons.

Silcock, F. 2014. Uncovered: Stripping as an occupation. *Women’s Studies Journal* 28 (1): 68-73.

Smart, L., and D. M. Wegner, D. M. 1999. Covering up what can’t be seen: Concealable stigma and mental control. *Journal of Personality and Social Psychology* 77: 474–486.

Stevenson, C., and J. Petrak, J. 2007. Setting up a clinical psychology service for commercial sex workers. *International Journal of STD & AIDS* 18: 231–234.

Thoits, P. A. 2011. Resisting the stigma of mental illness. *Social Psychology Quarterly* 74: 6–28.

Tomura, M. 2009. A Prostitute's Lived Experiences of Stigma. *Journal of Phenomenological Psychology* 40: *51–84.*

Trautner, M. N., and J. L. Collett. 2010. Students who strip: the benefits of alternate identities for managing stigma. *Symbolic Interaction* 33 (2): 257–279.

Uddin, M. D. J., and L. Ashrafun. 2011. Daughters of the dark: A qualitative study of street-based sex workers in Bangladesh. Suomen Antropologi: *Journal of the Finnish Anthropological Society* 36 (3): 23-41.

Van Blerk, L. 2011. Negotiating boundaries: The sex work identities of 'bar girls' in Nazareth, Ethiopia. *Gender, Place & Culture* 18 (2): 217-233.

Vanwesenbeeck, I. 2001. Another decade of social scientific work on sex work: A review of research 1990-2000. *Annual Review of Sex Research* 12: 242-289.

Weine, S., A. Golobof, M. Bahromov, A. Kashuba, T. Kalandarov, J. Jonbekov, and S. Loue. 2013. Female migrant sex workers in Moscow: Gender and power factors and HIV risk. *Women and Health* 53 (1): 56-73.

Weitzer, R. 2009. Sociology of sex work. *Annual Review of Sociology* 35: 213–34.

Wong, W. C. W., E. Holroyd, E., and A. Bingham. 2011 Stigma and sex work from the perspective of female sex workers in Hong Kong. *Sociology of Health and Illness* 33 (1): 50–65.

Wright, S. C., D. M. Taylor, and F. M. Moghaddam. 1990. Responding to membership in a disadvantaged group: From acceptance to collective protest. *Journal of Personality and Social Psychology* 58 (6): 994-1003.

Figure Legends

Table 1: Search terms applied to each database

Figure 1: Diagrammatic representation of search procedure

Table 2: Methodological summary of included papers

Table 3: Quality appraisal of included review papers

Figure 2: Diagrammatic representation of themes

Table 1. Search terms applied to each database

Combined with AND	Search Terms
Sex work	“prostitution” or “sexual risk taking" or "sex industry" or “sex trade” or “street walk*” or "sell* sex" or brothel* or parlour* or strip* or escort* or "sex work*" or "exchang* sex" or prostitut*
Stigma	stigma or shame or discrimination or "social discrimination" or prejudice or "stereotyped attitudes" or stigma or prejudice or disapprov* or discriminat* or stereotype or label* or disgrace or disgust or judg* or reputation or shame or attitude
Qualitative*	qualitative or interview or “focus group” or “case stud*” or observ* or “grounded theory” or narrative or thematic or phenomenolog* or experience* or “content analysis” or ethnolog* or IPA or discourse

* Not used with Psychinfo and Psycharticles where a filter for qualitative research was utilised

Figure 1. Diagrammatic representation of search procedure

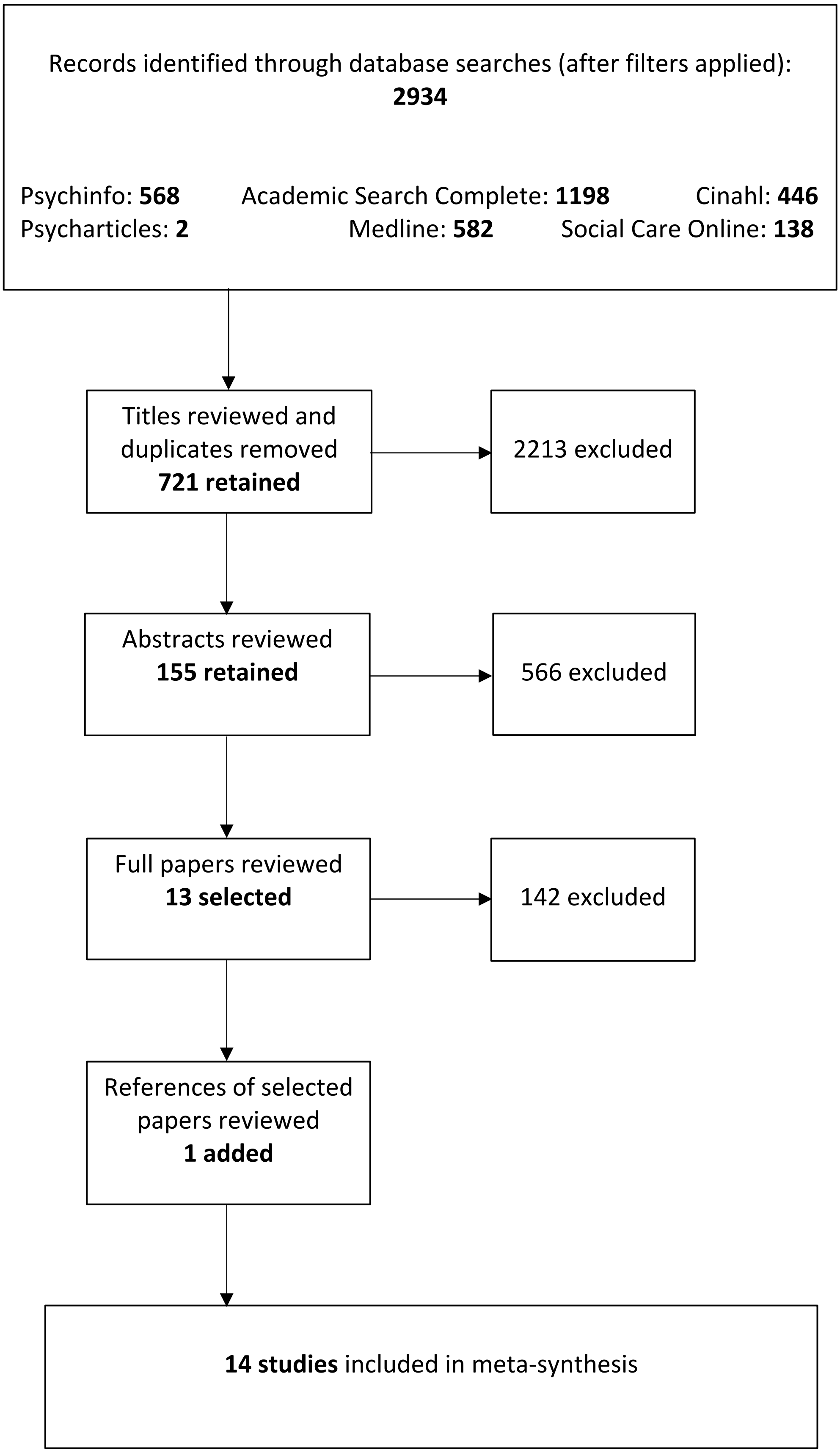


Table 2. Methodological summary of included papers

Author(s)	Year	Country	Stated Aims	Participants	Type/ Location of Sex Work	Data Collection	Data Analysis
Maticka-Tyndale et al.	2000	Canada	Examines health and safety from the perspective of the social organization of places of employment and the broader social context of exotic dancing.	30 women (aged 18-42)	Exotic dancing	Observations in 10 clubs; in depth interviews with dancers and club employees	Described triangulation of interview data with dancers and observations across work categories.
Campbell	2000	South Africa	To highlight factors which are likely to help or hinder the programme's goal of promoting condom use among commercial sex workers	21 women (aged 19-38)	Shacks attached to mining community	Interviews	Thematic analysis - not specified
Ngo et al.	2007	Vietnam	An examination of sex workers' social and economic lives, working environment, social relationships and presentation of self in everyday social contact and interaction to inform the development of more effective policies and interventions to reduce vulnerability to HIV/AIDS.	99 women (aged 16-45)	Venue based (e.g. dancing); streets; brothels	30 Interviews; 14 focus groups	Grounded theory

Jackson et al.	2007	Canada	To examine the emotional stressors in sex workers' lives	68 women (aged 19-48)	Street, escort services, other settings e.g. bars	Interviews	Thematic analysis
Tomura	2009	USA	To capture the fundamental nature of prostitutes subjective and often subtle psychological experience of stigma	1 woman (aged late 40s)	escort	Interview	IPA
Sallman	2010	USA	To describe women's common practices and shared meanings surrounding their involvement in prostitution	14 women	Street, strip clubs, escort services, direct exchange for drugs	Interviews	IPA
Trautner and Collett	2010	USA	To examine whether students who strip use their alternative positive identity to buffer themselves from the negative effects of stripping and to protect and enhance their sense of self	10 women	strippers	Interviews	Grounded theory
Wong et al.	2011	Hong Kong	To identify specific ways in which stigma may affect Hong Kong FSWs and how this may relate to their health	48 women	Karaoke, dancers, bars, streets, one-woman brothels	Interviews	Grounded theory

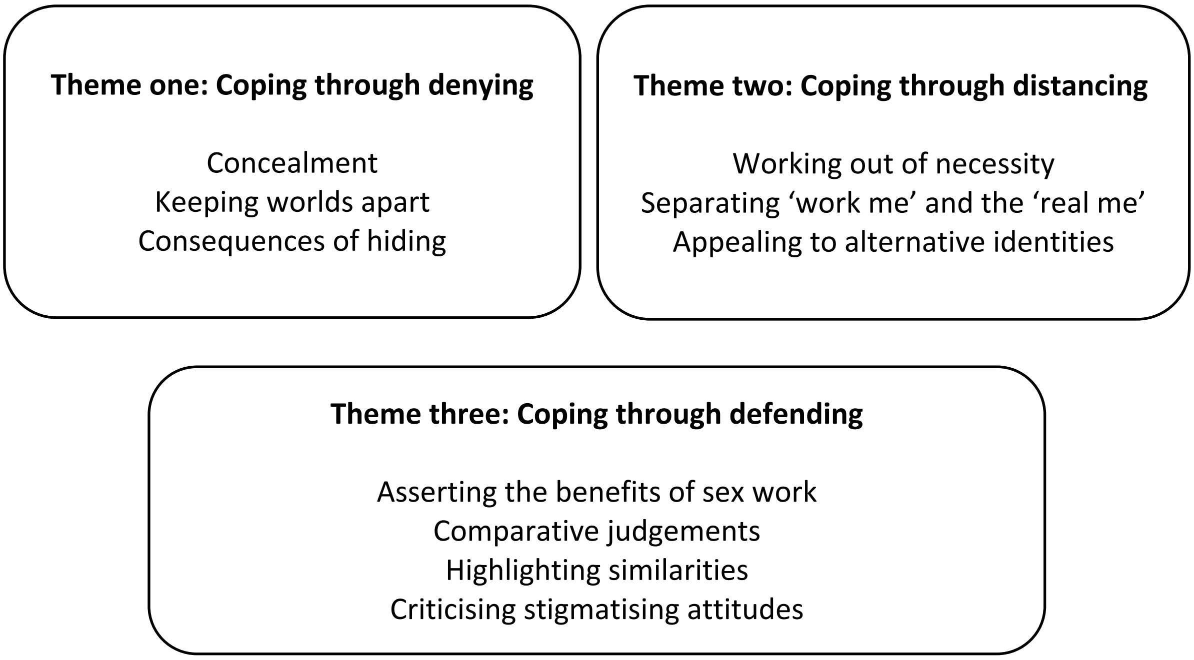
Uddin and Ashrafun	2011	Bangladesh	How street-based sex workers combat the pervasive negativity that surrounds their work	15 women (aged 15-35)	Street-based	Interviews	Grounded theory
Van Blerk	2011	Ethiopia	To explore how the spatial and temporal performances of multiple fractured identities are used in the negotiation of relationships that take place within and beyond the spaces of sex work	30 girls (aged 14-19)	Bars	Focus groups and semi-structured interviews	Qualitative – not specified
Cox et al.	2012	Nicaragua	To explore these women’s construction of their identity, to see if their sense of identity helped explain their global sense of misery. How did they understand and articulate their own life?	30 women	Street	Life story interviews	Inductive analysis based on grounded theory
Phrasisombath et al.	2012	Laos	To explore the working environment and perceived risks and benefits among FSWs in Savannakhet province in Laos	39 women	Entertainment establishments	7 interviews, 5 focus groups with 7-9 women in each	Latent content analysis

Basnyat	2014	Nepal	Stressing the lived experiences of female sex workers, focussing on their self-understandings, collective identities and associated cultural practices	35 women (aged 32-45)	street	Interviews	Thematic analysis
Levey and Pinsky	2015	America and Europe	To explore stigma management among dominatrices	33 women (13 interviewed)	Dominatrices	Interviews and analysis of 10 weblogs and 10 published memoirs	Content analysis of books and blogs. Analysis of interview data not stated

Table 3. Quality appraisal of included review papers

	Research Design	Sampling	Data Collection	Reflexivity	Ethical Issues	Data Analysis	Findings	Value	Total
Maticka-Tyndale et al. (2000)	1	3	2	1	2	2	2	2	15
Campbell (2000)	3	1	1	1	1	1	2	1	11
Ngo et al. (2007)	1	2	3	1	2	3	3	3	18
Jackson et al. (2007)	3	3	3	1	3	3	2	2	20
Tomura (2009)	3	2	3	1	3	3	3	2	20
Sallman (2010)	2	3	2	1	2	3	2	3	18
Trautner and Collett (2010)	2	3	2	1	1	2	3	3	17
Wong et al. (2011)	3	3	3	1	2	3	3	3	21
Uddin and Ashrafun (2011)	2	3	2	2	2	2	3	1	17
Van Blerk (2011)	3	2	3	1	2	2	3	3	19
Cox et al. (2012)	2	3	3	2	2	3	3	2	20
Phrasisombath et al. (2012)	3	3	3	1	2	3	2	3	20
Basnyat (2014)	3	2	1	2	1	1	2	2	14
Levey and Pinsky (2015)	2	2	3	1	2	2	2	2	16

Figure 2. Diagrammatic representation of themes



Section One Appendices

Appendix 1-A Manuscript preparation guidelines

Women and Health
Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements. For general guidance on the publication process at Taylor & Francis please visit our Author Services website.

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ScholarOne Guide End

Aims and Scope: Widely accepted as the standard reference source for specialists in the field, Women & Health contains information that is eminently useful to researchers, policy planners, and all providers of health care for women. The journal covers findings from studies concerning health and illness and physical and psychological well-being of women, as well as the environmental, lifestyle and sociocultural factors that are associated with health and disease, which have implications for prevention, early detection and treatment, limitation of disability and rehabilitation.

Features include:
- original research articles
- contributed critical, systematic research reviews
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Contributors provide the technical and scientific backdrop that women's health issues require. From time to time, special symposium issues on a single theme are published.

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All manuscripts reporting on studies in which human participants have been included must indicate that institutional review board approval was obtained for the study protocol and that informed consent was obtained from all study participants.

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become the property of the publisher. As an author you are required to secure permission if you want to reproduce any figure, table or extract text from any other source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source).

All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Manuscripts should be limited to 23 double-spaced pages, including abstract, text, and references. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of no more than 200 words. Avoid abbreviations, diagrams, and reference to the text in the abstract. Please consult our guidance on keywords here.

References

References, citations, and general style of manuscripts should be prepared in accordance with the Chicago Manual of Style, 16 th

Edition. Cite in the text by author and date (Pacini 1997) and include an alphabetical list at the end of the article.
Examples:

Journal: Taylor, J., and B. C. Ogilvie. 1994. A conceptual model of adaptation to retirement among athletes. Journal of Applied Sport Psychology 6 (1):1–20.
Book: Bowlby, J. 1982. Loss: Sadness and depression.Vol. 3 of Attachment and loss. 3rd ed. New York, NY: Basic Books.
Chapter in a book: Remael, A. 2012. Audiovisual translation. In Handbook of translation studies, ed. by Y. Gambier and L. van Dooslaer, vol. 1, 2nd ed., 12–17. Amsterdam, the Netherlands: John Benjamins.
Website: United States Census Bureau. 2014. American housing survey: 2013 detailed tables. http://www.census.gov/newsroom/press-releases/2014/cb14-tps78.html (accessed October 21, 2014).
Dissertation: Allison, N. 1981. Bacterial degradation of halogenated aliphatic acids. PhD. diss., Trent Polytechnic.
Conference presentation: Alfermann, D., and A. Gross. 1997. Coping with career termination: It all depends on freedom of choice. Paper presented at the 9th annual World Congress on Sport Psychology, Netanya, Israel, January 23.
Paper/report: Grigg, W., R. Moran, and M. Kuang. 2010. National Indian education study. NCES 2010-462, National Center for Education Statistics, Washington, DC.

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- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files
-

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Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

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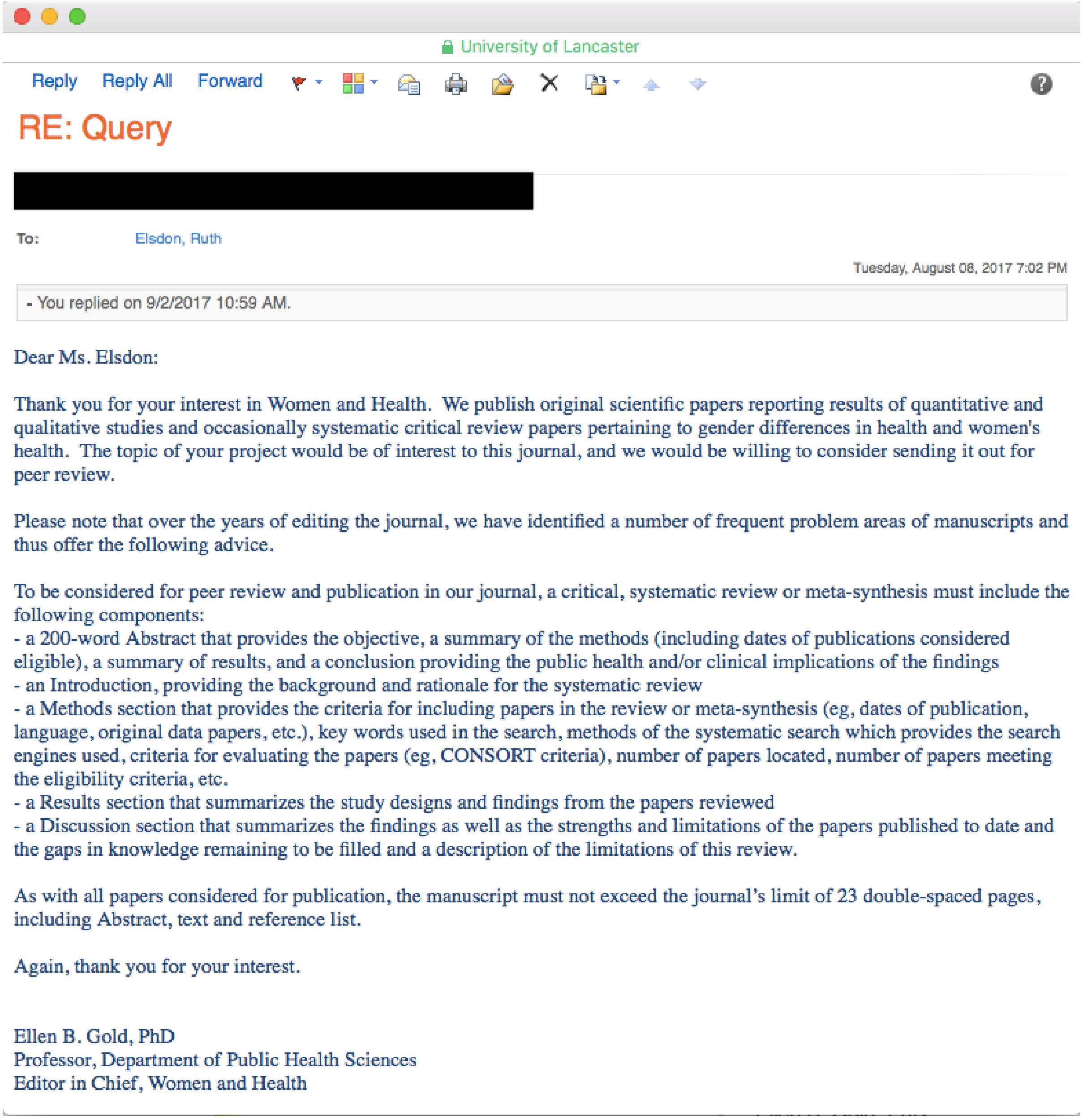
Appendix 1-B Email from editor in chief of Women and Health



RE: Query

[redacted]

To: Elsdon, Ruth

Tuesday, August 08, 2017 7:02 PM

- You replied on 9/2/2017 10:59 AM.

Dear Ms. Elsdon:

Thank you for your interest in Women and Health. We publish original scientific papers reporting results of quantitative and qualitative studies and occasionally systematic critical review papers pertaining to gender differences in health and women's health. The topic of your project would be of interest to this journal, and we would be willing to consider sending it out for peer review.

Please note that over the years of editing the journal, we have identified a number of frequent problem areas of manuscripts and thus offer the following advice.

To be considered for peer review and publication in our journal, a critical, systematic review or meta-synthesis must include the following components:
- a 200-word Abstract that provides the objective, a summary of the methods (including dates of publications considered eligible), a summary of results, and a conclusion providing the public health and/or clinical implications of the findings
- an Introduction, providing the background and rationale for the systematic review
- a Methods section that provides the criteria for including papers in the review or meta-synthesis (eg, dates of publication, language, original data papers, etc.), key words used in the search, methods of the systematic search which provides the search engines used, criteria for evaluating the papers (eg, CONSORT criteria), number of papers located, number of papers meeting the eligibility criteria, etc.
- a Results section that summarizes the study designs and findings from the papers reviewed
- a Discussion section that summarizes the findings as well as the strengths and limitations of the papers published to date and the gaps in knowledge remaining to be filled and a description of the limitations of this review.

As with all papers considered for publication, the manuscript must not exceed the journal's limit of 23 double-spaced pages, including Abstract, text and reference list.

Again, thank you for your interest.

Ellen B. Gold, PhD
Professor, Department of Public Health Sciences
Editor in Chief, Women and Health

Appendix 1-C An example of data extraction from Campbell (2000)

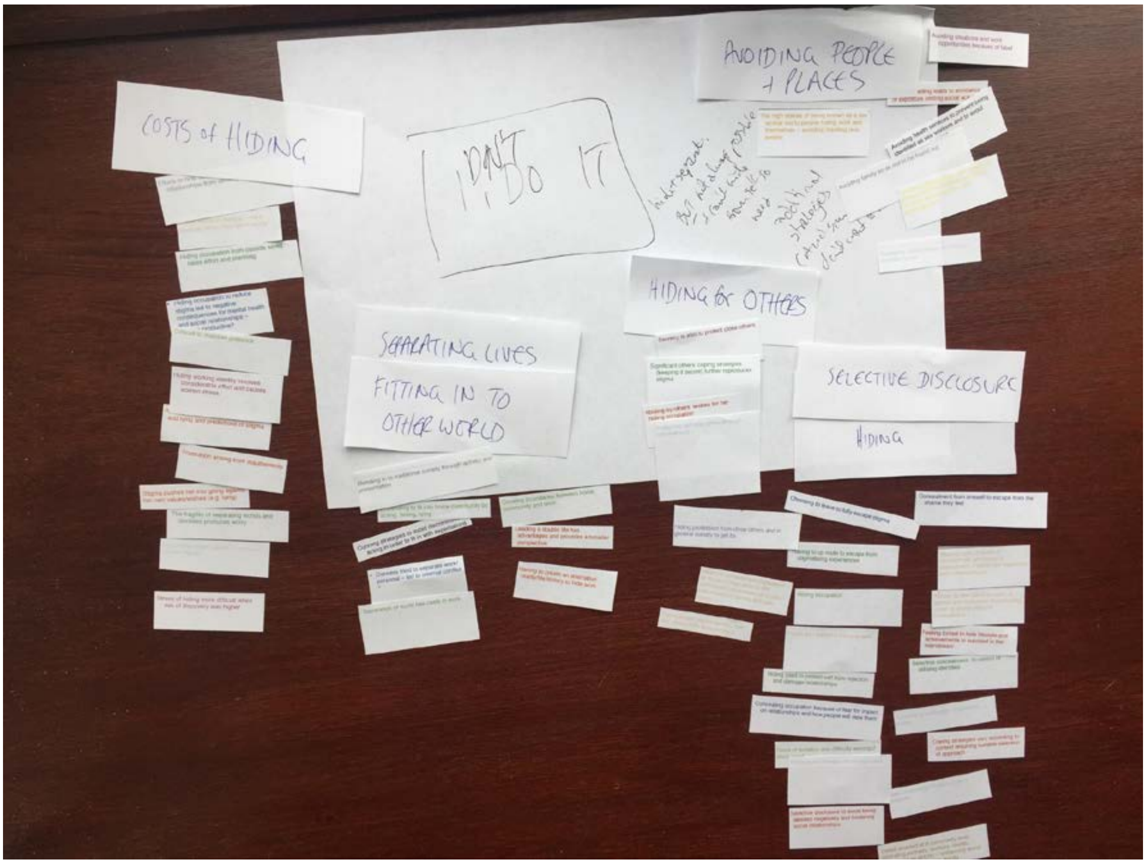
Author Theme Titles	Author Interpretations, Metaphors and Key Phrases	Representative Participant Quotes	Initial Comments and Interpretations
		Study: Campbell (2000)	
Confidence, dignity and self-efficacy	• Redefined criteria for respectability within their context • Elaborate forms of denial about work: the profession that has no name • Work hidden from family • Partners colluded with secrecy • Elaborate charades modelling interaction as non-commercial sexual encounter • Transgressors of ideal behaviour generated anger and bitterness • Use of justificatory discourses and creation of false stories to distance self from spoiled identity	"What language do you use with your colleagues when you discuss the sale of sex? Inf. 1: We call it working. If I brought a man over for the night I would say to my friends that I am going to work. We don't ever even talk about selling" (23). "Inf. 18: When we sit at the bar waiting for clients we pretend we are not selling. If a man approaches me too openly I act as if I am amazed, and insist that I am not selling. I ask him what makes him thinks this is the case, I might even pretend not to understand the words he is using" (23). "Inf. 16: I give my clients respect by telling them I don't like doing this job. I tell them I only do it due to poverty" (24). "Inf. 9: This is a job that lowers our dignity. We discuss this often – that we should look for other jobs. But the truth it there are no alternatives" (24). "Inf. 9: On the whole I am a happy person, but I do sometimes worry about going home… I	• Norms and standards of acceptability established within sex work setting paralleling norms in mainstream society. Finding a new means of being accepted (within this setting) akin to big fish in a little pond? • Establishment of in/out group within stigmatised group to protect notions of respectability • Hiding sex work • Denial enacted at a community level (including partners, workers, clients, colleagues as actors) – enhancing social cohesion and protecting dignity • Creating and rehearsing (contradictory) stories separates self from stigmatised identity, i.e. this says something about my *situation*

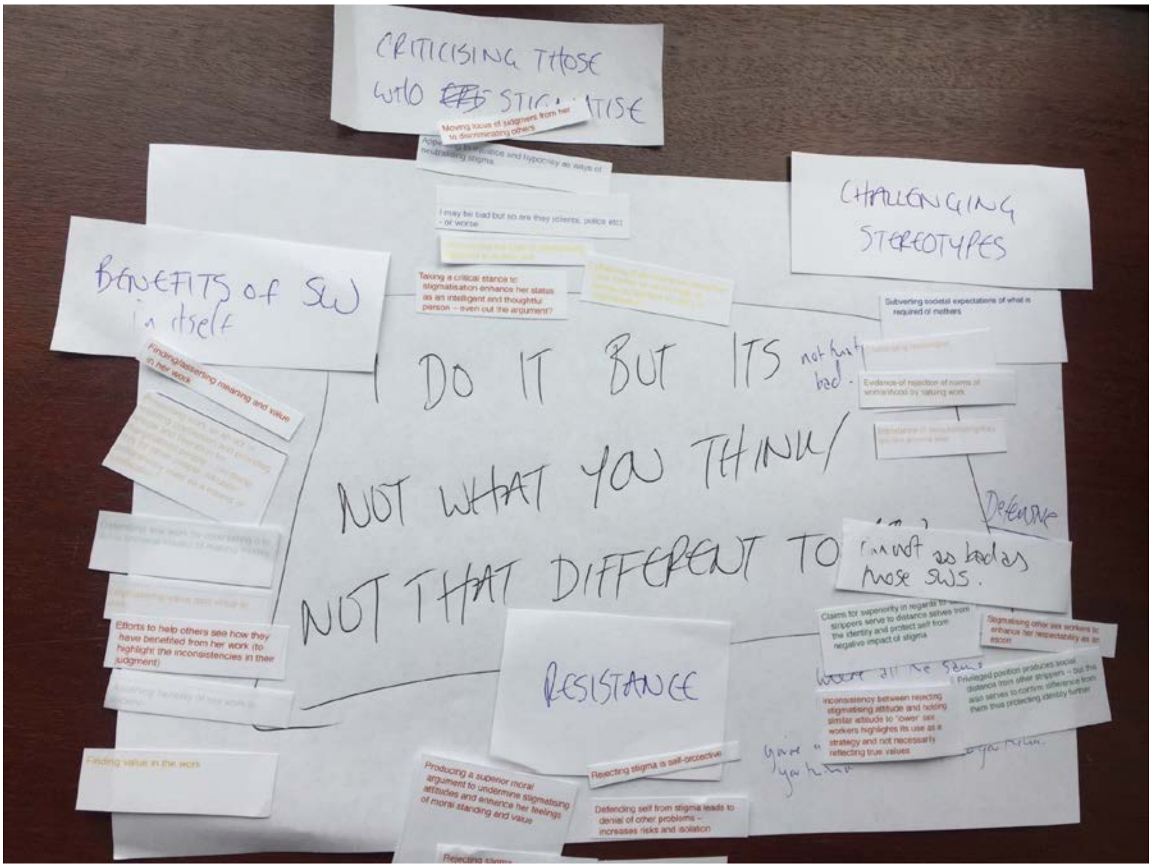
	• Discourse of having no option/victims of fate – forced and tricked into sex work by people and poverty • Rhetorical device of 'going home' – contradictory accounts of plans to leave sex work. • Portrayal of work as temporary another distancing strategy • Some expressed enjoyment of freedom and radical break from drudgery of more respectable roles • Profession offered advantages despite stigma	wonder if my child is still alive or not. Interviewer: Do people at home know where you are? Inf. (: I don't think they know I am alive… I'm ashamed and sad that I'm not a responsible mother. Interviewer: What do you mean by this? Inf. 9: That I don't buy food and clothing for the child and I don't visit the child – on these ways I am not responsible" (26). "Inf. 4: When I'm at home I don't have problems. My friends and sisters are always there so I'm always happy. But I'm also scared that I might get drunk and do funny things that might make me argue with people. At home men have responsibilities to their wives – if a man were to buy alcohol for me his wife would come and argue with me. Here there is no such problem – I don't have to answer questions to anybody" (27).	(poor) not *me* (that I would choose to behave this way) • Portraying work as forced and temporary • Weighing up benefits of work against stigma • Evidence of rejection of norms of womanhood by valuing work
Women had established a shared approach to managing stigma by pretending the work was not happening. The fact this was a shared endeavour also enhanced social cohesion, creating a new social order strengthened by differentiating between those adhering to the norms and rules and those who did not. This was accompanied by well-rehearsed accounts of reasons for working and attitudes towards it and the future. It was presented both as not a choice (to be working) and as something they would choose to leave when they were ready – an apparent contradiction. The contradictions in women's accounts were interpreted by the author as evidence of the strategic nature of such narratives in distancing themselves from a stigmatised and downgraded occupation. Findings relate to the very specific setting whereby women lived in the sex work environment – they did not leave it so on the whole did not have to manage life outside of work (other than a few who had relationships outside of work). This seemed to be protective and perhaps also influenced women staying and not returning home to a place they would have to account for their work differently which would require different strategies to navigate the stigma they would experience.			

Appendix 1-D Initial emerging themes

Emerging Theme	Descriptive Theme Title
1	Hiding
2	The stress and costs of hiding
3	Selective disclosure
4	Hiding for others
5	Separating lives
6	Fitting into other worlds
7	Separating self from role
8	Avoiding people
9	Using alcohol to cope
10	Individual variation in impact
11	Resistance
12	Sex workers as victimised
13	Criticising those who stigmatise
14	Challenging stereotypes
15	In/out group: differential status
16	Work as forced or temporary
17	Benefits of work
18	Wanting a new start
19	Connection with similar others
20	Accepting stigma

Appendix 1-E Photographed examples of development of final themes





Appendix 1-F Contribution of each study to final themes

Theme	Sub-theme	Contributing Studies		
Theme one: Coping through denial	Concealment	• Maticka-Tyndale et al. • Campbell • Ngo et al. • Jackson et al. • Tomura	• Sallman • Trautner and Collett • Wong et al. • Uddin and Ashrafun • Van Blerk • Cox et al.	• Phrasisombath et al. • Basnyat • Levey and Pinsky
	Keeping worlds apart	• Maticka-Tyndale et al. • Campbell • Tomura	• Trautner and Collett • Van Blerk • Phrasisombath et al.	• Basnyat • Levey and Pinsky
	Consequences of hiding	• Maticka-Tyndale et al. • Ngo et al. • Jackson et al.	• Tomura • Trautner and Collett • Uddin and Ashrafun • Van Blerk	• Cox et al. • Basnyat • Levey and Pinsky
Theme two: Coping through distancing	Working out of necessity	• Maticka-Tyndale et al. • Campbell • Ngo et al. • Jackson et al.	• Sallman • Wong et al. • Uddin and Ashrafun • Van Blerk	• Cox et al. • Phrasisombath et al. • Basnyat
	Separating ‘work me’ and the ‘real me’	• Maticka-Tyndale et al.	• Trautner and Collett	• Levey and Pinsky

	Appealing to alternative identities	• Maticka-Tyndale et al. • Tomura • Trautner and Collett	• Uddin and Ashrafun • Cox et al. • Phrasisombath et al.	• Basnyat • Levey and Pinsky
Theme three: Coping through defending	Asserting the benefits of sex work	• Campbell • Ngo et al. • Tomura	• Trautner and Collett • Wong et al. • Uddin and Ashrafun	• Phrasisombath et al. • Basnyat • Levey and Pinsky
	Comparative judgments	• Campbell • Ngo et al. • Tomura	• Trautner and Collett • Uddin and Ashrafun	• Van Blerk • Basnyat
	Highlighting similarities	• Maticka-Tyndale et al. • Campbell	• Ngo et al. • Tomura	• Sallman • Levey and Pinsky
	Criticising stigmatising attitudes	• Maticka-Tyndale et al. • Tomura	• Sallman	• Uddin and Ashrafun

SECTION TWO

EMPIRICAL PAPER

Becoming a Mother in the Context of Sex Work: Women's Experiences of Bonding with their Children

Ruth Elsdon

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word Count: 7981

(Excluding tables and figures, reference lists and appendices)

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Prepared for submission to *The Journal of Reproductive and Infant Psychology*.
Please refer to Appendix 2-A for manuscript preparation guidelines.

Abstract

Objective: To explore women's experiences of bonding with their children in the context of sex work.

Background: Approximately 70% of females engaged in sex work in the UK are mothers, many experiencing poverty, violence, marginalisation, and psychological distress, factors also found to affect parental bonds. However, little is known about forming relationships with children in this context.

Methods: Six women who were sex working during the first two years of their child's life were interviewed about their bonding experiences. Data was analysed using Interpretative Phenomenological Analysis.

Results: Four themes were identified: (1) the complex process of bonding; (2) 'I never felt like my baby was my baby': the impact of powerlessness on bonding; (3) 'give them the help that they need': the powerful impact of receiving help, and (4) new perspectives of the body and sex work in the light of motherhood.

Conclusions: Findings contribute to bonding literature by emphasising the value of supportive care and the importance of social context to bonding, indicating specific factors to inform psychological support among sex working women.

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

Introduction

The significance of the parent-child relationship is well established in attachment theory and research, highlighting its impact on children's biological, emotional and cognitive development (Benoit, 2004; Slade, 2002), with difficulties predicting long term problems with behaviour (Rackett & Holmes, 2010) and mental health (Travis & Combs-Orme, 2007).

Accordingly, public policy increasingly recommends provision supporting the development of secure attachments (e.g. Moullin, Waldfogel, & Washbrook, 2014), emphasising a need for engaging vulnerable families (Department of Health [DH], 2015). Sex-working mothers are often particularly vulnerable due to factors such as drug use (Balfour & Allen, 2014); poverty (Home Affairs Committee [HAC] 2017), and separation from their children (Bletzler, 2005). However, little is known about parenting in this context (Beard et al. 2010; Sloss, Harper, & Budd, 2004), indicating a need for research to inform appropriate and accessible support.

Sex-working mothers

Estimates suggest approximately 72,800 people in the UK sell sex for money (HAC, 2017). These are mostly women, of whom approximately 70% are mothers (The English Collective of Prostitutes, 2004). The UK sex trade is diverse (Pitcher, 2105) with particular changes evidenced recently in terms of demographics and motivations of workers, for example, increasing numbers of students selling sex to fund their studies (Sanders, 2013). However, research and literature has tended to focus on women facing multiple social difficulties related to their involvement in sex work. Accordingly, the present study focusses on those working in a context for whom factors such as drug use, violence, and poverty may present particular challenges to parenting. Previous studies have identified how such factors can pose risks to sex-working women and their children (Duff et al., 2014; McClelland & Newell, 2008). Studies have also described guilt, stigma, and shame (Dalla, 2003; Sloss et al., 2004), often focussing on difficulty occupying a dual identity (Dodsworth, 2014; Castañeda, Ortíz, & Allen, 1996) 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). A UK study involving 333 women 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, Cossar, Lorgelly, & Young, 2010) and increased maternal suicide (Oates & Cantwell, 2011). Specific to sex work, studies have found separation from children increased chaotic drug use and sexual risk taking (Sloss & Harper, 2004; McClelland & Newell, 2008) and can prompt exiting sex work (Hester & McFarland, 2004).

However, much remains unknown about the relationship between sex work and parenting (McClelland & Newell, 2008), specifically workers' relationships with children (Dodsworth, 2014). Although one study explored intergenerational patterns within sex-working women and their families (Dalla, 2003), it focussed on being parented rather than parenting. The present study aimed to address this gap in understanding mothers' relationships with their children in the sex work context by exploring their bonding experiences.

Bonding

Bonding concerns affection, love and warmth felt towards a child (Bouchard, 2011), and behaviours representing such feelings (Shieh & Kravitz, 2006), a process continuing from pregnancy to beyond birth (Slade, 2002). In contrast to attachment, measureable through observations of children's behaviours towards their caregivers (Benoit, 2004), bonding concerns caregivers' internal emotional experiences (Maestripieri, 2001). Various self-reporting scales have thus been developed to measure bonding and identify related factors (Perrelli, Zambaldi, Cantalini, & Sougey, 2014), for example, finding maternal bonds during and after pregnancy influence confidence in interacting with an infant (Fegran, Helseth, & Fagermoen, 2008) and are associated with childhood attachment security (Miller, Sable, & Csizmadia, 2008). Bonding difficulties may also contribute to parental distress and isolation (Larkin, 2006).

Bonding and sex work

Although no studies have explored bonding and sex work, overlaps in literature on both subjects indicate potentially relevant factors. Sex work involvement has been associated with numerous mental health difficulties (Ling, Wong, Holroyd, & Gray, 2007), some of which have been shown to affect maternal bonding (Perry, Ettinger, Mendelson, & Le, 2011). Sex work is also commonly associated with violence (e.g. Rossler et al., 2010), which can lead to more negative attitudes towards pregnancy and the foetus (Almeida, Sia, Cunha, & Pires, 2013). Furthermore, studies 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 also affecting parents' ability to care for their children (Fraiberg, Adelson, & Shapiro, 1975; Leckman et al., 2004) including bonding pre-birth (Schwerdtfeger & Goff, 2007).

Additionally, poverty, discrimination and homelessness have all been associated with sex work (Balfour & Allen, 2014; Brents & Sanders, 2010), factors likely to reduce parents' confidence (Hooper, Gorin, Cabral, & Dyson, 2007), and sensitivity to child distress (Miller et al., 2008). Furthermore, many sex-working women use substances such as crack cocaine and heroin (Tri-X Childcare, 2011). Previous research has highlighted difficulties for substance-abusing mothers considering their own and their child's emotions (Pajulo et al., 2012); marking increases in emotionally avoidant language (Borelli, West, Decoste & Suchman, 2012) and ambivalence regarding pregnancy (Soderstrom, 2012).

Hypothesising potential bonding difficulties must be done with caution, partly due to difficulty generalising findings which often hide the sex trade's diversity (Pitcher, 2014; Seib, Fischer, & Najman, 2009). Additionally, evidence suggests parents show reflective capacity (Baker & Carson, 1999) and resilience in addressing obstacles (Travis & Combs-Orme, 2007; Hooper et al., 2007), factors that may be missed by quantitative studies measuring bonding correlates. Furthermore, much is yet to be learned about bonding generally (Mason, Briggs, & Silver, 2011; Maestripieri, 2001) with existing evidence describing heterogeneous experiences, regarding immediacy and stability over time (Goldberg, Moyer, & Kinkler, 2013; Van Reenen & Van Rensburg, 2015).

It is also important to recognise cultural narratives concerning bonding. An emphasis on the repercussions of early parenting failures can unwittingly construct parenting as a fragile and daunting undertaking (Gillies, 2007), within which bonding presents another task on which parents are assessed and the child's future depends (Crouch & Mandelson, 1995). Such pressure and scrutiny can cause considerable guilt and anxiety for mothers (Lowe, Lee, & Macvarish, 2015) and neglect consideration of systemic factors affecting parenting capacity, particularly relevant for sex-working women whose marginalisation excludes them from narratives of an asexual, home-bound mother (Forna, 1999; Dodsworth, 2014). In acknowledging such influences, research enabling mothers to share their lived experiences is essential to further understanding of bonding within this context.

Significance for Clinical Psychology

Multiple psychological interventions exist to support parent-child relationships (Asmussen, Feinstein, Martin, & Chowdry, 2016), aiming to improve outcomes for children and mothers, and safely reduce numbers of children entering the care system (Little & Sodha, 2012; The Care Inquiry, 2013). A greater understanding of specific maternal bonding experiences can contribute to developing and delivering interventions relevant to the sex-working population. Similarly, findings may inform clinical work with sex-working women within mental health services, including those specifically supporting mothers, particularly relevant given the current NHS transformation programme to extend perinatal mental health support (NHS England, 2016).

Despite increasing evidence linking sex work with psychological distress (e.g. Gorry, Roen, & Reilly, 2010) there remains a disconnect in provision, reflected by sex work's absence within mental health policies (e.g. DH 2003), including British Psychological Society (BPS) sexual health psychology strategy papers (2002; 2006), and conversely the neglect of psychological needs within sex work strategies (Home Office, 2006). It is hoped this study will contribute to bridging this gap by recognising sex workers within clinical psychology, and psychological factors within sex work. Stevenson and Petrak (2007) report a unique clinical psychology model within a physical health clinic for people involved in sex work, offering brief consultations for service users and staff; crisis intervention; signposting, and brief interventions. Replicated models could incorporate specific provision for mothers within this context. Similar provision could be offered to others supporting sex-working women, for example midwives, recognising clinical psychology's role in supporting professionals to work psychologically (BPS, 2007).

Learning from lived experiences can also inform professional attitudes towards sex-working mothers and families. NHS strategies emphasise the importance of removing barriers and improving access to care (DH, 2015), particularly relevant here given women's difficulty accessing support (Duff et al., 2014). Understanding their context can help to develop accessible clinical psychology services (Stevenson & Petrak, 2007), increasing empathy essential to therapeutic work (Feller & Cottone, 2003).

Finally, clinical psychology's role in addressing societal problems contributing to psychological difficulties is being increasingly recognised (Kinderman, 2014). This is particularly relevant here, as marginalisation may affect sex-working women's motherhood experiences as well as silencing them in society (Dalla, 2003; Peled & Leven-Rotberg, 2013). Using qualitative methods to recognise mothers' voice limits the risks of increasing their marginalisation, moving beyond 'mother-blaming' (Wegar, 2007) towards more holistic and nuanced accounts of their experiences. This can enable advocacy for sex-working mothers in health and social care services, and inform policies and strategies concerning sex work and parenting.

The present study therefore aims to explore *how women experience the bonding process with their children in the context of sex work,* seeking to understand personal meanings attributed to bonding; perceptions of how work and related factors impact upon this process, and the personal impact of these relationships.

Method

Design

Interpretative Phenomenological Analysis (IPA, Smith, Flowers, & Larkin, 2009) was the methodological approach chosen. IPA is concerned with understanding the "participant's personal world" (Smith & Osborn, 2008, p.53), including their understanding of particular events or phenomena. It acknowledges the complexity in people's experiential accounts, requiring the researcher to adopt an interpretative role, itself influenced by their understandings and assumptions, which need to be identified and bracketed so as to privilege participants' sense-making.

Semi-structured interviews were used, recommended with IPA, enabling flexibility and space for discovering novel issues (Smith & Osborn, 2008), whilst focussing on the study's aims. Participants could attend with a companion if preferred and were invited to bring an item relating to their child to facilitate sharing their experiences; one participant shared scan photos from her current pregnancy.

Participants and recruitment

Smith et al. (2009) recommend obtaining small homogenous samples to facilitate detailed case-by-case analysis; published IPA studies commonly have sample sizes of 4-10 participants. Accordingly, purposive sampling was used to recruit a small number of participants whose experience was relevant to the research aims. Recruitment was conducted through five services who agreed to participate and had sufficient staff resources to support the research: two substance misuse services, two voluntary sex work projects, and one specialist midwifery service. Inclusion criteria are shown in Figure 1. Participants themselves interpreted what sex work involved, recognising the scope of the occupation (Balfour & Allen, 2014). Criteria included mothers who had little direct contact with children but nonetheless wished to share their bonding experiences, acknowledging potentially complex care arrangements experienced (Hester & Westmarland, 2004).

[INSERT FIGURE 1]

Gatekeepers within each service through which recruitment took place were provided with research information which they shared with other staff members. This was supported by the researcher visiting services and speaking to staff where possible. Staff identified service-users who they worked with who may be eligible to participate and informed them about the research, issuing information sheets, and answering any questions. Interviews were arranged through staff members. Services had the option of indirect recruitment using posters, fliers, and providing service users with a research phone number; none opted for this due to service policies and decisions to recruit through staff. Although this approach excluded women not in contact with services and meant staff knew who participated, it was chosen to ensure participants had access to additional support if necessary and contributed to the sample's homogeneity. Participants were reassured involvement would not impact care.

Participation was voluntary but travel expenses related to participation were reimbursed and a £10 voucher provided to express appreciation, common in similar research (e.g. McClelland and Newell, 2008), and recommended by services involved. Services suggested suitable shops for the vouchers, for example, a local supermarket.

The final sample comprised of six participants (See Table 1 for details). All participants were white British. Participants occasionally provided conflicting details regarding dates, perhaps due to difficulties remembering events or the complexity and fluctuation of drug use and sex work involvement. Details thus reflect the researcher's best efforts in interpreting responses.

[INSERT TABLE 1]

Data collection

Face-to-face interviews were conducted between October 2015 and March 2017; five 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 began by revisiting the information sheet, answering questions, and taking written consent regarding participation and audio recording. Limits of confidentiality were clarified. Efforts were made to create a relaxed environment including providing refreshments and building rapport. Interviews lasted between 45 and 102 minutes. The interview guide (Appendix 4-H) included example questions exploring key areas, such as, "what can you remember about your experience of giving birth and the events surrounding it?" Follow up questions, for example, "could you tell me more?" encouraged elaboration.

Topics were identified through relevant literature and in discussion with the field supervisor, a clinical psychologist specialising in child and infant mental health. Participants reflected on the process during the debrief, raising any concerns. Contacts were provided for support if needed. Ideas for dissemination were discussed with participants who could opt to be involved. The academic supervisor listened to the first recording, commenting on style and content.

The research proposal was reviewed by research staff at Lancaster University, and the field supervisor. Research design and materials were developed through discussion with services working with women involved in sex work, and a former service-user. The service-user helped particularly in considering relevant topics and questions for the interview.

Analysis

Interviews were transcribed verbatim by the researcher and pseudonyms applied. The first stage of analysis took place with individual interviews, allowing for IPA's aims to identify commonalities and divergences in experience within a well-defined group (Smith & Osborn, 2008). Transcripts were initially read repeatedly to aid familiarity. 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, notations were printed on separate pieces of paper and spread over a table where they were grouped and re-grouped as new relationships were recognised, forming clusters reflecting different dimensions of participants' experiences. The analytic process aimed to understand participants' meaning whilst critically analysing the text (Smith & Osborn, 2008). A narrative account was written summarising each cluster, and expressing its central meaning in relation to the research topic. The number of clusters ranged from five to seven for each interview, and were all titled. This process was repeated for all transcripts, deliberately not using existing clusters as a framework for further analysis to enable identification of novel themes. The academic supervisor reviewed one transcript's clusters to ensure methodological rigour.

The second stage involved integrating the analysis across all transcripts. Cluster titles were printed on pieces of paper and grouped and re-grouped on a table, according to thematic relationships. Emerging themes were continually checked and refined against transcripts, ensuring they were grounded in the data (Willig, 2008). (Appendices 2-B-D provide examples of the analysis). In total, four themes were created. The final analytic stage involved writing a narrative encompassing experiences in each theme, evidenced by participant quotations (see Results). Figure 2 provides a diagrammatic representation of themes.

Reflexivity

A core feature of IPA is recognising the “active role” the researcher plays (Smith & Osborn, 2008, p. 53), involving reflecting on their own experiences and understandings to recognise how these inform data collection and interpretation, and to move towards new conceptualisations (Finlay, 2011). Accordingly, I accessed supervision from a clinical psychologist unrelated to the study and kept a journal to reflect on assumptions and experiences relevant to the research. Specifically, I considered my own preconceptions of sex work and of bonding, for example by writing them down prior to data collection. I also considered the influence of being a pregnant mother of a similar age to some participants, realising this might lead to myself or participants drawing comparisons. Although participants asked about this, it had no obvious impact on their engagement.

Ethics

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.

Particular consideration was given to participants' safety and wellbeing through using a sensitive and empathic interviewing style, key to phenomenological research (Finlay, 2011), for example, checking participants' comfort with questions and debriefing. Several participants became upset during interviews and interviewing was paused to ensure their wellbeing and confirm whether they wished to continue. Additionally, recruitment took place via services where staff members were available after the interview to respond to any distress or safeguarding issues, although this was not necessary. (Section Three offers further discussion of reflexivity and ethics).

[INSERT FIGURE 2]

Results

Theme one: The complex process of bonding

Theme one represents how participants understood the nature of bonds formed with their babies, which although initially experienced as overwhelmingly positive, 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.

Striking similarities existed across women's accounts of initial bonding, largely focussing on their wonder concerning the baby, for example: "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). This unique bond created a sacred space separate from the outside world.

Additionally, bonding was portrayed as inevitable, occurring automatically at birth: "…with me two younger ones … *obviously* I got that rush of love with both of them" (Sue).

Despite this assumption, women's experiences of bonding reflected a more complicated picture:

> 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 mastitis and post-natal depression. Furthermore, highlighting her unsuitability as 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 with the same children also highlighted different facets of bonding, suggesting initial feelings did not represent or guarantee what was to come. It was an ongoing process of reforming bonds amidst the complexities of real life. Most participants' reality included domestic violence, sometimes complicating bonding: "…he 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, 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). Linda actively resisted bonding through physically rejecting her son. Feeling she “couldn’t” attach to him emphasised the powerful underlying feelings influencing women’s responses to their children. In contrast to beautiful bonding experiences, bonding was not always neutral but here was threatening and painful, making it safer for Linda to perceive him as an object than risk bonding.

Jenny exemplified a more deliberate approach to managing bonds: “I 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, she emotionally withdrew from him until she finally had “no bond...I literally just let go of it”, implying bonds could be switched on and off in response to circumstances and women’s emotional needs. In contrast to an understanding of bonds as inevitable and automatic, such experiences demonstrated they could be resisted or even severed as a result of women’s conscious and subconscious choices. However, Kate found ways to keep her children in mind 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.” Despite no further physical contact, bonds were preserved through maintaining the reciprocal knowledge of her identity as their mum and her love for them, marked by symbolic gifts.

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.

Theme two: ‘I never felt like my baby was my baby’: the impact of powerlessness on bonding

Theme two examines women’s 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. Such experiences highlighted the significance to bonding of a sense of autonomy as mothers and of mutual belonging with the child.

Every participant had a child involuntarily removed, consistently feeling out of control of the decision and process. 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?

Her relationship with her son was ended by decisions beyond her knowledge, desire and control, accentuated by the trivial manner of the revelation and highlighting 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 significant 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 replaced and redundant as her mother, without an active role in her life. Similarly, Helen's (above) maternal role was threatened by denying her rights to make decisions for her child, something she had earned through physically birthing her son. The undermining of this role was most pronounced regarding professional surveillance. Women feared making mistakes and having children 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.

This directly impacted bonding by preventing 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 to bonding of autonomy in managing the responsibilities and decisions of childcare.

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 child protected Kate from spiralling into sex work and drugs. Similarly, Jenny described how when her baby’s foster carer involved her in his care, for example, letting her bathe him, it made her feel “so special”. In contrast to the doubt caused by continual surveillance, being trusted as a mother, even amidst separation, restored Jenny’s self-worth.

The powerlessness women experienced in relation to their children undermined their mutual 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 and self-worth.

Theme three: 'Give them the help that they need': the powerful impact of receiving help

The third theme presents the significance to mothers of receiving help to care for their children in a context where they often felt isolated and overwhelmed by the burden of parenting. Varying experiences of help highlighted the importance of both practical and emotional support to bonding.

Most participants discussed the overwhelming 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 lives" (Sue). The baby's vulnerability confronted Sue with demands which provoked fear, perhaps due to feeling inadequate to meet them. Women identified the challenge of meeting children's emotional as well as physical needs: "I was only young meself and … my mum … didn't care … so no-one taught me how to look after them emotionally" (Helen).

Difficulty in providing care thus related to absence of guidance. Indeed, the caregiving burden was heavier when carried alone:

> 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)

Kirsty highlighted the social isolation most participants experienced, due to complex family relationships leaving them without a wider network of support, and because of unsupportive, absent (here, a punter) or abusive partners: "Every partner, apart from this one I'm with now, has been violent in some way. Whether it's been physical, mental, never sexual abuse apart from, well you're sexually abused by going out there" (Kirsty). Thus, violence was the norm for most participants, inside and outside of work, exacerbating their isolation.

Being alone was repeatedly associated with difficulty coping, partly relating to practical factors such as no childcare support, which for Kate meant she had to put her daughter into respite care when she was in labour. Conversely, Sue described the impact of her mother's practical support: "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." Sue experienced valuable relief in sharing and alleviating responsibility. Helen further emphasised the emotional impact of sharing 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.

The stark contrast between the partners' responses highlighted the deep loneliness and lack of care she felt, echoing past experiences. She wanted to be cared for personally through the process of becoming a mother, a desire emphasised when participants sought help from professionals, by whom they often felt betrayed: "Instead of running to each other why didn't they come to me, ask me how I was feeling? In the early stages of motherhood why didn't they come to me and ask me?" (Sue). The lack of interest in Sue individually emphasised the isolation and rejection accentuated by motherhood. In contrast, Linda believed a positive experience of services with her second child was due to her relationship with the worker: "I seem to get on with her so I think that's the difference". Having their needs met had a notable impact on women's 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, making her feel fundamentally different and increasing her availability to her baby; having her own needs met enabled her to meet her child's. Similarly, Jenny described how a charity's practical help and befriending changed her outlook, demonstrating the powerful impact of support on caring for her child: "Maybe if I had had [SUPPORT PROJECT] in my life when it happened … I would've kept Edward".

In the absence of supportive 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 were 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. Accordingly, bonding provided a sense of security in terms of what it might return in the future, for example, Helen hoped bonds with her children would guarantee their practical and financial support later in life. However, depending solely on children seemed insufficient to meet women's needs, further emphasising loneliness: "The work's lonely and if you go home and you've got children and that's your only outlet, it's lonely" (Helen).

Becoming a mother was daunting, exacerbated by social isolation, highlighting practical and emotional support needs. 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.

Theme four: New perspectives of the body and sex work in the light of 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. This often conflicted with sex work, which took on new meanings accordingly, leaving women attempting to reconcile both.

Upon becoming pregnant, four of five women working stopped immediately, presented as a natural reaction. This partly reflected beliefs about the baby's safety: "I thought…it could harm the baby" (Linda). Linda's mental representation of the baby and her responsibility towards it prevented her from working. Conversely, Sue described how not developing a sense of her baby during pregnancy due to fear of motherhood and being in a "drugs state of mind" meant she continued working: "I was in … denial all the way through me pregnancy because I was … just carrying on doing whatever, whenever… I wanted".

Accordingly, not working evidenced maternal love and commitment, as they didn't want to "let [THE CHILD] down" (Jenny). However, most women continued using drugs throughout pregnancy, indicating something distinct about their understanding of sex work in relation to themselves and their children. 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). Bonding was expressed through women 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 after 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. Interestingly, this is reminiscent of her strategy to cope with the grief following losing her son: “People would see me and think look at that hard bitch but I cried myself to sleep at night and I had to act … if I didn’t have this armour up I would’ve … withered away.” Helen’s armour prevented painful feelings from destroying her, portraying sex work as a context where the separation from motherhood exemplified a continual need for disguise. Furthermore, women attempted to hide sex work from their friends, services, and their children, indicating the shame they associated with it.

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. The need to defend sex work indicated disapproval women encountered regarding it: “[SOCIAL SERVICES] was … bringing up me past … ‘oh you was a sex worker’… my past has brought up a lot against me” (Kate).

However, despite defending sex work and attributing positive meanings to it, women hoped their children would not follow their life choices: ‘I just don’t want him going down that road’ (Kirsty). They thus used their experiences to motivate change: “[MY DAUGHTER’S] always said … I will never go down that route now…knowing what you’ve been through in your life” (Sue).

Motherhood changed women’s perceptions of their bodies, as connected to their children and partners, which sex work violated. Consequently, women worked hard to separate the two, primarily by stopping working, but when not possible, by maintaining separate identities, and attributed meanings to sex work more congruent with their desire to love and provide for their children.

Discussion

The present study identified four themes representing aspects of bonding for women involved in sex work. Themes indicated the complexity of bonding, varying between individuals and across time and situation. Specifically, bonding was aided by feelings of autonomy and belonging, which were threatened by the powerless position many women occupied; likewise, receiving help and care significantly impacted bonding and mothers themselves. Finally, relationships with children changed women’s perspectives of their bodies and their approach to sex work.

A major contribution of the study is highlighting the impact of contextual factors on bonding, broadening the focus from the mother-child dyad (e.g. Van den Bergh & Simons, 2009). Women identified factors surrounding work, including drug use, financial hardship and problematic relationships, factors commonly identified in sex work research (Perdue et al., 2012). Specifically, powerlessness, often identified in sex work literature (e.g. Gorry et al., 2010), significantly impacted bonding. Women felt 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, Helseth, & Fagermoen, 2008) and adoptive parents (Goldberg et al., 2013), suggesting its general importance for bonding, particularly when threatened.

A related finding was the painful and enduring grief following losing custody of a child, contributing to the limited evidence base regarding birth parents' separation experiences (Smeeton & Boxall, 2011). However, meaningful participation in child protection decisions and procedures was protective, reducing problematic coping strategies. Furthermore, corresponding with literature concerning bereavement after a death (Klass, Silverman & Nickman, 1996), continuing bonds with separated children was healing for some, confirming findings elsewhere (Bletzler, 2005). Nevertheless, as recognised previously, (Neil et al., 2010; Hunt, 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 for birth parents (Department for Children, Schools and Families, 2010), in practice, women described poor communication, judgment, and betrayal, highlighting the impact of the adversarial stance professionals often take (Smeeton & Boxall, 2011).

A final systemic factor impacting bonding was social isolation. Elsewhere bonding difficulties have been found to increase isolation (Sluckin, 1998) indicating a vicious cycle for women struggling to bond without support. Contrastingly, 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, McMahon, Slade and Luthar (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, reflected in wider sex work literature (Duff et al., 2014), producing shame and defensiveness. However, findings challenged such judgments by indicating how, in many ways, women's bonding experiences mirrored 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, Bell, Tribble, Paul, & Lang, 1998). Findings also challenged simplistic representations of bonding by demonstrating that, despite being frequently presented as secure and stable (e.g. Fegran et al., 2008), bonds may fluctuate over time, reported by mothers generally (Mercer & Ferketich, 1994). Additionally, bonding can hold negative associations, for example the threat of loss or violence, an important finding when promoting bonding. Furthermore, women demonstrated shame and resignation regarding bonding difficulties, highlighting the need for more realistic and non-blaming bonding narratives.

Finally, in contrast to previous studies, where pregnancy had little impact on women's sex-working lifestyle (Deisher, Farrow, Hope & Litchfield, 1989; Dalla, 2002), most women stopped working immediately in pregnancy. This specifically related to acknowledging the reality of the baby, emphasising the impact of keeping the baby in mind (Slade, 2002). Accordingly, 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 (Soderstrom, 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 (Duff et al., 2014; Basu and Dutta, 2011; Sloss & Harper, 2004).

Clinical implications

Although many will not require it, 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, Harris, Van Horn & Lieberman, 2011). Incorporating mentalisation techniques 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 such as matchmothers.org, 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, findings 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, Kilvington, Day, Ziersch, & Ward, 2001), psychological provision could be offered, within these services. 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, 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 Empowering Parents, Empowering Communities (Centre for Parent and Child Support, 2017) and the Family Nurse Partnership (fnp.nhs.uk). Additionally, in relation to care proceedings, approaches must recognise strengths and hope as well as risks (Featherstone, Morris & White, 2014), and treat parents with care, compassion and dignity (Schofield et al., 2011; Crittendon, 2005), 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 (Farmer & Lutman, 2012). Furthermore, clinical psychologists should challenge the simplistic blaming of 'troubled families' within political and societal discourses (Featherstone et al., 2014) by highlighting social factors influencing the psychological experiences of disadvantaged mothers, to policy makers, commissioners of health and social provisions, and the media.

Limitations and future research

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, both major factors here. As accessing a wider sex work population can be problematic (Shaver, 2005), this may require innovative methods, for example utilising internet sex work sites. Additionally, a knowledge gap exists regarding male experiences in both sex work and bonding literature, which future studies could explore.

Another limitation was that, particularly due to social expectations, women may have felt compelled to present positive portrayals of bonding, or to interpret experiences within a framework of bonding that they would not have done otherwise. Additionally, although interviews focussed on early maternal experiences, many participants' children were older. 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, 2010), which could be explored utilising qualitative methods.

Conclusion

The 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 'normal' bonding, they were also significantly influenced by contextual factors surrounding their work. Findings specifically highlighted the importance of women's empowerment and care in facilitating bonding. As well as supporting previous findings, the study extends understandings of bonding by emphasising it does not occur in a vacuum but is intricately connected to psychological and social factors. Furthermore, it showed the potential bonding has for motivating powerful change in mothers' lives.

References

Asmussen, K., Feinstein, L., Martin, J., & Chowdry, H. (2016). *Early Intervention Foundation. Foundations for life: What works to support parent child interaction in the early years.* Retrieved 14 August 2017, from http://www.eif.org.uk/publication/foundations-for-life-what-works-to-support-parent-child-interaction-in-the-early-years/

Baker, P. L., & Carson, A. (1999). "I take care of my kids" mothering practices of substance-abusing women. *Gender and Society, 13*(3), 347-363.

Balfour, R., & Allen, J. (2014). *A review of the literature on sex workers and social exclusion.* London: Department of Health.

Basu, A., & Dutta, M. J. (2011). "We are mothers first": Localocentric articulation of sex worker identity as key in HIV/AIDS communication. *Women and Health, 51*, 106-123.

Beard, J., Biemba, G, Brooks, M. I., Costello, J., Ommerborn, M., Bresnahan, M., Flynn, D., & Simon, J. L. (2010). Children of female sex workers and drug users: A review of vulnerability, resilience and family-centred models of care. *Journal of the International AIDS Society, 23*(13), 1-8.

Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Paediatric Child Health*, *9*(8), 541-545.

Bletzler, K. V. (2005). Sex workers in agricultural areas: Their drugs, their children. *Culture, Health & Sexuality, 7*(6), 543–555.

Borelli, J. L., West, J. L., Decoste, C., & Suchman, N. E. (2012). Emotionally avoidant language in the parenting interviews of substance-dependent mothers: Associations with reflective functioning, recent substance use, and parenting behaviour. *Infant Mental Health Journal, 33*(5), 506–519.

Bouchard, G. (2011). The role of psychosocial variables in prenatal attachment: An examination of moderational effects. *Journal of Reproductive and Infant Psychology, 29*(3), 197–207.

Brents, B. G., & Sanders, T. (2010). Mainstreaming the sex industry: Economic inclusion and social ambivalence. *Journal of Law and Society, 37*, 40–60.

British Psychological Society. (2002). *Clinical psychology services in HIV and sexual health: A guide for commissioners of clinical psychology services*. Leicester: Division of Clinical Psychology Publications.

British Psychological Society. (2006). *Clinical psychology sexual dysfunction services in sexual health and HIV and other NHS Services.* Leicester: British Psychological Society.

British Psychological Society. (2007). *New ways of working for applied psychologists in health and social care: working psychologically in teams*. Leicester: British Psychological Society.

Castañeda, X., Ortíz, V., & Allen, B. (1996). Sex masks: The double life of female commercial sex workers in Mexico City. *Cultural and Medical Psychology, 20*, 229-247.

Centre for Parent and Child Support. (2017). *EPEC Research Evidence.* Retrieved 16 August 2017, from http://www.cpcs.org.uk/uploads/Empowering%20Parents%20Empowering%20Communities%20(EPEC)/EPEC%20Research%20Summary%20Evaluation.pdf

Cooper, K., Kilvington, J., Day, S., Ziersch, A., & Ward, H. (2001). HIV prevention and sexual health services for sex workers in the UK. *Health Education Journal*, *60*(1), 26–34.

Crittenden, P. M. (2005). *Attachment theory, psychopathology, and psychotherapy: The* *dynamic–maturational approach.* Retrieved 11 November 2015, from http://familyrelationsinstitute.org/include/docs/attachment_theory_2005.pdf

Crockenberg, S. (1988). Social support and parenting. In W. Fitzgerald, B. Lester & M. Yogman (Eds.), *Research on support for parents and infants in the postnatal period* (pp. 67-85). New York: Cambridge University Press.

Crouch, M., & Mandelson, L. (1995). The social life of bonding theory. *Social science medicine, 41*(6), 837-844.

Dalla, R. L. (2002). Night moves: A qualitative investigation of street-level sex work. *Psychology of Women Quarterly, 26*(1), 63–73.

Dalla, R. L. (2003). When the bough breaks…: Examining intergenerational parent-child relational patterns among street level sex workers and their parents and children. *Applied Developmental Science, 7*(4), 216–228.

Deisher, R. W., Farrow, J. A., Hope, K., & Litchfield, C. (1989). The pregnant adolescent prostitute. *American Journal of Diseases of Children, 143,* 1162–1165.

Department for Children Schools and Families. (2010). *The Children Act 1989 guidance and regulations volume 2: Care planning, placement and case review.* London: Department for Children, Schools and Families.

Department for Education. (2016). *Outcomes for children looked after by local authorities in England*. London: Department of Education.

Department of Health. (2003). *Mainstreaming gender and women's mental health: Implementation guidance.* London: Department of Health.

Department of Health. (2015). *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*. London: Department of Health.

Dodsworth, J. (2014). Sex worker and mother: Managing dual and threatened identities. *Child and Family Social Work, 19*, 99-108.

Duff, P., Shoveller, J., Chettiar, J., Feng, C., Nicoletti, R., & Shannon, K. (2014). Sex work and motherhood: Social and structural barriers to health and social services for pregnant and parenting street and off-street sex workers. *Health Care for Women International, 0,* 1-17.

Farmer, E., & Lutman, E. (2012). *Effective working with neglected children and their families: linking interventions to long-term outcomes*. London: Jessica Kingsley Publishers.

Featherstone, B., White, S., & Morris, K. (2014). *Re-imagining child protection: Towards humane social work with families.* Bristol: Policy Press.

Fegran, L., Helseth, S., & Fagermoen, M. S. (2008). A comparison of mothers' and fathers' experiences of the attachment process in a neonatal intensive care unit. *Journal of clinical nursing, 17,* 810–816.

Feller, C. P., & Cottone, R. R. (2003). The importance of empathy in the therapeutic alliance. *The Journal of Humanistic Counseling, Education and Development*, *42*(1), 53-61.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world.* Chichester, UK: John Wiley & Sons.

Forna, A. (1999). *Mother of all myths: How society moulds and constrains mothers.* Harper Collins.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant–mother relationships. *Journal of the American Academy of Child Psychiatry, 14,* 387–421.

Ghosh Ippen, C., Harris, W. W., Van Horn, P. l., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse and Neglect, 35,* 504 -513.

Gillies, V. (2007). *Marginalised M others: Exploring working-class experiences of parenting.* Routledge: Abingdon.

Goldberg, A. E., Moyer, A. M., & Kinkler, L. A. (2013). Lesbian, gay and heterosexual adoptive parents' perceptions of parental bonding during early parenthood. *Couple and Family Psychology: Research and Practice*, *2*(2), 146-162.

Goldberg, A. E., Moyer, A. M., & Kinkler, L. A. (2013). Lesbian, gay, and heterosexual adoptive parents' perceptions of parental bonding during early parenthood. *Couple and Family Psychology: Research and Practice*, *2*(2), 146–162.

Golding, K. S. (2007). Attachment theory, debate, controversy and hope: A clinician's perspective in BPS (Ed.), *Attachment theory into practice.* Leicester: BPS.

Gorry, J., Roen, K., & Reilly, J. (2010). Selling your self? The psychological impact of street sex work and factors affecting support seeking. *Health and Social Care in the Community 18*(5), 492–499.

Goulet, C., Bell, L., Tribble, D. S., Paul, D., & Lang, A. (1998). A concept analysis of parent-infant attachment. *Journal of Advanced Nursing 28,* 1071–1081.

Hester, M., & Westmarland, N. (2004). *Tackling Street Prostitution: Towards an holistic approach. Home Office Research Study 279.* London: Home Office.

Home Affairs Committee. (2017). *Prostitution: Third Report of Session 2016–17.* London: House of Commons.

Home Office. (2006) *A Co-ordinated Prostitution Strategy and a Summary of Responses to 'Paying the Price'.* London: Home Office Communications Directorate.

Hooper, C., Gorin, S., Cabral, C., & Dyson, C. (2007). *Living with hardship 24/7: The diverse experiences of families in poverty in England.* London: The Frank Buttle Trust.

Hunt, J. (2010). Parental perspectives on family justice system in England and Wales: A review of research. Retrieved 4 April 2017, from www.judiciary.gov.uk/wp-content/uploads/ JCO/Documents/FJC/Publications/Parental_Perspectives_final.pdf.

Kinderman, P. (2014). The role of the psychologist ion social change. *International Journal of Social Psychiatry, 60*(4), 403-405.

Klass, D., Silverman, P. R., & Nickman, S. (1996). *Continuing bonds: New understandings of grief (Death education, aging and health care).* Oxon: Routledge.

Larkin, E. (2006). The importance of developing emotional bonds between parents and children. In D. Iwaniec (Ed.), *The child's journey through care: Placement stability, care planning, and achieving permanency* (pp. 41–59). New York: Wiley.

Leckman, J.F., Feldman, R., Swain, J.E., Eicher, V., Thompson, N., & Mayes, L.C. (2004). Primary parental preoccupation: Circuits, genes and the crucial role of the environment. *Journal of Neural Transmission, 111*, 1435–1463.

Ling, D. C., Wong, W. C. W., Holroyd, E. A. and Gray, S. A. 2007. Silent killers of the night: An exploration of psychological health and suicidality among female street workers. *Journal of Sex and Marital Therapy,* 33: 281–299.

Little, M., & Sodha, S. (2012). *Prevention and early intervention in children's services.* London: Nesta.

Lowe, P., Lee, E., & Macvarish, J. (2015). Biologising parenting: Neuroscience discourse, English social and public health policy and understandings of the child. *Sociology of Health and Illness, 37*, 198–211.

Maestripieri, D. (2001). Is there mother-infant bonding in primates? *Developmental Review,* *21*, 93– 120.

Markin, R. D. (2013). Mentalization-based psychotherapy interventions with mothers-to-be. *Psychotherapy, 50*(3), 360–365.

Mason, Z. S., Briggs, R.D., & Silver, E. J. (2011). Maternal attachment feelings mediate between maternal reports of depression, infant social-emotional development, and parenting stress. *Journal of Reproductive and Infant Psychology, 29*(4), 382-394.

McCelland, G. T., & Newell, R. (2008). A qualitative study of the experiences of mothers involved in street-based prostitution and problematic substance use. *Journal of Research in Nursing, 13*(5), 437-447.

McGee, M. D. (2016). Contemporary formulation-based assessment and treatment: A framework for clinical discourse. *Journal of Psychology and Psychotherapy, 6*(3), 1-7.

McLeish, J., & Redshaw, M. (2017). Mother's accounts of the impact on emotional wellbeing of organised peer support in pregnancy and early parenthood: A qualitative study. *BMC Pregnancy and Childbirth, 17,* 1-14.

Mercer, R., & Ferketich, S. (1994). Maternal-infant attachment of experienced and inexperienced mothers during infancy. *Nursing Research, 43,* 344 –351.

Miller, W. B., Sable, M. R., & Csizmadia, A. (2008). Pregnancy wantedness and child attachment security: Is there a relationship? *Maternal Child Health Journal, 12,* 478–487.

Moullin, S., Waldfogel, J., & Washbrook, E. (2014). *Baby bonds: Parenting, attachment and a secure base for children.* London: The Sutton Trust.

Neil, E., Cossar, J., Lorgelly, P., & Young, J. (2010). *Helping birth families: A study of service provision, cost and outcomes.* Centre for research on the child and family. Retrieved 10 April 2017, from http://www.adoptionresearchinitiative.org.uk/briefs/DCSF-RBX10-05.pdf

NHS England (2016). *Implementing the five year forward view for mental health.* Retrieved 8 August 2017, from https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

Oates, M., & Cantwell, R. (2011). Deaths from psychiatric causes. Centre for Maternal and Child Enquiries (CMACE). *BJOG, 118,* 1–203.

Pajulo, M., Nen, N. P., Kalland, M., Sinkkonen, J., Helenius, H., Punama Ki, R., & Suchman, N. (2012). Substance-abusing mothers in residential treatment with their babies: Importance of pre-and postnatal maternal reflective functioning. *Infant Mental Health Journal, 33*(1), 70–81.

Peled, E., & Levin-Rotberg, T. (2013). The perceptions of child protection officers toward mothering in prostitution. *Social Service Review, 87*(1), 40-69.

Perdue, T. R. Williamson, C., Ventura, L. A., Hairston, T. R., Osborne, L. T. C., Laux, J. M., … Nathan, V. M. (2012). Offenders who are mothers with and without experience in prostitution: difference in historical trauma, current stressors and physical and mental health difficulties. *Women's Health Issues 22*(2), 195-200.

Perrelli, J. G. A., Zambaldi, C. F., Cantilino, A., & Sougey, E. B. (2014). Prenatal depression predicts postpartum maternal attachment in low-income Latina mothers with infants. *Revista Paulistia de Pediatria, 32*(3), 257-265.

Perry, D. F., Ettinger, A. K., Mendelson, T., & Le, H. (2011). Prenatal depression predicts postpartum maternal attachment in low-income Latina mothers with infants. *Infant Behavior & Development, 34,* 339–350.

Pires de Almeida, C. P., Sá, S., Cunha, F., & Pires, E. P. (2013). Violence during pregnancy and its effects on mother–baby relationship during pregnancy. *Journal of Reproductive and Infant Psychology, 31*(4), 370-380.

Pitcher, J. (2015). Direct sex work in Great Britain: Reflecting diversity. *Graduate Journal of Social Science, 11*(2), 76–100.

Rackett, P. & Holmes, B. M. (2010). Enhancing the attachment relationship: A prenatal perspective. *Educational & Child Psychology, 27*(3), 33-50.

Richardson, J., & Lelliot, P. (2003). Mental health of looked after children. *Advances in Psychiatric Treatment, 9*(4), 249-256.

Schofield, G., Moldestad, B., Höjer, I., Ward, E., Skilbred, D., Young, J., & Havik, T. (2011). Managing loss and a threatened identity: Experiences of parents of children growing up in foster care, the perspectives of their social workers and implications for practice. *British Journal of Social Work, 41*(1), 74-92.

Schwerdtfeger, K. L., & Goff, B. S. N. (2007). Intergenerational transmission of trauma: exploring mother–infant prenatal attachment. *Journal of Traumatic Stress, 20*(1), 39–51.

Seib, C., Fischer, J., & Najman, J. M. (2009). The health of female sex workers from three industry sectors in Queensland, Australia. *Social Science & Medicine, 68,* 473–478.

Shaver, F. (2005). Sex work research: methodological and ethical challenges. *Journal of Interpersonal Violence, 20*(3), 269–319.

Shieh, C. & Kravitz, M. (2006). Severity of Drug Use, Initiation of Prenatal Care, and Maternal-Fetal Attachment in Pregnant Marijuana and Cocaine/Heroin Users. *Association of Women's Health, Obstetric and Neonatal Nurses, 35*(4), 499-508.

Slade, A. (2002). Keeping the baby in mind: A critical factor in perinatal mental health. *Zero to Three, 22*(6), 10-16.

Sloss, C. M., & Harper, G. W. (2004). When street sex workers are mothers. *Archives of Sexual Behavior, 33*(4), 329–341.

Sloss, C.M., Harper, G.W., Budd, K.S. (2004). Street sex work and mothering. *Journal of the Association for Research on Mothering, 6*(2), 102–115.

Sluckin, A. (1998). Bonding failure: "I don't know this baby, she's nothing to do with me". *Clinical Child Psychology and Psychiatry, 3,* 11–24.

Smeeton, J., & Boxall, K. (2011). Birth parents' perceptions of professional practice in child care and adoption proceedings: implications for practice. *Child and Family Social Work, 16,* 444–453.

Smith, J. A., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J. A. Smith, (Ed.), *Qualitative psychology: A practical guide to research methods*. London: Sage.

Smith, J. A., Flowers. P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis.* London: Sage.

Smith, L. A. (1994). Reconstructing selves: An analysis of discrepancies between women's contemporaneous and retrospective accounts of the transition to motherhood. *British Journal of Psychology, 85,* 371-392.

Soderstrom, K. (2012). Mental preparation during pregnancy in women with substance addiction: A qualitative interview study. *Child and Family Social Work, 17,* 458–467.

Speier, D. (2001). Becoming a mother. *Journal of the Association for Research on Mothering, 3*(1), 7-18.

Stevenson, C., & Petrak, J. (2007). Setting up a clinical psychology service for commercial sex workers. *International Journal of STD & AIDS 2007, 18,* 231–234.

Suchman, N. E., McMahon, T. J., Slade, A., & Luthar, S. S. (2005). How early bonding, depression, illicit drug use, and perceived support work together to influence drug-dependent mothers' caregiving. *American Journal of Orthopsychiatry, 75*(3), 431-445.

The Care Inquiry. (2013). *Making not breaking: Building relationships for our most vulnerable children.* Retrieved 22 April 2017, from https://thecareinquiry.files.wordpress.com/2013/04/care-inquiry-full-report-april-2013.pdf

Travis, W. J., & Combs-Orme, T. (2007). Resilient parenting: Overcoming poor bonding. *Social Work Research, 31,*135-149.

Tri-X Childcare ltd. (2011). *Safeguarding children of women involved in street prostitution.* Retrieved 6 September 2012, from http://www.trixonline.co.uk/website/news/pdf/practice_guide_No-10.pdf.

Van den Bergh, B., & Simons, A. (2009). A review of scales to measure the mother–foetus relationship. *Journal of Reproductive and Infant Psychology, 27*(2), 114-126.

Van Reenen, S. V. & Van Rensburg, E. (2015). South African mothers' coping with an unplanned caesarean section. *Health Care for Women International, 36*(6), 663-683.

Wegar, K. (1997). In search of bad mothers: Social constructions of birth and adoptive motherhood. *Women's Studies International Forum, 20*(1), 77-86.

Wilkinson, J., & Bowyer, S. (2017). *The impact of abuse and neglect on children and comparison of different placement options: Evidence review.* London: Department for Education.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method.* Buckingham: Open University Press.

Figure legends

Figure 1. Inclusion criteria

Table 1. Summary of participants' descriptive information

Figure 2. Diagrammatic representation of themes

Figure 1. Inclusion criteria

Female

Aged 18+

Have one or more child/ren who is/are currently at least one month old

Identify themselves as sex working now or at least during the first two years of child’s life

Had some contact with child during first two years of child’s life

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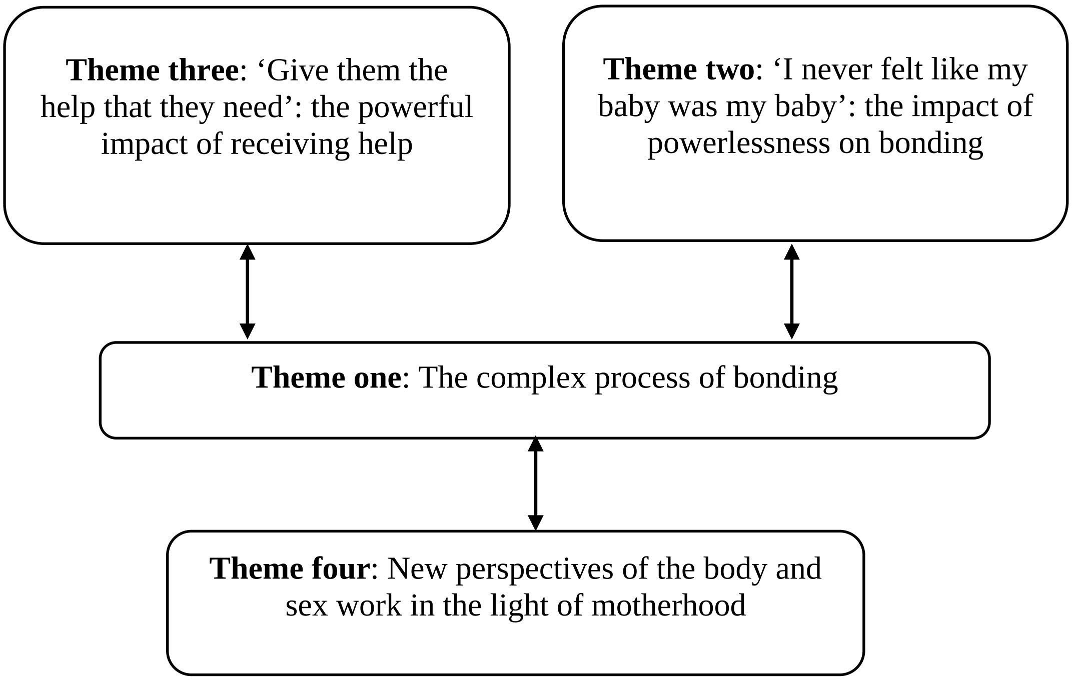
Table 1. Summary of participants' descriptive information

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 parents since. Current contact) 17 (Lived with for 15-18 months then in foster care. Current contact)	Street	Started 16 years ago	Stopped one years ago	19	Yes
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

Figure 2. Diagrammatic representation of themes



Section 2 Appendices

2-A	Manuscript preparation guidelines: Journal for Reproductive and Infant Psychology
2-B	Initial coding of the data: An extract from the analysis of Kate’s transcript
2-C	A narrative summary of a cluster: An example taken from Kate’s interview
2-D	Illustration of how initial clusters led to final themes

Appendix 2-A Manuscript preparation guidelines: Journal of reproductive and infant psychology

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Appendix 2-B Initial coding of the data: An extract from the analysis of Kate's transcript

Initial codes	Transcript excerpt
Felt unable to cope alone Difficult to cope with child's behaviour Recognising difficult for child to adjust to sibling Deliberate attempts to bond As any other mother Trying common maternal activities to bond Attempts to bond failed so went into care Child's behaviour difficult Gave up children for adoption Difficult behaviour led to choosing adoption Adoption was a brave choice Adoption was harsh for her Putting child's needs first Some regret over adopting children Uncertainty about whether she made right decision Treasuring memory of last day with children	**Kate**: Yeah respite, yeah that's what it's called and then um, Lucy came too, um came out and then she came with me and um I couldn't cope on me own, so coz Lucy was being um very rebellant because she came from no baby there to a baby there, I tried um giving her dollies um trying to like do all kinds of stuff a mother would do to you know like to try and and um bond and do you know, like stuff like that, but it weren't um it weren't working so we went into a mother and baby unit but it weren't a mother and baby unit it was like a um, **Midwife**: Was it a foster placement for both of you? **Kate**: Yeah that's right yeah. And um, we went into one of those and um, and Lucy was still um being like being like really rebellant and stuff and that and so um I give my children up for adoption well I, I gave them up, and um, **Interviewer**: And that's Lucy and Amber? **Kate**: Yeah it did take a lot of guts for me to do that and it was really really harsh for me but I thought of their needs before mine and um, sometimes I regret it and sometimes I don't, because at the time I thought it was right for me, for them, and um the last day I see them we had like a bit of a party and stuff and um ill always remember that day and that but yeah-

Appendix 2-C A narrative summary of a cluster: An example taken from Kate’s interview

Emergent themes	Narrative summary of a cluster: Children’s future taken out of my hands. Others stopping me being mum
• Family messed it up for her • Partner spoilt plans • Feels mad with partner for ruining chances of having child • Violent partner • Partner drinking and violent • Partner messed it all up • Men have made problems with children • Conflict between partner and family • Partner and dad spoilt chances of having child live with her • Family’s actions messed up everything up for me • People getting in the way of being a mum • Angry with partner for increasing social services involvement • Men not right for her • Her choice of men has caused problems • Own fault for picking bad lads • Weighing up her responsibility for letting people get in the way of being mum • Conflict in deciding where blame lies • Interrogated by social services • Lack of trust of social services • Social services came on heavily • Burdened by social services investigations • Social services were nosy	This cluster presents the ways that other people stopping Kate from being mum to her children. Kate’s experience is of being on the receiving end of unfair events and practices that led to her losing care of her children. She largely feels she was unable to influence this but questions her level of responsibility in it all too. It seems that Kate was prevented from being mum in the way she wanted by her violent partner, her family, and social services. The moment that led to Kate’s first child being removed was a very significant one for her and one she returns to repeatedly, reliving it and questioning out loud ‘if only’ things had been different. There is a sense that plans for the child were fragile and that it took one event to change everything, so that if things had happened even 20 minutes later everything would have been different. Something very positive and hopeful was ruined and messed up by a conflict between her violent partner and her dad. Their actions triggered a course of events that led to heavy social services involvement and the child being taken from her care. Social services involvement is an important part of Kate’s experience and one she discusses several times. She felt burdened by them and that they were something she couldn’t get away from. They seem very separate from her, like a rigid system that she cannot interact with, influence, or even

• Lengthy adoption process • Can’t get away from social services once they are involved • Being a sex worker held against her by social services • Past used against her • Past held against her by social services • Attempts to get baby affected by drug use • Social services involvement put a dampener on pregnancy • Social services affected pregnancy • Pregnancy experiences affected by social services involvement • Seeing children dependent on mood of their carer • Uncertainty about social care terminology • Seeking reassurance from midwife • Uncertainty about terminology • Confusing pregnancy and labour • Didn’t feel like baby was hers • Mum pushed herself into role as mother • Mum got too attached to child – confused care • Horrible feeling child being taken by grandmother • Mum had more influence over child than her • Grandmother wanting to be mum • Mum had more influence than she did on baby • Competitive element of childcare between her and mum • Daughters think her aunty is their mother • Grandchild as replacement child • Parents feeling they’d lost their daughter to drugs and prostitution • Sudden changed care arrangements • Her and children moved around by social services • Children being moved around	understand, but that has taken control of her most significant relationships. Several times she struggles to make sense of terminology they use and seeks clarification from the midwife present. She believes that being a sex worker was held against her unfairly and influenced their decision for removing her children. There is a sense of passivity and not having any control in the situation, describing her children as being moved around, and not even knowing what the arrangements were or where they all were going to be. Once childcare arrangements have been made with her family, there is still a sense of others preventing her from being mum, as she describes her mum taking over her role. There appears to be a competitive element to the dynamic of her mum and her caring for the children, whereby grandma ‘pushed herself’ into the role as mum. Again, there is a confusion of relational roles and a blurring of boundaries which Kate describes as her mum getting too attached to the child. This left Kate feeling like the baby wasn’t her own and she had no influence over its life. She makes sense of this as her mum trying to replace her as the daughter they had lost to drugs and prostitution. It is as if she is being punished for these things and that they not only prevent her from being a mum by social services, but even from being a daughter. In relationships with her violent partner, her dad, social services, and her mum, it seems Kate feels that the role was taken from her in a way that was unjust and out of her control and she expresses anger towards particularly her ex-partner for this. However, this is not completely clear cut as she also questions her own role in choosing ‘bad lads’ and weighs up her responsibility for letting them get in the way of her having

- Realisation children would be removed - Fragility of care arrangements - Wasn’t allowed child to live with her - Realisation child would be removed - Reliving the event that triggered removal - Unaware of childcare arrangements - Put on the protection - ‘if only…’	her children. She seems undecided how much she could have made different choices though and her main frustration remains with the people and systems around her.

Appendix 2-D Illustration of how initial clusters led to final themes

Participant	Theme 1: The complex process of bonding	Theme 2: ‘I never felt like my baby was my baby’: the impact of powerlessness on bonding	Theme 3: ‘Give them the help that they need’: the powerful impact of receiving help	Theme 4: New perspectives of the body and sex work in the light of motherhood
Kate	Shattered dreams of being with child Bonding as beautiful, inevitable and reciprocal	Children’s future taken out of my hands. Others stopping me being mum Shattered dreams of being with child maintaining her identity as mum	Becoming a mother amidst complexity and chaos. Everything is connected?	maintaining her identity as mum
Linda	Drugs and removal preventing bonding Turning to drugs and sex work to cope with losing her child	Battling for control of her role with her children		I won’t let the same thing happen again Developing an identity as a mum Wanting something different for her children
Helen	A special bond that she hopes is reciprocal and long lasting	Shutting down from emotions and future children after the pain of separation	The difference a partner makes to the double loneliness of sex working and becoming a mother	Defending sex working as a demonstration of her commitment to her children

	Shutting down from emotions and future children after the pain of separation		A special bond that she hopes is reciprocal and long lasting	in the light of people's judgments Internal and external pressure to separate sex work and motherhood Using her past to change her children's future
Sue	Mixed feelings towards children Feeling mentally and emotionally distant	Powerless in a web of drug use, violence and sex work	Receiving care relieves the burden of care giving	Not being the mum she thinks she should have been
Kirsty	The power of beautifully bonding with a baby Losing a child lead to going off the rails and keeping a distance from children	Kept from having relationships with her children Bonding paralysed by surveillance	Feeling betrayed and unsupported from every angle	Am I a good enough mum or even a mum at all?
Jenny	Strategic approach to bonding: determined to bond while she has the chance Letting go of the bond	Being trusted as a mum empowers her as a person and leads to a closer bond	Level of support determines keeping baby or not	Trying to do what's best for the child Responding to past experiences by protecting self from the pain of loss

SECTION THREE

CRITICAL APPRAISAL

Reflections on Conducting Qualitative Research with Women Involved in Sex Work about their Bonding Experiences

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Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word Count: 3912

(Excluding tables and figures, reference lists and appendices)

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Introduction

Section Two of this thesis presents qualitative research into women's experiences of bonding with their children whilst involved in sex work, revealing how women navigate the challenges presented by the complex situations they faced regarding their work and wider lives. Using Interpretative Phenomenological Analysis (IPA, Smith, Flowers, & Larkin, 2009) four themes were identified: 1) the complex process of bonding; 2) 'I never felt like my baby was my baby': the impact of powerlessness on bonding; 3) 'give them the help that they need': the powerful impact of receiving help, and 4) new perspectives of the body and sex work in the light of motherhood. The research enabled women often silenced and marginalised in society, to share their stories of what, for most participants, were incredibly significant parts of their lives.

The main research report relates findings to the research question and broader theoretical fields. Additionally, much has been learned through the process of planning and conducting the research. Accordingly, this critical appraisal reviews key elements relating to carrying out the research, specifically focussing on challenges of conducting research within the sex work industry and exploring a sensitive topic.

Recruitment

Recruiting participants for the study presented a significant challenge. This had been anticipated in terms of gaining participation from a population commonly thought of as difficult to engage (Shaver, 2005) and indeed, there was a significant amount of non-attendance of planned appointments. However, what was not predicted were the difficulties in gaining service support. The study design necessitated the use of gatekeepers for accessing participants. The decision regarding this was informed by discussions with others who have conducted research with women involved in sex work and by recommendations in existing sex work research (Sanders, 2006b). Recommendations identify the importance for both the research and the safety of all involved of working closely with those who have existing relationships with those who sex work and who understand the field generally and the specific location of the study.

The process of establishing research collaboration involved directly contacting services that work with women in sex work to request their involvement and help with recruitment, including specific projects and services frequently working with women involved in sex work, e.g. specialist midwifery and substance misuse services. This identified five services agreeing to participate, making the research tenable.

The first major obstacle to recruitment related to practical factors concerning services. In the period of time between securing service support and beginning recruitment (a period of approximately five months), all encountered problems threatening their involvement. Specifically, the manager of one service was on long-term sick; another had all funding cut for their sex work provision; and the remaining three were re-commissioned and thus uncertain if they could uphold their commitment. As well as presenting difficulties for the research, these circumstances highlighted the volatile context in which many such services function, particularly when they depend on continually securing funding. Whilst frustrating for me, the impact on staff within these services, in terms of stress, loss of morale, and a sense of being powerless to affect change, was evident in our conversations. I also expected it may affect women who depended on the support these services offered.

As a result of service changes, it was necessary to revert to contingency plans. Due to difficulties in predicting samples due to the fluidity and hidden nature of sex work (Shaver, 2005) and problems that can arise with relying on gatekeepers regarding their concerns about the research (Sanders, 2006b), Sanders recommends having several ‘Plan B’s when recruiting within the sex work industry. Accordingly, I had included in my research protocol plans for expanding recruitment if necessary by broadening inclusion criteria and recruiting through additional services (See Section Four). I therefore contacted approximately 25 more services across the country, many multiple times. Five agreed to participate, two of which comprised of multiple teams, leading to successful recruitment of sufficient participants for the study.

Factors seemingly aiding collaboration included identifying a member of staff who ‘got’ the research topic and believed it was important to recognise the needs of sex working mothers; if a member of staff or organisation were committed to research (at least two people described an interest in research following the study of Psychology and were excited to be involved); and if there were existing relationships. Building relationships with services is important to reassure them of the researcher’s character and that they will not jeopardise existing relationships with clients (Sanders, 2006b). In this regard, my previous experience working and volunteering with sex work projects was valuable in demonstrating commitment to and understanding of the area.

Of the many reasons given for service non-participation, what stuck out to me was a belief the research was too sensitive and/or that services had insufficient resources to manage any related emotional distress, indicating something important about the relationship between services and those they support. Some organisations expressed concern that talking about bonding, particularly for women separated from their children, would raise painful emotions. Several mentioned their fear of ‘opening a can of worms’ which they would be unable to manage, or may result in an increase in harmful behaviours such as drug use. Similarly, in relation to suicide and self-harm based research, Biddle et al. (2013) discuss the prevalence of concerns regarding involvement of vulnerable participants due to fears it may exacerbate distress. Accordingly, one organisation requested a full list of specific interview questions for them to review, despite me explaining its semi-structured and flexible nature. Elsewhere, Sinha (2017) reports Non-Governmental Organisations requesting lists of questions in what she describes as an attempt for them to exert control and vigilance over the methodology. It was evident here that concerns arose from a desire not to expose women to unnecessary harm. However, I wondered if this tended towards being paternalistic, depriving women of choice. The following journal excerpt summarises my reflections following a conversation with a service:

> I appreciate the protectiveness as it shows services are being thoughtful about the people they support and that they care a lot about them but I have also been thinking about the role women have in making these choices…I wonder what would be the harm in women choosing for themselves whether they want to sit and talk with a stranger about difficulties with their children or not… wouldn't they be the best judge of this and whether they think they could cope or want to go there? It feels like services are assuming women don't have the capacity to make these decisions for themselves. (13th October 2015)

Biddle et al. (2013) report how ethics committees' overprotectiveness can reflect a misunderstanding of the risks involved and can prevent valuable research. This is a particularly significant issue in the area of sex work in which offering opportunity for women's empowerment is made more poignant by the ever-present debates regarding choice and power in their working lives.

Cautious responses also highlighted an unmet need within many services for appropriate ways of dealing with difficult emotions. It is imperative to consider the impact of research on participants and not to underestimate what we ask of them (Peter, 2015). Likewise, relaying sensitive events that may have been buried for self-protection has the potential to bring things to the surface that may destabilise participants' current state.

However, it was surprising to me how resistant some services were regarding talking about emotional issues with their clients, as if it would reveal something women were not already painfully aware of:

> I wonder how women are being supported to deal with the trauma they have experienced generally as it’s not as if they are completely unaware of it or it doesn’t affect their day to day lives… if the organisation can’t manage it then who does and who will? And what happens normally if these topics come up? Are they avoided? What is that like for women? (13th October 2015)

I wondered if this repeated message to not go near painful emotions was indirectly communicated to clients and what the impact might be in terms of women feeling emotional distress was prohibited and unsafe, and separating physical and emotional needs. This became apparent when I met a woman who wanted to discuss participation. During a ten-minute discussion about the research and eligibility, she relayed several traumatic experiences regarding her children and the impact on her:

> She was teary talking about the trauma she has experienced and said she normally locks it away and doesn’t talk about it but it’s probably why she uses drugs...it reminded me again how little there is for people in her situation – all seems to be practical support, help to get off drugs, housing, safety etc. – all so valuable but ignores the underlying factors and there don’t seem to be many options for dealing with this in a safe way. Services seem to be set up in a way that enables women to keep things hidden and denied. (26th January 2016)

It was thus clear that some women desired opportunities to deal with difficult experiences but without a clear means of finding support. This corresponds with a general prioritisation of physical over mental or emotional health needs within sex work research and practice (Gorry, Roen, & Reilly, 2010; Sanders, 2004). It was clear that several professionals were acutely aware of the unmet emotional needs of women within their services but felt ill-equipped and under-resourced to respond. This highlights a role for clinical psychology in providing flexible services to women involved in sex work regarding their multiple and diverse needs and in supporting services to offer more holistic care.

Power and Ethics

Due to the sensitive nature of the research and the potential vulnerability of clients, as discussed, considerable attention was given to ethics. I was especially aware of issues of power in relation to the research, particularly poignant in this context, in terms of the degree of power women have over their own bodies and in relation to the law and wider society. I was therefore aware of potentially occupying a relatively powerful position, in terms of occupational status as well as wealth, class, education, and family situation. Furthermore, the research process possesses inherent power imbalances (Beaunae, 2011). Specifically, I was in control of the aims, plans and outcomes of the research, and was asking participants to share personal and intimate memories and experiences to be recorded, interpreted and disseminated by someone else. I particularly considered this during data collection and analysis where I reflected upon my own assumptions and how they impacted the process by which I interpreted women’s experiences.

Previous research has found that people involved in sex work have felt they have been treated as sexual objects by researchers (Sinha, 2017). Similarly, concerns have been raised by researchers, including those who sex work, about academics securing their careers on their study of the difficult experiences of those who sex work (Wolffers, 2014), leading to “suspicions of exploitation” (Sanders, 2006b, p. 463). An awareness of such issues made the research uncomfortable at times, as reflected during planning:

> …it feels like there is an element of exploitation to it – asking services if I can ‘use’ the women for the purposes of my research to complete my qualification. For women in an industry where they are treated as commodities on a daily basis, this is the last thing I want to be doing. How can this be something that women have some control over? Where they genuinely have a voice and a say in how it will work? I’m aware that I will come in as an outsider and potentially from a very different background …ask questions, then analyse them from my perspective and present them in an academic context that feels far removed from the grit and grime of work on the streets. How can it be representative of women’s real experiences and feelings? (4th November 2014)

As indicated, considering power led to attempts to make the research more participatory. I read about participatory research (e.g. Hussein, 2010) and spoke with services and at length with a service user about what they thought was important in terms of the research focus and design. Ideas such as Participatory Action Research ((PAR) Baum, MacDougall, & Smith, 2006) seemed extremely valuable as well as simply involving people sex working more meaningfully throughout the research process, but limitations regarding time, finances, my personal commitments, and the remits of the doctoral programme prevented engaging fully with these options, demonstrating the influence of practical factors upon research decisions.

Despite the above obstacles, I sought to incorporate these ideas within the research. One example was through inviting participants to bring something of personal importance regarding their child, such as a photo or other meaningful item, in line with suggestions to adapt research methods creatively with vulnerable groups (Aldridge, 2012). It was hoped this might give women more ownership of the interview and might enable keeping the child in mind (Slade, 2002). However, most did not do this. This may have been because women did not want to; because they did not have anything to bring; because they were not informed or reminded by staff; or it was another thing to do in the context of lives that for many were overwhelming and chaotic. Although possibly unplanned as she had them with her anyway, one woman showed me scan pictures of her current pregnancy. This led to a positive conversation about her pregnancy and seemed to put her at ease in the interview, indicating this idea may have use in future research with greater consideration regarding practical feasibility.

I also tried to increase empowerment through participants choosing when to do the interview (from a choice of dates and times), and whether to be interviewed by phone or in person. Whilst two selected phone interviews it was not possible to find a time suitable for them. A further option was to ask someone to accompany them. Two women brought their midwife, serving to increase their confidence and alleviate fears about the process. This also seemed to rebalance power dynamics as I became the ‘outsider’ in their world.

Finally, I involved participants through discussion of dissemination. I asked women for ideas about communicating findings, in terms of where, how, and who with. This was important in respecting personal experiences women were sharing and giving them some control over how they were used. Women informed me of people and places that they would like me to share the findings, for example social services and a local drug support team. I also agreed to send a summary of the findings to both the women who participated and the services involved with recruitment. Previous studies have shown that people benefit personally from involvement in research if they think it is worthwhile (Biddle et al., 2013).

Several women identified this, stating that they wanted to use their experiences to help others and so were happy to take part. Similarly, most participants said they appreciated talking about their experiences. However, they also commented on how hard it was to do so, highlighting the importance of considering the emotional needs of participants.

Managing Emotional Distress

Several aspects of the research process already discussed also served to prevent or manage any emotional distress arising for participants from the research, for example, choosing services that could provide post-participation support. Furthermore, the debrief involved reflecting on the interview as well as bringing attention back to the present and providing contacts for further support. The process of gaining informed consent was also important. One woman, for example, expressed interest in participating. However, whilst reviewing the information sheet she seemed anxious and distracted. I reflected on this with her and reiterated participation was voluntary and it might not be a good time for her. She seemed relieved and said she had changed her mind, reassuring me of the safety of the process.

A related consideration was preparing for potential safeguarding concerns arising during interviews. I sought guidance from a colleague who had managed safeguarding issues within similar research, and from an academic from the university with considerable experience in research ethics issues. I developed a clear plan of how to respond to any specific concerns, detailed in Section Four. My clinical role provided experience and confidence in managing these issues, highlighting benefits of the dual role of clinician and researcher.

A final ethical consideration concerned providing participants with a voucher following participation. Although often standard practice among research with people involved in sex work (e.g. Sinha, 2017), this remains a contentious issue, with some arguing it is exploitative (Sanders, 2006a). My reasons for doing so were to express gratitude and to value the time sacrificed, which may have been time away from work. The need to recognise women's expertise and contribution has been highlighted in recommendations by a think tank on sex work research which includes payment for participation as best ethical practice (Jeffreys, 2009). My concerns were that it could persuade people to participate who otherwise would not have. Similarly, Singer and Couper (2008) assert it is only problematic if used to encourage participation in research that is unreasonably risky. It is likely that knowledge about the voucher influenced people's decision to participate as I think was the case for the woman mentioned above, but the fact she withdrew reassured me the process was not coercive. Others however seemed genuinely surprised and appreciative of the voucher.

Me in the Research

Another consideration of the research process was my personal role within it. As I have no personal experience of sex work it has been important to reflect on my own attitudes and assumptions regarding it throughout the entire thesis process. This was particularly apparent when conducting the literature review (Section One). My feelings of sadness and indignation when reading accounts of the impact of discriminatory attitudes women experienced, led me to reflect on my own views. I found myself asking questions such as "do I agree with that (particular view of sex work)?", "What would I do, say or feel in response to my friend or family member telling me about their involvement in sex work?" Recognising my responses to these questions made me aware of my own personal biases and reminded me of the importance of research that allows sex workers to present their own experiences and views in promoting a more holistic understanding of their work and situations. The relevance of this reflective process was affirmed to me in a professional context during a team discussion of a referral for a woman identified as sex working. People reacted by joking about her profession and speaking about her in a derogatory manner, demonstrating the reality of stigma and the need to challenge it.

I also became aware of my assumptions during data collection and analysis. I realised I was expecting sex work to have greater significance in women's lives than it seemed to. As a non-sex worker, sex work was different and interesting to me, but to many participants, it was just one (relatively unimportant) aspect of life, a means to get by. Accordingly, I came to see sex work as one element of women's lives, that in a context whereby they mostly faced multiple disadvantages, was not necessarily the most salient part. Although not true for all women within this study or generally, this demonstrated the influence of my own views as a researcher and the need to acknowledge them, affirming the requirement to do so within IPA research (Smith, Flowers & Larkin, 2009). Similarly, the research influenced my understanding of bonding. I initially chose to focus the interviews particularly on the first two years of children's lives as this has been identified broadly within bonding and attachment literature as a significant stage for infant development and for forming attachments with children (Gerhardt, 2009). However, it was clear from women's experiences that bonding was an ongoing process that continued beyond this period; it fluctuated and was approached differently over time and dependent on circumstance. This not only widened my own thinking but highlighted the importance of developing a more inclusive and diverse discourse culturally about bonding.

My own experiences of pregnancy and motherhood

Although I did not share participants' experiences of sex work, I have personal experience of pregnancy and motherhood. I was pregnant during most of the data collection with my second child. This may have enabled me to approach the research with greater empathy and increased knowledge of the experiences participants described, asking more sensitive and relevant questions accordingly. It may however have influenced my interpretation of the interviews, as discussed above in terms of my views and assumptions. Accordingly, I deliberately sought to bracket my views of bonding by writing a list of assumptions prior to the research. I also noticed how, although earlier in the research I was mostly concerned with the wellbeing of women's children and the potential impact of women's lives on them, as the research progressed, particularly when pregnant myself, I found it easier to empathise with the women as mothers and to consider their needs within this context.

Despite shared experiences, I was acutely aware of the contrasts. This was particularly apparent during an interview where the participant was at a similar stage of pregnancy to me. As she relayed her experiences of having previous children removed and the likelihood of the same outcome for the current pregnancy I was struck by the inequalities between our situations. The closeness in circumstances also meant I perhaps experienced more emotional responses to hearing experiences than I may have otherwise, for example, imagining my own child in some of the difficult situations described, or imagining my responses to having my child removed from my care. I was also aware of the potential impact of my pregnancy on the women during the two interviews where it was visible. Research into pregnancy in the context of therapy has found that a pregnant therapist can represent an intrusion into the therapeutic space (Fenster, Phllips, & Rapoport, 1986) which can lead to feelings of envy, abandonment and rivalry (Grieser, 2006) as well as over-protectiveness and feeling compelled to engage so as not to upset the therapist (McGourty, 2013). Similarly, particularly given the apparent inequalities, I was concerned my pregnancy could provoke difficult emotions for participants or negatively affect the interviews. Although not possible to determine whether this occurred, women's observable responses were in fact positive and the shared experience seemed to build connection. Women were interested to know about the pregnancy and keen to share advice.

Speaking to a mentor and my field supervisor during this process was greatly beneficial, providing a space to reflect on my reactions to women's stories in relation to my own experiences. Although much consideration is often given to the emotional risks of research for participants, less attention is paid to the impact on researchers (Bahn & Weatherill, 2012). My experience here highlighted the value in identifying suitable support for managing emotional aspects of the research.

A final and positive consequence of shared experience with participants was learning from women's insights and experiences. Below is a journal excerpt following an interview where the participant described a particularly optimistic attitude to her child in difficult circumstances:

> How amazing to approach your child like that, so open-handedly and with so much gratitude. I'd like to think more of my time with my children like that, to make the most of every moment and do everything I can for it to be precious and sacred.
> (March 31st 2017)

This demonstrates the gratitude I felt towards participants for sharing their personal stories and how the research process provided a meaningful learning experience to me as both a researcher and mother.

Implications for research

Based on reflections here, to meaningfully implement participatory approaches in sex work research, bottom up research where those involved in sex work are the researchers, either solely or through meaningful collaboration with others with research experience (Sanders, 2006) is vital. They can identify areas of interest and importance to them and ensure processes are respectful, empowering and relevant. One way to promote this would be to offer resources to sex work organisations in terms of research expertise through training or supporting research projects. Furthermore, the use of qualitative methods that provide the opportunity for sex-working women to speak for themselves, as done here, is crucial (Jeffreys, 2009). One example interestingly extended this by publishing unedited transcripts of interviews with sex workers (Perkins & Lovejoy, 2007), removing the potential for researcher bias in shaping interpretation.

Conclusion

In reviewing key elements of the research process, this critical appraisal has discussed significant challenges of conducting research within the sex work industry, and on researching a sensitive topic with potentially vulnerable participants. Specifically, it has considered issues of access, ethics and power, offering suggestions relevant for broader clinical and research practice.

References

Aldridge, J. (2012). Working with vulnerable groups in social research: Dilemmas by default and design. *Qualitative Research*, 14(1), 112-130.

Bahn, S., & Weatherill, P. (2012). Qualitative social research: A risky business when it comes to collecting 'sensitive' data. *Qualitative Research, 13*(1), 19-35.

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health, 60*(10), 854-857.

Beaunae. C., Wu. V., & Koro-Ljungberg. M. (2011). Exploring performativity and resistance in qualitative research interviews: A play in four acts. *Qualitative Inquiry, 17,* 412–421.

Biddle, L., Cooper, J., Owen-Smith, A., Klineberg, E., Bennewith, O., Hawton, K., … Gunnell, D. (2013). Qualitative interviewing with vulnerable populations: Individuals' experiences of participating in suicide and self-harm based research. *Journal of Affective Disorders, 145*. 356-362.

Fenster, S., Phillips, S., & Rapoport, E. (1986). *Therapist's pregnancy: An intrusion in the analytic space.* Hillsdale, NJ: The Analytic Press.

Gerhardt, S. (2004). Why love matters: How affection shapes a baby's brain. Brunner-Routledge: Hove.

Gorry, J., Roen, K., & Reilly, J. (2010). Selling your self? The psychological impact of street sex work and factors affecting support seeking. *Health and Social Care in the Community 18*(5), 492–499.

Grieser, M. T. D. (2006). When the psychotherapist is pregnant. *Kinderanalyse, 14,* 172–195.

Hussein, E. (2010). *Women's experiences, perceptions and attitudes of female genital mutilation: The Bristol PEER study.* London: FORWARD.

Jeffreys, E. (2010). Sex worker-driven research: Best practice ethics. *Challenging Politics:*

Critical Voices. Retrieved 10 September 2016, from http://www.nswp.org/sites/nswp.org/files/Elena-Jeffreys- Sex-Worker-Driven-Research-1.pdf

McGourty, A. (2013). The pregnant therapist and the psychotic client: A phenomenological understanding of the impact of the therapist's pregnancy on the therapeutic process. *European Journal of Psychotherapy & Counselling, 15*(1), 18-31.

Perkins, R., & Lovejoy, F. (2007). *Private sex workers in Australia*. Crawley, W.A.: University of Western Australia Press.

Peter, E. (2015). The ethics in qualitative health research: Special considerations. *Ciência & Saúde Coletiva, 20*(9), 2625-2630.

Sanders, T. (2004). A continuum of risk? The management of health, physical and emotional risks by female sex workers. *Sociology of Health and Illness, 26,* 557–74.

Sanders, T. (2006a). Researching sex work: Dynamics, difficulties, and decisions. In D. Hobbs & R. Wright (Eds.), *The Sage handbook of fieldwork* (pp. 202-221). London: Sage.

Sanders, T. (2006b). Sexing up the subject: Methodological nuances in researching the female sex industry. *Sexualities, 9,* 449–468.

Shaver, F. (2005). Sex work research: Methodological and ethical challenges. *Journal of Interpersonal Violence, 20,* 296–319.

Singer, E., & Couper, P. M. (2008). Do incentives exert undue influence on survey participation? Experimental evidence. *Journal of Empirical Research on Human Research Ethics, 3,* 49–56.

Sinha, S. (2017). Ethical and safety issues in doing sex work research: Reflections from a field-based ethnographic study in Kolkata, India. *Qualitative Health Research, 27*(6), 893–908.

Slade, A. (2002). Keeping the baby in mind: A critical factor in perinatal mental health. *Zero to Three, 22*(6), 10-16.

Smith, J. A., Flowers. P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis.* London: Sage.

Wolffers, I. (2014, June). Sex worker's health, HIV/AIDS, and ethical issues in care and research [Editorial]. *Research for Sex Work,* 1-2. Retrieved 14 October 2016, from http://www.nswp.org/sites/nswp.org/files/research-for-sex-work-7-english.pdf

SECTION FOUR

ETHICS SECTION

Becoming Mothers in the Context of Sex Work: Women's Experiences of Bonding with their Children

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Word Count: 5171

Eexcluding tables, reference lists, and appendices)

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Introduction

Early attachment relationships have been widely demonstrated to have a lasting impact on outcomes for a child's biological, emotional and cognitive development (Slade, 2002). Identified as crucial to the formation of secure attachments is the concept of maternal sensitivity, that is, a mother's ability to recognise and attend to the expressed needs of her child. In recent years, an increasing interest has developed regarding a mother's ability to 'hold a baby in mind', referring to the capacity to reflect upon and understand her child's state of mind, as the foundations to such sensitivity (Slade, 2002). Such reflection begins in pregnancy and continues throughout the child's development and has correlations with secure attachment relationships (Slade, 2002).

The majority of the literature about attachment has focused on the child's attachment to the parent and ways of measuring the quality of this. Less attention has been given to the attachment relationship from the parents' perspective in terms of the bond they feel towards the child. However, given the significance of the mother's ability to be mindful of their baby, this is important to understand as it may be indicative of the quality of the attachment relationship they will form with the child (Goldberg, Moyer, & Kinkler, 2013).

Multiple factors can contribute to a mother's ability to bond with her child and to nurture their children's development of secure attachments. This relates to all women due to the range of threats posed by entry into motherhood, such as shifts in identity and role and changing relationships with others (Soderstrom, 2012). However, the mother-child relationship can be particularly problematic when additional stressors exists such as maternal mental health difficulties, a history of problematic attachment relationships for the mother, drug and alcohol abuse, or social difficulties.

Female street sex workers are a population for whom such challenges will frequently be present. While many types of sex work exist, sex work on the streets (as opposed to in a brothel or via an escort agency for example) has been shown to pose particular risks to women (McClelland & Newell, 2008; Sloss & Harper, 2004). Many women involved in street sex work are marginalised within society, and commonly face challenges such as drug and alcohol abuse, housing difficulties, and social deprivation (Tri-X Childcare, 2011). Previous research has suggested particular difficulties for substance abusing women in developing secure attachments with their children (e.g. Suchman et al., 2010). In addition, selling sex on the streets is often accompanied by experiences of violence, exploitation, and danger (Dodsworth, 2011). Existing research suggests links between sex work and psychological distress such as depression and PTSD (Rossler, Koch, Hass, Altwegg, Ajsacic-Gross, & Landolt, 2010).

These factors pose potential barriers to sex working mothers' capacity to form nurturing relationships where their children can develop secure attachments. This may be due in part to the multiple demands placed on mothers' emotional, financial, and physical resources, and the impact of physical threat experienced through work and other relationships. Dodsworth (2014) described stigma and shame with regards to parenting as expressed by sex workers in her research (e.g. Dodsworth, 2014), potentially influencing the way in which a mother relates to her child. In addition, correlations have been found between childhood abuse and trauma and involvement in the sex trade (Dodsworth, 2011). Significantly, for women where a history of abuse has hindered their own development of a secure attachment, it is likely to be more difficult for them to nurture such an attachment with their own children (Slade, 2002).

The challenges women in this context may face with regards to caring for their children results in a large number of children being removed from their mothers at an early age. From data involving 333 sex-working women across the UK, Hester and Westmarland (2004) found it was twice as likely for children to be living away from the mother as with them. Whilst removal of the child is often necessary for their protection, this is likely to have long-term effects on both mother and child. Some report that this separation leads to women spiralling into more chaotic and dangerous lifestyles (e.g. Sloss & Harper, 2004). The most recent Centre for Maternal and Child Enquiries report documents the negative impact of child protection on mental health for mothers and increased maternal suicide (Oates & Cantwell, 2011).

Despite the high proportion of sex workers who are mothers (Sloss & Harper, 2004), limited research exists concerning the impact of this or the nature of the relationship between these two roles. Some researchers have considered the parenting role in relation to other aspects of women’s lives connected to sex work, for example, HIV (Basu & Dutta, 2011), or involvement in the criminal justice system (Perdue et al., 2012). Several studies have focussed on dual roles or identities and how women negotiate their involvement in two occupations seemingly at odds with one another (e.g. Dodsworth, 2014; Sloss & Harper, 2004), although often the focus has how parenting affects attitudes towards work rather than the impact of the work on parenting. McClelland and Newell (2008) completed a small qualitative study with women involved in street-based prostitution and problematic substance to explore their overall situation and the challenges they faced. They present themes relating to risky lifestyle choices, high levels of stress and emotional difficulties of separation of children and suggest the need for further in depth research to understand factors relating these two experiences.

To my knowledge no studies to date have explored specifically the experience of mothers regarding bonding with their children within this multifaceted and chaotic context. Considering the high numbers of women working in street sex-work thought to be mothers and the vulnerabilities connected to the work, it is important to understand how women relate to their children in this context; what factors impact upon their capacity for nurturing secure attachments with them, and how this process impacts on the women themselves. Further explorations of these areas can potentially broaden understanding about the lives of women involved in sex work and their specific needs and strengths.

Greater understanding of attachment processes can lead to more suitable early intervention in supporting parents to develop their ability to be sensitive to the needs of their child (Crittendon, 2005). In the context of sex working mothers, there may be an important role for clinical psychology at several levels including direct work with women during pregnancy; interventions with mother and child, and consultation and training for midwives or other professionals working directly with sex workers to encourage appropriate responsiveness to their psychological needs around mothering. Additionally, developing our understanding of the impact of sex work on the mother-child relationship may inform work with children of sex workers or with women to whom this applies but who have entered services for unrelated reasons.

Within this theoretical and clinical context, *the present study will explore how women experience the bonding process with their children in the context of street-based sex work, specifically seeking to understand their perceptions of how their work impacts upon this bonding process and what impact these relationships have on them individually.*

This study is primarily concerned with the early bonds mothers form with their children in the first two years of life because of the significance of this period in attachment and development for children. However, as this process might be disrupted for many women in this context due to reduced contact with their children as well as contributing factors such as social difficulties, drug use, or relational difficulties, bonding may occur in a less predictable manner and over a different time period. To accommodate for this and to learn more about how bonding is experienced by sex working mothers, the study will include mothers regardless of their children’s age and mothers with varying amounts of contact with their children.

The study will use a qualitative methodology, suitable for exploring experience in depth and offering the opportunity to listen to the experiences of women who are often silenced by society (Dalla, 2003) and are not often included in clinical psychology research and practice. The research is phenomenologically informed, prioritising the lived experience of the women involved. This is particularly important in the context of parenting whereby mothers’ own experiences, including their experiences of resilience and coping, may be missed due to legal processes that necessarily prioritise children’s safety. This study aims to allow women to relate their own experiences of developing relationships with their children rather than making assumptions based upon research with other populations or in different contexts.

Method

Participants

The study aims to recruit up to 12 participants although qualitative analysis will be possible with fewer. Participants will meet the following inclusion criteria:

- Female
- 18+
- Have a child aged between 1 month-5 years who was born whilst involved in street-based sex work (self-defined)
- Currently involved in street-based sex work (self-defined)
- Have some regular contact with child
- Able to converse in English

Design

The study will have a phenomenologically informed qualitative design, interested in gathering participant's understanding of their experiences. Services that work with women in sex work, including those involved here have been consulted in planning this research, as has a service user from one of the recruitment sites. Their feedback has been incorporated in the design.

Individual semi-structured interviews will be used to collect data. The semi-structured design provides some guidance in the form of pre-conceived topic areas which offer a containing structure and direction to the interview whilst also allowing space for the participant to discuss experiences not covered directly by questions, and for the interviewer to follow up on material. The interviewer will offer choice to the participant in terms of the direction of the interview and will follow their lead in terms of how many prompt questions are required. Interviews are expected to last up to an hour but will be longer if the participant wishes and there is more material to cover. Interviews will be cut short or paused at the request of the participant.

Participants will be given the option of bringing to the interview an item of importance to them relating to their child. This is in line with adapting research methods to be more creative and participatory when working with vulnerable groups (Aldridge, 2012). It is hoped that if participants choose to do this it will offer them a greater sense of ownership over the interview process and will provide the opportunity for the child to be remembered during in the research. It will be made clear that this is optional and if participants choose to do so, this will act as a focus for questioning.

The interviewer will aim to make the interview as relaxed as possible for the participant by conducting the interview in a familiar and comfortable setting and providing refreshments. Participants will also have the option of bringing a companion to the interview (e.g. a friend or key worker) if this enables them to feel more comfortable. It will be made clear that the focus is on what the participant shares and only their contributions will be analysed or included in the report. Including this option was suggested by two of the services involved based on previous experience of conducting research with service users.

Participants can choose to be interviewed over the phone if they prefer, in which case they may still choose to select an item to discuss but this will not be seen by the chief investigator.

Recruitment

Participants will be recruited across 5 different sites:

[NAMES REMOVED TO PRESERVE CONFIDENTIALITY]

A gatekeeper has been identified at each site whom the chief investigator has developed a working relationship with in order to work closely on recruitment. Recruiting solely through services, although excluding those who have no contact with services, has been planned deliberately to ensure that any additional support required by participants can be provided by the service involved. This has also allowed for services to influence the design of the research in relation to making it as accommodating to service-users’ needs as possible.

The following plans have been made in the case of difficulties with recruitment:

Phase two: If after four weeks of recruitment less than 4 participants have been recruited

- Inclusion criteria may be broadened to participants who:
    - Have children minimum age one month but no maximum age limit
    - were/are involved in sex work during first two years of child’s life (or up to present time if child under 2)
    - Had some contact with child during first two years of child’s life

Phase three: If after 6 weeks less than 6 participants have been recruited

- Inclusion criteria may be broadened to participants who:
    - were/are involved in sex work (self-defined – not necessarily street-based) during first two years of child's life (or up to present time if child under 2)
- Additional services that offer support to women involved in sex work may be used for recruitment, providing they meet the following criteria:
    - Staff available to facilitate recruitment as set out in this document
    - Support available for women after involvement in research if needed
    - Safeguarding procedures in place to follow during research process
    - The service can provide a private room for interviewing for face to face interviews. Depending on resources, recruitment through services far from the chief investigator's base may only offer phone interviews (see poster advertising this).

Procedure

The following diagram explains the recruitment procedure. Steps have been taken to ensure the confidentiality of participants is respected and to ensure their safety and wellbeing remain a priority.

1. Information shared with relevant staff from all recruitment sites about the project. Chief investigator to provide each service with available interview times.
2. Posters put up at recruitment sites and fliers left in waiting rooms where this is possible practically. A named staff member or the chief investigator will be identified who can be contacted for more information*.
3. Staff to identify service users who may meet criteria and inform them directly about the project and what it involves. They will give out information fliers.

4. Staff to ask women if they would like more information or to be involved, making clear there is no obligation to say yes. Staff member can provide information sheet to service user, answer their questions, and give out contact details for the chief investigator where possible*.
5. If interested, staff member will arrange an appointment time with the service user or provide the chief investigator's contact number for the service user to arrange an appointment directly. This will be as soon as possible after interest has been expressed to give the best opportunity for service users to participate. This reflects the challenges recognised by services of arranging appointments in advance.
6. Chief investigator will attend planned appointments arranged with service users through staff members. This appointment may take place on the phone.
7. For face-to-face interviews, staff member will introduce service user to chief investigator and opportunity will be given for further information to be shared/ questions asked. If any other service users express interest whilst the chief investigator is at the service, the research will be discussed with them using the information sheet and opportunity will be given to take part in the research at a convenient time.
8. If service user wants to participate after discussing further, interview will be conducted immediately or arranged for a later time with the service user at their request.
9. Interview will take place in a private room provided by the service. Refreshments will be provided. Only the chief investigator, participant and any person they have chosen to accompany them will be present. The interview may also be conducted on the phone if preferred by the participant or in cases where resources do not allow for the chief investigator to travel, as long as this is on line with service policy.
10. Opportunity for debrief will be given both with the chief investigator after the interview and with a staff member if requested. In the case of phone interviews, the participant will

be directed to the service for this if wanted.

* A research phone is available for the chief investigator to use provided by Lancaster University DClinPsy programme. This phone number will be added to recruitment material so service users can contact the chief investigator to find out more or arrange an interview. Some of the recruitment sites have policies that do not allow for phone numbers to be given out to service users in this way. Such policies exist to provide a consistent contact for women within services and to ensure communication with service users is in line with the service's approach to supporting women. Accordingly, phone numbers will only be provided in agreement with individual services. Similarly, phone interviews will only be offered where in keeping with service policy.

Interviews will take place in centres used by the services involved or over the phone. For face to face interviews, service's buildings are likely to be familiar to most participants so should be accessible and comfortable for most participants. Conducting the interviews in these locations also enables easy access to staff members from the service if required. A staff member will be available to contact during interview times regardless of whether the interview is pre-planned. Although this may limit confidentiality concerning participation, this has been chosen to prioritise the safety of participants and the chief investigator so that any concerns arising can be managed through the procedures and policies in place at the particular service. Offering phone interviews may be preferable for some participants in maintaining some anonymity and having the conversation in a setting of their choosing. Phone interviews will be conducted within working hours of the service when staff will be available for debriefing afterwards if necessary. The chief investigator will conduct phone interviews in a private room using the research phone allocated from Lancaster University.

Materials

Interview schedule: The interview schedule outlines topic areas to cover during the interview in a flexible manner. The emphasis will be on allowing the participant to describe their experiences as fully as possible with little interruption or leading from the interviewer and to share thoughts and feelings that are important to them in relation to their experiences. Example questions are included within each topic area to guide both the interviewer and participant if needed. The schedule also includes important factual information to gather during the interview. The interviewer will judge the most appropriate time to ask for this information if it has not been provided naturally during narrative responses.

The topic areas and questions have been informed by the research question and draw on attachment theory and research (e.g. Adult attachment interview, Haltigan, Roisman, & Haydon, 2014; The parent development interview, Slade, Aber, Bresgi, Berger, & Kaplan, 2004).

Audio recording equipment: All interviews will be recorded using digital recording equipment available to loan from Lancaster University, subject to participants' written consent.

Recruitment materials: Flier, poster, information sheet as described above. Separate documents have been prepared for each phase of recruitment. Details will be changed according to recruitment site.

Consent form and Request for further involvement form

Research phone: As discussed above.

Analysis

Interview transcripts will be analysed using Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009). This will focus on interpreting the data and identifying themes that focus on participants' lived experiences. Reading and re-reading of the transcripts will form an important part of the analysis to ensure as close an understanding of participants' described experiences as possible. The analytical process will be an iterative one of going back and forth checking and refining themes against the data, rather than a unidirectional linear progression through the stages (Howitt, 2010). The development of themes will be checked by the Academic Supervisor.

Costs

- Paper and printing for participant information sheets, consent forms, interview schedules: covered by University.
- Travel expenses to recruitment sites for interviews and meetings
- £10 voucher for each participant (up to total of £120)
- Reimburse expenses of attending interview (up to total of £20 for each participant with a copy of their travel documents e.g. bus ticket)

Ethical issues

Consent

Consent will be sought from patients before conducting interviews. This will include consent to audio-record the interview. An explanation will be given regarding the study's aims and what participation will involve referring back to the information sheet. Opportunities for questions will be provided. Participants will be informed of the choice to end the interview at any point and to withdraw their consent to use their information up to two weeks post-interview. For face-to-face interviews, consent will be written. For those opting for a phone interview, a consent form, along with a stamped addressed envelope will be provided with the information sheet either by a member of staff or by post if the person has contacted the chief investigator directly to express interest in the research. Interviews will not take place until the signed consent form has been received by the chief investigator, and this will be explained to potential participants. Upon commencing the phone interview, the chief investigator will review the consent form with the participant over the phone to check their understanding and that they want to proceed. They will have the opportunity to ask any questions and withdraw their consent if they choose.

For those opting for a phone interview, a consent form will be provided with the information sheet either by a member of staff or by post if the person has contacted the chief investigator directly to express interest in the research. At the time of the phone interview, the chief investigator will check that the potential participant has read the information sheet and answer any questions they may have. They will then read and reiterate the aim of the study before taking verbal consent over the phone. This will be done by reading each individual clause from the consent form and asking if the person agrees. The chief investigator will state their name at the beginning of the recording and the participant must state their name and the date at the end of agreeing to all of the items on the consent form. After consent has been given, a new recording will begin for the interview and the two audio files will be stored separately. These procedures for taking verbal consent have been discussed with the ethics representative for the DClinPsy course.

Confidentiality

- As face-to-face interviews will take place at centres used by services and interviews will be arranged through staff for many participants, it is likely that services will know who has participated in the research. This has been planned with the safety of both the researcher and participant in mind as discussed above. However, names of participants will not be shared with the service unless there are safeguarding concerns that need to be reported to the service. Women will be informed that the service may know about their involvement before consenting to participate. It is not expected that participating in this research will have any impact on the service they receive as the research is external.

- Recordings will be transferred from the audio recording device and saved on Lancaster University's password-protected virtual learning environment on the same day as the interviews take place. Audio recordings will be permanently deleted after transcription.
- Transcribed data will be stored on Lancaster University's Virtual Learning Environment which is password-protected.
- Consent forms and request for further involvement forms will be stored securely in a locked case at the chief investigator's home until possible to scan and save as individual password protected electronic files on Lancaster University's server. Recordings of verbal consent will be stored as separate electronic files on Lancaster University's server. For phone interviews, if participants choose to be involved in dissemination and wish to provide contact details for this, the chief investigator will take their details and complete a 'request for further involvement form' which will be stored in the same way as for face to face interviews. This will be done at the end of the interview with the recording turned off so no personal data is recorded with the interview.
- After the completion of the project, electronic copies of transcripts, recordings of verbal consent, and scanned copies of all consent forms and request for further involvement forms will be saved as individually encrypted password protected electronic files and transferred to the DClinPsy Research Coordinator using ZendTo File transfer software. Data will be stored by the Research Coordinator in a password protected file space on the encrypted Lancaster University server. Personal data (consent forms and request for further involvement forms) will be destroyed after 12 months and other research data after 10 years from the date of submission. If the study is written up for publication in an academic journal research data may be stored for ten years after the date of publication, in keeping with academic publication protocols.

- Anonymity will be ensured through the use of pseudonyms, which will be assigned at the transcription phase. Only the chief investigator and academic supervisor will read the original transcripts and the academic supervisor will listen to the first audio recording.
- The research phone, including any potential participants’ contacts stored on it will be password protected and be stored in the chief investigator’s home.

Safeguarding

It is possible that participants may discuss content in the interview that raises concern that either the participant or somebody they refer to is at risk of significant harm. If this occurs, the following steps will be taken:

1. Clarify what the participant has said if there is any confusion (e.g. if a participant talks about ‘ending it all’ ask them what they meant by this).
2. If it is clear that somebody is in immediate danger of serious harm, (e.g. if a participant refers to a baby who has been left alone at home), the chief investigator will explain to the participant that the interview needs to be paused and the information will be passed on to the service contact. They will then follow the service’s safeguarding procedures. The interview can be continued or rearranged if appropriate.
3. If the disclosure regards on-going risks to the participant or other (e.g. if a participant refers to regularly leaving their child in the care of a violent partner), the chief investigator will follow it up at the end so as not to interrupt the interview. The chief investigator will then discuss with the participant if this information has been shared previously with the service or other relevant services. They will be encouraged to discuss it with a member of staff from the service if not already done. If they are not willing to do so, the participant will be informed that the chief investigator has an

obligation to share this information with the service and they will follow their safeguarding policy accordingly.

4. If the chief investigator is unclear whether a disclosure is of concern and needs to be discussed with the service, they will consult a research supervisor first and seek their advice, recording their query in writing via email without personally identifying the participant. The issue will then be discussed with the service if necessary.

Participants will be informed of these boundaries of confidentiality before they consent to participate. The chief investigator has experience in making similar judgments regarding risk to clients and others through their role as a trainee clinical psychologist, and has participated in training regarding this.

Influence of alcohol or substances

Interviews will not be conducted if participants are obviously under the influence of alcohol or other substances when they attend. This is to ensure the safety of both the chief investigator and the participant and to ensure participants have the capacity to consent to participate and are able to engage in the interview. If this occurs, it will be explained to participants and a future interview will be arranged if wished.

Emotional distress

As participants will be discussing personal and potentially emotive topics during the interviews, there is the possibility that they may become distressed during or after taking part. The interviewer will monitor this throughout the interviews and offer the choice of taking a break if a participant is becoming visually distressed. The chief investigator will use their skills gained from clinical psychology training in this process.

An opportunity for debrief will be offered at the end of each interview with the chief investigator, where the participant will be invited to share any concerns raised during the interview and details of other support services will be provided. They will also be offered the opportunity to talk further with a member of staff if they wish. Recruitment is only being conducted at sites where they have the resources to respond to any such emotional distress arising from the research. Whilst support is available, it is hoped that this will not be necessary and that participating in the research will be a positive experience for participants.

Researcher safety

Due to the personal nature of the research, material may be discussed in interviews that is distressing to the interviewer. In order to manage the impact on the chief investigator and reflect on how this may influence the research, supervision focussing on process issues has been arranged throughout the period of data collection through the DClinPsy programme. This will involve either face to face or phone supervision following each interview. The focus of this will be on the impact on the researcher rather than discussing details of the participant. The participant’s personal details will not be shared with this supervisor. Such reflection has been recommended when doing qualitative research with sensitive topics (Bahn & Weatherill, 2012).

Conducting interviews within service locations or over the phone enables any threats to physical safety to the chief investigator to be minimised as staff from services will be available if needed.

Dissemination

- Findings from the research will be written in a report as per the requirements of the DClinPsy programme.
- Findings from the research will be presented at Lancaster University as part of the DClinPsy programme.
- The chief investigator aims to publish the research in a relevant academic journal.

- Each service involved will be given a summary of the findings of the research.
- Each participant will have the option to be given a summary of the findings, either sent in the post, by email, or provided through a worker at the service, depending on service policies and the preference of each participant.
- As part of the debrief section of the interviews, the chief investigator will discuss with participants the possibility of participating in the dissemination of the findings. The chief investigator will suggest ideas such as doing a presentation to the service about the findings, or helping to present the findings at a relevant conference. Participants will also be asked if they have any ideas about how they would like the findings to be used which they can participate in either with the chief investigator or with the service, dependent on resources.

Timescale

Activity	**Date**
Submit ethics proposal	March 2015
Data collection	May-July 2015
Data analysis	May-August 2015
Comment on first draft of report	September 2015
Comment on second draft of report	October 2015
Submit thesis	December 2015
Viva	February 2016
Dissemination of findings	February-March 2016
Submit paper for publication	April 2016

References

Aldridge, J. (2012). “Working with vulnerable groups in social research: Dilemmas by default and design”, *Qualitative Research*, 1-19.

Bahn, S., & Weatherill, P. (2012). Qualitative social research: A risky business when it comes to collecting ‘sensitive’ data. *Qualitative Research*, *13*(1), 19-35.

Basu, A., & Dutta, M. J. (2011). “We’re mothers first”: Localocentric articulation of sex worker identity as key in HIV/AIDS communication. *Women and Health, 51*, 106-123.

Crittenden, P. M. (2005). Attachment theory, psychopathology, and psychotherapy: The dynamic – maturational approach. Retrieved 11 November 2015, from http://familyrelationsinstitute.org/include/docs/attachment_theory_2005.pdf

Dalla, R. L. (2003). When the bough breaks…: Examining intergenerational parent-child relational patterns among street level sex workers and their parents and children. *Applied Developmental Science*, *7*(4), 216–228.

Dodsworth, J. (2011). Pathways through sex work: Childhood experiences and adult identities. *British Journal of Social Work*, 1-18.

Dodsworth, J. (2014). Sex worker and mother: Managing dual and threatened identities. *Child and Family Social Work, 19*, 99-108.

Goldberg, A. E., Moyer, A. M., & Kinkler, L. A. (2013). Lesbian, gay and heterosexual adoptive parents’ perceptions of parental bonding during early parenthood. *Couple and Family Psychology: Research and Practice, 2*(2), 146-162.

Haltigan, J. D., Roisman, G. I., & Haydon, K. C. (2014). The latent structure of the adult attachment interview: Exploratory and confirmatory evidence. *Monographs of the Society for Research in Child Development, 79*, 15–35.

Hester, M., & Westmarland, N. (2004). *Tackling street prostitution: Towards an holistic approach. Home Office Research Study 279*, London: Home Office.

Howitt, D. (2010). *Introduction to Qualitative Methods in Psychology*. Pearson: Essex.

McCelland, G. T., & Newell, R. (2008). A qualitative study of the experiences of mothers involved in street-based prostitution and problematic substance use. *Journal of Research in Nursing, 13*(5), 437-447.

Oates, M. & Cantwell, R. (2011). *Deaths from psychiatric causes*. Centre for Maternal and Child Enquiries (CMACE), *BJOG, 118*, 1–203.

Perdue, T. R. et al. (2012). Offenders who are mothers with and without experience in prostitution: Difference in historical trauma, current stressors and physical and mental health difficulties. *Women's health issues 22*(2), 195-200.

Rössler, W., Koch, U., Lauber, C., Hass, A.K., Altwegg, M., Ajdacic-Gross, V., & Landolt, K. (2010). The mental health of female sex workers. *Acta psychiatrica Scandinavica, 122*(2), 143-52.

Slade, A. (2002). Keeping the baby in mind: A critical factor in perinatal health. Retrieved 27 January 2013, from http://main.zerotothree.org/site/DocServer/DocServer/vol22-6a.pdf?docID=2121&AddInterest=1144

Slade, A., Aber, J.L., Bresgi, I., Berger, B., & Kaplan. (2004). *The parent development interview, revised*. Unpublished protocol. The City University of New York.

Sloss, C. M., & Harper, G. W. (2004). When street sex workers are mothers. *Archives of Sexual Behavior, 33*(4), 329–341.

Smith, J. A., Flowers, P., & Larkin, M. (2009) *Interpretative Phenomenological Analysis.* London: Sage.

Soderstrom, K. (2012). Mental preparation during pregnancy in women with substance addiction: A qualitative interview study. *Child and Family Social Work, 17*, 458–467.

Suchman, N. E., McMahon, T. J., Slade, A., & Luthar, S. S. (2005). How early bonding, depression, illicit drug use, and perceived support work together to influence drug-dependent mothers’ caregiving. *American Journal of Orthopsychiatry, 75*(3), 431-445.

Tri-x Childcare ltd. (2011). *Safeguarding children of women involved in street prostitution.* Retrieved 6 September 2012, from http://www.trixonline.co.uk/website/news/pdf/practice_guide_No-10.pdf.

Section 4 Appendices

4-A	Research information for staff
4-B	Participant information sheet
4-C	Research poster
4-D	Research flier
4-E	Consent form
4-F	Request for further involvement form
4-G	Contacts for debrief
4-H	Interview topic guide
4-I	NHS Ethics Integrated Research Application System Form (Version 5)
4-J	NRES REC Conditions Final approval letter
4-K	Substantial amendment (1) favourable opinion form
4-L	Substantial amendment (2) favourable opinion
4-M	Substantial amendment (3) favourable opinion
4-N	Substantial amendment (4) favourable opinion
4-O	NHS Site-Specific Information form
4-P	R&D Approval letter
4-Q	Research Proposal Application for an individual service
4-R	Confirmation of approval by individual service

Appendix 4-A Research information for staff

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Research information for staff - version 3

My name is Ruth Elsdon.
I am training to be a clinical psychologist at Lancaster University.

STUDY TITLE: Becoming mothers in the context of sex work: women's experiences of bonding with their children.

I hope to interview women individually about their experiences of becoming mothers while involved in street-based sex work. I am interested to know what this experience has been like and what it has been like for them to form a relationship with their child.

I would appreciate your help in identifying women who might be suitable for the study and asking them if they are interested. Suitable participants will:

- Be over 18
- Have one or more children at least one month old
- Identify themselves as sex working now or at least during the first two years of child's life if child is older
- Had some contact with child during first two years of child's life

If women are interested in taking part, they can arrange an interview through you or by contacting me directly using the details below. Phone interviews are an option for those who would prefer and can be arranged by contacting me on the same number below. All participants will need to read a copy of the information sheet before taking part.

I will need a private space to do face-to-face interviews in a private room. I will need a member of staff to introduce me to the participant on the day if necessary and to be available after the interview in person or on the phone in case they need to debrief with somebody they know. I will also need to report any safeguarding concerns that arise during interviews to a member of staff to be followed up according to the service's normal protocols.

For more information see the information sheet attached or speak to me on r.elsdon@lancaster.ac.uk or 07508375655.

Thank you for your help!

Concerns
If you want to make a complaint or raise concerns about any aspect of this study and do not want to speak directly to me, you can contact:
Jane Simpson. Research director. Clinical Psychology. Divisions of Health Research. Lancaster University. LA1 4YT. Phone: 01524 592858. Email: simpsonj@exchange.lancs.ac.uk

Appendix 4-B Participant information sheet

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Research information

My name is Ruth Elsdon. I am training to be a clinical psychologist at Lancaster University. I am doing a study with women who have had children while sex working.

STUDY TITLE: Becoming mothers in the context of sex work: women's experiences of bonding with their children

You have been asked to take part because you became a mother during the time you were involved in sex work and I am interested to hear about your experiences of having a child. I hope to find out more about what helps mothers in similar situations to you and what, if any, are the challenges.

This study has ethical approval by the RES Committee North West – Haydock, who have agreed it is safe for participants to take part.

What's involved?

1. If you choose to be involved, you will take part in an informal interview with me in a quiet room at ________ or over the phone. It will take about an hour. I will ask you questions about what it was like having your child and what life has been like since, e.g. 'what can you remember about being pregnant?' or 'what difference has being a mum made to your life?' I am interested in what is important to you and your experience.

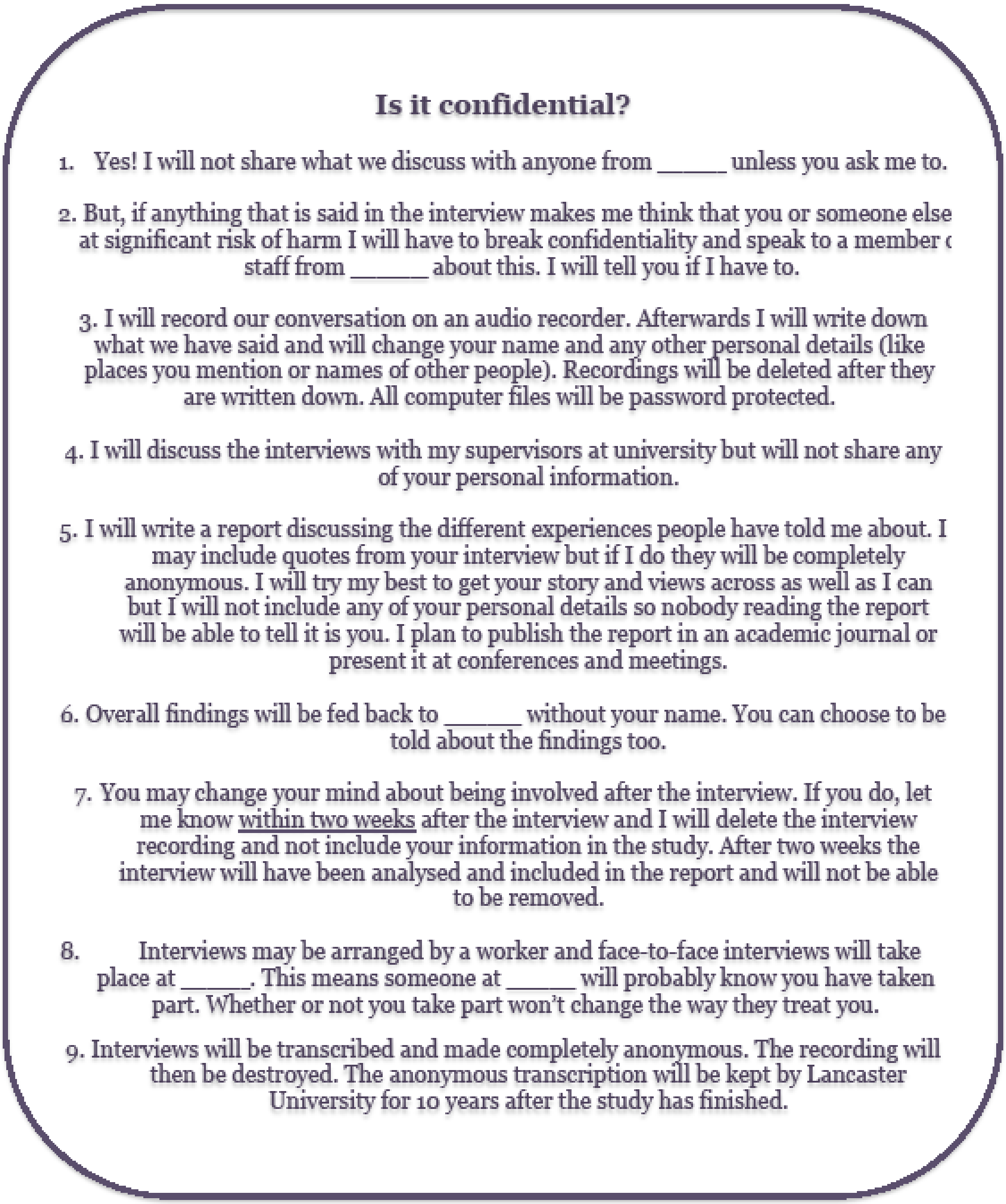
2. You don't have to answer all questions or talk about anything you don't want to. If we meet face-to-face you can bring someone with you if you like (e.g. friend or support worker) but what I am interested in is hearing what you say.

3. I hope that you will find it helpful to talk about your experiences but if you feel upset about anything we discuss you can choose to have a break or stop the interview completely. Afterwards you will have chance to talk with someone from _________ about anything that might be concerning you.

4. You are invited to bring to the interview something to do with your child that's important to you, for example a photo or a toy. You don't have to do this but it may help you talk about your child and help me to understand more about them.

5. You will not be paid for taking part but to compensate for the inconvenience and to thank you for your time I can offer a £10 shop voucher. Your travel expenses, up to £20, can be reimbursed and these will require relevant receipts, e.g. bus ticket. For phone interviews, vouchers can be posted to you or left at _________.

6. For phone interviews, I will take verbal consent over the phone before we start.



Is it confidential?

1. Yes! I will not share what we discuss with anyone from _____ unless you ask me to.

2. But, if anything that is said in the interview makes me think that you or someone else at significant risk of harm I will have to break confidentiality and speak to a member staff from ______ about this. I will tell you if I have to.

3. I will record our conversation on an audio recorder. Afterwards I will write down what we have said and will change your name and any other personal details (like places you mention or names of other people). Recordings will be deleted after they are written down. All computer files will be password protected.

4. I will discuss the interviews with my supervisors at university but will not share any of your personal information.

5. I will write a report discussing the different experiences people have told me about. I may include quotes from your interview but if I do they will be completely anonymous. I will try my best to get your story and views across as well as I can but I will not include any of your personal details so nobody reading the report will be able to tell it is you. I plan to publish the report in an academic journal or present it at conferences and meetings.

6. Overall findings will be fed back to ______ without your name. You can choose to be told about the findings too.

7. You may change your mind about being involved after the interview. If you do, let me know <u>within two weeks</u> after the interview and I will delete the interview recording and not include your information in the study. After two weeks the interview will have been analysed and included in the report and will not be able to be removed.

8. Interviews may be arranged by a worker and face-to-face interviews will take place at _____. This means someone at _____ will probably know you have taken part. Whether or not you take part won't change the way they treat you.

9. Interviews will be transcribed and made completely anonymous. The recording will then be destroyed. The anonymous transcription will be kept by Lancaster University for 10 years after the study has finished.

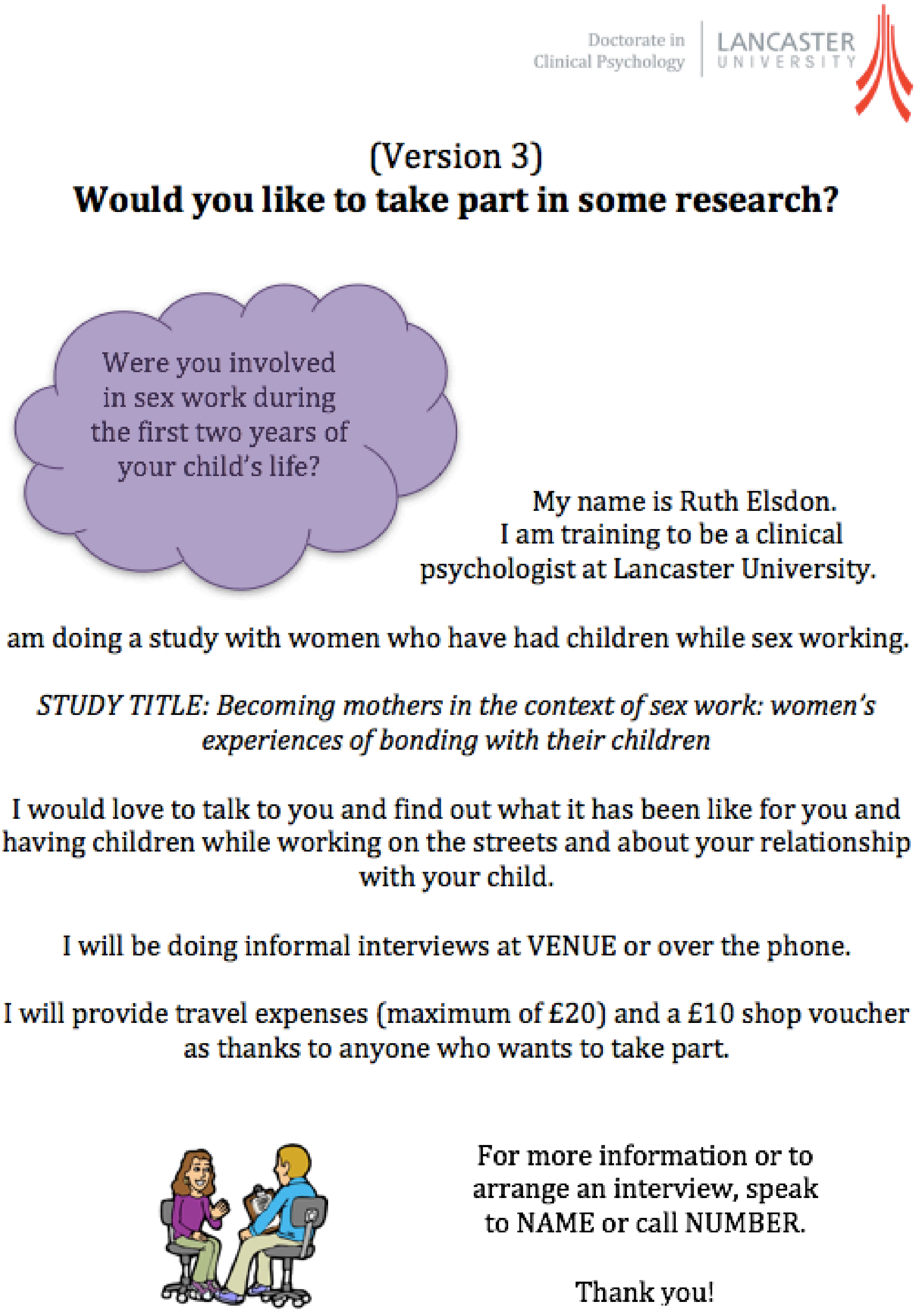
If you would like to take part or want to know more please speak to the person who gave you this information or ring 07508375655.

Thank you for reading!

Complaints

If you want to make a complaint or raise concerns about any aspect of this study and do not want to speak directly to me, you can contact: *Jane Simpson. Research director. Clinical Psychology. Divisions of Health Research. Lancaster University. LA1 4YT. Phone: 01524 592858.Email:simpsonj@exchange.lancs.ac.uk*

Appendix 4-C Research poster



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(Version 3)

Would you like to take part in some research?

Were you involved in sex work during the first two years of your child's life?

My name is Ruth Elsdon.
I am training to be a clinical psychologist at Lancaster University.

I am doing a study with women who have had children while sex working.

STUDY TITLE: Becoming mothers in the context of sex work: women's experiences of bonding with their children

I would love to talk to you and find out what it has been like for you and having children while working on the streets and about your relationship with your child.

I will be doing informal interviews at VENUE or over the phone.

I will provide travel expenses (maximum of £20) and a £10 shop voucher as thanks to anyone who wants to take part.

For more information or to arrange an interview, speak to NAME or call NUMBER.

Thank you!

Appendix 4-D Research flier

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Would you like to take part in some research?

Were you involved in sex work during the first two years of your child's life?

I am doing a study with mothers involved in sex work and would be interested to hear about your experiences.

Please ask INSERT NAME/ or ring INSERT NUMBER for more info.

Thank you, Ruth Elsdon
Trainee Clinical Psychologist
Lancaster University

I will provide travel expenses (up to £20) & a £10 shop voucher as thanks to anyone who takes part

Appendix 4-E Consent form

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Consent Form (version 2)

Study Title: Becoming mothers in the context of sex work: women's experiences of bonding with their children.

You have been asked to take part in a research project exploring women's experiences of having children while involved in sex work. Before you consent to participating in the study please read the information sheet and tick each box if you agree. If you have any questions or queries before signing the consent form please speak to Ruth Elsdon or INSERT STAFF NAME.

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript. ☐
4. I understand that audio recordings will be kept until they have been transcribed. ☐
5. I understand that I am not obliged to take part in this study and can withdraw my participation before, during, or up to 2 weeks after my interview ☐
6. I understand that the information from my interview will be put together with other participants' responses, anonymised and may be included in publications ☐
7. I consent to anonymous information and quotations from my interview being used in reports, publications, conferences and training events. ☐
8. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the researcher will need to share this information with a worker from INSERT SERVICE NAME. ☐
9. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. ☐
10. I understand that personal data in this form and my request for information form will be stored in a password protected computer space and deleted 12 months after the study ends. ☐
11. I consent to take part in the above study. ☐

Name of participant ____
Signature ____________________________Date ____________________
Name of researcher ____
Signature ____________________________Date ___________________

Appendix 4-F Request for further involvement form

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Request for further involvement (version 1)

As a participant in this research you can choose to be involved again in the future in any of the ways listed below. You do not have to do any of these things. Please put your initials in the boxes to show whether you want any further involvement:

I would like to be given a summary of the overall findings when the research is finished ☐

I would like to be involved in sharing the findings with others ☐

I have the following ideas for sharing the findings…

____

____

____

I would like to be contacted (please provide details as appropriate):

By email*____

By post*____

By phone*____

Through INSERT NAME OF SERVICE________________________________

You will only be contacted if you have requested it here. If you change your mind, you do not have to respond when contacted.

**where in line with service policy*

Appendix 4-G Contacts for debrief

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Thank you for taking part in the study.

If you feel upset by anything after this interview you might find it helpful to talk to somebody. These contacts might be useful:

- A member of staff from SERVICE
- Samaritans 08457 90 90 90
- Victim support 0845 30 30 900
- Other local services recommended by each recruitment site

Appendix 4-H Interview topic guide

Interview topic guide (version 1)

a) Participant information

Age

How long have you been working? How frequently do you work?

Current drug use

b) Information about child/ren

Details of children including ages and care and contact arrangements

NB if more than one child, it might be helpful for the participant to choose to focus the interview on one child but they can talk about all children if preferred

The following is a guide of topic areas to cover with example questions that may be asked relating to each topic.

Discussion of object (if brought to interview)

- Can you describe to me the object and its importance to you?

Pregnancy, birth and early days

- Can you tell me what you remember about your experience of being pregnant with this child, including what it was like and how you felt about it?
- What can you remember about your experience of giving birth and the events that surrounded it?
- What happened in the early days? Was the baby with you? Did you have much support?

Relationship with child

- Could you describe your relationship with your child/ren now? Would you say there is a bond* between you? Could you tell me what that is like and how it developed?
- Could you tell me a bit about your child? How would you describe them?
- How easy has it been to develop a bond with your child?

- How has your relationship changed over time?

**check understanding of 'bond' and use language relevant to individual*

Experiences of being a mum

- Could you tell me about your experiences of being a mum generally and what difference it has made to your life?
- How has having a child/ren met your expectations?
- How would you describe yourself as a mum?
- How supported have you felt in being a mum and caring for your child/ren?

Impact of sex work on relationship with child/ren

- How do you think being involved in sex work has affected your relationship with your child/ren, if at all? Has it in any way affected the way you are with your children and could you tell me a bit about this?
- What do you think the impact of using drugs has, if any, on your relationship with your children or on you as a mother? (if relevant)

Impact of having children on sex work

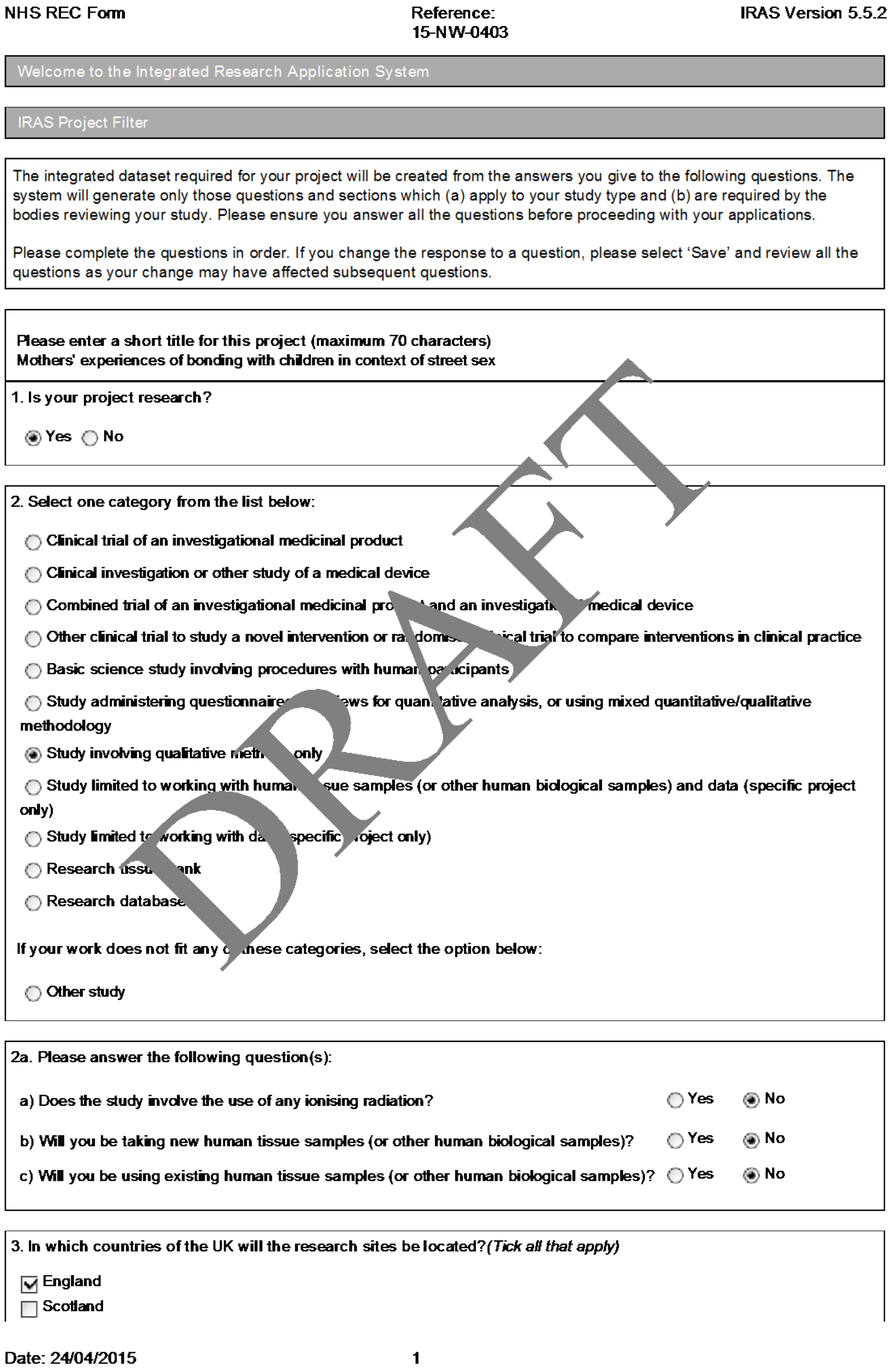
- Has having children affected your work in any way or how you think and feel about your work? Could you tell me more about this?
- Has having a child changed any of the relationships you have with other workers/punters/professionals?

Looking forward and more general questions

- Overall, 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?
- Is there any support that you think might have made it easier for you to bond with your child?
- What has helped you to cope with any difficulties you have had in building relationships with your child/ren?
- Is there anything else you would like to discuss that might be relevant?

Appendix 4-I NHS ethics Integrated Research Application System form

NB. Due to amendments being made to the original REC application, a draft version is presented here, which includes all approved changes to the research.



NHS REC Form Reference: 15-NW-0403 IRAS Version 5.5.2

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Mothers' experiences of bonding with children in context of street sex

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
● Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

3. In which countries of the UK will the research sites be located?*(Tick all that apply)*

☑ England
☐ Scotland

Date: 24/04/2015 1

☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

IMPORTANT: If your project is taking place in the NHS and is led from England select 'IRAS Form'. If your project is led from Northern Ireland, Scotland or Wales select 'NHS/HSC Research and Development Offices' and/or relevant Research Ethics Committee applications, as appropriate.

☐ IRAS Form
☑ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☑ Research Ethics Committee
☐ Confidentiality Advisory Group (CAG)
☐ National Offender Management Service (NOMS) (Prison & Probation)

For NHS/HSC R&D Offices in Northern Ireland, Scotland and Wales the CI must create NHS/HSC Site Specific Information forms, for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

For participating NHS organisations in England different arrangements apply for the provision of site specific information. Refer to IRAS Help for more information.

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or a Diagnostic Evidence Co-operative in all study sites?

Please see information button for further details.

○ Yes ● No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ● No

The NIHR Clinical Research Network provides researchers with the practical support they need to make clinical studies happen in the NHS e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.

6. Do you plan to include any participants who are children?

○ Yes ● No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
The student is the chief investigator and is conducting the research as part of a doctorate in clinical psychology

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

● Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No

Integrated Research Application System
Application Form for Research involving qualitative methods only

NHS
Health Research Authority

Application to NHS/HSC Research Ethics Committee

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Mothers' experiences of bonding with children in context of street sex

Please complete these details after you have booked the REC application for review.

REC Name:
North West - Haydock

REC Reference Number:
15-NW-0403

Submission date:
24/04/2015

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Exploring women's experiences of bonding with their children in the context of street-based sex work

A2-1. Educational projects

Name and contact details of student(s):

Student 1

Title	Forename/Initials	Surname
Mrs	Ruth	Elsdon

Address: Clinical Psychology, Division of Health Research
Lancaster University
Lancaster
Post Code: LA1 4YT
E-mail: r.elsdon@lancaster.ac.uk
Telephone: 01524592970
Fax:

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in clinical psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

Title Forename/Initials Surname
Dr Craig Murray
Address Clinical Psychology, Division of Health Research
Lancaster University
Lancaster
Post Code LA1 4YT
E-mail c.murray@lancaster.ac.uk
Telephone 01524592730
Fax

Academic supervisor 2

Title Forename/Initials Surname
Dr Suzanne Hodge
Address Clinical Psychology, Division of Health Research
Lancaster University
Lancaster
Post Code LA1 4YT
E-mail s.hodge@lancaster.ac.uk
Telephone 01[illegible]12
Fax

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Mrs Ruth Elsdon	☑ Dr Craig Murray ☑ Dr Suzanne Hodge

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

● Student
○ Academic supervisor
○ Other

A3-1. Chief Investigator:

	Title Forename/Initials Surname Mrs Ruth Elsdon
Post	Trainee Clinical Psychologist
Qualifications	BA honours in English Literature and Development Studies Graduate Certificate in Psychology Graduate Diploma in Psychology
ORCID ID	
Employer	Lancashire Care NHS Trust
Work Address	Clinical Psychology, Division of Health Research Lancaster University Lancaster
Post Code	LA1 4YT
Work E-mail	r.elsdon@lancaster.ac.uk
* Personal E-mail	
Work Telephone	01524592970
* Personal Telephone/Mobile	
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

Title Forename/Initials Surname

Address
Post Code
E-mail
Telephone
Fax

[redacted]

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	n/a
Sponsor's/protocol number:	n/a
Protocol Version:	1
Protocol Date:	02/03/2015
Funder's reference number:	n/a
Project website:	n/a

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ● No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

This study will explore the lived experiences of women who are both involved in street-based sex work and who are mothers to young children. It aims to gain a better understanding of what it is like for women to bond with their children within this context including what they believe has helped them to develop relationships with their children and what has made this difficult.
Although no reliable statistics exist, many women are involved in sex work on streets across Britain and a large proportion of these are mothers. It is a lifestyle often accompanied by violence, poverty, and drug use and research suggests links between sex work and psychological distress for many women (Rossler, Koch, Hass, Altwegg, Ajsacic-Gross, & Landolt, 2010). These factors may present challenges to women when they have children in terms of being able to care for their children both practically and emotionally. This is reflected in the fact that many children are removed from the care of mothers who are involved in street-based sex work (Hester & Westmarland, 2004).
It is widely accepted that the quality of the attachment relationship a child develops with their parent in the early days, weeks and months of their life has a long lasting impact on their future overall development (Slade, 2002). It is important to understand the factors that impact on forming this relationship for different mothers. This knowledge can help to provide additional and focussed support for women in developing healthy relationships with their children, and in this context inform professionals working regularly with sex working mothers, and help to better understand the needs of women themselves.
The study will use individual interviews to give women the opportunity to describe their experiences in detail and provide insight into factors relating to bonding with their children.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Purpose and design

While it is accepted that street-based sex workers often represent a fairly vulnerable population and research exists detailing some of the challenges facing them generally, there is limited understanding of the subpopulation who are also mothers. This is particularly true in the field of clinical psychology where sex workers are often a missed population in research and clinical work, possibly due to the complex nature of the needs of many women in this situation which pose a threat to accessing mainstream services.

While many types of sex work exist, this study will focus on women involved in street based sex work whereby sexual services are traded at street level (as opposed to in a brothel or via an escort agency for example). Street sex work has been shown to pose particular risks to women, particularly in terms of health and exposure to violence, and women involved in this type of sex work have been shown to be those who are most vulnerable and stigmatised (McClelland & Newell, 2008; Sloss & Harper, 2004). This study will focus on the particular needs facing women working in this context and how they interact with their experiences of bonding with their children.

It is important to understand the experiences of women in this situation more fully in order to inform both theory about parenting and attachment, and to provide evidence for interventions and to tailor professional support appropriately. This is crucial given the long lasting effect on both mothers and children when early attachment relationships are disrupted due to problematic care or when children need to be removed from the parents' care altogether.

This study has been designed to contribute to understanding the specific needs of this population. It also hopes to give women the opportunity to describe their experiences when they may often have been dismissed as a marginalised population and may have been the subject of scrutiny from professional services and not been able to give their perspective on how sex work has impacted their experiences as mothers. For this reason, semi-structured interviews will be used to allow women to talk openly about their experiences. Participants will be invited to bring along an item of significance to the interview if they choose in relation to their child as an aid to sharing their experiences and to give them greater ownership over the direction of the interviews. This will be optional so that participants do not feel pressured to do so or decide not to participate. Participants will also be given the option of having a phone interview instead if they prefer or where resources do not allow for the chief investigator to travel for interviews.

The study has been designed with input from professionals from services that support women in sex work, including those involved here; from professionals who have completed research with this specific population, from academic tutors who have supervised research in this area, and from a service user from one of the recruitment sites. Their input has been crucial in developing a design that will answer the research question, is practically feasible and is sensitive to the participants involved.

Recruitment

Several issues have been considered in planning how to recruit for this study.

Participants will be recruited through 5 or more specialist services. These include a specialist midwifery service, a substance misuse team, a harm minimisation Service, a service providing holistic support to sex workers, and a service providing general support to women. Recruiting through services means that women with no contact with services will not be included. Snowball sampling was considered to reach these women, but was decided against as it was considered essential to have the framework of a service to provide any necessary support for both the participants and chief investigator regarding any issues arising through the research. It was also felt important that the research does not conflict with the ongoing work of services in each area which can be ensured by working closely with them. However, it is hoped that including a range of services allows for recruitment of women with a range of needs, i.e. not just those accessing support for substance misuse. Additionally, two of the services reach a wider range of women through street outreach who may not access any other support from services.

Some of the recruitment sites have policies prohibiting giving out contact details for researchers and instead choose to coordinate recruitment within the service by arranging appointments with service users and responding to any questions about the research themselves. Whilst again this will not allow for anonymity within these services, the policy aims to provide a consistent and safe support service to women and will be abided by for this research. Where services allow, a phone contact will be given for people to call to find out more about the research or to arrange an interview. This will be a specific research phone provided by the clinical psychology doctorate programme at Lancaster University and will only be used for this project and by the chief investigator. A voicemail message will be recorded onto the phone before recruitment begins stating the purpose of the phone and that only calls regarding the research can be responded to. Any contact details provided over the phone will be stored on the phone which will be kept at the chief investigator's house with a password installed.

From discussions with services and other researchers, the chief investigator is aware that recruiting sex workers can be difficult due to the multiple demands they face and an anecdotal difficulty with planning and attending appointments. To increase the possibility of recruiting sufficient numbers for the research the following steps have been taken:
- Recruit from multiple sites covering different geographical areas
- Allow as long a period of recruitment as possible
- Use a range of recruitment methods including posters and fliers advertising the project and staff from services informing service users directly.
- Arrange appointments through service staff where possible/wished and as soon as possible after service users express an interest, in order to increase likelihood of attendance
- A plan to include additional services after 6 weeks if insufficient numbers recruited by this time. Research has already begun into accessing such services if needed. Additional services would need to be able to follow the recruitment requirements set out in the research protocol, in particular the ability to provide support for women if

needed with regards to the research.
- The option of having a phone interview will be given where this is in keeping with services' policies.

It has been decided that participants will be given a small gift as reimbursement for involvement in the research as well as offering reimbursement for any costs incurred in attending the interview (i.e. travel expenses). This has been decided as a way of valuing the time given by participants to being involved which potentially may result in a loss of business and in recognition of the financial difficulties facing many service users. It is common practice among research with this population to do so (e.g. McClelland and Newell, 2008) and has been recommended by each service. The gift will be in the form of a £10 shop voucher rather than a monetary gift that may be viewed as contributing to any ongoing addictions some service users may have. It is hoped that service users will not experience this voucher as coercive but will weigh up the other potential benefits and risks of involvement in their choice to participate.

Inclusion criteria
Several issues have been considered in identified inclusion criteria.

Lengthly consideration has been given to the age of children of the participants. The study is primarily concerned with the early bonds mothers form with their children, particularly in the first two years of life, because of the significance of this period in attachment and development for children. However, restricting inclusion to mothers of children this age might prevent hearing about experiences of women for whom this process might [illegible] disrupted or altered due to factors such as reduced contact with their children, social difficulties, or drug use, or relationship difficulties. It also might limit the numbers of women who can participate, contributing to recruitment difficulties. To accommodate for this and to learn more about how bonding is experienced by sex working mothers, the study will include mothers whose children are older but who still feel they are able to discuss the early years of bonding with their children.

A minimum age for the child of one month has been included as women may be in a more fragile emotional state in the month after birth which may make participation more challenging and distressing. Although the process of bonding may continue long after this time, it has been left for women to decide for themselves if they feel they have enough to talk about in terms of their relationship with their child to participate at any point after the first month.

As many sex working mothers will have children removed from their care (Hester and Westmarland, 2004) and may have varying levels of contact after that, it has been decided to allow women to decide if they have enough relevant experience to talk about bonding with their child without specifying a minimum amount of contact to have for inclusion. This recognises the broad experience of bonding that begins in pregnancy and continues beyond, and the internal element of maternal bonding that can take place even without direct contact with the child.

Only street based sex workers will [illegible] recruited initially due to the particular challenges they face (McClellan and Newell, 2008).

Consent

This is not a population where capacity to consent is known to be an issue and as such the chief investigator will assume each participant has capacity to consent to participate unless there is evidence to suggest otherwise in which case this will be assessed at the time using the clinical skills and training acquired though the clinical psychology doctoral training.
For phone interviews, a consent form will be provided with the information sheet either by a member of staff or by post if the person has contacted the chief investigator directly to express interest in the research. At the time of the phone interview, the chief investigator will check that the potential participant has read the information sheet and answer any questions they may have. They will then read and reiterate the aim of the study before taking verbal consent over the phone. This will be done by reading each individual clause from the consent form and asking if the person agrees. The chief investigator will state their name at the beginning of the recording and the participant must state their name and the date at the end of agreeing to all of the items on the consent form. After consent has been given, a new recording will begin for the interview and the two audio files will be stored separately.

If a participant attends the interview obviously under the influence of alcohol or other substances the interview will not take place at that time. This is to ensure the safety of both the chief investigator and the participant and to ensure participants have the capacity to consent to participate and are able to engage in the interview. In the case this happens, it will be discussed with participants and a future interview will be arranged if wished. It may be necessary to discuss this with a member of staff at the service if this is the case.

Confidentiality

Choosing to recruit directly through services and conduct interviews in centres used by services means it will not be possible to ensure anonymity from services in terms of participation. Although it might be preferable to keep this information confidential, it has been planned this way so that any difficulties arising in the research can be responded to by services who already have contact with the women involved and specialise in supporting them. It also allows for the chief investigator to receive guidance from services and provides a framework for managing any safeguarding concerns. Efforts will be made to keep involvement confidential from the service where possible, for example, names of participants will not be shared with the service unless there are safeguarding concerns that need to be reported to the service. Women will be informed that the service may know about their involvement before consenting to participate in the information sheet and in any verbal communications explaining the research during recruitment. It is not expected that participating in this research will have any impact on the service they receive as the research is external.

Safeguarding concerns

It is possible that participants might discuss content in the interviews that raises concern that they or someone else may be at risk of significant harm, particularly given the focus on family relationships and caring for children in potential stressful circumstances. It is vital to respond to this when necessary but retain confidentiality for the participants where possible. If such a concern arises, it will be responded to within the interview by the chief investigator clarifying what has been said if they are unclear. If it is an issue of immediate concern, it will be dealt with right then by pausing the interview and explaining that there is a duty of care to share this information with the service where the interview is taking place. Each site has agreed to have a member of staff from the service available at the time of the interview if this arises and then the safeguarding procedures for that service will be followed by that person. If an issue is raised that concerns on-going risks of significant harm, this will be discussed at the end of the interview. The chief investigator will enquire if the participant has informed any professionals about the issue and will be encouraged to do so if not. If they are unwilling, the chief investigator will explain that they are obligated to share this information and will follow the same process of reporting to a member of staff described previously. If the chief investigator is unsure whether something needs to be shared with the service they will consult the academic supervisor after the interview, recording her query in email, and then report back to the service if necessary.

Participants will be informed of these parameters of confidentiality on the information sheet and before giving consent in the interview. Wherever possible participants will be informed of the need to break confidentiality. Again, the chief investigator has experience of managing safeguarding concerns within her clinical role.

Emotional distress

Although it is hoped participants will find some benefit from taking part in the research and discussing their experiences (Biddle et al., 2013), it is possible that some may become distressed by talking about emotive subjects. This is particularly relevant for women whose experiences have not been what they hoped for or have involved separation from their children. In order to do research that explores the real experiences of women in this situation in a way that can broaden perspectives held of them and can inform future support being provided, it is not possible or desirable to remove this risk. However, in order to make participation as safe and positive as possible, it will be made clear in recruitment materials what the research is about, including examples of topics that will be covered and this will be reiterated when women attend interviews so they can make an informed decision to participate. Throughout the interview the chief investigator will check in with the participant if it seems they are becoming particularly upset or distressed and will remind them of their right to pause the interview or withdraw from participating entirely. At the end of each interview a debrief will take place so the participant has the opportunity to share if they feel they have been negatively affected. Contact details for where to go for support will be given out and participants will have the opportunity to talk with a member of staff after the interview if they wish. Where interviews take place over the phone, contact details of the service will be provided. Each service has agreed to this and only services where this is possible have been included in the study.

Discussing emotionally distressing topics may also be upsetting for the chief investigator and supervision has been arranged through the Clinical Psychology programme throughout the period of data collection to discuss process issues. The focus of this will be on the impact of the research on the chief investigator and how this can be managed and responded to in interviews and so will not include the sharing of personal details of participants.

Researching with a vulnerable population
The chief investigator is mindful of the vulnerability of many women who will meet the criteria for this study. The design has tried to be as non-threatening as possible and to provide opportunities for participants to be involved and have their views listened to and respected throughout.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control

☐ Cohort observation
☐ Controlled trial without randomisation
☐ Cross-sectional study
☐ Database analysis
☐ Epidemiology
☐ Feasibility/ pilot study
☐ Laboratory study
☐ Metanalysis
☑ Qualitative research
☑ Questionnaire, interview or observation study
☐ Randomised controlled trial
☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

To explore how women experience the bonding process with their children in the context of street-based sex work

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

To gain an understanding of women's perspectives of [illegible] sex work impacts upon bonding with their child/ren

To understand how women themselves feel affected by the bonding experience with their child

To identify needs and strengths of women in relation to the main research question

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

Following the work of Bowlby (1969) much research has been done into the area of childhood attachment, referring to the need for a child to develop [illegible] attachment to a consistent adult who will meet their needs. The security of this relationship relates to how reliably [illegible] child will have its basic needs met, and there is widespread evidence that this relationship forms the basis of how [illegible] child grows up and responds to both themselves and those around them. This has lasting effects [illegible] a person's overall development (Slade, 2002).

Many factors have been studied in terms of their impact on attachment. Recently the focus has largely been on the ability of the parent to be mindful of their child and to think of them as a separate individual and consider and respond appropriately to their needs (Slade, 2002). Many things may make it difficult for parents to do this or may affect the attachment relationship generally, such as bereavement and illness or disability in the child or parent, including mental health difficulties or unresolved trauma and loss. Research exists that explores some of the difficulties of developing secure attachments in such situations (e.g. Clegg & Lansdall-Welfare,1995).

Much research exists into the challenges and needs of sex workers (e.g. Farley, 2000). They are a population often faced with physical and emotional risks such as experiencing violence and exploitation (Dodsworth, 2011) and many studies have found an increased prevalence of mental health difficulties (Rossler et al., 2010). It is likely that these factors affect how sex workers who are mothers relate to their children. Many sex working women are also dependent on substances and this has been shown to impact on children's attachment (Suchman et al., 2010). In addition, many sex working mothers have social service involvement and have reduced contact with their children. All of these factors are likely to impact on the bond mothers develop towards their child, which in turn impacts the quality of the attachment relationship they form with their child (Goldberg, Moyer and Kinkler, 2013). However, little is known about this and how sex working impacts parental-child bonding. Several studies have looked at the needs of sex working mothers (e.g. Dodsworth, 2014) in a broader sense but have not focussed specifically on this aspect of the parent-child relationship.

Research into this area will enable a greater understanding of factors that impact the development of parental bonds and how these are managed by individuals, particularly in challenging circumstances. It will also broaden understanding of the lives of sex working mothers whose strengths and needs may often go unnoticed (Dalla, 2003). As this research is novel, it is important to take an exploratory stance and to begin with the experiences of sex working mothers themselves in order to better understand how they bond with their children.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

The research has a qualitative design, suitable to explore the real life experiences of sex working mothers. Semi-structured interviews will be used with up to 12 individuals which are aimed to allow women time to discuss their experiences in full but also offer a guide for topics to ask about in order to cover the research aims and to help direct the participants. Participants will also be invited to bring an item with them that is important to them in relation to their child to use as a focus for the discussion but this will be optional.

The procedure will be as follows:

The chief investigator will provide information sheets, fliers, and posters to 5 different recruitment sites. A discussion will take place with the gatekeeper at each site and other staff involved to clarify the recruitment procedure and inclusion criteria and they will be given information sheets to refer to.

Posters and fliers will be put in public spaces in each recruitment site where there is room to do so.

Staff from each service will give out fliers to service users and will inform service users of the research in conversations. Service users can ask questions of the staff member who will be able to give out information sheets and provide further details of the study. At some recruitment sites a phone number will be given for service users to contact the chief investigator to find out more (see previous discussion of ethical issues).

Service users who are interested in participating can either:
a) call the chief investigator and arrange an interview (for sites where this is relevant)
c) arrange an interview through a member of staff from the service

The chief investigator will meet with service users who have chosen to participate in a private room in the centre of the relevant recruitment site. They may be introduced to the chief investigator by a staff member if they have arranged an interview through them or if they have expressed a desire for this. The staff member can stay for the interview if the participant chooses or they may have brought somebody else with them. The chief investigator will talk through the information sheet with the service user and answer any questions. If they choose to continue, written consent will be taken.
Alternatively, where service policy allows for it, phone interviews will be offered. The chief investigator will conduct these in a private room and they will be recorded. The research phone provided by Lancaster University will be used.In the case of phone interviews an information sheet and consent form will be given to the potential participant either by a member of staff or in the post by the chief investigator. Verbal consent will be taken over the phone at the time of interview. This will be done by the chief investigator reiterating the purpose and title of the research and their name before reading through all the clauses in the consent form and asking for the potential participant to state their agreement. At the end of reading the form, the person will state their name and the date to give their consent. The recording will be ended at this point and a new recording started for the interview. This two audio files will be stored separately on password protected space on Lancaster University server.

The semi-structured interview will take place and will be audio-recorded. Opportunity for debrief will take place at the end and the chief investigator will offer participants the chance to debrief with a staff member also. The service details will be provided for this for phone interviews. The debrief will include discussion about whether the participant would like to be contacted again by being sent a summary of the findings and/or being involved in dissemination.

If any other service users express interest whilst the chief investigator is at the service, the research will be discussed with them using the information sheet and opportunity will be given to take part in the research at a convenient time.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☑ Design of the research
☐ Management of the research
☐ Undertaking the research
☐ Analysis of results
☑ Dissemination of findings

☐ None of the above

Give details of involvement, or if none please justify the absence of involvement.
Tutors and peers at Lancaster University in terms of developing a research question and designing the research.
Services involved in supporting street based sex workers including those participating through face to face and phone discussions.
A service user form one recruitment site who the chief investigator discussed the design with and sought advice about the interview schedule, publicity documents and information sheets.

Participants can choose to be given a summary of the findings when the project is completed, and by suggesting ideas for disseminating the findings and being involved with this if they choose.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Female
Age 18+
have a child aged between one month and 5 years who was born whilst involved in street-based sex work (self-defined)
Currently involved in street-based sex work (self-defined)
Have contact with child at least once per month

The following plans have been put in place to broaden inclusion criteria if there are difficulties with recruitment:

Phase two: If after four weeks of recruitment less than 4 participants [illegible] been recruited

• Inclusion criteria may be broadened to participants who:
- Have children whose children are any age above one month
- Were/are involved in sex work during first two years of child's life (or up to present time if child under 2)
- Had some contact with child during first two years of child's life

Phase three: If after 6 weeks less than [illegible] participants have been recruited
• Inclusion criteria may [illegible] to participants who:
- Were/are involved in sex work (self-defined - [illegible] necessarily street-based) during first two years of child's life (or up to present time if child under 2)

• Additional services [illegible] offer support to women involved in sex work may be used for recruitment, providing they meet the following criteria:
- Staff available to facilitate recruitment as set out in this document
- Support available for women [illegible] involvement in research if needed
- Safeguarding procedures in place to follow during research process
- The service can provide a private room for interviewing

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Noticeably under the influence of alcohol or substances when attending interview.
Noticeably distressed when attending interview - a discussion will then take place regarding whether the participant is feeling well enough to continue or would like to rearrange/cancel
People who cannot converse in English.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Seeking consent	1	0	10 minutes	Chief investigator will review the information sheet with the service user, answer any questions, and ask if they wish to continue. If they choose to continue, the consent form will be given to sign.
Interview	1	0	1 hour	The chief investigator will conduct the interviews in private rooms at centres used by recruitment sites or over the phone. It will be semi-structured. Opportunity for debrief will take place at the end.

A21. How long do you expect each participant to be in the study in total?

From being informed about the project there may be a period of up to three months where data collection will take place before they participate but it is likely to be much sooner than that and interviews will likely take place within three weeks of being informed. The interview is likely to last no more than two hours including gaining consent and debrief but this will vary for individuals. Participants can choose to have a summary of the findings sent to them and this will involve one further written contact.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

There is a risk that participants will find it distressing to discuss their relationships with their children in the interview. In order to minimise and manage this the following plans have been made:

It will be made clear in recruitment materials what the research is about including examples of topics that will be covered and this will be [illegible] when women attend interviews so they can make an informed decision to participate and can be prepared for the discussion.

Throughout the interview and at the end, the chief investigator will check in with the participant if it seems they are becoming particularly upset or distressed and will remind them of the choice to pause or stop the interview.

At the end of each interview a debrief will take place so the participant has the opportunity to share if they feel they have been negatively affected. Contact details of where to go for support will be given out and participants will have the opportunity to talk with a member of staff after the interview if they wish. Each service has agreed to this and only services where this is possible have been included in the study.

It is also recognised that participating involves a time commitment in terms of getting to and from the interview and doing the interview and that there is potential that participants will lose money for not being able to work during this time. To minimise this, participants will be reimbursed for transport costs and giving a small gift of a voucher as thanks for participating.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

● Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

Topics cover sensitive topics as discussed above.

It is possible that disclosures requiring action could be made during interviews. If this occurs, the chief investigator will inform the participant of the need to share this information and will report the disclosure to the gatekeeper at the recruitment site. This will take place after the interview unless the disclosure regards a matter of immediate danger in which case the interview will be stopped so the issue can be reported. In all cases the chief investigator will endeavour to inform the participant that they will be breaking confidentiality to share information and why. They will also encourage the participant to be involved in sharing this information themselves where possible. Participants will be informed of this potential need to break confidentiality before giving consent to participate.

A24. What is the potential for benefit to research participants?

It is hoped that participants might find it beneficial to have the opportunity to discuss their personal experiences.

Although not of direct benefit to participants, it is hoped that the findings will shed light on the participant's situations in a way that will contribute to appropriate and sensitive support being offered to other women in their situation.

A26. What are the potential risks for the researchers themselves? *(if any)*

As it is possible that participants may behave in an unpredictable manner, all face-to-face interviews will take place in centres used by recruitment sites where staff are available if any problems arise. Interviews will also not be conducted if a participant is noticeably under the influence of drugs or alcohol.

As participants may discuss distressing content during interviews, it is possible this may cause distress to the chief investigator. Supervision covering process issues has been arranged during the period of data collection to provide a space for this to be discussed and reflected upon.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Participants will be recruited from services which offer support to sex workers. Some services do this as their sole purpose and others do it alongside other general and specialised support for women. The research will be publicised generally in these services and women will be directly approached and informed of it from staff members. They will inform everyone who may be eligible to take part but will not directly inform women who they know to not meet the inclusion criteria.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ● No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

● Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

In services where there is a centre with a public area, posters will be put up by staff and fliers left in an appropriate space. Posters and fliers will have a small amount of information about the research and invite people who are interested to either contact the chief investigator directly (if the service's policies allow this) or to contact a named staff member for more information.

A29. How and by whom will potential participants first be approached?

Staff in all services who have direct contact with sex workers though their role will be informed about the project either directly from the chief investigator attending a team meeting or through the gatekeeper at that service. They will also be given information sheets with details of the research.

They will inform women directly about the research and give out fliers. This will mainly be as part of their routine contact with them e.g. in a key working appointment or on street outreach, but women may be contacted by staff specifically to inform them about the research if they have no contact arranged but may be eligible to participate. Staff members can answer questions themselves and hand out information sheets to women who are interested, or they can direct them to contact the chief investigator if the service's policy allows for this.

Whilst the chief investigator is at services they may meet other service users who express an interest in the research. If this occurs, the research will be discussed with them using the information sheet and opportunity will be given to take part in the research at a convenient time.

A30-1. Will you obtain informed consent from or on behalf of research participants?

● Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Potential participants will be given information verbally from staff members or the chief investigator. They will also be given an information sheet that details what the research involves. When women attend the interview the information sheet will be discussed again and they will have chance to ask further questions. If they state that they would like to go ahead then written consent will be recorded, including consent for recording the interviews.
For those opting for a phone interview, a consent form will be given alongside the information sheet either by a member of staff or in the post if the enquiry was made directly to the chief investigator over the phone. They will have the opportunity to ask questions of the staff member or chief investigator over the phone. In the case of phone interviews, an information sheet and consent form will be given to the potential participant either by a member of staff or in the post from the chief investigator. Verbal consent will be taken over the phone at the time of interview. This will be done by the chief investigator reiterating the purpose and title of the research and their name before reading through all the clauses on the consent form and asking for the potential participant to state their agreement. At the end of reading the form the participant will state their name and the date to give their consent. The recording will be ended at this point and a new recording started for the interview. This two audio files will be stored separately on password protected space on Lancaster University server.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

● Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

Participants will be able to decide whether to take part at any point during the recruitment period, which will last until sufficient interviews have been completed (this is expected to cover at least a two month period). When they are initially informed of the research they can decide immediately that they would like to take part or not and an interview can be arranged if they choose to. Alternatively they can choose to think about it and inform a staff ember of the chief investigator at a later date, or request to be reminded about the project and asked again at a future date.

In discussions with services, it has been recognised that it can be difficult to arrange appointments in advance with service users and successful recruitment in previous research projects has involved service users taking part soon after they have expressed interest. For this reason, after expressing interest, interviews will be conducted as soon as they can be arranged with the chief investigator and participant. This may occur on the same day as being informed about the project although is more likely to be arranged for another day within the following fortnight.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Although posters and fliers will be used, recruitment will largely take place through verbal conversations between staff members and service users. Staff members will have prior knowledge of the most suitable way of communicating with individual service users. Language on posters and fliers will be kept simple. The information sheet will be discussed and understanding will be checked prior to taking consent.

Funds are not available to translate material or provide interpreters for interviews

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

● The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

In the likely event that the researcher has any reason to believe that capacity to consent has been lost during the interview itself, the interview ill either be discontinued if it seems continuing would be distressing to the participant.

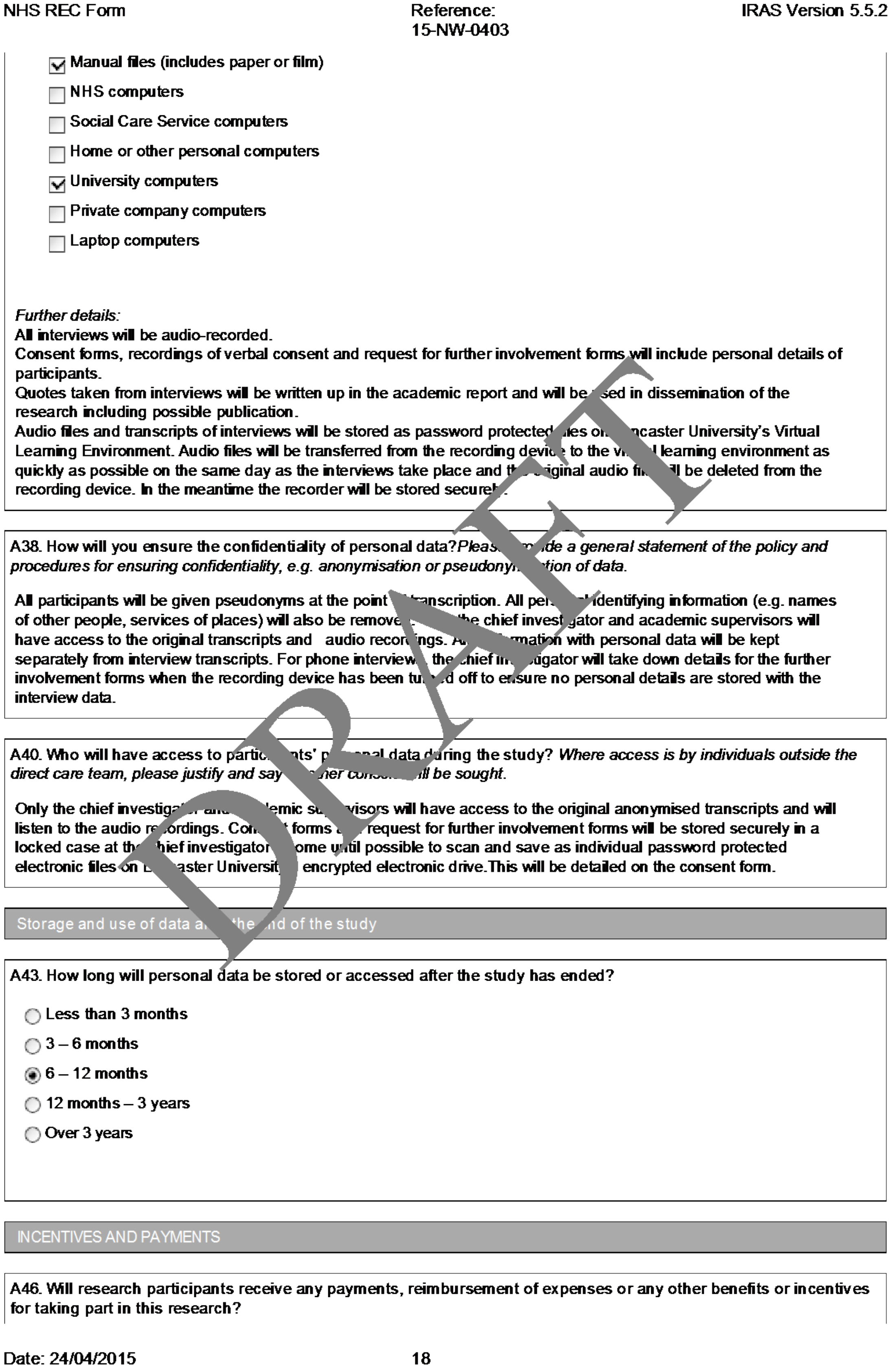
CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

☐ Access to medical records by those outside the direct healthcare team
☐ Access to social care records by those outside the direct social care team
☐ Electronic transfer by magnetic or optical media, email or computer networks
☐ Sharing of personal data with other organisations
☐ Export of personal data outside the EEA
☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
☑ Publication of direct quotations from respondents
☐ Publication of data that might allow identification of individuals
☑ Use of audio/visual recording devices
☑ Storage of personal data on any of the following:



☑ Manual files (includes paper or film)
☐ NHS computers
☐ Social Care Service computers
☐ Home or other personal computers
☑ University computers
☐ Private company computers
☐ Laptop computers

Further details:
All interviews will be audio-recorded.
Consent forms, recordings of verbal consent and request for further involvement forms will include personal details of participants.
Quotes taken from interviews will be written up in the academic report and will be used in dissemination of the research including possible publication.
Audio files and transcripts of interviews will be stored as password protected files on Lancaster University's Virtual Learning Environment. Audio files will be transferred from the recording device to the virtual learning environment as quickly as possible on the same day as the interviews take place and the original audio files will be deleted from the recording device. In the meantime the recorder will be stored securely.

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

All participants will be given pseudonyms at the point of transcription. All personal identifying information (e.g. names of other people, services of places) will also be removed. [illegible] the chief investigator and academic supervisors will have access to the original transcripts and audio recordings. All information with personal data will be kept separately from interview transcripts. For phone interviews, the chief investigator will take down details for the further involvement forms when the recording device has been turned off to ensure no personal details are stored with the interview data.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Only the chief investigator and academic supervisors will have access to the original anonymised transcripts and will listen to the audio recordings. Consent forms and request for further involvement forms will be stored securely in a locked case at the chief investigator's home until possible to scan and save as individual password protected electronic files on Lancaster University's encrypted electronic drive.This will be detailed on the consent form.

Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

○ Less than 3 months
○ 3 – 6 months
● 6 – 12 months
○ 12 months – 3 years
○ Over 3 years

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

● Yes ○ No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
Participants will be given a small gift as reimbursement for involvement in the research as well as offering reimbursement for any costs incurred in attending the interview up to the value of £20 (i.e. travel expenses). This has been decided as a way of valuing the time given by participants to being involved which potentially may result in a loss of business and in recognition of the financial difficulties facing many service users. It is common practice among research with this population to do so (e.g. McClelland and Newell, 2008) and has been recommended by each service. The gift will be in the form of a £10 shop voucher rather than a monetary gift that may be viewed as contributing to any ongoing addictions some service users may have.
For phone interviews vouchers will be posted to the participant immediately after the interview or left with a member of staff at the relevant service depending on the participants' preference.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ● No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ● No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

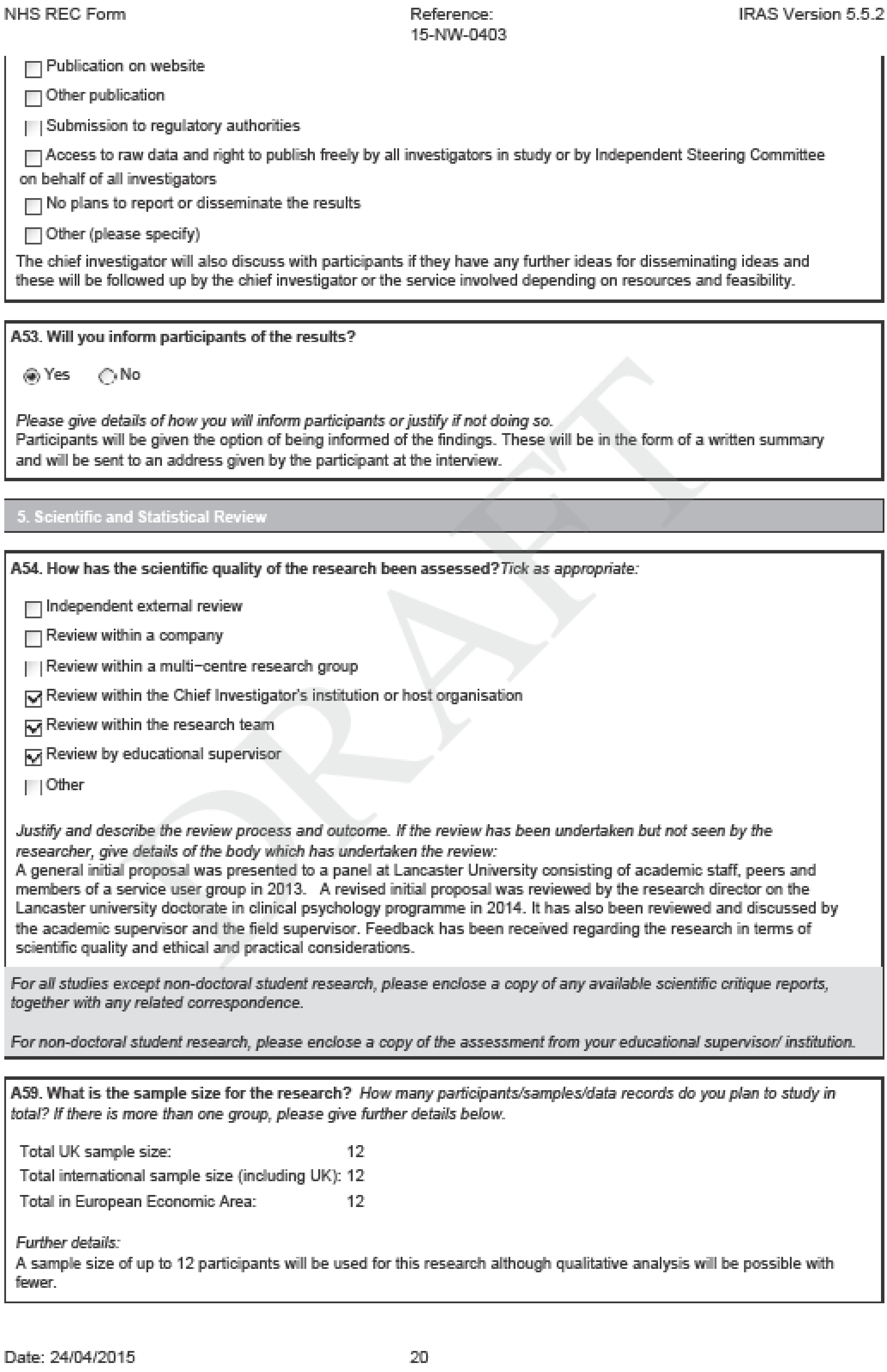
○ Yes ● No

Please give details, or justify if not registering the research.
The research team are unaware of a suitable register for the research to be listed on.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

☑ Peer reviewed scientific journals
☑ Internal report
☑ Conference presentation



☐ Publication on website

☐ Other publication

☐ Submission to regulatory authorities

☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators

☐ No plans to report or disseminate the results

☐ Other (please specify)

The chief investigator will also discuss with participants if they have any further ideas for disseminating ideas and these will be followed up by the chief investigator or the service involved depending on resources and feasibility.

A53. Will you inform participants of the results?

● Yes ○ No

Please give details of how you will inform participants or justify if not doing so.
Participants will be given the option of being informed of the findings. These will be in the form of a written summary and will be sent to an address given by the participant at the interview.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

☐ Independent external review

☐ Review within a company

☐ Review within a multi−centre research group

☑ Review within the Chief Investigator's institution or host organisation

☑ Review within the research team

☑ Review by educational supervisor

☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
A general initial proposal was presented to a panel at Lancaster University consisting of academic staff, peers and members of a service user group in 2013. A revised initial proposal was reviewed by the research director on the Lancaster university doctorate in clinical psychology programme in 2014. It has also been reviewed and discussed by the academic supervisor and the field supervisor. Feedback has been received regarding the research in terms of scientific quality and ethical and practical considerations.

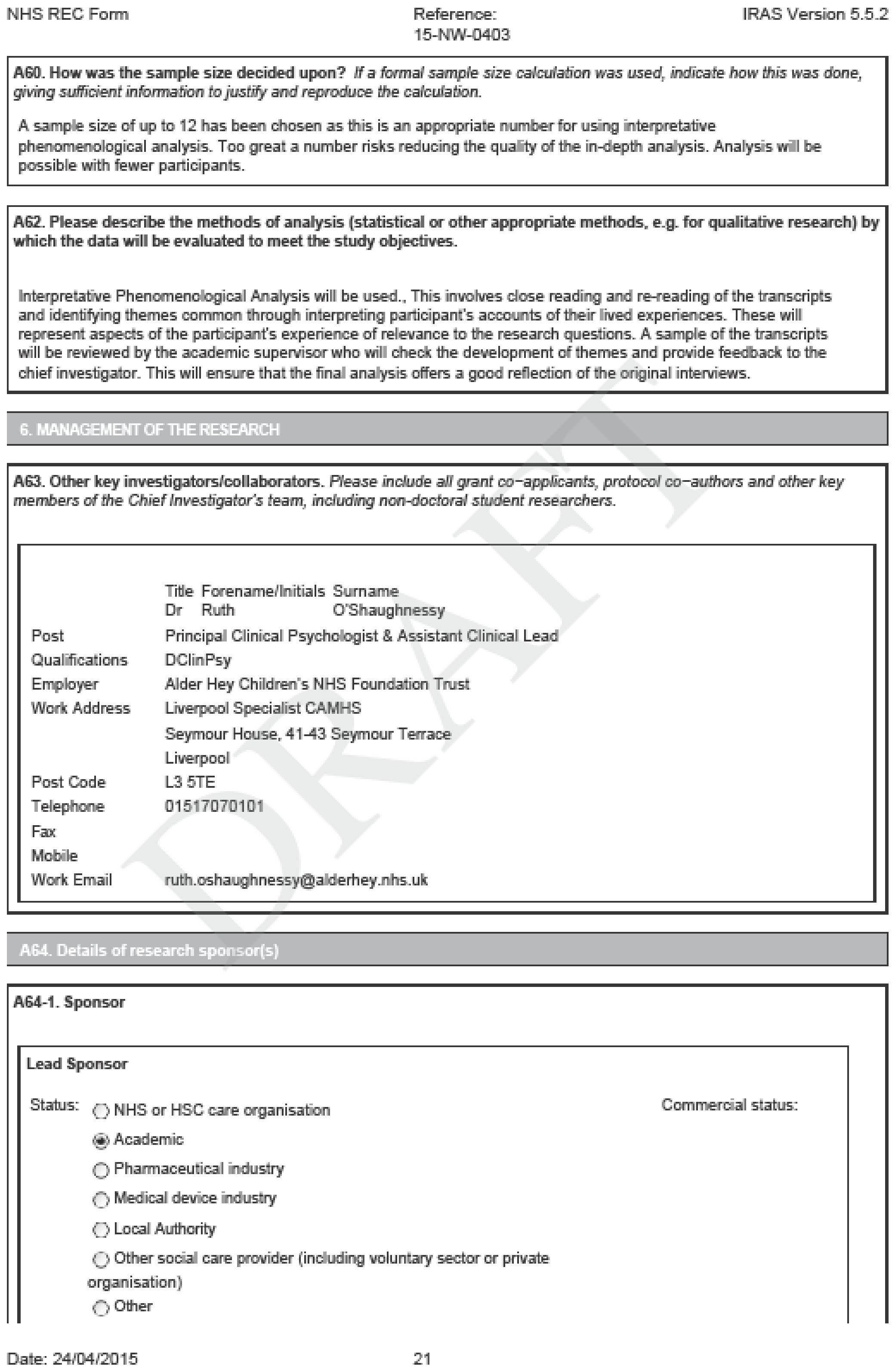
For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 12
Total international sample size (including UK): 12
Total in European Economic Area: 12

Further details:
A sample size of up to 12 participants will be used for this research although qualitative analysis will be possible with fewer.



A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

A sample size of up to 12 has been chosen as this is an appropriate number for using interpretative phenomenological analysis. Too great a number risks reducing the quality of the in-depth analysis. Analysis will be possible with fewer participants.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Interpretative Phenomenological Analysis will be used., This involves close reading and re-reading of the transcripts and identifying themes common through interpreting participant's accounts of their lived experiences. These will represent aspects of the participant's experience of relevance to the research questions. A sample of the transcripts will be reviewed by the academic supervisor who will check the development of themes and provide feedback to the chief investigator. This will ensure that the final analysis offers a good reflection of the original interviews.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co−applicants, protocol co−authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Dr	Ruth	O'Shaughnessy

Post Principal Clinical Psychologist & Assistant Clinical Lead
Qualifications DClinPsy
Employer Alder Hey Children's NHS Foundation Trust
Work Address Liverpool Specialist CAMHS
Seymour House, 41-43 Seymour Terrace
Liverpool
Post Code L3 5TE
Telephone 01517070101
Fax
Mobile
Work Email ruth.oshaughnessy@alderhey.nhs.uk

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
○ NHS or HSC care organisation
● Academic
○ Pharmaceutical industry
○ Medical device industry
○ Local Authority
○ Other social care provider (including voluntary sector or private organisation)
○ Other

Commercial status:

If Other, please specify:

Contact person

Name of organisation Lancaster University
Given name [redacted]
Family name
Address
Town/city
Post code
Country
Telephone
Fax
E-mail

Is the sponsor based outside the UK?
○ Yes ● No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

☐ Funding secured from one or more funders
☐ External funding application to one or more funders in progress
☑ No application for external funding will be made

What type of research project is this?

● Standalone project
○ Project that is part of a programme grant
○ Project that is part of a Centre grant
○ Project that is part of a fellowship/ personal award/ research training award
○ Other

Other – please state:

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ● No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title Forename/Initials Surname

[redacted]

Organisation
Address

Post Code
Work Email
Telephone
Fax
Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/04/2015
Planned end date: 26/02/2016
Total duration:
Years: 0 Months: 10 Days: 26

A71-2. Where will the research take place? *(Tick as appropriate)*

- ☑ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland
- ☐ Other countries in European Economic Area

Total UK sites in study 5

Does this trial involve countries outside the EU?
○ Yes ● No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

- ☑ NHS organisations in England 2
- ☐ NHS organisations in Wales
- ☐ NHS organisations in Scotland
- ☐ HSC organisations in Northern Ireland
- ☐ GP practices in England
- ☐ GP practices in Wales
- ☐ GP practices in Scotland
- ☐ GP practices in Northern Ireland
- ☐ Joint health and social care agencies (eg community mental health teams)

☐ Local authorities
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas
☑ Independent (private or voluntary sector) organisations 3
☐ Educational establishments
☐ Independent research units
☐ Other (give details)

Total UK sites in study: 5

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

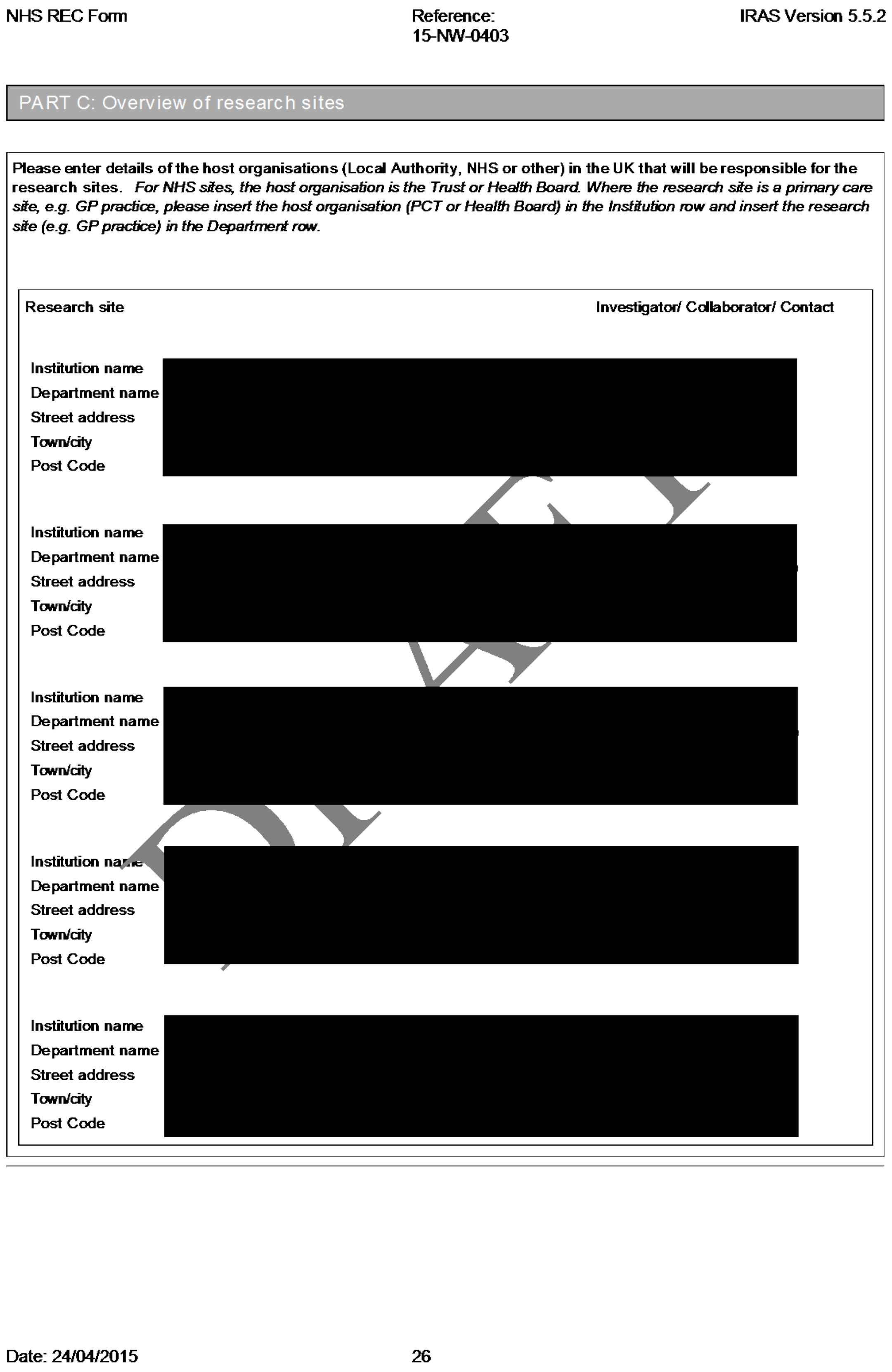
Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☐ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☑ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.



PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.*

Research site **Investigator/ Collaborator/ Contact**

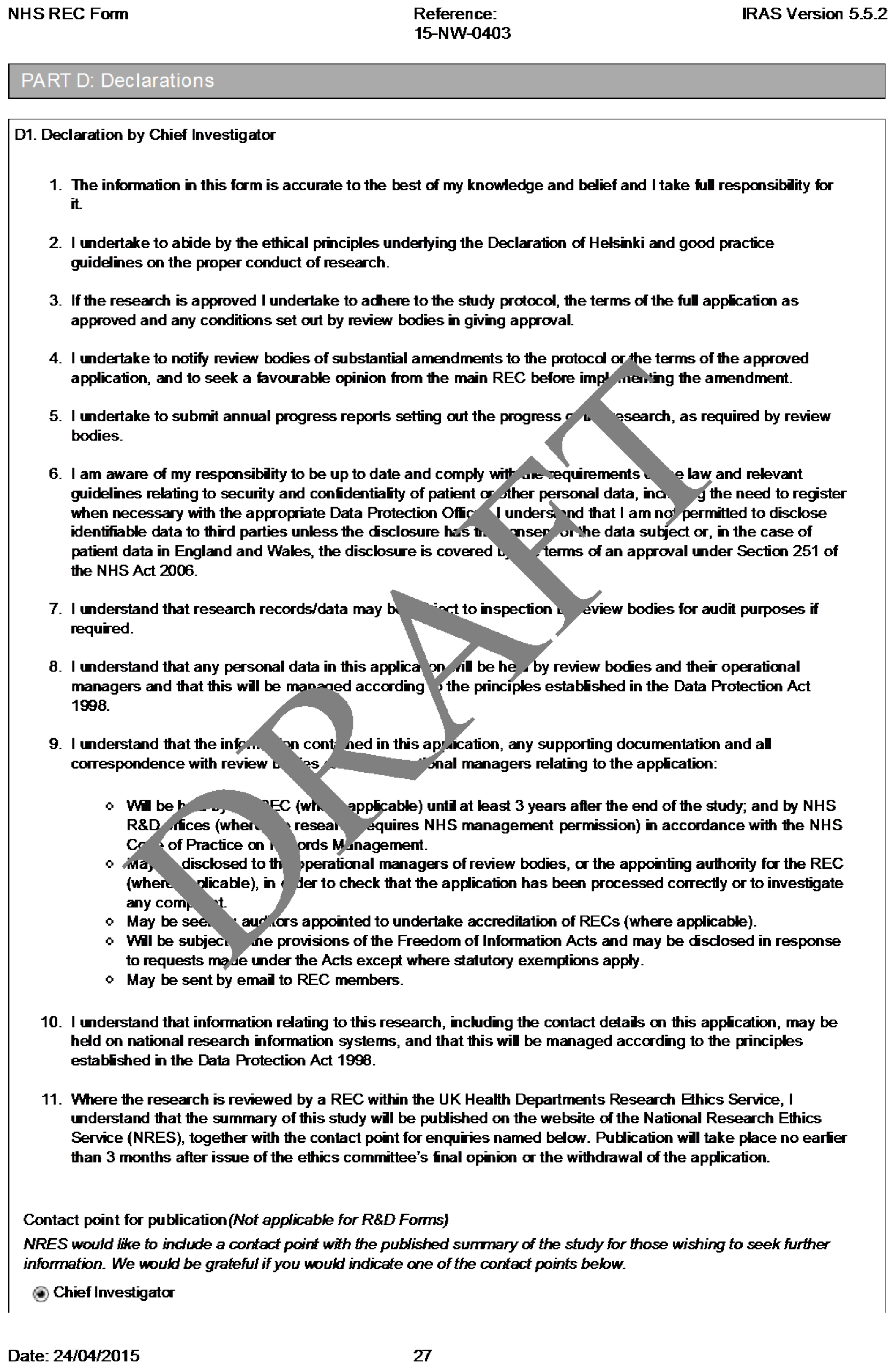
Institution name
Department name
Street address
Town/city
Post Code
[redacted]

Institution name
Department name
Street address
Town/city
Post Code
[redacted]

Institution name
Department name
Street address
Town/city
Post Code
[redacted]

Institution name
Department name
Street address
Town/city
Post Code
[redacted]

Institution name
Department name
Street address
Town/city
Post Code
[redacted]



NHS REC Form
Reference:
15-NW-0403
IRAS Version 5.5.2

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.

3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.

4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.

5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.

6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.

7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.

8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.

9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies [illegible] operational managers relating to the application:

    - Will be held by [illegible] REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May [illegible] disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen [illegible] auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject [illegible] the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.

10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication *(Not applicable for R&D Forms)*

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

● Chief Investigator

Date: 24/04/2015
27

○ Sponsor
○ Study co-ordinator
○ Student
○ Other – please give details
○ None

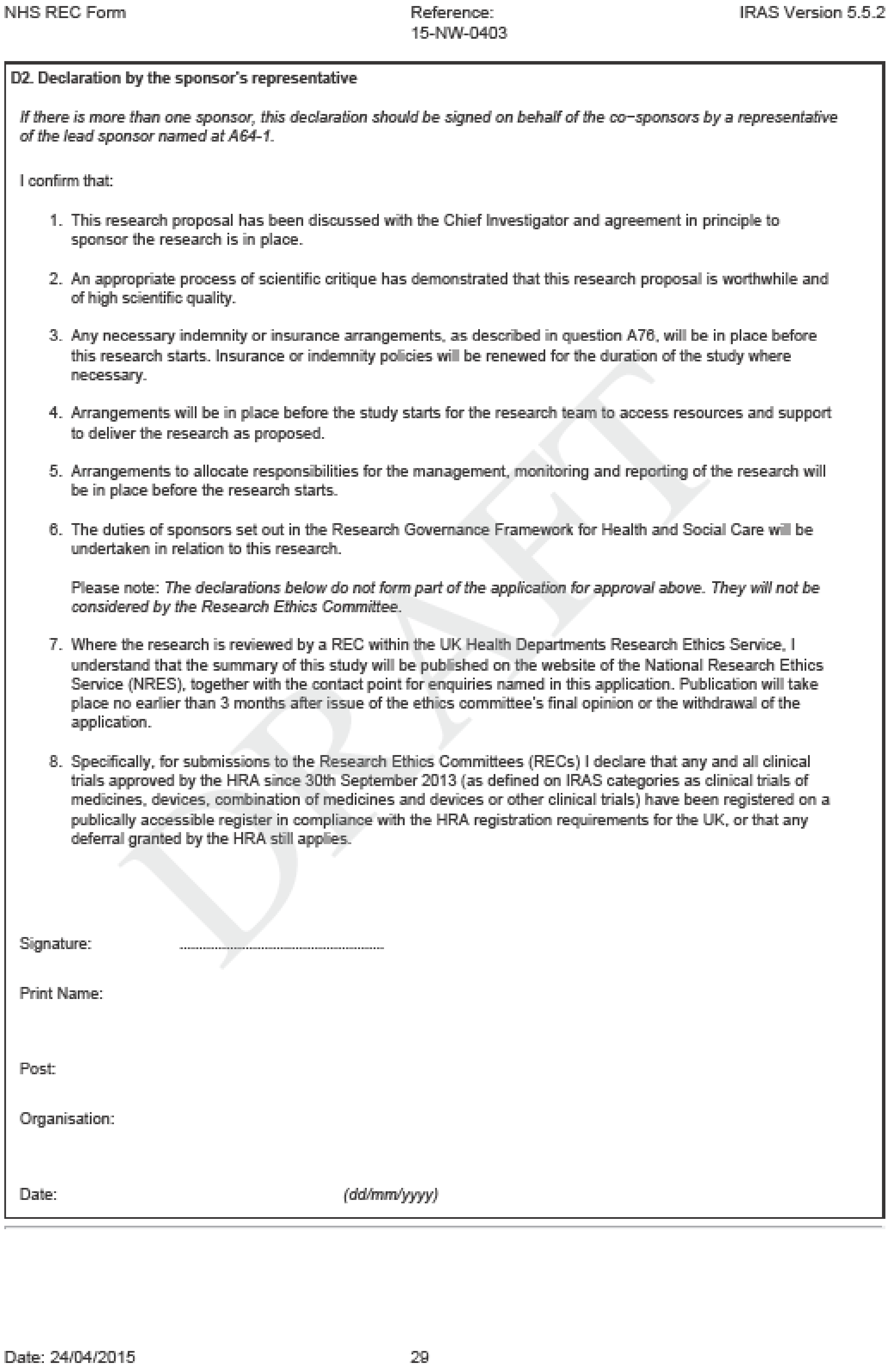
Access to application for training purposes *(Not applicable for R&D Forms)*
Optional – please tick as appropriate:

☑ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature: ....

Print Name: Ruth Elsdon

Date: 25/03/2015 *(dd/mm/yyyy)*



D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co−sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

Signature: ....

Print Name:

Post:

Organisation:

Date: *(dd/mm/yyyy)*

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

Signature: ....

Print Name: Craig Murray

Post:

Organisation: Clinical Psychology, Lancaster Univer

Date: *(dd/mm/yyyy)*

Academic supervisor 2

Signature: ....

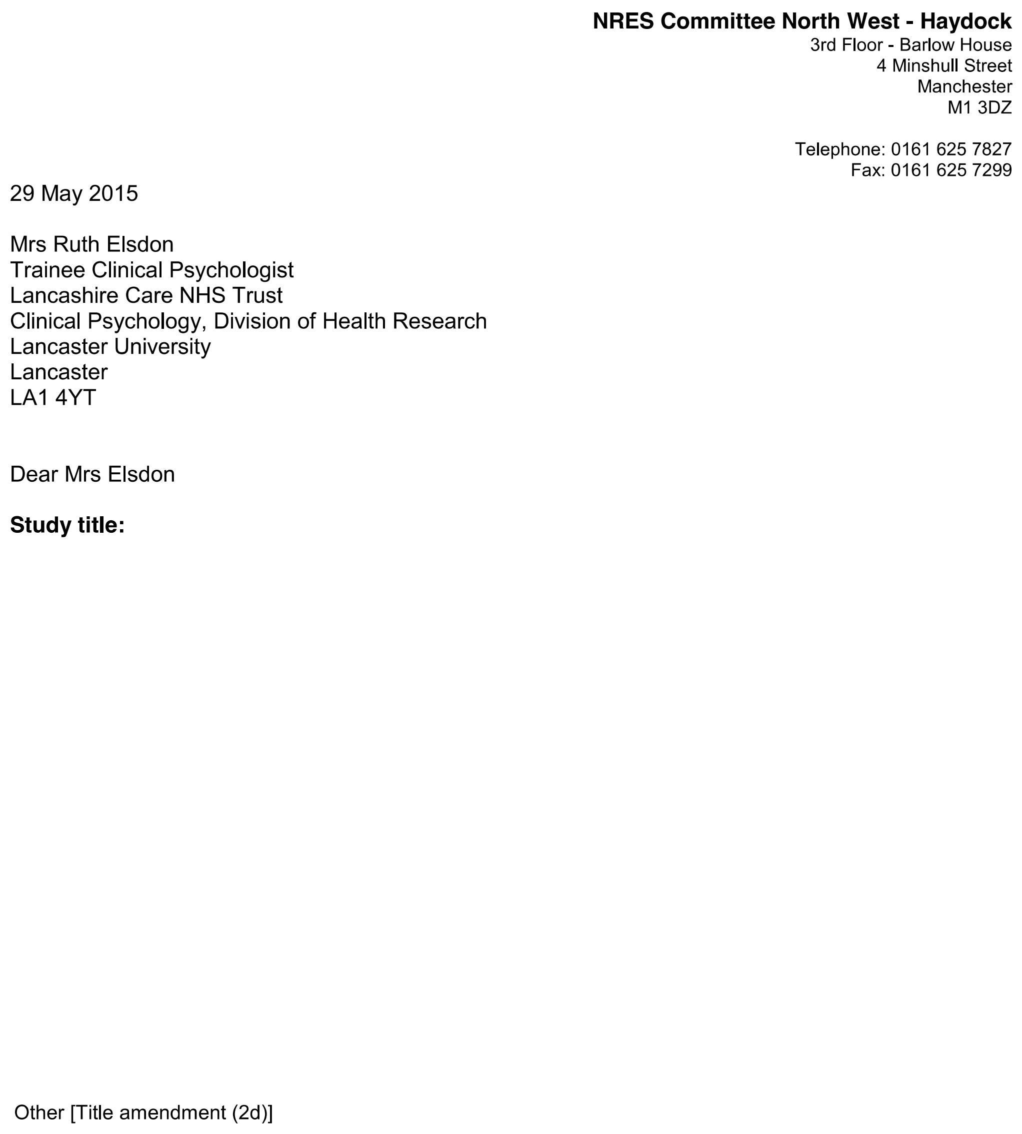
Print Name:

Post:

Organisation:

Date: *(dd/mm/yyyy)*

Appendix 4-J NHS REC final approval letter



NRES Committee North West - Haydock
3rd Floor - Barlow House
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7827
Fax: 0161 625 7299

29 May 2015

Mrs Ruth Elsdon
Trainee Clinical Psychologist
Lancashire Care NHS Trust
Clinical Psychology, Division of Health Research
Lancaster University
Lancaster
LA1 4YT

Dear Mrs Elsdon

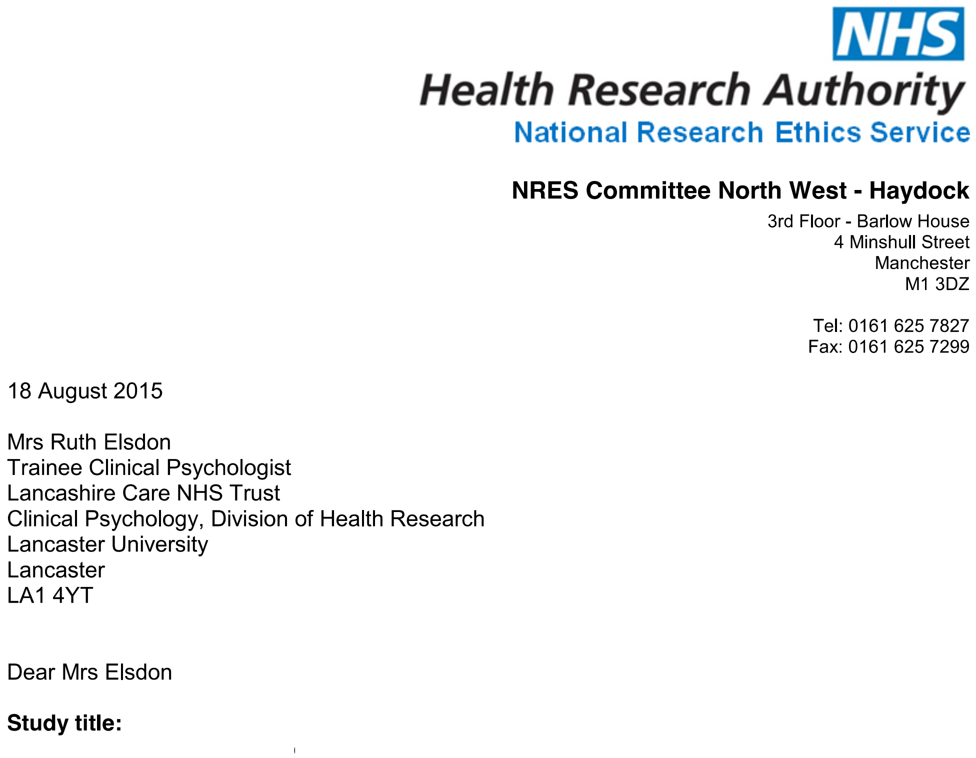
Study title:

Other [Title amendment (2d)]

Participant consent form [consent form version 2]

made available to R&D offices at all participating sites.

Appendix 4-K Substantial amendment (1) favourable opinion letter



NHS
Health Research Authority
National Research Ethics Service

NRES Committee North West - Haydock
3rd Floor - Barlow House
4 Minshull Street
Manchester
M1 3DZ

Tel: 0161 625 7827
Fax: 0161 625 7299

18 August 2015

Mrs Ruth Elsdon
Trainee Clinical Psychologist
Lancashire Care NHS Trust
Clinical Psychology, Division of Health Research
Lancaster University
Lancaster
LA1 4YT

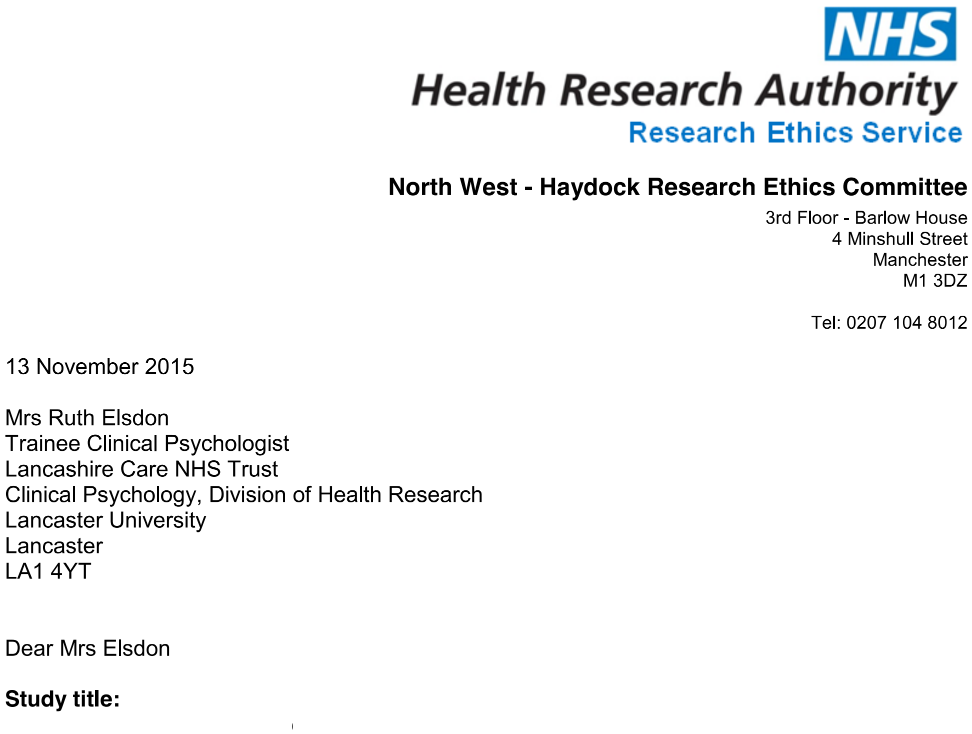
Dear Mrs Elsdon

Study title:

Copies of advertisement materials for research participants [Phase 2 poster]

sity

Appendix 4-L Substantial amendment (2) favourable opinion letter



NHS
Health Research Authority
Research Ethics Service

North West - Haydock Research Ethics Committee
3rd Floor - Barlow House
4 Minshull Street
Manchester
M1 3DZ

Tel: 0207 104 8012

13 November 2015

Mrs Ruth Elsdon
Trainee Clinical Psychologist
Lancashire Care NHS Trust
Clinical Psychology, Division of Health Research
Lancaster University
Lancaster
LA1 4YT

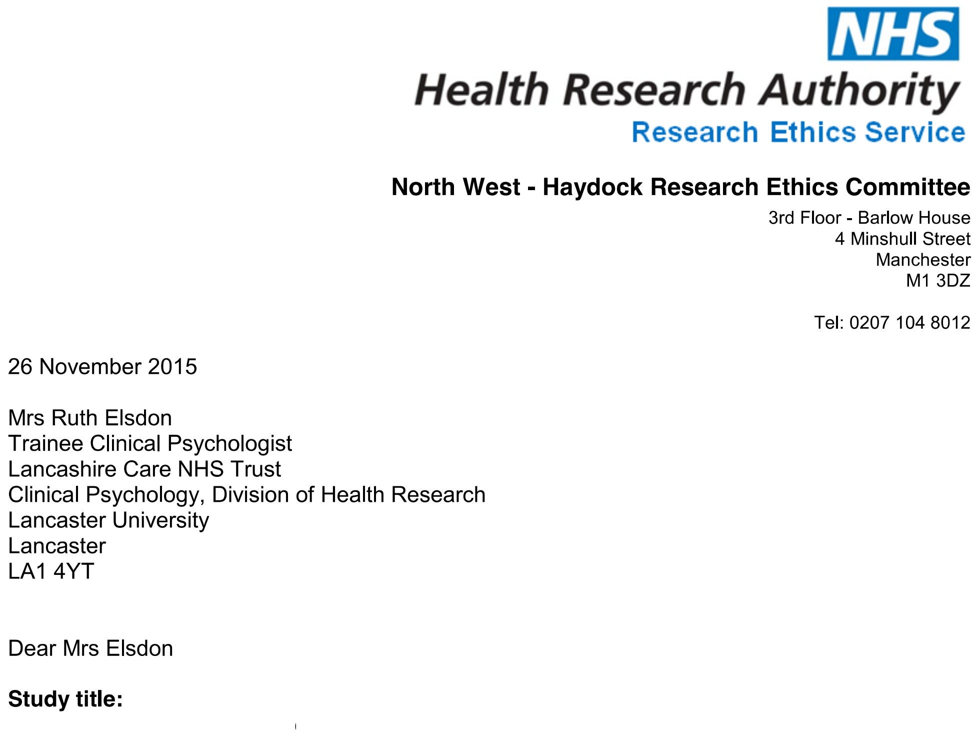
Dear Mrs Elsdon

Study title:

Summary CV for supervisor (student research) [Dr Suzanne Hodge]

ndation Trust
Ms Debbie Knight, Lancaster University

Appendix 4-M Substantial amendment (3) favourable opinion letter



NHS
Health Research Authority
Research Ethics Service

North West - Haydock Research Ethics Committee
3rd Floor - Barlow House
4 Minshull Street
Manchester
M1 3DZ

Tel: 0207 104 8012

26 November 2015

Mrs Ruth Elsdon
Trainee Clinical Psychologist
Lancashire Care NHS Trust
Clinical Psychology, Division of Health Research
Lancaster University
Lancaster
LA1 4YT

Dear Mrs Elsdon

Study title:

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

15/NW/0403:	**Please quote this number on all correspondence**

Yours sincerely

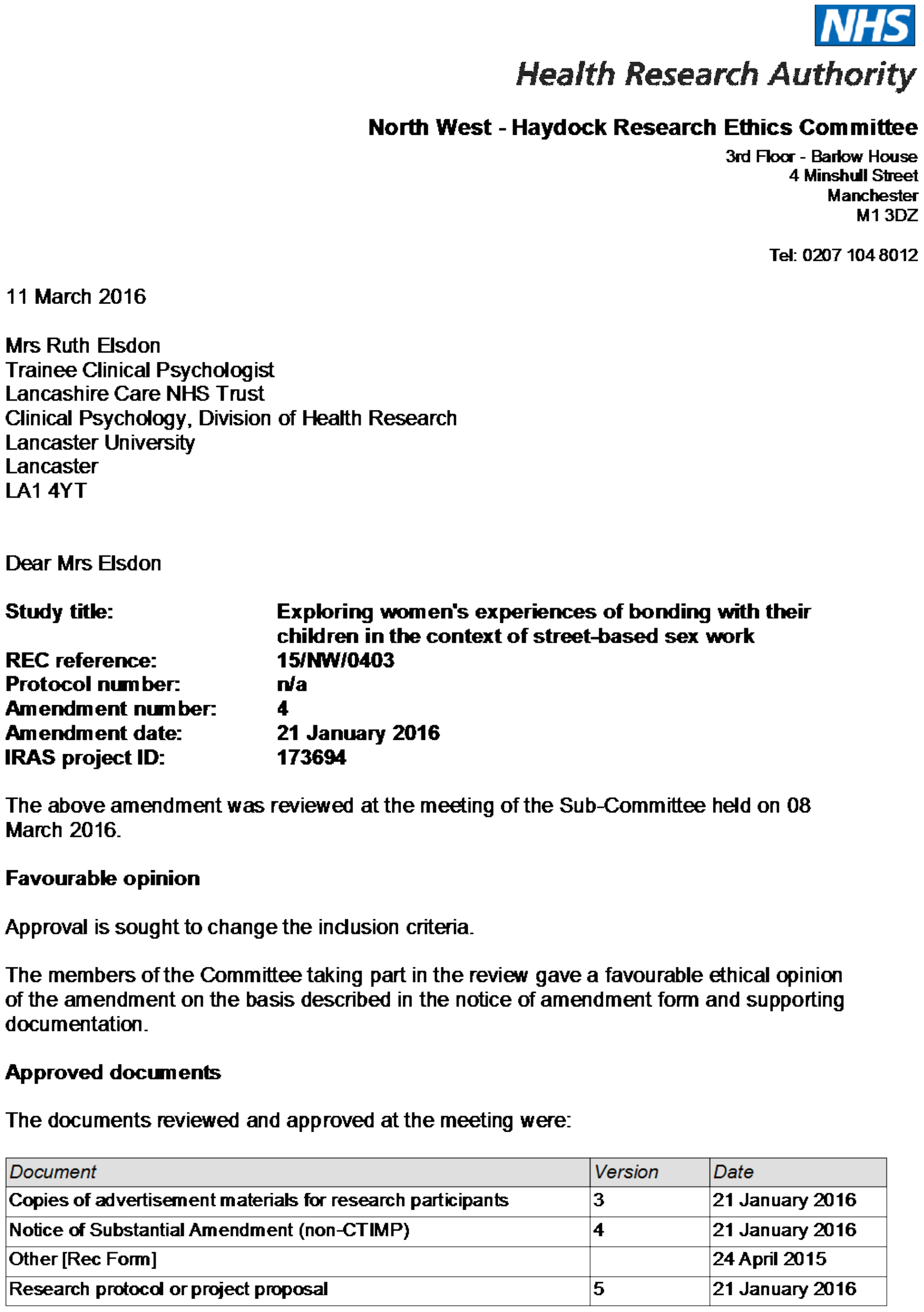
Dr Tim S Sprosen
Chair

E-mail: nrescommittee.northwest-haydock@nhs.net

Enclosures:

[redacted]

Appendix 4-N Substantial amendment (4) favourable opinion letter



NHS
Health Research Authority

North West - Haydock Research Ethics Committee
3rd Floor - Barlow House
4 Minshull Street
Manchester
M1 3DZ

Tel: 0207 104 8012

11 March 2016

Mrs Ruth Elsdon
Trainee Clinical Psychologist
Lancashire Care NHS Trust
Clinical Psychology, Division of Health Research
Lancaster University
Lancaster
LA1 4YT

Dear Mrs Elsdon

Study title:	**Exploring women's experiences of bonding with their children in the context of street-based sex work**
REC reference:	**15/NW/0403**
Protocol number:	**n/a**
Amendment number:	**4**
Amendment date:	**21 January 2016**
IRAS project ID:	**173694**

The above amendment was reviewed at the meeting of the Sub-Committee held on 08 March 2016.

Favourable opinion

Approval is sought to change the inclusion criteria.

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Copies of advertisement materials for research participants	3	21 January 2016
Notice of Substantial Amendment (non-CTIMP)	4	21 January 2016
Other [Rec Form]		24 April 2015
Research protocol or project proposal	5	21 January 2016

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

15/NW/0403:	**Please quote this number on all correspondence**

Yours sincerely

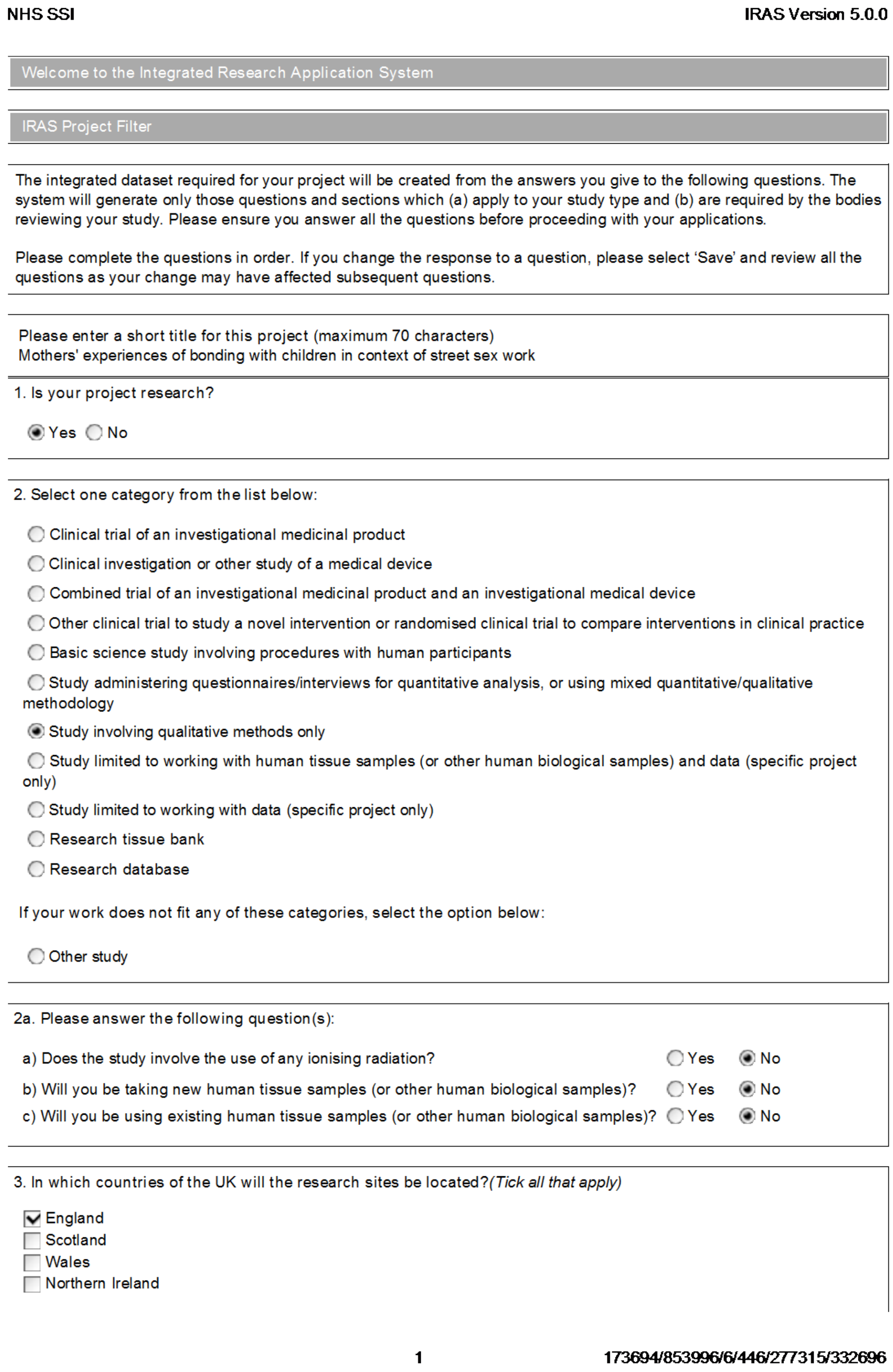
Dr Tim S Sprosen
Chair

E-mail: nrescommittee.northwest-haydock@nhs.net

Enclosures:

[redacted]

Appendix 4-O NHS Site-Specific Information form



NHS SSI **IRAS Version 5.0.0**

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Mothers' experiences of bonding with children in context of street sex work

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
● Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

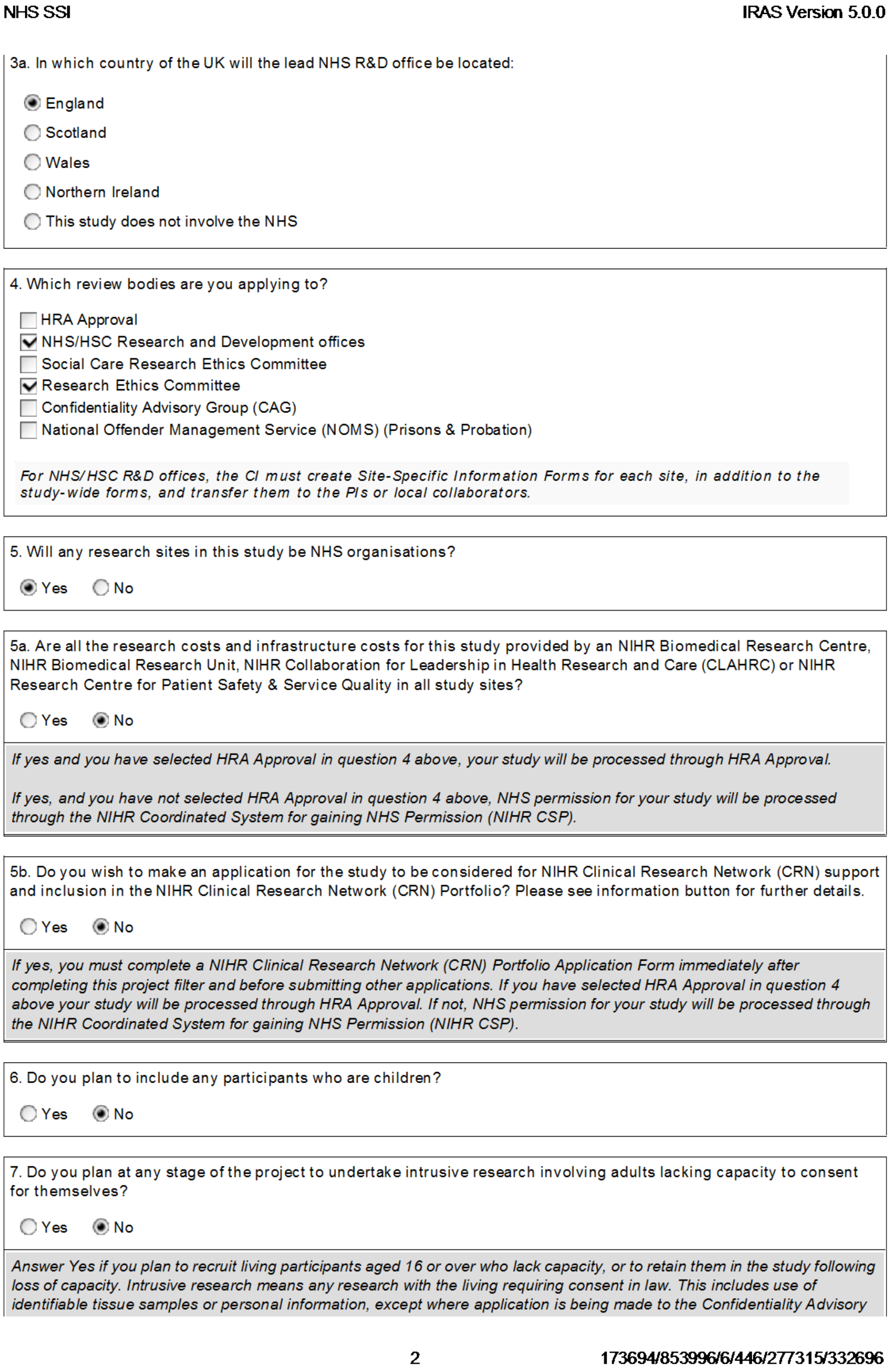
2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

3. In which countries of the UK will the research sites be located?*(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

1 **173694/853996/6/446/277315/332696**



NHS SSI IRAS Version 5.0.0

3a. In which country of the UK will the lead NHS R&D office be located:

● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which review bodies are you applying to?

☐ HRA Approval
☑ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☑ Research Ethics Committee
☐ Confidentiality Advisory Group (CAG)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

○ Yes ● No

If yes and you have selected HRA Approval in question 4 above, your study will be processed through HRA Approval.

If yes, and you have not selected HRA Approval in question 4 above, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

○ Yes ● No

If yes, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before submitting other applications. If you have selected HRA Approval in question 4 above your study will be processed through HRA Approval. If not, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

6. Do you plan to include any participants who are children?

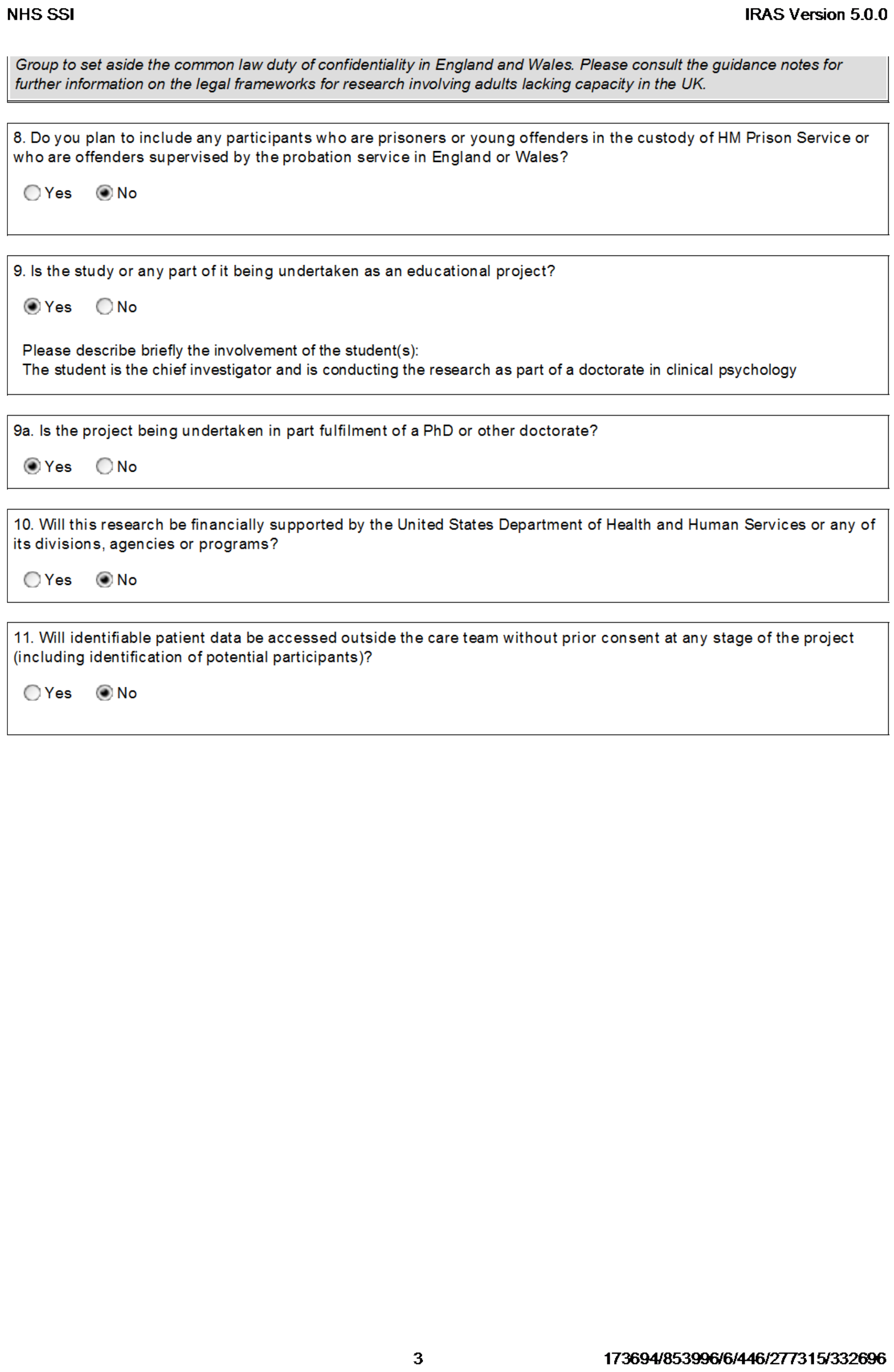
○ Yes ● No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory

2 173694/853996/6/446/277315/332696



Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
The student is the chief investigator and is conducting the research as part of a doctorate in clinical psychology

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

● Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No

Site-Specific Information Form (NHS sites)

Is the site hosting this research a NHS site or a non-NHS site? *NHS sites include Health and Social Care organisations in Northern Ireland. The sites hosting the research are the sites in which or through which research procedures are conducted. For NHS sites, this includes sites where NHS staff are participants.*

● NHS site
○ Non-NHS site

This question must be completed before proceeding. The filter will customise the form, disabling questions which are not relevant to this application.

One Site-Specific Information Form should be completed for each research site and submitted to the relevant R&D office with the documents in the checklist. See guidance notes.

The data in this box is populated from Part A:

Title of research:
Exploring women's experiences of bonding with their children in the context of street-based sex work

Short title: Mothers' experiences of bonding with children in context of street sex work

	Title	Forename/Initials	Surname
Chief Investigator:	Mrs	Ruth	Elsdon

Name of NHS Research Ethics Committee to which application for ethical review is being made:
North West - Haydock

Project reference number from above REC: 15-NW-0403

1-1. Give the name of the NHS organisation responsible for this research site

[redacted]

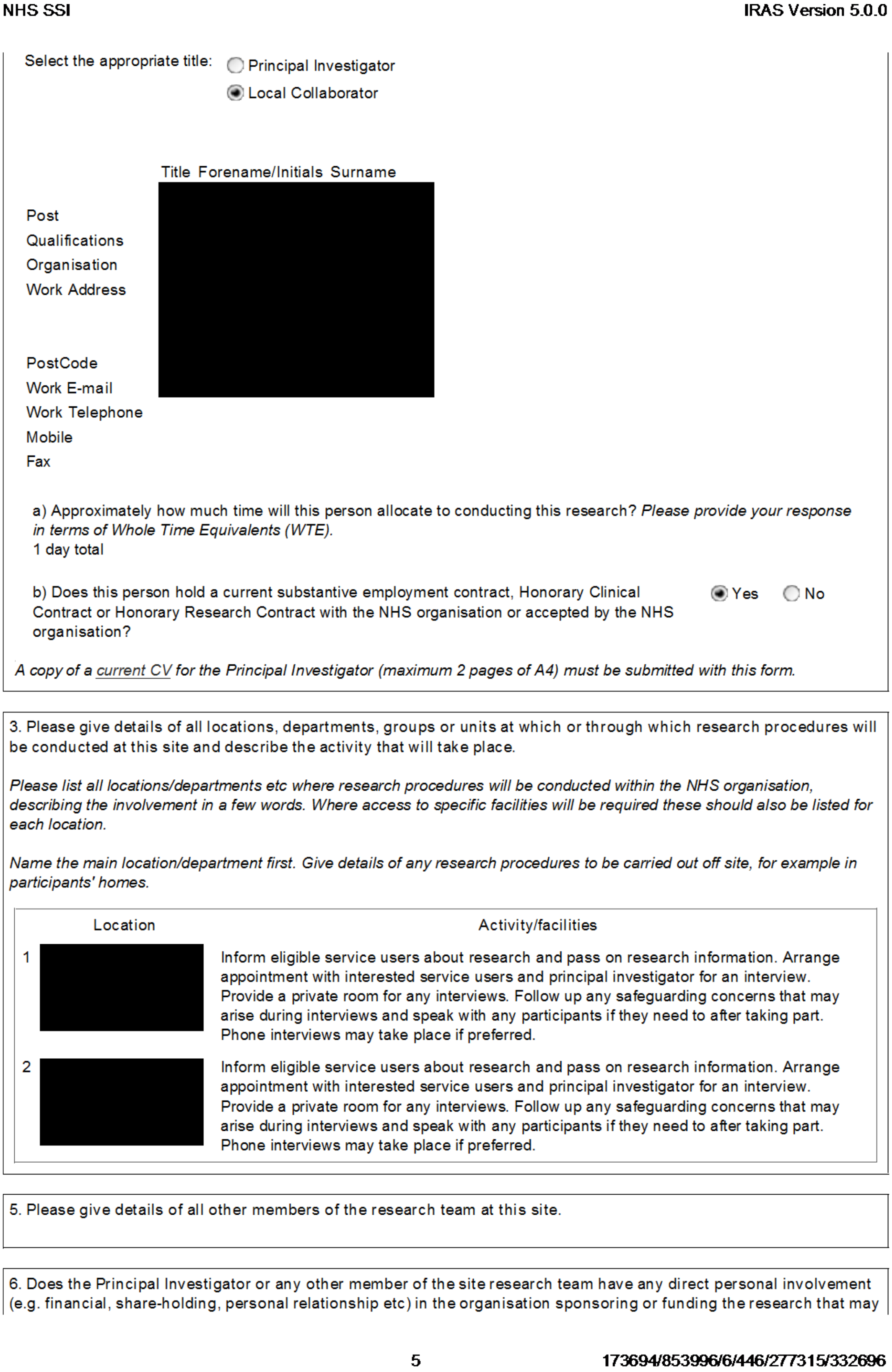
1-3. In which country is the research site located?

● England
○ Wales
○ Scotland
○ Northern Ireland

1-4. Is the research site a GP practice or other Primary Care Organisation?

○ Yes ● No

2. Who is the Principal Investigator or Local Collaborator for this research at this site?



NHS SSI **IRAS Version 5.0.0**

Select the appropriate title: ○ Principal Investigator
● Local Collaborator

Title Forename/Initials Surname

Post
Qualifications
Organisation
Work Address
PostCode
Work E-mail
Work Telephone
Mobile
Fax

[redacted]

a) Approximately how much time will this person allocate to conducting this research? *Please provide your response in terms of Whole Time Equivalents (WTE).*
1 day total

b) Does this person hold a current substantive employment contract, Honorary Clinical Contract or Honorary Research Contract with the NHS organisation or accepted by the NHS organisation? ● Yes ○ No

A copy of a current CV for the Principal Investigator (maximum 2 pages of A4) must be submitted with this form.

3. Please give details of all locations, departments, groups or units at which or through which research procedures will be conducted at this site and describe the activity that will take place.

Please list all locations/departments etc where research procedures will be conducted within the NHS organisation, describing the involvement in a few words. Where access to specific facilities will be required these should also be listed for each location.

Name the main location/department first. Give details of any research procedures to be carried out off site, for example in participants' homes.

	Location	Activity/facilities
1	[redacted]	Inform eligible service users about research and pass on research information. Arrange appointment with interested service users and principal investigator for an interview. Provide a private room for any interviews. Follow up any safeguarding concerns that may arise during interviews and speak with any participants if they need to after taking part. Phone interviews may take place if preferred.
2	[redacted]	Inform eligible service users about research and pass on research information. Arrange appointment with interested service users and principal investigator for an interview. Provide a private room for any interviews. Follow up any safeguarding concerns that may arise during interviews and speak with any participants if they need to after taking part. Phone interviews may take place if preferred.

5. Please give details of all other members of the research team at this site.

6. Does the Principal Investigator or any other member of the site research team have any direct personal involvement (e.g. financial, share-holding, personal relationship etc) in the organisation sponsoring or funding the research that may

5 **173694/853996/6/446/277315/332696**

give rise to a possible conflict of interest?

○ Yes ● No

7. What is the proposed local start and end date for the research at this site?

Start date:	12/10/2015
End date:	29/01/2016
Duration (Months):	3

8-1. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *(These include seeking consent, interviews, non-clinical observations and use of questionnaires.)*

Columns 1-4 have been completed with information from A18 as below:

1. *Total number of interventions/procedures to be received by each participant as part of the research protocol.*
2. *If this intervention would have been routinely given to participants as part of their care, how many of the total would have been routine?*
3. *Average time taken per intervention (minutes, hours or days)*
4. *Details of who will conduct the procedure, and where it will take place*

Please complete Column 5 with details of the names of individuals or names of staff groups who will conduct the procedure at this site.

Intervention or procedure	1	2	3	4	5
Seeking consent	1	0	10 minutes	Chief investigator will review the information sheet with the service user, answer any questions, and ask if they wish to continue. If they choose to continue, the consent form will be given to sign.	Chief investigator (Ruth Elsdon)
Interview	1	0	1 hour	The chief investigator will conduct the interviews in private rooms at centres used by recruitment sites or over the phone. It will be semi-structured. Opportunity for debrief will take place at the end.	Chief investigator (Ruth Elsdon)

8-2. Will any aspects of the research at this site be conducted in a different way to that described in Part A or the protocol?

○ Yes ● No

If Yes, please note any relevant changes to the information in the above table.

Are there any changes other than those noted in the table?

10. How many research participants/samples is it expected will be recruited/obtained from this site?

Up to a maximum of 12 but likely to be less

11. Give details of how potential participants will be identified locally and who will be making the first approach to them

to take part in the study.

Staff will be informed of the research and will identify service users on their case load who they think may be eligible and will approach them directly about it during their normal contact with them, unless they think discussing the research with particular individuals would not be appropriate given the service user's current situation. They will hand out information about the project and can follow up with anyone who expresses an interest to participate.

Research posters and fliers are available and can be used depending whether staff at each location think it is appropriate for their setting.In this case, interested individuals will be directed to call the chief investigator directly or speak to a member of staff for more information.

12. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?

Name	Expertise/training
Ruth Elsdon	I have had training in taking informed consent as part of the Doctorate in Clinical Psychology Course I am currently undergoing. This has included considering issues around capacity to consent. I have had experience of this in my role as trainee clinical psychologist e.g. in conducting psychological assessments or delivering therapy, and have conducted research previously within [redacted] which involved obtaining informed consent from inpatients on a psychiatric ward.

15-1. Is there an independent contact point where potential participants can seek general advice about taking part in research?

As the chief investigator is external to the Trust, staff at each location are independent and so can offer impartial advice or guidance about taking part. In addition, a contact has been provided on the information sheets regarding where to go with any complaints or concerns about the research.

15-2. Is there a contact point where potential participants can seek further details about this specific research project?

They can initially ask the staff member who informs them of the project and the information sheet provided. The chief investigator has a research phone that potential participants can call if they have further questions about involvement. Before interviews commence, there will be opportunity for people to ask further questions and to change their mind about participating.

16. Are there any changes that should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study? *A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.*

No. Blank spaces have been left on the information sheet to insert the name of the service and this has been approved by the REC.

Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally. Unless indicated above, this must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).

17. What local arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters etc.)*

Due to limited resources, it is not possible to provide interpreters for the research so all participants must be able to communicate in english. Information sheets will be given out by staff who can go through them with potential participants if they need assistance.

18. What local arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?

To protect confidentiality, the service will not be routinely informed about service user's participation. However, staff informing potential participants about the research are likely to know if they opt to take part and may be there to introduce service users to the chief investigator at the time of interview. Additionally, any safeguarding concerns after the interview will need to be followed up by the service, participants will be encouraged to take any concerns they may have following the research (e.g. if they feel upset and want to discuss this with someone) back to the service.

19. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?

As above, any safeguarding concerns raised during the interviews regarding risk of harm being caused to or by the participants, will be reported directly to the service by the chief investigator after the interview. If a more immediate response is required, the interview will be stopped and this will be followed up immediately. A relevant contact within the service will have been identified prior to commencing the interview.
At the end of each interview, the chief investigator will offer a debrief where participants are invited to consider if they feel upset or distressed in any way by what has been discussed. They will be encouraged to speak with their worker from the service afterwards if they need to and a list of other helpful contacts will be provided. The chief investigator will ensure a member of staff is available after the interview in case this is required.

20. What are the arrangements for the supervision of the conduct of the research at this site? *Please give the name and contact details of any supervisor not already listed in the application.*

The research is supervised through the DClinPsy course at Lancaster University by an academic supervisor (Craig Murray) and a field supervisor is also provided (Ruth O'Shaugnessey) who is based within Alder Hey Children's NHS Trust.

21. What external funding will be provided for the research at this site?

○ Funded by commercial sponsor
○ Other funding
● No external funding

How will the costs of the research be covered?
Lancaster University are sponsoring the research.

23. Authorisations required prior to R&D approval

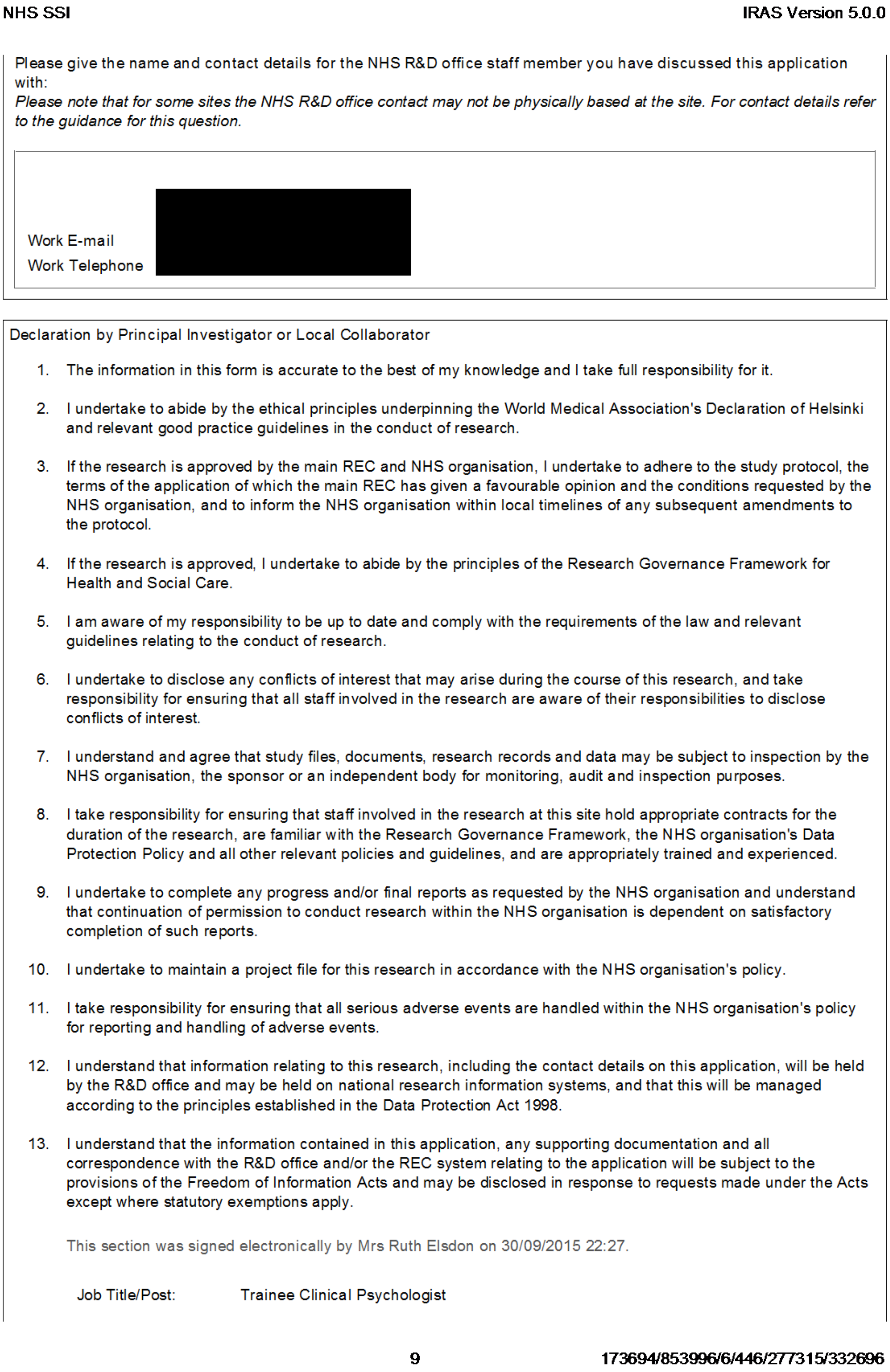
The local research team are responsible for contacting the local NHS R&D office about the research project. Where the research project is proposed to be coordinated centrally and therefore there is no local research team, it is the responsibility of the central research team to instigate this contact with local R&D.

NHS R&D offices can offer advice and support on the set-up of a research project at their organisation, including information on local arrangements for support services relevant to the project. These support services may include clinical supervisors, line managers, service managers, support department managers, pharmacy, data protection officers or finance managers depending on the nature of the research.

Obtaining the necessary support service authorisations is not a pre-requisite to submission of an application for NHS research permission, but all appropriate authorisations must be in place before NHS research permission will be granted. Processes for obtaining authorisations will be subject to local arrangements, but the minimum expectation is that the local R&D office has been contacted to notify it of the proposed research project and to discuss the project's needs prior to submission of the application for NHS research permission via IRAS.

Failure to engage with local NHS R&D offices prior to submission may lead to unnecessary delays in the process of this application for NHS research permissions.

Declaration:
☑ I confirm that the relevant NHS organisation R&D office has been contacted to discuss the needs of the project and local arrangements for support services. I understand that failure to engage with the local NHS R&D office before submission of this application may result in unnecessary delays in obtaining NHS research permission for this project.



Please give the name and contact details for the NHS R&D office staff member you have discussed this application with:
Please note that for some sites the NHS R&D office contact may not be physically based at the site. For contact details refer to the guidance for this question.

Work E-mail
Work Telephone
[redacted]

Declaration by Principal Investigator or Local Collaborator

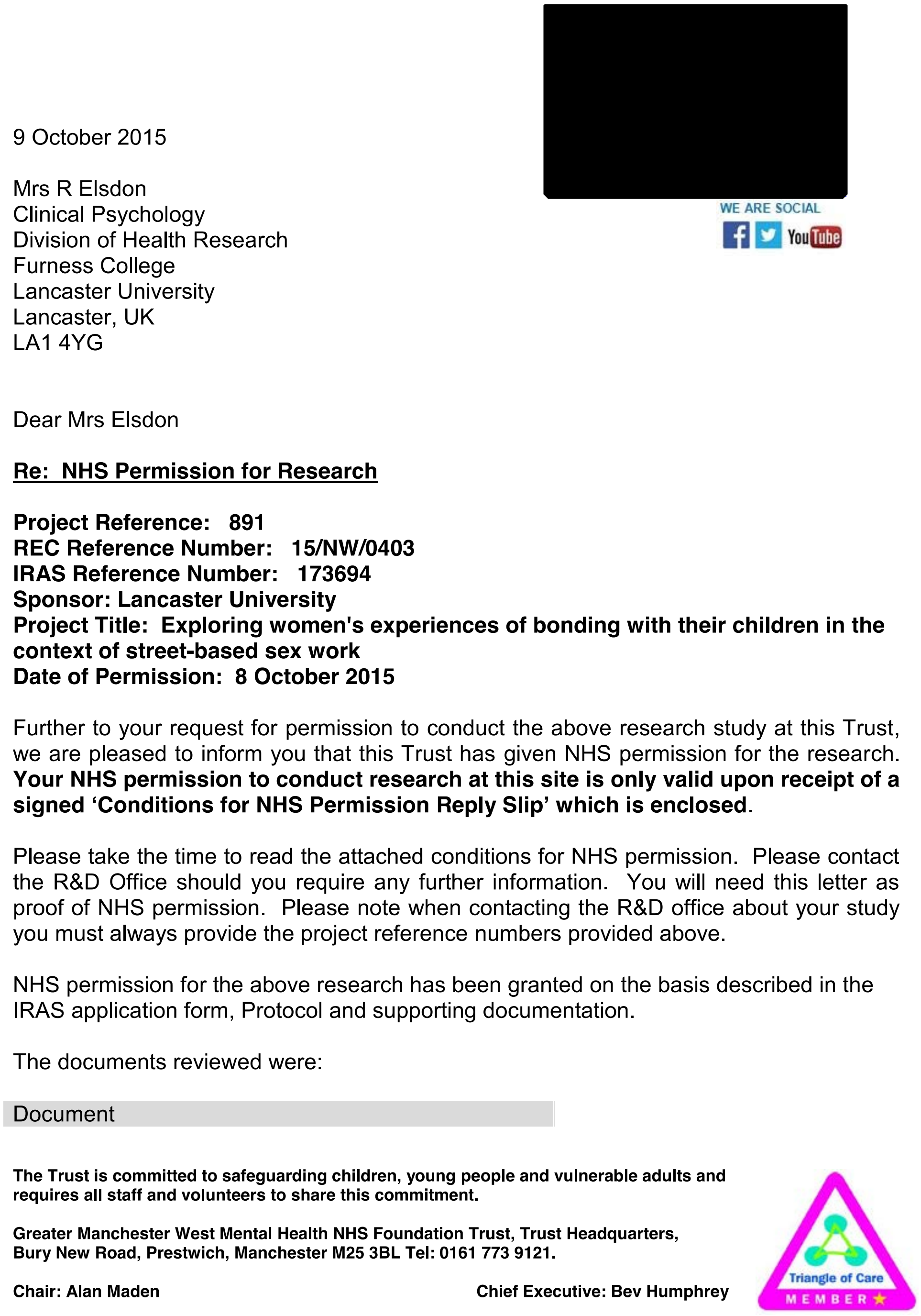
1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.
3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.
4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.
5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.
6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.
7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.
8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.
9. I undertake to complete any progress and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.
10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.
11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.
12. I understand that information relating to this research, including the contact details on this application, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
13. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

This section was signed electronically by Mrs Ruth Elsdon on 30/09/2015 22:27.

Job Title/Post: Trainee Clinical Psychologist

Organisation:	Lancaster University
Email:	r.elsdon@lancaster.ac.uk

Appendix 4-P R & D approval letter



[redacted]

WE ARE SOCIAL

9 October 2015

Mrs R Elsdon
Clinical Psychology
Division of Health Research
Furness College
Lancaster University
Lancaster, UK
LA1 4YG

Dear Mrs Elsdon

Re: NHS Permission for Research

Project Reference: 891
REC Reference Number: 15/NW/0403
IRAS Reference Number: 173694
Sponsor: Lancaster University
Project Title: Exploring women's experiences of bonding with their children in the context of street-based sex work
Date of Permission: 8 October 2015

Further to your request for permission to conduct the above research study at this Trust, we are pleased to inform you that this Trust has given NHS permission for the research. **Your NHS permission to conduct research at this site is only valid upon receipt of a signed 'Conditions for NHS Permission Reply Slip' which is enclosed**.

Please take the time to read the attached conditions for NHS permission. Please contact the R&D Office should you require any further information. You will need this letter as proof of NHS permission. Please note when contacting the R&D office about your study you must always provide the project reference numbers provided above.

NHS permission for the above research has been granted on the basis described in the IRAS application form, Protocol and supporting documentation.

The documents reviewed were:

Document

The Trust is committed to safeguarding children, young people and vulnerable adults and requires all staff and volunteers to share this commitment.

Greater Manchester West Mental Health NHS Foundation Trust, Trust Headquarters,
Bury New Road, Prestwich, Manchester M25 3BL Tel: 0161 773 9121.

Chair: Alan Maden **Chief Executive: Bev Humphrey**

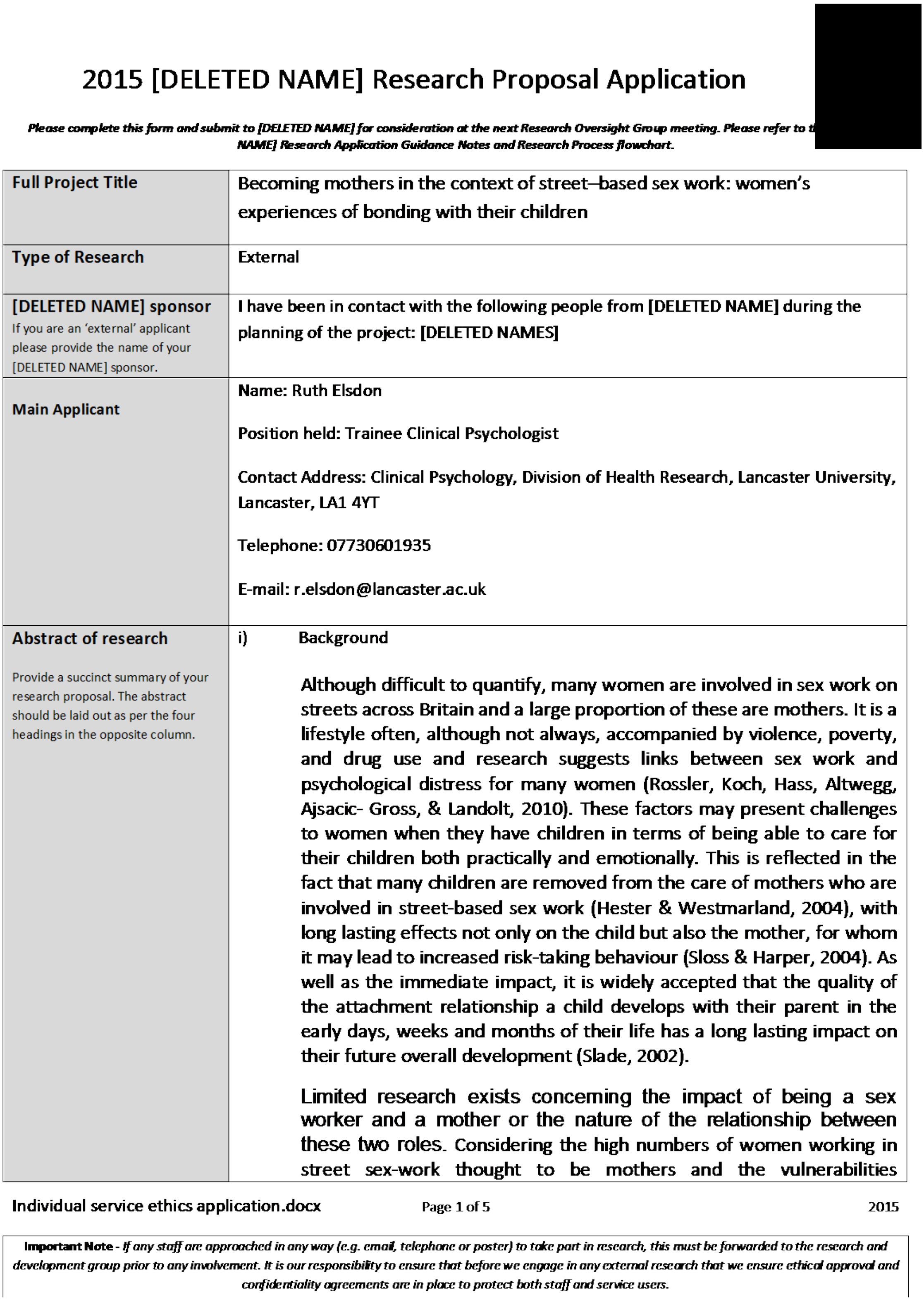
Participant Information Sheet

[redacted]

r University

Enc: Approval Conditions Leaflet
Induction & ID Badge Information

Appendix 4-Q Research Proposal Application for an individual service



[redacted]

2015 [DELETED NAME] Research Proposal Application

Please complete this form and submit to [DELETED NAME] for consideration at the next Research Oversight Group meeting. Please refer to [redacted] ***NAME] Research Application Guidance Notes and Research Process flowchart.***

Full Project Title	Becoming mothers in the context of street–based sex work: women's experiences of bonding with their children
Type of Research	External
[DELETED NAME] sponsor If you are an 'external' applicant please provide the name of your [DELETED NAME] sponsor.	I have been in contact with the following people from [DELETED NAME] during the planning of the project: [DELETED NAMES]
Main Applicant	Name: Ruth Elsdon Position held: Trainee Clinical Psychologist Contact Address: Clinical Psychology, Division of Health Research, Lancaster University, Lancaster, LA1 4YT Telephone: 07730601935 E-mail: r.elsdon@lancaster.ac.uk
Abstract of research Provide a succinct summary of your research proposal. The abstract should be laid out as per the four headings in the opposite column.	i) Background Although difficult to quantify, many women are involved in sex work on streets across Britain and a large proportion of these are mothers. It is a lifestyle often, although not always, accompanied by violence, poverty, and drug use and research suggests links between sex work and psychological distress for many women (Rossler, Koch, Hass, Altwegg, Ajsacic- Gross, & Landolt, 2010). These factors may present challenges to women when they have children in terms of being able to care for their children both practically and emotionally. This is reflected in the fact that many children are removed from the care of mothers who are involved in street-based sex work (Hester & Westmarland, 2004), with long lasting effects not only on the child but also the mother, for whom it may lead to increased risk-taking behaviour (Sloss & Harper, 2004). As well as the immediate impact, it is widely accepted that the quality of the attachment relationship a child develops with their parent in the early days, weeks and months of their life has a long lasting impact on their future overall development (Slade, 2002). Limited research exists concerning the impact of being a sex worker and a mother or the nature of the relationship between these two roles. Considering the high numbers of women working in street sex-work thought to be mothers and the vulnerabilities

Individual service ethics application.docx Page 1 of 5 2015

Important Note - *If any staff are approached in any way (e.g. email, telephone or poster) to take part in research, this must be forwarded to the research and development group prior to any involvement. It is our responsibility to ensure that before we engage in any external research that we ensure ethical approval and confidentiality agreements are in place to protect both staff and service users.*

[redacted]

connected to the work, it is important to understand how women relate to their children in this context; what factors impact upon their capacity for nurturing secure attachments with them, and how this process impacts on the women themselves. Further explorations of these areas can potentially broaden understanding about the lives of women involved in sex work and their specific needs and strengths. This knowledge can help professionals and services to provide additional and focused support for women in developing healthy relationships with their children, and promoting women's wellbeing in this context.

ii) Aims

To explore how women experience the bonding process with their children in the context of street-based sex work, specifically seeking to understand their perceptions of how their work impacts upon this bonding process and what impact these relationships have on them individually; to find out what women believe has helped them to develop relationships with their children and what has made this difficult.

iii) Techniques and Methodology (including any assessment measures)

The study will use a phenomenologically-informed qualitative methodology, suitable for exploring experience in depth, and privileging the lived experience of the women involved. In depth semi-structured interviews will be used (see attached topic guide). These will be predominantly face-to-face but I have submitted an amendment to IRAS to include phone interviews if participants prefer. Data will be analysed using thematic analysis.

iv) Impact for [DELETED NAME] service users and quality improvement

Service users who the research is relevant for will be informed about the research by staff, as well as posters/ fliers being put in public spaces where appropriate. The research is 'opt-in' so people who are interested can contact me or a staff member to find out more and arrange an interview if they choose. Interviews will be confidential and all data will be anonymised before being used.

It is hoped that participants may find it beneficial to have the opportunity to talk about their experiences. Additionally, the findings will be fed back to the relevant [DELETED NAME] services and to other services working directly with sex workers. It is hoped these findings will inform improvements to the quality of services in the future, by increasing their awareness of service-users'

[redacted]

	specific needs relating to having children and leading to more timely support for women who are having children in similar circumstances.
Is this a clinical trial?	**No**
What are the funding arrangements? Please state if you are seeking financial support for your project. If funding arrangements are in place please provide evidence of this with your application.	The research is sponsored by Lancaster University and all costs covered by the DClinPsy programme. No additional funding is being sought.
Commercially Funded research If the research is sponsored by a commercial agency please complete this section and enclose any relevant information with your application.	Contact Name: Telephone: E-mail: Name of Company/Organisation: On what basis is the agency funding the research? (per patient, fixed fee etc.)?
Which body has provided ethical review? e.g. University/IRAS Please submit evidence of this with your application.	IRAS. REC committee North West- Haydock.
Please provide details of the indemnity arrangements (insurance) for the project.	Lancaster University legal liability cover will apply.
Timetable. **Please indicate dates at which you are planning to commence the research activities.**	Start Data Collection: As soon as possible End Data Collection: January 2016 Data Analysis: September-January 2016 Write Up and Dissemination of findings: February 2016

[redacted]

How will the results be disseminated? (e.g. peer reviewed journal, conference presentations)	☐ Findings from the research will be written in a report as per the requirements of the DClinPsy programme. ☐ Findings from the research will be presented at Lancaster University as part of the DClinPsy programme. ☐ I aim to publish the research in a relevant academic journal. ☐ I will look to present the research findings at a relevant conference after completion of the project. ☐ Each service involved will be given a summary of the findings of the research. ☐ Each participant will have the option to be given a summary of the findings, either sent in the post, by email, or provided through a worker at the service, depending on service policies and the preference of each participant. ☐ As part of the debrief section of the interviews, I will discuss with participants the possibility of participating in the dissemination of the findings. I will suggest ideas such as doing a presentation to the service about the findings, or helping to present the findings at a relevant conference. Participants will also be asked if they have any ideas about how they would like the findings to be used which they can participate in either with myself or with the service, dependent on resources.
If you require the involvement of [DELETED NAME] staff, service users, peer mentors, volunteers in your research please clearly state the reason for their involvement. If they are not to be involved please state this.	[DELETED NAME] staff who are in contact with women involved in sex work have expressed willingness to distribute research information and speak with service users about the research. They will facilitate service users arranging interviews with myself. It is possible participants will want to speak with [DELETED NAME] staff after the interviews to debrief but this will be arranged directly with staff. I will also need to report any safeguarding concerns to the relevant service within [DELETED NAME] to be followed up by their procedures. This is clearly explained in the research information to participants. The research will involve interviews service-users who wish to participate.
Please provide details of additional non-[DELETED NAME] staff to be involved (if any) and the reason for their involvement.	I am not a member of [DELETED NAME] staff and will be conducting the interviews.
Please des[DELETED NAME]be how participation in this project might place service users or staff at	I do not envisage staff or service users being placed in any direct risk as a result of participation. However, it is possible that participants may find it upsetting to discuss their experiences. To minimise this, research information makes clear what participation involves, a debrief will take place after the interview and details of relevant support services provided in case necessary, and

any risk.	participants can be directed back to the service to speak to a staff me[redacted] they wish.
Progress reports If you answer no, please provide additional information	**Please confirm that you will report to [DELETED NAME] on the progress of your research at appropriate intervals to be determined by [DELETED NAME]?** **Yes x☐ No ☐**
Research findings If you answer no, please provide additional information	**Please confirm that you will share your research findings with [DELETED NAME] on completion of your research project?** **Yes x☐ No ☐**

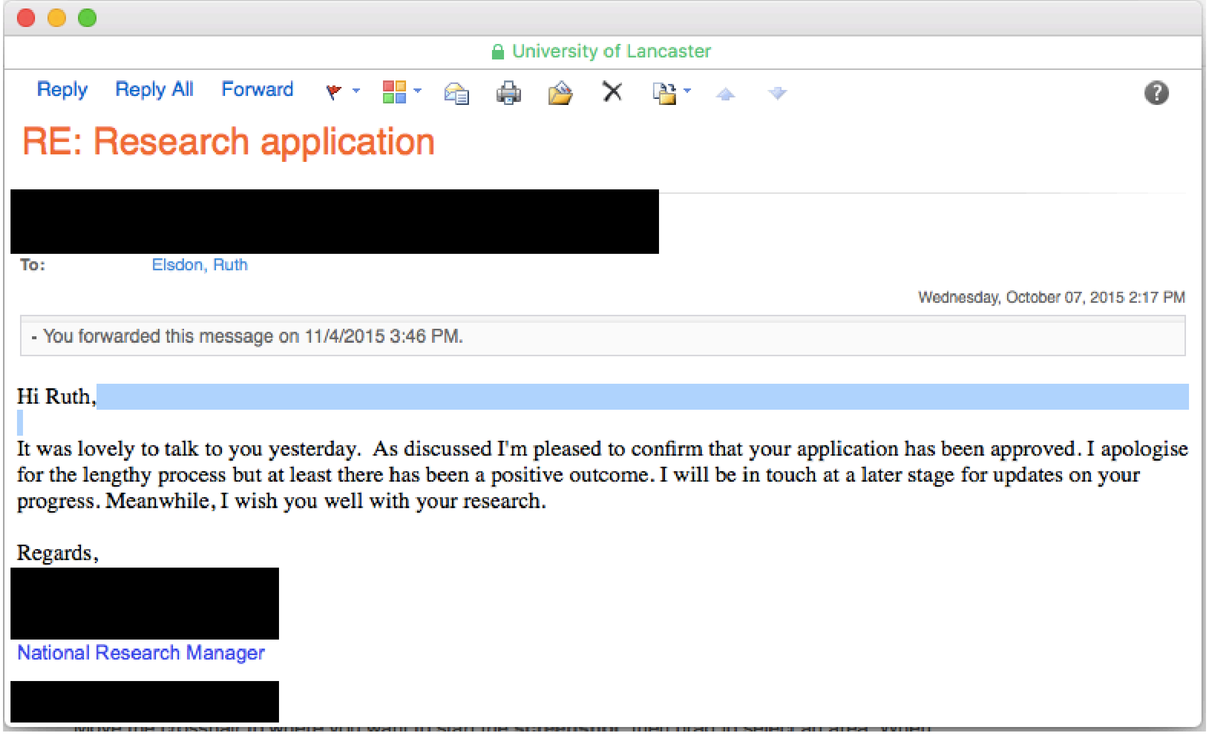
For internal use only

Application checklist

All sections of application form completed as required	Yes ☐	No ☐
Details of funding arrangements enclosed (where applicable)	Yes ☐	No ☐
Proof of ethical review enclosed (where applicable)	Yes ☐	No ☐
Agreement to report on research progress to [DELETED NAME]	Yes ☐	No ☐
Agreement to share research findings with [DELETED NAME]	Yes ☐	No ☐

Research Chair Decision	Approved ☐ Declined ☐	Research Tracker updated: Yes ☐ No ☐
Additional Comments (if applicable)		
Research Code (assigned on approval):		
Project completion date:		

Appendix 4-R Confirmation of approval by individual service



RE: Research application

[redacted]

To: Elsdon, Ruth

Wednesday, October 07, 2015 2:17 PM

- You forwarded this message on 11/4/2015 3:46 PM.

Hi Ruth,

It was lovely to talk to you yesterday. As discussed I'm pleased to confirm that your application has been approved. I apologise for the lengthy process but at least there has been a positive outcome. I will be in touch at a later stage for updates on your progress. Meanwhile, I wish you well with your research.

Regards,

[redacted]

National Research Manager

[redacted]