Sex Work Stigma and Sex Workers' Quality of Life in Finland

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Master's Thesis in Psychology

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Subject: Psychology
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Title: Sex Work Stigma and Sex Workers' Quality of Life in Finland
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Abstract: Stigma associated with sex work has previously been associated with lower health. The current study was set to quantitatively investigate the associations between sex work stigma (external and internal stigma) and quality of life, as well as substance-related problematic behavior (alcohol and drug use). We surveyed 155 sex workers who provided their services in/from Finland. Measures of self-perceived quality of life, sex work stigma, and substance-related problematic behavior were preformed through previously developed scales, with a few modifications. External and internal sex work stigma were significant predictors of quality of life: Sex workers who reported more sex work stigma also reported lower quality of life. Internal sex work stigma was a significant predictor of drug-related problematic behavior, and sex workers who reported more sex work stigma also reported more substance-related problematic behavior. The current study had various limitations and should be interpreted with consideration. Our results can be used to address sex work stigma and to be implemented in future services provided for sex workers.
Keywords: Sex Work, Sex Work Stigma, Quality of Life, Substance-Related Problematic Behavior
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Abstrakt:
Stigma relaterat till sexarbete har tidigare associerats med sämre hälsa. Denna studie fokuserade på att kvantitativt undersöka sambanden mellan sexarbetarstigma (externt och internt stigma) och livskvalitet, såväl som substansrelaterat problembeteende (alkohol- och droganvändning). Vi undersökte 155 sexarbetare som erbjöd sina tjänster i/från Finland. Mätningar på självupplevd livskvalitet, sexarbetarstigma och substansrelaterat problembeteende utfördes genom tidigare utvecklade skalor, med några modifieringar. Externt och internt sexarbetarstigma var betydande prediktorer för livskvalitet: sexarbetare som rapporterade mer sexarbetarstigma rapporterade även lägre livskvalitet. Internt sexarbetarstigma var en signifikant prediktor för drogrelaterat problembeteende, och sexarbetare som rapporterade mer sexarbetarstigma rapporterade också mer substansrelaterat problematiskt beteende. Denna studie hade en del begränsningar och därmed bör resultaten tolkas med försiktighet. Resultaten i studien kan användas för att arbeta emot sexarbetarstigma och för att implementera framtida tjänster som erbjuds åt sexarbetare.

Nyckelord: Sexarbete, Sexarbetarstigma, Livskvalitet, Substans-relaterad problematisk beteende

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Sex Work Stigma is Associated with Decreased Health and Increased Substance Use

Sex workers are often considered one of the most marginalized and stigmatized populations (Amnesty International, 2016). Sex workers are often viewed as deviants, victims, or criminals because of their occupation (Koken, 2011; Lehto, 2006; Liu et al., 2011; Wolf, 2019), and, naturally, these kinds of stereotypes stigmatize sex workers (Benoit et al., 2020). Stigma associated with sex work, that is, sex work stigma, is often mentioned by sex workers as a detrimental aspect of the occupation (Kontula, 2008; Wolf, 2019), and some sex workers have argued that the stigma, in and by itself, has more negative effects than the potential safety or health issues associated with the occupation (Kontula, 2008). In Finland, sex work is not considered a socially accepted occupation (Pro-tukipiste, n.d.), and many sex workers report experiencing sex work stigma (Kontula, 2008; Liitsola et al., 2013; TAMPEP, 2010).

Sex work stigma has been associated with a reduction in health (e.g., Koken, 2011; Rayson & Alba, 2019), and increased use of substances (e.g., Benoit et al., 2015b). However, not all sex workers report sex work stigma (Benoit et al., 2015a; Hargreaves et al., 2016) or problems with their health (Rayson & Alba, 2019; Romans et al., 2001). This individual variation underlines the importance of mapping out the association between sex work stigma and quality of life, as well as the association between sex work stigma and substance-related problematic behavior. To our best knowledge, no quantitative study has been designed to investigate the association between sex work stigma and sex workers' quality of life or substance-related problematic behavior in Finland.

Defining Sex Work

Previous research has defined sex work in several ways, but most studies have considered sex workers as individuals who sell physical forms of sex in exchange for money, goods, or other benefits (e.g., Liu et al., 2011; White et al., 2017; Wolf, 2019). Sex work has not been defined by the Finnish law, and thus the legal boundaries are vague (Pro-tukipiste, 2022). For example, Liitsola et al. (2013) mention that the field of sex work is broad and consists of many subgroups. A broader definition of sex work can include both media-based services (e.g., webcamming, OnlyFans, and pornography) and in-person services (e.g., erotic services, escort services, and girl-/boyfriend experiences). Hence, sex work must not always involve physical or sexual contact with clients (e.g., media-based services and some in-person services, such as stripping). Moreover, not all sex workers included in this definition identify themselves as sex workers (New Zeeland Government, 2008); a reason for this could

be that some sex workers only work occasionally or that they do not provide in-person services. Importantly, many previous studies on sex workers' well-being have included only a specific group of sex workers, for instance, only female sex workers (e.g., Buttram et al., 2014; Decker et al., 2020; Diatlova, 2019; Footer et al., 2019; Nestadt et al., 2020) or sex workers who sell physical sex (e.g., White et al., 2017). This complicates generalizing findings to sex workers as a broader group.

Sex Work in Finland

The vague and varied definitions of sex work make it difficult to estimate how common sex work is (Khodabakhshi Koolaee & Damirchi, 2016). According to Statistics Finland, more than 100 million euros move through the Finnish sex work industry annually (Parikka, 2020; "Finnish Sex Trade," 2019). Previous estimates of the number of sex workers in Finland vary from 5,000 to 8,000 (Kontula, 2008; TAMPEP, 2010). However, these estimates only consider a narrow field of sex workers. In addition, Kontula (2008) mentioned that these estimates are probably an underestimate. Furthermore, the organization Pro-tukipiste estimated in 2008 that most sex workers work indoors and are women, and around two-thirds are migrants (TAMPEP, 2010). These estimates are more than one decade old and the field of sex work has likely changed during this period. For instance, changes have been reported in Australia, where obtaining clients and promoting sex work services online have increased considerably during the past ten years (Selvey et al., 2017).

According to Rössler et al. (2010), it is worthwhile to investigate sex work in countries like Finland where it is impacted by jurisdiction. Both providing and purchasing sex work services are legal in Finland. However, several laws as well as various common-law regulations have restricted providing and purchasing of sex work services in Finland (Pro-tukipiste, 2022). For instance, according to the Public Order Act (2:7.1 §), it is illegal to provide sex work services and to purchase sex work services against payment in public places. Furthermore, according to the Aliens Act (9:148.6 §), a foreigner can be refused entry into Finland if there are reasonable grounds for suspecting he or she provides sex work services. In Finland, individuals who sell physical forms of sex are required to work independently (see e.g., laws concerning pandering in the Seksuaalirikokista; 20:10.1 § and 20:11.1 §), whereas other types of sex workers (e.g., working at an erotic restaurant) may have some form of employment (Kontula, 2008). Nevertheless, it can be challenging to understand the jurisdiction impacting sex workers in Finland (TAMPEP, 2010), and due to

the complex jurisdiction, it is even more important to study the sex workers' quality of life in Finland.

Different Types of Stigmas

Stigma encompasses stereotyping, labeling, and discriminating, as well as the person's resulting loss of social status (Link & Phelan, 2001). Several studies have divided stigma into internal and external stigma (Brouard & Wills, 2006; Brown et al., 2003; Catona et al., 2016; Hasan et al., 2012; Lazarus et al., 2012; Scambler & Hopkins, 1986). Internal stigma—sometimes called felt stigma—can be described as stigma that is felt or perceived. In this context, internal stigma can refer to both unrealistic and realistic fear of other peoples' attitudes and discrimination, due to, unfavorable conditions, behaviors (e.g., posting naked pictures online), or belonging to a specific group (e.g., sex workers; Brown et al., 2003). Internal stigma is associated with developing negative self-identity (Hallgrímsdóttir et al., 2008) as well as negative feelings, such as shame, guilt, hopelessness, and self-blame (Hasan et al., 2012).

In contrast, external stigma—sometimes called enacted stigma—is defined as the experience of actual discriminatory or negative behavior (Brown et al., 2003). External stigma thus includes experiences of both past and present psychological and physical violence (e.g., humiliation or being pushed), as well as avoidance, specific restrictions, or denial of opportunities (e.g., workplace or health care services; Catona et al., 2016). The internal and external stigma are intertwined (Hasan et al., 2012); sometimes an actual experience of discrimination can become internalized (Hallgrímsdóttir et al., 2008). Taken together, it is important to address both internal and external stigma to better understand sex worker stigma (Lazarus et al., 2012).

Stigma Associated with Sex Work

In comparison with other service occupations, sex workers are more likely to be exposed to stigmatization, discrimination, and/or criminalization (Rayson & Alba, 2019). Several studies demonstrate that sex workers face stigma in many different life settings (Benoit et al., 2005; Kontula, 2008; Lazarus et al., 2012; Rayson & Alba, 2019). For instance, it is concerningly common that sex workers experience stigma when seeking help from health care workers (Rayson & Alba, 2019). Sex workers selling sex in Finland have also reported experiencing stigma from clients, police officers, and health care workers (Kontula, 2008). In addition, they have reported discriminatory behavior in their additional workplaces, eviction attempts, and being questioned regarding their custodial right to their children (Kontula,

2008). In a previous study, almost all sex workers reported experiences of sex work stigma (Hargreaves et al., 2016). Many sex workers avoid talking about their occupation because of previous stigma experiences (Kontula, 2008). Although it would have been important in the situation, only a few respondents reported talking about their occupation to a social worker and/or health care worker (Liitsola et al., 2013). In addition, some sex workers avoid using health care services, because of how they have been previously treated (TAMPEP, 2010). Furthermore, the most common type of violence that sex workers experience in Finland is psychological (e.g., humiliation; Liitsola et al., 2013). Stigmatization prevents many sex workers from reporting violence for fear of possible unfair treatment and discrimination by police and courts (TAMPEP, 2010). However, all sex workers in Finland have not reported experiences of violence at work (Liitsola et al., 2013; TAMPEP, 2010), nor experiences of stigma; stigma seems to depend on personal resources, own attitudes, and how central the occupation is in their lives (Kontula, 2008).

Quality of Life Among Sex Workers

Quality of life has been defined as "an individual's perception of their position in life in the context of the culture and value systems in which they live and concerning their own goals, expectations, standards and concerns" (WHOQOL Group, 1998). In other words, quality of life is a multidimensional concept (Rubin & Peyrot, 1999) that describes how an individual sees their social relationships, their environment, as well as psychological and physical functioning (Lucas-Carrasco, 2011).

To our best knowledge, only a handful of studies have investigated sex workers' quality of life in accordance with the aforementioned definition (Khodabakhshi Koolaee & Damirchi, 2016; Picos et al., 2018; Pinedo González et al., 2021; Wang et al., 2015; Wong et al., 2006). Two of these were comparative studies from China, and the results indicated a decreased quality of life among sex workers compared to non-sex workers (Wang et al., 2015; Wong et al., 2006). Moreover, Khodabakhshi Koolaee and Damirchi (2016) suggest previous findings on sex workers' quality of life, with the aforementioned definition and other definitions, are inconclusive. Studies with other definitions have investigated sex workers' quality of life or life satisfaction in a less multidimensional way (e.g., only measuring this with one or a few items; Brody et al., 2015; Liitsola et al., 2013; Milner et al., 2019; Wang et al., 2007). One of these studies conducted in the Dominican Republic indicated a lower quality of life among sex workers compared to non-sex workers (Milner et al., 2019). Another study conducted in Senegal indicated that only 7.5% were satisfied or

very satisfied with their lives (Wang et al., 2007). In contrast to these previous findings, a study from Cambodia found that most of the respondents rated their quality of life as good (Brody et al., 2015). Although many previous studies from different countries indicated a low or a decreased quality of life among sex workers (Milner et al., 2019; Wang et al., 2015; Wong et al., 2006; Wang et al., 2007), Liitsola et al. (2013) reported that majority of Finnish sex workers are satisfied with their life's, and Vaarama et al. (2014) suggest that people in Finland have a good quality of life in general. Taken together, previous findings are inconclusive, and no previous study has measured quality of life in a multidimensional way among sex workers in Finland.

Substance Use Among Sex Workers

As it has a negative impact on the quality of life also among sex workers, Khodabakhshi Koolaee & Damirchi (2016) have noted that substance abuse is important to acknowledge in this context. Indeed, several studies have investigated substance use among sex workers (e.g., Argento et al., 2015; Benoit et al., 2015b; Chow et al., 2015; Li et al., 2010; Khodabakhshi Koolaee & Damirchi, 2016; Matusiewicz et al., 2016; Romans et al., 2001; Tavakoli et al., 2021). For example, Matusiewicz et al. (2016) note the high rates of substance use that have been reported among sex workers in the U.S. In a comparative study conducted in New Zealand, results indicated that sex workers use more alcohol than a comparison group (Romans et al., 2001). However, according to Benoit et al. (2015b), it was a substantial minority of sex workers from Canada and the USA reported drug use. To our knowledge, substance-related problematic behavior among sex workers has not been investigated quantitatively in Finland.

Furthermore, results from a Spanish study investigating drug use among sex workers suggest that there is a negative association between drug use and the psychological dimension of quality of life (Picos et al., 2018). A more recent investigation on drug use among sex workers in Spain was found to have a negative association with both the psychological and physiological dimensions of quality of life (Pinedo González et al., 2021). In addition, female sex workers in Teheran who used drugs have been found to have a lower level of quality of life compared to sex workers who did not use drugs (Khodabakhshi Koolaee & Damirchi, 2016). Taken together, neither substance-related problematic behavior nor the quality of life has been measured among sex workers in Finland.

Sex Work Stigma and Quality of Life Among Sex Workers

Sex work stigma might affect the quality of life. A handful of studies indicate that sex work stigma is associated with both increased social isolation and/or poor health outcomes for some sex workers (see e.g., Bellhouse et al., 2015; Benoit et al., 2015a; Benoit et al., 2015b; Jiao & Bungay, 2018; Koken, 2011; Krüsi et al., 2016; McCausland et al., 2020; Tomko et al., 2020; Wolf, 2019). These studies shed light on the expected association between sex work stigma and quality of life. For instance, Benoit et al. (2015a) mentioned that previous studies suggest that stigma, social exclusion, and isolation are negatively associated with sex workers' health and positively associated with drug use. This is consistent with two other studies, one of which suggested that loneliness was positively associated with drug use among sex workers (Pinedo González et al., 2021), and another one which suggested that sex work stigma mediates part of the link between sex work and drug use (Benoit et al., 2015b). Furthermore, an association between stigma and substance use disorder has been supported in a literature review (Yang et al., 2017).

Because of their stigmatized occupation, sex workers face challenges in social interactions, as well as in interpersonal relationships (McCausland et al., 2020). For example, Picos et al. (2018) mention that several studies report that stigma is negatively associated with sex workers' relationship quality. One of the most common ways for sex workers to deal with sex work stigma is to conceal their occupation (McCausland et al., 2020; Wolf, 2019). Sex work stigma can have a negative impact on the sex worker's identity (Benoit et al., 2015a), and concealing one's occupation can result in increased negative feelings (e.g., guilt or loneliness) and even more social isolation (Koken, 2011; Wolf, 2019). In conclusion, sex work stigma can have negative consequences on the sex worker's social life and health.

Furthermore, sex workers risk becoming victims of psychological/physical violence, which is associated with lower psychological/physical health outcomes (Pinedo González et al., 2021). Indeed, studies show that violence negatively impacts psychological health among sex workers (Hong et al., 2013; Picos et al., 2018). However, not all sex workers have experienced violence (Liitsola et al., 2013; TAMPEP, 2010). Taken together, the risk for violence can explain a negative association between sex work stigma and quality of life.

The Current Study

The situation of sex workers living in Finland has been only sparsely investigated. The study by Liitsola et al. (2013) that quantitatively analyzed the health and welfare of sex workers in Finland was conducted almost a decade ago. To our knowledge, no previous study

has quantitatively investigated the association between sex work stigma and quality of life or substance-related problematic behavior in Finland. To further improve generalizability to all sex workers, we used a relatively broad definition of sex work and included all genders in our study. Our definition of sex work included providing any kind of sex work services with consent in exchange for payment, economic benefits (e.g., paid hotel accommodation), or immediate needs (e.g., food). We included both media-based services and in-person services.

The aim of the current study was to quantitatively investigate the association between sex work stigma and sex workers' quality of life in Finland. Based on the previously mentioned research, we expected

1) A negative association between sex work stigma and sex workers' quality of life.
2) A positive association between sex work stigma and substance-related problematic behavior.
3) A positive association between external and internal sex work stigma.

In addition, we investigated the association between quality of life and substance-related problematic behavior, as well as how descriptive variables were associated with sex work stigma, quality of life, and substance-related problematic behavior.

Methods

Ethical Permission

The current study was part of a larger data collection on sex workers' quality of life in Finland. The larger data collection received ethical permission from the Board for Research Ethics at Åbo Akademi University.

Respondents

Sex workers were eligible to participate in the study if they were at least 18 years old and had been providing sex work services for at least the past six months, either from Finland (media-based services) and/or in Finland (in-person services), meaning that sex workers who were included in the study could have provided sex work services either regularly or occasionally during this period. Sex workers of all genders were included in the study.

One hundred and fifty-five respondents began the survey, and 99 respondents completed the whole survey. This resulted in a completion rate of 63.1%. Fifteen of the 155 respondents filled out the survey in English and 140 in Finnish. The mean age of the respondents was 32.26 years (n = 137, SD = 10.30; age ranged from 18 to 80 years or older). The respondents were approximately 25 years old when they started providing sex work services (n = 104, M = 24.71, SD = 8.45), and they had, on average, provided services for six

years (n = 104, M = 6.20, SD = 6.52). Most respondents were women with Finnish citizenship. Most respondents had completed an upper secondary educational level or higher educational level. The median for monthly gross income from sex work was between 1,500 and 1,999€, and the median for total monthly gross income was between 2,000 and 2,499€. Most respondents reported a good or very good economic situation. More demographic characteristics of the sample are included in Table 1.

Table 1

Demographic Characteristics of the Sample

Variable	*n*	%
Gender	137	
Man	11	8.0
Woman	108	78.8
Transman	1	0.7
Transwoman	3	2.2
Non-binary	13	9.5
Other	1	0.7
Sexual orientation	137	
Heterosexual	64	46.7
Homosexual	2	1.5
Bisexual	34	24.8
Pansexual	30	21.9
Asexual	6	4.4
Other	1	0.7
Relationship status	137	
Single	60	43.8
In a relationship	33	24.1
Cohabiting	17	12.4
Married	16	11.7
Other	11	8.0
Has children, *yes* [a]	57	41.6
Birth country	137	
Finland	127	92.7
Other	10	7.2
Work country	137	
Only from/in Finland [b]	126	92.0
Also somewhere else	11	8.0
Residence in Finland	135	
Finnish citizen	125	92.6
Permanent residence permit	3	2.2
Temporary residence permit	3	2.2
No residence permit	0	0.0
Did not want to say	4	3.0
Highest completed level of education	135	
No education	0	0.0
Primary (6 or less years)	4	3.0
Lower secondary (7-9 years)	20	14.8
Upper secondary (10-12 years)	55	40.7
University/applied university (13 years or more)	56	41.5
Work besides sex work [c]	135	
Other paid full-time/part-time work	48	29.1
Volunteer work	16	9.7

Variable	*n*	%
Studying/completing an internship	32	19.4
Caregiver [d]	6	3.6
Something else	23	14.0
No other work	40	24.2
Monthly gross income – sex work	104	
0-1499€	49	47.1
1500-2999€	22	21.2
3000-4499 €	20	19.2
4500- or more €	13	12.5
Monthly gross income – total	104	
0-1499€	37	35.6
1500-2999€	22	21.1
3000-4499 €	16	15.4
4500- or more €	29	27.9
Economic situation	104	
Bad, had to take a loan	5	4.8
Tight, not enough money	3	2.9
Quite tight, just enough money	22	21.2
Good, but spends all money	22	21.2
Very good, saves money	52	50.0

Note. $N = 137$. The number of respondents (*n*) varies between different variables due to dropout. The percentages reflect the proportion between respondents. [a] The percentage reflects respondents answering "yes" to this variable. [b] Includes both media-based services provided from Finland and/or in-person services provided in Finland. [c] An exception where the respondents could choose several response options in these cases, percentages reflect the proportion of responses. [d] Caregiver to parents, children, or other family members.

Measures

All items and questions from the current study's survey can be found in Appendix A, Table 8. All measures and scales were translated from English into Finnish, except items in the World Health Organization Quality of Life (WHOQOL)-BREF scale, original items used from the Alcohol Use Disorders Identification Test (AUDIT), and original items used from the Drug Use Disorders Identification Test (DUDIT). All items and questions were mandatory to answer and included fixed response options (except for some free-text options). The measures included in this study are presented below.

Demographic and Descriptive Measures

We asked respondents to provide the following demographic and descriptive information: age, gender, sexual orientation, relationship status, country of birth, residence

status in Finland, education level, whether they had children, monthly gross income, and financial situation. Furthermore, our survey included a few questions related to their working situation (e.g., work besides providing sex work services) and questions related to their sex work (e.g., type of interaction with clients).

Quality of Life

The World Health Organization Quality of Life (WHOQOL)-BREF scale was used to measure the self-perceived quality of life during the past two weeks (WHOQOL Group, 1998). Twenty-four of the 26 items measure four different dimensions of quality of life: physical (seven items), psychological (six items), social (three items), and environmental (eight items). The remaining two items measure general health and overall quality of life. All items were rated on a 5-point Likert scale (1-5). A higher total score (score ranging from 26-130 points) indicates a higher level of self-perceived quality of life during the past two weeks. The WHOQOL-BREF scale has been demonstrated to be a reliable and valid brief method to assess the self-perceived quality of life (WHOQOL Group, 1998). In the current study, the internal consistency of this scale was excellent (Cronbach's $\alpha = 0.96$).

Sex Work Stigma

Two scales were used to measure sex work stigma: the Internalized Sex Work Stigma Scale (ISWSS; Tomko et al., 2020) and our adapted version of the Sex Work Experienced Stigma Scale (SWESS; original scale by Oga et al., 2020).

Internalized Sex Work Stigma. ISWSS consists of 12 items with four subscales measuring internal sex work stigma: worthlessness (four items), acceptance (three items), illegitimacy (two items), and guilt and shame (three items). ISWSS is adapted by Tomko et al. (2020) from previous stigma scales by Carrasco et al. (2018) and Liu et al. (2011). All items were rated on a 4-point Likert scale (1-4). A higher total score (score ranging from 12 to 48 points) indicates a higher frequency of internal sex work stigma. ISWSS has previously demonstrated good construct validity and high internal consistency (Cronbach's $\alpha = 0.82$; Tomko et al., 2020). In the current study, the internal consistency of this scale was good (Cronbach's $\alpha = 0.89$).

External Sex Work Stigma. The original version of SWESS consists of 19 items with four subscales measuring external sex work stigma: health care stigma (seven items), police officer/law enforcement stigma (five items), family/partner stigma (four items), and other people stigma (three items). We made the following changes: we added an extra subscale (client stigma) with three new items (items 21, 22, and 23 in Appendix A), and we

added an extra item (item 17 in Appendix A) to the family subscale. Furthermore, we changed some of the items to clarify the meaning of the items (items 3, 7, 8, 9, 14, 15, 16, 19, and 20 in Appendix A) and to adjust the items to different types of sex work (items 6, 10 and 11 in Appendix A). Finally, after our changes, the scale included 23 items and five subscales. We changed the original SWESS response options to match the six months inclusion criteria for providing sex work services. All items were rated on a 4-point Likert scale (0-3). A higher total score (score ranging from 0-69) indicates a higher frequency of external sex work stigma. The original 19-item SWESS has previously demonstrated good discriminant and excellent internal consistency (Cronbach's $\alpha = 0.93$; Oga et al., 2020). In the current study, the internal consistency of this scale (including three subscales: family, other people, and client) was good (Cronbach's $\alpha = 0.79$).

We added eight yes or no questions related to the external sex work stigma scale (SWESS). Four questions addressed if any one of the following knew about their occupation: a health care worker, a police officer/someone in law enforcement, a family member/partner, or other people (e.g., a friend). This was done to ensure that the stigma reported by the respondents could be associated with their sex work occupation because one or more of the previously mentioned knew about the occupation. The remaining questions addressed whether the respondent had been in contact with or visited a health care worker/facility, a police officer/someone in law enforcement, during the past six months. If the respondent had neither been in contact nor visited the following, then they were asked if the reason was previous negative experiences. These questions were included to ensure that external sex work stigma was not the reason behind no contact or no visits during the past six months. If the respondent had not been in contact or visited the following they did not answer the current subscales' SWESS items.

Substance-Related Problematic Behavior

Alcohol-Related Problematic Behavior. The original 10-item Alcohol Use Disorders Identification Test (AUDIT) was developed to identify harmful and hazardous consumption of alcohol over the past year (Saunders et al., 1993). We made the following changes in AUDIT: We removed the first three items and added instead one yes or no question regarding whether the respondent had consumed alcohol during the past six months, if they answered yes then they proceeded with answering seven items from the original scale (including AUDIT's original items 4-10; items 2-8 in Appendix A, Table 8). The adapted version of AUDIT was changed to match the six months inclusion criteria for providing sex

work services. Our goal was to assess respondents' substance-related problematic behavior during this period, not to specify the amount of consumption. All responses from the original scale were given using fixed alternatives and they were rated from 0 to 4; a lower total score (score ranging from 0 to 28 points) indicated less substance-related problematic behavior. The original scale has previously demonstrated good internal consistency (Cronbach's $\alpha >$ 0.8; Allen et al., 1997). In the current study, the internal consistency of this adapted scale (including original items 4-10) was good (Cronbach's $\alpha = 0.88$).

Drug-Related Problematic Behavior. The original 11-item Drug Use Disorders Identification Test (DUDIT) was developed to identify drug-related problems over the past year (Berman et al., 2002). We made the same changes to DUDIT as in AUDIT (including DUDIT's original items 5-11; items 2-8 in Appendix A, Table 8), and we had the same goal and rating scale. The original DUDIT has previously demonstrated excellent internal consistency (Cronbach's $\alpha > 0.9$; Hildebrand, 2015). In the current study, the internal consistency of this adapted scale (including original items 5-11) was good (Cronbach's $\alpha =$ 0.85).

Procedure

Survey Piloting

Prior to the start of data collection, we piloted the survey, with recruitment help from Pro-tukipiste (i.e., an organization in Finland that provides support services for all kinds of sex workers, as well as victims of sex trafficking), four sex workers completed the survey and provided us feedback. The feedback led to a few changes before finalizing the survey.

Sample Recruitment

To obtain a representative sample, we used several channels to recruit respondents. The recruitment of respondents for the study was partly done with the help from Pro-tukipiste and FTS Finland (i.e., a network in Finland for sex workers), as they distributed the online survey to sex workers via their network. The online survey was also distributed through social media platforms (Instagram and Facebook) and via online forums related to sex work (e.g., Seksisaitti.net, Seksitreffit.fi). We invited publicly known sex workers in Finland to participate by contacting them via their social media accounts or by e-mail. We also requested them to distribute the online survey forward to other sex workers. The data collection was carried out between February and March 2022 and lasted for 25 days.

Survey Participation

We created the secure online survey with the commercial tool SurveyAnalytics. Respondents could complete the survey in either Finnish or English. To participate in the study, the respondent had to give informed consent. Before giving informed consent, the respondent received information regarding the purpose of the study, the subjects covered in the survey, anonymity, voluntariness, and data management policy. After completing the survey, the respondents were given the opportunity to take part in a lottery of three gift cards worth 50€ to their choice from three business options by filling out their e-mail in a separate survey. The e-mail addresses were separately stored from the survey responses.

Statistical Analyses

Statistical analyses were conducted using SPSS (IBM SPSS Statistics 28.0.0.0 (195)). As an initial step, we calculated frequencies and percentages, as well as group means (respondents' age, age when starting to provide and years providing) and medians (monthly gross income from sex work and monthly gross income total) for the descriptive variables. In addition, one outlier was excluded from analyses involving the measure of alcohol-related problematic behavior, due to a standard deviation of 4.19. Thereafter, we conducted Pearson bivariate correlations with 2,000 bootstrap samples between different variables: WHOQOL-BREF, AUDIT, DUDIT, ISWSS (full scale including all subscales), separately ISWSS subscales, SWESS (full scale including subscales: family, other, and client), separately SWESS subscales, SWESS additional questions, as well as variables inquiring demographic and descriptive measures. In analyses of SWESS full scale, both the health subscale and the police subscale were excluded, because of their substantial negative effect on the sample size. In bootstrapped analyses, we report bias corrected accelerated confidence intervals (BCa) instead of 95% confidence intervals.

For our research questions, we conducted linear regressions and multiple linear regressions with parameter estimates with robust standard errors, these were preformed because linear regressions' assumptions were not met. We preformed regression analyses with the full sample and with a restricted sample (only included respondents who had a family member/partner and someone else that knew about their occupation). Dependent variables were the measures of quality of life and substance-related problematic behavior. Because the high internal reliability suggests high correlations between the different quality of life subscales, we decided to perform analyses only with the total score as an outcome.

Results

Descriptive Results

Respondents' most typical clients were men, and the most common interaction with clients involved sexual contact. Thirty-nine (37.5%) sex workers reported providing both media-based and in-person services. Eleven (10.6%) sex workers reported providing media-based services, while 54 (51.9%) sex workers reported only providing in-person services. Table 2 includes frequencies of sex workers' interactions with clients, type of services provided, service location, and thoughts about quitting sex work.

Table 2

Frequencies of Sex Workers Client Interaction, Provided Services, Service Location and Thoughts about Quitting

Variable	*n*	%
Most typical client [a]		
Man	99	95.2
Woman	3	2.1
Other	2	1.9
Most common client interaction [a]		
No interaction, no contact [b]	20	9.4
Interaction, online/by phone	51	23.9
Interaction in person	95	
No physical nor sexual contact [c]	13	6.1
Physical contact, no sexual contact [d]	44	20.7
Sexual contact	85	39.9
Media-based services, *yes* [e]	50	48.1
Type of media-based services		
Photos/videos	40	42.6
Webcamming	19	20.2
Phone calls/messages	31	33.0
Other	4	4.3
In-person services, *yes* [e]	93	89.4
Type of in-person services		
Full service [f]	70	25.2
Escorting	43	15.5
Massage	33	11.9
Dance/stripping	18	6.5
Girl-/boyfriend experience	59	21.2
Sugar dating	17	6.1
Fetish sessions/BDSM	35	12.6
Other	3	1.1
Service location		
Only media-based services	11	4.3
Own home	49	19.0
Client's home	53	20.5
Brothel	1	0.4
Strip club/erotic bar	7	2.7
Massage parlor	1	0.4
Hotel	54	20.9
Studio [g]	14	5.4
Street	4	1.6
Car	26	10.1
Rented apartment	31	12.0
Somewhere else	7	2.7

Variable	*n*	%
Often thinking about quitting		
Not at all true	64	61.5
Slightly true	25	24.0
Very true	15	14.4
Reasons to quit [h]	40	
Try a new job	5	4.3
Better job offers	0	0.0
This is only a temporary job	16	13.9
Not paid enough	7	6.1
I do not like my job	20	17.4
Want to study	8	7.0
Expecting a child	0	0.0
Affecting relationship/s	13	11.3
Too much stigma	10	8.7
Physical/mental health	23	20.0
Retiring soon	4	3.5
Other reason	9	7.8

Note. $N = 104$. The number of respondents (n) varies between different variables due to dropout and survey logic. The percentages reflect the proportion of responses (not the proportion of respondents) because respondents could choose several response options.

[a] Exceptions where the percentages reflect the proportion between respondents. [b] Includes services such as posting photos on a platform without any interaction or contact with clients. [c] Includes e.g., stripping on a scene. [d] Includes e.g., massage, kissing, or hugging. [e] The percentage reflects respondents answering "yes" to this variable. [f] Full service means intercourse/complete sex. [g] Includes e.g., SM-studio. [h] Includes only respondents who answered slightly true or very true to the variable "often thinking about quitting".

Quality of life was reported as good by most of the respondents ($n = 128$, $M = 100.10$, $SD = 21.68$). Seventy-two respondents (56.2%) reported either high or very high quality of life, while twenty-five respondents (19.5%) reported low or very low quality of life. Seventy-one respondents (68.3%) reported use of alcohol during the past six months, and alcohol-related problematic behavior was low among respondents ($n = 68$, $M = 3.32$, $SD = 5.03$). Twenty-four respondents (23.8%) reported use of drugs during the past six months, and drug-related problematic behavior was low among respondents ($n = 24$, $M = 7.25$, $SD = 7.73$).

Hundred out of 107 respondents (93.5%) reported internal sex work stigma, and it was relatively high among respondents ($n = 107$, $M = 39.54$, $SD = 7.23$). Sixty-four out of 105 respondents (61.0%) reported external sex work stigma (including subscales: family,

other, and client), and it was low among respondents (n = 105, M = 0.36, SD = 0.45). Our modified version of SWESS included eight additional yes or no questions. According to the additional questions associated with the SWESS health subscale, 53 (49.5%) respondents reported that a health care worker knew about their occupation and 79 (73.8%) respondents reported that they have during the past six months been in contact with a health care worker/facility in Finland. Two out of the 28 respondents reported that they had not been in contact with a health care worker/facility because of previous negative experiences. According to the additional questions associated with the SWESS police subscale, 23 (21.9%) respondents reported that a police officer/someone in law enforcement in Finland knew about their occupation and 16 (15.2%) reported that they have during the past six months been in contact with a police officer/someone in law enforcement in Finland. Eight out of 89 respondents reported that they had not been in contact with a police officer/someone in law enforcement because of previous negative experiences. Furthermore, regarding the other subscales in SWESS, 83 (79.0%) respondents reported that a family member/partner knew about their occupation, and 86 (81.9%) respondents reported that other people (e.g., a friend) knew about their occupation.

Table 3 contains mean levels of sex work stigma, quality of life, and substance-related problematic behavior.

Table 3

Mean Levels, Standard Deviations, Cronbach's α for Scales and Subscales.

Variable	*n*	*M*	*SD*	Range	*Cronbach's α*
WHOQOL-BREF	128	100.10	21.68	26–130	.96
Psychological	128	21.90	5.53	6–30	.90
Physical	128	27.33	6.74	7–35	.91
Social	120	11.38	3.10	3–15	.84
Environmental	128	31.89	6.52	8–40	.87
Overall quality of life [a]	128	7.59	2.05	2–10	.85
AUDIT [b]	68	3.32	5.03	0–28	.88
DUDIT [c]	24	7.25	7.63	0–28	.85
ISWSS	107	39.54	7.23	12–48	.89
Worthlessness	107	13.22	2.64	4–16	.79
Guilt and shame	107	10.14	2.22	3–12	.77
Stigma acceptance	107	9.28	2.41	3–12	.77
Illegitimacy	107	6.90	1.44	2–8	.61
SWESS [d]	105	8.49	4.53	0–33	.79
Health	77	0.47	1.17	0–21	.59
Police	16	0.25	1.00	0–15	
Family	105	5.70	1.72	0–15	.74
Other	105	0.97	1.77	0–9	.75
Client	105	1.82	2.68	0–9	.88

Note. Full sex work sample $N = 137$. The number of respondents (n) varies in the different variables due to dropout or survey logic. The empty cell in the table was not calculable. Higher scores mean a higher quality of life, more stigma, and more substance-related problematic behavior. AUDIT = Modified version of the Alcohol Use Disorders Identification Test, DUDIT = Modified version of the Drug Use Disorders Identification Test, ISWSS = Internalized Sex Work Stigma Scale, SWESS = Modified version of the Sex Work Experienced Stigma Scale, WHOQOL-BREF = The World Health Organization Quality of Life-BREF.

[a] Including items one and two from WHOQOL-BREF. [b] Including only those who reported alcohol use during the past 6 months ($n = 69$). [c] Including only those who reported drug use during the past 6 months ($n = 24$). [d] Including only subscales: family, other people, and client, while excluding health care and police subscales due to a significant drop in sample size ($n = 15$, $M = 11.47$, $SD = 7.95$, range 0-69, $\alpha = .90$).

Analyses of Correlations

Correlations between different study aspects are illustrated in Table 4. These results are discussed after Table 4. The BCa confidence intervals for the correlation analyses are illustrated in Appendix A, Table 9.

Table 4

Correlations for Study Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1.WHOQOL-BREF	–												
2.AUDIT	-.37**	–											
3.DUDIT	-.63**	.52*	–										
4.ISWSS	-.67***	.44***	.53**	–									
5.ISWSS Worthlessness	-.44***	.31*	.45*	.84***	–								
6.ISWSS Acceptance	-.69***	.44***	.48*	.85***	.50***	–							
7.ISWSS Illegitimacy	.61***	-.39**	-.57**	-.68***	-.30***	-.72***	–						
8.ISWSS Guilt & Shame	.52***	-.27*	-.27	-.89***	-.80***	-.63***	.43***	–					
9.SWESS [a]	-.67***	.49***	.57*	.60***	.46***	.55***	-.38***	-.47***	–				
10.SWESS Health [b]	-.26	.22[f]	.57[f]	.29	.53***	.07	.16	-.34*	.60***	–			
11.SWESS Family [c]	-.33**	.35**	.40	.45***	.40***	.34**	-.32**	-.39***	.59***	.24[f]	–		
12.SWESS Other [d]	-.27*	.40**	.27	.26*	.38***	.09	-.02	-.25*	.69***	.66***	.32**	–	
13.SWESS Client	-.77***	.36**	.70***	.54***	.28**	.66***	-.48***	-.36***	.83***	.38*	.41***	.25*	–
Health knew [e]	.02	-.01	.20	-.11	-.10	-.09	-.03	.17	.05	.10	-.06	-.03	.06
Health contact	.23*	-.17	-.53**	-.27**	-.16	-.27**	.27**	.21*	-.17		-.23*	.00	-.29**
Health negative contact	-.39*[f]	.83***[f]	.34[f]	.41*[f]	.18[f]	.47*[f]	-.58**[f]	-.17[f]	.45[f]		.13[f]	.46*[f]	.30[f]
Police knew [e]	-.21*	.34**	.36[f]	.19	.07	.23*	-.24*	-.11	.33**	.25	.13	.19	.23*
Police contact	-.04	.02	-.06[f]	.01	.02	.01	-.03	.04	.27*	.36*	-.02	.19	.18
Police negative contact	-.09	.12[f]	-.15[f]	-.18[f]	-.15[f]	-.14[f]	.10[f]	.17[f]	-.05	.54**[f]	-.05[f]	.04[f]	.03
Family knew [e]	.070	.01	.12[f]	-.25*	-.17	-.18	.12	.30**	.12	.10[f]		.13	.10
Other knew [e]	.18	-.22	-.44*	-.30**	-.17	-.29**	.33***	.22*	-.09	.10[f]	-.20		-.09
Age	.06	-.05	-.18	-.04	.02	-.06	.10	.02	-.17	.17	-.25*	-.18	-.20*
Sexual orientation	.08	.22	.44*	.17	.09	.19	.20*	-.12	.03	.08	.18	-.04	.02
Relationship status	-.21*	.06	-.08	.12	-.00	.17	-.17	-.10	.09	.01	-.18	-.11	.07
Children	.01	.09	.04[f]	.15	.06	.26**	-.13	-.06	.18	.14	.09	.10	.05
Birth country	.30***	.01[f]	-.07[f]	-.36***	-.28**	-.30**	.12	.43***	-.31**[f]	-.32*[f]	-.26*	-.20[f]	-.37***
Work country	.18*	-.06[f]	.13[f]	-.24*	-.22*	-.18	.10	.28**	-.10	-.16[f]	-.15	-.06[f]	-.19
Education	.49***	-.46***	-.46*	-.44***	-.25*	-.54***	.46***	.26**	-.55***	-.14	-.40***	-.24*	-.58***
Years providing services	-.36***	.38**	.36	.32**	.19	.39***	-.33***	-.15	.35**	.01	.12	.05	.43***
Starting age	.40***	-.31*	-.37	-.24*	-.10	-.29**	.31**	.13	-.44***	.19	-.36***	-.18	-.49***
Additional work	.26**	-.13	-.19	-.29**	-.21*	-.26**	.27**	.22*	-.28*	-.25	-.05	-.14	-.26**
Media-based services	.15	-.03	.21	-.26**	-.14	-.30**	.26**	.18	.10	.37*	-.03	.15	-.09
In-person services	-.06	.13	-.15[f]	.17	.06	.22*	-.20*	-.14	-.09	-.32*[f]	.10	-.36***	.07
Quitting thoughts	-.61***	.19	.16	.56***	.25*	.66***	-.50***	-.44***	.41***	.03	.29**	.10	.51***
Income from sex work	.39***	-.17	-.17	-.18	-.06	-.23*	.23*	.12	-.17	.00	-.17	.09	-.30**
Total income	.46***	-.21	-.30	-.20*	-.08	-.25*	.25**	.11	-.21	.01	-.21	.04	-.38***
Economic situation	.58***	-.21	-.50*	-.31**	-.21*	-.31**	.25*	.23*	-.29**	-.22	-.14	-.09	-.37***

Note. The exact number of bootstrapped samples is 2000 unless otherwise mentioned. The correlation analyses with empty cells in the table were not calculable. WHOQOL-BREF = The World Health Organization Quality of Life-BREF. AUDIT = Modified version of the Alcohol Use Disorders Identification Test. DUDIT = Modified version of the Drug Use Disorders Identification Test. ISWSS = Internalized Sex Work Stigma Scale (subscales: worthlessness, acceptance, illegitimacy, guilt & shame). SWESS = Modified version of the Sex Work Experienced Stigma Scale (full scale including subscales: family, other, and client; subscale: health analyzed separately; subscale: police, not calculable). Higher scores mean a higher quality of life, more substance-related problematic behavior, and more sex work stigma. Health knew: a health care worker knew about the occupation (0 = no; 1 = yes). Health contact: contact with a health care worker/facility during the past six months (0 = no; 1 = yes). Health negative contact: no contact during the past six months because of previous negative experiences (0 = no; 1 = yes). Police knew: a police officer/someone in law enforcement knew about the occupation (0 = no; 1 = yes). Police contact: contact with a police officer/someone in law enforcement during the past six months (0 = no; 1 = yes). Police negative contact: no contact during the past six months because of previous negative experiences (0 = no; 1 = yes). Family knew: a family member/partner knew about the occupation (0 = no; 1 = yes). Other knew: someone else knew about the occupation (0 = no; 1 = yes). Age = respondents' age in years. Sexual orientation: 0 = other; 1 = heterosexual. Relationship status: 0 = in a relationship; 1 = single. Children: has a child/children (0 = no; 1 = yes). Birth country: 0 = other than Finland; 1 = Finland. Work country: 0 = in/from Finland and another country; 1 = only in/from Finland. Education = highest level of education completed. Years providing services = the length of providing sex work in years. Starting age: the age when starting to provide sex work in years. Additional work: additional work/studies besides sex work (0 = no; 1 = yes). Media-based services: provides media-based services (0 = no; 1 = yes). In-person services: provides in-person services (0 = no; 1 = yes). Quitting thoughts: 0 = not at all; 1 = slightly/very true. Income from sex work = monthly gross income from sex work. Total income = total monthly gross income. Economic situation = economic situation over the last 6 months from bad to good. [a] Including subscales family, other, and client; and only including cases when a family member/partner and other people (e.g., a friend) knew about the sex worker's occupation. [b] Only including cases when health care worker knew about the sex worker's occupation (answered yes on item: health knew). [c] Only including when family member/partner knew about the sex worker's occupation (answered yes on item: family knew). [d] Only including cases when other people knew about the sex worker's occupation (answered yes on item: other knew). [e] This was an exception, including cases with both yes and no answers in the current item. [f] The number of bootstrapped samples is less than 2000.

*$p \leq .05$. **$p \leq .01$. ***$p < .001$.

1

Associations Between Sex Work Stigma and Quality of Life

Higher internal sex work stigma was associated with lower quality of life (r = -.67, p < .001). Higher external sex work stigma was associated with lower quality of life (r = -.67, p < .001). In addition, most internal and external sex work stigma subscales were negatively associated with quality of life. These associations supported the hypothesis that sex work stigma is negatively associated with quality of life.

Associations Between Sex Work Stigma and Substance-related Problematic Behavior

Higher internal sex work stigma was associated with more alcohol-related problematic behavior (r = .44, p < .001) and more drug-related problematic behavior (r = .53, $p \leq$.01). In addition, higher external sex work stigma was associated with more alcohol-related problematic behavior (r = .49, p < .001) and more drug-related problematic behavior (r = .57, $p \leq$.05). Majority of internal and external sex work stigma subscales were associated with alcohol-related problematic behavior. These associations supported the hypothesis that sex work stigma is positively associated with substance-related problematic behavior.

Associations Between Internal and External Sex Work Stigma

Higher internal sex work stigma was associated with higher external sex work stigma (r = .60, p < .001). The majority of internal and external sex work stigma subscales were positively associated with each other. This supported the hypothesis that internal sex work stigma is positively associated with external sex work stigma.

Associations Between Quality of Life and Substance-related Problematic Behavior

Lower quality of life was associated with more alcohol-related problematic behavior (r = -.37, $p \leq$.01) and drug-related problematic behavior (r = -.63, $p \leq$.01). In addition, more alcohol-related problematic behavior was associated with more drug-related problematic behavior (r = .52, $p \leq$.05).

Significant Associations Between Sex Work Stigma and Additional Variables

Internal Sex Work Stigma. Lower internal sex work stigma was associated with respondents being in contact with a health care worker/facility during the past six months (r = -.27, $p \leq$.01). In addition, higher internal sex work stigma was associated with respondents having no contact with a health care worker/facility during the past six months because of previous negative experiences (r = .41, $p \leq$.05).

Furthermore, lower internal sex work stigma was associated with a family member/partner knew about their sex work occupation (r = -.25, $p \leq$.05). In addition, lower

internal sex work stigma was associated with other people (e.g., a friend) knew about their sex work occupation (r = -.30, $p \leq$.01).

Respondents with a birth country other than Finland reported higher internal sex work stigma (r = -.36, p <.001). Lower internal sex work stigma was associated with only working from/in Finland (r = -.24, $p \leq$.05). In addition, respondents with a higher educational level reported lower internal sex work stigma (r = -.44, p <.001). Furthermore, respondents who had provided sex work for longer reported higher internal sex work stigma (r = .32, $p \leq$.01). Respondents who started providing sex work at an earlier age reported higher internal sex work stigma (r = -.24, $p \leq$.05). In addition, respondents who worked besides sex work with something else (e.g., part-time job or as a caregiver) reported lower internal sex work stigma (r = -.29, $p \leq$.01). Lower internal sex work stigma was associated with providing media-based sex work services (r = -.26, $p \leq$.01). Respondents with thoughts about quitting sex work reported higher internal sex work stigma (r = .56, p <.001). A higher total income was associated with lower internal sex work stigma (r = -.20, $p \leq$.05). In addition, respondents reporting a better economic situation reported lower internal sex work stigma (r = -.31, $p \leq$.01).

External Sex Work Stigma. Higher external sex work stigma was associated with a police officer/someone in law enforcement that knew about their sex work occupation (r = .33, $p \leq$.01). In addition, higher external sex work stigma was associated with respondents having no contact with a police officer/someone in law enforcement during the past six months because of previous negative experiences (r = .27, $p \leq$.05).

Respondents with a birth country other than Finland reported higher external sex work stigma (r = -.31, $p \leq$.01). Lower external sex work stigma was associated with higher educational level (r = -.55, p <.001). Respondents who had provided sex work for longer reported higher external sex work stigma (r = .35, $p \leq$.01). In addition, respondents who started providing sex work at an earlier age reported higher external sex work stigma (r = -.44, p <.001). Lower external sex work stigma was associated with work besides sex work (r = -.28, $p \leq$.05). Respondents with thoughts about quitting sex work reported higher external sex work stigma (r =.41, p <.001). In addition, respondents reporting better economic situations reported lower external sex work stigma (r = -.29, $p \leq$.01).

Multiple Linear Regressions

Results from the multiple linear regressions with robust standard errors for measures of quality of life are shown in Table 5. Both measures of internal sex work stigma (full scale)

and external sex work stigma (full scale) significantly contributed to the model when including the full sample. When including the restricted sample internal sex work stigma (full scale) contributed to the model, while external sex work stigma (full scale) did not. In addition, subscale illegitimacy measuring internal sex work stigma contributed significantly to the model in both analyses (full sample and restricted sample). As well as client subscale measuring external sex work stigma contributed significantly to the model in both analyses.

Table 5

Results from the Multiple Linear Regression with Robust SE for the Measure of Quality of Life

Analysis	Dependent variable	Independent variable	*B*	*β*	*SE*	*t*	*p*
Full sample	WHOQOL-BREF	**ISWSS**	**-.61**	**-.41**	**0.18**	**-3.38**	**.001**
		SWESS [a]	**-.89**	**-.47**	**0.38**	**-2.34**	**.021**
		ISWSS Worthlessness	-.09	-.07	0.12	-0.75	.455
		ISWSS Acceptance	-.04	-.03	0.14	-0.25	.805
		ISWSS Illegitimacy	**.30**	**.25**	**0.13**	**2.33**	**.022**
		ISWSS Guilt and Shame	.16	.13	0.13	1.27	.206
		SWESS Family	.17	.07	0.33	0.52	.606
		SWESS Other	-.12	-.09	0.17	-0.76	.458
		SWESS Client	**-.55**	**-.58**	**0.09**	**-6.45**	**<.001**
Restricted sample	WHOQOL-BREF	**ISWSS**	**-.66**	**-.39**	**0.33**	**-2.02**	**.047**
		SWESS [a]	-.80	-.44	0.55	-1.46	.148
		ISWSS Worthlessness	-.01	-.01	0.20	-0.04	.968
		ISWSS Acceptance	-.06	-.05	0.22	-0.28	.783
		ISWSS Illegitimacy	**.37**	**.27**	**0.18**	**2.07**	**.042**
		ISWSS Guilt and Shame	.19	.13	0.23	0.89	.416
		SWESS Family	.15	.06	0.45	0.34	.737
		SWESS Other	-.12	-.09	0.20	-0.59	.559
		SWESS Client	**-.51**	**-.54**	**0.13**	**-3.97**	**<.001**

Note. The exact *n* for the sample ranged between 73 to 105 due to exclusion of some cases. Significant results are bolded. Restricted sample: only including cases when a family member/partner and other people did know about respondents' sex work occupation. ISWSS = Internalized Sex Work Stigma Scale, SWESS = Modified version of the Sex Work Experienced Stigma Scale, WHOQOL-BREF = The World Health Organization Quality of Life-BREF.

[a] Including subscales family/partner, other, and client.

Results from the multiple linear regressions with robust standard errors for measures of alcohol-related problematic behavior are shown in Table 6. None of the measures of sex work stigma (full scale or subscales) included in the model were significant predictors for alcohol-related problematic behavior (neither when including full sample nor restricted sample).

Table 6

Results from the Multiple Linear Regression with Robust SE for the Measure of Alcohol-Related Problematic Behavior

Analysis	Dependent variable	Independent variable	*B*	*β*	*SE*	*t*	*p*
Full sample	AUDIT	ISWSS	.38	.29	0.21	1.85	.069
		SWESS [a]	.45	.32	0.26	1.73	.089
		ISWSS Worthlessness	.08	.08	0.17	0.48	.634
		ISWSS Acceptance	.29	.31	0.19	1.53	.131
		ISWSS Illegitimacy	-.18	-.17	0.17	-1.10	.275
		ISWSS Guilt and Shame	.15	.14	0.18	0.83	.408
		SWESS Family	.32	.16	0.48	0.66	.510
		SWESS Other	.21	.22	0.15	1.37	.175
		SWESS Client	.06	.07	0.13	0.43	.666
Restricted sample	AUDIT	ISWSS	.41	.30	0.22	1.82	.076
		SWESS [a]	.41	.34	0.38	1.08	.285
		ISWSS Worthlessness	.02	.02	0.29	0.07	.943
		ISWSS Acceptance	.20	.19	0.20	0.98	.332
		ISWSS Illegitimacy	-.25	-.22	0.21	-1.15	.259
		ISWSS Guilt and Shame	-.02	-.02	0.29	-0.09	.932
		SWESS Family	.27	.16	0.68	0.40	.693
		SWESS Other	.12	.15	0.14	0.82	.419
		SWESS Client	.15	.19	0.19	0.78	.442

Note. The exact *n* for the sample ranged between 49 to 68 due to exclusion of some cases. No significant results. Restricted sample: only including cases when a family member/ partner and other people did know about respondents' sex work occupation. AUDIT = Modified version of the Alcohol Use Disorders Identification Test, ISWSS = Internalized Sex Work Stigma Scale, SWESS = Modified version of the Sex Work Experienced Stigma Scale.

[a] Including subscales family/partner, other, and client.

Results from the multiple linear regressions with robust standard errors for measures of drug-related problematic behavior are shown in Table 7. None of the measures of sex work stigma (full scales or subscales) included in the model were significant predictors for drug-related problematic behavior when including the full sample. When including the restricted sample, the measure of internal sex work stigma (full scale) contributed significantly to the model.

Table 7

Results from the Multiple Linear Regression with Robust SE for the Measure of Drug-Related Problematic Behavior

Analysis	Dependent variable	Independent variable	*B*	*β*	*SE*	*t*	*p*
Full sample	DUDIT	ISWSS	.55	.31	0.51	1.08	.292
		SWESS [a]	.78	.42	0.43	1.80	.086
		ISWSS Worthlessness	.69	.36	1.14	0.61	.553
		ISWSS Acceptance	-.17	-.14	0.91	-0.19	.854
		ISWSS Illegitimacy	-.41	-.31	0.87	-0.47	.642
		ISWSS Guilt and Shame	.21	.15	0.54	0.40	.698
		SWESS Family	-.66	-.31	1.09	-0.60	.554
		SWESS Other	.03	.02	0.52	0.06	.953
		SWESS Client	.74	.68	0.51	1.44	.170
Restricted sample	DUDIT	**ISWSS**	**1.61**	**.59**	**0.49**	**3.32**	**.005**
		SWESS [a]	.38	.23	0.29	1.33	.206
		ISWSS Worthlessness	.43	.18	1.57	0.27	.790
		ISWSS Acceptance	.011	.01	1.35	0.01	.994
		ISWSS Illegitimacy	-.43	-.28	1.10	-0.39	.707
		ISWSS Guilt and Shame	-.72	-.36	0.99	-0.73	.487
		SWESS Family	.84	.37	2.29	0.37	.723
		SWESS Other	-.36	-.31	0.62	-0.58	.576
		SWESS Client	.17	.16	0.91	0.18	.859

Note. The exact *n* for the sample regressions ranged between 17 to 24, due to exclusion of some cases. Restricted sample: only including cases when a family member/partner and other people did know about respondents' sex work occupation. DUDIT = Modified version of the Drug Use Disorders Identification Test, ISWSS = Internalized Sex Work Stigma Scale, SWESS = Modified version of the Sex Work Experienced Stigma Scale.

[a] Including subscales family/partner, other, and client.

Discussion

In the current study, we investigated sex work stigma, sex workers' quality of life, and substance-related problematic behavior in Finland, surveying 137 sex workers through convenience sampling. We expected sex workers in Finland to report high quality of life in general, as the majority reported life satisfaction as good in a previous Finnish study (Liitsola et al., 2013). We expected a negative association between sex work stigma and quality of life as several previous studies have shown that sex work stigma is associated with poor health outcomes and/or increased isolation (e.g., Bellhouse et al., 2015; McCausland et al., 2020). In addition, we expected sex work stigma to be associated with increased substance-related problematic behavior, as several previous studies suggest stigma to be associated with substance use (e.g., Benoit et al., 2015b; Yang et al., 2017). The current study was, to our knowledge, the first quantitative study on sex work stigma and sex workers' quality of life, and substance-related problematic behavior in Finland.

Demographic and Descriptive Aspects

In the current study, most respondents were women born in Finland and had an upper secondary education or higher educational level. The majority did additional work or something else besides providing sex work services (e.g., studying) and reported having a good economic situation. The mean age for respondents was 32 years.

In comparison to samples from other countries (e.g., Kerrigan et al., 2021; Wong, 2006), our sample reported, on average, a higher educational level. A reason for the relatively high educational level in our sample compared to previous studies could be that over 74% of the Finnish population have an upper secondary education (Finlands Officiella Statistik, 2022). A study including a sample of the Finnish population reported a higher quality of life in respondents with a university or a tertiary education (Vaarama et al., 2014). We found a similar association in the current study, as respondents reporting a higher educational level also reported a higher quality of life. In addition, respondents reporting a higher educational level also reported lower substance-related problematic behavior, and lower sex work stigma. A possible reason for these associations could be that a higher educational level often offers more occupational opportunities. The median gross total income (between 2,000–2,499€/month) reported in the current study was lower than the median gross income in Finland (2,968€/month; Tilastokeskus, 2022). However, similarly to Liitsola et al. (2013) most of the respondents reported a good or a very good economic situation. In the current study, a better economic situation was associated with a higher quality of life, lower sex work

stigma and lower drug-related problematic behavior. In sum, sex workers reported a relatively high educational level and a good economic situation in the current study.

The current study's results indicated that sex workers in Finland had provided sex work services for an average of six years. Respondents that had provided services for a longer time reported lower quality of life, more alcohol-related problematic behavior, and more sex work stigma. In addition, the average age was 25 years when they started providing services. An older starting age was associated with a higher quality of life, less alcohol-related problematic behavior, and less sex work stigma. Furthermore, most respondents did not think about quitting sex work. However, thoughts about quitting sex work were associated with a lower quality of life and more sex work stigma. These associations would be important to acknowledge by organizations providing help and support for sex workers.

Only a few respondents reported providing in-person and media-based services, while more than half reported providing only in-person services. This was surprising because of the increase of various online platforms (e.g., OnlyFans) where sex workers can provide media-based services. However, the most common client interaction involved sexual contact. The most common service locations were at the respondents' homes, clients' homes, or hotel rooms. To publicly provide sex work services (incl. brothels) is illegal in Finland, which can explain the use of more private locations. The current study's descriptive aspects could be used to further improve the services provided to sex workers.

Frequencies of Sex Work Stigma, Quality of Life, and Substance-related Problematic Behavior

In previous studies, sex workers have reported experiencing sex work stigma (Benoit et al., 2020; Hargreaves et al., 2016; Kontula, 2008; Liitsola et al., 2013). This was supported by our study: internal sex work stigma was reported by almost everyone, and more than half reported external sex work stigma. As Pro-tukipiste (n.d.) mentioned, sex work has previously not been a socially accepted occupation in Finland. This could explain why most sex workers in Finland experience sex work stigma. In addition, previously, it has been reported that some sex workers avoid using health care services in Finland because of previous experiences (TAMPEP, 2010). In the current study, only a few reported that they had not been in contact with a health care worker/facility or a police officer/someone in law enforcement for the past six months because of previous negative experiences. In other words, there is a possibility that reports of external sex work stigma (compared to internal) were lower due to sex workers avoiding contact with other people because of previous

negative experiences. In addition, respondents that did not report external sex work stigma during the past six months may have experienced stigma before, as respondents that had provided services for a longer time also reported more sex work stigma. Taken together, sex workers reported more internal sex work stigma than external sex work stigma in Finland.

Quality of life was expected to be relatively high, in accordance with the previous Finnish study measuring life satisfaction among sex workers (Liitsola et al., 2013) and the generally high quality of life in Finland (Vaarama et al., 2014). In the current study, more than half reported their quality of life as high or very high, and approximately one in five reported low or very low quality of life. It is, however, important to acknowledge that many previous studies reported in general low or a decreased quality of life among sex workers (Milner et al., 2019; Wang et al., 2015; Wong et al., 2006; Wang et al., 2007). The discrepancy between the current study and some of the previous studies could be related to Finland having different laws affecting sex workers (e.g., the law regarding where sex workers can promote/sell their services) and a different social structure (e.g., the possibility to study for free). In addition, some organizations in Finland support and help especially sex workers (e.g., FTS Finland and Pro-tukipiste); these can have a significant impact on working against sex work stigma and supporting sex workers when in need. Taken together, most sex workers in Finland have a good quality of life.

In the current study, substance use was measured to approximate substance-related problematic behavior. In comparison to previous studies investigating substance use among the Finnish population during the past year (Nahkuri, 2022; Karjalainen, 2021): In the current study, it was more common to use drugs than to use alcohol during the past six months (the time intervals were different in the previous studies). Furthermore, the current study aimed to measure substance-related problematic behavior among sex workers, and this was reported only by a small minority. The number of respondents reporting drug-related problematic behavior was low, while the number of respondents reporting alcohol-related problematic behavior was even lower. In line with previous studies (Khodabakhshi Koolaee & Damirchi, 2016; Picos et al., 2018; Pinedo González et al., 2021) the results in the current study indicated a significant negative association between substance-related problematic behavior and quality of life. The relatively low substance use, and low substance-related problematic behavior could potentially be explained by sex workers' good quality of life.

Main Findings and Interpretations

Supporting the first hypothesis of the study, sex work stigma was significantly and negatively associated with quality of life. This was expected because previous studies indicated that sex work stigma is associated with lower health outcomes in other countries (Bellhouse et al., 2015; Benoit et al., 2015a; Benoit et al., 2015b; Jiao & Bungay, 2018; Koken, 2011; Krüsi et al., 2016; McCausland et al., 2020; Tomko et al., 2020; Wolf, 2019). In addition, previous studies indicated that violence is associated with negative health outcomes (Hong et al., 2013; Picos et al., 2018; Pinedo González et al., 2021). Our findings were in line with these previous findings. However, when excluding some of the respondents the sex work stigma scale did not significantly predict quality of life. This might be because the excluded respondents (respondents who did not have a family member/partner and other people that knew about the occupation) reported more internal sex work stigma in general. For instance, they might experience more negative feelings about their occupation which could be the reason for not telling others about their occupation. In addition, they might report external stigma because they interpret their environment more as a threat and are more likely to experience things as discriminatory behavior against them. Hence, the external sex work stigma reported by the excluded respondents may strongly be associated with internal sex work stigma. Taken together, sex work stigma was negatively associated with the quality of life among sex workers in Finland.

Several previous studies have reported an association between stigma and drug use among sex workers (Benoit et al., 2015a; Benoit et al., 2015b). In addition, a previous review indicated that substance use disorder is very stigmatized (Yang et al., 2017), which can partially support the association between substance-related problematic behavior and stigma. In line with our second hypothesis, sex work stigma was significantly positively associated with substance-related problematic behavior. In the current study, internal and external sex work stigma did not significantly predict alcohol- or drug-related problematic behavior. However, internal sex work stigma did significantly predict drug-related problematic behavior only when including respondents who had a family member/partner and someone else (other people) who knew about their occupation. This may reflect the possibility that drug use/drug-related problematic behavior may be a way to cope with internal sex work stigma, and contrariwise drug use/drug-related problematic behavior may increase internal stigma (e.g., more negative feelings). Taken together, both external and internal sex work stigma were positively associated with substance-related problematic behavior, even though

only internal sex work stigma predicted drug-related problematic behavior when including the restricted sample.

Finally, in support of the last hypothesis, external sex work stigma was positively associated with internal sex work stigma. This association was expected since previously mentioned that internal and external stigma are intertwined (Hasan et al., 2012). For example, sometimes experiences of discriminatory behavior (external stigma) may lead to increased fear (internal stigma; Hallgrímsdóttir et al., 2008); while in other cases, some can examine their environment as hostile or discriminatory (external stigma) due to high level of fear (internal stigma).

Strengths and Limitations

The current study was the first of its kind to quantitatively study sex work stigma, sex workers' quality of life, and substance-related problematic behavior in Finland. We used previously validated measurements (e.g., WHOQOL-BREF) and had a 63.1% completion rate. Although the current study had some strengths it should be interpreted with consideration, due to various limitations. A potential major limitation of the current study was the use of a convenience sample, which affects the generalization of the results. Furthermore, the current study involved cross-sectional data, which makes it impossible to draw conclusions about causal relationships.

Sex workers are a diverse group of people (Pinedo González et al., 2021). The current study's definition of sex work was broad, and the goal was to include as many sex workers as possible. The current study's informed consent included our definition of sex work. Yet, some sex workers might not see themselves as sex workers due to the vague definition of sex work in the world (Harcourt & Donovan, 2005), and for this reason not be reached by our study. Although the current study's online survey was distributed through social media and versatile online forums, our sample was quite homogenous: Almost all respondents were women born in Finland. This may impact the generalization of the results to all sex workers (Spice, 2007). It is possible that the most stigmatized sex workers did not take part in the study, and that some sex workers did not take part in fear of possible negative consequences of the current study. For instance, some sex workers might have worried that finding a very low quality of life and high substance-related problematic behavior among sex workers could lead to even stronger stereotypes and more stigma for sex workers.

The current study involved self-reports which increases the risk of biased reports. Additionally, the sample size was small, which affected some of the analyses. For example,

the sample size was small in analyses of substance-related problematic behavior. Hence, we conducted Pearson bivariate correlations with 2,000 bootstrap samples. Furthermore, the survey of the current study was long (approximately 20 minutes), and this may have increased attrition. In addition, the survey was translated to only Finnish and English limiting who could participate in the study.

Other limitations of the current study were that only respondents who worked as sex workers during the past six months were included in the study. Some sex workers might have been more affected by the Covid pandemic or might have taken a break from sex work during this period. The definition of doing sex work during the past six months could have been more specific, for example, more than three clients during this period, to increase understanding of the meaning. In addition, we modified some of the scales: For instance, the external sex work stigma scale and substance-related problematic behavior scales were modified to match the current study's criterion of providing sex work services during the past six months. Furthermore, the reports of external sex work stigma might have been affected by the fixed alternatives focusing only on specific experiences over the past six months. However, when measuring data from a shorter period there is a higher likelihood of remembering, for example, discriminatory behavior. Additionally, the reason for having such a short period as an inclusion criterion was to include as many sex workers as possible, also people who had worked as sex workers for less than a year. The modifications done to the original scales makes it more challenging to compare results from the current study with other studies using the original scales as well as the modifications can have affected the validity of the scales. In addition, in the current study, two of the internal sex work stigma subscales did not correlate in the expected direction. In conclusion, the current study had various limitations, and the results should be interpreted with consideration.

Conclusions

The current study provides information about the stigma associated with sex work and sex workers' quality of life in Finland. Sex workers who experienced more stigma also reported lower quality of life and more substance-related problematic behavior. The results can inform services provided to sex workers. Although the causal direction of the associations remains unclear, decreasing stigma could be an effective way to further improve the quality of life and decrease substance-related problematic behavior among sex workers. Future studies should aim to clarify the causal direction of the association between internal and external sex work stigma, quality of life, and substance-related problematic behavior.

Summary in Swedish – Svensk sammanfattning

Sexarbetarstigma och sexarbetarnas livskvalitet i Finland

Sexarbetare anses ofta vara en av de mest marginaliserade och stigmatiserade befolkningsgrupperna (Amnesty International, 2016). Sexarbetare anses ofta vara annorlunda, offer eller brottslingar på grund av sitt yrke (Koken, 2011; Lehto, 2006; Liu m.fl., 2011; Wolf, 2019), och dessa typer av stereotypiserande uttryck kan stigmatisera sexarbetare (Benoit m.fl., 2020). Stigma som är förknippat med sexarbete kallas för sexarbetarstigma (eng. sex work stigma). Somliga sexarbetare nämner sexarbetarstigman som det värsta med själva yrket (Kontula, 2008; Wolf, 2019). I Finland är sexarbete inte ett socialt godtagbart yrke (Pro-tukipiste, u.å.), och flera sexarbetare har rapporterat om sexarbetarstigma (Kontula, 2008; Liitsola m.fl., 2013; TAMPEP, 2010).

Sambandet mellan sexarbetarstigma och livskvalitet eller substansrelaterat problembeteende bland sexarbetare är inte tillräckligt utforskat. Stigmatisering av sexarbete har tidigare associerats med en försämring av hälsan (t.ex. Koken, 2011; Rayson & Alba, 2019) och ökad användning av substanser (t.ex. Benoit m.fl., 2015b). Det är dock inte alla sexarbetare som rapporterat upplever av sexarbetarstigma (Benoit m.fl., 2015a; Hargreaves m.fl., 2016) eller problem med sin hälsa (Rayson & Alba, 2019; Romans m.fl., 2001). Denna individuella variation understryker vikten av att bättre kartlägga sambandet mellan sexarbetarstigma och livskvaliteten, samt sexarbetarstigma och substansrelaterat problembeteende. Såvitt känt finns det ingen kvantitativ studie som undersökt sambanden i Finland.

Sexarbete i Finland

Alla sexarbetare identifierar sig inte som sexarbetare (Harcourt & Donovan, 2005; New Zeeland Government, 2008). Den finska kvantitativa studien av Liitsola m.fl. (2013) nämner att branschen är bred och består av många undergrupper. En bredare definition av sexarbete kan inkludera både mediebaserade tjänster (t.ex. webbkamera, OnlyFans och pornografi) och fysiska tjänster (t.ex. erotiska tjänster, eskorttjänster, flick-/pojkvänsupplevelser). På grund av de olika definitionerna av sexarbete är det svårt att uppskatta hur många sexarbetare det finns (Khodabakhshi Koolaee & Damirchi, 2016). Enligt Statistikcentralen rör det sig mer än 100 miljoner euro årligen genom den finska sexarbetsbranschen (Parikka, 2020; "Finnish Sex Trade", 2019). Tidigare uppskattningar av antalet sexarbetare i Finland varierade från 5 000 till 8 000 (Kontula, 2008; TAMPEP, 2010).

Därtill uppskattade organisationen Pro-tukipiste (dvs. en organisation i Finland som erbjuder stödtjänster till alla typer av sexarbetare, såväl som offer för sexhandel) år 2008 att de flesta sexarbetare i Finland arbetar inomhus och är kvinnor, och att cirka två tredjedelar är migranter (TAMPEP, 2010). Dessa uppskattningar från Finland är mer än ett decennium gamla och branschen har förändrats under denna period. Vad gäller förändringar inom sexarbetsbranschen har det rapporterats till exempel i Australien att det ökat avsevärt att sexarbetare under de senaste tio åren skaffat sina kunder och marknadsfört sina tjänster online (Selvey m.fl., 2017).

Enligt Rössler m.fl. (2010) är det värt att undersöka sexarbete i länder som Finland där yrket påverkas av jurisdiktion. Både att erbjuda och köpa sextjänster är lagligt i Finland, dock finns det flera lagar som begränsat tillhandahållandet och köpet av sextjänster (Pro-tukipiste, 2022). Exempelvis är det enligt ordningslagen (eng. Public order act; 2:7.1 §) olagligt att tillhandahålla sextjänster och att köpa sextjänster mot betalning på offentliga platser. Därtill, enligt utlänningslagen (9:148.6 §) kan en utlänning nekas inresa till Finland ifall det finns skälig misstanke om att personen kommer att tillhandahålla sextjänster. På grund av all jurisdiktion som påverkar sexarbetare är det betydelsefullt att studera sexarbete i Finland.

Definition på stigma

Stigma omfattar stereotyper, diskriminering, och statusförlust (Link & Phelan, 2001). Flera studier har delat upp stigma i internt och externt stigma (t.ex. Brouard & Wills, 2006; Brown m.fl., 2003; Catona m.fl., 2016; Hasan m.fl., 2012; Lazarus m.fl., 2012; Scambler & Hopkins, 1986). Internt stigma kan beskrivas som stigma som individen själv känner eller uppfattar; det hänvisar till både orealistisk och realistisk rädsla för andra människors attityder och rädsla för diskriminering på grund av ett ogynnsamt tillstånd, beteende (t.ex. att ta nakenbilder och publicera dem) eller tillhörighet till en specifik grupp (t.ex. sexarbetare; Brown m.fl., 2003). Internt stigma har även associeras med utveckling av en negativ självbild (Hallgrímsdóttir m.fl., 2008), såväl som negativa känslor, såsom skam, uppgivenhet och skuld (Hasan m.fl., 2012).

Externt stigma kan beskrivas som utsatthet för diskriminerande beteende (Brown m.fl., 2003). Det kan innebära både tidigare eller nuvarande utsatthet för psykiskt och fysiskt våld (t.ex. förnedring eller att bli knuffad), såväl som undvikande, specifika begränsningar eller uteblivna möjligheter (t.ex. vid arbetsplatsen; Catona m.fl., 2016). Internt och externt stigma är sammankopplade (Hasan m.fl., 2012); ibland kan en upplevelse av diskriminering

internaliseras (Hallgrímsdóttir m.fl., 2008). Det är viktigt att beakta både internt och externt stigma för att öka förståelse av sexarbetarstigma (Lazarus m.fl., 2012). I denna studie undersöktes både internt och externt sexarbetarstigma.

Sexarbetarstigma, livskvalitet och substansanvändning

Tidigare studier belyser det förväntade sambandet mellan sexarbetarstigma och livskvaliteten. Flera studier har indikerat att sexarbetarstigma var associerat med ökad isolering och/eller försämring av hälsan bland sexarbetare (t.ex. Bellhouse m.fl., 2015; Benoit m.fl., 2015a; Benoit m.fl., 2015b; Jiao & Bungay, 2018; Koken, 2011; Krüsi m.fl., 2016; McCausland m.fl., 2020; Tomko m.fl., 2020; Wolf, 2019). Därtill hävdar Benoit m.fl. (2015a) att tidigare studier indikerat att stigma, social exkludering och isolering, var negativt associerat med sexarbetarnas hälsa samt positivt associerat med droganvändning. Detta stämmer överens med en studie som indikerat att ensamhet var positivt associerat med droganvändning bland sexarbetare (Pinedo González m.fl., 2021). Dessutom indikerar en annan studie på att stigma delvis förklarar sambandet mellan sexarbete och droganvändning (Benoit m.fl., 2015b). Därtill har sambandet mellan stigma och missbruksstörning fått stöd i en litteraturöversikt (Yang et al., 2017). På grund av dessa tidigare resultat är det viktigt att studera sambandet mellan sex arbetar stigma, livskvalitet och substansrelaterat problematiskt beteende bland sex arbetare.

Syfte och hypoteser

Sexarbetarnas situation i Finland är sparsamt undersökt. En studie av Liitsola m.fl. (2013) har kvantitativt undersökt sexarbetarnas hälsa och välfärd i Finland. Studien utfördes dock för nästan ett decennium sedan. Såvitt känt har ingen tidigare studie kvantitativt undersökt sambandet mellan sexarbetarstigma och livskvaliteten eller substansrelaterat problembeteende i Finland. Den definition av sexarbete som används i den här studien inkluderade erbjudandet av alla typer av sextjänster i utbyte mot betalning, ekonomiska förmåner (t.ex. hotellövernattning) eller tillfredsställandet av omedelbara behov (t.ex. hunger). Därmed inkluderades både mediebaserade tjänster och fysiskt erbjudna tjänster. Dessutom inkluderades alla kön i studien.

Syftet med denna studie var att kvantitativt undersöka sambandet mellan sexarbetarstigma och sexarbetarnas livskvalitet samt deras substansrelaterade problembeteende i Finland. Baserat på den tidigare nämnda forskningen förväntades

1) ett negativt samband mellan sexarbetarstigma och sexarbetarnas livskvalitet,

2) ett positivt samband mellan sexarbetarstigma och substansrelaterat problembeteende och

3) ett positivt samband mellan externt och internt sexarbetarstigma.

Metod

Denna studie tog del av en större datainsamling om sexarbetarnas livskvalitet i Finland. Studien fick etiskt tillstånd av den forskningsetiska nämnden vid Åbo Akademi. Studien baserades på en anonym frivillig online-enkät. Distributionen av enkäten gjordes delvis med hjälp av Pro-tukipiste och FTS Finland (dvs. ett nätverk i Finland för sexarbetare). Därtill distribuerades enkäten via sociala medieplattformar (Instagram och Facebook) och via olika online forum (t.ex. Seksisaitti.net, Seksitreffit.fi). Meddelanden skickades även till offentliga sexarbetare i Finland som fick ta del av studien och distribuera studien vidare. Datainsamlingen genomfördes mellan februari och mars 2022 och varade i 25 dagar. Totalt gav 155 respondenter sitt samtycke till att delta i studien. Sexarbetare var berättigade att delta i studien, om de var minst 18 år gamla och hade erbjudit sextjänster under de senaste sex månaderna, antingen från Finland (mediabaserade tjänster) och/eller i Finland (fysiska tjänster). Sexarbetare av alla kön inkluderades i studien.

Respondenternas ålder varierade från 18 till 80 år eller äldre, och medelåldern var 32,26 (n = 137, SD = 10,30). Respondenterna var cirka 25 år när de började erbjuda sextjänster (n = 104, M = 24,71, SD = 8,45), och de hade erbjudit sextjänster i cirka 6 år (n = 104, M = 6,20, SD = 6,52). Majoriteten av de respondenterna var kvinnor med finskt medborgarskap.

Följande variabler användes i de statistiska analyserna. Världshälsoorganisationens skala över livskvalitet (WHOQOL)-BREF-skalan användes för att mäta självupplevd livskvalitet under de två veckor som föregick mätningen (WHOQOL Group, 1998). Sexarbetarstigma mättes med två olika skalor: Internalized Sex Work Stigma Scale (ISWSS; Tomko m.fl., 2020) och studiens modifierade version av Sex Work Experienced Stigma Scale (SWESS; originalskala av Oga m.fl., 2020). Substansrelaterat problembeteende mättes med hjälp av studiens modifierade versioner av testen ”Alcohol Use Disorders Identification Test” (AUDIT; originalskalan av Saunders m.fl., 1993) och ” Drug Use Disorders Identification Test” (DUDIT; originalskalan av Berman m.fl., 2002).

Statistiska analyser

Alla statistiska analyser utfördes med användning av SPSS (IBM SPSS Statistics 28.0.0.0 (195)). Som ett första steg uträknades frekvenser och procentsatser, samt

medelvärden och medianer för olika deskriptiva variabler. Därefter genomfördes Pearson bivariata korrelationer med 2000 bootstrap-sampel mellan de olika variablerna. För att besvara studiens forskningsfrågor genomfördes linjära regressioner och multipla linjära regressioner med parameteruppskattningar och robusta standardfel.

Resultat

I Pearsons bivariata korrelationer framkom det att sexarbetarstigma var signifikant negativt associerat med livskvaliteten vid mätning av internt och externt sexarbetarstigma. Dessutom var sexarbetarstigma signifikant associerat med substansrelaterat problembeteende vid mätning av internt och externt sexarbetarstigma. Därtill var externt sexarbetarstigma signifikant associerat med internt sexarbetarstigma.

Resultat från de multipla linjära regressionerna med robusta standardfel för mått på livskvaliteten indikerar att sexarbetarstigma bidrog signifikant till modellen då hela samplet inkluderades. Då vissa respondenter exkluderades (de vars familj och/eller partner, och andra personer, som inte kände till om yrket) bidrog endast internt sexarbetarstigma till modellen. För måttet på alkoholrelaterat problembeteende bidrog varken internt eller externt sexarbetarstigma till modellen. Däremot bidrog internt sexarbetarstigma till måttet på drogrelaterat problembeteende då vi exkluderade vissa respondenter (de vars familj och/eller partner, och andra personer, som inte kände till om yrket).

Diskussion

I denna studie undersöktes sexarbetarstigma, sexarbetarnas livskvalitet och deras substansrelaterade problembeteenden i Finland. Respondenterna förvärvades genom bekvämlighetsurval. Vi förväntade oss att sexarbetare skulle rapportera hög livskvalitet i allmänhet, eftersom den tidigare kvantitativa studien rapporterat hög livstillfredsställelse bland sexarbetare i Finland (Liitsola m.fl., 2013). Emellertid förväntades ett potentiellt negativt samband mellan sexarbetarstigma och livskvaliteten på grund av flera tidigare studier som tyder på att sexarbetarstigma var associerat med sämre hälsa och/eller ökad social isolering (t.ex. Bellhouse m.fl., 2015; Benoit m.fl., 2015a; Benoit m.fl., 2015b; Jiao & Bungay, 2018; Koken, 2011; Krüsi m.fl., 2016; McCausland m.fl., 2020; Tomko m.fl., 2020; Wolf, 2019). Dessutom förväntades det att sexarbetarstigma skulle vara associerat med substansrelaterat problembeteende.

Som stöd för den första hypotesen i studien var sexarbetarstigma (både internt och externt stigma) negativt associerat med livskvaliteten. Det indikerar att sexarbetare som rapporterade mera stigma även rapporterade en lägre livskvalitet. Som stöd för den andra

hypotesen i studien, var sexarbetarstigma (både internt och externt stigma) vidare positivt associerat med substansrelaterat problembeteende. Detta indikerar att de som rapporterat mera stigma även rapporterat mera substansrelaterat problembeteende. Det som slutligen stöder den sista hypotesen i studien, var att internt sexarbetarstigma var positivt associerat med externt sexarbetarstigma. Därmed finns det ett signifikant samband mellan dessa två typer av stigma.

Begräsning och sammanfattning

Denna studie ger information om stigmatiseringen av sexarbete och sexarbetares livskvalitet i Finland. Även om studien hade vissa styrkor bör resultaten tolkas med försiktighet. En begränsning med studien var användningen av bekvämlighetsurval, vilket påverkar generaliseringen av resultaten. Vidare involverade denna studie tvärsnittsdata och studien hade inga jämförelsegrupper, vilket gör det omöjligt att uttala sig om orsakssamband. Fastän online enkäten distribuerades via olika sociala medier och online forum, var nästan alla respondenter kvinnor, födda i Finland och hade finskt medborgarskap. Den möjliga begränsningen av sexarbetarnas heterogenitet kan påverka generaliseringen av resultaten till alla sexarbetare (Spice, 2007). Därtill involverade denna studie självrapporterat data, vilket ökar risken för subjektiva rapporteringar.

Sexarbetare som upplevde mer stigmatisering rapporterade också lägre livskvalitet och mer substansrelaterat problembeteende. Resultaten kan medföra viktig information till tjänster som erbjuds åt sexarbetare. Även om orsaksriktningen förblir oklar mellan sambanden, kan motarbetandet av stigma vara ett effektivt sätt att ytterligare förbättra livskvaliteten och minska substansrelaterat problembeteende bland sexarbetare. Framtida studier bör klargöra orsaksriktningen för sambanden mellan internt och externt sexarbetesstigma, livskvalitet och substansrelaterat problembeteende.

References

Aliens Act 30.4.2004/301. https://www.finlex.fi/en/laki/kaannokset/2004/en20040301.pdf

Allen, J. P., Litten, R. Z., Fertig, J. B., & Babor, T. (1997). A review of research on the Alcohol Use Disorders Identification Test (audit). *Alcoholism: Clinical and Experimental Research, 21*(4), 613–619. https://doi.org/10.1111/j.1530-0277.1997.tb03811.x

Amnesty International. (2016). *Sex workers at risk: a research summary on human rights abuses against sex workers*. https://www.amnesty.org/en/documents/pol40/4061/2016/en/

Argento, E., Chettiar, J., Nguyen, P., Montaner, J., & Shannon, K. (2015). Prevalence and correlates of nonmedical prescription opioid use among a cohort of sex workers in Vancouver, Canada. *International Journal of Drug Policy, 26*(1), 59–66. https://doi.org/10.1016/j.drugpo.2014.07.010

Bellhouse, C., Crebbin, S., Fairley, C. K., & Bilardi, J. E. (2015). The Impact of Sex Work on Women's Personal Romantic Relationships and the Mental Separation of Their Work and Personal Lives: A Mixed-Methods Study. *PLoS ONE, 10*(10), 1–20. https://doi.org/10.1371/journal.pone.0141575

Benoit, C., Jansson, M., Millar, A., & Phillips, R. (2005). Community-academic research on hard-to-reach populations: Benefits and challenges. *Qualitative Health Research, 15*(2), 263–282. https://doi.org/10.1177/1049732304267752

Benoit, C., Maurice, R., Abel, G., Smith, M., Jansson, M., Healey, P., & Magnuson, D. (2020). 'I dodged the stigma bullet': Canadian sex workers' situated responses to occupational stigma. *Culture, Health & Sexuality, 22*(1), 81–95. https://doi.org/10.1080/13691058.2019.1576226

Benoit, C., McCarthy, B., & Jansson, M. (2015a). Occupational Stigma and Mental Health: Discrimination and depression among front-line service workers. *Canadian Public Policy, 41*(2). https://doi.org/10.3138/cpp.2014-077

Benoit, C., McCarthy, B., & Jansson, M. (2015b). Stigma, sex work, and substance use: A comparative analysis. *Sociology of Health & Illness, 37*(3), 437–451. https://doi.org/10.1111/1467-9566.12201

Berman, A. H., Bergman, H., Palmstierna, T., & Schlyter, F. (2002). Drug use disorders identification test. *European Addiction Research*. https://doi.org/10.1037/t02890-000

Brody, C., Chhoun, P., Tuot, S., Pal, K., Chhim, K., & Yi, S. (2015). HIV risk and psychological distress among female entertainment workers in Cambodia: A cross-sectional study. *BMC Public Health, 16*(1). https://doi.org/10.1186/s12889-016-2814-6

Brouard, P., & Wills, C. (2006). A closer look: the internalization of stigma related to HIV. *DC: United States Agency for International Development*. http://www.policyproject.com/pubs/generalreport/GEN_Internal_Stigma.pdf

Brown, L., Macintyre, K., & Trujillo, L. (2003). Interventions to reduce HIV/AIDS stigma: What have we learned?. *AIDS education and prevention, 15*(1), 49–69. https://doi.org/10.1521/aeap.15.1.49.23844

Buttram, M. E., Surratt, H. L., & Kurtz, S. P. (2014). Resilience and syndemic risk factors among African-American female sex workers. *Psychology, Health & Medicine, 19*(4), 442–452. https://doi.org/10.1080/13548506.2013.824595

Carrasco, M. A., Nguyen, T. Q., Barrington, C., Perez, M., Donastorg, Y., & Kerrigan, D. (2018). HIV stigma mediates the association between social cohesion and consistent condom use among female sex workers living with HIV in the Dominican Republic. *Archives of Sexual Behavior, 47*(5), 1529–1539. https://doi.org/10.1007/s10508-018-1186-7

Catona, D., Greene, K., Magsamen-Conrad, K., & Carpenter, A. (2016). Perceived and experienced stigma among people living with HIV: Examining the role of prior stigmatization on reasons for and against future disclosures. *Journal of Applied Communication Research, 44*(2), 136–155. https://doi.org/10.1080/00909882.2016.1155726

Chow, E. P., Muessig, K. E., Yuan, L., Wang, Y., Zhang, X., Zhao, R., Sun, P., Sun, X., Tucker, J. D., Jing, J., & Zhang, L. (2015). Risk behaviours among female sex workers in China: A systematic review and Data Synthesis. *PLoS ONE, 10*(3). https://doi.org/10.1371/journal.pone.0120595

Decker, M. R., Park, J. N., Allen, S. T., Silberzahn, B., Footer, K., Huettner, S., Galai, N., & Sherman, S. G. (2020). Inconsistent Condom Use Among Female Sex Workers: Partner-specific Influences of Substance Use, Violence, and Condom Coercion. *AIDS and Behavior, 24*(3), 762–774. https://doi.org/10.1007/s10461-019-02569-7

Diatlova, A. (2019). Between Visibility and Invisibility: Russian-speaking Women engaged in Commercial Sex in Finland (Publication No. 126) [Doctoral dissertation,

University of Helsinki]. https://helda.helsinki.fi/bitstream/handle/10138/305227/BetweenV.pdf?sequence=1&isAllowed=y

Finlands officiella statistik. (2022). Befolkningens utbildningsstruktur [The educational structure of the population]. *Helsinki: Statistikcentralen*. Retrieved August 18, 2022, https://www.stat.fi/tup/suoluk/suoluk_koulutus_sv.html#Befolkning%20efter%20utbildningsnivå

Finnish sex trade tops 100 million euros. (2019). *YLE*. https://yle.fi/news/3-10876612

Footer, K. H. A., Park, J. N., Allen, S. T., Decker, M. R., Silberzahn, B. E., Huettner, S., Galai, N., & Sherman, S. G. (2019). Police-related correlates of client-perpetrated violence among female sex workers in Baltimore City, Maryland. *In American Journal of Public Health, 109*(2), 289–295. https://doi.org/10.2105/AJPH.2018.304809

Hakkarainen, P. (2021). Huumeiden käyttö Suomessa [Drug use in Finland]. *Päihdelinkki*. Retrieved August 18, 2022, https://paihdelinkki.fi/fi/tietopankki/tietoiskut/huumeet-ja-muut-paihdyttavat-aineet/huumeiden-kaytto-suomessa

Hallgrímsdóttir, H. K., Phillips, R., Benoit, C., & Walby, K. (2008). Sporting girls, streetwalkers, and inmates of houses of ill repute: Media narratives and the historical mutability of prostitution stigmas. *Sociological Perspectives, 51*(1), 119–138. https://doi.org/10.1525/sop.2008.51.1.119

Harcourt, C., & Donovan, B. (2005). The many faces of sex work. *Sexually Transmitted Infections, 81*(3), 201–206. https://doi.org/10.1136/sti.2004.012468

Hargreaves, J. R., Busza, J., Mushati, P., Fearon, E., & Cowan, F. M. (2016). Overlapping HIV and sex-work stigma among female sex workers recruited to 14 respondent-driven sampling surveys across Zimbabwe, 2013. *AIDS Care, 29*(6), 675–685. https://doi.org/10.1080/09540121.2016.1268673

Hasan, M. T., Nath, S. R., Khan, N. S., Akram, O., & Gomes, T. M. (2012). Internalized HIV/AIDS-related stigma in a sample of HIV-positive people in Bangladesh. *Journal of Health, Population and Nutrition, 30*(1). https://doi.org/10.3329/jhpn.v30i1.11272

Hildebrand, M. (2015). The Psychometric Properties of the Drug Use Disorders Identification Test (DUDIT): A Review of Recent Research. *Journal of Substance Abuse Treatment, 53*, 52–59. https://doi.org/10.1016/j.jsat.2015.01.008

Hong, Y., Zhang, C., Li, X., Liu, W., & Zhou, Y. (2013). Partner violence and psychosocial distress among female sex workers in China. *PLoS ONE, 8*(4). https://doi.org/10.1371/journal.pone.0062290

Jiao, S., & Bungay, V. (2018). Intersections of stigma, mental health, and sex work: How Canadian men engaged in sex work navigate and resist stigma to protect their mental health. *The Journal of Sex Research, 56*(4–5), 641–649. https://doi.org/10.1080/00224499.2018.1459446

Kerrigan, D., Karver, T. S., Barrington, C., Davis, W., Donastorg, Y., Perez, M., Gomez, H., Mbwambo, J., Likindikoki, S., Shembilu, C., Mantsios, A., Beckham, S. W., Galai, N., & Chan, K. S. (2021). Development of the experiences of sex work stigma scale using item response theory: Implications for research on the social determinants of HIV. *AIDS and Behavior, 25*, 175–188. https://doi.org/10.1007/s10461-021-03211-1

Khodabakhshi Koolaee, A., & Damirchi, F. (2016). Comparing Quality of Life Among Female Sex Workers With and Without Addiction. *Journal of Client-Centered Nursing Care, 2*(4), 201–206. https://doi.org/10.32598/jccnc.2.4.201

Koken, J. A. (2011). Independent female escort's strategies for coping with sex work related stigma. *Sexuality & Culture, 16*, 209–229. https://doi.org/10.1007/s12119-011-9120-3

Kontula, A. (2008). Punainen eksodus tutkimus seksityöstä Suomessa [Red exodus research on sex work in Finland] (Publication No. 802) [Doctoral dissertation, Tampere University]. https://trepo.tuni.fi/bitstream/handle/10024/67897/978-951-44-7579-5.pdf?sequence=1&isAllowed=y

Krüsi, A., Kerr, T., Taylor, C., Rhodes, T., & Shannon, K. (2016). 'They won't change it back in their heads that we're trash': the intersection of sex work-related stigma and evolving policing strategies. *Sociology of Health & Illness, 38*(7), 1137–1150. https://doi.org/10.1111/1467-9566.12436

Lazarus, L., Deering, K. N., Nabess, R., Gibson, K., Tyndall, M. W., & Shannon, K. (2012). Occupational stigma as a primary barrier to health care for street-based sex workers in Canada. *Culture, Health & Sexuality, 14*(2), 139–150. https://doi.org/10.1080/13691058.2011.628411

Lehto, T-M. (2006). Tahra tasa-arvovaltiossa – Prostituutio ja seksin oston kriminalisointi Helsingin Sanomissa ja Pohjolan Sanomissa [A stain on equality in the state – Prostitution and the criminalization of buying sex in Helsingin Sanomat and Pohjolan Sanomat] [Master's thesis, Tampere University].

https://trepo.tuni.fi/bitstream/handle/10024/93704/gradu01241.pdf?sequence=1&isAllowed=y

Li, Q., Li, X., & Stanton, B. (2010). Alcohol use among female sex workers and male clients: An integrative review of global literature. *Alcohol and Alcoholism, 45*(2), 188–199. https://doi.org/10.1093/alcalc/agp095

Liitsola, K., Kauppinen, J., Nikula, M., Thesslund, E., Huovinen, M., Aalto, E., Ollgren, J., Brummer-Korvenkontio, H. (2013). Terveyttä seksi- ja erotiikka-alalla. Erotiikka-, escort-, ja seksityötä tekevien terveys- ja hyvinvointi Suomessa [Health in sex and erotic work. The health and welfare of erotic, escort and sex workers in Finland]. *National Institute for Health and Welfare (THL)*. http://urn.fi/URN:ISBN:978-952-302-105-1

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Liu, S., Srikrishnan, A., Zelaya, C. E., Solomon, S., Celentano, D. D., & Sherman, S. G. (2011). Measuring perceived stigma in female sex workers in Chennai, India. *AIDS Care, 23*(5), 619–627. https://doi.org/10.1080/09540121.2010.525606

Lucas-Carrasco, R. (2011). The Who Quality of Life (WHOQOL) questionnaire: Spanish development and Validation Studies. *Quality of Life Research, 21*(1), 161–165. https://doi.org/10.1007/s11136-011-9926-3

Matusiewicz, A. K., Ilgen, M. A., Bonar, E. E., Price, A., & Bohnert, A. S. B. (2016). The relationship between non-medical use of prescription opioids and sex work among adults in residential substance use treatment. *Journal of Substance Abuse Treatment, 64*, 24–28. https://doi.org/10.1016/j.jsat.2016.01.010

McCausland, K., Lobo, R., Lazarou, M., Hallett, J., Bates, J., Donovan, B., & Selvey, L. A. (2020). 'It is stigma that makes my work dangerous': experiences and consequences of disclosure, stigma and discrimination among sex workers in Western Australia. *Culture, Health & Sexuality, 24*(2), 180–195. https://doi.org/10.1080/13691058.2020.1825813

Milner, A. N., Hearld, K. R., Abreau, N., Budhwani, H., Rodriguez-Lauzurique, R. M., & Paulino-Ramirez, R. (2019). Sex work, social support, and stigma: Experiences of transgender women in the Dominican Republic. *The international journal of transgenderism, 20*(4), 403–412. https://doi.org/10.1080/15532739.2019.1596862

Nahkuri, J. (2022). Alkoholinkäyttö Suomessa [Alcohol consumption in Finland]. *Päihdelinkki*. Retrieved June 6, 2022, https://paihdelinkki.fi/fi/tietopankki/tietoiskut/alkoholi/alkoholinkaytto-suomessa

Nestadt, D. F., Tomko, C., Schneider, K. E., Kerrigan, D., Decker, M. R., & Sherman, S. G. (2020). Co-occurring threats to agency among female sex workers in Baltimore, Maryland. *Journal of Interpersonal Violence, 37*(11–12). https://doi.org/10.1177/0886260520978188

New Zeeland Government. (2008). Report of the Prostitution Law Review Committee on the Operation of the Prostitution Reform Act 2003. *Ministry of Justice*. https://prostitutescollective.net/wp-content/uploads/2016/10/report-of-the-nz-prostitution-law-committee-2008.pdf

Oga, E. A., Kraemer, J., Stewart, C., Mbote, D., Njuguna, S., Stockton, M., & Nyblade, L. (2020). Experienced sex-work stigma in male and female sex workers in Kenya: Development and validation of a scale. *Stigma and Health, 5*(3), 342–350. https://doi.org/10.1037/sah0000205

Parikka, V. (2020). Piilotettu bisnes [Hidden business]. *Helsingin Sanomat*. https://www.hs.fi/kaupunki/art-2000006603204.html

Picos, A. P., Pinedo González, R., & de la Iglesia Gutiérrez, M. (2018). Exploring causes and consequences of sex workers' psychological health: Implications for health care policy. A study conducted in Spain. *Health Care for Women International, 39*(8), 844–858. https://doi.org/10.1080/07399332.2018.1452928

Pinedo González, R., Palacios Picos, A., & de la Iglesia Gutiérrez, M. (2021). "Surviving the Violence, Humiliation, and Loneliness Means Getting High": Violence, Loneliness, and Health of Female Sex Workers. *Journal of Interpersonal Violence, 36*(9–10), 4593–4614. https://doi.org/10.1177/0886260518789904

Pro-tukipiste. (2022). Legislation. Retrieved June 6, 2022, from https://protukipiste.fi/en/good-to-know/legislation/

Pro-tukipiste. (n.d.). Stigma. Retrieved November 10, 2021, from https://protukipiste.fi/hyva-tietaa/stigma/

Public Order Act, 27.6.2003/612. https://www.finlex.fi/en/laki/kaannokset/2003/en20030612_20100774.pdf

Rayson, J., & Alba, B. (2019). Experiences of stigma and discrimination as predictors of mental health help-seeking among sex workers. *Sexual and Relationship Therapy, 34*(3), 277–289. https://doi.org/10.1080/14681994.2019.1628488

Romans, S. E., Potter, K., Martin, J., & Herbison, P. (2001). The mental and physical health of Female Sex Workers: A Comparative Study. *Australian & New Zealand Journal of Psychiatry, 35*(1), 75–80. https://doi.org/10.1046/j.1440-1614.2001.00857.x

Rubin, R. R., & Peyrot, M. (1999). Quality of life and diabetes. *Diabetes/Metabolism Research and Reviews, 15*(3), 205–218. https://doi.org/10.1002/(sici)1520-7560(199905/06)15:3<205::aid-dmrr29>3.0.co;2-o

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), 143–152. https://doi.org/10.1111/j.1600-0447.2009.01533.x

Saunders, J. B., Aasland, O. G., Babor, T. F., De La Fuente, J. R., & Grant, M. (1993). Development of the alcohol use disorders identification test (AUDIT): Who Collaborative Project on early detection of persons with harmful alcohol consumption-II. *Addiction, 88*(6), 791–804. https://doi.org/10.1111/j.1360-0443.1993.tb02093.x

Scambler, G., & Hopkins, A. (1986). Being epileptic: Coming to terms with stigma. *Sociology of Health and Illness, 8*(1), 26–43. https://doi.org/10.1111/1467-9566.ep11346455

Seksuaalirikoksista 8.7.2022/723. https://www.finlex.fi/fi/laki/ajantasa/1889/18890039001?search%5Btype%5D=pika&search%5Bpika%5D=rikoslaki#L20

Selvey, L., Hallett, J., Lobo, R., McClausland, K., Bates, J., Donovan, B. (2017). Western Australian law and sex worker health (lash). School of Public Health, Curtin University. https://www.policeprostitutionandpolitics.com/pdfs_all/Academic_pro_decrim_articles_pdfs/2016%20LASH%20Australia.pdf

Spice, W. (2007). Management of sex workers and other high-risk groups. *Occupational Medicine, 57*(5), 322–328. https://doi.org/10.1093/occmed/kqm045

TAMPEP. (2010). Mapping of National Prostitution Scene. https://tampep.eu/wp-content/uploads/2017/11/ANNEX-4-National-Reports.pdf

Tavakoli, F., Khezri, M., Tam, M., Bazrafshan, A., Sharifi, H., & Shokoohi, M. (2021). Injection and non-injection drug use among female sex workers in Iran: A systematic review and meta-analysis. *Drug and Alcohol Dependence, 221*. https://doi.org/10.1016/j.drugalcdep.2021.108655

Tilastokeskus. (2022). Palkka- ja palkkiotulojen mediaani 2 968 euroa tammikuussa 2022 [Median salary and bonus income 2,968 euros in January 2022]. https://www.stat.fi/tup/kokeelliset-tilastot/tulorekisterin_palkat_ja_palkkiot/mediaani-tammikuussa-2022/index.html

Tomko, C., Nestadt, D. F., Rouhani, S., Silberzahn, B. E., Haney, K., Park, J. N., Galai, N., Logie, C. H., & Sherman, S. G. (2020). Confirmatory factor analysis and construct validity of the internalized sex work stigma scale among a cohort of cisgender female sex workers in Baltimore, Maryland, United States. *The Journal of Sex Research, 58*(6), 713–723. https://doi.org/10.1080/00224499.2020.1755821

Tähtinen, M. (2021). Seksityöntekijöiden terveys ja terveyden edistäminen [Sex workers' health and health promotion] [Master's thesis, University of Eastern Finland]. https://erepo.uef.fi/bitstream/handle/123456789/24887/1618987911723159765.pdf?sequence=1&isAllowed=y

Vaarama, M., Luoma, M-L., Siljander, E., & Merillinen-Porras, S. (2014). Validity and reliability of Finnish version of WHOQOL-Bref on adult population in Finland. *National Institute for Health and Welfare*. https://doi.org/10.2139/ssrn.2373890

Wang, C., Hawes, S. E., Gaye, A., Sow, P. S., Ndoye, I., Manhart, L. E., Wald, A., Critchlow, C. W., & Kiviat, N. B. (2007). HIV prevalence, previous HIV testing, and condom use with clients and regular partners among Senegalese commercial sex workers. *Sexually Transmitted Infections, 83*(7), 534–540. https://doi.org/10.1136/sti.2007.027151

Wang, J., Lin, F., Yang, W., Yu, F., Zhao, Y., He, N., & Zhang, T. (2015). [Research on the smoking status and influence factors among female sex workers and general migrant women in Shanghai City]. *Wei Sheng Yan Jiu = Journal of hygiene research, 44*(2), 206–210. https://pubmed.ncbi.nlm.nih.gov/25997220/

White, E., Swaner, R., Genetta, E., Hynynen Lambson, S., Johnson Dash, J., & Wolf, A. (2017). Navigating force and choice: Experiences in the New York City sex trade and the criminal justice system's response.

https://www.courtinnovation.org/sites/default/files/media/documents/2018-03/nyc_sex_trade.pdf

WHOQOL Group. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological medicine, 28*(3), 551–558. https://doi.org/10.1017/S0033291798006667

Wolf, A. (2019). Stigma in the sex trades. *Sexual and Relationship Therapy, 34*(3), 290–308. https://doi.org/10.1080/14681994.2019.1573979

Wong, W. C. W., Holroyd, E. A., Gray, A., & Ling, D. C. (2006). Female street sex workers in Hong Kong: Moving beyond sexual health. *Journal of Women's Health, 15*(4), 390–399. https://doi.org/10.1089/jwh.2006.15.390

Yang, L. H., Wong, L. Y., Grivel, M. M., & Hasin, D. S. (2017). Stigma and substance use disorders: an international phenomenon. *Current opinion in psychiatry, 30*(5), 378–388. https://doi.org/10.1097/YCO.0000000000000351

Appendix A

Table 8

Measured Variables, Questions/Items and Response Options in the Current Survey

Variable	Question/Item	Response Options
Demographic and Descriptives	Your current age in years	18; 19; 20; 21; 22; 23; 24; 25; 26; 27; 28; 29; 30; 31; 32; 33; 34; 35; 36; 37; 38; 39; 40; 41; 42; 43; 44; 45; 46; 47; 48; 49; 50; 51; 52; 53; 54; 55; 56; 57; 58; 59; 60; 61; 62; 63; 64; 65; 66; 67; 68; 69; 70; 71; 72; 73; 74; 75; 76; 77; 78; 79; 80 years or older
	Your gender:	Man; Woman; Transman, Transwoman; Non-binary; Other, what?
	Your sexual orientation:	Heterosexual; Homosexual; Bisexual; Pansexual; Asexual; Other, what?
	Your relationship status:	Single; In a relationship; Cohabiting, Married; Other, what?
	Do you have children?	Yes; No
	Your country of birth:	Open-ended question
	Do you currently provide sexual services in some other country/countries than Finland?	No, only in Finland (in person) or from Finland (online); Yes, also somewhere else than Finland
	[a] Please write which other country/countries than Finland you are currently providing sexual services in:	Open-ended question
	Choose the option that suits you best:	I am a Finnish citizen; I have a permanent residence permit in Finland; I have a temporary residence permit in Finland; I do not have a residence permit in Finland; I do not want to say
	What is the highest level of education you have completed?	No education; Primary (6 years or less); Secondary (7-9 years); High school or vocational school (10-12 years); University or applied university (13 years or more)
	Besides providing sexual services, choose which of the following work-related options suits you: (You can choose one or several answers that suits you best).	I have other paid full-time or part-time work; I do volunteer work; I am studying or completing an internship; I am a caregiver (to parents, children, or other family member); Something else; I do not have any other work
Quality of Life: WHOQOL-BREF	In this part of the study you will be asked how you feel about your quality of life, health, or other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response. We ask that you think about your life in the last two weeks.	
Overall quality of life	How would you rate your quality of life?	Very good; Good; Neither poor nor good; Poor; Very poor
General health	How satisfied are you with your health?	Very satisfied; Fairly satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Physical subscale	To what extent do you feel that physical pain prevents you from doing what you need to do?	An extreme amount; A great deal; A moderate amount; A small amount; Not at all

Physical subscale	How much do you need any medical treatment to function in your daily life?	An extreme amount; A great deal; A moderate amount; A small amount; Not at all
Psychological subscale	How much do you enjoy life?	An extreme amount; A great deal; A moderate amount; A small amount; Not at all
Psychological subscale	To what extent do you feel your life to be meaningful?	An extreme amount; A great deal; A moderate amount; A small amount; Not at all
Psychological subscale	How well are you able to concentrate?	Extremely; Very; Moderately; Slightly; Not at all
Environmental subscale	How safe do you feel in your daily life?	Extremely; Very; Moderately; Slightly; Not at all
Environmental subscale	How healthy is your physical environment?	Extremely; Very; Moderately; Slightly; Not at all
Physical subscale	Do you have enough energy for everyday life?	Completely; To a great extent; Somewhat; Slightly; Not at all
Psychological subscale	Are you able to accept your bodily appearance?	Completely; To a great extent; Somewhat; Slightly; Not at all
Environmental subscale	Have you enough money to meet your needs?	Completely; To a great extent; Somewhat; Slightly; Not at all
Environmental subscale	How available to you is the information you need in your daily life?	Completely; To a great extent; Somewhat; Slightly; Not at all
Environmental subscale	To what extent do you have the opportunity for leisure activities (hobbies)?	Completely; To a great extent; Somewhat; Slightly; Not at all
Environmental subscale	How well are you able to get around physically?	Extremely; Very; Moderately; Slightly; Not at all
Physical subscale	How satisfied are you with your sleep?	Very satisfied; Fairy satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Physical subscale	How satisfied are you with your ability to perform your daily living activities?	Very satisfied; Fairy satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Physical subscale	How satisfied are you with your capacity for work?	Very satisfied; Fairy satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Psychological subscale	How satisfied are you with yourself?	Very satisfied; Fairy satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Social subscale	How satisfied are you with your personal relationships?	Very satisfied; Fairy satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Social subscale	How satisfied are you with your sex life?	Very satisfied; Fairy satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Social subscale	How satisfied are you with the support you get from your friends?	Very satisfied; Fairy satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Environmental subscale	How satisfied are you with the conditions of your living place?	Very satisfied; Fairy satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Environmental subscale	How satisfied are you with your access to health services?	Very satisfied; Fairy satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Environmental subscale	How satisfied are you with your transport?	Very satisfied; Fairy satisfied; Neither satisfied nor dissatisfied; Fairly dissatisfied; Very dissatisfied
Psychological subscale	How often do you have negative feelings such as blue mood, despair, anxiety or depression?	Never; Infrequently; Sometimes; Frequently; Always
Stigma: Internalized Sex Work Stigma Scale (ISWSS)	In this part of the study you will be asked about stigma related to your work.	
Subscale Acceptance	I like my job as a sex worker.	Totally agree; Agree; Disagree; Totally disagree
Subscale Illegitimacy	I deserve respect as a sex worker.	Totally agree; Agree; Disagree; Totally disagree
Subscale Acceptance	I feel comfortable telling others that I am a sex worker.	Totally agree; Agree; Disagree; Totally disagree

Subscale Worthlessness	People's attitudes about sex work make me feel worse about myself.	Totally agree; Agree; Disagree; Totally disagree
Subscale Worthlessness	I feel like I am not as good as others because I am a sex worker.	Totally agree; Agree; Disagree; Totally disagree
Subscale Guilt and Shame	Working as a sex worker makes me feel like a bad person.	Totally agree; Agree; Disagree; Totally disagree
Subscale Worthlessness	I feel completely worthless because I am a sex worker.	Totally agree; Agree; Disagree; Totally disagree
Subscale Guilt and Shame	I feel guilty because I am a sex worker.	Totally agree; Agree; Disagree; Totally disagree
Subscale Guilt and Shame	I feel ashamed of my sex work.	Totally agree; Agree; Disagree; Totally disagree
Subscale Guilt and Shame	It's easier to avoid friendships than worry about telling others that I am a sex worker.	Totally agree; Agree; Disagree; Totally disagree
Subscale Acceptance	I feel okay about being a sex worker.	Totally agree; Agree; Disagree; Totally disagree
Subscale Illegitimacy	I see sex work as work, just like any other job.	Totally agree; Agree; Disagree; Totally disagree
Stigma: Adapted version of Sex Work Experienced Stigma Scale (SWESS)	Next, you will be asked about potentially negative experiences related to your work.	
SWESS additional questions	Have you ever told a health care worker or have a health care worker found out that you provide sexual services in Finland?	Yes; No
	[b] Have you during the last six months visited or contacted a health care facility in Finland?	Yes; No
	[c] Is previous negative experiences one of the reasons for you to not visit or contact a health care facility in Finland?	Yes; No
SWESS subscale: Health care worker stigma	The following statements are about your experiences at any type of health care facility in Finland. Have any of the following happened to you during the past 6 months?	
	I have been denied health services.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have been discharged or asked to leave while still needing care.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have been made to wait longer compared with other patients who were not sex workers.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have not been treated as well compared with other patients who were not sex workers.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	A health care worker has gossiped or spoke badly about me.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	A health care worker has disclosed that I am a sex worker without my consent.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	A health care worker has introduced to me religious or morality issues related to sex work.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months

SWESS additional questions	Have you, in Finland, ever told a police officer and/or someone in law enforcement or have a police officer and/or someone in law enforcement found out that you provide sexual services?	Yes; No
	[b] Have you during the last six months been in contact with a police officer and/or someone in law enforcement in Finland?	Yes; No
	[c] Is previous negative experiences one of the reasons for you to not contact a police officer and/or someone in law enforcement in Finland?	Yes; No
SWESS subscale: Police officer/ Law enforcement stigma	The following statements are about your experiences related to a police officer and/or someone in the law enforcement in Finland. Have any of the following happened to you during the past 6 months?	
	I have experienced psychological violence (verbally assaulted, harassed or threatened) by them.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have experienced physical violence (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by them.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	They have illegally confiscated or destroyed my belongings (things).	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have been arrested for providing sexual services.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	They have refused to protect me or to take a statement from me.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
SWESS additional questions	Have you ever told a family member and/or your partner or has a family member and/or your partner found out that you provide sexual services?	Yes; No
SWESS subscale: Family member/ partner stigma	The following statements are about your experiences related to your family member and/or your partner. Have any of the following happened to you during the past 6 months?	
	I have been excluded from gatherings (e.g., cooking/eating together, sleeping in the same room).	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have been disowned (rejected) by them or lost inheritance.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have experienced psychological violence (verbally assaulted, harassed or threatened) by them.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have experienced physical violence (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by them.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have experienced sexual violence (assaulted or harassed) by them.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months

SWESS additional questions	Have you ever told other people or have other people found out that you provide sexual services? (e.g., friends or colleagues outside sex work)	Yes; No
SWESS subscale: Other people stigma	The following statements are about your experiences related to other people (e.g., friends or colleagues outside sex work). Have any of the following happened to you during the past 6 months?	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	Someone spoke badly or gossiped about me.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have experienced psychological violence (verbally assaulted, harassed or threatened) by others.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have been rejected or ditched by others.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
SWESS subscale: Client stigma	The following statements are about your experiences related to clients. Have any of the following happened to you during the past 6 months?	
	I have experienced physical violence (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by a client.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have experienced psychological violence (verbally assaulted, harassed or threatened) by a client.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
	I have experienced sexual violence (assaulted or harassed) by a client.	Not during the past 6 months; Once during the past 6 months; 2-5 times during the past 6 months; 6 or more times during the past 6 months
Work Descriptives	In this part of the study you will be asked more about your work.	
	What kind of interaction do you regularly have with your clients? (You can choose one or several answers that suits you best).	No interaction (e.g., photos on a platform); Interaction online or by phone (e.g., chatting, talking or webcamming); Interaction in person but no physical nor sexual contact (e.g., stripping on a scene); Interaction in person with physical but no sexual contact (e.g., massage, kissing or hugging); Interaction in person with sexual contact (e.g., touching genitals or penetration)
	What kind of sexual services do you provide online/by phone? (You can choose one or several answers that suits you best).	I do not provide sexual services online/by phone; Photos/videos; Webcamming; Phone calls/messages with client; Other, what?
	What kind of sexual services are you providing in person?(You can choose one or several answers that suits you best).	I do not provide sexual services in person, only online/by phone; Full services; Escorting; Massage; Dance/stripping; Girl-/boyfriend experience; Sugar dating; Fetish sessions; Other, what?
	Where do you provide sexual services in person?(You can choose one or several answers that suits you best).	I do not provide sexual services in person, only online/by phone; In my home; In client's home; In a brothel; In a strip club/an erotic bar; In a massage parlour; In a hotel; In a studio (e.g., SM); On the street; In a car; In a rented apartment (not my own home); Somewhere else, where?
	For how many years have you been providing sexual services?	Less than 1 year; 1; 2; 3; 4; 5; 6; 7; 8; 9; 10; 11; 12; 13; 14; 15; 16; 17; 18; 19; 20; 21; 22; 23; 24; 25; 26; 27; 28; 29; 30; 31; 32; 33; 34; 35; 36; 37; 38;

		39; 40; 41; 42; 43; 44; 45; 46; 47; 48; 49; 50; More than 50 years
	How old were you when you started providing sexual services?	10 years or younger; 11; 12; 13; 14; 15; 16; 17; 18; 19; 20; 21; 22; 23; 24; 25; 26; 27; 28; 29; 30; 31; 32; 33; 34; 35; 36; 37; 38; 39; 40; 41; 42; 43; 44; 45; 46; 47; 48; 49; 50; 51; 52; 53; 54; 55; 56; 57; 58; 59; 60; 61; 62; 63; 64; 65; 66; 67; 68; 69; 70 years or older
	Please, consider how true the following statement is for you: "I often think about quitting my work"	Not at all true; Slightly true; Very true
	When you consider stopping providing sexual services, what are the most common reasons to stop? (You can choose one or several answers that suits you best).	I want to try a new work; I got a better work offer; This is only a temporary work; I do not earn enough money; I do not like my work; I want to study; I am expecting a child; It is affecting my relationship/relationships; I experience too much stigma because of my work; I feel physically/mentally ill; I am retiring soon; Other reason, what?
	What gender is your most typical client?	Man; Woman; Transman; Transwoman; Non-binary; Other, what?
	What is your monthly gross income (before taxes) from providing sexual services?	0-499 €; 500-999 €; 1000-1499 €; 1500-1999 €; 2000-2499 €; 2500-2999 €; 3000-3499 €; 3500-3999 €; 4000-4499 €; 4500-4999 €; 5000-5499 €; 5500-5999 €; 6000-6499 €; 6500-6999 €; 7000-7499 €; 7500-7999 €; 8000-8499 €; 8500-8999 €; 9000-9499 €; 9500-9999 €; 10 000 € or more
	What is your monthly gross income (before taxes) in total (from both providing sexual services and other work)?	0-499 €; 500-999 €; 1000-1499 €; 1500-1999 €; 2000-2499 €; 2500-2999 €; 3000-3499 €; 3500-3999 €; 4000-4499 €; 4500-4999 €; 5000-5499 €; 5500-5999 €; 6000-6499 €; 6500-6999 €; 7000-7499 €; 7500-7999 €; 8000-8499 €; 8500-8999 €; 9000-9499 €; 9500-9999 €; 10 000 € or more
	Assess your economic situation over the last 6 months:	My economic situation is good, and I can save some of my income; My economic situation is good, but I spend all of my income; My economic situation is quite tight, and the money is just enough for the necessary expenses; My economic situation is tight and there is not enough money even for the necessary expenses; My money does not cover all the expenses and I had to take a loan
Adapted version of AUDIT	[b] The following questions are about alcohol use. Answer as accurately and honestly as possible by choosing the most appropriate option for your situation.	
	Have you used alcohol during the last 6 months? Also include those times when you drink only small amounts, such as a medium bottle of beer or a little bit of wine.	Yes; No
	During the past 6 months...	
	How often have you found that you were not able to stop drinking once you had started?	Never; Less than monthly; Monthly; Weekly; Daily or almost daily
	How often have you failed to do what was normally expected of you because of drinking?	Never; Less than monthly; Monthly; Weekly; Daily or almost daily

	How often have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never; Less than monthly; Monthly; Weekly; Daily or almost daily
	How often have you had a feeling of guilt or remorse after drinking?	Never; Less than monthly; Monthly; Weekly; Daily or almost daily
	Have you been unable to remember what happened the night before because you had been drinking?	Never; Less than monthly; Monthly; Weekly; Daily or almost daily
	Have you or someone else been injured as a result of your drinking?	No; Yes, but not in the past 6 months; Yes, during the past 6 months
	Has a relative or friend, a doctor or another health worker been concerned about your drinking or suggested you cut down?	No; Yes, but not in the past 6 months; Yes, during the past 6 months
Adapted version of DUDIT	The following questions are about drug use. Answer as accurately and honestly as possible by choosing the most appropriate option for your situation.	
	[b] Have you used drugs during the last 6 months? Note. medicines are NOT considered drugs if they have been prescribed for you by a doctor and you are taking them in the doses prescribed by your doctor.	Yes; No
	Over the past 6 months, have you felt that your longing for drugs was so strong that you could not resist it?	Never; Less than monthly; Monthly; Weekly; Daily or almost daily
	Has it happened, over the past 6 months, that you have not been able to stop taking drugs once you started?	Never; Less than monthly; Monthly; Weekly; Daily or almost daily
	How often over the past 6 months have you taken drugs and then neglected to do something you should have done?	Never; Less than monthly; Monthly; Weekly; Daily or almost daily
	How often over the past 6 months have you needed to take a drug the morning after heavy drug use the day before?	Never; Less than monthly; Monthly; Weekly; Daily or almost daily
	How often over the past 6 months have you had guilt feelings or a bad conscience because you used drugs?	Never; Less than monthly; Monthly; Weekly; Daily or almost daily
	Have you or anyone else been hurt (mentally or physically) because you used drugs?	No; Yes, but not in the past 6 months; Yes, during the past 6 months
	Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?	No; Yes, but not in the past 6 months; Yes, during the past 6 months

Note. [a] Only answered if the answer to the previous questions was "Yes, also somewhere else than Finland". [b] If the answer was yes, then automatically skipping the following question. [c] Only answered if the answer to the previous question was "No", then skipping the current subscale items.

Table 9

BCa Confidence Intervals for Correlation Analyses

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1.WHOQOL-BREF	–												
2.AUDIT	[-.59;-.07]	–											
3.DUDIT	[-.81;-.42]	[.09;.95]	–										
4.ISWSS	[-.76;-.57]	[.17;.66]	[.25;.80]	–									
5.ISWSS Worthlessness	[-.60;-.27]	[.02;.54]	[.14;.67]	[.75;.89]	–								
6.ISWSS Acceptance	[-.79;-.55]	[.16;.66]	[.13;.77]	[.77;.91]	[.31;.65]	–							
7.ISWSS Illegitimacy	[.43;.74]	[-.67;-.02]	[-.85;-.24]	[-.81;-.50]	[-.52;.07]	[-.82;-.57]	–						
8.ISWSS Guilt & Shame	[.37;.66]	[-.49;-.03]	[-.60;.11]	[-.93;-.84]	[-.87;-.69]	[-.76;-.46]	[.22;.60]	–					
9.SWESS [a]	[-.84;-.48]	[-.02;.75]	[.15;.83]	[.42;.76]	[.24;.65]	[.29;.78]	[-.64;.10]	[-.64;.27]	–				
10.SWESS Health [b]	[-.57;.03]	[-.22;.64]	[-.52;.97]	[-.13;.64]	[-.05;.80]	[-.28;.47]	[-.13;.34]	[-.75;.17]	[-.00;.85]	–			
11.SWESS Family [c]	[-.56;-.11]	[-.10;.64]	[.09;.78]	[.17;.67]	[.17;.63]	[.06;.60]	[-.60;-.03]	[-.64;-.13]	[.32;.77]	[-.19;.67]	–		
12.SWESS Other [d]	[-.46;-.10]	[.08;.67]	[-.19;.74]	[.10;.46]	[.22;.52]	[-.12;.34]	[-.25;.16]	[-.45;-.06]	[.49;.83]	[.05;.88]	[-.04;.67]	–	
13.SWESS Client	[-.86;-.67]	[.06;.60]	[.52;.85]	[.36;.68]	[.06;-.50]	[.49;.77]	[-.67;-.25]	[-.56;-.13]	[.74;.91]	[-.05;.74]	[.16;.61]	[.01;.50]	–
Health knew [e]	[-.18;.22]	[-.25;.24]	[-.20;.67]	[-.33;.08]	[-.29;.09]	[-.29;.09]	[-.21;.16]	[-.03;.38]	[-.20;.26]	[-.12;.27]	[-.26;.16]	[-.25;.18]	[-.13;.23]
Health contact	[.02;.43]	[-.45;.12]	[-.84;-.18]	[-.44;-.08]	[-.34;.01]	[-.47;-.07]	[.08;.44]	[.02;.41]	[-.44;.08]		[-.46;-.01]	[-.21;.16]	[-.49;-.09]
Health negative contact	[-.65;-.22]	[.54;.99]	[-.58;-.33]	[.17;.77]	[-.24;.60]	[.26;.77]	[-.84;-.36]	[-.46;.05]			[-.29;.81]	[-.70;-.40]	[-.01;.68]
Police knew [e]	[-.43;.03]	[.05;.62]	[-.03;.78]	[-.04;.42]	[-.17;.30]	[-.02;.45]	[-.44;-.01]	[-.31;.08]	[.06;.56]	[-.15;.58]	[.12;.37]	[-.03;.43]	[-.02;.44]
Police contact	[-.27;.19]	[-.20;.29]	[-.37;.31v	[-.21;.23]	[-.22;.27]	[-.19;.23]	[-.25;.17]	[-.22;.27]	[-.01;.52]	[.00;.62]	[-.22;.24]	[-.09;.44]	[-.04;.39]
Police negative contact	[-.30;.09]	[-.15;.41]	[-.49;.26]	[-.29;-.04]	[-.27;-.01]	[-.29;.03]	[-.06;.24]	[.04;.29]	[-.20;.13]	[-.10;.90]	[-.16;.12]	[-.15;.28]	[-.14;.25]
Family knew [e]	[-.08;.24]	[-.27;.23]	[-.31;.47]	[-.42;-.08]	[-.36;.00	[-.35;-.03]	[-.07;.34]	[.11;.50]	[-.08;.28]	[.050;.18]		[-.04;.25]	[-.06;.23]
Other knew [e]	[-.02;.40]	[-.51;.08]	[-.74;-.10]	[-.50;-.07]	[-.37;.02]	[-.47;-.09]	[.12;.53]	[-.01;.43]	[-.32;.13]	[.05;.19]	[-.50;.08]		[-.31;.11]
Age	[-.13;.25]	[-.30;.24]	[-.55;.14]	[-.25;.18]	[-19.;.22]	[-.26;.15]	[-.07;.24]	[-.20;.25]	[-.37;.07]	[-.35;.05]	[-.41;-.08]	[-.35;-.01]	[-.38;-.01]
Sexual orientation	[-.10;.24]	[-.03;.46]	[-.01;.85]	[-.02;.36]	[-.11;.30]	[.01;.36]	[-.37;-.02]	[-.32;.08]	[-.13;.33]	[-.23;.40]	[-.05;.36]	[-.24;.20]	[-.17;.21]
Relationship status	[-.39;-.02]	[-.18;.32]	[-.51;.33]	[-.07;.29]	[-.20;.18]	[.00;.34]	[-.34;.02]	[-.28;.10]	[-.13;.35]	[-.29;.32]	[-.30;-.02]	[-.29;.11]	[-.14;.25]
Children	[-.17;.19]	[-.16;.34]	[-.33;.46]	[-.04;.35]	[-.13;.25]	[.06;.46]	[-.31;.04]	[-24.;.12]	[-.03;.41]	[-.22;.47]	[-.11;.33]	[-.12;.33]	[-.16;.24]
Birth country	[.12;.46]	[-.15;.14]	[-.35;.18]	[-.59;-.08]	[-.55;.04]	[-.54;-.01]	[-.09;.34]	[.19;.62]	[-.55;-.07]	[-.76;.10]	[-.54;.00]	[-.39;-.07]	[-.58;-.11]
Work country	[-.02;.36	[-.36;.15]	[-.14;.37]	[-49.;.05]	[-.50;.01]	[-.44;.12]	[-.08;.29]	[-.02;.53]	[-.32;.12]	[-.65;.17]	[-.48;.12]	[-.22;.09]	[-.43;.06]
Education	[.32;.64]	[-.64;-.17]	[-.78;-.10]	[-.59;-.26]	[-.43;-.06]	[-.68;-.35]	[.26;.63]	[.04;.46]	[-.71;-.32]	[-45.;.16]	[-.58;-.16]	[-.40;-.07]	[-.74;-.37]
Years providing services	[-.53;-.15]	[.15;.57]	[-.04;.68]	[.13;.48]	[.00;.37]	[.19;.57]	[-.52;-.14]	[-.33;.04]	[.15;.56]	[-.22;.28]	[-.07;.33]	[-.37;.01]	[.22;.61]
Starting age	[.21;.58]	[-.50;-.08]	[-.70;-.17]	[-.45;-.04]	[-.31;.11]	[-.47;-.09]	[.12;.47]	[-.13;.37]	[-.61;-.25]	v-.26;.57]	[-.47;-.23]	[-.15;.27]	[-.63;-.33]
Additional work	[.05;.46]	[-.39;.12]	[-.57;.16]	[-.48;-.08]	[-.40;.01]	[-.48;-.04]	[.07;.47]	[.01;.40]	[-.50;.046]	[-.53;.12]	[-.28;.21]	[-.37;.11]	[-.47;-.02]
Media-based services	[-.04;.33]	[-.26;.22]	[-.22;.57]	[-.43;-.09]	[-.33;.05]	[-.45;-.11]	[.09;.41]	[-.03;.38]	[-.18;.26]	[.20;.53]	[-.24;.19]	[-.05;.32]	[-.29;.11]
In-person services	[-.22;.12]	[-.01;.25]	[-.64;.35]	[.03;.29]	[-.11;.21]	[.07;.33]	[-.29;-.09]	[-.24;.03]	[-.32;.13]	[-.79;.10]	[-.01;.18]	[-.64;-.05]	[-.05;.19]
Quitting thoughts	[-.73;-.48]	[-.06;.43]	[-.34;.61]	[.42;.67]	[.08;.41]	[.54;.76]	[-.62;-.35]	[-.60;-.26]	[.25;.77]	[.22;.35]	[.05;.51]	[-.10;.31]	[.35;.66]
Income from sex work	[.27;.50]	[-.34;.00]	[-.51;.13]	[-.32;-.05]	[-.21;.12]	[-.35;-.10]	[.06;.37]	[-.04;.27]	[-.34;.00]	[-.34;.42]	[-.29;-.02]	[-.17;.35]	[-.41;-.20]
Total income	[.35;.59]	[-.39;-.02]	[-.65;-.01]	[-.34;-.06]	[-.21;.07]	[-.40;-.09]	[.09;.41]	[-.07;.25]	[-.41;.01]	[-.33;.42]	[-.34;-.07]	[-.22;.31]	[-.50;-.24]
Economic situation	[.43;.71]	[-.47;.052]	[-.76;-.16]	[-48.;-.11]	[-.41;.01]	[-.49;-.14]	[.07;.43]	[.01;.41]	[-.54;-.07]	[-.62;.22]	[-.34;.05]	[-.31;.11]	[-.53;-.19]

Note. Table 4 contains correlation coefficients and significance levels for these confidence intervals. The analyses with empty cells in the table were not calculable. WHOQOL-BREF = The World Health Organization Quality of Life-BREF. AUDIT = Modified version of the Alcohol Use Disorders Identification Test. DUDIT = Modified version of the Drug Use Disorders Identification Test. ISWSS = Internalized Sex Work Stigma Scale (subscales: worthlessness, acceptance, illegitimacy, guilt & shame). SWESS = Modified version of the Sex Work Experienced Stigma Scale (full scale including subscales: family, other, and client; subscale: health analyzed separately; subscale: police, not calculable). Higher scores mean a higher quality of life, more substance-related problematic behavior, and more sex work stigma. Health knew: a health care worker knew about the occupation (0 = no; 1 = yes). Health contact: contact with a health care worker/facility during the past six months (0 = no; 1 = yes). Health negative contact: no contact during the past six months because of previous negative experiences (0 = no; 1 = yes). Police knew: a police officer/someone in law enforcement knew about the occupation (0 = no; 1 = yes). Police contact: contact with a police officer/someone in law enforcement during the past six months (0 = no; 1 = yes). Police negative contact: no contact during the past six months because of previous negative experiences (0 = no; 1 = yes). Family knew: a family member/partner knew about the occupation (0 = no; 1 = yes). Other knew: someone else knew about the occupation (0 = no; 1 = yes). Age = respondents' age in years. Sexual orientation: 0 = other; 1 = heterosexual. Relationship status: 0 = in a relationship; 1 = single. Children: has a child/children (0 = no; 1 = yes). Birth country: 0 = other than Finland; 1 = Finland. Work country: 0 = in/from Finland and another country; 1 = only in/from Finland. Education = highest level of education completed. Years providing services = the length of providing sex work in years. Starting age: the age when starting to provide sex work in years. Additional work: additional work/studies besides sex work (0 = no; 1 = yes). Media-based services: provides media-based services (0 = no; 1 = yes). In-person services: provides in-person services (0 = no; 1 = yes). Quitting thoughts: 0 = not at all; 1 = slightly/very true. Income from sex work = monthly gross income from sex work. Total income = total monthly gross income. Economic situation = economic situation over the last 6 months from bad to good.

[a] Including subscales family, other, and client; and only including cases when a family member/partner and other people (e.g., a friend) knew about the sex worker's occupation. [b] Only including cases when health care worker knew about the sex worker's occupation (answered yes on item: health knew). [c] Only including when family member/partner knew about the sex worker's occupation (answered yes on item: family knew). [d] Only including cases when other people knew about the sex worker's occupation (answered yes on item: other knew). [e] This was an exception, including cases with both yes and no answers in the current item. [f] The number of bootstrapped samples is less than 2000.

*$p \leq .05$. **$p \leq .01$. ***$p < .001$.

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PRESSMEDDELANDE

Sexarbetarstigma och sexarbetarnas livskvalitet i Finland
Pro-gradu avhandling i psykologi
Fakulteten för humaniora, psykologi och teologi, Åbo Akademi

Pro-gradu avhandlingen i psykologi vid Åbo Akademin undersökte stigma bland sex arbetare och sex arbetarnas livskvalitet i Finland. Resultaten indikerar på att sexarbetare upplever stigma relaterat till deras arbete och att majoriteten av sex arbetare i Finland hade i genomsnitt en relativt hög livskvalitet. Utöver detta indikerade resultaten att de sexarbetare som rapporterade mera sexarbetarstigma rapporterade även lägre livskvalitet och mer substans-relaterad problematisk beteende. Studiens urval bestod av 155 sexarbetare som arbetar i/från Finland. Flesta sexarbetare erbjöd fysiska tjänster, medan en mindre grupp erbjöd endast mediabaserade tjänster. Sexarbetarna fick delta i studien via en anonym online-enkät som spreds ut på olika forum.

Angående resultaten kan man inte dra slutsatser om orsakssamband mellan sexarbetarstigma och försämrad livskvalitet, eftersom data är insamlat vid endast ett tillfälle och det kan finnas en antal faktorer som inte kontrollerats för i avhandlingen. Samtidigt bör man ta i beaktande att sampelstorleken var liten och att de flesta deltagare var finländska kvinnor. Därmed kan resultaten inte generalisera till alla sex arbetare som arbetar i/från Finland. Resultaten kan tyda på att stigmat bland sex arbetare bör motarbetas genom att öka medvetande och med hjälp av olika stödtjänster.

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