

## Surviving shame

### Adolescent sex workers' experiences of accessing and avoiding helping services

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#### Abstract

Adolescents involved with sex work are largely hidden from formal systems, and typically view counselling, social work, and health services with distrust. This article reports the findings of a study involving semi-structured interviews with a sample of eight young people who started sex work between the ages of 12 and 16. The study found that participants' experiences with formal services were overwhelmingly negative and emotionally harmful. The combination of the participants' outcome expectations, interactions with individual practitioners, and feelings of shame was found to preclude sustained engagement, irrespective of the participants' level of need. Helpful elements of the client-practitioner alliance are identified, and components of service design that promote emotional safety and the positive development of self are discussed.

**Keywords:** adolescents, sex workers, research, counselling, client-practitioner alliance

Involvement in underage sex work has been associated with exposure to physical and sexual violence; long-lasting psychological, physical, emotional, and cognitive impacts including post-traumatic stress disorder (PTSD); and a range of adverse physical health outcomes (Ahrens, Katon, McCarty, Richardson, & Courtney, 2012; Herman, 1987). Children and adolescents involved with underage sex work are likely to exhibit a range of inimical mental health outcomes related directly to the effects of the treatment they have received at the hands of others (Svensson, Fredlund, Goransvedin, Priebe, & Wadsby, 2012).

Alisen (2003) makes the distinction between mental health problems that are rooted in a biological predisposition and those that are fundamentally "caused by

humans,” such as PTSD, eating disorders, and dissociative disorders, many of which originate from abusive experiences. The extent of an individual young person’s traumatic response to abuse is dependent on a number of variables, including the frequency with which the abuse occurred; its severity, degree of violence, and whether there was physical pathology; the number of abusers, whether the abuse occurred concurrently or in discrete instances; and the relational proximity of the abuser to the victim (Alisen, 2003). Cumulative exposure and intra-familial abuse contexts have both been shown to result in significantly worse mental health outcomes (Ministry of Women’s Affairs, 2012).

Notably high levels of avoidant, intrusive, and arousal symptoms in young people engaging in underage sex work have been linked both with their prior histories of penetrative sexual abuse and with the legal restrictions and cognitive immaturity that place them in higher-risk situations than adult sex workers (ECPAT NZ, 2003; Potter, Martin, & Romans, 1999). In addition, it is theorised that psychosocial stressors such as homelessness or involuntary transience, addiction, and tenuous socially supportive relationships preclude the opportunity to heal from adverse experiences (Briere, 2006). As young people using sex for survival are more likely to demonstrate these clusters of risk factors and fewer protective factors, magnified mental health implications following traumatic events are anticipated (Potter et al., 1999).

In Aotearoa New Zealand, purchasing sexual services from young people under the age of 18 is illegal, and is viewed as an undeniable violation of children’s rights within New Zealand’s legislative framework (Ministry of Justice, 2002). Nevertheless, international studies have shown the age at which young people first become involved in transactional sex to be between 12 and 15 (Chase & Statham, 2005; Holger-Ambrose, Langmade, Edinburgh, & Saewyc, 2013; Jordan, Patel, & Rapp, 2013; Lukman et al., 2011). Correspondingly, a New Zealand study (Saphira & Herbert, 2004) found that of a sample of 47 sex workers, the average age at which they began was 14.5 years. Saphira’s (2002) earlier New Zealand study asking professionals about their contact with sex-working adolescents identified 194 individual adolescents known to be trading sex for money or goods. Although it is unclear how recently the respondents had worked with the adolescents they reported having knowledge of, the extent of their contact with these young people ranged from single sessions to long-term engagement (Saphira, 2002).

Young people engaging in underage sex work are a group who may clearly benefit from intervention at both individual and policy levels. However, attempts to investigate

and target this phenomenon are hindered by the traumatic histories of these adolescents, the symptoms of which may perpetuate their involvement; adolescents' fear of stigma; and the largely hidden nature of the interactions between these young people and their clients (Cusick, 2002; Halter, 2010; Saphira & Oliver, 2002).

Typically, adolescents engaging in underage sex work view practitioners and figures of authority with distrust, which can be attributed to their anticipation of traditionally punitive or stigmatising responses (Cusick, 2002). Seeking help to leave underage sex work behind may also be hindered by the circumstances that prompted young people's initial involvement, and additional barriers such as dealing with shame or stigma may inhibit adolescents from accessing services (Saphira & Herbert, 2004). Internalisation of society's differentiation between moral and immoral victims may also occur for these sex workers, leading to fixed negative expectations about helping providers' responses (Saphira & Oliver, 2002). In addition, addiction to drugs and/or alcohol may add to adolescents' reluctance to engage with formal systems (Saphira & Oliver, 2002). Moreover, social services practitioners' awareness of adolescent involvement in underage sex work is uneven and inconsistent (Scott & Harper, 2006), which is conceivably a factor in the professional perception of adolescents involved in this work as being "hard to reach."

As very little research has been conducted with young people involved with underage sex work in New Zealand, there are elements of their experiences and perceptions that have not been studied and which may therefore be poorly understood. This lack of research-based knowledge may contribute to ambiguity and ambivalence among practitioners in social services about the subject of underage sex work and these young people's subjective realities (Saphira & Herbert, 2004; Saphira & Oliver, 2002). Consequently the experiences of these young people were the focus of the current research.

## **Method**

Qualitative research, while often being criticised for having less generalisability than quantitative research, provides an opportunity to conduct in-depth research into experiences, perspectives, and phenomena that would not be possible using quantitative methods (Dawson, 2009). It differs from quantitative research in the epistemological values that underpin the design and process of such studies (Grey, 2004). For example, qualitative researchers assume that there is a range of differences between individuals' experiences, and aim to explain these (Tolich & Davidson, 2011). This was particularly pertinent in previous studies given the diversity of experiences among adolescents

involved in underage sex work. Moreover, qualitative methods can be seen as essentially reflective of the helping services' goals of reflexivity, respect for participants' stories, and partnership in the research process (Denzin & Lincoln, 2000).

Convenience sampling refers to the recruitment of participants or respondents based on their accessibility (Hoskins & Mariano, 2004; Morse, 2004), and this approach was used to recruit the participants in this study. While convenience sampling has been criticised for its lack of rigour in qualitative studies, it may also be necessary if access to participants is limited, and may retain validity provided the participants still accurately reflect the aims of the study (Marshall, 1996).

Agencies working with youth were asked to display recruitment flyers, resulting in ten adolescents making contact and expressing interest in taking part. Two of these young people were subsequently excluded owing to their being at imminent risk of interpersonal violence. This left eight participants which, while comprising a small sample, was considered sufficient given the inherent challenge in gaining access to a largely hidden population. All participants were aged between 16 and 20, and had entered underage sex work between the ages of 12 and 16. One was male and the other seven were female. Six were New Zealand Pākehā, and two were New Zealand Māori.

Semi-structured interviews were chosen for this study, as they allow for the targeted eliciting of information to answer the primary research questions, while also maintaining sufficient flexibility to allow participants to share components they deem important, and which may not have been previously recognised as such by the researcher (Gill, Stewart, Treasure, & Chadwick, 2008). These interviews were each of between 40 and 60 minutes, they were conducted at the participants' pace, and the questions used in the interviews were minimal to enable a conversational style. Participants discussed their childhood and family experiences, their peer context, and their involvement in sex work. They told stories about their emotional and psychological wellbeing, and about their experiences and expectations of being a client of social or health services. However, this article focuses primarily on participants' experiences of their interactions with counsellors and other helping professionals.

The interview transcripts were analysed using thematic analysis (Thomas, 2000), a systematic technique that allowed categories to emerge naturally from the data (Hsieh & Shannon, 2005). It also allowed for the dual identification of themes, firstly at the semantic level in response to explicit phrases or foci, and secondly at an interpretive level as the underlying significance became evident (Patton, 2002). This approach was utilised in this research through a two-tiered coding process, firstly to identify the

explicit patterns and secondly to identify the significance of the initial findings and potential connections between patterns, which were then visually mapped.

Approval for the study was gained from the University of Auckland Human Participants Ethics Committee.

## Results

All the participants' backgrounds included trauma, parental absence or inconsistency, and exposure to violence, except for the sole male participant who had lost his father at a young age. All the female participants had been subjected to physical and sexual violence, usually from a very young age and often by multiple perpetrators in a variety of contexts. Parental substance abuse and mental illness, frequently changing caregivers, and exposure to family violence were all common experiences among the participants.

All participants had histories of either depression or anxiety (though this was self-labelled rather than formally diagnosed in most cases) and connected this to certain feelings such as a pervasive sense of inadequacy, self-hatred, feeling down or low, and feeling suicidal.

I was afraid of being hurt. But I wanted to hurt myself, 'cos I didn't like who I was. And I didn't think anybody else liked who I was neither.—Shaz<sup>1</sup>

I hated myself, didn't even want to be in my own head, I don't know, I just, I didn't think I was worth anything or that I could ever like myself, you know?—Kayla

I get real uptight about all the things that happen in my life and start to panic and stuff if I don't take [Valium].—Jayde

Five had attempted suicide by taking overdoses, all between the ages of 14 and 16, and six participants had engaged in self-harming behaviour in the past.

I tried overdosing myself and stuff. I don't know, I was just so low. It was a low point.... I didn't want to face the pain anymore.—Jessica

No one wanted me, no one cared. I had to try to kill myself, it was literally the only way out, you know.—Kayla

I also hated my body, and it [cutting] was kind of like punishing myself, 'cos for such a long time I felt like it was my fault. If I had been different, or done something different, it wouldn't have happened.—Sian

All the participants had developed the ability to dissociate in order to protect themselves from the full range of potential emotional impacts of sex work or prior abuse. Dissociation occurred on a spectrum ranging from active cognitive avoidance to unintentional splitting of mind and body. This was variously described by participants as dissociation, a shutting down of the body, an ability to block out the work, and the separation of self from reality.

I didn't feel my body anyway...I learnt when I was real little not to feel what was happening, so I just shut off from it.—Jayde

A lot of the time I do, I do dissociate you know, like switch off in my mind, and a lot of them like if they're on top they're just looking at me like are you okay? And I'm just like...I think they can tell. And it just gets worse and worse over time, because the more I hate it, the more I dissociate.—Ruby

I could just go blank...but it still felt like rape, after, and stuff.—Sian

While participants accessed many social services, whether voluntarily or otherwise, overall there was a sense of dissatisfaction with the services provided. Participants who had had negative experiences with either social services or the police previously were more hesitant to access any services, regardless of level of distress or symptom severity.

I had contact with tons of social workers and case workers, but all of them just didn't ask the right questions. I thought it wasn't safe. You know, like when you just sense it—so I shut it down, right there, every time.—Jayde

The types of services accessed could be broadly categorised into four groups: addiction services; youth mental health, statutory child protection, or youth justice services; community social services; and individual counsellors. Mental health services and statutory services were considered most unsatisfactory; participants considered practitioners employed by helping agencies to be lacking in genuine empathy, and felt that they regarded the participants as nuisances.

The person just treated me like a nuisance, like oh you're the third one I've had today...like oh great, another person I have to see. I felt like I was worth nothing, eh. They weren't interested in me at all so I sure as hell wasn't gonna tell them anything.—Sian

Those who had accessed Child and Adolescent Mental Health Services (CAMHS) had felt further demoralised by their interactions with the service. Two participants

described their frustration when, while speaking to a clinician after an overdose that they linked to their histories of sexual abuse or violence, the clinician refused to hear their disclosure.

The psychologist guy who insisted on talking to me before I went home didn't listen at all. He like asked some questions and you could tell he didn't want you to say anything bad, I tried to tell him anyway though, about Dad, what I told you. And he just said oh you can't tell me that, that's not my job. Just um tell me whether you're suicidal, basically. So I just um felt even more ashamed, it must just, like just be something about me.—Jayde

I sort of tried to say it, what had happened to me to make me not wanna be here, and she just was like nah. You should stop talking about it. We're not here to talk about that. I was like well what the f\*\*\* are we here to talk about then. Uh, obviously I'm not like important enough to listen to bro.—Kayla

The quality of the services and the length of engagement with the participants were considered to be dependent on the skills, genuineness, and approachability of individual practitioners. This also dictated participants' level of disclosure, as several described "testing the water" to judge probable reactions to shocking content. Positive initial experiences with these practitioners were associated with longer-term engagement and more sustained change. Finally, there was a distinct difference between the ways in which statutory or community agencies were perceived and how individual counsellors were perceived, as the latter were considered more trustworthy.

These counsellors (accessed through sexual violence or school counselling services) were regarded as significantly more empathic and were correspondingly perceived as more trustworthy, in turn engendering higher rates of self-disclosure. Participants described their intense scrutiny of these counsellors to gauge their trustworthiness, observing characteristics such as eye contact, time-checking, willingness to hear their feelings, and signs of genuine warmth such as leaning toward the client, interpreting this as indicative of their safety as a potential source of support. However, even with self-initiated counselling appointments, participants scanned the counsellors for signs of potential judgement and their ability to handle traumatic disclosures, and their reactions dictated the subsequent levels of honesty on the part of the young clients within sessions.

Maybe if they were all like her, like listened and wanted to help, maybe there would have been a way, like, to tell them all of it...and feel like, I don't

know...like maybe what I wanted would be heard and they could find a place for me to live with people that did care.—Sian

## **Discussion**

As identified in the results, participants' experiences of engaging with helping services almost universally featured unsatisfactory responses from practitioners, which discouraged further help-seeking. This is in accordance with prior studies, which consistently document the unremitting gap between the provision of services, particularly for mental health, addiction, or trauma counselling, and the high-need groups requiring them (Abdel-Salam & Gunter, 2014; Christie & Merry, 2010; French, Reardon, & Smith, 2003; Walsh, Shier, & Graham, 2010; Watsford, Rickwood, & Vanags, 2012).

Participants evaluated practitioners' responsiveness both consciously and intuitively. Signals that practitioners were unable or unwilling to hear disclosures about sensitive topics and respond without judgement or horror resulted in the young people ceasing contact with the service. Conversely, after "testing" practitioners' capacity to respond to potentially shocking disclosures, their positive reactions such as supportive and empathetic responses engendered honesty in subsequent interactions. The participants' intensely attuned assessments of practitioners' non-verbal signals, together with frequent perceptions of judgement and rejection typical of all adolescents, serve as significant barriers for this age group (Collins & Steinberg, 2006; Jordan et al., 2013; Kaltman, Krupnick, Stockton, Hooper, & Green, 2005).

As with specific practitioner characteristics, the overall quality of therapeutic alliances was arguably vital to participants' levels of engagement. These may take more time to develop in cases where clients have previously established a distrust of services (Gulliver, Griffiths, & Christensen, 2010), as was the case with the participants in this study. This phenomenon reinforces previous findings that engagement with young clients is a dynamic process premised on quality therapeutic alliances that are formed over time (Appleby & Phillips, 2013; French et al., 2003), but also indicates that this particular group is prone to disengage after a failure to gain their confidence in the initial session.

Adolescents invariably have preconceived ideas about the nature of any alliance with helping services, which determines their initial willingness to engage (Glass, Arnkoff, & Shapiro, 2001; Karver et al., 2008; Rickwood, Deane, & Wilson, 2007). These expectations may be about how they will be perceived, what the helper's role

might entail, or the impact of the alliance (Watsford et al., 2012). Adolescents are likely to anticipate a directive process rather than a collaborative one, resulting in a reluctance to engage and surrender self-determination. These negative expectations are then associated with higher attrition rates (Watsford et al., 2012). Specific appraisals of services are then generalised, resulting in increased reluctance to seek help in the future (Gulliver et al., 2010; Karver et al., 2008).

Correspondingly, the participants in this study all exhibited a general distrust of state services, which appeared to be mutually reinforced by others within their immediate environments. Negative perceptions of initial services then textured their expectations of service providers, resulting in avoidance of services even in times of extreme need. It is therefore imperative that early help-seeking is experienced positively through the therapeutic or treatment processes, the alliance with a practitioner, and the promotion of personal commitment, as recommended by Watsford et al. (2012).

Experiences of shame, while appearing highly convergent to attachment considerations, appeared to be an additional mediator of the participants' willingness to engage in services. Shame occurs out of perceptions of the self as undesirable or defective, and a self-conscious concern that others will discover one's flaws (Matos & Pinto-Gouveia, 2014). Behaviourally, it manifests primarily through avoidant behaviour, motivated by the need to disappear in order to avoid the reactivation of shame emotions (Muris & Meesters, 2002). Participants all disclosed multiple shame memories, which were principally associated with unpredictable caregiving in childhood. Moreover, they described inescapable feelings of shame in adolescence that reinforced their desire to employ methods of escape and deterred them from accessing services, as they were reluctant for this shame to be witnessed.

However, while the anticipation of receiving shaming responses when practitioners discovered their involvement in underage sex work was considered a major obstacle to disclosure, the exposure of their emotionality was portrayed as comparatively more shameful. While the cause of this is unknown, this is a notable departure from the findings of previous studies (DeLong & Kahn, 2014; Lukman et al., 2011; Matos & Pinto-Gouveia, 2014; Muris & Meesters, 2002), and shows that careful management of emotional disclosure within the therapeutic alliance is paramount to prevent disengagement.

Finally, reactions from practitioners unrelated to participants' involvement in underage sex work also precipitated intense feelings of internalised shame, as perceived rejection was interpreted as indicative of intrinsic unworthiness. This is consistent with

Matos and Pinto-Gouveia's (2014) explanation that the reinforcement of shame through the responses of subjectively powerful others constitutes a significant barrier to relationship-building, in the form of self-concealment. This tendency towards self-concealment may manifest in clients' reluctance to disclose symptom severity, obstructing effective treatment (Farber & Hall, 2002). Moreover, the expectation of shaming responses, regardless of the rationale, is alone sufficient to prevent self-disclosure within the therapeutic alliance (Hook & Andrews, 2005; Macdonald & Morley, 2001). However, participants also indicated that acceptance, warmth, and unconditional and consistent positive regard enable trust and self-disclosure which, in turn, forms the foundation for successful alliances and treatment.

### **Conclusion**

This study has identified challenges inherent in achieving sustained engagement with this unique population group. However, the scope of the study was insufficient to fully ascertain the nature of the participants' histories of service engagement, as it was designed to capture their retrospective perceptions of services within the limitation of a single interview. In addition, the lack of longitudinal research with this population group makes it difficult to establish the nature of normative and non-normative adolescent development and its relevance to involvement in underage sex work and service engagement, highlighting this as a further research need.

The ability to manage distress and make goal-directed decisions is dependent on the development of a positive self-concept, highlighting this as an area for effective intervention. While childhood experiences described by participants typically fostered negative self-concept, new relational experiences can result in its reformulation, leaving scope for practitioners to positively modify adolescents' self-concept through affirming interactions. Relationship-building using key counselling skills is vital to establishing an environment in which adolescents such as those in this study could experience being seen, heard, and accepted with genuine and unconditional positive regard, enabling them to feel validated and affirmed. Such quality of relationship is foundational to creating a working alliance in which young clients can trust an adult to work with them in developing their own positive appraisal of their strengths and survival strategies, and at an appropriate pace, addressing their wider psychosocial and therapeutic needs to support their wellbeing.

## Note

1. A pseudonym was chosen by each participant at the beginning of their interview.

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