LOCUS OF CONTROL ON RESILIENCE, DEPRESSION AND STRESS: A STUDY OF FEMALE COMMERCIAL SEX WORKERS IN AIZAWL CITY

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LOCUS OF CONTROL ON RESILIENCE, DEPRESSION AND STRESS: A STUDY OF FEMALE COMMERCIAL SEX WORKERS IN AIZAWL CITY

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Submitted

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CERTIFICATE

This is to certify that the present research work titled, **"Locus of Control on Resilience, Depression and Stress: A study of Female Commercial Sex Workers in Aizawl city"** is the original research work carried out by Ms Lalhriatpuii under my supervision. The work done is being submitted for the Award of the degree of Doctor of Philosophy in Psychology of Mizoram University.

This is to further certify that the research conducted by Ms. Lalhriatpuii has not been submitted in support of an application to this or any other University or an Institute of Learning.

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DECLARATION

I, Ms. Lalhriatpuii, hereby declare that the subject matter of this thesis is the record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to do the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institute.

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Aizawl: August, 2023 (LALHRIATPUII)
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INTRODUCTION

Sex work refers to a wide range of activities involving the exchange of money (or its equivalent) for the provision of sexual services. Carol Leigh, define ‘Sex work’ in the year 1998 and since its inception, the term has been used to denote sex work around the world (Doezema, 2001). The person who receives payment for sexual services is known as a ‘Sex worker’ or ‘sex worker’, and the person who receives such services is known by many terms (Overs, 2002). According to UNAIDS (2005), sex work is defined as the practice or business of exchanging money or goods for sexual services among female, male and transgender adults. The most common population in the sex industry is Female Commercial Sex Workers (FCSW), who are often considered passive victims that are forced into sex work through poverty, trafficking, or power inequalities. It is also important to acknowledge that there are consenting adults who voluntarily choose sex work as a means of livelihood. Factors such as financial need, limited employment opportunities, or personal agency can influence an individual's decision to enter the sex industry (Overall, 1992; Ross et al., 2012).

Sex work is a gendered profession differentiated by the exchange of sexual services for monetary (or some other) rewards (Musto et al., 2020). It involves different kinds of intimate relationships and commercial arrangements somewhat different from emotional affairs and other economic or wage labour (Della-Giusta et al., 2009). Sex work is more common among women and girls, but it is not always limited by sex or gender. Men and boys (and transgender) also engage in sex work activities for certain benefits and are usually included in the general definition of sex workers (Musto et al., 2020).Women and girls who engage in sex work professions and earn all or part of their daily income as commercial sex workers in brothels and at street corners are the focus of this study.

Sex work encompasses a range of activities, including but not limited to escorting, pornography, street-based sex work, and online platforms for sexual services. It involves the exchange of sexual activity for goods or money between consenting adults. Individuals engage in sex work for diverse reasons and in various circumstances. Some may choose sex work as a means of income, personal empowerment, or to exercise agency over their bodies and sexuality. Others may enter sex work due to limited economic opportunities, coercion, or other factors that restrict

their choices. It's important to consider the complexity and individuality of each person's experience. At one end of the spectrum, some individuals are willing to choose sex work as a means of employment, exercise agency over their decisions, and have control over the sexual exchanges they engage in. These individuals may view sex work as a way to express their sexuality, earn a living, gain financial independence, or explore personal empowerment. In such cases, sex work can be seen as a consensual transaction between adults, where both parties involved have agreed upon the terms and conditions. On the other end of the spectrum, there are instances where individuals may be coerced, forced, or trafficked into engaging in sex work against their will. These situations involve a lack of choice, control, and agency over a sexual exchange (British Columbia Coalition of Experiential Communities, 2009; Desyllas, 2013; Sloan & Wahab, 2000).

The term “sex worker” is preferred to the term ‘prostitution’ which recognizes that sex work is work whereas prostitution has connotations of criminality and immorality. Many people who sell sexual services prefer the term “sex worker” and find “prostitute” demeaning and stigmatizing, which contributes to their exclusion from health, legal, and social services (www.opensocietyfoundations.org, 2023).

Evolutionary psychology is based on the premise that an array of behaviours and psychosocial indicators will vary in response to life expectancy cues in the environment. Individuals allocate different amounts of resources for somatic effort (resources allocated toward individual survival) and reproductive effort (resources allocated towards the production of new individuals) based on their environment (Jonason, Koenig & Tost, 2010; Gladden, Figueredo & Jacobs, 2008). This theory was originally to explain between-species differences and has also proven to be effective in predicting within-species differences as well, including humans (Rushton, 1985), that systematic differences within humans are referred to as individual differences or personality traits. Life-history theory and personality traits have been recognized for the importance of the prediction of sexual behaviour in the wider population (Patch & Figueredo, 2016). Several studies stated that personality traits have been related to sexual promiscuity, risky sexual behaviour, and general sexuality (Lodi-Smith, Shepard & Wagner, 2014). Narcissism is a feeling of superiority and entitlement,

Machiavellism is a manipulative and exploitative tendency, and Psychopathy is interpersonal hostility (Jonason & Lavertu, 2017; Valentova et al., 2019). The three traits entail a tendency towards emotional coldness, aggressiveness, and dishonesty (Paulhus & Williams, 2002; Jonason, Koeing & Tost, 2010; Jonason et al., 2012). Psychopathy reflects a fast life history strategy (Jonason, Koeing & Tost, 2010)

Female Commercial Sex Workers

Female Commercial Sex Workers (FCSW) can have diverse backgrounds and experiences. While some individuals may choose to engage in sex work as a means of income or personal choice, others may be forced into it through human trafficking, sexual exploitation, or other forms of coercion and abuse (Orchard, 2007). The dichotomy between FCSW being seen as "passive victims" or "active agents" reflects differing perspectives on the motivations and agency of individuals involved in sex work. Some argue that many FCSW are victims of structural inequalities, including poverty, lack of education, or limited employment opportunities, which leave them with few options other than engaging in sex work (Overall, 1992; Ross et al., 2012). They may face coercion, exploitation, or trafficking, making it difficult for them to leave the profession (Overall, 1992; Ross et al., 2012). Because of the special nature of their work, FCSW are entangled in a complex social network composed of gatekeepers (e.g., bosses or managers of their workplaces), clients, nonpaid partners, law enforcement authorities, and health professionals.

Female Commercial Sex Workers come from a wide range of socio-economic contexts. In the case of students, the increasing cost of education, including the introduction of top-up tuition fees, has indeed been cited as a factor that may push some individuals toward sex work as a means of financial support. When faced with rising education expenses and limited options for part-time work, some students may assume sex work as a way to earn the necessary funds to cover their costs (Roberts et al., 2010). While some individuals may turn to sex work due to economic hardships, it is not accurate to generalize that all sex workers come due to economic hardships or from disadvantaged backgrounds. Some individuals choose sex work as a means to support themselves through education, particularly in contexts where other job

opportunities may be limited or pay insufficiently to cover educational expenses (Scambler, 2007). People from various socioeconomic backgrounds, including those with higher education or professional aspirations, may engage in sex work for a variety of reasons. 'Sex worker' is the preferred term used throughout the literature on the subject which is more commonly used with the term 'prostitute' (May, Harocopos & Hough, 2000).

The exact number of sex workers is unknown as sex work is mostly hidden and transient with moving in and out of sex work constantly (Cusick et al., 2009). Female Commercial Sex Workers (FCSW) are stigmatized and marginalized around the world. They are generally not accepted in society and are regarded as criminals, immoral troublemakers, sexual deviants and vectors or reservoirs of disease (Erving, 1963; Durisin et al., 2018). The criminalization or stigmatization of sex work can create barriers to accessing healthcare and harm reduction resources, which can further exacerbate the risks of Sexually Transmitted Infections (STIs). In settings where sex work is illegal, FCSW may be less likely to seek regular medical care, including testing and treatment for STIs, due to fear of legal repercussions or societal judgment. According to the Center for Disease Control and Prevention, rates of sexually transmitted diseases such as syphilis, gonorrhoea, and Human Immunodeficiency Viruses (HIV) have increased in the past 10 years, with high-risk sexual behaviour as a major cause of transmission (Center for Disease Control and Prevention, 2009).

Several factors contribute to the cyclical nature of sex work involvement for some individuals. These factors can include social and economic circumstances, lack of alternative employment options, limited access to education or job training, addiction issues, mental health challenges, and systemic factors such as poverty and inequality. For some people, entering sex work may be a result of desperate circumstances, including financial hardship or coercion. Leaving sex work can be challenging due to various factors such as limited job prospects, social stigma and the difficulties of breaking free from exploitative situations or networks. Additionally, re-entry into sex work can occur for a range of reasons. These might include financial instability, the allure of quick money, lack of support networks, personal circumstances, or the perceived inability to find alternative employment that offers

comparable financial benefits (Dalla, 2006a; Mayhew & Mossman, 2007; Williamson & Folaron, 2003).

Female Commercial Sex Workers performing sexual acts for money include prostitutes, call girls, escorts, and dominatrices. Prostitutes are also commonly known as streetwalkers and are considered to be the lowest rung of sex workers by the other members of the industry. Because of the work on the street, the lack of screening of customers, and the variability of the location of the sexual act, streetwalking prostitutes face the most danger this group (Ngo et al., 2007).

There have been several trade shows or expositions (Expo-Sex) that attract porn starts, sex-toy companies, the media and thousands of fans, but despite the efforts to normalize the overall sex industry, commercial sex continues to be viewed by many as deviant and harmful for society (Weitzer, 2011). Most sex workers in the United States in New York City found that 48% were female, 45% were male and 8% were transgender (Curtis et al., 2008). Prostitution and sex work are terms that refer to an income-generating activity and are used interchangeably throughout the culture (Ditmore, 2010).

Female Non Sex Worker

The term "Female Non Sex Worker (FNSW)" in the present study is used to refer to the general female population who are not engaged in sex work or the commercial exchange of sexual services for money or goods. This term is used to differentiate women who are not involved in such paid sexual activities from those who may be engaged in sex work as a means of income or employment. FNSW samples represented the general female population from Aizawl city, the capital of Mizoram who were working in offices for 1 to 4 years. These samples were selected by following random sampling procedures to match the demographic profiles of the FCSW samples for the study by employing Socio-demographic profile.

History of sex work

Sex work indeed has a long history that can be traced back thousands of years, but it is not driven by physical pleasure alone, but rather by economic and psychological distress, which is a primary reason why people enter the profession. The

reasons for engaging in sex work are diverse and multifaceted, varying from person to person. Some individuals may choose sex work willingly and find empowerment or satisfaction in their work, others may be forced or coerced into the profession due to circumstances such as human trafficking, exploitation or limited alternatives. The experiences and motivations of individuals involved in sex work can vary significantly, and it is essential to consider the diverse range of perspectives and circumstances within this complex issue. Additionally, some individuals may enter the industry due to coercion, trafficking, or other forms of exploitation, which further emphasizes the importance of addressing the complex social, economic, and legal factors that contribute to these situations. The sex industry, encompassing various forms of commercialized sexual activities, does indeed exist in many countries around the world, and its history is traced back 4000 years to ancient Babylon (Pratik Goyal, 2011).

Sex work includes various forms of work such as prostitution, pornography and escort services which have existed for centuries and are indeed considered a long-standing profession. However, it is also important to acknowledge that sex work can be associated with various challenges, including dangers and stresses. Sex workers often face social stigma, discrimination and marginalization, which can have adverse effects on their mental and emotional well-being. The nature of the work itself, which can involve managing boundaries, dealing with client's expectations, and navigating potentially risky situations, can also contribute to stress and emotional strain (Rekart, 2005; Ross, Crisp, Mansson, & Hawkes, 2012).

It was found that no written document was available on the existence of sex workers or prostitution during the Indus Valley Civilization which could be around 3000 B.C. except the bronze dancing girl statue found in Mohenjo-Daro (Sarode, 2015). The Indus Valley culture was famous for its glamorous economic development and wealthy merchants who spent lavishly on women and wine (Mukherji & Deepa, 1966).

From the time of the Vedas, there were references to beautiful females who entertained divinities and their guests in the court of the Hindu God, Indra- they were described as celestial beauties of music and dance and a perfect manifestation of beauty and feminine charms. After the fall of the Mughal Empire, those dancing and singing women left the royal palaces, in the absence of alternative means of support and limited education or training for other professions, some women from these backgrounds may have turned to sex work as a means of survival (Biswanath, 1984).

The British regime in India did not prioritize extensive efforts to improve the position of women in India, the situation of women in India was shaped by a combination of factors, including cultural, social, and economic dynamics that predated British rule. In the absence of state-controlled regulations, sex workers thrived on a large scale. Social disabilities and economic hardships made women easy prey for gangsters in this profession (Biswanath, 1984). In India, temple women generally come from lower castes; non-Brahmins and other higher-caste women were rare. These women were called Devadasis and Mukhieses respectively (Biswanath, 1984). The only women at that time were those who received the highest social and political prestige and were adorned by the rulers, but gradually, because of the poor morals of the priests, these women became prostitutes by entertaining pilgrims.

Type of Sex works

Sex work is a wide range of activities relating to sexual service in exchange for money. According to Harcourt and Donovan (2005), there are various types of sexual services practised by sex workers throughout the world. To classify the types of sexual services provided, they categorized them into two categories: direct and indirect sex work.

Direct sex work is indoor and outdoor prostitution as well as escort services typically involve the exchange of sex for a fee. Working in a brothel is the most common and well-known example of involvement in direct sex work. Direct prostitution (street prostitution, escort services, and brothels) has been described as a form of sex work that involves an explicit exchange of material goods, favours, and/or services in return for sexual intimacy or erotic acts with no required commitment

(Harcourt & Donovan, 2005). The type of sex work in this profession usually involves the exchange of sexual services for a fee, with genital contact being the norm.

Indirect sex work refers to sex-related services that do not involve direct sexual intercourse but still involve the exchange of a fee for the service. Indirect sex work includes activities such as lap dancing, stripping, and virtual sex services, which can be provided over the Internet or phone, and fall under the umbrella of indirect sex work. Genital contact is less common in indirect sex work; however, a fee is still exchanged for the service.

On-street sex worker: Economic factors such as a lack of viable employment opportunities and overwhelming debt, can contribute to individuals, particularly women, entering on-street sex work. These circumstances can leave individuals feeling compelled to engage in sex work as a means of survival and income generation. Research conducted by organizations like the UK Network of Sex Work Projects (UK NSWP) in 2008 has highlighted the connection between economic vulnerability and entry into on-street sex work. Financial hardships, limited job prospects, and the need to support oneself, and potential dependents can draw a person towards this form of work. Moreover, factors such as drug addiction, homelessness, mental health issues, and family breakdown can also contribute to individuals entering street sex work (Jeal &Salisbury, 2004). Substance abuse can sometimes be linked to coping mechanisms or as a response to the difficult circumstances individuals' face, while homelessness and family breakdowns can leave individuals without stable support systems or housing.

It should be also remembered that street-based sex work is liable to evolve into a cyclical phenomenon. The difficulties and dangers associated with the work itself, such as the risk of violent attacks from clients or harassment from both clients and law enforcement, can further exacerbate the challenges that an individual sex worker can face. Thus, it can be clearly understood that the marginalized and stigmatized nature of the profession often leaves sex workers vulnerable to exploitation and abuse (Sanders, McDonagh & Neville, 2012).

Various studies have proved that there is a strong connection between sex work, homelessness, and drug addiction, particularly concerning on-street sex work. According to Jeal and Salisbury's (2004) study of 72 on-street sex workers in Bristol, two-thirds of the women claimed they were homeless or under threat of becoming homeless; and that they were staying in temporary accommodations including hostels, bed and breakfasts or crack houses. A report by Davis (2004), which looks at homeless women, stated that specialist agencies regularly contact high numbers of homeless women who engage in sexual activities on the streets (between 200-300). Due to their work and the lack of screening of clients, sex workers face the greatest danger among this group due to the diversity of where they perform their sexual acts, as well as the fact that they are most likely to be excluded from hostels and other temporary accommodations (Ngo et al., 2007).

Off-street sex worker: The belief that offering sex in brothels, flats, saunas, and escort services is generally considered more secure and less vulnerable than doing so on the street is based on several factors (Home Office, 2004; Jeal & Salisbury, 2004). Brothels, in some contexts, can function as businesses with certain rules and regulations in place. These rules can include guidelines against drug use or alcohol consumption on the premises, as well as various other policies that aim to maintain a safe and healthy environment for both the sex workers and their clients. Some brothels may also operate within the legal framework and be subject to taxation. However, sex workers in brothels can still face various risks and challenges. While brothels may provide a level of security and reduce certain risks compared to street-based sex work, they do not eliminate all the potential hazards associated with the industry. Sex workers in brothels may still face health risks, such as the spread of sexually transmitted infections if proper precautions and safe practices are not followed. They may also be vulnerable to violence or harassment from clients or even within the brothel itself, despite the presence of rules and regulations. Additionally, the legal status and regulation of brothels can vary significantly across different jurisdictions, which can impact the overall safety and well-being of sex workers (Sanders, 2007b).

A study performed by Jeal and Salisbury (2007) compared the health needs of on-street and off-street sex workers, they found that off-street sex workers report fewer chronic health issues (often caused by drug use) and are less likely to inject drugs and share injecting equipment, thus spending less of their income on drugs. In general, off-street sex workers appeared to demonstrate a healthier lifestyle and a lower rate of drug use than on-street sex workers. However, they remain more vulnerable to poor physical and mental health compared to the general population.

Due to their fear of stigmatization, off-street sex workers prefer to keep their occupation hidden from service providers, which prevents them from receiving the necessary assistance (Jeal & Salisbury 2007). Further, fear of judgment and discriminatory attitudes from health professionals and other service providers can lead to reluctance to disclose drug use and other risky behaviour (as well as sex work) and prevent access to necessary services.

Causes of Sex Work

Many factors and reasons may be involved in motivating women to become prostitutes. Men and women may take sex work initiatives in different ways; voluntarily and involuntarily (UNESCO, 2002). The voluntary category includes women who start as sex workers because of poverty, hunger, economic crisis, family pressure, illness, etc., and the involuntary category includes women forced into the sex industry, such as through trafficking, kidnapping, or coercion. Women in India who engage in sex work mostly involuntarily, but some of them join voluntarily (Nag, 2006).

According to the literature, there is an accumulation of "push" and "pull" factors that cause women to become prostitutes (Mayhew & Mossman, 2007). Poor economic circumstances are a common push factor that leads some women to engage in street-level sex work (Farley & Kelly, 2000; Sanders, 2007; Williamson & Folaron, 2003). Children who have experienced physical or sexual abuse as children, neglect or drug abuse are additional push factors (Farley et al., 2003; McClanahan et al., 1999; Nadon et al., 1998; Norton-Hawk, 2001; Silbert & Pines, 1982; Ward & Roe-Sepowitz, 2009; Weitzer, 2009; Williamson & Folaron, 2003; Brawn & Roe-

Sepowitz, 2008; Edlund & Korn, 2002; Young, Boyd, & Hubbell, 2000). People are attracted to dangerous lifestyles for a variety of reasons, such as glamorizing the lifestyle, feeling energized or empowered, or being encouraged by others and the desire for economic independence (Williamson & Folaron, 2003; Dalla, 2006a; Mayhew & Mossman, 2007; Kennedy et al., 2007; Edlund & Korn, 2002; Weitzer, 2009).

Several studies have examined the effects of family breakdown on institutionalised care services, vulnerability, and chronic exclusion as relates to sex work and broader social exclusion (Berelowitz et al., 2012). Jeal and Salisbury (2004) studied on-street sex workers in Bristol and found that a third of the women they interviewed had been 'looked-after' children or young people as a result of family breakdown. Nearly two-thirds of women reported experiencing physical, sexual or emotional abuse during childhood, and a third had left school by 14 years of age, with those in care leaving even earlier. Leaving hospitals or mental healthcare systems can also contribute to social exclusion, especially if individuals do not have access to appropriate follow-up care, medication, or community-based support. Without the necessary support systems in place, individuals may struggle to reintegrate into society and may face challenges in maintaining stable employment, housing, and social relationships. Studies have shown that these transitions out of institutional care can intersect with vulnerabilities and chronic exclusion, including engagement in sex work. Individuals who lack support systems may turn to sex work as a means of survival or face increased vulnerability to exploitation and abuse (Tonybee & Hall, 2007; Fitzpatrick, Bramley & Johnsen, 2012).

Substance abuse, such as drug and alcohol addiction, can lead individuals to engage in sex work as a means to support their addiction and obtain funds for drugs. Furthermore, the nature of sex work itself can expose individuals to environments where drug use is prevalent. Some sex workers may use drugs as a coping mechanism to numb the emotional or physical pain associated with their work. Substance abuse can further exacerbate the challenges faced by sex workers and hinder their ability to break free from the cycle of street-based sex work. A lack of stable housing options can leave individuals with limited choices for survival and income generation. Sex

work may become a viable option for individuals who are homeless and lack alternative means of financial support. Homelessness poses additional challenges for sex workers, such as increased exposure to violence, exploitation, and health risks. Jeal and Salisbury (2004) reported that a high proportion of those who claimed to be homeless lived in insecure/temporary housing (two-thirds) and that nearly everyone admitted to drug dependence among on-street sex workers in Bristol. This type of sex work is often described as 'survival sex', where people engage in sex work as a last resort, to provide shelter, food, or fund severe addictions in a 'work-score-use' cycle (McNaughton & Sanders, 2007; Sanders, 2007b). Additionally, research exploring problematic alcohol use amongst FCSW across England and Wales found that drinking alcohol before entering into sex work was used as a strategy to cope with childhood and adolescent experiences of loneliness and abuse (Brown, 2013).

Often people who engage in sex work are excluded from social groups, even chronically excluded, and begin to engage in sex work as a result of experiencing many of the factors leading to exclusion. Social exclusion is defined as a series of linked and/or mutually reinforcing processes, including low income, poverty, debt, unemployment, poor education, health problems, housing problems, crime, lack of social support and other adverse life events (Bradshaw et al., 2004). Individuals with experiences of these can become vulnerable and be excluded from enjoying employment opportunities, health care, secure housing and living at a decent standard of living (Popay, Povall & Mathieson, 2012). In addition to affecting individuals, social exclusion also affects groups of people including migrants, disabled people, homeless people, and people with mental illnesses; often due to poverty, discrimination, and insufficient public services.

Women become involved in sex work because of their responsibilities at home, the economic crisis and insufficient household resources (Wawer et al., 1996). In India, economic factors cause women to engage in sexual work (Blanchard et al., 2005). Economic reasons may drive women to sex work and certain classes, castes, and social groups tend to support them (Somaiya et al., 1990). Most women who work in the sex industry are illiterate, below-caste, from poor economic backgrounds and have no education (Ramesh et al., 2008).

It is common for women to be tricked into sex work by promising adequate job opportunities in the town or abroad, or they have been kidnapped and forced to do sex work. The desire to satisfy family expectations and problems are common factors that lead to them to sex work. It is not uncommon for women in a particular geographical region to be pressured to pay for their siblings' education or take care of sick family members. Other aspects include constraints such as parental abuse leading adolescence to leave their homes and seek sex work as a means of survival. In situations in which women appear powerless and incapable of setting the boundaries of sexual activity, they will attract men who may wish to legitimize someone's act of sexual abuse with payment for sex work (Parker, 1998).

Likely, women who appear powerless and incapable of setting boundaries for sexual activity will attract men who wish to legitimize the act of sexual abuse by paying cash. There is indeed a relationship between the low economic status of prostitution customers and their involvement in prostitution. Several factors lead women to enter sex work including unemployment, poor education, scarce employment opportunities, peer pressure, orphanages, sex desires, and easy employment models (Bindel, 2018). The most common factors of sex works may be summarized as follow:

(1) Money, Debt and Low level of welfare benefits: Financial difficulty is among the most drivers which often push people into sex work (Brents & Sanders, 2010). Workers in the indoor parlour industry are getting financial rewards for some involved in sex work (Moffat & Peters, 2004). A well-paid job is not available and welfare benefits may be too low to meet the cost of living with increasing debt among marginalized women financial difficulty drives them to engage in sex work as no other choice is available (Brents & Sanders, 2010).

(2) Housing and Addiction: Homelessness and drug addiction are among the most significant factors which prompt engagement in on-street sex work and two of the main barriers to stabilizing the lives of sex workers (Spice, 2007; Davis, 2004), most of them are either homeless or living in insecure/temporary accommodation (Jeal & Salisbury,

2004) and drug-addicted; and named it as ‘survival sex’ (McNaughton & Sanders, 2007; Sanders, 2007b).

***(3) Violence and Power*:** The influence of violence and power is one of the important driving forces of sex work involvement e.g sex trafficking is an extreme form of violence (Cusick & Berney, 2005) that socio-economic, financial, power and dependency factors which drive into sex work (Jackson, Jeffery & Adamson, 2010).

***(4) Family Problem**:* The family breakdown has links to institutionalized care services, vulnerability and chronic exclusion related to sex work and wider social exclusion (Berelowitz et al., 2012) as one-third among on-street sex workers women had been a ‘looked-after’ child and/or young person as a result of family breakdown (Jeal & Salisbury, 2004), two-thirds of women had experienced physical, sexual or emotional abuse during childhood, and third had left school by in care left earlier as leaving care, prison, hospital, education and mental healthcare systems lead to social exclusion (Hall, 2007; Fitzpatrick, Bramley & Johnsen, 2012) and coerced into sex work due to their vulnerable situations (Stein et al., 2009). Those who are ‘Cut off care’ may experience a lack of money, housing, employment, social capital and appropriate networks of support which lead to engagement in sex work as a survival technique as a way out (McNaughton & Sanders, 2007).

(5) Mental health: The comprehensive study of the mental health of sex workers documented the traumatic experiences of physical or sexual abuse in earlier life that experience negative implications for mental health in their life course as 72% of sex workers experienced physical, sexual and verbal violence accompanied by feelings of worthlessness (Bindel et al., 2012) and mental health problems such as chronic social exclusion, social relationships and difficulty in dealing with day-to-day life (Fitzpatrick, Bramley & Johnsen,2012).

(6) Low education: Poor educational quality and lack of training impact driving into sex work and reducing the chances of finding another form of employment (Jeal & Salisbury, 2004) as one-third of sex workers had left education at the age of 14 years or younger, 39 % had no training or formal qualifications (Bindel et al., 2012) that

affect the ability to earn; and most of the sex workers come from low social backgrounds (Sanders, 2007a).

(7) Discrimination: Many forms of discrimination like racism, stigmatization and prejudice exacerbate feelings of isolation, loneliness, social exclusion, and social isolation and obstruct access to services and employment which may drive to use other means of survival to sex work (UK NSWP, 2008a).

(8) Health problem: Sex work leads to different levels of adverse health problems (Harcourt &Donovan, 2005). Lack of necessary healthcare detriment participation in societal 'norms and services' results in adverse consequences of poor health (Jeal & Salisbury, 2004). The nature of the work is highly vulnerable to sexually transmitted diseases (Jeal, Salisbury &Turner, 2008).

(9) ***Violence***: Different kinds of abuse such as physical, sexual and verbal violence are common in a sex work setting, and physical violence is the most threat faced by sex workers (Spice, 2007)as all women had experienced some form of violence (Harding, 2005), two-thirds experienced violence (Bindel et al., 2012) including harassment by police (Sanders, McDonagh & Neville,2012). The consequences of physical violence experienced by sex workers often result in poor physical health as well as poor mental health (Rossler et al., 2010) and most extreme cases death.

(10) Addiction: Drug addiction amongst sex workers is characterized by a 'work-score-use' cycle (Jeal, Salisbury & Turner, 2008) almost all on-street sex workers have a history of alcohol and/or drug use (Jeal & Salisbury, 2004) to help mask some of the negative feelings of sex work including distress, anxiety (Brown, 2013).

(11) Mental health: Female on-street and off-street sex workers had a high rate of anxiety, stress and post-traumatic stress disorder due to the high levels of violence experienced (Rossler et al., 2010).

(12) Criminalisation and stigma: Over a decade, government legislation tackled prostitution by criminalizing sex work (Home Office, 2004) but was criticized for failing to address a larger and wide range of issues like the health and poverty of sex workers overlooking the reasons for sex working such as poverty, unemployment,

inequality, debt and vulnerability (Cusick & Berney, 2005). They have received stigmatisation in all aspects of their life: from clients, the general public, healthcare and other service providers, and police (Sanders, 2007b) increased stress and adverse effects on mental health (Cusick & Berney, 2005; UK NSWP, 2009).

(13) Personality: Prostitutes appeared to be more psychotic, neurotic, and extraverted, as well as more socially nonconformist, personally disturbed, and alienated. Prostitutes belonged to families of slightly lower socioeconomic levels (Singh & Singh, 1982).

Common problem of sex workers

Many factors contribute to the potential for trauma and mental health issues among people in the sex industry. Some individuals may enter the industry due to financial hardships, limited job opportunities, or other personal circumstances. Others may have experienced prior traumas, such as childhood abuse, neglect, or other forms of violence, which can make them more vulnerable to further trauma. During their time in the sex industry, individuals may encounter various forms of violence, exploitation, or coercion, which can have profound effects on their mental well-being. Stigma, social isolation, and lack of support can further exacerbate the challenges they face. Depression, anxiety, and posttraumatic stress disorder (PTSD) are common mental health concerns among individuals in the sex industry. These conditions may arise from their experiences of trauma, the emotional toll of the work, or the societal stigma and discrimination they encounter. However, it's important to emphasize that mental health issues can affect anyone, and not all individuals in the sex industry will develop these specific conditions (Shoham et al., 1983). The DSM-IV-TR (APA, 2000) lists insomnia or hypersomnia, feelings of worthlessness or excessive inappropriate guilt, diminished ability to think or concentrate, and recurrent thoughts of death and suicide ideation as symptoms of depression. The symptoms of female commercial sex workers can pose a significant threat to their welfare since they are often forced to make critical decisions for their safety during their work shifts (Shoham et al., 1983).

Female Commercial Sex Workers often face social stigmas and discrimination, which can have significant negative consequences, including an increased risk of violence. The stigmatization of sex work is a complex issue that intersects with various

factors such as gender, class, and societal attitudes towards sexuality. The stigmatization of sex work often stems from deep-rooted societal norms, moral judgments, and cultural biases surrounding sexuality and the commodification of sex. Sex workers are frequently "othered," marginalized, and stripped of community citizenship, leading to their exclusion from social support systems and legal protections. This exclusion can further perpetuate a cycle of vulnerability, making it challenging for sex workers to seek help, report violence, or access essential services (Sayers, 2013; Vanwesenbeeck, 2001, Campbell, 2015, Scambler, 2007).

The stigmatization and criminalization of sex work contribute to a climate where violence against sex workers can occur with impunity. The marginalized and criminalized status of sex workers can make them targets for abuse, exploitation and violence from clients, pimps, or even law enforcement officials. Moreover, the stigma associated with sex work can also discourage sex workers from seeking legal recourse, fearing the potential negative consequences such as arrest, harassment or further discrimination (Lewis et al., 2013; Sanders & Campbell, 2007; Seshia, 2010; Vanwesenbeeck, 2001).

People who work in the sex industry face a great deal of health and safety risks. There may be others suffering from physical and/or mental health problems that have not been diagnosed or reported, as according to Bindel and colleagues (2012) 79 per cent of the women complained of physical or mental health problems. Sexual workers represent a high-risk group of people who frequently contract communicable diseases such as TB, HIV and other blood-borne diseases, such as STIs (Collinson, Straub & Perry, 2011). The study of the mental health of sex workers in Switzerland revealed many of them suffered from mental health problems such as depression, anxiety and Post-Traumatic Stress Disorder (PTSD) that can also negatively impact their physical health (Rossler et al., 2010).

Stigmatization is negatively correlated with quality-of-life measures, such as social isolation, employment and income. Additionally, stigma is related to physical and mental health problems as well as poor use of health (Benoit et al., 2013; Link & Phelan, 2001; Green et al., 2005; Link & Phelan, 2001; Pescosolido et al., 2008).

Every sex worker faces a dilemma of disclosure, which is widely discussed among sex workers in several different settings and with a variety of characteristics. The decision to disclose or conceal their work is a personal one that can vary depending on individual circumstances, societal attitudes and legal considerations. There are indeed discussions among sex workers about the challenges and implications of disclosure (Abel & Fitzgerald, 2010; Basnyat, 2015; Closson et al., 2015; Forsyth & Deshotels, 1998; Ganju & Saggurti, 2017; King et al., 2013; Koken, 2012; Koken et al., 2004; Kong, 2006; Murphy, Dunk-West, & Chonody, 2015; Sanders, 2005; Wong et al., 2011). Concealing one's profession as a sex worker can be challenging and requires the creation of cover stories to hide their work activities from various people in their lives. This may include partners, family members, friends, and community members. Many societies hold negative perceptions and stereotypes about sex work, which can lead to discrimination, marginalization, and potential harm to individuals engaged in this profession. By concealing their occupation, sex workers aim to avoid the associated stigma and the potential negative consequences it may bring (Dodsworth, 2014; Murphy et al., 2015; Closson et al., 2015; Ganju & Saggurti, 2017; Kong, 2006; Ngo et al., 2007; Roche & Keith, 2014; Zalwango et al., 2010).

Despite financial constraints driving the women to the street, it has been found that the women make less than $1000 per month and that they receive little to no support from family and friends (Cohan et al., 2005; Dalla, 2002). As with all types of sex workers, street-based sex workers are subjected to the highest levels of violence, abuse and stigma (Sanders & Campbell, 2007; Weitzer 2009). Street-based sex workers are also likely to use drugs and experience violence, which leads to an increase in premature mortality (Potterat et al., 2004; Burnette et al., 2008; Nuttbrock, Rosenblum, Magura, Villano, & Wallace, 2004). The burden of the lifestyle has most often been identified as the cause of mental health issues like depression, anxiety and posttraumatic stress disorder (Perdue et al., 2012; Sartor et al., 2012; Rossler et al., 2010). Still, women on the street-based sex work are more unlikely to report or be screened for acute and chronic physical and mental health difficulties.

Research shows that sex hurts women's health and social life. Despite all these complications, women still engage in sexual activities. In the past, sex work has been considered a threat to health and the economy, as well as to social structures and women's rights (Visser, Randers-Pehrson, & Day, 2004). Socially excluded sex workers have often been considered weak to negotiate health and welfare benefits (Hernandez et al., 2006; Ramaiah, 2006). Women working in brothels as sex workers are likely at high risk of contracting HIV (Paudel & Carryer, 2000). For women sex workers, money is more important to sex work than AIDS, so they may not be concerned about the threat of acquiring it (Hosain & Chatterjee, 2005). Often, sex work results in unintended pregnancy, drug addiction, conflict, HIV and AIDS that lead to death (UNESCO, 2003).

Sex work is associated with psychological, sexual and emotional issues that have been extensively studied and documented. As a result, even when there aren't overt physical and emotional abuses, women often report and receive treatment for these conditions. There are problems associated with drug abuse, poor nutrition, and lack of housing, and others stem from their involvement with prostitution, either directly or indirectly (Zimmerman et al., 2006).

Female Commercial Sex Workers repeatedly report psychological damage, emotional distress and destruction of normal relationships. This suggests that causing harm is an important part of the experience of commercialized sexual activity (Farley, 2004; Hoigard & Finstad, 1992). Typically, women use a variety of coping mechanisms to deal with the pains and trauma associated with intimate sexual relations, including disassociation along with the regular use of drugs and alcohol to distance themselves from the effects of impersonal relationships. In the end, women's sense of self and identity are often harmed. They may feel hollow, lack self-esteem, or suffer from depression, anxiety, and other mental illness conditions. Study after study indicates that sex workers also perpetuate (intentionally or unintentionally) the very stigmatizing notions associated with the job that has been inflicted on them. This is evident in their attempt to differentiate themselves from workers with more discreditable characteristics (street sex workers, exploited or trafficked sex workers, substance users, ethnic minorities, etc.) (Biradavolu et al., 2009).

Additionally, Fitzpatrick, Bramley and Johnsen (2012) found mental health problems to be prevalent among people who experience chronic social exclusion in their study on pathways into multiple levels of exclusion and homelessness. A mental illness can lead to employment problems, interpersonal conflict and difficulties dealing with daily tasks, as well as physical problems that may lead to social exclusion (Social Exclusion Unit, 2004).

In addition, according to Bindel and colleagues (2012) study, many people expressed an inability to imagine a life outside of sex work, especially those who began selling sex before they turned 18 years. Combining an inability to contemplate a life outside of sex work with other destructive behaviours, such as substance abuse, poses a particular challenge to the possibility of stabilization. Similarly, poor physical and mental health would make maintaining more formal forms of employment quite difficult or in some cases impossible because of the severity of the problem.

McNaughton and Sanders (2007) believe that housing is an important issue. Housing can help people transition out of sex work, as housing can provide a feeling of safety and security. However, housing can also trap people in vulnerable situations. The Government and local authorities often fail to meet basic needs, such as housing, which has a serious impact on the lives of sex workers, particularly those operating on the street. In Bindel et al.'s (2018) study, 77 per cent said they had a problem with homelessness or housing. An accommodation that is warm, safe, and secure is a fundamental need for any human being. As a result of the lack of appropriate housing, addressing sex workers' more complex needs is very difficult. Some women who are homeless are forced to seek accommodation in places that increase their vulnerability, exclusion, and destructive behaviours, such as staying with abusive partners, partners with drug addictions, or sleeping in crack houses. Many of them confessed to selling sex to meet the demands of high rent and mortgage payments, while others noted that the accommodation given by local authorities was located in locations where sex and drugs are commonly sold.

The majority of Female Commercial Sex Workers are assaulted while working (Shoham, et al., 1983). Because commercial sex workers are potentially less inclined to report abuse, there is a greater risk of them not receiving care or counselling after the assault and, due to the dangers, returning to work may retraumatize them. The disorders, combined with a lack of resources (real or perceived), and frequent substance abuse deprive these men and women of the opportunities they need to receive psychiatric evaluations, counselling, or therapy (Dalla, 2001).

In addition, Female Commercial Sex Workers (FCSW) are subject to the stigma associated with sex work and are constantly in fear of being exposed as sex workers by their friends or families (Wong et al., 2011). Due to the personal reasons and life circumstances that lead women to enter sex work, some women may perceive the emotional risks as out of control, thereby contributing to health-compromising behaviours such as substance abuse and inconsistent condom use which increase their risk of contracting sexually transmitted infections (Sanders, 2004; Hong et al., 2007; Lau et al., 2010).

A majority of studies have shown that sex work negatively impacts mental health; however, only a few have documented positive results (Bucardo et al., 2004; Gorry et al., 2010). There have been relatively few studies on the development of positive self-image and empowerment utilizing a feminist approach (Choudhury, 2010; Kong, 2006). As with research conducted on vulnerable groups of women, including refugees living under stressful and isolating conditions, it is believed that despite their challenging working environment, female sex workers are capable of positive psychological adaptation to their work (Leipert & Reutter, 2005; Sossou et al., 2008). Additionally, posited that positive experiences and individual strengths are two central concepts in positive psychology (Seligman, 2002).

Literature suggests that personality traits influence how an individual solves adaptive problems (Jonason & Zeigler-Hill, 2018). Several scholars attribute prostitution to poverty, hunger, lack of education, migration to the city, lack of knowledge, drug addiction, divorce, and family conflict as well as the parents' deviation. Furthermore, mental health conditions such as depression, anxiety, post-

traumatic stress disorder (PTSD), and borderline personality disorder can contribute to vulnerability and increase the likelihood of someone entering the sex trade. These conditions may be present before engaging in sex work or may develop as a result of the experiences encountered in the industry, and the absence of a safe and stable living environment can make it difficult for sex workers to prioritize their well-being, access healthcare, or escape dangerous situations (Spice, 2007). Prostitutes appeared to be more psychotic, neurotic, and extraverted, as well as more socially nonconformist, personally disturbed, and alienated (Singh & Singh, 1982). Locus of control, Depression, Stress Resilience and satisfaction with Life are supposed to be related to sex work while very minimal research was available, this is where the present study tries to explore it.

Locus of Control

The concept 'locus of control' was developed by Julian Rotter in 1966. It originally referred to a stable belief of personal efficacy that was characteristic of an individual (Rotter, 1966). However, locus of control can also be an important coping resource for certain coping styles (Lazarus & Folkman, 1984; Newton & Keenan, 1990; Van den Brande et al., 2016). Locus of control is a personality construct that reflects one's belief or perception about who controls life and the environment (Lefcourt, 1976). A belief can exist on a variety of levels, reflecting how much control is perceived in life and over the environment (Connolly, 1980). Locus of control has been described as a dimension with two opposing differentiates (Lee-Kelley, 2006); they reflect how much individuals believe that their lives are within their control, and how much they feel they don't (Carrim et al., 2006).

Locus of control refers to an individual's belief about the extent to which they have control over events and outcomes in their life. Originally, locus of control was described as a stable personality characteristic that reflected a person's general belief about their ability to cope with life's challenges. Individuals with an internal locus of control believe that they have control over their actions and the outcomes they experience, while those with an external locus of control attribute events and outcomes to external factors such as luck or fate. However, over time, researchers have

recognized that locus of control can also be seen as a coping resource that individuals can draw upon in certain coping scenarios. In other words, an individual's locus of control can influence how they approach and deal with stressful situations (Rotter, 1966; Lazarus & Folkman, 1984; Newton & Keenan, 1990; Van den Brande et al., 2016).

Locus of control has also been described as a coping resource facilitating certain coping styles (Lazarus & Folkman, 1984; Newton & Keenan, 1990; Van den Brande et al., 2016). Illustrative of this, placing the cause of an outcome upon others (i.e., external locus of control) has been related to avoidance of coping/ resignation, greater stress and poor health (Evers et al., 2000; Gianakos, 2002; Gore et al., 2016). Internal locus of control, on the other hand, has been associated with help-seeking and positive thinking, as well as lower levels of work stress in general (Gianakos, 2002; Gray-Stanley & Muramatsu, 2011; Gore et al., 2016).

There is a general understanding that life events occur for two basic reasons: (Friedman, & Schustack, 2009). A person's perception influences how they balance what they believe should happen with what does. Work-life balance may also be affected by adults developing boundaries between work and home. However, if boundaries cannot be set, or if an unexpected event happens, the conflict between the roles may increase, and as a result, stress may occur (Bulger et al., 2007).

In a sense, locus of control is the belief that an individual's successes, failures and outcomes are determined by his actions and behaviours (internal); or that such things as success, failure and outcome are determined by factors like chance, luck, and fate (external) (Spector, 1988). There have been many studies that have been conducted to explain the locus of control internal and external control; indeed, control plays a vital role in well-being (Meier et al., 2008).

Competency, efficacy, and opportunity are factors that can influence an individual's ability to achieve their goals and feel satisfied with their accomplishments. When internal individuals lack these factors, they may struggle with feelings of inadequacy or low self-esteem, which can contribute to neuroticism or depression.

Similarly, external individuals may face their own set of challenges that can impact their well-being (Hans, 2000; Hattie et al., 1997).

Internal Locus of control: Internal locus of control refers to the belief that one has control over their actions and the outcomes one experiences. Individuals with an internal locus of control tend to attribute their successes and failures to their abilities, efforts, and decisions. They believe that their actions and choices directly influence the results they achieve (Slavin, 1994).

An individual with an internal locus of control tends to believe that their actions, decisions, and abilities have a direct influence on the outcomes they experience. They view themselves as having control over their lives and believe that their efforts and skills can lead to positive outcomes. They are more likely to take personal responsibility for their successes or failures. Internal locus of control has been associated with help-seeking and positive thinking, as well as lower work-related stress generally (Gianakos, 2002; Gray-Stanley & Muramatsu, 2011; Gore et al., 2016).

Within an internal locus of control, there are dependent events related primarily to a person's permanent characteristics. Three types of locus of control had been acknowledged. Foremost, a person's internal locus of control reflects the trust they have in the process of making something possible. Succeeding, an authoritative other locus of control has the conviction that the outcome will be determined not by one's actions, but by persons in positions of power. Third, the unknown locus of control is the time when a person does not understand why a particular action takes place (Doumas et al., 1999).

People with an Internal Locus of Control believe that important things in their lives happen because of their efforts, skills, or abilities. It can be discussed as those events and outcomes that can be influenced by people's own beliefs and actions (Rotter, 1966; Ng, Sorensen, & Eby, 2006). Individuals with an internal locus of control believe that they can take charge of and manage their lives by making decisions about the events that occur in their lives (James & Wright, 1993). According to Hsu (2011), individuals with a high internal locus of control believe their accomplishments

and failures depend on their efforts and efforts, to put it simply, they have the power to determine their successes and failures.

According to Dela Coleta (1982), people with an internal locus are more resistant to coercion, engage in activities to achieve their goals more directly, accept challenges better, are more persistent and hardworking for results, and choose which situations to submit to. They also have higher ambition and motivation, as well as success in their professional careers, workplace learning, and organisational performance (Macia & Camargo, 2010).

Internally focused individuals believe that their actions are a consequence of their personal efforts, abilities, or personal characteristics. They believe that hard work and personal ability lead to success (Andrisani & Nestel, 1976; Carrim et al., 2006; Littunen & Storhammar, 2000; Carrim et al., 2006). Hence, these individuals view the reinforcements they receive from their surroundings as contingent upon their actions (Lee-Kelley, 2006). In the belief that they are masters of their fate, internals believes there is a connection between behaviour and outcome, and between outcome and effort (Connolly, 1980; Boone, van Olffen & van Witteloostuijn, 2005).

In the context of environmental behaviour, individuals with an internal locus of control are more likely to believe that their actions and choices can make a difference in the environment. They have a sense of personal agency and feel that their efforts can contribute to positive environmental outcomes. Moreover, individuals with an internal locus of control tend to perceive that rewards for their environmentally responsible behaviours are predictable. They believe that their actions will lead to desired outcomes or rewards, such as improved environmental conditions or personal satisfaction (Adom & Affum-Osei, 2019).

The locus of control concept outlines the concept of an individual's responsibility and independence. Internals tend to be more independent in their judgment and depend less on other people's opinions (Rotter, 1966). Persuasion both overtly and subtly does not seem to affect them as much as it does on externals.

The above definition emphasizes that the internal side focuses on directing incidents with optimism, confidence and responsibility, while the external side seeks exogenous support with a passive and passive attitude (Ng et al., 2006). The internal locus of control has been linked to more success-oriented, sociable, close-minded, and competent behaviour than people with an external locus of control acting suspiciously and defensively when they are insecure (Basım et al., 2009). Having positive perceptions and strong bonds between events and outcomes will help internals overcome negative job attitudes such as managing stress, depression, anxiety, burnout, turnover and withdrawal intentions, mobbing, role overload, absenteeism, role conflict, and work-family conflicts. In contrast, positive variables associated with an internal locus of control include mental and physical health, life satisfaction, job satisfaction, job performance, organizational commitment, intrapreneurship, self-efficacy, psychological capital, hours worked, attendance, social support and integration, and relationships with supervisors (Çetin, 2011; Erdem, 2014; Judge et al., 2003; Martin et al., 2005; Ng et al., 2006; Wang et al., 2010; Yıkılmaz, 2014).

External Locus of Control

On the other hand, individuals with an external locus of control perceive events and outcomes as being primarily influenced by external forces such as luck, fate, or the actions of powerful others. People with an external locus of control tend to feel that they have little control over their lives and that their efforts and choices have minimal impact on shaping their circumstances. They may adopt a passive attitude and feel resigned to their fate, believing that their actions are inconsequential in determining the outcomes they desire (Rotter, 1966; Keenan & McBain, 1979). It refers to the extent to which individuals believe they have control over the outcomes of their actions and the events that occur in their lives. It involves the perception of the underlying causes of events and the degree to which individuals attribute these causes to internal or external factors (Rotter, 1954).

People with an external locus of control believe that their actions are dependent on factors beyond their control (Martin et al., 2005). The consequences of behaviour are randomly administered and are thought to be controlled by outside forces

(Connolly, 1980). According to Rotter, external beliefs can be divided into four categories: powerful others, luck, fate, and the belief that the world is too complex to predict (Marks, 1998). According to the popular model, the external locus of control is divided into control by others with power and control by luck (Levenson, 1973). The externals are unwilling to change behaviour because they do not view it as the primary source for altering reinforcements. Even in a positive reinforcement situation, the credit may not be taken personally, but rather attributed to the ease of the task, luck, or the help of others (Marks, 1998; Hyatt & Prawitt, 2001).

Evidence suggests that placing the blame (external locus of control) on the result of an event can have negative consequences for individuals. When people believe that they have little control over their lives and that external forces determine their outcomes, it can lead to many detrimental effects such as avoidance of coping, resignation, increased stress and poor health (Evers et al., 2000; Gianakos, 2002; Gore et al., 2016).

People with an external locus of control, believe that external factors such as luck, fate, chance, managers, supervisors, or organizations have a significant influence on their lives and the outcomes they achieve. They may perceive themselves as being at the mercy of circumstances beyond their control and may attribute their successes or failures to external forces rather than their efforts or abilities (Rotter, 1966).

Locus of control is one of the most important aspects of a person's personality. Those who are external in the light of locus of control, have a lack of control over their life and believe that what has happened to them is the product of something outside themselves such as chance, fate, other people or their behaviour. In other words, they have no active role in their lives, whereas those with internal control see themselves as rulers of their fate and responsible for their success or failure. While externals are passive and inactive concerning the flow of behaviour, the internals are dominant and active. The internal locus of control is accompanied by recognition, justice, and realistic expectations. Those with an external locus of control display little recognition, no sentimentality, and little regard for individuals or events that cause behaviour (Heinrich & Gullone, 2006).

An additional concept derived from social learning theory is the locus of control (Rotter, 1966) and it is based on generalized expectations about behaviour. Taylor (1982), presented the difference between an internal and external locus of control. Internal locus of control individuals will believe they have more control over their lives and will be more responsible for them as compared with an external locus of control individuals will attribute their actions to events that are outside of their control. Externals exhibit more emotions but also experience more affective impact, do not directly take ownership of goals, and are more likely to be persuaded (Dela Coleta, 1982). Individuals who think their performance is more dependent on external than internal reasons frequently show greater regard for the individuals they supervise.

Given the above, the Locus of Control is not a new concept (Macia & Camargo, 2010) for the research. The construct has already been used in studies across a variety of fields, including psychology, administration, human resources, and entrepreneurship. Although there is still a research shortage in some areas, such as accounting, it is clear from these studies that the concept has evolved somewhat in the development of various metrics since it was first introduced.

Resilience

Resilience refers to the ability to recover, adapt, and bounce back from challenges, setbacks, or adversity. It involves maintaining mental and emotional well-being in the face of stress, trauma, or significant life changes (Tugade & Fredrickson, 2004). Resilience originates from the Latin word resilience, which refers to the pliant or elastic quality of a substance (Greene et al., 2002). The term resilience is used by Masten (2005) as a term for describing the resilience of an organization to threats against the adaptation of development despite the need to adapt (Rutter, 1999)

Nevertheless, resilience is not only being able to withstand harm or threatening conditions or being passive in the face of dangerous situations but also being able to actively contribute to the environment. In other words, resilience is maintaining ecological-mental balance in dangerous situations (Connor & Davidson, 2003).

As defined by Rutter, resilience is a measure of how well one handles psychosocial risks. As a consequence, this approach stresses a variety of outcomes,

not just positive ones; it does not assume that protection lies in positive experiences or that the solution lies in what the individual does at the time. It recognizes that individuals may face various challenges and that their ability to navigate those challenges successfully is an essential aspect of resilience. Resilience does not assume that protection solely comes from positive experiences or that the solution lies solely in the individual's actions at the moment (Rutter, 1999; 2000).

Perry (2002) defines resilience as the capacity to face stressors without significant negative disruption in functioning. Resilience is typically discussed in developmental literature in terms of protective psychological risk factors that promote positive outcomes and healthy personality traits (Bonanno, 2004). Additionally, resilience may also be referred to as positive coping, adaptation, or persistence (Greene et al., 2002). Researchers agree on the basic concept of resilience, which is the ability to cope with risks in different ways according to individual differences. While some people succumb to stress and adversity, others can adjust to challenges and thrive despite them (Rutter, 1987).

The definition of resilience given by Braverman (2001) includes two components: (a) the ability to cope with significant stressors or risks, and (b) demonstrating competence in adapting to those stressors. By this definition, resilience is a set of processes rather than a fixed characteristic. Furthermore, this definition fits the concept of ‘sex work and resilience’ as sex workers are exposed to risks such as HIV (Bastow, 1995), human rights abuse (Ritcher, 2013; Scorgie et al., 2011) and have been adapting to sex work for millennia (McNeil, 2010).

Resilience is defined by the American Psychological Association (2014) as the ability to adapt well in the face of adversity, trauma, tragedy, threats or even significant sources of stress. Biological factors can play a role in resilience, such as genetic predispositions, neurobiological processes and physiological responses to stress. Psychological factors encompass cognitive processes, problem-solving skills, positive emotions, self-esteem and the ability to regulate emotions effectively. Social factors involve the presence of supportive relationships, access to resources, social support networks, and community connections. Cultural factors, including cultural beliefs, values, and traditions, shape individuals' understanding and expression of resilience.

Richardson, Neiger, Jensen and Kumpfer (1990) define resilience as "a way to deal with disruption, stress or challenges in a way that provides the individual with additional skills than before the disruption was experienced", while Wolin and Wolin (1993) defined resiliency as "the capacity to bounce back, to withstand hardship and to repair yourself."

Individuals showing resilience are often studied to identify characteristics or skills that explain their ability to adapt and maintain healthy functioning when others are struggling (Tugade & Frederickson, 2004). When considering resilience, it is important to specify whether it is being defined as a trait, process, or outcome, since it is frequently tempting to think in terms of binary comparisons. However, resilience is more likely to exist on a continuum that may be present in varying degrees across a variety of contexts (Pietrzak & Southwick, 2011). Studies and research on human resilience aim to comprehend how some people while enduring similar adversity, develop a better ability to endure than others (Minello & Scherer, 2014). In this view, resilience is a process that occurs between people and their environment rather than an innate quality or skill gained during development (Rutter, 2012).

A person's ability to remain resilient is also determined by the combination of personal, social and physical assets he/she collects from her/his environment (de Terte, Becker & Stephens, 2009). Meschke and Patterson (2003) used this perspective to describe how people recovering from substance misuse develop resilience throughout the recovery process. The study presented the ecological systems theory as a framework for understanding resiliency, explaining that decisions regarding substance use/misuse are made in the context of multiple social systems presenting any number of risks and protective factors. An individual develops resiliency when supportive elements across their ecosystem provide "chains of protective factors" that work together to support and protect them in the face of adversity (Meschke & Patterson, 2003). They explain that these factors can be relational (i.e. a mentor, teacher, or social worker), physical (e.g. relocation to a safer living environment), and individual, as experienced by someone with improved mental health, self-esteem, or in recovery from addiction. It is difficult to predict resiliency because there are no universally defined concepts of what constitutes resilient behaviour (Southwick et al., 2014).

Further, they suggest that resilience may be defined by the absence of psychopathology, prolonged stress responses, or maladaptive coping strategies, but in other cases, it may be defined by superior coping mechanisms over the life span, on average.

When people face adversity, they develop resilience because supportive elements across their ecosystem provide chains of protective factors that work together to protect them from harm' (Meschke & Patterson, 2003). These factors include relational (a mentor, teacher, or social worker) physical (e.g. relocation to a safer living environment) and individual supports including improved mental health, self-esteem, or recovery from addiction, those who do not have access to these supports are at a disadvantage. There is a possibility that they are less likely to seek out new support or feel less confident in their ability to build attachments with trustworthy individuals and institutions to build social capital (Oliver & Cheff, 2014).

Relational factors (such as a mentor, teacher, or social worker), physical factors (e.g. relocation to a safer environment), and individual factors can all contribute to improving mental health, self-esteem, or recovering from addiction. Lack of support across the ecosystem puts individuals at a disadvantage. They could be less inclined to look for additional resources or less assured in their capacity to establish connections with reliable people and organisations and lessen the effects of hardship (Oliver & Cheff, 2014).

Throughout life, resilience may change, depending on one's development and interactions with the environment. For example, high levels of maternal care and protection may enhance resilience during infancy but may interfere with individuation during adolescence or young adulthood (Kim-Cohen & Turkewitz, 2012). Moreover, our response to stress and trauma is influenced by interactions with others, available resources, specific cultures and religions, and organizations, communities, and societies (Sherrieb et al., 2010; Walsh, 2006). Each of these contexts may be more or less resilient in their right and therefore, more or less capable of supporting the individual.

Protective Factors: Protective factors are factors or characteristics that promote resilience and serve as buffers against the negative effects of adversity. Protective factors come in many shapes and sizes, but all combine to shape a person's resilience. Several researchers concentrate on studying resilience on one level of analysis, often to develop interventions for resilience at that level (Richardson, 2002; Werner, 1995).

Individual factors: Individual factors, both psychological and neurobiological, play a significant role in maintaining and recovering well-being after traumatic events or setbacks. Resilience research explores various aspects of an individual's makeup that can influence their ability to cope with adversity and achieve well-being. These factors can include personality traits, coping styles, physical and cognitive abilities, as well as neurocognitive structures and neural responses to stress (Feder, Nestler, & Charney, 2009; Luthar et al., 2000)

Social factors: One's social network and the availability of support from others can significantly impact an individual's ability to cope with various life stresses and crises. These can include family, friends, co-workers, or anyone in one's circle of friends who can provide social, emotional, and even financial support. Several studies have demonstrated that having such relationships can be an important determinant of whether an individual can cope with major stresses like losing a job, ending a marriage, or suffering chronic illness. Social support is often construed as combining instrumental and affective aspects (Masten, 2007; Reinelt et al., 2015).

Community factors: Resilience can be applied not only to individuals but also to communities and even larger entities like nations. When we talk about community resilience, we consider the ability of a community to withstand and recover from various challenges, such as terrorist attacks, natural disasters, and economic downturns (Cutter et al., 2008; Norris et al., 2008; Murphy, 2007). When it comes to emergency services in a given area, it may not only matter that the services are provided, but also how well they are integrated in terms of communication and coordination. Community resilience is not limited to government institutions.

Yuen and colleagues (2013) state that individuals exposed to stressful situations, such as those encountered by sex workers, may suffer psychological distress while others may be able to adapt well and function as effectively as before. This type of positive adaptation is known as resilience. Studies of people who demonstrate resilience are often aimed at discovering characteristics or skills behind their ability to adapt and function when others are struggling (Jew, Green, & Kroger, 1999; Tugade & Frederickson, 2004). Individuals lacking support in their ecosystem may be less likely to seek out support or feel a lack of confidence in their ability to form social attachments with people and institutions they trust, which build social capital (Oliver & Cheff, 2014) and buffer against adversity.

Research has primarily been conducted with women who have exited street-based sex work or those who are getting ready to exit or working in the sex trade (Dalla, 2006; Davis, 2000; Mansson & Hedin, 1999; Williamson & Folaron, 2003; Sanders, 2007). Much of the focus has been on the process of exiting illegal and/or coerced sex work, and the complex individual, relational, and structural barriers that make voluntary exiting difficult.

Even though research identifies some protective factors associated with a successful exit from the sex trade industry (Cecchet & Thoburn, 2014). An intervention generally embeds findings in its context (Diversion, case management, or outreach program), focused on a single aspect of protection or support (social, financial) and the research has most often included women exiting street-based sex work (Sanders, 2007).

A resilience-based model of sex work can provide alternative perspectives on sex workers. Brownes and colleagues (2012) proposed a resilience-based lens for conceptualising sex workers that can be used for research, scholarship, advocacy, and clinical practice. Sex work can be stressful similar to other kinds of work, and it is important to understand the types of stresses that sex workers face (Fick, 2005).

Women leaving the sex trade industry may also need to develop job skills and gain access to other employment opportunities for those without previous job experience outside of the sex trade industry, limited education, and dependents to

support, this can be challenging without financial assistance. Criminal records may also pose a barrier to employment (Maxwell & Maxwell, 2000). While women continue to face significant barriers to exit, they can reach a range of support services, demonstrating resilient capabilities to overcome obstacles and adapt to difficult circumstances as they move through the exit process (Cecchet & Thoburn, 2014).

Various types of social support have been suggested to be the primary reason why individuals enter the sex industry. According to psychologists, social support is considered an important aspect of resilience, which means that social support can be considered a positive part of a resilience lens that appears within the sex workers' industry (McClure et al., 2008). Social support is lacking for many sex workers on many different ecological and systemic levels, and they may become involved in sex work to find such support (Wolffers & van Beelen, 2003). Researchers have found that sex workers with poor social support often face discrimination because of factors such as sex, gender, race, ethnicity, and socioeconomic background (McIntosh, 1981; McIntosh, 1981; Campbell & Mzaidume, 2001; Young, Boyd & Hubbell, 2000).

Depression

Depression is a mental disorder that is characterized by low mood, loss of interest or pleasure, low energy, guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Additionally, depression is often accompanied by symptoms of anxiety. An individual's ability to take care of his or her everyday responsibilities can be seriously impaired when these problems become chronic or recurrent. Depressive disorders can also lead to suicide. Approximately 280 million people in the world have depression. It was estimated that depression affects 3.8% of the population. Among adults, the prevalence of depression is 5%. The rate varies between genders, with 4% of men and 6% of women experiencing depression. This means that depression is about 50% more common in women than in men. Among adults aged 60 years and older, the prevalence of depression is 5.7%. This indicates that depression is relatively common in this age group (GHDx, 2023).

According to Seligman (1990), depression is a common mental health issue that can affect individuals in every society. It is characterized by persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities. Depression can have a significant impact on a person's overall well-being and quality of life. Depression is a complex condition with various contributing factors. It can be caused by a combination of genetic, biological, environmental, and psychological factors. Stressful life events, such as the loss of a loved one, relationship problems, financial difficulties, or major life transitions, can trigger or worsen depressive episodes.

As predicted by the World Health Organization (2001), mental illness will rank second to heart disease as the most common cause of disability by 2020. The International Labour Organization (ILO) (2000) reports that mental illness negatively affects more lives and wastes more human resources than any other disability. There are three leading causes of disability, and mental health disorders are one of them. In the European Union, mental health disorders are one of the top reasons for getting disability benefits. The ten leading causes of disability in the world are all mental health related - major depression, schizophrenia, bipolar disorder, alcohol consumption, and obsessive-compulsive disorders and account for 25-35% of all disabilities (Cameron, 2000). The mental health of employers is directly related to the mental health of their employees, and employers affect the mental health of their employees - positively or negatively.

Depression is the third largest contributor to the global disease burden, with mental health disorders making up 13% of the disease burden worldwide (Collins, Patel & Joestl, 2011). Among adolescents aged 10 to 19, mental health disorders comprise 16 per cent of the disease burden, a higher proportion than for other age groups, and depression is among the leading causes of morbidity (WHO, 2019). Mental health disorders often begin during childhood or shortly after adolescence (by 14) and frequently being undetected for decades according to a study conducted in 17 countries (Kessler et al., 2007). Even though depression is the leading cause of disability for men and women alike, it affects women at a higher rate than men (WHO, 2008). Depression is the leading cause of disease burden among women in both high- and low-income nations (WHO, 2008). Although there are known, effective treatments

for mental disorders, more than 75% of people in low- and middle-income countries receive no treatment (Evans-Lacko et al., 2018).

One out of ten people suffer from major depression and almost one out of five persons have suffered from this disorder during his (or her) lifetime with 17% whereas the one-year prevalence is 10% (Kessler et al., 1994). According to the World Health Organization (WHO), depression may become the second leading cause of disability by 2020, and the leading cause of disease burden by 2030 (WHO, 2008).

Depression affects a person's interpersonal, social, and occupational functioning in a multifaceted manner (Sadock & Kaplan, 2007). An individual with depression experiences sadness, emptiness, or irritation with accompanying somatic and cognitive changes that impact the ability to function significantly (APA, 2013). An individual suffering from depression experiences noticeable changes in eating habits, sleeping patterns and thinking style, so depression can affect daily life activities (Aghakani et al., 2011).

In the general population, women suffer from depression and anxiety at higher rates (Angst et al., 2005). Studies have linked women's anxiety and depression to health-detrimental psychosocial factors, such as difficult work conditions and limited decision-making flexibility at work (Lennon, 1995; Williams et al., 1987). FCSW as a marginalized group, often face numerous challenges and can experience poorer health outcomes compared to the general population. Several factors contribute to this situation, including social, economic, and structural factors that influence their working conditions and access to healthcare. The mental health of individuals greatly influences their propensity to engage in high-risk behaviour (Alegría et al., 1994). According to studies, depression may lead to unprotected sexual activity, drug consumption and other unsafe behaviours (Hutton et al., 2004). FCSW suffer from occupational hazards that include various kinds of stress and injuries, as well as sexually transmitted infections. This is especially true since FCSW have been identified as a high-risk group for HIV transmission (Aral & Peterman 2002; Blanchard et al., 2008).

There is evidence that Female Commercial Sex Workers are more likely to suffer from mental health disorders, including depression. Therefore, those suffering from mental health disorders might be more likely to engage in unsafe behaviour, such as unsanctioned sexual activity or substance use (Foss ey al., 2004). As a group, they show little interest and aspiration in planning future-oriented activities such as financial planning (Chandra, Desai & Ranjan, 2005). The stigmatized and marginalized status of FCSW puts them at higher risk for accusing HIV infection, in addition to posing greater challenges to accessing care or support services. All these underlying factors inhibit FCSW's access to treatment and other support services, as they are the most common victims of violence, abuse and social discrimination (Popoola, 2013). Depression could have profound ramifications on the lives of sex workers, and could adversely affected them (Collins et al., 2006). Studies in the USA have identified high levels of mental illnesses such as depression among sex workers (Bassel et al., 1997). Researchers have found that depression is significantly associated with a high risk of contracting HIV (Cournos et al., 1991; Brawner et al., 2012).

Globally, mental health problems are among the leading causes of disability and major health issues due to their prevalence and prevalence trends (GBD, 2017). Stress, depression, and anxiety negatively impact a person's psychological well-being, which can lead to negative consequences if untreated (Tse et al., 2010). Anxiety and depression are both emotional responses that produce similar symptoms, such as insomnia, fatigue, muscle aches, and irritability while stress is usually triggered by an external factor and is usually short-lived, anxiety is persistent, even when there is no external factor (APA, 2020). Depressive symptoms include some different symptoms, including losing interest in daily activities, losing energy, losing concentration, feeling unworthy or guilty, and even thinking about suicide or death frequently (APA, 2020). Mental health issues in young adults frequently cause physical and emotional problems in the long run. Furthermore, mental health issues end up resulting in a higher incidence of physical and emotional problems (Scott et al., 2016), labour market marginalization (Niederkrotenthaler et al., 2014) and worse quality of sleep and dysfunctional relationships (Kerr & Capaldi, 2011).

Stress

In psychological sciences, stress is a feeling of mental tension and pressure. Low levels of stress may be desirable, useful, and even healthy, and can improve health and achieve performance goals. In addition, positive stress is thought to be an important factor in motivating people, enabling them to adapt to their environment, and responding to them. However, high levels of stress can lead to serious biological, psychological, and social problems (Tucker, 2008).

The impact of stress can be seen across different domains, including physical health, mental well-being, and workplace performance (Singh & Dubey, 2011). Despite some debate regarding the specific definition of stress, most researchers generally agree that stress is a collection of unpleasant emotional experiences associated with "fear, terror, anxiety, discomfort, anxiety, anger, sadness, grief and depression" (Cropanzano et al., 1997; Bolino & Turnley, 2005).

According to Leung and colleagues (2009), stress is classified into four categories; task stress, physical stress, psychological stress and organizational stress. In addition to task stressors like work overload, role conflict, and role ambiguity; stressors like organizational stressors (the sources of stress coming from and within an organization itself) i.e.; organizational structure and career-developing environment and physical stressors which are the environmental sources of stress existing in either the work or the home environment like poor work environment (Leung et al., 2009).

The presence of stress among people has been highlighted in both fine arts and literature of all eras so it has been discussed as one of the special characteristics of life (De Raeve, 2007). The reason for the wide prevalence of stress in human communities is the complexity of human social, personal, and ecological environments, the multiple and simultaneous interactions of humans with their surroundings, and the diversity of stress expressions (Edwards et al., 2008).

Studies have identified many actual and potential sources of stress in the context of commercial sex, including heavy workload, encounters with government officials, drug abuse, abusive clients, exposure to violence, HIV/STD infections,

exploitation, discrimination, and stigmatization (Rekart, 2005; Ross et al., 2012; Yi et al., 2012).

Events that people face internally or externally may be referred to as stressors (Lazarus & Folkman, 1984). Stress may be positive or negative, and it can occur acutely or chronically. Acute stressors have a limited impact and may not require substantial coping, whereas chronic stressors arise from life's conditions that require constant adaptation to or management (Lazarus, 2000). When adults stutter as adults, the experience of stuttering is a persistent or chronic life condition that is inherently difficult to manage on a psychosocial and/or behavioural level (Craig et al., 2011). It can be stressful for an individual to experience change or difference, especially if the experience is a change from fluency to disfluency or identification as a disfluent rather than a fluent speaker.

Female Commercial Sex Workers are typically portrayed as lazy or immoral women trying to make quick money by selling their bodies (Zheng, 2009). They rarely disclose their occupation to their families and are concerned about such a disclosure, resulting in them receiving less sympathy when they experience violence and abuse (Hong, 2008; Sanders, 2004).

One of the contributing factors to inefficiency, absenteeism, increased healthcare costs, and other unfavourable workplace outcomes is stress. Stress is related to specific circumstances, features of the work environment, and individual perceptions and reactions (Stacciarini & Troccoli, 2004).

Lazarus and Folkman (1984) state that stress occurs when demands placed upon a person exceed their capacity to meet those demands. Stress occurs and one often forgets all the training and knowledge gained about stress and how to effectively manage it. This is part of being human since we are all vulnerable.

There are two types of stress: external stress related to environmental factors, and internal stress from the person's perceptions. This latter form, in turn, can cause anxiety, and/or other negative emotions and feelings such as pain, sadness, etc., resulting in serious psychological disorders such as post-traumatic stress disorder (Tse & Mearns, 2010).

Individual perception systems perceive external factors as stressful or threatening although they are not in essence stressful or threatening. Stress-causing factors, such as sudden and horrifying claps, or observing specific types of objects that seem to resemble acute incidents to individuals, may be interpreted as strains. A human perceives stress or issues as threatening or dangerous if he/she does not believe he/she has adequate resources to deal with obstacles such as stimuli, people, situations, and so on (Lucas, et.al., 2005).

Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association recognizes two types of stress disorders: Acute Stress Disorder and Posttraumatic Stress Disorder. An individual with acute stress disorder must exhibit at least three dissociative symptoms during the trauma or after the event: numbing, detachment, becoming less emotionally responsive, reduced awareness of surroundings, depersonalization, or amnesia from the trauma. As a result, the traumatic event is persistently re-experienced, the individual avoids stimuli that may evoke recollections of the traumatic event, and they experience anxiety or increased arousal. Trauma causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. In posttraumatic stress disorder (PTSD), a traumatic event is persistently re-experienced in intrusive recollections, dreams or dissociative flashbacks. Cues to the event lead to distress and are avoided, and there are symptoms of increased arousal. To meet the diagnostic criteria of the DSM-5, a full symptom picture must persist for at least one month, and the disturbance must lead to clinically significant distress or impairment.

Various neurological and physiological processes are involved in the internal component of stress. Selye (1985) viewed stress as "nonspecific" because it can arise from a wide variety of different external or internal stresses, and hence focused on its internal aspects. As Selye noted, a person subjected to prolonged stress undergoes three phases: Alarm Reaction, Stage of Resistance, and Exhaustion. He termed this set of responses as the General Adaptation Syndrome (GAS). This general stress reaction is viewed as a set of reactions that mobilize the organism's resources to deal with an impending threat. The alarm reaction is the equivalent of the fight-or-flight response, and it comprises the various physiological and neurological reactions to stress.

Hans Selye was the first person to use the word stress in the context of biomedicine and to define the concept and phenomenon of stress in a generic and nonspecific way. Selye's definition and concept of stress remain controversial. His definition has been criticized for ignoring cognitive and psychological factors. This criticism may originate from the belief that cognition is not a brain or biological phenomenon (a reversion to Rene Descartes' outmoded theory that mind and body are separate). The definition of Selye is far too general for others and responded systematically to some of these criticisms (Selye, 1975).

The General Adaptation Syndrome is divided into three phases:

Alarm Reaction: When individuals are exposed to a stressor, they initially experience an alarm reaction. This is the immediate response to the stressor, where the body is taken off guard and initiates a "fight-or-flight" response.

Stage of Resistance: After the initial shock of the alarm reaction, the body tries to adapt and maintain homeostasis by resisting the stressor. During this phase, the body attempts to cope with the ongoing stress.

Stage of Exhaustion: If the stress continues for an extended period without relief, the body's resources become depleted, and it enters the stage of exhaustion. At this point, the individual becomes vulnerable to various health issues and may suffer from burnout or other stress-related illnesses.

Selye's perspective on stress is not limited to a psychological term but rather encompasses a choreographed series of physiological events in response to stressors. These responses are not restricted to specific types of stress but apply to any stressor encountered by an individual.

Contrasting Selye's concept of chronic stress response, the "fight-or-flight" response, also known as the acute stress response, was first described by physiologist Walter Cannon in 1915. The acute stress response is a rapid and immediate reaction to a perceived threat or danger. It involves the release of neurotransmitters from the sympathetic and central nervous systems, as well as hormones from the adrenal cortex and medulla, pituitary, and other endocrine glands. This acute stress response helps prepare the body to deal with the immediate threat by increasing alertness, heart rate, and other physiological changes (Tan & Yip, 2018).

The World Health Organization defines sex work as the provision of sexual services in exchange for money or goods. When high demand for sexual services is combined with a commendatory or favourable setting, it appears that sex work flourishes. The conditions under which it usually occurs include a high ratio of males to females, sufficient anonymity, and a concentration of sexually active individuals. It is most important that the socioeconomic disparities make sex work affordable for clients and economic opportunities for workers. A number of them are found in mining, industrial areas, ports, markets on frontiers, and villages along main transit lines and transportation routes. These circumstances are also related to travel and tourism, and sex tourism in particular (Chudakov et al., 2002).

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Sex work is the most stressful and dangerous profession in history as well as one of the few professions that have been in existence for centuries (Rekart, 2005; Ross, Crisp, Mansson, & Hawkes, 2012). Female Commercial Sex Workers (FCSW), who constitute the majority of the industry's workforce, are either characterized as passive victims who are coerced into sex work through poverty, power imbalances, or active agents who engage in sex work by their own choice (Overall, 1992; Ross et al., 2012; Kesler, 2002). Female Commercial Sex Workers may experience many stress-related health problems due to the characteristics of their work, just as any other profession (Mark & Smith, 2008).

Numerous studies have examined the behaviours and risks of Female Commercial Sex Workers, but most of them focused on the sexual risks they face or other aspects of their health (Pirkle, Soundardjee, & Stella, 2007). Researchers have rarely examined how sex work's stressful aspects impact their well-being (Ross et al., 2012). Vanwesenbeeck (2005) identified several sex-work stressors, such as low support from co-workers and gatekeepers, low autonomy, low reward, and stigma at work, which had detrimental effects on Female Commercial Sex Workers' psychological functioning.

Negative societal views of sex work and its psychological challenges cause sex workers to conceal aspects of their identities, leading to low self-esteem and self-worth. Typically, sex workers don't disclose their occupation to family, friends, and close ones, which leaves them socially isolated and lonely. This in turn makes them vulnerable to psychopaths. Some defined mental health disorders afflict those working in the sex industry, such as anxiety disorders, anxiety-related depression, mood disorders, and substance abuse (Poliah & Paruk, 2017).

In addition to workload variations, role conflict, job ambiguity, and stress, job burnout is also associated with specific demands at work. People experiencing high levels of stress and resulting job burnout have poor coping mechanisms and a lack of job satisfaction, which can erode their commitment to the organization and increase turnover (Lee & Ashforth, 1996).

A wide variety of psychosocial stimuli, either physiologically or emotionally threatening, cause the body's homeostasis to be disrupted, triggering the stress reaction (Cannon, 1932). We are usually aware of stressors when we feel conflicted, frustrated, or pressured. The leading stressors are, in general, personal, social or family, work-related, and environmental stressors. These stressors have been linked to psychological and physical conditions, for instance, bereavement is a particularly difficult stressor and has provided evidence linking stress and immunity. According to research on bereavement, an individual experiencing loss has a lower immune system functioning. Stressful work demands, job insecurity, and job changes are also associated with health problems and increased accidents (Bernard & Krupat, 1994). There is also a difference

in the duration of the stresses. Acute stressors are those that present themselves for a short period and are usually not regarded as health risks because they are time-limited, whereas chronic stressors are those that present themselves for an extended period, and are potentially hazardous to health.

Female Commercial Sex Workers often face social isolation and may not disclose their work to their families. This can lead to a variety of challenges, including an increased vulnerability to mental health issues (Wong, 2009). The nature of their work, which often involves engaging in risky and potentially traumatic situations, can contribute to the development of mental health disorders. Some of the specific disorders commonly found among sex workers include anxiety disorders, post-traumatic stress disorder (PTSD), and mood disorders. Anxiety disorders can manifest in the form of excessive worry, panic attacks, or a constant state of fear and apprehension. The stressful and unpredictable nature of the sex work industry, combined with the stigma and social isolation, can contribute to the development of these disorders. Post-traumatic stress disorder is another mental health disorder that can affect sex workers. Many individuals in this line of work may experience traumatic events, such as physical or sexual violence, which can lead to the development of PTSD symptoms. Mood disorders, such as depression and bipolar disorder, are also prevalent among sex workers. The challenging and often stigmatized nature of their work, coupled with the social isolation and lack of support, can contribute to feelings of sadness, hopelessness, and emotional instability (Rossler et al., 2010; Jung et al., 2008; Yacoubian et al., 2002; Roxburgh et al., 2006).

Satisfaction with Life

Life satisfaction has been defined as “A person's cognitive and emotive judgements of their life are referred to as life satisfaction” (Diener et al., 2002). Indeed, life satisfaction, meaning in life, and hope play crucial roles in shaping an individual's thoughts and feelings, particularly in situations of danger or adversity. These factors significantly influence how people perceive and evaluate their current circumstances, as well as their expectations for the future, especially when facing prolonged or severe threats that disrupt the normal course of life.

When individuals experience danger or challenging situations, their level of life satisfaction becomes a critical factor in determining their emotional well-being and resilience. Those with higher life satisfaction levels tend to have better-coping mechanisms and a more positive outlook, even in the face of danger or deteriorating conditions. Having a strong sense of meaning provides individuals with a framework to interpret their experiences and find a greater purpose even during times of danger. When people perceive a purpose or find meaning in their actions and circumstances, it enhances their resilience and ability to cope with challenging situations. Hope instils resilience, motivates proactive behaviour, and facilitates the ability to endure challenging situations. When individuals maintain hope, they are more likely to persevere, seek solutions, and remain committed to their goals, even when faced with obstacles or when their order of life starts to deteriorate. These factors provide individuals with the mental and emotional resources to navigate uncertainties, adapt to changing circumstances, and maintain a positive outlook (Abrams et al., 2005; Batthyany& Russo-Netzer, 2014).

The term "satisfaction" can indeed refer to a feeling of being pleased or content with something. In the context of life satisfaction, this perspective emphasizes the subjective experience of individuals and places importance on the emotional component of overall happiness and well-being. According to this view, life satisfaction is determined by a combination of factors. It involves the presence of positive emotions, such as joy, happiness, and fulfilment, which contribute to a sense of well-being and contentment. Additionally, the absence of negative emotions, such as sadness, stress, or dissatisfaction, can also impact one's life satisfaction. Life satisfaction is not solely determined by objective measures, such as material wealth, social status, or achievements, but rather by the individual's subjective evaluation of their overall emotional state and well-being. It acknowledges that different people may derive satisfaction from different aspects of life, and what brings contentment to one person may not necessarily be the same for another (Alexandrova, 2008).

The concept of life satisfaction is employed in both philosophical and psychological discussions on happiness and well-being. The term "life satisfaction" is often used interchangeably with "happiness" and is considered a crucial aspect of

overall well-being. However, it's important to recognize that there are two distinct senses of "satisfaction" that are used in these discussions, leading to two different conceptions of life satisfaction. The first sense of "satisfaction" refers to the perceived fulfilment of expectations or standards. In this view, life satisfaction is associated with the degree to which an individual's life matches their desired or expected outcomes, achievements, or goals. It focuses on the objective evaluation of one's life circumstances concerning predetermined criteria. This perspective considers life satisfaction as a cognitive judgment based on a person's assessment of how well their life aligns with their aspirations. The second sense of "satisfaction" refers to a subjective feeling of being pleased with something. Here, life satisfaction is associated with an individual's overall emotional state or subjective well-being. It emphasizes the individual's affective experiences and the extent to which they experience positive emotions and feelings of contentment in their life. This perspective views life satisfaction as a primarily emotional or affective response to one's life circumstances. These two conceptions of life satisfaction are not mutually exclusive, and both can be relevant in understanding an individual's overall well-being. Some accounts may focus more on the cognitive evaluation of life circumstances and the fulfilment of expectations, while others emphasize the emotional aspect of satisfaction and overall subjective well-being (Hall, 2014).

Life satisfaction is a significant component of subjective well-being and an essential area of study in the field of psychology. It refers to an individual's overall evaluation or cognitive judgment of their life as a whole. Life satisfaction encompasses various aspects, including personal fulfilment, happiness, contentment, and the extent to which one's aspirations and desires are met (Landry, 2000).

Indeed Life satisfaction is considered a social indicator that reflects how individuals perceive and evaluate their lives. It encompasses various dimensions, including personal well-being, fulfilment of goals and desires, social relationships, and overall happiness. The level of life satisfaction can be seen as a measure of an individual's quality of life because it represents their subjective evaluation of their overall well-being and contentment with various aspects of their life (Branholm et al., 1998).

Life satisfaction is influenced by dispositionalmood (positive/negative affect) and personality (neuroticism and extraversion). However, it suggests that the impact of other dimensions of personality on life satisfaction is unclear. Additionally, it mentions that life satisfaction tends to remain stable over time (Andrew & Withey, 1976: Heady & Wearing, 1989).

While dispositional mood and certain personality traits have been consistently linked to life satisfaction, the relationship between other dimensions of personality and life satisfaction is not yet fully understood. Garretto (2000) states that the effect of these other personality dimensions on life satisfaction is equivocal, meaning that the evidence is inconclusive or conflicting. Further research is needed to determine the precise influence of these personality dimensions on life satisfaction.

The notion that life satisfaction tends to remain stable over time is supported by some studies (Andrew & Withey, 1976; Heady & Wearing, 1989). This suggests that an individual's level of life satisfaction tends to be relatively consistent over the long term.

People have a natural inclination to seek understanding, both of themselves and the world around them. This pursuit of understanding and self-discovery is a cognitive and behavioural process that individuals engage in to find meaning and purpose in their lives (Higgins, 2000). When individuals have a theoretical understanding of themselves, the world, and their place in it, they can develop a sense of meaning. This understanding helps them determine their values, goals, and aspirations, which in turn provide direction and purpose in their lives. The concept of meaning in life refers to the degree of effort individuals put into understanding and increasing the significance, importance, and purpose they find in their lives. It is a subjective experience that varies from person to person. Some individuals may find meaning through personal relationships, others through career accomplishments, and some through spiritual or philosophical beliefs (Steger et al., 2008).

According to Kashdan and Steger (2007), finding meaning in life is indeed associated with well-being. They argue that having a sense of purpose and meaning in life contributes to psychological well-being. When individuals perceive their lives as meaningful, they tend to experience higher levels of life satisfaction, resilience, and positive well-being. This aligns with the findings from other studies as well.

Pan and colleagues (2008) found that individuals who reported a higher sense of meaning in life also tended to have greater life satisfaction. This suggests that perceiving life as meaningful can contribute to overall satisfaction with one's life.

Similarly, Lightsey (2006) investigated the relationship between meaning in life, resilience, and well-being. The study revealed that individuals who reported a higher sense of meaning in life also exhibited higher levels of resilience and well-being. This implies that finding meaning can enhance one's ability to cope with challenges and promote overall psychological well-being.

Additionally, Scannell and colleagues (2002) explored the connection between meaning in life and positive and negative well-being. They found that individuals who experienced a greater sense of meaning reported higher levels of positive well-being, such as happiness and fulfilment, and lower levels of negative well-being, such as depression and anxiety.

Having a sense of meaning in life can play a key role to sustain and maintain the psychological health of those who suffer from problems. Meaningful living has indeed emerged as a crucial topic in existential positive psychology, particularly in the work of Wong (2011, 2019). This approach recognizes the importance of a balanced understanding of the good life, which involves acknowledging and integrating both positive and negative aspects of human experience.

According to some researchers in the field of positive psychology and well-being, life satisfaction is influenced by various determinants, including both material and non-material factors. While socioeconomic status, health status, and social relationships are important non-material factors that significantly contribute to life satisfaction (Loewe et al., 2014; Hsu et al., 2017). Women in less educated societies have lower earnings, and less negotiating and decision-making authority, and many of them are not as happy with their lives. Additionally, youth and adult well-being and happiness are highly linked to life satisfaction (Proctor et al., 2009; Jewell et al., 2015). According to research from industrialised nations, characteristics that significantly affect life happiness include income, health status, age, marital status, the greatest level

of education, and gender (Dumludag, 2015; Capone et al., 2021; Diego-Rosell et al., 2018; Kutubaeva, 2019; Luhmann et al.,2013; Park et al.,2020).

People are complex beings with diverse needs and aspirations, and it's natural for their levels of satisfaction to vary across different domains. The reasons behind this discrepancy can be multifaceted. Personal values, life circumstances, external factors, and individual preferences all play a role. Some individuals may prioritize certain domains over others, directing more time, effort, and resources toward those areas. As a result, they may experience higher satisfaction in those prioritized domains while neglecting or not investing as much in other areas. Satisfaction in different areas of life, such as relationships, careers, health, hobbies, and personal growth, can contribute to overall well-being and contentment. However, if there is a specific domain that significantly affects the individual's overall happiness and satisfaction, it can overshadow the positive aspects of other areas (Diener, 1984). Objective life circumstances refer to the tangible and measurable aspects of a person's life, such as income, education level, employment status, housing conditions, access to healthcare, and social support networks. These circumstances are external to the individual and can have a significant influence on their overall well-being and life satisfaction (Michalos, 1991). This perspective is in line with the theory of subjective well-being, which suggests that people's evaluations of their own lives are influenced by both objective and subjective factors. While objective life circumstances provide the context in which individuals live, their subjective interpretation and perception of these circumstances play a crucial role in determining their level of life satisfaction. People will feel more content when they believe their standards of fulfilment have been met and less content when they believe they have not (Diener, Suh, Lucas, & Smith, 1999).

Chapter – II

REVIEW OF LITERATURE

There is evidence that sex work is a widely and rapidly emerging profession, and it exists in all major regions of the world. Globally, the International Labour Organization estimates that over 1.8 million young people are involved in prostitution (ILO, 2000). A combination of legal offences and isolation from positive social support makes it difficult for people to leave the sex trade industry (Finn, Muftić, & Marsh, 2014; Maxwell, 2000; Williamson & Cluse-Tolar, 2002). Women working in the sex industry confront many structural inequalities, including poverty, gender inequality, racism, and social conditions that are hard to alleviate by viewing both illegal and trafficking sex work as problems that can be defined by the criminal justice system alone (Farrell & Fahy, 2009; Martin et al., 2010; Monroe, 2005).

Women working in the sex industry are rarely studied concerning their mental health (Romans, Potter, Martin, Herbison, 2001). There are very few studies available on the subject: either they focus on disorders like posttraumatic stress disorder or drug use, or they are restricted to only select settings like outdoor sex work or they are concerned about the violence of customers towards female sex workers or youth sex workers (Farley, Barkan,1998; Hutton et al., 2004; Cusick et al., 2003; Burnette et al., 2008; El-Bassel et al., 2000; Surratt et al., 2005; Jeal et al., 2008; Church et al., 2001; Cusick, 2002; Svedin & Priebe, 2007).

The majority of research has been conducted with women leaving street-based sex work and with women in the process of leaving or still working in the sex trade industry (Williamson, & Folaron, 2003; Dalla, 2006; Davis, 2000; Sanders, 2007). Several studies have examined the process of exiting an illegal or coerced sex operation, including individual, relational and structural obstacles that make voluntary exit difficult. The average age at which a person enters commercial sex work ranges from 12 to 14 to 22 years of age (Nadon, Koverola, & Schludermann, 1998; Silbert & Pines, 1982; Kramer & Berg, 2003). The estimates, however, do little to explain the diversity of experiences among women and girls who exchange sex for the first time at different points in their lives and for different reasons (Martin, Hearst, & Widome, 2010).

Research findings related to sex work and mental health are insufficient. Research by Rossler and colleagues (2010) looked at 193 female sex workers who worked on the street and off the street (5% of all registered sex workers in Zurich) to establish whether any mental health issues were present. The study found high rates of anxiety, stress, and post-traumatic stress disorder, mainly caused by the high level of violence these women experienced. The study also examined whether women with mental illness were more likely to engage in sex work, and could not find a clear relationship.

Women involved in the sex trade industry report abuse at rates that are well documented. They are at risk of being exploited by pimps and traffickers, as well as suffering injuries from repeated violence (Davis, 2000; Nadon et al., 1998; Potterat et al., 1998; Williamson & Cluse-Tolar, 2002; Raphael, Reichert, & Powers, 2010; Salfati, James & Ferguson, 2008; Valera, Sawyer, & Schiraldi, 2001). Mental and physical health problems may develop, as well as emotional and psychological outcomes related to sex work stigma, and the need to hide their involvement with sex work (Farley & Kelly, 2000; Williamson & Folaron, 2003; Sanders, 2004).

Warf and colleagues (2013) reported that young homeless women engaged in sex work had a similar rate of sexual abuse, the same rates of involvement in foster care and juvenile justice, and the same number of treatment admissions in psychiatric hospitals. Even though the young women involved in sex work had significantly higher rates of physical abuse, higher rates of STIs, and higher rates of suicide attempts.

Sex workers were at high risk for alcohol and drug abuse, and poor mental health is a major contributing factor (Alegría et al., 1994). The presence of poor mental health is a major determinant of alcohol and drug abuse among high-risk individuals (Hutton et al., 2004). FCSW do face occupational hazards, including various types of stress and injuries, including sexually transmitted infections. As they are considered an important high-risk group in HIV transmission dynamics, this is of even greater importance (Aral et al., 2008).

Researchers have found that women who have experienced intimate partner violence and other forms of violence are more likely to suffer from symptoms of depression (Tsai, 2013). Violence against women is a leading cause of gender-related depression among women, according to the World Health Organization (2000). Research shows that women who move a lot throughout the day for work are also very likely to encounter violence during their commute, as well as during their daily lives. In addition, violence is more prevalent in certain places and at specific times depending on the venues or locations where FCSW provide services and the nature of their interactions with clients (Harcourt, Van Beek, Heslop, McMahon, & Donovan, 2001; Church et al., 2001).

According to a systematic review of sex work research on emotional burnout, specific aspects of the job were correlated with self-reported burnout (Vanwesenbeeck, 2005). It can be stressful to work in the sex industry due to long waiting hours, the uncertainty of business, competition for clients, verbal and physical abuse, and risks of becoming a victim of sexual abuse or robbery (Holroyd, Wong, Gray, & Ling, 2008). At the same time, Female Commercial Sex Workers are exposed to the stigma attached to sex work and live in constant fear of being discovered by their families and friends (Wong, Holroyd, & Bingham, 2011). With personal reasons and life circumstances that drive women into sex work, some women might perceive the emotional risks to be out of control and contribute to health-compromising behaviours such as substance abuse and inconsistent condom use, increasing their risk of contracting sexually transmitted infections (STIs) (Sanders, 2004; Hong, Li, Fang, & Zhao, 2007; Lau et al., 2010). The majority of studies have documented the negative pathway of sex work to poor mental health, but only a few have documented the positive effects of sex work on mental health (Gorryet al., 2010). A few studies have examined the role of positive self-image development and empowerment from a feminist perspective (Choudhury, 2010; Kong, 2006). Drawing parallels between the research on women of other vulnerable groups, including refugees living under stressful and isolated circumstances, it is believed that Female Commercial Sex Workers are capable of positive psychological adaptation despite their challenging working environment. In addition to understanding how they function competently

using a strengths-based psychological framework, a more in-depth understanding of their personal growth and adjustment processes could prove helpful (Leipert & Reutter, 2005; Sossou, Craig, Ogren, & Schnak, 2008).

Sex work, like any other occupation, can have various impacts on an individual's well-being, both positive and negative. Some studies suggest that people engaged in consensual sex work can experience certain benefits, such as financial stability, flexibility in working hours, and a sense of autonomy and empowerment. However, there are also well-documented challenges and potential negative consequences associated with sex work (Ross et al., 2012). Vanwesenbeeck (2005) analyzed several sex-work stressors, such as lack of support from colleagues, lack of job autonomy, failure to reward and stigma related to their employment. Each of these factors adversely affected Female Commercial Sex Workers' psychological functioning.

In recent years, there has been an increase in evidence that shows how sex work can negatively impact the mental health of female sex workers. Female Commercial Sex Workers have a higher tendency to develop psychopathologies like anxiety, depression, and paranoid thinking (El-Bassel et al., 1997; Rössler et al., 2010; Roxburgh, Degenhardt, & Copeland, 2006).

The need for a better understanding of psychological stressors associated with sex work is, therefore, much needed to study. Scholars have derived multiple theories to explain occupational factors and their relationship with work-related stress. Work-stress models like demands, resources and individual effects, capture the process by which work characteristics and individual differences (e.g., demographics, personal resources, self-efficacy, personality, coping styles, personal experience, and role of conflicts) affect health outcomes such as anxiety, depression and job satisfaction (Mark & Smith, 2008).

The experience of change or difference can be stressful for individuals, especially when that experience is a change from fluency to disfluency or identification as a disfluent speaker instead of a fluent speaker (Sagtani, Bhattarai, Adhikari, Baral, Yadav & Pokharel, 2013). Mild Depression is not only caused by conflict but also by

chronic physical illnesses, traumatic life events, loss of loved ones, social adversity, extreme poverty, and the gender of the patient (Senarath, Wickramage & Peiris, 2014; Ovuga, Boardman & Wasserman,2005). Among Female Commercial Sex Workers, specific contributing factors to mild depression include exposure to different forms of gender-based violence (GBV), psychological and physical stresses of sexual work, and alcohol and drug use (Rössler et al., 2010; Coetzee, Buckley, Otwombe, Milovanovic, Gray & Jewkes, 2018; Odabaşı, Şahinoglu, Genç & Bilge, 2012).

Researchers have also found higher rates of psychological disorders among Female Commercial Sex Workers (el-Bassel et al., 1997; Inciardi, Surratt, Kurtz, & Weaver, 2005; Jones et al., 1998; Romero-Daza, Weeks, & Singer, 2003). A significant amount of burnout has been reported among Female Commercial Sex Workers in the Netherlands (Vanwesenbeeck, 2005). Researchers found that 53% of Female Commercial Sex Workers in Scotland had ever considered suicide (Gilchrist, Gruer, & Atkinson, 2005). According to Brody and colleagues (2005), found suicide accounts for 4.5% of total deaths among Female Commercial Sex Workers in the United States (Brody, Potterat, Muth, & Woodhouse, 2005). Existing studies, although very informative, have largely focused on survey designs that focus on the prevalence of psychological pathology and its demographic and behavioural correlates. A qualitative study of various forms and manifestations of job stressors concerning sex work will raise awareness of occupational characteristics and work-related stress among Female Commercial Sex Workers, who are highly vulnerable to psychological problems.

Psychopathologies such as anxiety, posttraumatic stress disorder, depression, and paranoia are more common in women involved in sex work (El-Bassel et al., 1997; Rössler et al., 2010; Roxburgh et al., 2006). Researchers in Hong Kong found that 53.9% of women in the sex industry had probable depression (Lau et al., 2010). Another study found that women in the sex industry scored significantly lower in almost every aspect of quality of life than men (Wong et al., 2008). Researchers have found that many female commercial sex workers have negative views about themselves and feelings of guilt and shame as a result of their work. These findings

suggest that sex work increases the risk of psychological distress among female commercial sex workers (Gorry et al., 2010; Wong et al., 2008).

Women suffer from anxiety and depression at a higher rate than the general population (Rossler et al., 2010). The sex industry is a vulnerable population that faces many health conditions such as infectious diseases like sexually transmitted diseases (STIs) and mental illnesses such as depression (Shen et al. 2016; Patel et al. 2015). People with low socioeconomic status and unfavourable family circumstances are believed to be more susceptible to mental health disorders because of their low socioeconomic status and family circumstances (Sagtani et al., 2014; Chavan, 2015).

There is a high prevalence of mental disorders, including depression, according to U.S. studies (Bassel et al., 1997). Researchers have noticed that depression is significantly associated with an increased risk of HIV infection (Cournos et al., 1991 & Brawner et al., 2012).

Indian sex workers face several cultural challenges that can put them at a higher risk of depression due to the unique cultural dynamics they experience (Pereira et al., 2007). Depression leads to social isolation, which is exacerbated by the stigma associated with mental health, and is a common occurrence among those who suffer from it (Chandra et al., 2006; Tarakeshwar et al., 2006). It is rare, however, to find research specifically focused on depression among Female Commercial Sex Workers in India, which appears to be associated with an elevated HIV risk. Further, no specific strategy and intent to initiate mental health interventions to target sex workers to address depression, including its association with HIV risk-taking behaviour, exists.

While sex workers are more vulnerable to mental health disorders, there have been variations in the prevalence of depression among them in international literature. The reported prevalence rates of depression and anxiety have ranged from as low as 4.2% in Bangladesh to no difference compared with the general population in an Australian study, while the lifetime prevalence for both disorders in a Swiss study found that it was 36.3% and 34.2% respectively in Zurich (Rossler, et al. 2010; Romans et al., 2001; Hengartner et al., 2015). According to one Nepali study, as many as 84% of female sex workers suffer from depression (Sagtani et al., 2013).

There is an association between depression among Female Commercial Sex Workers in India and in the world as a whole and certain socioeconomic and sex trade factors. It should also be noted that research has suggested that sex work itself does not necessarily lead to depression. However, the combination of challenging socioeconomic conditions and marginalization of Female Commercial Sex Workers may play a contributing or predisposing factor behind the increasing rate of depression. Research has shown that poor mental health is correlated with problems relating to their families and partners, stigma, discrimination, social isolation, loneliness, and violence (Ngugi et al., 1996).

Life satisfaction and psychological well-being are strongly correlated. Poor mental health will prevent people from being satisfied with what they have in life. People may have their own needs, desires, and wishes, so all these factors play a key role in determining how satisfied each individual is with life. A person's level of satisfaction in their life is affected by many different aspects such as interpersonal relations, having great problem-solving abilities, having good friends, and having success in their academics, business, or job. Additionally, having loving parents, a spouse, and children are all important (Guney, 2009).

Not only women working in the sex business are likely to have psychological problems, but also women who have already left the industry. McClanahan and colleagues (1999) suggested that there may be a connection between the nature of the journey that the women took when they entered the sex business and their subsequent state of mind. A study by Jung et al. (2008) shows that ex-prostitutes have higher rates of stress reactions, somatization, depression, fatigue, frustration, problems with alcohol and smoking, and more frequent PTSD symptoms than other women. In some cases, whether a woman entered the sex business voluntarily or by force can impact her mental health. For instance, Tome et al., (2016) assert that women working under force have limited freedom, can experience threats in various ways, and their mental health is compromised. Because these women frequently have severely disturbed relationships with their surroundings or social network, they should be treated professionally even after they leave the sex business (Hedin & Mansson 2004).

Women without positive support may find it difficult to leave behind negative social networks and may feel isolated (Davis, 2000). In a study of 23 former sex trade industry workers in Sweden, contact with family, including rebuilding relationships with children and forming new relationships with helping professionals, friends, and romantic partners, were crucial to successful recovery (Hedin & Månsson, 2003). The most common needs for formal support services are drug and alcohol rehab services, mental health services, and legal services such as divorce and protection from abusive partners. Although these services (e.g. via domestic violence shelters or access to services providing for general physical and mental health), may be available, prior research suggests the need to provide treatment tailored to the specific needs of workers in the sex trade industry (Arnold, et al., 2000; Dalla, 2006; Hedin & Månsson, 2003; Roe-Sepowitz, et al., 2011).

When women leave the sex industry, they may also need to develop job skills and gain access to other employment options. Without financial assistance, this can be impossible, as they may not have any work experience outside the sex trade industry, limited education, and dependents to support. Criminal records are another barrier to employment (Maxwell & Maxwell, 2000). While women face significant barriers to exit, they continue to experience a range of support services, demonstrating resiliency by overcoming obstacles and adjusting to difficult circumstances as they proceed through the exiting process (Cecchet & Thoburn, 2014).

Although research has identified some protective factors for a successful exit from the sex trade industry, it is often embedded within the context of an intervention that focuses on a particular aspect of protection or support, and the research has mainly examined women who are leaving street-based sex work (Cecchet & Thoburn, 2014; Sanders, 2007).

Literature suggests that individuals enter the sex industry to receive support on a social level in various forms. Psychologists have noted social support as being important to resilience, and therefore social support is an important part of a resiliency lens that can be used to view the sex work industry (McClure, Chavez, Agars, Peacock, & Matosian, 2008). The lack of social support may characterize sex workers on a

variety of ecological and systemic levels, and these workers may be drawn to sex work as a result (Wolffers & van Beelen, 2003). Researchers have found that a lack of social support generally correlates with discrimination against sex workers as a result of their sex, gender, race, ethnicity, and socioeconomic status (McIntosh, 1981; McIntosh, 1981; Campbell & Mzaidume, 2001; Young, Boyd, & Hubbell, 2000; Inciardi, Surratt, Kurtz, & Weaver, 2006).

Locus of Control and Resilience

A person's perception of internal control is often linked to their resilience, for the more internal control they perceive, the more likely they will be to handle adverse situations in a determined, calm, and mentally healthy manner (Grob et al., 1995; Leontopoulou, 2006). More Internal Locus of Control has been associated with the capacity to adapt resiliently to trauma in cases involving trauma exposure (Frazier et al., 2011).

Resilient people tend to process adverse conditions more positively and consider themselves capable of dealing with them. However, resilience is not only about ensuring stability against harm or threatening conditions, nor is it about becoming passive in the face of dangerous situations; it also entails being active and participating in the environment. Researchers consider positive emotions to be crucial psychological resources that can enable a person to cope with stress by choosing effective coping strategies. Positive emotions, then, may lead to greater resistance against difficult events, and thereby a greater sense of tolerance for those events (Zautra et al., 2005).

Individuals with a high internal locus of control think that events are mainly the result of their behaviour and actions since they believe that they have a choice over their lives and control over their circumstances. They feel happier, less stressed and more free as a result of this perception (Pilisuk et al., 1993, 151; Singh & Dubey, 2011).

Locus of Control and Depression

Several studies have examined the relationship between locus of control and depression and found that individuals with an external locus of control are more likely to experience depressive symptoms. Depression is a complex mental health condition influenced by various factors, including biological, psychological, and environmental factors. While the locus of control can be one of the contributing factors (Lefcourt, 2014; Wiersma et al., 2011). As depressed people tend to blame themselves for their failures, Peterson (1979) states that those with an internal locus of control would likely have higher levels of depression than those with an external locus of control (Clark, Steer, & Beck, 1994). According to research, external locus of control was positively associated with depression, contrary to such predictions (Presson & Benassi, 1996; Benassi & Sweeney, 1988; Cheng, Cheung, Chio, & Chan, 2013). Levenson (1973), further distinguished between beliefs in the power of others and beliefs in chance. Higher levels of internal locus of control were believed to be associated with lower levels of depression, while higher levels of external locus of control referred to both powerful others and chance were likely to be associated with higher levels of depression.

There is a positive correlation between external locus of control expectancy and higher psychological distress and depression vulnerabilities and worse anti-depressant effectiveness (Reynaert et al., 1995; Holder & Levi, 1988). Literature suggests that people with high Internal Locus of Control are less likely to feel hopeless, helpless and powerless, and proactively engage in behaviours that benefit their environment and induce change (Seipel, 1988; Jakoby & Jacob, 2001). Research has indeed shown that individuals who have a sense of control over their lives tend to experience less stress and greater life satisfaction. Individuals with an external locus of control believe that external factors, such as luck, fate, or powerful others, primarily determine the outcomes in their lives. They may feel a lack of control over their circumstances, leading to increased stress and reduced life satisfaction (Dağ, 2002). Individuals with an external locus of control, on the other hand, are more prone to depression and other health problems (Khan et al., 2012).

Locus of Control and Stress

According to psychological theory, individual differences play a significant role in how people respond to stressful situations. The concept of locus of control is one such individual difference that has been found to influence how individuals perceive and cope with stress (Hobfoll, 1989; Newton & Keenan, 1990). The level of perceived control in stressful situations is closely related to people's causal explanations of negative events. Attribution theory, developed by psychologist Fritz Heider (1958), suggests that individuals try to understand the causes of events or behaviours and make attributions about them. According to attribution theory, the causes of outcomes or events can be attributed to either internal factors (internal orientation) or external factors (external orientation). A personal locus of control refers to finding that negative outcomes in life are due to characteristics like mood, abilities, and personality, while an external locus of control refers to viewing negative outcomes as a result of external circumstances such as the situation, luck, or social pressure (Crisp & Turner, 2007). A person may be negatively affected by being suspected of being responsible for the treatment they are receiving from others or superiors if they believe that they are to blame (Weiner, 1986). A person who places the cause of their negative behaviours outside of them may be more likely to rationalize their behaviour, and therefore less likely to suffer negative outcomes.

According to Khan and colleagues (2012), locus of control plays a mediating role in stress as individuals with an internal locus of control show lower stress levels as opposed to those with an external locus of control. Furthermore, the study confirmed that individuals with an external locus of control were more inclined to experience stress. Based on his research, Srivastava (2009) demonstrates the role of locus of control in moderating the relationship between organisational role distress and managerial effectiveness. In his study, Huang (2007) demonstrated that internal locus of control was significantly and negatively correlated with work stress. Individuals with an external locus of control in times of stress, experience feelings of helplessness, shame, grief, and anxiety (Khan et al., 2012). In addition, other studies suggest there is an association between perceptions of Internal Locus of Control and stress (Abouserie, 1994; Diehl & Hay, 2010).

Workers with internal locus of control beliefs are more likely to manage or actively cope with job-related stress and be less likely to be depressed and cope more effectively with circumstances than those with external locus of control beliefs, who believe that they are at the mercy of fate, luck, or chance (Gray- Stanley et. al, 2010). The literature presents numerous studies which attempt to predict work stress based on locus of control (Bernardi, 2003).

Locus of Control and Satisfaction with Life

The relationship of internal locus of control is positive with life satisfaction and the same relationship is reversed with the relationship of locus of control of people with powerful and chance. Internal locus of control and life satisfaction is indeed generally considered to be positive. Internal locus of control refers to the belief that individuals have control over their own lives and that their actions can influence outcomes. People with a high internal locus of control tend to feel more empowered and capable of achieving their goals, leading to higher levels of life satisfaction. On the other hand, the relationship between locus of control and mental health can vary depending on the specific type of locus of control. Individuals with an internal locus of control tend to have better mental health outcomes compared to those with an external locus of control (Hatami, 2010).

Furthermore, other findings also suggested a positive correlation between internal locus of control and life satisfaction (Seipel, 1988; Hong & Giannakopoulos, 1994). This would imply that individuals who perceive themselves as having more control over their lives are more likely to experience higher levels of life satisfaction.

Resilience Relations to Depression

Empirical studies have demonstrated a negative correlation between resilience and indicators of mental ill-health, such as depression, anxiety, and negative emotions. People with higher levels of resilience tend to have better mental health outcomes and are less likely to experience symptoms of mental illness. Research has consistently shown that individuals with higher levels of resilience are more likely to report lower levels of depression, anxiety, and other mental health disorders. They exhibit better-coping strategies and are more equipped to handle challenging life circumstances.

Resilient individuals tend to have a more positive outlook, perceive greater social support, and possess effective problem-solving skills, which contribute to their ability to manage stress and maintain good mental health (Hu et al., 2015).

Several findings support the association between resilience and lower levels of depression and anxiety symptoms (Nrugham et al., 2010; Wells et al., 2012; Poole et al., 2017; Shapero et al., 2019; Skrove et al., 2012). Anyan and Hjemdal (2016) examined the relationship between stress, anxiety, depression symptoms, and resilience. They found a link between stress, symptoms of anxiety and depression that could be explained by resilience; individuals with higher resilience may be better equipped to cope with stress, resulting in fewer symptoms of anxiety and depression.

If a person with depression lacks a supportive social network, is sceptical of others, and does not have adaptive coping skills, they are at a higher risk for low resilience (Southwick et al., 2005). In addition, the severity of the disorder played a significant role in the individual's development of resilience. This indicates that protective factors can only buffer to a certain extent (Craig et al., 2011; Southwick et al., 2005). Research has shown that a feeling of self-mastery is one of the most important factors in improving resilience (Taylor et al., 2010). Therefore, it may be observed that those who stutter and also feel they have control over their speech are more resilient.

Research focuses on the predictive function of resilience for indicators of mental health (Goldstein et al., 2013; Vitale, 2015; Satici, 2016). The majority of intervention studies emphasize the influence of resilience training on the improvement of mental health status and the majority of intervention studies emphasize the influence of resilience training on the improvement of mental health status. Positive emotion training interventions designed to increase well-being, improve positive emotions and strengthen resilience were found to be beneficial for depression, according to Waugh and Koster (2015). Research relating resilience to depression and anxiety supports the hypothesis that a resilient personality protects depression and anxiety experiences, as well as that resilience increases an individual's odds of not experiencing depression or

stress (Judd et al., 2003; Komiti et al., 2003; Ryden, Karlsson, Sullivan, Torgerson, & Taft, 2003).

Resilience Relation to Stress

In turn, resilience is associated with positive assessments of one's own physical health and physical symptoms (Judkins, 2004; Soderstrom et al., 2000; Beasley et al., 2003). Despite experiencing high levels of stress and experiencing symptoms of illness, Schaubroeck and colleagues (2011) pointed out that people with high levels of resiliency recovered relatively rapidly from them relative to those with low levels.

Research has shown that individuals with higher levels of resilience tend to experience lower levels of stress and are better equipped to cope with various life stressors. When faced with setbacks or hardships, resilient individuals are more likely to maintain a positive outlook, seek support from others, and engage in adaptive coping strategies. Positive coping strategies play a crucial role in building resilience and promoting personal well-being. These strategies involve effectively managing stress, maintaining a positive mindset, and utilizing resources and support systems. Examples of positive coping strategies include problem-solving, seeking social support, engaging in physical activity, practising mindfulness or relaxation techniques, and reframing negative thoughts (Gibbons, Dempster, Moutray, 2011).

The research focuses on understanding the phenomenological basis of epistemological research and considers adaptation and overcoming adversity to be psychological processes involving positive results, seeking psychological equilibrium and recovery (Masten, 2001; Placco, 2002). A resilient person can cope with stress, decrease the incidence of negative emotional states such as anger, depression, or anxiety and increase their emotional health (Hiew, 2001; Sagtani et al. 2014).

To explain stress, Lazarus and Folkman (1984) defined it as a transaction between a person and their environment, in which individuals perceive environmental demands as exceeding their abilities to meet those demands. As a personal quality in the current study, resilience may have a positive impact on individuals' appraisals of stressful situations from a transactional/interactive perspective. Researchers have found that resilience can directly predict a variety of well-being outcomes such as

depression, stress, work satisfaction, and subjective well-being (Loh et al., 2014; Luthans et al., 2007; Liu et al., 2014). As Ryff and Singer (2003) asserted, resilient individuals are more likely to keep their physical and psychological health as well as recover more quickly from stressful experiences.

Resilience Relation to Satisfaction with Life

Several studies have shown that individuals with higher levels of resilience tend to report higher levels of life satisfaction. This means that they generally have a more positive evaluation of their overall life circumstances, including various domains such as work, relationships, and personal achievements. Resilient individuals are often better able to find meaning and purpose in their lives, maintain a positive outlook, and experience greater satisfaction with the direction their lives are taking (Haddadi & Besharat, 2010; Vitale, 2015; Satici, 2016; Tomyn & Weinberg, 2016). Tomyn and Weinberg (2016) found a moderate, positive correlation between resilience and well-being. It implies that individuals with higher levels of resilience tend to have better overall well-being. A recent study by Satici (2016) suggested that hope plays a mediating role in resilience's relation to subjective well-being. Based on a multiple regression analysis, Abolghasemi and Varaniyab (2010) found that psychological resilience and perceived stress explained 31% and 49 %, respectively, of the variance in life satisfaction.

The study conducted by Vitale (2015) highlights the potential impact of resilience on the life satisfaction of young adults who have experienced child abuse. Resilience refers to an individual's ability to bounce back from adversity and effectively cope with stressors. The findings of this study suggested that resilient young adults with a history of child abuse may experience higher levels of life satisfaction compared to those who are less resilient.

Previous research has indeed shown a strong association between low levels of life satisfaction and various adjustment difficulties. Individuals who report low levels of life satisfaction are more likely to experience a range of negative outcomes, including increased long-term risk for suicide and depressive symptoms. These individuals may struggle with feelings of dissatisfaction, lack of fulfilment, and a

general sense of unhappiness with their lives. On the other hand, high levels of life satisfaction have been consistently linked to positive adjustment and well-being. When individuals have a strong sense of life satisfaction, they are more likely to experience positive outcomes such as college persistence and retention. Higher life satisfaction can contribute to greater motivation, resilience, and overall psychological well-being, which in turn can enhance one's ability to adapt to challenges and persevere in academic or other pursuits (Choi, 2012; Yang & Kim, 2016; Koivumaa-Honkanen et al., 2001). Alternatively, a high level of life satisfaction was a significant predictor for a positive adjustment such as college persistence and retention (Bean and Bradley, 1986). These previous studies have primarily focused on the effects of life satisfaction as a predictor of negative and positive life adjustment issues. Recently, the focus has shifted to investigating the factors that affect life satisfaction as an indicator of individuals' well-being (Pavot & Diener, 2008) which was supported by other research findings that a positive relationship between resilience and life satisfaction (Plexico et al., 2018), individuals with higher levels of resilience tend to report greater overall satisfaction with their lives. This indicates that resilience plays a significant role in promoting subjective well-being.

Bore and colleagues (2016) reported that high resilience is associated with better psychological well-being among undergraduate psychology students. In a study of Chinese primary and secondary school students, Zeng, Hou, and Peng (2016) also showed a moderate positive relationship between resilience and psychological health. Resilient individuals can find positive meaning in adversity, which can serve as a buffer against negative emotions (Tugade & Fredrickson, 2004; Mak & Wong, 2011).

Depression Relation to Stress

Stressful events can trigger a cascade of physiological and psychological responses in the body, leading to changes in brain chemistry and functioning. These changes can contribute to the development of depressive symptoms. Moreover, stressful events often disrupt an individual's social support networks and coping mechanisms, making it more challenging to manage emotional distress effectively (Hammen, 2005). According to estimates, approximately 50 to 80% of depressed

individuals mention a recent, stressful life event before developing depression (Brown & Harris, 1989; Mazure, 1998). Among available markers of depression's impending onset, such events are at least among the strongest. Stress as a central cause of depression and whether it's a central etiological element. Depression commonly occurs before major life stress, in most cases, those under major stress won't experience a breakdown. A study estimates that approximately one in five of those exposed to severe life events also develop depression in the following years (although the proportion can be higher depending on the nature of the traumatic life event (Brown & Harris, 1989; Kendler, Hettema, Butera, Gardner, & Prescott, 2003). The results suggest that other factors contribute to depression caused by life stress (Brown & Harris, 1978; Monroe, Slavich, & Georgiades, 2009). Childhood abuse and trauma have been associated with an increased risk of depression later in life, which may make individuals more susceptible to the effects of later stressors (Hammen, 2005). Furthermore, individuals who experience high levels of stress have been found to buffer themselves against depression through social support. A person's genetic makeup, biological susceptibility, and personal traits are all thought to influence the likelihood that they are prone to depression after experiencing a stressful event (Brown & Harris, 1978; van Praag, de Kloet, & van Os, 2004).

Stress Relation to Satisfaction with Life

There is a strong connection between these stressors and well-being (Almeida, 2005; Schönfeld, Brailovskaia, Bieda, Zhang, & Margraf, 2016; Thoits, 2010). People who work may experience considerable work-related tension (Eurofound, 2005). Additionally, prolonged stress can lead to stress-related disorders, which are included in the Eleventh Revision of the International Classification of Diseases and Related Health Problems (ICD-11) (Keeley et al., 2016; Maercker et al., 2013). A variety of negative health outcomes have been associated with alcohol consumption, including anxiety and depression, coronary disease, and insomnia (Fawzy & Hamed, 2017; Herr et al., 2017; Melchior et al., 2007; Tennant, 2001; Li, Zhang, Loerbroks, Angerer, & Siegrist, 2014; Faber & Schlarb, 2016).

Stress can harm individuals' well-being or functioning when they perceive a situation as stressful and feel that their resources or coping mechanisms are insufficient to handle the environmental stimuli (e.g., exam, illness, break-up with a romantic partner, loss of loved one, financial strains). This perception of stress can vary from person to person, as individuals may perceive and react differently to the same situation based on their personal experiences, beliefs, and coping strategies (Roddenberry, 2007).

Life satisfaction, happiness, hopefulness and self-efficacy have been associated with several positive outcomes, including lower levels of stress and lower rates of mental health problems. These factors can be influenced by various aspects of an individual's life, such as supportive social relationships, a nurturing family environment, and engagement in physical activity (Natvig, Albrektsen & Qvarnstrøm, 2003; Gilman & Huebner, 2006; Valois, Zullig, Huebner & Drane, 2004; Schiffrin & Nelson, 2010; Siddique & D'Arcy, 1984).

Eller and Mahat (2007) found that sex workers often face various challenges and risks that can impact their overall well-being, including physical and mental health issues, social stigma, and limited access to resources and support systems. These factors can potentially influence their life satisfaction and quality of life.

Chapter – III

STATEMENT OF THE PROBLEM

According to the National AIDS Control Organization (NACO), there are over 8 lakh women sex workers in India, and more than 6000 female sex workers have been subject to physical violence, and other forms of abuse according to the National Crimes Records Bureau Report 2020-21. Several studies conducted have found that Female Commercial Sex Workers (FCSW) tend to have higher rates of psychiatric problems and health-related issues compared to the general population (Burnette, 2008). Researches on the psychiatric morbidity of female commercial sex workers (FCSW) in India are very few.

The psychological health of female commercial sex workers is an important public health concern. Sex workers often face a range of challenges that can impact their mental well-being, including stigma, discrimination, violence, social isolation, and economic instability. Understanding and addressing their mental health needs is essential for providing appropriate support and interventions. Although research on the mental health of female sex workers is limited, several studies and assessments have been conducted to gain insights into this population. Few studies have explored the links between psychological factors and mental health among sex workers (Shannon et al., 2015). Studies indeed suggest that female commercial sex workers (FCSW) face higher rates of psychiatric problems and health-related issues compared to the general population. Engaging in sex work can indeed expose individuals to various challenges that impact their physical, psychological, and social well-being. The disparities faced by FCSW are often the result of complex factors, including societal attitudes, stigmatization, criminalization, and marginalization of sex work. However, it is important to note that the issues faced by FCSW are not inherent to sex work itself but are largely a consequence of societal factors that marginalize and stigmatize sex workers (Burnette et al., 2008).

Sex work often operates within a complex social and legal framework that can contribute to the challenges faced by individuals in this profession. Stigma and discrimination against sex workers can exacerbate the psychological burden they experience, leading to poor mental health outcomes such as anxiety and depression. Additionally, the nature of the work itself, including long hours, physical abuse, and

the threat of violence, can further impact their well-being and quality of life (Wong et al., 2011).

There are studies and research that indicate potential positive health outcomes or protective factors associated with sex work. However, the majority of studies on sex work tend to focus on the negative aspects and risks associated with the profession (Bucardo et al., 2004; Gorry et al., 2010).

There have been numerous studies conducted on the psychological well-being and experiences of women working in various types of sex businesses. Women working in sex businesses may face elevated levels of psychological stress compared to individuals in other professions (Weitzer, 2009).

Locus of Control among FCSW

Locus of Control is characterized as a generalized attitude, belief, or expectancy regarding the nature of the causal relationship between one's behaviour and its consequences. People with an internal locus of control view themselves as having control over their lives and believe that their decisions and actions can shape their future. Internals typically have a sense of personal responsibility and believe in their capacity to influence outcomes. On the other hand, individuals with an external locus of control perceive themselves as having less control over their lives and may feel that their actions have little impact on their future. They may attribute successes or failures to external factors rather than their abilities or efforts. Locus of Control has been studied extensively in the field of psychology and has been shown to have significant effects on various aspects of economic behaviour and decision-making in the labour market. Research has found that individuals with an internal locus of control tend to exhibit higher levels of educational attainment, and occupational attainment, are more likely to seek out new opportunities, change jobs, and adapt to changing labour market conditions and tend to exhibit behaviours and decision-making patterns that align with higher educational attainment, job search effort, occupational attainment, entrepreneurial activity, and labour market mobility (Coleman & DeLeire, 2003; Mendolia & Walker, 2015; Caliendo et al., 2015; McGee & McGee, 2016; Cobb-Clark & Tan, 2011; Heywood et al., 2017; Caliendo et al.,

2014; Hansemark, 2003; Caliendo et al., 2019; Osborne Groves, 2005, Schnitzlein & Stephani, 2016; Semykina & Linz, 2007).

A study conducted by Jha and Bano (2012) found that employees with an internal locus of control perceive that they can influence their work environment and outcomes through their actions, which can lead to a greater sense of job control and satisfaction while employees with an external locus of control may feel that they have less influence over their work environment and outcomes. In the context of female sex workers, those with an internal locus of control may believe that they have chosen or have control over their involvement in sex work. They may perceive their choices and actions as the primary factors influencing their work and its consequences.

The notion that an external locus of control positively impacts job stress, as reported by Sinha and Sharma in 2019, suggests that individuals who perceive their circumstances as being influenced by external factors may experience higher levels of stress in their jobs. This concept can be applied to the context of female sex workers, where those with an external locus of control may view their involvement in sex work as being driven by factors beyond their control. For female sex workers, an external locus of control may manifest in the belief that their participation in sex work is primarily shaped by economic circumstances, coercion, or a lack of alternative opportunities. They may feel that their decisions and actions have limited influence on their work and its consequences. This perception can contribute to increased job stress among female sex workers. Female Commercial Sex Workers who hold an external locus of control may experience elevated stress due to the perception that they have little agency in their work and are subject to circumstances beyond their control.

Studying the locus of control among female sex workers can provide insights into their perceptions of agency, control, and decision-making concerning their work. It can help researchers, policymakers, and service providers understand the factors that contribute to engagement in sex work, as well as the potential implications for mental health, well-being, and empowerment. This understanding can inform the

development of interventions and support services that acknowledge and address the individual needs and circumstances of female sex workers.

Prevalence of Resilience among FCSW

While there is a substantial body of research on the risks and barriers faced by Female Commercial Sex Workers when trying to leave the industry, there has been comparatively less focus on the resilience factors and resiliency practices that can contribute to their well-being. Resilience refers to an individual's ability to adapt, cope, and recover from challenging or traumatic experiences. In the context of sex work, resilience factors are the personal, social, and environmental factors that can contribute to a sex worker's ability to navigate the challenges they face and ultimately exit the industry. By acknowledging and supporting the resilience of sex workers, it becomes possible to develop more comprehensive and effective services that address their unique needs and promote their overall well-being.

In the context of sex work specifically, resilience provides individuals with the ability to better respond to and manage the stressors, danger, and discrimination they face. Burnes, Long, and Schept (2012) argued that adopting a resilience-focused lens on sex work allows for a more comprehensive understanding of the experiences of sex workers. They criticize studies that solely focus on the perceived pathology of sex work without taking into account the strengths and resilience factors exhibited by individuals involved in the industry. By emphasizing resilience, researchers and scholars are acknowledging the existence of positive attributes and coping mechanisms among sex workers, rather than solely highlighting their vulnerabilities and challenges.

The increasing interest in resilience within the study of sex work reflects a broader shift away from a deficit approach. Traditionally, research in this field has focused on identifying problems, risks, and negative outcomes associated with sex work. However, this deficit-oriented perspective fails to capture the full range of experiences and overlooks the agency, resilience, and strengths that sex workers possess (Brien, 2014).

Stress factors that can affect sex workers. It is important to recognize that sex work is a complex and diverse industry, and the experiences and challenges faced by sex workers can vary significantly based on factors such as local legislation, cultural attitudes, and individual circumstances (Yuen et al., 2014; Buttram et al., 2014; Rouhani et al., 2021; Scorgie et al., 2013).

Despite the challenges, many individuals within sex-working communities demonstrate remarkable resilience and resourcefulness in navigating their circumstances. The ability to enforce sexual boundaries and safety protocols is crucial for sex workers to protect themselves and maintain their well-being. Engaging in boundary-setting and risk-reduction strategies can contribute to a sense of agency and control over their work environments. By establishing and enforcing boundaries, sex workers may mitigate risks associated with their profession, such as negotiating condom use, choosing clients, setting limits on activities, and ensuring their physical and emotional safety. Possessing resilience may also enhance the ability to enforce sexual boundaries and safety protocols (Yuen et al., 2014; Buttram et al., 2014; Mamabolo et al., 2018; Burnes et al., 2012).

Prevalence of Depression among FCSW

Researchers have discovered a high prevalence of depression among Female Commercial Sex Workers (Deb, 2008; Vanwesenbeeck, 2005; Pandiyan et al., 2012; Bhatt et al., 2009; Roxburgh et al., 2006). A study found that 71% of the respondents were suffering from depression, while 21% of them reported having PTSD. These figures suggested that mental health issues, particularly depression and PTSD, are prevalent among the population being studied. In addition to the current study, previous research conducted on sex workers also reported a high prevalence of PTSD. These studies likely contribute to the understanding of the mental health challenges faced by sex workers and provide additional evidence of the high prevalence of PTSD in this population (Farley et al., 2003; Schlenger et al., 1992; Weathers et al., 1993; Kim et al., 2002; Roxburgh et al., 2006). Roxburgh and colleagues (2006) reported that 47% of the sample met DSM-IV criteria for a lifetime diagnosis of PTSD. Vanwesenbeeck (2005) studied a sample of 96 sex workers and found that the

prevalence of PTSD among them was 30%. Farley and colleagues (2003) reported a prevalence rate of 68% for PTSD in Female Commercial Sex Workers. This finding suggests a high prevalence of PTSD among this specific group of individuals.

The experiences and prevalence rates of depression can vary among FCSW depending on individual factors such as socioeconomic status, personal history, support systems, and cultural context. Nonetheless, several studies have suggested that female CSWs face an increased risk of depression compared to the general population.

Prevalence of Stress among FCSW

Although an ample number of studies have been conducted among Female Commercial Sex Workers (FCSW), the majority of them have focused on their sexual risks or other health behaviours. Studies conducted among (FCSW) have often focused on their sexual risks and other health behaviours. This emphasis is due to the recognition that FCSW face unique health challenges and vulnerabilities related to their occupation (Pirkle, Soundardjee, & Stella, 2007). Sex work is a complex and multifaceted issue that intersects with various social, cultural, and economic factors. While research on the well-being of individuals involved in sex work is limited, there have been studies and discussions examining the impact of the stressful characteristics of sex work on their well-being (Ross et al., 2012). A study conducted by Vanwesenbeeck in 2005, and found various stressors experienced by female commercial sex workers (FCSW) and their impact on psychological functioning. The identified stressors included a lack of support from co-workers and gatekeepers, lack of job autonomy, lack of reward from work, and work-related stigma. These stressors were found to have detrimental effects on the psychological well-being of FCSW.

Scholars and researchers have identified several potential stressors and challenges that individuals engaged in commercial sex may face including heavy workload, encounters with law-enforcement officials, drug abuse, abusive clients, and exposure to violence, HIV/STD infections, exploitation, discrimination, and stigmatization. These stressors can have significant physical, psychological, and social impacts on FCSW (Rekart, 2005; Ross et al., 2012; Yi et al., 2012).

Mental health issues are prevalent among individuals engaged in sex work, and various factors have been suggested to contribute to these challenges as several studies provided evidence (Roxburgh et al., 2006; Ling et al., 2007; Grandey, 2000) that shed light on this issue.

The research conducted by Roxburgh and colleagues (2006) found that a significant percentage of American sex workers experienced symptoms of serious mental illnesses. This indicates a higher prevalence of mental health problems among this population compared to the general population. Ling and colleagues (2007) similarly reported that a substantial proportion of Australian sex workers met the criteria for post-traumatic stress disorder. This suggests that exposure to trauma is a significant factor affecting the mental well-being of individuals in the sex work industry.

Ling and colleagues (2007) conducted a study in Hong Kong and found that a significant percentage of sex workers reported suicidal ideation or attempts. This highlights the severity of mental health challenges faced by individuals in the industry, indicating a need for support and interventions.

There is a limited amount of research that quantifies occupational stress among sex workers, especially in contexts where sex work is illegal. The study of sex work is complex and challenging due to various legal, social, and ethical factors, which can hinder research efforts. However, due to the complexity and sensitivity of studying sex work, it can be challenging to obtain representative samples and reliable data. Factors such as the hidden nature of the profession, fear of legal repercussions, and mistrust of researchers may contribute to underreporting or difficulties in recruiting participants.

Prevalence of Satisfaction with Life among FCSW

Research on satisfaction with life among Female Commercial Sex Workers has yielded mixed findings. Several studies have indeed found that many female sex workers experience low levels of life satisfaction and face various challenges. These challenges are often rooted in societal factors, such as stigma, social marginalization, and the potential for exploitation or violence. The physical and mental health of sex

workers can also be negatively impacted. They may face increased risks of sexually transmitted infections (STIs), substance abuse, and mental health issues, including depression, anxiety, and post-traumatic stress disorder. The nature of their work and the associated risks can lead to significant stress and strain on their overall health and well-being. Furthermore, limited opportunities for personal and professional development can further contribute to a lower quality of life for female sex workers. The lack of alternative employment options and educational opportunities can create barriers to pursuing other career paths and personal goals, limiting their ability to improve their circumstances (McDonnell, et. al., 2005; Shukla & Mehrotra, 2016).

However, it is important to recognize that not all female sex workers have the same experiences, and some individuals may report higher levels of satisfaction with their lives. For some, sex work can be a means of earning income, exercising agency, and achieving financial independence. Some studies have highlighted positive aspects of sex work, such as flexible working hours, higher income compared to other available jobs, and the ability to support their families or achieve personal goals. Studies have reported that sex workers are generally satisfied in their life (Diener, 2006; Turner et al., 2013).

A study conducted by Eller and Mahat in 2007 examined the relationship between various factors and the life satisfaction of female commercial sex workers. The researchers found that several aspects of well-being were significantly associated with the life satisfaction of FCSW. They found that life satisfaction was linked to physical functioning, role-physical, bodily pain, mental health, anxiety, depression, social functioning, and health transition. These factors encompass a broad range of dimensions, including physical well-being, mental well-being, and social functioning. Furthermore, the researchers identified that anxiety, health transition, role-physical, physical function, and mental health collectively accounted for 60% of the variance in life satisfaction among FCSW.

The complexity and diversity of experiences among female sex workers, it's challenging to provide a definitive prevalence of satisfaction with life. More research is needed to better understand the factors that contribute to the varying levels of satisfaction and well-being among this population.

Sex work in India

The sex work profession is at its peak in the sub-continent. India and Pakistan are the most vulnerable states. It is noted that India's sex industry operates under cover of secrecy (Dandona et al., 2006). In India, there are more than 100,000 prostitutes in the six major cities of Mumbai, Delhi, Kolkata, Bengaluru, and Hyderabad (ECPAT, 2005). There are approximately 26,000 women who are living and working in four concentrated areas of Lahore, inherited by Pakistan in 1947 after partition. These areas are primarily located in Lahore, Faisalabad, Rawalpindi, Karachi, and Multan (World Bank, 2006). The sex trade of prostitution in Pakistan is a taboo culture that is an open secret that is illegal.

Targetted Population (Mizoram)

Mizoram is one of the 28 states in India. It is indeed located in the northeastern part of the country, sharing borders with the states of Assam, Manipur, and Tripura, as well as the neighbouring countries of Bangladesh and Myanmar (Burma). The capital city of Mizoram is Aizawl, and the state is known for its scenic landscapes, rich tribal culture, and diverse flora and fauna. Mizoram covers an area of about 21,087 square kilometres, of which about 91% is covered with forest. On 20th February 1987, Mizoram was granted statehood, becoming the 23rd state of India. The primary official language of Mizoram is Mizo and in addition to Mizo, several other languages are spoken by different ethnic groups residing in Mizoram. Some of these languages include Hmar, Mara, Lai, Paite, and Gangte, among others. These languages reflect the rich linguistic diversity of the state and are an integral part of the cultural heritage of the various communities in Mizoram. According to the most recent population census, Mizoram's literacy rate has been increasing and now stands at 91.33 %. Mizoram, as of the 2011 census data, had a population of 1,091,014. This

makes it the second least populous state in India, with Sikkim being the least populous state at that time, with a population of 610,577.

The Mizoram State Legislative Assembly consists of 40 seats. The Village Councils play a crucial role in the grassroots level of democracy and leadership and are responsible for local governance and decision-making at the village level. The state government of Mizoram is headed by a Chief Minister, who is the head of the elected government. The Chief Minister is responsible for the overall governance of the state and exercises executive powers. The Council of Ministers, also known as the cabinet, consists of ministers who are assigned specific portfolios to oversee various government departments and ministries. Each minister is responsible for their respective ministry's functioning and implementing policies and programs related to their portfolio.

In Mizoram, there are 11 districts. Each district is headed by a Deputy Commissioner (DC), who serves as the executive head of the district's administration. The Deputy Commissioner holds a crucial role in implementing government policies and regulations within the district. The Deputy Commissioner plays a vital role in the governance and administration of the district, focusing on maintaining law and order, implementing government policies, and overseeing tax collection.

Mizoram generally experiences a moderate climate. The temperature range varies throughout the year, with cooler months from November to February and warmer months from June to August. During the coolest months, such as November through February, Aizawl, the capital city of Mizoram, sees temperatures starting from the low 50s Fahrenheit (low 10s Celsius) and rising into the high 60s Fahrenheit (about 20 degrees Celsius) during the day. These months typically have pleasant weather. In the warmest months of June through August, the minimum temperatures in Aizawl are in the high 60s Fahrenheit, while the maximum temperatures usually reach the mid-80s Fahrenheit (about 30 degrees Celsius). This period tends to be relatively warmer, but still not excessively hot. Mizoram receives a significant amount of rainfall, with an average of about 100 inches (2,500 mm) annually. The majority of the rainfall is brought by the southwest monsoon, which typically blows from May to

September. The monsoon season is responsible for the bulk of the precipitation in Mizoram.

During the early 21st century, more than two-thirds of the workforce in Mizoram were engaged in agricultural activities. There are two primary types of agriculture practised in the region: terrace cultivation and shifting agriculture. Terrace cultivation is particularly suitable for hilly regions like Mizoram because it helps conserve water and prevent soil erosion, as the terraces reduce the speed of water runoff and facilitate better retention of moisture in the soil. Shifting agriculture involves clearing small tracts of land by burning the vegetation, followed by cultivation for a limited period. Afterwards, the land is abandoned for several years to allow natural vegetation to regenerate and restore soil fertility. Traditionally, the jhum cycle in Mizoram lasted around eight years. However, due to an increase in the number of people engaged in farming, the cycle has been shortened, leading to decreased farm productivity. The main crops grown in Mizoram include rice, corn (maize), cotton, and vegetables.

The government of Mizoram has recognized the importance of promoting small-scale industries at the village level to foster local economic development and create employment opportunities. These industries include sericulture (silk production), handloom and handicraft workshops, sawmills and furniture manufacturing, oil refining, grain milling, and ginger processing. These initiatives aim to harness the region's resources and traditional skills to promote sustainable livelihoods and economic growth.

Sex workers in Mizoram:

According to the Samaritan Society of Mizoram, the number of Female Commercial Sex workers ever registered in Mizoram till January 2022 was 1014 and the number of validated clients was 226. And the age gap between them was 16-53 years. In many places, including Mizoram, commercial sex workers can be categorized as street-based or home-based workers. Street-based sex workers operate in public spaces such as streets, parks, or other open areas, while home-based sex

workers may work from their residences or in establishments like cheap hotels or thatched houses on the outskirts of towns.

Though there were women sex workers in all districts of the state, the majority of them 90% were working in the capital-Aizawl. It is unfortunate that many women in the state, particularly in the capital city of Aizawl, have turned to sex work due to financial difficulties. Economic challenges can often drive individuals into vulnerable situations, and it's important to address the root causes of these problems and provide support to those affected.

Substance misuse can be a significant issue among some individuals involved in sex work. Factors such as social stigma, psychological stress, and economic challenges can contribute to substance misuse, including injecting drug use and alcohol consumption. As sex work is highly related to substance misused, most of them indulged in injecting drug use and alcohol.

Mizoram State Aids Control Society (MSACS) is actively working with church and youth leaders to bring about a change in attitude towards HIV/AIDS. Collaborating with community leaders is crucial for addressing the challenges associated with high-risk groups, such as sex workers and injecting drug users, who are more susceptible to HIV infection. By involving church and youth leaders, MSACS can leverage their influence and reach within the community to raise awareness about HIV/AIDS, promote safe practices, and reduce stigma and discrimination. These leaders can play a significant role in disseminating accurate information, fostering a supportive environment, and encouraging individuals to seek testing, treatment, and prevention services.

Government programs that focus on HIV prevention campaigns often face the challenge of overcoming the fear of identification and the associated stigma. Public identification can lead to discrimination, social exclusion, and humiliation. To address this issue, drop-in centres have been established as safe spaces to provide support and services to marginalized populations, including those living with HIV. Drop-in centres play a crucial role in reaching out to individuals who have been rejected by society, providing them with a non-judgmental environment where they can access

the help they need. By offering comprehensive support services, drop-in centres aim to reduce the barriers faced by individuals living with HIV and promote their overall well-being. These services may include HIV testing and counselling, access to healthcare and medications, support groups, mental health services, substance abuse treatment, educational workshops, and vocational training. These centres provide a safe and non-judgmental space where people can access a range of services. The aim is to create an environment that encourages individuals to seek help without the fear of stigma or discrimination. Drop-in centres play a vital role in reaching out to these individuals who have been rejected by society. By adopting a non-judgmental approach, these centres create a safe and welcoming environment where health workers can engage with sex workers and injecting drug users without fear of humiliation or stigma. This approach is essential in building trust and establishing effective communication channels.

In drop-in centres, services like free condoms and regular check-ups for sexually transmitted infections are provided. These measures are critical in preventing the transmission of HIV and other sexually transmitted infections. By offering these resources, health workers not only provide immediate protection but also educate individuals on safe practices, helping them make informed decisions regarding their sexual health.

Sex work like in any other place, can be influenced by various factors in Mizoram viz, Poverty and unemployment, broken families, lack of parental skills, neglect of children, domestic violence, alcohol and drug addiction, negative peer influences and delinquency, some individuals may be drawn to prostitution due to perceptions of quick financial gains or an easy lifestyle, substance abuse issues, such as alcohol and drug addiction or experiencing domestic violence or being in an abusive relationship.

To effectively reduce the spread of HIV within these populations, it is crucial to address hidden groups like sex workers and injecting drug users is essential because they often face social marginalization and are at increased vulnerability to HIV infection due to various factors, including limited access to healthcare, higher-risk

behaviours, and stigma. By reaching out to these groups and providing them with comprehensive HIV prevention services, including access to condoms, needle exchange programs, harm reduction strategies, and counselling, MSACS can help reduce the spread of HIV within these populations.

Female Commercial Sex Workers often face significant psychosocial challenges that can have a detrimental impact on their mental well-being. Engaging in sex work can expose individuals to a range of difficult and potentially traumatic situations, including violence, exploitation, stigmatization, and social isolation. These experiences can contribute to a variety of psychosocial challenges. Due to the nature of their work and the societal attitudes towards it, they may experience high levels of stress, anxiety, depression, post-traumatic stress disorder (PTSD), and other mental health issues. The mental health issues of Female Commercial Sex Workers have largely been understudied, despite their potential policy and programmatic implications.

By studying the prevalence of mental health problems, policymakers and healthcare professionals can gain insights into the specific challenges faced by this population and develop targeted interventions to address their needs.

Be it is whatever the factor of engaging in sex work, given the mentioned theoretical backgrounds, provided relevant studies about the psychosocial problems of the current scenarios of sex workers, the present study was framed to serve the research gap especially for the present targeted group to provide valuable insights into the psychosocial challenges faced by sex workers and contribute to understanding their mental health needs.

OBJECTIVES:

To embark upon the present study, the following specific objectives were laid out:

1) To compare the level of Resilience, Depression, Stress and Satisfaction with life among the four comparision groups (i.e. External Female Commercial Sex Workers, Internal Female Commercial Sex Workers, External Females Non Sex Workers, and Internal Females Non Sex Workers).

2) To examine the significant difference between Female Commercial Sex Workers and Female Non Sex Workers) on Resilience, Depression, Stress and Satisfaction with life.

3) To study the relationship between Locus of Control, Resilience, Depression, Stress and Satisfaction with life.

4) To examine the independent effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life.

5) To examine the interaction effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life.

HYPOTHESES:

Based on the literature presented and observations and anecdotal reports in the target population, the following hypotheses were framed to address the objectives:

1) There will be a significantly different level of Resilience, Depression, Stress and Satisfaction with life among the groups, External Female Commercial Sex Workers will have the highest scores than Internal Female Commercial Sex Workers, External Females Non Sex workers, and Internal Females Non Sex Workers on Depression and stress but reverse scores on Resilience and Satisfaction with Life.

2) It was expected that Female Commercial Sex Workers will have significantly higher scores on Depression and Stress but lower scores on Resilience and Satisfaction than Female Non Sex Workers.

3) There will be a significant positive relationship between Locus of Control, Depression and Stress, and Resilience and Satisfaction with life whereas Locus of Control, Depression and Stress will have a negative relationship with Resilience and Satisfaction with life.

4) There will be a significant independent effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life.

5) There will be a significant interaction effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life.

Chapter – IV

METHOD AND PROCEDURE

Sample

To achieve the objectives, ***100 Female Commercial Sex Workers (FCSW)*** who have been in the sex industry for more than 1year to 4 years were screened out, comprises of 50 Female Commercial sex Workers with External Locus of Control (External Female Comercial Sex Workers; EFCSW) and 50 Female Commercial sex Workers with Internal Locus of Control (Internal Female Commercial sex Workers; IFCSW) using the Rotter's Locus of Control Scale (Rotter, 1966) were screened out from 168 Female Commercial Sex Workers. Samples were drawn from the list of registered Protective home/centres under Mizoram Social Welfare, Mizoram State Aids Control Society (MSACS) or registered NGOs in Aizawl city following random sampling procedure. To compare with the FCSW, ***100 Female Non Sex Worker*** (FNSW) comprises 50 Female Non Sex Worker with an external locus of control (External Female Non Sex Workers; EFNSW) and 50 Female Non Sex Workers with an Internal Locus of Control (Internal Female Non Sex Worker; IFNSW) who were working in private / Non-Governmental Organizations (NGOs) and has been working in the organization more than 1year to 4 years were also screened out using the Rotter's Locus of Control Scale (Rotter, 1966), who were screened out from 560 Female Non Commercial Sex Workers by following random sampling procedures from Aizawl city, the capital of Mizoram. Other variables include age level (ranging between 18-43 years), monthly income of the sample, marital status of the sample, their mother's and father's occupation, family size, family monthly income of the sample, number of siblings, educational background, their parental status, their house living condition, duration of work in their job, work shifts in a day, duration working hour in a day were under controlled to have well matched between the four groups and also to get the socio-demographic variables distribution of the samples using the social-demographic profiles.

Design of the Study

The study aims to compare External Female Commercial Sex Workers, Internal Female Commercial Sex Workers, External Females Non Sex Workers, and Internal Females Non Sex Workers on Depression, Stress, Resilience and Satisfaction with Life on the dependent variables. It will be 2 x 2 factorial designs that 200 female samples consisting of 100 Female Commercial Sex Workers (50 External Female Commercial Sex Workers and 50 Internal Female Commercial Sex Workers) and 100 Female Non Sex Workers (50 External Female Non Sex Workers and 50 Internal Female Non Sex Workers) to find any significant difference among the groups, any relation between the dependent variables, any significant effect of 'Commercial Sex work and Locus of Control', and interaction effect of 'Commercial Sex Work and Locus of Control' on the dependent variables.

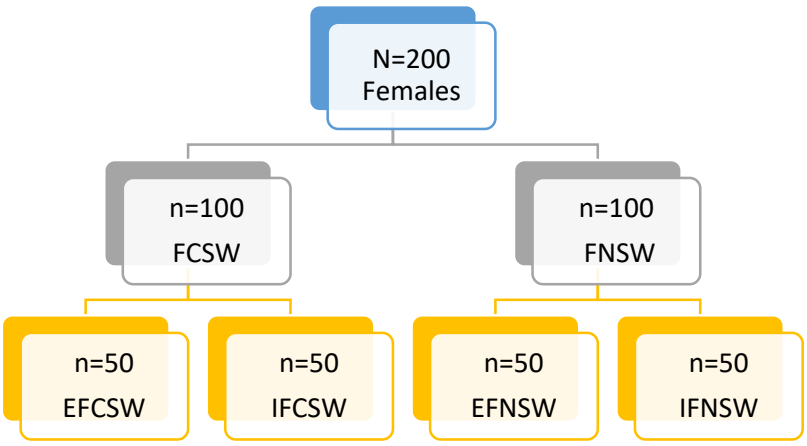

Fig-1: Diagram representing the design of the study.

PROCEDURE

The Psychological tools were selected to be used in the study- Rotter's Locus of Control Scale (Rotter, 1966), the Resilience Scale (RS; Gail M.Wagnild and Heather M. Young, 1993), The Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) and The DASS-21 (Lovibond & Lovibond, 1995) were translated into Mizo language since the participants speak Mizo. The Psychometric adequacy of the scales was checked through a Pilot study of the study, all the psychometric properties were found applicable to the targeted population.

The representative of FCSW (with equal representation of external and internal locus of control) were randomly taken from the list of registered under Mizoram State Aids Control Society (MSACS) through Agape Moral Reformation Organization (AMRO) whereas the FNSWs were chosen randomly from government departments, hospitals, and non-governmental organizations as much as possible to well matched to the FCSW samples. However, due to the COVID-19 pandemic, sex workers were unable to continue their services and thus, participants were approached at Protective Homes and Centres and some were even approached at their homes. The samples were well informed about the purpose of the study, and the expectation of participation in the study, and also ensure confidentiality of their identity as per ethical standards (APA 2014), made them clear any time they can leave if they wish, and only those who gave consent were included in the sample. Rapport formation and a careful explanation of instructions for completing the questionnaire were done with due consideration. Then the Psychological tools were administered to the participants in individual conditions.

All the prescribed administration procedures laid down by each scale were strictly followed. The response sheet was carefully checked to detect any missing or incomplete answers before leaving the administration set.

Scoring was done as per instruction in the manual of the psychological tests. After careful screening of the responses and removal of outliers and incomplete responses, 200 response sheets comprising of equal distribution of participants from each comparison group were made ready for further analysis.

Psychological Tools Used

1. Rotter's Locus of Control Scale (Rotter, 1966): J. B. Rotter's Internal-External Locus of Control Scale is a measure of personal belief. It consists of 29 items. Rotter's Internal-External Locus of Control questionnaire helps to identify how certain important events in our society affect different people. Each item in the scale consists of pair of alternatives, lettered A or B. The individual has to select one statement from each pair, which they strongly believe in or can relate to. The total point is between 0 and 23. A higher point indicates the external locus of control and a lower point indicates the internal locus of control. It was found that the Cronbach coefficient of the scale was .71 and the test-retest reliability was .83, and the scale was found applicable in the targeted population that the Cronbach coefficient of the scale was .70 and test-retest reliability was .81 through the pilot study.

2. Resilience Scale (RS; Gail M.Wagnild and Heather M. Young, 1993): The Resilience Scale (RS), developed by Wagnild and Young (1993), is a 25-item self-report questionnaire to identify the degree of individual resilience. The items of the Resilience scale were selected to reflect five interrelated components of resilience: *equanimity* (a balanced perspective of one's life and experiences); *perseverance* (the act of persistence despite adversity or discouragement); *self-reliance* (a belief in oneself and one's abilities); *meaningfulness* (the realization that life has a purpose); and *existential aloneness* (the realization that each person's life path is unique). The respondents are asked to state the degree to which they agree or disagree with each item on a 7-point Likert-type scale from 1 (strongly disagree) to 7 (strongly agree). All items are positively scored. The possible total scores thus range from 25 to 175 with higher scores reflecting higher resilience. The resilience scale had shown excellent internal consistency of .89 among undergraduate nursing students, and almost the same (α =.84) was found in the targetted population through the pilot study.

3. The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985): This scale was developed as a measure of the judgmental component of subjective well-being (SWB). The SWLS is shown to be a valid and reliable measure of life satisfaction, suited for use with a wide range of age groups and applications,

which makes possible the savings of interview time and resources compared to many measures of life satisfaction. Besides, the high convergence of self- and peer-reported measures of subjective well-being and life satisfaction provide strong evidence that subjective well-being is a relatively global and stable phenomenon, not simply a momentary judgment based on fleeting influences. Though scoring has some cut-offs to be used as benchmarks- extremely satisfied, satisfied, slightly satisfied, neutral, slightly dissatisfied, dissatisfied, and extremely dissatisfied. Participants indicate how much they agree or disagree with each of the 5 items using a 7-point scale that ranges from 7 strongly agree to 1 strongly disagree. The analysis of the scale's reliability showed good internal consistency ($\alpha = 0.74$) among the Mexican adults and also found high internal consistency ($\alpha = 0.77$) among the targetted population in the pilot study.

4. **The DASS-21 (Lovibond & Lovibond, 1995):** The DASS-21 is a self-report questionnaire consisting of 21 items, 7 items per subscale: *depression, anxiety and stress*. Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and stress experienced by normal subjects and clinical populations are essentially differences in degree. Participants are asked to score every item on a scale from 0 (did not apply to me at all) to 3 (applied to me very much). Sum scores are computed by adding up the scores on the items per (sub) scale and multiplying them by a factor of 2. Sum scores for the total DASS-total scale thus range between 0 and 120, and those for each of the subscales may range between 0 and 42. Cut-off scores of 60 and 21 are used for the total DASS score and the depression subscale respectively. These cut-off scores are derived from a set of severity ratings, proposed by Lovibond and Lovibond. Scores greater than 60 (for DASS-total) and greater than 21 (for the depression subscale) are labelled as "high" or "severe".The present study will employ only the 'stress' and 'depression' subscales which were found a high internal consistency ($\alpha = 0.78$) among the targetted population under study through a pilot study.

5. **Informed Consent Form**: The informed consent form was constructed by the research scholar (Lalhriatpuii, 2019a) for the present study to inform about the purpose of the study, expected participation of the participants, assurance of no harm to the participant, and has participated solely on free will and may leave at any time, and assurance of confidentiality on all personal responses; which is also taken as mandatory for fulfilment of research per APA ethical standard (2014) UGC regulation for Ph D (2019).

6. Socio-Demographic Profile: The Socio-Demographic profile constructed by the researcher for the present study (Lalhriatpuii, 2019b) contained socio-demographic variables such as age, sex, education level, marital status, parent's occupation of the samples, family size, number of a sibling, monthly income of the family, house living condition, duration of service, parent's marital status of the sample, type of shift in a day, duration of a working hour in a day, etc for screening of the desired sample as per design of the study.

Statistical Analysis:

To test the hypotheses set forth to determine the locus of control on resilience, depression, stress and satisfaction with life among FCSW, the psychometric properties of the items and scales of the psychological measures were ascertained to warrant their applicability for use in the population of the proposed study.

Firstly, the psychometric adequacy of the psychological tests was analyzed and Cronbach alpha reliability coefficients were employed for the present study.

Secondly, the mean and SD values were calculated for comparison of the test scores between the groups, and the Skewness and Kurtosis of the scales to check the nature of the data distributions for further analysis. Descriptive statistics, Levene's tests of homogeneity of variance and Browne- Forsythe Robust test of equality of variances were employed for parametric statistics assumption checking and also for choosing appropriate statistics.

Thirdly, Post Hoc Mean Comparison (Scheffe) was employed to find any significant Mean difference between the four groups on dependent variables.

Fourthly, Pearson Correlation was calculated to determine the relationship between the variables for the samples.

Lastly, one-way and Two-way Analysis of Variance was employed to examine the independent and interaction effects of ‘Commercial Sex Work’ and ‘Locus of Control’ on the Dependent Variables.

Chapter- V

RESULT AND DISCUSSION

The present study entitled “Locus of Control on Resilience, Depression and Stress: A Study of Female Commercial Sex Workers in Aizawl City ” aimed to study any significant difference in Resilience, Depression, Stress and Satisfaction in Life among Female Commercial Sex Workers along with their Personality (Locus of control), any significant relationship between the dependent variables, the independent effect of 'Commercial Sex Work' and 'Locus of Control', and their interaction effects on the dependent variables.

It was hypothesized that there will be a significantly different level of Resilience, Depression, Stress and Satisfaction with life between the 'Female Commercial Sex Workers’ and ‘Female Non Sex Workers', and two types of personality (External and Internal Locus of control); It was also hypothesized that there will be significant relationship among dependent variables, and that there will be significant independent and interaction effect of ‘Commercial Sex Work’ and ‘Locus of control’ on the dependent variable under study.

To achieve the objectives and hypotheses put forth, 200 participants comprising 100 Female Commercial Sex Workers and 100 Female Non Sex Workers consisting of equal representation of External and Internal Locus of Control having equally matched socio-demographic profiles were selected from Aizawl city by using a multi-stage random sampling method. The age group of the participants was between 18-41 years.

Rotter’s Locus of Control Scale (Rotter, 1966); Resilience Scale (Wagnild and Young, 1993); Satisfaction With Life Scale (Diener et al.,1985) and The DASS-21 (Lovibond & Lovibond, 1995), Socio-Demographic Profile (Lalhriatpuii, 2019a), and Inform Consent Form (Lalhriatpuii, 2019b) were employed for psychological evaluation to the samples. The administration was done with due care to the instructions provided in the manual and APA (2014)

1. **Sample Characteristics:** The sample consists of 200 Females consisting of 100 Female Commercial Sex Workers (50 External and 50 Internal Locus of Control) and 100 Female Non Sex Workers (50 External and 50 Internal Locus of Control) from Aizawl city. The socio-demographic profile of the FCSW was presented in Table 1 and Figures-2 to 15 which tells about the possible reason for FCSW.

Table-1: *Showing demographic variables (marital status, age groups, mother's occupation, father's occupation, family size, family monthly income, number of siblings Education qualification,parent's marital status,residential status, duration of job, monthly income and work shift of the day) distribution among the samples (Female Commercial Sex Workers)*

1	**Distribution of marital status of the FCSW in % (Numbers)**				
	Married		Unmarried		Divorced
	15%		63%		22%
2	**Distribution of age groups of FCSW in % (Numbers)**				
	18-23	24-29		30-35	36-41
	12%	55%		27%	6%
3	**Distribution of their mother's occupation of the FCSW in % (Numbers)**				
	Govt		Private		Unemployed
	15%		21%		64%
4	**Distribution of their father's occupation of the FCSW in % (Numbers)**				
	Govt		Private		Unemployed
	43%		29%		28%
5	**Distribution of family size of FCSW in % (Numbers)**				
	1-3	4-6		7-9	10-12
	18%	41%		12%	9%
6	**Distribution of family monthly income of FCSW in % (Numbers)**				
	5000	5000-15000	15000-30000	30000-50000	50000 above
	2%	26%	37%	27%	18%
7	**The number of siblings among FCSW in % (Numbers)**				
	1-3		4-6		7-10
	55%		38%		7%
8	**Education qualification of FCSW in % (Numbers)**				
	HSLC	HSSLC		Graduate	Post Graduate
	38%	15%		21%	26%
9	**Distribution of their parent's marital status of FCSW in % (Numbers)**				
	Married	Divorced	Widow	Widower	Deceased parents
	50%	20%	6%	19%	5%
10	**Distribution of residential status among FCSW in % (Numbers)**				
	Rent		Owned		
	83%		17%		
11	**Distribution of the duration of job of the FCSW in % (Numbers)**				
	Less than 1 year	1 year	2 years	3 years	More than 3 years
	17%	18%	14%	11%	40%
12	**Distribution of monthly income of FCSW in % (Numbers)**				
	5000	5000-15000	15000-30000	30000-50000	50000 above
	4%	6%	62%	19%	9%
13	**The distribution of the work shift in a day for FCSW in % (Numbers)**				
	Morning		Day		Night
	10%		67%		23%

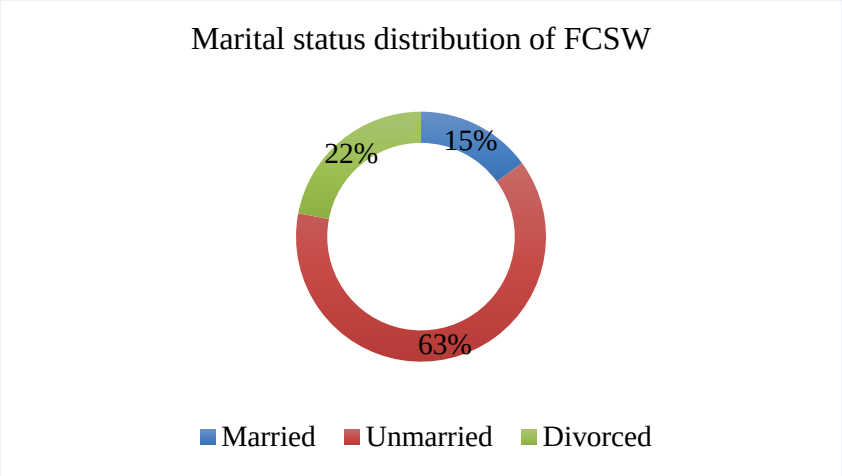

Figure -2: Showing the distribution of marital status of the FCSW

The distribution of marital status of the FCSW sample showed that 63% were unmarried, 22% were divorced and 15% were married (*Figure-2*) which may indicate that divorce could be one reason for Commercial Sex Work (CSW).

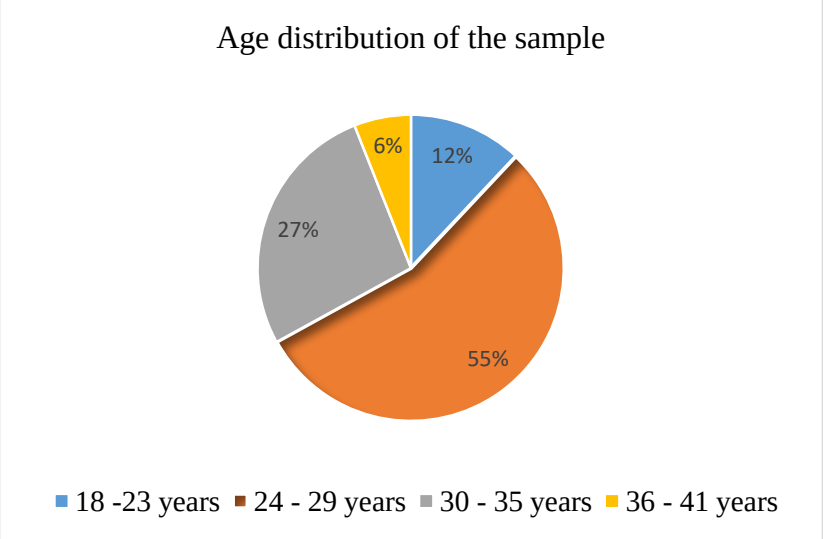

Figure -3: Showing the distribution of age groups of the FCSW

The distribution of age group of the FCSW samples had shown that 12% were 18-23 years, 55% were 24-29 years, 27% were 30-35 years, and 6% were 36-41 years (*Figure-3*). The highest peak for commercial sex work was 24 to 29 years of age.

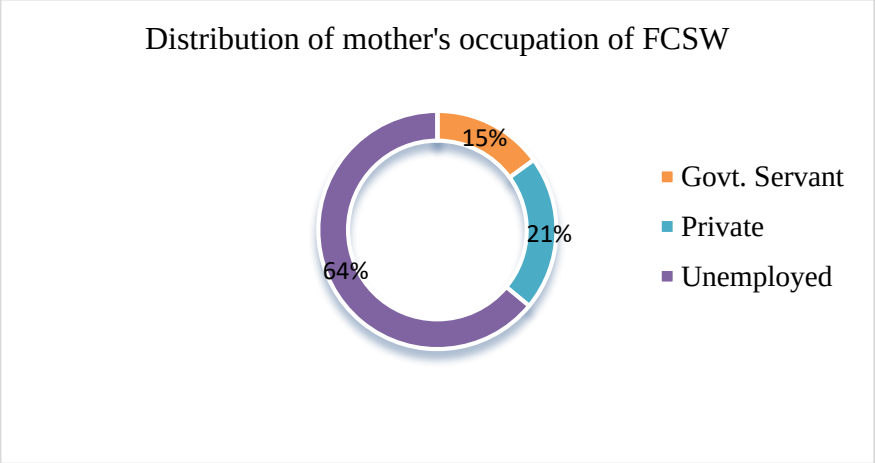

Figure -4: Showing the distribution of their mother's occupation of the FCSW

The distribution of their mother's occupations had shown that 15% were Government Servants, 21% were working in private and 64% were unemployed (*Figure-4*) which suggested that the unemployment of their mother may have an indirect effect on Commercial Sex Work.

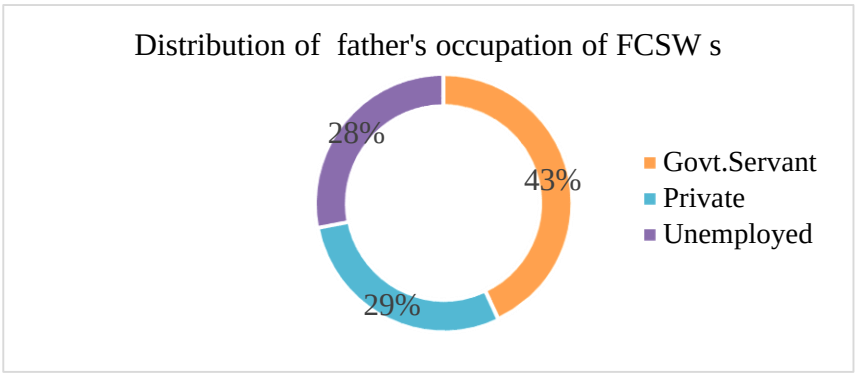

Figure -5: Showing the distribution of their Father's occupation of the FCSW

The distribution of their father's occupation indicated that 43% were engaged in Government services, 29% were working in private sectors and 28% were unemployed (*Figure -5*) showing that father's occupation may have indirect effect on CSW.

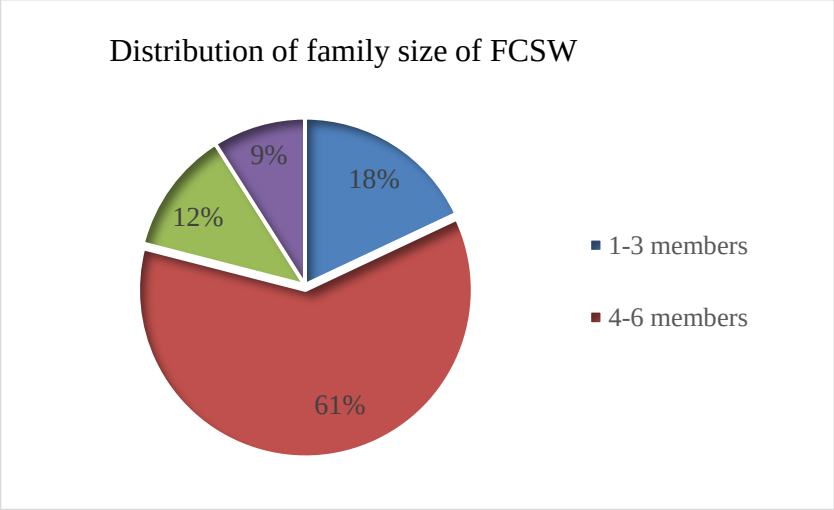

Figure -6: Showing the distribution of family size of FCSW

The distribution of the family size of the sample showed 18% were having 1-3 family members, 41% had 4-6 family members, 12% had 7-9 family members, and 9% have 10-12 family members (*Figure-6*) which displayed that medium family members may have some impact on CSW.

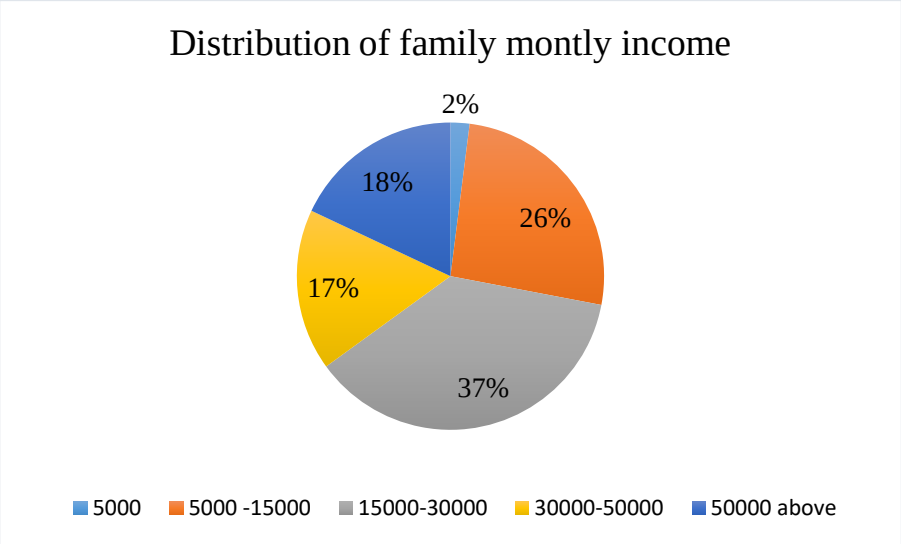

Figure -7: Showing the distribution of family monthly income of FCSW

The distribution of the Family annual income of the FCSW sample revealed that 2% were below 5000, 26% were between 5000-15000, 37% between 15000-30000, 27% between 30000-50000 and 18% were above 50000 (*Figure-7*) which may indicate that their monthly income was not sufficient for their livelihood.

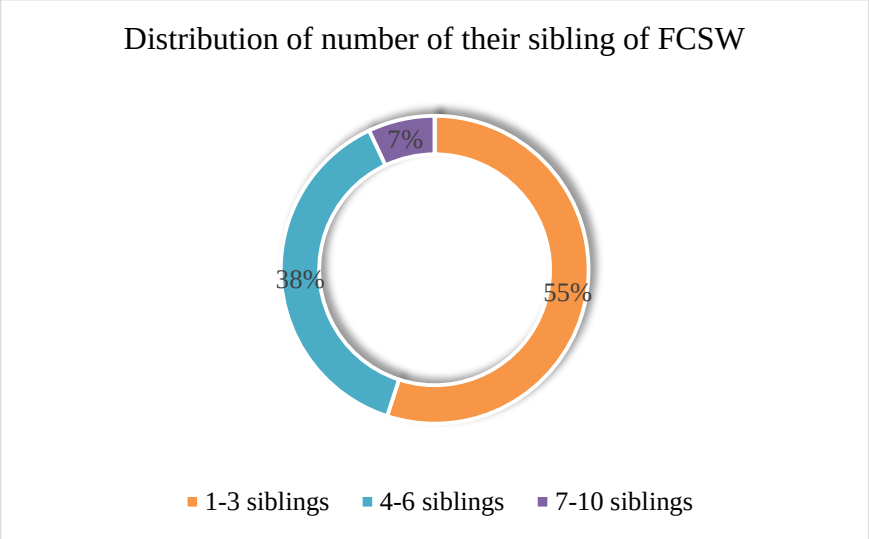

Figure -8: Showing the number of siblings among FCSW

The distribution of the number of siblings in the sample showed that 55% of the sample had 1-3 siblings, 38% had 4-6 siblings and 7% of the sample had 7-10 siblings (*Figure-8*) indicating 5-6 sibling size were highest among FCSW.

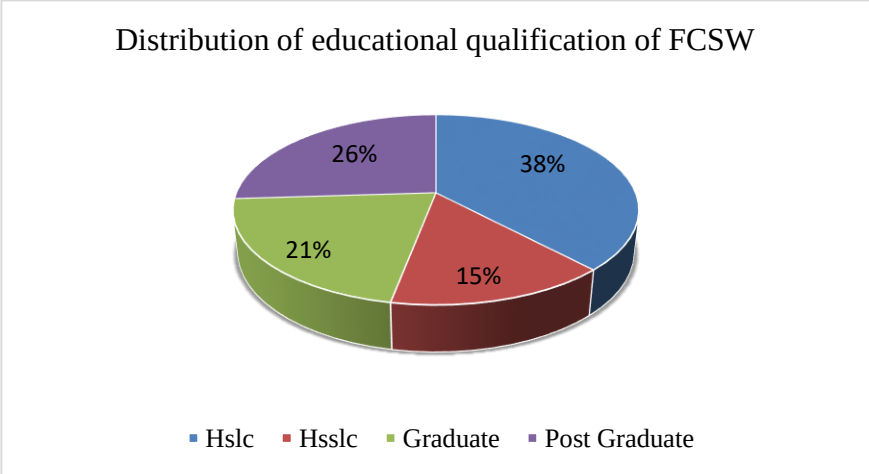

Figure -9: Showing the education qualification of FCSW

The distribution of the educational level of the sample showed that 38% falls under HSLC, 15% under HSSLC, 21% were graduate degrees and 26% were Postgraduate levels of education (*Figure-9*) demonstrating the importance of educational level for Commercial Sex Work.

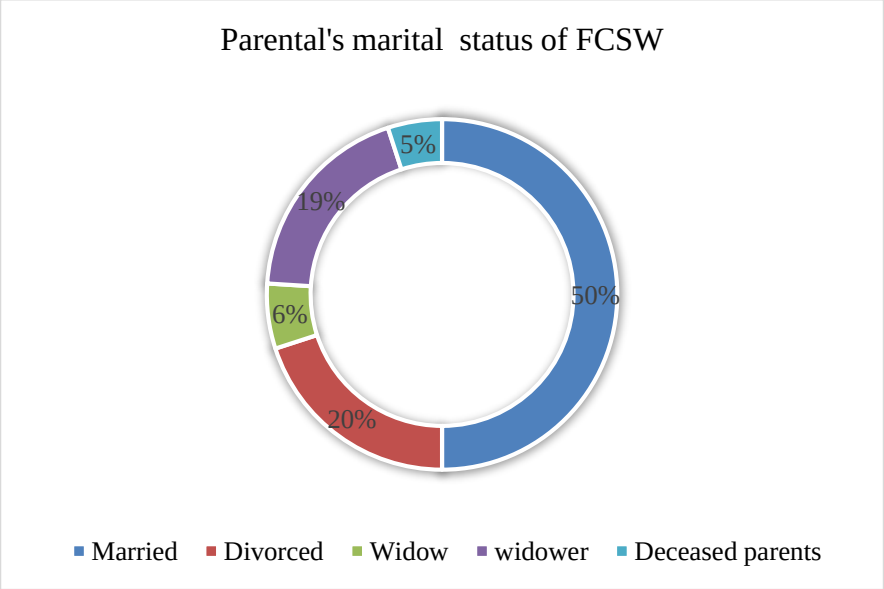

Figure -10: Showing the distribution of their parent's marital status of FCSW

The distribution of their parent's marital status of the sample showed that 50% were married, 20% divorced, 6% widowed/single, 19% and 5% belonged to deceased parents (*Figure-10*) which conveys that parent's marital status has some indication for the reason of CSW.

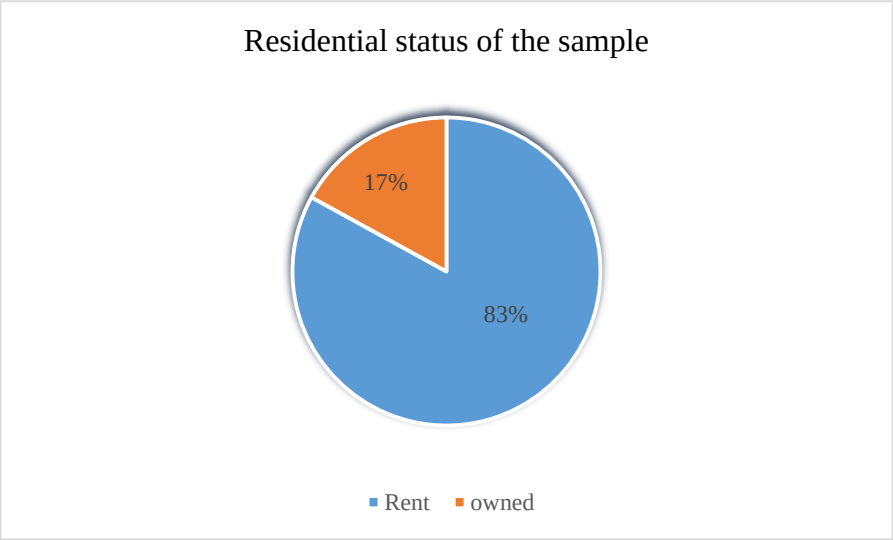

Figure-11: Showing the distribution of residential status among the sample

The distribution of house living conditions revealed 17% lived in owned houses and 83% lived in a rented house (*Figure-11*) which may demonstrate that house living conditions may be one reason for FCSW.

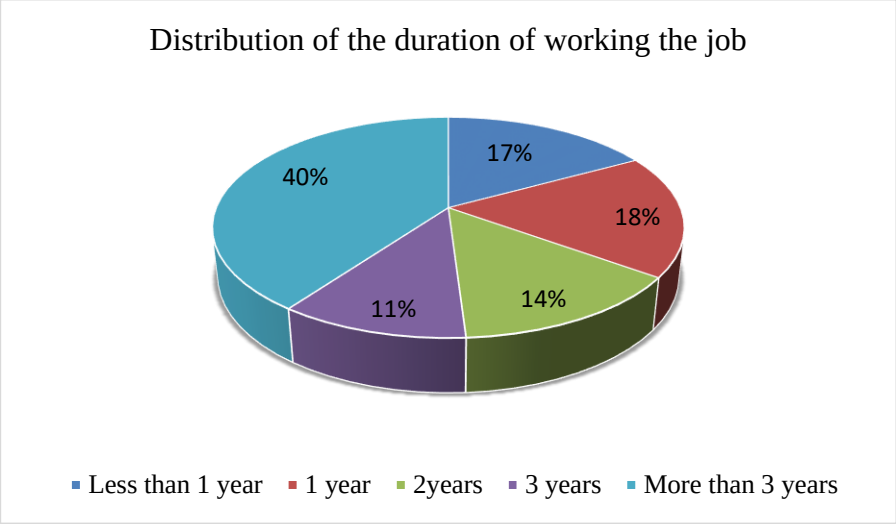

Figure -12: Showing the distribution of the duration of job of the FCSW

The distribution of the duration of job showed that 17% had worked less than a year, 18% for one year, 14% for 2 years, 11% for 3 years and 40% of the sample have been working for more than 4 years (*Figure-12*) which may indicate non-availability of other jobs for survival.

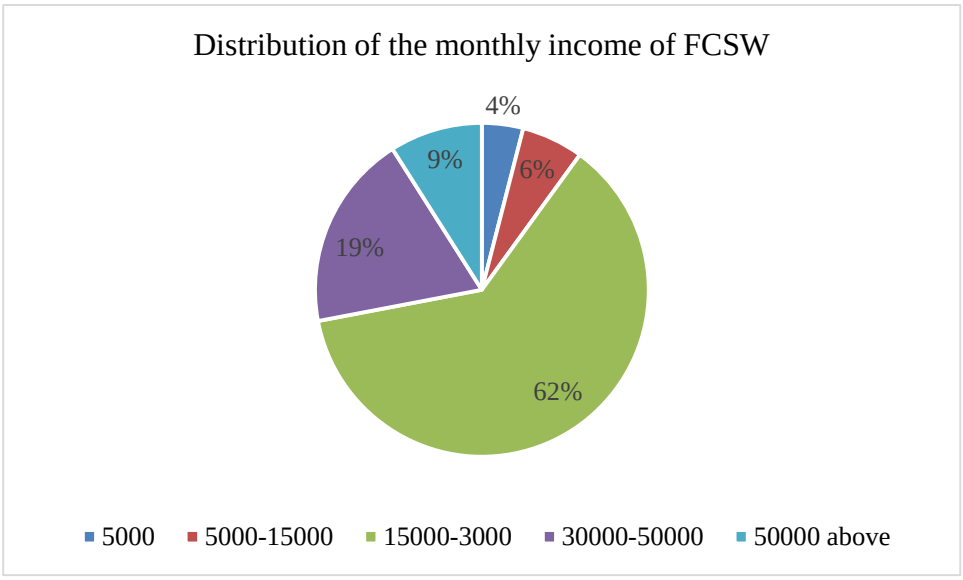

Figure -13: Showing the distribution of monthly income of FCSW

The distribution of monthly income of the sample revealed 4% had an annual income of below 5000, 6% were between 5000-15000, 62% between 15000-30000, 19% between 30000-50000 while 9% more than 50000 (*Figure-13*) which conveyed that CSW support was needed for their livelihood.

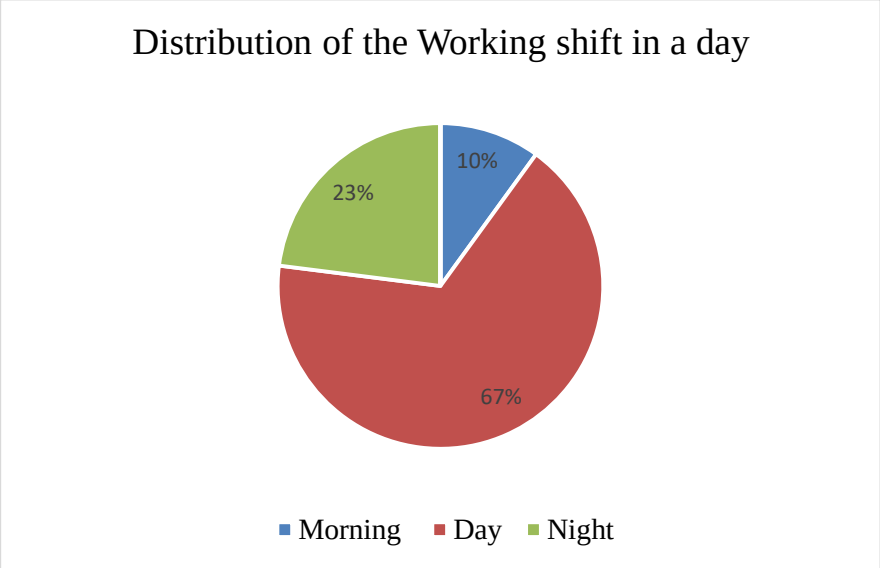

Figure -14: Showing the distribution of the work shift in a day for FCSW

The distribution of the work shift in a day for the sample exhibited that 10% worked in the morning, 67% worked during the daytime and 23% worked at night (*Figure-14*) indicating that the daytime shift may be more comfortable for them as more numbers fall in this shift.

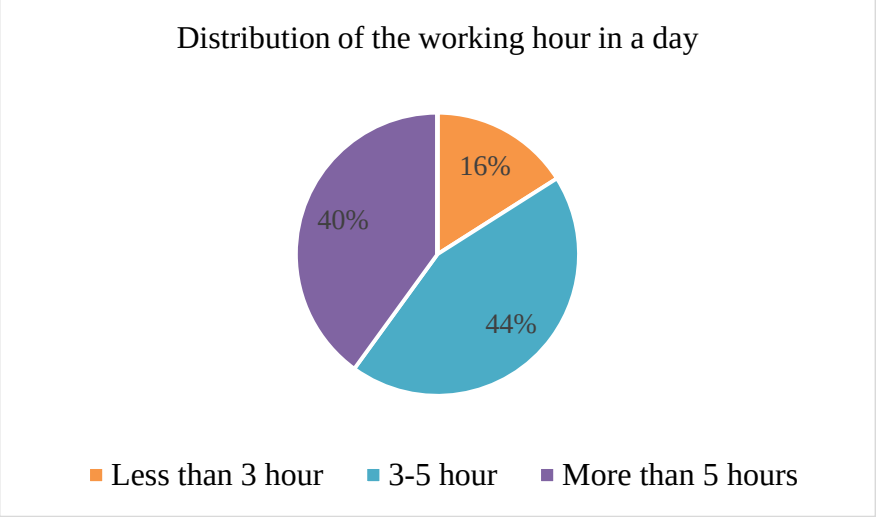

Figure -15: Showing the distribution of working hours in a day among FCSW

The distribution of working hours in a day among the sample demonstrated that 16% worked less than 3 hours, 44% worked between 3-5 hours and 40% of the sample worked for more than 5 hours in a day (*Figure-15*) as most of them worked between 3-5 hrs which may be not overtime working hour.

2. Psychometric Properties of the Psychological Scales

The psychological tests used in the present study were originally developed for another culture and therefore, it becomes necessary to ensure the scales are acceptable for the current population under study (Witkin & Berry, 1975) as such the psychometric test was done to verify the trustworthiness of the scales for the population under study. The reliability of the scales was analysed using Cronbach's Alpha to check the psychometric adequacy among the samples.

The result in *Table-2* reveals the reliability coefficients (Cronbach's Alpha) of the scales over the two levels of analysis (Female Commercial Sex Workers and Female Non Sex Workers). The internal consistency of the scales was found to be highly reliable for Locus of Control (α = .67), Resilience (α = .79), Satisfaction with life (α = .77), and Depression (α = .82) and Stress (α = .81) demonstrated the trustworthiness of the psychological scales for the targetted population.

3. Parametric Statistics Assumption Check

To check the homogeneity of variances of the scales, Levene's Test of Equality of variances and Browne Forsythe tests were employed. Results in *Table-2* also revealed that the significance of Levene's Test of Equality of variances ($p<=.05$) and non-significant for Browne Forsythe tests which indicated that the parametric statistics assumption has been met and may be employed in further analysis to meet the objectives of the study.

Table- 2

Reliability and Homogeneity test on Psychological Scales for the samples

Scales	Cronbach's alpha	Levene's Test of Equality of Variance	Brown Forsythe
Locus of Control	.67	.24	.00
Resilience	.79	.14	.00
Satisfaction with Life	.77	.15	.00
Depression	.82	.09	.00
Stress	.81	.17	.00

Descriptive statistics including the mean, SD, Kurtosis and Skewness (Table-3) revealed the normality of data of the present study which also indicated the fulfillment of the parametric statistics for choosing appropriate statistics. The mean score on the dependent variables was (*M*=13.12; *SD*=3.65) for Locus of control, (*M*=113.44; *SD*=12.91) for Resilience, (*M*=18.01; *SD*=8.02) for Depression, (*M*=16.30; *SD*=6.64) for Stress and (*M*=19.62; *SD*=5.37) for Satisfaction with life.

Table-3

Showing Mean, SD, Skewness and Kurtosis for the whole sample

Scales	Mean	*SD*	Skewness	Kurtosis
Locus of Control	13.12	3.65	-0.03	-0.07
Resilience	113.44	12.91	0.03	-0.90
Depression	18.01	8.02	0.00	-0.58
Stress	16.30	6.64	0.00	-0.58
Satisfaction with Life	19.62	5.37	0.04	-0.81

4. Mean Difference and Significant Difference on Dependent Variables

The results of the study were displayed following the objectives of the study sequentially as follow**.**

Objectives- 1: To compare the level of Resilience, Depression, Stress and Satisfaction with life among the four comparision groups.

To compare the four comparision groups-(i) External Female Commercial Sex Workers, (ii) Internal Female Commercial Sex Workers, (iii) External Females Non Sex Workers and (iv) Internal Females Non Sex Workers, the descriptive statistics and Post Hoc Mean comparision (Scheffe) were employed to find out any significant difference between the four comparision groups for the dependent variables, and are presented in Tables-4a to 4d.

Table 4a shows the Mean, *SD*, Skewness and Kurtosis on Resilience. The mean score on Resilience for the four comparision groups indicated that IFNSW

scored highest (*M* = 128.80), followed by EFNSW (*M* = 120.48), IFCSW (*M* = 108.14) and EFCSW scored lowest (*M* = 98.26, *SD* = 6.40). Earlier research finding indicated individual with an internal locus of control tends to have higher levels of resilience and better adaptive coping strategies (Frazier et al., 2011). There is a limited study available on the Internal Locus of Control and External Locus of Control on Resilience within Female Commercial Sex workers and Female Non Sex Workers. However, the present study found Resilience to be the highest among IFNSW.

Table 4a

Showing the Mean, SD, Skewness, and Kurtosis difference between the four groups on Resilience.

Statistics	Mean	SD	Skewness	Kurtosis
EFCSW	98.26	6.4	0.53	-0.78
IFCSW	108.14	5.72	0.51	-0.71
EFNSW	120.48	7.62	0.84	-0.1
IFNSW	128.8	5.14	-0.04	-0.99

Table - 4b

Showing the Mean, SD, Skewness, and Kurtosis difference between four groups of Depression.

Statistics	Mean	SD	Skewness	Kurtosis
EFCSW	25.26	5.55	-0.23	-0.59
IFCSW	21.97	6.55	-0.03	-0.3
EFNSW	20.46	7.06	0.29	-0.79
IFNSW	17.02	6.49	-0.02	-0.83

Table-4b shows the Mean, SD, Skewness and Kurtosis for all the comparison groups on Depression. The results on Depression indicate that EFCSW scored highest (M=25.26), second highest found in IFCSW (M=21.97), third highest found in EFNSW (M=20.46) and the lowest found in IFNSW (M=17.02). This is consistent with the research findings that external locus of control was positively associated with

depression (Benassi et al., 1996; Cheng et. al., 2013). Studies on the relationship between locus of control (internal and external) and depression among Female Commercial Sex Workers are limited, however, the result of the study found depression to be highest among EFCSW.

Table 4c shows the Mean, SD, Skewness and Kurtosis of all the comparison groups on Stress. The results indicated that EFCSW scored highest (M=30.11), followed by IFCSW (M=22.86), EFNSW (M=17.03), and the lowest found in IFNSW (M=15.06). Studies have indeed indicated a significant negative relationship between perceptions of internal locus of control and stress (Abouserie, 1994; Diehl & Hay, 2010).

Table - 4c
Showing the Mean, SD, Skewness, and Kurtosis difference between the four groups on Stress

Statistics	Mean	SD	Skewness	Kurtosis
EFCSW	30.11	3.35	0.02	0.12
IFCSW	22.86	3	0.05	-0.56
EFNSW	17.03	5.64	-0.47	-1.08
IFNSW	15.06	2.58	-0.5	0.18

Table 4d shows the Mean, SD, Skewness and Kurtosis difference among the four groups on Satisfaction with life. The mean score on Satisfaction with life scored highest in IFNSW (*M* = 27.04), followed by EFNSW (M= 22.18), IFCSW (M= 17.31), and found lowest scores in EFCSW (M =13.06). The result is consistent with the findings of Fiori (2006) that people with an internal locus of control are aware that results they have experienced in life results from their actions and accept happiness, sorrow and responsibility more than others. Research on Locus of control (Internal and External) and satisfaction with life among sex workers has been limited compared to other populations. The present study found that IFNSW scored highest in Satisfaction with Life.

Table -4d

Showing the Mean, SD, Skewness, and Kurtosis difference between the four groups on Satisfaction with life.

Statistics	Mean	SD	Skewness	Kurtosis
EFCSW	13.06	2.3	0.06	-0.84
IFCSW	17.31	1.89	-0.62	0.66
EFNSW	22.18	1.78	0.42	0.18
IFNSW	27.04	2.23	-0.68	2.26

Significant Mean difference between the four groups on dependent variables

To find any significant Mean difference between the four groups on dependent variables, the Post Hoc Mean Comparision (Scheffe) was used, and the findings were presented in *Table- 5.*

(1) Four groups differences in Resilience

The EFCSW scored lower and significant at the level.01 than the IFCSW (*M* = 98.26; 108.14; mean diff = -9.88; p<. 01), EFNSW (*M* = 98.26; 120.48; mean diff=-22.21; p<. 01), and IFNSW (*M* = 98.26; 128.80; mean diff = -30.54; p<. 01) on Resilience.

The IFCSW scored lower than other groups and significant at a .01 level such as EFNSW (*M* = 108.14; 120.48; mean diff = -12.345; p<. 01), and IFNSW (*M*=108.14; 128.80; mean diff = -20.66; p<. 01) on Resilience.

The EFNSW scored lower than IFNSW (*M* = 120.48; 128.80; mean diff = -8.33; p<. 01) and significant at .01 level on Resilience.

Regardless of Commercial Sex Work, EFCSW scored higher than the IFCSW (mean diff = -9.88; p<. 01) and EFNSW also scored higher than IFNSW (mean diff = -8.33; p<. 01) at .01 significant levels in Resilience which demonstrated LoC effect.

(2) Four groups have differences in Satisfaction with Life

The EFCSW scored lower and have significant levels .01 than the IFCSW (*M* =13.08; 17.31; mean diff = -4.25; p<. 01), EFNSW (*M* =13.08; 22.16; mean diff = -9.11; p<. 01), and IFNSW (*M*=13.08; 27.16; mean diff = -13.98; p<. 01) on Satisfaction with Life.

The IFCSW scored lower and significant at .01 level than EFNSW (*M* = 17.31; 22.18; mean diff = -4.87; p<. 01), and IFNSW (*M* = 17.31; 27.04; mean diff = -9.73; p<. 01) on Satisfaction with Life.

The EFNSW scored lower and the difference was at a significant .01 level than IFNSW (*M* = 22.18; 27.04; mean diff = -4.87; p<. 01) and significant at a .01 level of Satisfaction with Life.

Despite Commercial Sex Work, EFCSW scored higher than the IFCSW (mean diff = -4.25; p<. 01) and EFCSW also scored higher than IFNSW (mean diff = -4.87; p<. 01) at .01 significant levels in Resilience.

(3) Four groups difference in Depression

The EFCSW scored higher and differences were significant at level. 01 than the IFCSW (*M* = 25.26; 21.97; mean diff = 3.29; p<. 01), EFNSW (*M* = 25.26; 20.46; mean diff = 4.79; p<. 01), and IFNSW (*M* = 25.26; 17.02; mean diff = 8.24; p<. 01) on Depression.

The IFCSW scored higher but not significantly different than EFNSW (*M* = 21.97; 20.46; mean diff = 1.50; p<. NS) whereas higher scores with a significant difference level at .01 level than IFNSW (*M* = 21.97; 17.02; mean diff = 4.94; p<. 01) on Depression.

The EFNSW scored higher and the difference was significant at a .01 level than IFNSW (*M* = 20.46; 17.02; mean diff = 3.44; p<. 01) on Depression.

Additionally, EFCSW scored higher than the IFCSW (mean diff = 3.29; p<. 01) and IFCSW also scored higher than IFNSW (mean diff = 3.44; p<. 01) at .01 significant levels on Depression.

(4) Four groups difference in Stress

The EFCSW scored higher and differences were significant at level.01 than the IFCSW (*M* = 30.11; 22.66; mean diff = 7.245; p<. 01), EFNSW (*M* =30.11; 17.03; mean diff = 13.08; p<. 01), and IFNSW (*M*=30.11; 15.06; mean diff = 15.05; p<. 01) on Stress.

The IFCSW scored higher but no significant difference than EFNSW (*M* = 22.66; 17.03; mean diff = 5.84; p<. NS) whereas higher scores with a significant difference level at .01 level than IFNSW (*M* = 22.66; 15.06; mean diff = 7.80; p<. 01) on Stress.

The EFNSW scored higher but not at a significance level than IFNSW (*M* = 17.03; 15.06; mean diff = 1.97; p<. NS) on Stress.

Despite Commercial Sex Work, External FCSW scored higher than the Internal FCSW (mean diff= 7.245; p<. 01) significant at .01 level, and EFCSW also scored higher than IFNSW (mean diff= 1.97; p<. NS) but not at significant levels in Resilience.

Table-5

Showing Post Hoc Mean Comparision (Scheffe) between the four groups- 'Internal Female Commercial Sex Workers', 'External Female Commercial Sex Workers', 'Internal Female Non Sex Workers', and 'External Female Non Workers' on dependent variables

Dependent variable	Group	Comparision groups	Mean diff	Sig
Resilience	EFCSW	IFCSW	-9.88*	0.00
		EFNSW	-22.21*	0.00
		IFNSW	-30.54*	0.00
	IFCSW	EFNSW	-12.345*	0.00
		IFNSW	-20.66*	0.00
	EFNSW	IFNSW	-8.33*	0.00
Satisfaction in Life	EFCSW	IFCSW	-4.25*	0.00
		EFNSW	-9.11*	0.00
		IFNSW	-13.98*	0.00
	IFCSW	EFNSW	-4.87*	0.00
		IFNSW	-9.73*	0.00
	EFNSW	IFNSW	-4.87*	0.00
Depression	EFCSW	IFCSW	3.29**	0.04
		EFNSW	4.79*	0.00
		IFNSW	8.24*	0.00
	IFCSW	EFNSW	1.50	0.58
		IFNSW	4.94*	0.00
	EFNSW	IFNSW	3.44**	0.04
Stress	EFCSW	IFCSW	7.245*	0.00
		EFNSW	13.08*	0.00
		IFNSW	15.05*	0.00
	IFCSW	EFNSW	5.84*	0.00
		IFNSW	7.80*	0.00
	EFNSW	IFNSW	1.97	0.06

**The mean difference is significant at the 0.01 level.
*The mean difference is significant at the 0.05 level.

The results through *Table-4a to Table-5* suggested accepting ***Hypothesis no - 1*** of the study that: There was a significantly different level of Resilience, Depression, Stress and Satisfaction with life among the groups, and the External Female Commercial Sex Workers showed the greatest scores than Internal Female Commercial Sex Workers, External Females Non Sex Workers, and Internal Females

Non Sex Workers on Depression and Stress but reverse scores on Resilience and Satisfaction with Life.

5. Mean and Significant Difference between Female Commercial Sex workers and Female Non Sex workers on Dependent Variables

Objective -2: To examine the significant difference between Female Commercial Sex workers and Female Non Sex workers on Resilience, Depression, Stress and Satisfaction with life.

Table 6a to 6d shows the Mean and significant (t-test) difference between 'Female Commercial Sex Workers and General Female' on the dependent variables. Results in *Table -6a* revealed that FNCSWs had significantly higher levels of Resilience (*M*=123.68) when compared to FCSW (*M*=103.20*)* at .01 level (t=21.03; p<.01*)*. This finding is consistent with the results of previous studies that showed lower overall quality of life and resilience among female sex workers (Wong et al., 2006).

Table - 6a

Showing the Mean, SD, Skewness, Kurtosis, and significant (independent t-test) difference between the' Female Commercial-Sex Workers and Female Non Sex Workers on Resilience

Group	Mean	SD	Skewness	Kurtosis	*t*-test
FCSW	103.20	7.82	0.11	-0.68	21.03**
FNSW	123.68	7.88	0.13	-1.03	

Results in *Table 6b* revealed that Female Commercial Sex Workers had significantly higher levels of Depression (*M*=23.62) than FNSW (*M*=19.14); and the two groups showed a significant difference at .01 (t= 5.42; p < .01). The finding is consistent with the research findings of that highlight the high prevalence of depression and PTSD amongst FCSW as compared to other populations (Coetzee et al., 2018).

Table - 6b

Showing the Mean, SD, Skewness, Kurtosis, and significant (independent t-test) difference between Female Commercial sex workers and Female non-Comercial Sex Workers on Depression.

Group	Mean	SD	Skewness	Kurtosis	*t*-test
FCSW	23.62	6.27	-0.03	-0.42	5.42**
FNSW	19.14	7.03	0.22	-0.58	

Results in *Table 6c* revealed that Female Commercial Sex Workers had significantly higher levels of Stress (*M* = 23.62) than Female Non Sex Workers (*M* = 16.27); and the difference was significant at .01 level (t=17.14, p<.05).This finding is consistent with the results of previous studies that Canadian female sex workers had a high level of stress compared with the general population (Shannon et al., 2006). There is also evidence of high Post Traumatic Stress Disorder in sex workers and other mental and health issues (Farley, 2004, 2005; Maddux et al., 2008).

Table – 6c

Showing the Mean and significant (t-test) difference between Female Commercial sex workers and Female Non Sex Workers on Stress.

Group	Mean	SD	Skewness	Kurtosis	*t*-test
FCSW	26.48	4.82	0.12	-0.67	17.14**
FNSW	16.27	4.79	-0.17	-0.73	

Results in *Table 6d* revealed that FNSW had a higher level of Satisfaction with life (*M* =24.05*)* than FCSW (*M* =15.18); and the two groups had a significant difference at .01 level (t=23.56; p <.01). Consistent with the finding, Vanilla (2020) found a little less than half of the sex workers scored a low level of life satisfaction.

Table – 6d

Showing the Mean, SD, Skewness, Kurtosis, and significant (independent t-test) difference between Female Commercial sex workers and Female non Comercial Sex Workers on Satisfaction with life.

Group	Mean	SD	Skewness	Kurtosis	*t*-test
FCSW	15.18	2.99	-0.27	-0.84	23.56**
FNSW	24.05	3.08	0.39	-0.72	

The results presented in *Tables 6a to 6d* supported ***hypothesis no- 2*** of the present study that Female Commercial Sex Workers had significantly higher scores on Depression and Stress but lower scores on Resilience and Satisfaction than Female Non Sex workers.

6. Significant Relationship between the Dependent Variables.

Objective-3: To study the relationship between Locus of Control, Resilience, Depression, Stress and Satisfaction with life

To determine the significant relationship between the dependent variables, the Pearson Correlation was employed and the results of the Pearson correlation were presented in *Table-7*.

The Locus of Control had a significant negative relationship with Resilience and Satisfaction with life (r = -.71, p < .01; r = -.91, p < .01) whereas a significant positive relationship with Depression and Stress (r = .37, p < .01; r = .74, p<.01). Research has shown that individuals who have a sense of control over their lives tend to experience less stress and greater life satisfaction (Dang, 2002). Furthermore, Seipel's (1988) and Hong and Giannakopoulos's (1994) findings suggest a positive correlation between internal locus of control and life satisfaction. Huang (2007) demonstrated that internal locus of control was significantly and negatively correlated with work stress.

Resilience has a significant positive relationship with Satisfaction with life (r = .75, p < .01) at a .01 level but a significant negative relationship with Depression

(r = -.34, p < .01) and stress (r = -.78, p < .01) at .01 level. Studies done by Anyan and Hjemdal (2016) on the relationship between stress, anxiety, depression symptoms, and resilience found that a link between stress and symptoms of anxiety and depression could be explained by resilience. Research has shown that individuals with higher levels of resilience tend to experience lower levels of stress and are better equipped to cope with various life stressors (Gibbons, Dempster, Moutray, 2011).

Satisfaction with life had a significant negative relationship with Depression (r = -.37, p < .01) at a .01 level and Stress (r = -.72, p < .01) at a .01 level whereas a significant positive correlation with stress (r = -.31, p < .01) ar .01 level. Life satisfaction, happiness, hopefulness and self-efficacy have been associated with several positive outcomes, including lower levels of stress and lower rates of mental health problems (Natvig et al., 2003; Gilman & Huebner, 2006; Valois et al., 2004; Schiffrin & Nelson, 2010; Siddique & D'Arcy, 1984).

Depression had a significant positive relationship with stress at the 01 levels (r=31; p<. 01). Similar findings suggest that stress can be a significant factor in contributing to depression (Brown & Harris, 1978; Monroe et al., 2009).

Table – 7

Showing the significant relationship (Pearson's) between the dependent variables.

	Scales	1	2	3	4	5
1.	Locus of Control	1				
2.	Resilience	-.71**	1			
3.	Satisfaction with life	-.91**	.75**	1		
4.	Depression	.37**	-.34**	-.37**	1	
5.	Stress	.74**	-.78**	-.72**	.31**	1

**Correlation is significant at the 0.01 level (2-tailed).

The results presented in *Table – 7* revealed a significant positive relationship between Locus of Control, Depression and Stress, and Resilience and Satisfaction with life whereas Locus of Control, Depression and Stress have a negative relationship

with Resilience and Satisfaction with life which suggested support the ***Hypothesis no-2*** of the present study.

7. Prediction of Independent effect of Commercial Sex Works and Locus of Control on Resilience, Depression, Stress and Satisfaction with life

Objective -4: To examine the independent effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life

To determine the independent effect of Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with Life, the ANOVA was calculated, and the results were shown in *Tables - 8a to 8d*.

The result in *Table- 8a* showed that Commercial Sex Work had a significant independent effect with an effect size of 63% (F= 442.32; Eta= 0.63), and Locus of Control also had a significant independent effect with 13% (F= 41.28; eta= .13) with 13%) on Resilience. Studies of Locus of Control and Resilience on sex work have shown to be limited however research suggested that the women in this study demonstrated a significant degree of internal strength and self-reliance in coping with challenges and overcoming adversity (Masten et al., 1990; Rutter, 1987).

Table -8a

Showing the significant independent and interaction effect of 'Commercial Sex working' and 'Locus of Control' on Resilience

Dependent Variables	Independent Variables	Sum of Squares	Mean Square	F	Sig	Eta Squared
Resilience	CSW	27254.78	27254.78	442.32	.00	.63
	LoC	5952.06	5952.06	41.28	.00	.13
	CSW x LoC	1863.68	186.37	0.78	.00	.03

Results in *Table- 8b* showed the independent and interaction effects of Commercial Sex Work (CSW) and Locus of Control (LoC) on Depression. The Commercial Sex Work had a significant independent effect with an effect size of 10% (F=29.39; eta sq= 10), LoC also had a significant independent effect at 5% (F=15.55; eta sq =6) on Depression. Studies have highlighted the high prevalence of depression among Female Commercial Sex Workers (Deb, 2008; Vanwesenbeeck, 2005; Pandiyan, et.al. 2012; Bhatt, et.al. 2009; Roxburgh, et.al. 2006). Depression was positively correlated with external control, indicating that an individual with a high external locus of control hardly experiences depression (Yu & Fan, 2014).

Table -8b

Showing the significant independent and interaction effect of 'Commercial Sex working' and 'Locus of Control' on Depression.

Dependent Variables	Independent Variables	Sum of Squares	Mean Square	F	Sig	Eta Squared
Depression	CSW	1302.78	1302.78	29.39	0.00	.10
	LoC	724.45	724.45	15.55	0.00	.06
	CSW x LoC	360.40	36.04	0.83	0.00	.03

The result in *Table- 8c* showed the independent and interaction effects of Commercial Sex Work (CSW) and Locus of Control (LoC) on Stress. Commercial Sex Work had a significant independent effect with an effect size of 53% (F=293.72; eta sq=53), and Locus of Control also had a significant independent effect with an effect size of 19% (F= 58.14; eta sq=19%) on Stress. Ling et al. (2007) reported that a substantial proportion of Australian sex workers met the criteria for post-traumatic stress disorder (PTSD). Khan and colleagues (2012), study confirmed that individuals with an external locus of control were more inclined to experience stress.

Table -8c

Showing the significant independent and interaction effect of 'Commercial Sex working' and 'Locus of Control' on Stress

Dependent Variables	Independent Variables	Sum of Squares	Mean Square	F	Sig	Eta Squared
Stress	CSW	6783.02	6783.02	293.72	0.00	.53
	LoC	2473.86	2473.86	58.14	0.00	.19
	CSW x LoC	469.23	46.92	1.09	0.00	.05

The result in *Table 8d* showed the independent and interaction effects of Commercial Sex Work (CSW) and Locus of Control (LoC) on Satisfaction with life. Commercial Sex Work had a significant independent effect with 68% (F= 554.88; eta= 68), Locus of Control (F= 43.17; eta sq= 16) with 16% on Satisfaction with life. Research done by Basat in 2004, found that Locus of Control orientation was significantly related to sexual satisfaction. Subjects reported higher sexual satisfaction when they has an Internal Locus of Control. Biswas-Diener and Diener's (2001) study, the Managuan sex workers were significantly less satisfied with their lives. Managuan sex workers' life satisfaction was lower than any other group mean found in the subjective well-being (SWB) literature.

Table -8d

Showing the significant independent and interaction effect of 'Commercial Sex working' and 'Locus of Control' on Satisfaction with Life.

Dependent Variables	Independent Variables	Sum of Squares	Mean Square	F	Sig	Eta Squared
Satisfaction with life	CSW	5104.25	5104.25	554.88	.00	.68
	LoC	1249.62	1249.62	43.17	.00	.16
	CSW x LoC	288.8	28.89	1.12	0.00	.05

The results portrayed in *Tables- 8a to 8d* showed that 'Commercial Sex work' and 'Locus of Control' had a significant independent effect on all dependent variables which supported ***hypothesis no 4*** of the study and suggested accepting it.

6. Prediction of the Interaction effect of Commercial Sex Works and Locus of Control on Resilience, Depression, Stress and Satisfaction with life

Objective no-5: There will be a significant interaction effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life

The two-way ANOVA was employed to work out any significant interaction effect of 'Commercial Sex Work x Locus of Control' on dependent variables which were presented in Table-8.

Results in ***Table-8a – 8d*** demonstrated that the interaction effect of 'Commercial Sex Work x Locus of Control' was found significant on Resilience with effect size of 3% (F=0.78; eta sq=.03), Depression significant at .01 level with 3% (F=.827; eta sq=.03),Stress significant at 01 level with 5% (F=1.09; eta sq=.05) and Satisfaction with life significant at.01 level with 5% (F=1.12; eta sq=.05).

The results in *Table- 8a-8d* revealed that there was a significant interaction effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life which accepted ***hypothesis no 5*** of the study.

Chapter- VI

SUMMARY AND CONCLUSION

The present study entitled *"**Locus of Control on Resilience, Depression and Stress: A Study of Female Commercial Sex Workers in Aizawl City**"* aimed to study the level of mental health conditions among Female Commercial Sex Workers in Aizawl City. The study focused on some of the factors of mental health such as locus of control, resilience, depression, stress and psychological Satisfaction with life.

It was hypothesized that there will be a significantly different level of Resilience, Depression, Stress and Satisfaction with life among the groups (External Female Commercial Sex Workers; Internal Female Commercial Sex Workers; External Females Non Sex workers and Internal Females Non Sex Workers). It was expected that Female Commercial Sex Workers will have significantly higher scores on Depression and Stress but lower scores on Resilience and Satisfaction than Female Non Sex Workers. It was also expected that there will be a significant positive relationship between Locus of Control, Depression and Stress, and Resilience and Satisfaction with life whereas Locus of Control, Depression and Stress will have a negative relationship with Resilience and Satisfaction with life. It was also hypothesized that there will be a significant independent effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life.

To achieve the research objective, 200 adult female comprising of 50 Female Commercial sex Workers with External Locus of Control (External Female Comercial Sex Workers; EFCSW) and 50 Female Commercial sex Workers with Internal Locus of Control (Internal Female Commercial sex Workers; IFCSW), To compare with the FCSW, 100 Female Non Sex Worker (FNCSW) comprises 50 Female Non Sex Worker with an External Locus of Control (External Female Non Sex Worker; EFNSW) and 50 Female Non Sex Workers with an Internal Locus of Control (Internal Female Non Sex Worker; IFNSW) who were working in private / Non-Governmental Organizations (NGOs) and has been working in the organization more than 1 year to 4 years were also screened out using the Rotter's Locus of Control Scale (Rotter, 1966)

Four psychological scales were used to measure the variables of interest:

i) Rotter's Locus of Control Scale (Rotter, 1966), ii) Resilience Scale (RS; Gail M.Wagnild and Heather M. Young, 1993), iii) The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985), iv) The DASS-21 (Lovibond & Lovibond, 1995).

Subject-wise scores on the specific item of the scales were separately prepared and analysed to check their psychometric adequacy for measurement purposes across the samples. The psychometric adequacies of the behavioural measures were analysed by employing SPSS 23 (Statistical Package for Social Sciences). Firstly, to check the psychometric adequacy of each scale used in the target population included i) Reliability coefficients (Cronbach's Alpha) ii) Descriptive statistics consisting of Mean, SD, Skewness and Kurtosis were included for comparision of the test scores between the groups.

The first objective was to compare the level of Resilience, Depression, Stress and Satisfaction with life among the four comparision groups (i.e. External Female Commercial Sex Workers, Internal Female Commercial Sex Workers, External Females Non Sex Workers, and Internal Females Non Sex Workers). Results indicated that Female Commercial Sex workers with an External Locus of Control depicted a lower level of Resilience and Satisfaction with life, however, they depicted a higher score on Depression and Stress compared to the other groups. The impact of sex work on the psychological satisfaction with the life of sex workers can vary depending on various factors such as personal circumstances, societal attitudes, legal frameworks, and support systems available.

In the context of female commercial sex workers, the combination of an external locus of control and the specific challenges associated with their profession may contribute to higher levels of depression and stress. The commercial sex work industry is often characterized by factors such as social stigma, legal and safety concerns, and potential exploitation, which can exacerbate feelings of helplessness and contribute to a sense of powerlessness over one's life circumstances. Perceiving a higher level of internal control can contribute to resilience by fostering a proactive and

determined mindset, leading to better mental health outcomes when facing challenging situations (Grob et al., 1995; Leontopoulou, 2006).

The second objective was to examine the significant difference between Female Commercial Sex Workers and Female Non Sex Workers on Resilience, Depression, Stress and Satisfaction with life. Results revealed that Female Commercial Sex Workers had significantly higher scores on Depression and Stress but lower scores on Resilience and Satisfaction than Female Non Sex workers. These finding is consistent with the results of previous studies on the quality of life, emotional health, and resilience among female sex workers have indeed indicated lower overall well-being compared to the general population (Wonget al., 2006). Studies also show that the mental status of FCSW differed due to work settings, nationalities as well as their propensity for ill mental health (Rössler et al., 2009).

Female commercial sex workers may face various psychosocial stressors, including financial instability, interpersonal conflicts, and a lack of social support networks. These stressors, combined with an external locus of control, can increase the risk of developing mental health issues such as depression and elevated levels of stress. Studies done by (Deering et al., 2014; Li Q et al., 2010) found that FCSW face increased levels of key risk factors for mental disorders, including financial stress, low education, inadequate housing, violence, alcohol and drug use, STIs including HIV, and stigma and discrimination, which may help explain the higher prevalence of mental health problems in comparison with the general population.

The third objective was to study the relationship between Locus of Control, Stress, Depression, Resilience and Satisfaction with life. The results revealed a significant positive relationship between Locus of Control, Depression and Stress, and Resilience and Satisfaction with life whereas Locus of Control, Depression and Stress have a negative relationship with Resilience and Satisfaction with life.

Research has shown a correlation between an external locus of control and poorer mental health outcomes, including higher levels of depression, stress, and lower levels of resilience and life satisfaction. Factors such as stigma, social marginalization, and lack of legal protections can contribute to increased stress and lower mental well-

being among sex workers. Sex work can involve challenging working conditions, vulnerability to violence and limited access to healthcare, and societal discrimination, all of which can affect mental health outcomes. These external factors can contribute to a heightened sense of lack of control and increase the likelihood of experiencing mental health challenges. Perceptions of internal locus of control refer to an individual's belief that they have control over the events and outcomes in their life. This belief is associated with empowerment, as it is thought to contribute to a sense of personal agency and the belief that one can influence their circumstances (Zimmerman, 2000).

While it is difficult to make broad generalizations about any specific group of individuals, including Female Commercial Sex Workers, individuals with an external locus of control may experience lower resilience and life satisfaction. The concept of locus of control has been linked to resilience, which is the ability to bounce back or adapt positively in the face of adversity or challenging situations. Research suggests that individuals with an internal locus of control are more likely to exhibit higher levels of resilience. This is because they perceive themselves as having more control over their circumstances, which can lead to a greater sense of empowerment, problem-solving skills, and a proactive approach to dealing with challenges (Masten et al., 2001; Dipayanti et al., & Rotter, 1954).

Studies explain that when individuals with an external locus of control experience a problem and get social support from others, their level of resilience will increase (Dalal, 2000 & Stewart, 2011). FCSW arise from their negative feelings toward themselves and poor living and working environments. Evidence in exposure to trauma, greater Internal Locus of Control has been positively associated with the ability to resiliently adapt to situations (Frazier et al., 2011).

Additionally, individuals with an internal locus of control tend to be hardworking and persistent in their endeavours. They believe that their efforts can make a difference more likely to invest time and energy in pursuing their goals. This strong work ethic can contribute to resilience by enhancing perseverance and determination when faced with adversity (Grant et al., 2007).

The fourth objective was to examine the independent effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life. The result showed that 'Commercial Sex work' and 'Locus of Control' had a significant independent effect on all dependent variables.

The nature of the commercial sex work industry can present additional challenges and stressors that may impact overall life satisfaction. These can include social isolation, physical and emotional risks, economic instability, and lack of social support. Such circumstances can contribute to a lower sense of well-being and satisfaction with life.

Resilience, depression, stress and satisfaction with life are complex psychological factors that can be influenced by a multitude of variables, including personal experiences, social support, and individual coping strategies. It is challenging to attribute specific effect sizes solely to commercial sex work, as these factors interact with and influence each other. Resilience conceived as a successful adaptation to challenging internal or external stressors predicts future psychological problems, such as depression, anxiety and stress (Connor & Davidson, 2003). The Resiliency Model (Richardson et al., 1990) stresses the difference between the disruptors of psychological balance, or "stressors" and the outcome of maladaptive coping mechanisms, such as symptoms of anxiety, depression and stress-resilience being a significant moderator or buffer between these psychological variables (Liu et al., 2014). Research on resilience stresses that it is a crucial factor in the study of life crises or transitions, operating as a potentially protective factor against psychological distress (Jayalakshmi & Magdalin, 2015).

The fifth objective was to there will be a significant interaction effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life. The result revealed that there was a significant interaction effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life. In the context of female sex workers, those with an internal locus of control may believe that they have chosen or have control over their

involvement in sex work. They may perceive their choices and actions as the primary factors influencing their work and its consequences.

Sex workers with an internal locus of control may believe that they have chosen their profession and have control over their work conditions and decisions. They may be more likely to view themselves as active agents in their lives, which could contribute to their resilience and satisfaction with life. On the other hand, sex workers with an external locus of control may feel that they are forced into the profession or that external factors dictate their choices and outcomes. This perception of limited control over their circumstances may increase their vulnerability to depression, stress, and lower satisfaction with life.

Sex workers in Mizoram enter into the profession voluntarily due to various reasons. Factors such as poverty, lack of education, limited employment opportunities, or personal circumstances may contribute to individuals choosing sex work as a means of livelihood. It states that many of them come from broken families and may have behavioural problems. Sex workers in Mizoram have a close link with the use of intoxicants such as alcohol, heroin, dendrite, and other substances that are available to them. The association of sex work with substance use is a concern that can be found in various regions, not just in Mizoram. Substance use can be both a cause and a consequence of engaging in sex work. Some individuals may use substances as a coping mechanism for the challenges they face, while others may turn to sex work to support their substance use. Each individual's experience and reasons for entering sex work can vary significantly. Factors such as economic circumstances, social stigma, lack of alternative opportunities, and coercion can also contribute to a person's decision to engage in sex work. It is crucial to approach the topic with sensitivity and respect for the diverse experiences and contexts of individuals involved in sex work (VOLCOMH, 2003).

Sex work, like any profession, involves a diverse range of individuals with different backgrounds, motivations, and financial situations. While some sex workers may face economic difficulties, others may be more financially stable and have effective money management strategies. In Mizoram, the majority of the money made

by sex workers is spent on drugs, clothing, accessories, and cosmetics. It implies that they might not have a strong financial foundation and have a propensity to put short-term demands or desires ahead of long-term savings. Sex workers in Mizoram are not involved in the trade for extended periods. This could be due to various factors such as social stigma, personal circumstances, or other opportunities available to them. The transient nature of their involvement in sex work may differentiate them from sex workers in metropolitan cities where some individuals may engage in the profession for longer durations (World Vision, 2003).

Sex workers often faced negative attitudes, discrimination and stigma within communities. This is a complex issue influenced by various factors such as cultural, social, and legal frameworks. While attitudes towards sex work and sex workers may differ across different communities and regions, it is true that many societies still carry negative perceptions about this profession.

The stigma faced by sex workers is often rooted in societal norms, moral judgments, and misconceptions about the nature of their work. This stigma can lead to exclusion, marginalization, and limited access to essential services and support networks. Sex workers who also use drugs face an additional layer of stigma due to the intersection of drug use and sex work.

Double stigma can intensify the challenges faced by sex workers who use drugs. It can exacerbate social isolation, limit their opportunities for seeking help, and increase the risk of violence and exploitation. These individuals may experience even greater barriers in accessing healthcare, harm reduction services, and other essential support systems. Female Commercial Sex Workers (FCSW) often face a range of risk factors that can contribute to mental health problems and an increased risk of suicidal behaviour. The factors such as financial stress, low education, inadequate housing, violence, alcohol and drug use, STIs including HIV, and stigma and discrimination, can all have a significant impact on their mental well-being (Blashill et al., 2011; Earnsha et al., 2013).

Sex work is a complex issue that requires careful consideration and an empathetic approach. Recognizing the dignity, respect, and fairness of individuals involved in sex work is crucial for fostering a more inclusive society. By promoting understanding, compassion, and evidence-based approaches, we can strive to reduce the stigma and discrimination that sex workers often face. Treating sex workers with dignity means acknowledging their autonomy and agency over their bodies and choices. It involves recognizing that engaging in sex work can be a valid and legitimate occupation for some individuals. Respecting their choices and experiences helps challenge the stereotypes and prejudices often associated with this profession. (FXB, 2004).

The efforts undertaken by Community-Based Organizations (CBOs) such as the Joint Action Committee (JAC) and the Young Mizo Association (YMA), to address the issue of sex work, seem to employ extreme and punitive measures. It is important to note that such retributive actions can have serious ethical and human rights implications.

While the intention behind these measures may be to discourage or deter individuals from engaging in sex work, the methods described, such as shaving off hair, making tattoos on their faces, chopping off private parts, expulsion from localities, and confinement to houses, are forms of physical and psychological abuse. These actions violate the fundamental rights and dignity of the individuals involved and are not effective in addressing the root causes of sex work.

Instead of solely relying on punitive measures, community-based organizations (CBOs) can adopt strategies that prioritize harm reduction, human rights, and social support. This approach recognizes that punishment alone may not effectively address the root causes of social issues or help individuals overcome the challenges they face. By focusing on harm reduction, human rights, and social support, CBOs can create more inclusive and effective interventions.

Moreover, it is important to involve sex workers themselves in discussions and decisions that affect their lives. Their voices and experiences should be valued and taken into account when formulating policies and strategies. This participatory

approach helps to ensure that any interventions are effective, realistic, and respectful of the diverse needs and perspectives within the sex work community.

It is crucial to approach the issue of sex work with empathy, understanding, and a focus on harm reduction rather than punishment. Punitive actions only force sex workers to relocate their operations, making it harder for them to access support, healthcare, and protection. A more effective approach would involve providing comprehensive support services, including access to healthcare, counselling, vocational training, and alternative income-generating opportunities. Additionally, creating awareness about safe sex practices, reducing stigma, and addressing the socio-economic factors that contribute to sex work are essential steps in addressing the issue more humanely and effectively.

It is important to recognize that sex work is often driven by various factors, including economic insecurity, lack of education and employment opportunities, discrimination, and social marginalization. Collaborative efforts should aim to address these underlying issues, such as offering alternative livelihood options, education and skill-building programs, and social support.

Healthcare provision: Access to healthcare services, including sexual and reproductive health services, should be a priority. Collaboration with healthcare providers can ensure that sex workers have access to non-judgmental and confidential care, including STI testing, contraception, and HIV prevention and treatment.

Legal expertise: Collaboration with legal experts is crucial to ensure that policies and laws surrounding sex work are based on human rights principles, harm reduction, and evidence-based approaches. Legal experts can help advocate for the decriminalization or regulation of sex work, which can enhance the safety and well-being of sex workers and facilitate their access to legal protections.

Social work support: The involvement of social workers can play a vital role in providing comprehensive support to individuals engaged in sex work. Social workers can assist in addressing the social determinants of sex work, such as housing instability, substance abuse, and mental health challenges. They can also provide counselling, support with navigating systems, and referrals to appropriate services.

Overall, collaboration among CBOs, government agencies, and society at large is essential to develop strategies that prioritize the well-being and human rights of individuals engaged in sex work. By involving diverse stakeholders and recognizing the complexities of sex work, we can work towards creating a more inclusive and supportive environment for sex workers (Zorammawia, 1998). .

Limitations of the study

The present study acknowledges several limitations which need to be addressed but are not able to include in this study due to time limitations. First, the sample size used in the study was not large enough to effectively represent the targeted population which may specify not big enough to generalize to the whole targetted population.

Another limitation of the study is that a more systematic and comprehensive empirical cross-examination of FCSW responses such as conducting qualitative interviews, longitudinal studies, or employing mixed-methods approaches to gain a more in-depth understanding of the issue.

Sex work is an underground or hidden profession, and high taboo in many regions, including Mizoram. The transient and secretive nature of the work makes it challenging to locate and establish contact with sex workers. This can lead to difficulties in recruiting a representative sample and capturing the diversity within the population.

Collecting data from sex workers can indeed present several challenges. Sex workers may face heightened risks during the pandemic due to the nature of their work and the potential for close physical contact with clients. As a result, they reluctant to share information or participate in data collection activities due to concerns about their safety and privacy which required a longer time to collect data.

The study could not include more independent variables which were assumed to be a reason for commercial sex work and more dependent variables which are assumed to be a consequence of Commercial sex work due to the limitations which were mentioned.

Suggestions for further studies

The inclusion of more demographic information to get valuable insights into the factors that contribute to why individuals enter the profession of sex work and potential underlying factors that influence their decision to engage in sex work would provide comprehensive factors and status of Commercial Sex Workers with comprehensive information and its complexities.

Bigger samples and a wider range of participants covering non-registered female sex workers like call girls to have more information for understanding the sex industry in Mizoram. It will help to capture the diversity of experiences and challenges faced by sex workers and their specific needs.

Further research in this area required close relationships with the participants with whom the participants can share their identities, experience, problem, the reason for joining commercial sex work, and so on.

Significance of the study

The results of the study illustrated revealed a significant difference among the four groups- Female Commercial Sex Workers in Mizoram had a higher mental problem compared to Female Non Sex Workers, Female Commercial Sex Workers had significantly higher depression and stress compared to Female Non Sex Workers whereas a lower resilience and satisfaction with Life which may be taken as the high need of psychological cares by the FCSW. The results may explain that the Female Commercial sex workers regardless of personality (internal or external Loc) had a higher mental problems personality.

The results provided the significant difference between the FCSW and FNSW on resilience, stress, depression and satisfaction with life which demonstrated that FCSW had higher depression, stress whereas lower resilience and satisfaction with life; which indicated that the FCSW were more in need including psychological cares and intervention.

The results provided a significant positive relationship between stress and depression, resilience and satisfaction with life, whereas both stress and depression

had a significant negative relationship to resilience and satisfaction with life. Accordingly, the FCSW had higher depression and stress but lower resilience and satisfaction with life than FNSW in this study.

The independent effect and interaction effect of 'Commercial Sex Works' and 'Locus of Control' was elucidated by this study, and may be utilized to make a strategy for the prevention, intervention, and/or rehabilitation of commercial sex workers.

By focusing on the psychological functioning of FCSW in Mizoram, the findings provide valuable insights into a population that may face unique challenges and circumstances. Understanding their psychological well-being is crucial for designing effective frameworks for the prevention of sex work and the rehabilitation of FCSW in Mizoram.The findings will not only contribute to the academic literature but also have practical implications for policymakers, healthcare professionals, and social workers involved in addressing the needs of FCSW in Mizoram

In conclusion, the study contributed to the existing academic literature about "Locus of Control on Resilience, Depression and Stress: A Study of Female Commercial Sex Workers in Aizawl City" where the 'Locus of control' and " Commercial Sex Work" effect on Resilience, Depression and Stress by highlighting the difference between (i) External and Internal Locus of control groups, and (ii) Female Commercial Sex Workers and Female Non Sex Workers; (iii) Relationship between the psychological variables- Resilience, Depression and Stress; overall results displayed the poor mental health of Commercial sex workers than Non Sex Workers along with an Externally control than Internally Control among the samples which were not available in the existing academic literature, and much needed to understanding for designing prevention of sex work, and rehabilitation to Female Commercial Sex Workers.

APPENDICES

APPENDIX – I

INFORM CONSENT (English)

The following questions will be used solely for research purposes, and any identifying information about participants will be kept confidential to the fullest extent possible. All information collected during this study will be treated with strict confidentiality. Your identity will remain anonymous, and any data collected will be stored securely. Only the researchers involved in this study will have access to the data, and the findings will be reported in aggregate form without any personally identifiable information. You can withdraw from the study at any time without providing a reason. If you have any questions, or concerns, or would like more information about this study, please feel free to ask.

Participant's signature_____

Date and time:_____

APPENDIX – II

INFORM CONSENT (Mizo)

Heng a hnuaia zawhnate hi Ph.D research atana tih a ni a, mimal chhana te hi confidential (uluk taka vawngin midangte hriat tur a pek tur a ni lo) vek niin research atan chauh a hman tur a ni a. Zawahna te hi I rilrua I hriatdan angina min chhansak ka dil a, heng I chhanna te hi midang hriatloh tur a vawn him tur ani bak ah I hming ziah lan pawh a ngai lo a. I duh hun hun ah I duh chuan I chawlhsan thei a. A pawimawh zia hria in nangmah duhthu ngei a min chhansak turin ka ngen a che. Zawhna I neih chuan inthlahrung loinb min zawt dawn nia.

Participant's signature_____

Date and time:_____

APPENDIX – III

DEMOGRAPHIC INFORMATION FORM (English)

1. Address:	**2. Birthplace**:
3. Age:	4. **Marital status**: Married/ Single/Widow
5. Mothers Occupation: Govt Servant / Private / Unemployed	
6. Fathers Occupation: Govt Servant / Private / Unemployed	
7. Family size:	
8. Family monthly income: i) 5000 ii) 5000 -15000 iii) 15000-30000 iv) 30000-50000 v) 50000 above	
9 Sibling size	**109. Educational Qualification**: X/ 12/ B.A/ M.A
11. Parental Status: Married ( ) Divorced ( ) Deceased mother ( ) Deceased father ( ) Deceased parents ( )	
12. Residential condition : Owned ( ) Rented ( )	
***13. Duration of Working**: i) Less than 1 year ii) 1 year iii) 2 years iv) 3 years v) More than 4 years	
14. Monthly income of the participants: i) 5000 ii) 5000 -15000 iii) 15000-30000 iv) 30000-50000 v) 50000 above	
15. Working Schedule: Morning / Noon / Night	
16. Working hours in a day: Less than 3 hours / 3-5 hours / more than 5 hours	

APPENDIX – IV

DEMOGRAPHIC INFORMATION FORM (Mizo)

1. I awmna veng hming:	**2. I Pianna khua**:
3. Kum zat:	4. **Pasal**: nei/ neilo/nei tawh thin
5. I Nu hnathawh: Sawrkar / Private / Hnathawh neilo	
6. I Pa hnathawh: Sawrkar / Private / Hnathawh neilo	
7. In Chhungkua a chengzat:	
8. Thla khata chhungkaw sum lak luh zat: i) 5000 ii) 5000 -15000 iii) 15000-30000 iv) 30000-50000 v) 50000 chunglam	
9. In Unau zat:	**10. Lehkha zir thlen**: X/ 12/ B.A/ M.A
11. Nu leh pa dinhmun: Innei lai ( ) Inthen ( ) Nu boral tawh ( ) Pa boral tawh ( ) Nu leh Pa boral tawh ( )	
12. Chenna in: Mahni in ( ) Mi inluah ( )	
***13. Engtia rei nge he hna hi I thawh tawh**: i) Kum la tling lo ii) Kum khat iii) Kum hnih iv) Kum thum v) Kum thum aia tam	
14. Thla khata I sum lak luh zat: i) 5000 ii) 5000 -15000 iii) 15000-30000 iv) 30000-50000 v) 50000 chunglam	
15. Engtik hunah nge hna I thawh thin?: Zing / Chhun / Zan	
16. Nikhat ah darkar engzah nge I thawh thin: darkar 3 aia tlem / darkar 3-5 / darkar 5 aia rei	

APPENDIX –V

ROTTER'S LOCUS OF CONTROL; Rotter, 1966 (English)

For each question select the statement that you agree with the most:

1 a. Children get into trouble because their parents punish them too much.

b. The trouble with most children nowadays is that their parents are too easy with them.

2 a. Many of the unhappy things in people's lives are partly due to bad luck.

b. People's misfortunes result from the mistakes they make.

3 a. One of the major reasons why we have wars is that people don't take enough interest in politics

b. There will always be wars, no matter how hard people try to prevent them.

4 a. In the long run, people get the respect they deserve in this world

b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5 a. The idea that teachers are unfair to students is nonsense.

b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6 a. Without the right breaks, one cannot be an effective leader.

b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7 a. No matter how hard you try some people just don't like you.

b. People who can't get others to like them don't understand how to get along with others.

8 a. Heredity plays a major role in determining one's personality

b. It is one's experiences in life which determine what they're like.

9 a. I have often found that what is going to happen will happen.

b. Trusting fate has never turned out as well for me as deciding to take a definite course of action.

10 a. In the case of the well-prepared student, there is rarely if ever such a thing as an unfair test.

b. Many times exam questions tend to be so unrelated to coursework that studying is useless.

11 a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
b. Getting a good job depends mainly on being in the right place at the right time.

12 a. The average citizen can influence government decisions.
b. This world is run by the few people in power, and there is not much the little guy can do about it

13 a. When I make plans, I am almost certain that I can make them work.
b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14 a. Certain people are just no good
b. There is some good in everybody.

15 a. In my case getting what I want has little or nothing to do with luck.
b. Many times we might just as well decide what to do by flipping a coin.

16 a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
b. Getting people to do the right thing depends upon ability. Luck has little or nothing to do with it.

17 a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand nor control.
b. By taking an active part in political and social affairs the people can control world events.

18 a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
b. There is no such thing as "luck."

19 a. One should always be willing to admit mistakes.
b. It is usually best to cover up one's mistakes.

20 a. It is hard to know whether or not a person likes you.
b. How many friends you have depends upon how nice a person you are.

21 a. In the long run the bad things that happen to us are balanced by the good ones.
b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22 a. With enough effort we can wipe out political corruption.

b. It is difficult for people to have much control over the things politicians do in office.

23 a. Sometimes I can't understand how teachers arrive at the grades they give

b. There is a direct connection between how hard 1 study and the grades I get.

24 a. A good leader expects people to decide for themselves what they should do

b. A good leader makes it clear to everybody what their jobs are.

25 a. Many times I feel that I have little influence over the things that happen to me.

b. It is impossible for me to believe that chance or luck plays an important role in my life.

26 a. People are lonely because they don't try to be friendly.

b. There's not much use in trying too hard to please people, if they like you, they like you.

27 a. There is too much emphasis on athletics in high school.

b. Team sports are an excellent way to build character.

28 a. What happens to me is my own doing.

b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29 a. Most of the time I can't understand why politicians behave the way they do.

b. In the long run the people are responsible for bad government on a national as well as on a local level

APPENDIX –VI

ROTTER'S LOCUS OF CONTROL; Rotter, 1966 (Mizo Version)

Zawhna pakhatah statement pahnih zel a awm a, dik leh pawmawm I tih zawk zel thlang rawh.

1 a. An nu leh pa ten an hrem ngun luatah naupangte hian harsatna an neih phah thin.
b. Tunlai naupang tam zawk harsatna an tawh chhan chu an nu leh pa te an nem lutuk thin vang ani

2 a. Mite nuna hlimlohna thil awm tamtak hi chu, engemaw chenah, vanduaina vang ani.
b. Mite vanduaina hi an thiltihsual vang ani.

3 a. Indona awm chhan pakhat chu mi te hian politics hi kan ngaihven tawk loh vang a ni.
b. Eng ang pawn dan/ven tum thin mah se indona hi chu a awm reng ang.

4 a. Khuareiah chuan mi te hian an phu tawk zah/zahawm-na he khawvelah hian an hmu thin.
b. Eng ang pawn bei nasa mahse, vanduaithlak takin, mi an hlutna hi hriat lohin am thin.

5 a. Zirtirtuten an zirlaite diktak leh intluktlang takin an en lo ni a ngaihdan hi belhchian dawl lo ani.
b. Tihpalh/vanduai vanga an grade chhiat hian eng angina nge a pawi naupang ten an hrethiam pha lo.

6 a. Vanneihna leh remchanna tawng lo tan chuan hotu/hruaitu tha tak anih theih loh.
b. Hotu/hruaitu ni tura theihna nei hlawhtling ta lo te hi an vanneihna leh remchanna dawn an hman tangkai tawk loh vang ani.

7 a. Eng ang pawn tum nasa mah la, mi thenkhat te chuan an ngaina chuang lo che.
b. Mi ngainat hlawh thei maihlo te hi chuan mi kawm nel dan an thiam loh vang ani.

8 a. Kan mizia/ziarang hi kan pianpui a ni.
b. Mi ziarang/nihphung hi an nuna an thil tawnhriat atang ani.

9 a. Thil thleng tur hi chu a thleng mai thin a ni

b. Thil thlen dana innghah ngawt leh thuthlukna siam hian danglamna anei lo.

10 a. Zirlai tha taka inpuahchah hmaah chuan test/exam fairlo tih hi a awm ve lo.

b. Kan zirlai nena inmil lo exam-naah a awm thin.

11 a. Hlawhtlinna hi chu thawhrimna-a innghat ani a, vanneihna hi chuan kawngro a su vaklo.

b. A hun leh a hmun a zirin hna tha hi alo thleng mai a ni.

12 a. Mipui vantlang hian sawrkar thuthlukna ah nghawng a nei

b. Khawvel hi chu thil titheite duhdan in a kal a, mi te zawkte sawi theih emaw tihtheih a tlem hle.

13 a. Ruahmana ka siam hian, a hlawhtling ang tih hi ka chiang thawkhat viau thin.

b. Ruahmanna thui tak siam hi a fin thlak ber lo, vanneihna leh vaduainaah a in nghat zawk.

14 a. Mi thenkhat hi chu mitha an nilo ve hrim hrim ani.

b. Mitin hian chhungrila thatna engemaw tal hi an nei vek.

15 a. Ka thil duh ka neihna ah hian vanneihna hian awmzia a nei lem lo.

b. Tum tam takah hi chuan pawisa thir vawrh hian thuthlukna siam angai thin.

16 a. Hotu tha ni tur chuan a hun lai tak a mi mamawhna hmun taka awm a pawimawh

b. Thil tha ti tur chuan theihnaah a innghat. Vanneihna hi chuan nghawng a nei lemlo

17 a. Khawvel thil thleng tam takah hi chuan thil tih theih kan nei lo

b. Politics leh khawtlanga kan inhman hian khawvel thil thleng ka ti danglam thei.

18 a. Mi tam tak chuan thil thleng palh hian an nun a kaihruai a ni tih an hrelo.

b. Vanneihna tih hian awmzia a neilo.

19 a. Kan thil tihsual te pawm ngam tur ani

b. Kan thil tihsual te thup bo zel hi a tha

.

20 a. Mi in min ngaina tak tak em tih hi thil hriatchian har tak ani.

b. Thian I ngah leh ngah loh chu mifel I nih leh nih loh ah a innghat.

21 a. Khuareiah kan chunga thilthalo thleng te hi thiltha te nen an in thluangrual leh mai thin.
b. Vanduaina tam zawk hi chu thiamna neih tlem, hriattlem, thatchhiatna, emaw an vai belhbawm rahchhuah an ni.

22 a. Theihtawp kan chhuah chuan eirukna hi kan nuai bo thei ang.
b. Politician thiltihthei tak te hi mipui tan lo thunun ve hi thil harsa tak a ni

23 a. Achang chuan kan marks hmuh te hi engtin nge kan hmuh theih zawk tih hi ka ngaihtuah thin.
b. Ka zir nasat dan leh ka mark hmuh zat te hian inzawmna chiang tak an nei.

24 a. Hruaitu tha chuan mite an tih tur anmahni theuh a thutlukna siam turin a beisei thin.
b. Hruaitu tha chuan mitinte an hna theuh chiang takin a hriattir thin.

25 a. Ka chunga thil thlengah hian tih theih ka nei tlem hle.
b. Vanneihna hian ka nunah thiltih pawimawh tak a nei tih rin hi ka tan chuan thil theihloh ani.

26 a. Mite khawhar taka an awm chhan chu thian an neih loh vang a ni.
b. Mi tih lungawi tum reng hi awmzia a awm lo, an ngaina che anih chuan an ngaina che ani mai.

27 a. High school ah hian infiamna hi an ngaihpawimawh mah mah.
b. A huhoa infiamna hi nungchang siamna tha tak an ni.

28 a. Ka chunga thilthleng te hi keimah vang liau liau an ni.
b. Ka nun kawng zawhah hian tih theih ka neilo in ka inhre thin.

29 a. Politician te hi engvanga awm hi nge an nih tih hi ka hrethiam lo thin.
b. Ram chhung inrelbawlna tha loah mipuiten mawh an phur ve a ni.

APPENDIX – VII

RESILIENCE SCALE; Gail M.Wagnild and Heather M. Young, 1993 (English)

Please read the following statements. To the right of each you will find seven numbers, ranging from "1" (Strongly Disagree) on the left to "7" (Strongly Agree) on the right. **Tick** the number which best indicates your feelings about that statement. For example, if you strongly disagree with a statement, tick "1". If you are neutral, tick "4", and if you strongly agree, tick "7", etc.		**Strongly Disagree**	**Disagree**	**Slightly disagree**	**Neither agree nor disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
1	When I make plans, I follow through with them	1	2	3	4	5	6	7
2	I usually manage one way or another	1	2	3	4	5	6	7
3	I am able to depend on myself more than anyone else	1	2	3	4	5	6	7
4	Keeping interested in things is important to me	1	2	3	4	5	6	7
5	I can be on my own if I have to	1	2	3	4	5	6	7
6	I feel proud that I have accomplished things in life	1	2	3	4	5	6	7
7	I usually take things in stride	1	2	3	4	5	6	7
8	I am friends with myself	1	2	3	4	5	6	7
9	I feel that I can handle many things at a time	1	2	3	4	5	6	7
10	I am determined	1	2	3	4	5	6	7
11	I seldom wonder what the point of it all is	1	2	3	4	5	6	7
12	I take things one day at a time	1	2	3	4	5	6	7
13	I can get through difficult times because I've experienced difficulty before	1	2	3	4	5	6	7
14	I have self-discipline	1	2	3	4	5	6	7
15	I keep interested in things	1	2	3	4	5	6	7
16	I can usually find something to laugh about	1	2	3	4	5	6	7
17	My belief in myself gets me through hard times	1	2	3	4	5	6	7
18	In an emergency, I'm someone people can generally rely on	1	2	3	4	5	6	7
19	I can usually look at a situation in a number of ways	1	2	3	4	5	6	7
20	Sometimes I make myself do things whether I want to or not	1	2	3	4	5	6	7
21	My life has meaning	1	2	3	4	5	6	7
22	I do not dwell on things that I can't do anything about	1	2	3	4	5	6	7
23	When I'm in a difficult situation, I can usually find my way out of it	1	2	3	4	5	6	7
24	I have enough energy to do what I have to do	1	2	3	4	5	6	7
25	It's okay if there are people who don't like me	1	2	3	4	5	6	7

APPENDIX – VIII

RESILIENCE SCALE; Gail M.Wagnild and Heather M. Young, 1993

(Mizo Version)

A hnuaia zawhna te hi uluk takin chhiar la, I pawm zawnah zel I thai dawn nia. Chhanna dik leh dik lo a awm lo.		Pzwm lutuk	Pawm	Pawm vaklo	Ngaihdan nei lo
1	Ruahmanna ka siam tawh chuan, a tawp ka thlenpui thin.	1	2	3	4
2	Kawng khat emaw kawng dang pawhin, ka puitlin nge nge thin.	1	2	3	4
3	Midang rin aiin keimah ka inring zawk.	1	2	3	4
4	Thil engemaw ngaihven renga awm hi ka tan a tha.	1	2	3	4
5	A tul chuan mahni chauhin ka awm thei.	1	2	3	4
6	Ka nunah thiltih hlawhtlin ka neihin ka inchhuang ve thin.	1	2	3	4
7	A hmachhawp indawt te te in thil ka ti tlangpui.	1	2	3	4
8	Keimah leh keimah hi ka inkawmngaih hle.	1	2	3	4
9	A rualin thil tam tak ka ti thei.	1	2	3	4
10	Ka tum a ruh.	1	2	3	4
11	A chang chuan enge a awmzia, enge a tulna tih hi ka ngaihtuahnawn leh thin.	1	2	3	4
12	Ka tih tur a ni tiamin ka ti thin,	1	2	3	4
13	Harsatna ka tawnhriat tawh vangin hun harsa leh khirh tak pawh ka pal tlang thei ang.	1	2	3	4
14	Mahni inthunun theihna ka nei.	1	2	3	4
15	Thil ngaihven reng hian ka awm thin.	1	2	3	4
16	Nuihna tur thil ka hmu thei zel.	1	2	3	4
17	Keimah ka inrinna hian hun harsa pawh min paltlang tir thin.	1	2	3	4
18	Tul thut thilah pawh mite innghah theihna ka ni tlangpui.	1	2	3	4
19	Kawng hrang tam takin thil dinhmun hi ka thlir thei fo.	1	2	3	4
20	Achang chuan, ka duh emaw duhlo emaw, thil engemaw ti turin ka innawrluih thei.	1	2	3	4
21	Nun awmze nei tak ka nei.	1	2	3	4
22	Engtin mah ka tih theih loh thil ah chuan ka inhamtang ngai lo.	1	2	3	4
23	Dinhmun harsa a ka awm pawn ka in haichhuak thei thin.	1	2	3	4
24	Ka tihtur tul ti turin ka mamawh tawk chakna ka nei.	1	2	3	4
25	Mi min ngaina lo tu an awm anih pawn a pawi lo ve, a tha vek tho.	1	2	3	4

APPENDIX – IX

DASS-21; Lovibond & Lovibond, 1995 (English)

	Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.	Never	Sometimes	Often	Almost Always
1.	I found it hard to wind down	0	1	2	3
2.	I was aware of dryness of my mouth	0	1	2	3
3.	I couldn't seem to experience any positive feeling at all	0	1	2	3
4.	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5.	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7.	I experienced trembling (eg, in the hands)	0	1	2	3
8.	I felt that I was using a lot of nervous energy	0	1	2	3
9.	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10.	I felt that I had nothing to look forward to	0	1	2	3
11.	I found myself getting agitated	0	1	2	3
12.	I found it difficult to relax	0	1	2	3
13.	I felt down-hearted and blue	0	1	2	3
14.	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15.	I felt I was close to panic	0	1	2	3
16.	I was unable to become enthusiastic about anything	0	1	2	3
17.	I felt I wasn't worth much as a person	0	1	2	3
18.	I felt that I was rather touchy	0	1	2	3
19.	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20.	I felt scared without any good reason	0	1	2	3
21.	I felt that life was meaningless	0	1	2	3

APPENDIX – X

DASS-21; Lovibond & Lovibond, 1995 (Mizo version)

	A hnuai thute hi chhiar la, I pawm zawnah zel i thai dawn nia. Chhanna dik leh dik lo a awm lo	Ngailo	Ve zeuh	Achang in	Engtik lai pawn
1.	A hnuai thute hi chhiar la, I pawm zawnah zel i thai dawn nia. Chhanna dik leh dik lo a awm lo	0	1	2	3
2.	Thinrim/lungawi lohin inbeng daih harsa ka ti.	0	1	2	3
3.	Mite ka hmachhawnin sawi turmai ka hrelo thin.	0	1	2	3
4.	A eng zawnga thil tlir hi a harsa ka ti.	0	1	2	3
5.	Taksa chet hah vang niloin, thawk lama harsatna ka nei thin (eg., rang taka thawk vak vak, taksa tihchet/ritlak a awm loh pawh in ka thawk a rit hle thin.	0	1	2	3
6	Thil ti tur a chetlak emaw bultan harsa ka ti hle thin.	0	1	2	3
7.	Thil engemaw a thlenin uchuakin ka chhanglet/tilet thin	0	1	2	3
8.	Khur hlet hlet te hian ka awm leh thin (eg., kut khur)	0	1	2	3
9.	Thil tul loah nasa takin ka zam thin.	0	1	2	3
10.	Thil ka tihah mi nuihzat nih ka hlau thin.	0	1	2	3
11.	Hmalam hunah thil beisei tur neilo te hian ka inhre thin.	0	1	2	3
12.	Ka thinrim/phawklek hma thin.	0	1	2	3
13.	Hahdam taka awm ka harsat thin.	0	1	2	3
14.	Rilru hnual ruihin ka awm thin.	0	1	2	3
15.	Ka thiltihah min tibuaitu an awmindawhtheihna ka tlachham hle thin.	0	1	2	3
16.	Thil reng reng ah ka hlauthawng hma	0	1	2	3
17.	Ka thil tih ah hian phur taka thil tih harsa ka ti.	0	1	2	3
18.	Hlutna neilo niin ka inhre thin.	0	1	2	3
19.	Thil reng rengin ka rilru a khawih hma thin.	0	1	2	3
20.	Taksa chet hah loh pawhin ka lungphu a rangin ka hre thin (eg., lungphu a rang tih hriat, lungphu chawl leh vang vang)	0	1	2	3
21.	Chhan tha engmah awmloin ka hlau leh chiam thin.	0	1	2	3

APPENDIX – XI

SATISFACTION WITH LIFE SCALE; Diener, Emmons, Larsen, & Griffin, 1985 (English)

Instructions: Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7 - Strongly agree
- 6 – Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

_____ In most ways my life is close to my ideal.

_____ The conditions of my life are excellent.

_____ I am satisfied with my life.

_____ So far I have gotten the important things I want in life.

_____ If I could live my life over, I would change almost nothing.

APPENDIX – XII

SATISFACTION WITH LIFE SCALE; Diener, Emmons, Larsen, & Griffin, 1985 (Mizo version)

A hnuaia zawhna hi uluk deuhin chhiar la, I pawm dan ang zelin a chunga number khi I ziak dawn nia. Chhanna dik leh dik lo a awm lo.

- 7 – Pawm lutuk
- 6 – Pawm
- 5 – Pawm ve deuh
- 4 – Ngaihdan neilo
- 3 – Pawm vaklo
- 2 - Pawmlo
- 1 – Pawmlo lutuk

_____ Kawng tam zawkah hi chuan ka nun hi ka duhthusam nen an hnaih hle.

_____ Ka nun innghahna te hi an tha tawk hle.

_____ Ka nunah hian ka lungawi.

_____ Nun atana pawimawh ka tih ho chu ka la nei thei ve zel.

_____ Ka nun hi bul tan tha leh thei dawn ta ila, thlak danglam tur ka nei tehchiam lo.

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ABSTRACT

LOCUS OF CONTROL ON RESILIENCE, DEPRESSION AND STRESS: A STUDY OF FEMALE COMMERCIAL SEX WORKERS IN AIZAWL CITY

AN ABSTRACT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
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LOCUS OF CONTROL ON RESILIENCE, DEPRESSION AND STRESS: A STUDY OF FEMALE COMMECIAL SEX WORKERS IN AIZAWL CITY

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In partial fulfillment of the requirement of the Degree of Doctor of

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Sex work is defined as the practice or business of exchanging money or goods for sexual services among female, male and transgender adults (UNAIDS, 2005) and such services are known by many terms (Overs, 2002). Female Commercial Sex Workers (FCSWs) are often considered to be passive victims, forced into sex work through poverty, power inequalities, exploitation, coercion, trafficking or voluntarily choosing as a means of livelihood. Factors such as financial need, limited employment opportunities, or personal agency can influence an individual's decision to enter the sex industry (Overall, 1992; Ross et al., 2012).

Sex work encompasses a range of activities, including but not limited to escorting, pornography, street-based sex work, and online platforms for sexual services. It involves the exchange of sexual activity for goods or money between consenting adults.

'Sex worker' is the preferred term used throughout the literature on the subject which is more commonly used with the term 'prostitute' (May, Harocopos & Hough, 2000). Sex work is a wide range of activities relating to sexual service in exchange for money which can be categorized into two types of sexual services - direct and indirect sex work. Direct sex is indoor and outdoor prostitution as well as escort services typically involve the exchange of sex for a fee. Indirect sex work refers to sex-related services that do not involve direct sexual intercourse but still involve the exchange of a fee for the service. Activities such as lap dancing, stripping, and virtual sex services, which can be provided over the Internet or phone, fall under the umbrella of indirect sex work.

Female Commercial Sex Workers are individuals who engage in sex work as a means of income through personal choice, forced into it through human trafficking, sexual exploitation, or other forms of coercion and abuse (Orchard, 2007). FCSWs are victims of structural inequalities, including poverty, lack of education, or limited employment opportunities, which leave them with few options other than engaging in sex work (Overall, 1992; Ross et al., 2012). Because of the special nature of their work, FCSWs are entangled in a complex social network composed of gatekeepers (e.g., bosses or managers of their workplaces), clients, nonpaid partners, law enforcement

authorities, and health professionals. As with any other professional, the characteristics of sex work may have implications concerning many stress-related health problems among FCSWs (Mark & Smith, 2008).

The exact number of sex workers is unknown as sex work is mostly hidden and transient with moving in and out of sex work constantly (Cusick et al., 2009). Female Commercial Sex Workers (FCSWs) are stigmatized and marginalized around the world. They are generally not accepted in society and are regarded as criminals, immoral troublemakers, sexual deviants and vectors or reservoirs of disease (Erving, 1963; Durisin, Van der Meulen & Bruckert, 2018). The criminalization or stigmatization of sex work can create barriers to accessing healthcare and harm reduction resources, which can further exacerbate the risks of Sexually Transmitted Infections (STIs). In settings where sex work is illegal, FCSWs may be less likely to seek regular medical care, including testing and treatment for STIs, due to fear of legal repercussions or societal judgment. According to the Center for Disease Control and Prevention, rates of sexually transmitted diseases such as syphilis, gonorrhoea, and Human Immunodeficiency Viruses (HIV) have increased in the past 10 years, with high-risk sexual behaviour as a major cause of transmission (Center for Disease Control and Prevention, 2009).

Female Non Sex Worker

The term "Female Non Sex Worker (FNSW)" in the present study is used to refer to the general female population who are not engaged in sex work or the commercial exchange of sexual services for money or goods. This term is used to differentiate women who are not involved in such paid sexual activities from those who may be engaged in sex work as a means of income or employment. FNSW samples represented the general female population from Aizawl city, the capital of Mizoram who were working in offices for 1 to 4 years. These samples were selected by following random sampling procedures to match the demographic profiles of the FCSW samples for the study by employing Socio-demographic profile.

Several factors contribute to the cyclical nature of sex work involvement for some individuals. These factors can include social and economic circumstances, lack of alternative employment options, limited access to education or job training,

addiction issues, mental health challenges, and systemic factors such as poverty and inequality. For some people, entering sex work may be a result of desperate circumstances, including financial hardship or coercion. Leaving sex work can be challenging due to various factors such as limited job prospects, social stigma and the difficulties of breaking free from exploitative situations or networks. Additionally, re-entry into sex work can occur for a range of reasons. These might include financial instability, the allure of quick money, lack of support networks, personal circumstances, or the perceived inability to find alternative employment that offers comparable financial benefits (Dalla, 2006a; Mayhew & Mossman, 2007; Williamson & Folaron, 2003). Factors such as drug addiction, homelessness, mental health issues, and family breakdown can also contribute to individuals entering street sex work (Jeal &Salisbury, 2004).

Female Commercial Sex Workers performing sexual acts for money include prostitutes, call girls, escorts, and dominatrices. Prostitutes are also commonly known as street walkers and are considered to be the lowest rung of sex workers by the other members of the industry. Because of the work on the street, the lack of screening of customers, and the variability of the location of the sexual act, streetwalking prostitutes face the most danger this group (Ngo, Ratliff, McCurdy, Ross, Markham, & Pham, 2007).

According to Harcourt and Donovan (2005), there are various types of sexual services practised by sex workers throughout the world.

Direct sex work encompasses services, such as prostitution and escorting. The type of sex work in this profession usually involves the exchange of sexual services for a fee, with genital contact being the norm.

Indirect sex work refers to services such as lap dancing, stripping, and virtual sex (over the Internet or by phone). Genital contact is less common in indirect sex work; however, a fee is still exchanged for the service.

On-street sex worker: Economic factors such as a lack of viable employment opportunities and overwhelming debt, can contribute to individuals, particularly women, entering on-street sex work.

Off-street sex worker: The belief that offering sex in brothels, flats, saunas, and escort services is generally considered more secure and less vulnerable than doing so on the street is based on several factors (Home Office, 2004; Jeal & Salisbury, 2004).

Many factors and reasons may be involved in motivating women to become prostitutes. Women in India who engage in sex work mostly join sex work involuntarily, but some of them join voluntarily (Nag, 2006). Poor economic circumstances are a common push factor that leads some women to engage in street-level sex work (Farley & Kelly, 2000; Sanders, 2007; Williamson & Folaron, 2003). Children who have experienced physical or sexual abuse as children, neglect or drug abuse are additional push factors (Farley et al., 2003; McClanahan, McClelland, Abram, & Teplin, 1999; Nadon, Koverola, & Schludermann, 1998; Ward & Roe-Sepowitz, 2009; Weitzer, 2009; Williamson & Folaron, 2003; Brawn & Roe-Sepowitz, 2008; Edlund & Korn, 2002; Young, Boyd, & Hubbell, 2000). People are attracted to dangerous lifestyles for a variety of reasons, such as glamorizing the lifestyle, feeling energized or empowered, or being encouraged by others and the desire for economic independence (Williamson & Folaron, 2003; Dalla, 2006a; Mayhew & Mossman, 2007; Kennedy, Klein, Bristowe, Cooper, & Yuille, 2007; Edlund & Korn, 2002; Weitzer, 2009).

Several studies have examined the effects of family breakdown on institutionalised care services, vulnerability and chronic exclusion as relates to sex work and broader social exclusion (Berelowitz et al., 2012). Jeal and Salisbury (2004), in their study of on-street sex workers in Bristol, found that a third of the women they interviewed had been 'looked-after' children or young people as a result of family breakdown. Individuals who lack support systems may turn to sex work as a means of survival or face increased vulnerability to exploitation and abuse (Tonybee & Hall, 2007; Fitzpatrick, Bramley & Johnsen, 2012).

Several scholars attribute prostitution to poverty, hunger, lack of education, migration to the city, lack of knowledge, drug addiction, divorce, and family conflict as well as the parents' deviation. Furthermore, mental health conditions such as depression, anxiety, post-traumatic stress disorder (PTSD), and borderline personality

disorder can contribute to vulnerability and increase the likelihood of someone entering the sex trade (Sherafatipour & Jaefar, 2005).

The absence of a safe and stable living environment can make it difficult for sex workers to prioritize their well-being, access healthcare, or escape dangerous situations (Spice, 2007; Davis, 2004). Jeal and Salisbury (2004) reported, in a study of on-street sex workers in Bristol, that a high proportion of those who claimed to be homeless lived in insecure/temporary housing (two-thirds) and that nearly everyone admitted to drug dependence. Sex work is often described as 'survival sex', where people engage in sex work as a last resort, to provide shelter, food, or fund severe addictions in a 'work-score-use' cycle (McNaughton & Sanders, 2007; Sanders, 2007b). Drinking alcohol before entering into sex work was used as a strategy to cope with childhood and adolescent experiences of loneliness and abuse (Brown, 2013).

Women become involved in sex work because of their responsibilities at home, the economic crisis and insufficient household resources (Wawer et al., 1996). In India, economic factors cause women to engage in sexual work (Blanchard et al., 2005). Economic reasons may drive women to sex work and certain classes, castes, and social groups tend to support them (Somaiya et al., 1990). Most women who work in the sex industry are illiterate, below-caste, from poor economic backgrounds and have no education (Ramesh et al., 2008). Locus of control, Depression, Stress Resilience and satisfaction with Life are supposed to be related to sex work while very minimal research was available, this is where the present study tries to explore it.

Locus of Control

The concept ‘locus of control’ is a stable belief of personal efficacy that was characteristic of an individual (Rotter, 1966) and an important coping resource for certain coping styles (Lazarus & Folkman, 1984; Newton & Keenan, 1990; Van den Brande et al., 2016) which is a personality construct that reflects one’s belief or perception about who controls life and the environment (Lefcourt, 1976); and reflection of how much individuals believe that their lives are within their control, and how much they feel they don't (Carrim et al., 2006). Individuals with an internal locus of control believe that they have control over their actions and the outcomes they experience. An external locus of control attributes events and outcomes to external

factors such as luck or fate. Individuals' locus of control can influence how they approach and deal with stressful situations (Rotter, 1966; Lazarus & Folkman, 1984; Newton & Keenan, 1990; Van den Brande et al., 2016).

Resilience

Resilience is a measure of how well one handles psychosocial risks (Rutter, 1999). It is an ability to recover, adapt, and bounce back from challenges, setbacks, or adversity. It involves maintaining mental and emotional well-being in the face of stress, trauma, or significant life changes (Tugade & Fredrickson, 2004). It is an ability to adapt well in the face of adversity, trauma, tragedy, threats or even significant sources of stress (APA, 2014).

Depression

Depression is a common mental health issue that can affect individuals in every society (Seligman, 1990). Depression is a mental disorder that is characterized by low mood, loss of interest or pleasure, low energy, guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Approximately 280 million people in the world have depression. It was estimated that depression affects 3.8% of the population. Among adults, the prevalence of depression is 5%. The rate varies between genders, with 4% of men and 6% of women experiencing depression. This means that depression is about 50% more common in women than in men (GHDx, 2023).

FCSWs suffer from occupational hazards that include various kinds of stress and injuries, as well as sexually transmitted infections. Depression could have profound ramifications on the lives of sex workers, and could adversely affect them (Collins et al., 2006). Studies in the USA have identified high levels of mental illnesses such as depression among sex workers (Bassel et al., 1997).

Stress

Stress is a collection of unpleasant emotional experiences associated with "fear, terror, anxiety, discomfort, anxiety, anger, sadness, grief and depression" (Cropanzano et al., 1997; Bolino & Turnley, 2005). Stress is classified into four categories; task

stress, physical stress, psychological stress and organizational stress (Leung et al., 2009); internal or external may be referred to as stressors (Lazarus & Folkman, 1984).

Studies have identified many actual and potential sources of stress in the context of commercial sex, including heavy workload, encounters with government officials, drug abuse, abusive clients, exposure to violence, HIV/STD infections, exploitation, discrimination, and stigmatization (Rekart, 2005; Ross et al., 2012; Yi et al., 2012). A human perceives stress or issues as threatening or dangerous if he/she does not believe he/she has adequate resources to deal with obstacles such as stimuli, people, situations, and so on (Lucas, et.al., 2005). Selye (1985) proposed the General Adaptation Syndrome (GAS) included three phases: Alarm Reaction, Stage of Resistance, and Exhaustion.

Satisfaction with Life

Life satisfaction has been defined as "A person's cognitive and emotive judgements of their life are referred to as life satisfaction" (Diener et al., 2002). How people perceive and evaluate their current circumstances, as well as their expectations for the future, especially when facing prolonged or severe threats that disrupt the normal course of life. Individuals with higher life satisfaction levels tend to have better-coping mechanisms and a more positive outlook, even in the face of danger or deteriorating conditions. Life satisfaction encompasses various aspects, including personal fulfilment, happiness, contentment, and the extent to which one's aspirations and desires are met (Landry, 2000).

There is evidence that sex work is a widely and rapidly emerging profession, and it exists in all major regions of the world. Globally, the International Labour Organization estimates that over 1.8 million young people are involved in prostitution (ILO 2000). A combination of legal offences and isolation from positive social support makes it difficult for people to leave the sex trade industry (Finn, Muftić, & Marsh, 2014; Maxwell, 2000; Williamson & Cluse-Tolar, 2002). Women working in the sex industry confront many structural inequalities, including poverty, gender inequality, racism, and social conditions that are hard to alleviate by viewing both illegal and trafficking sex work as problems that can be defined by the criminal justice system alone (Farrell & Fahy, 2009; Martin et al., 2010; Monroe, 2005).

The nature of the commercial sex work itself, including long hours, physical abuse, and the threat of violence, can further impact their well-being and quality of life. (Wong, Holroyd & Bingham, 2011). So, the majority of studies on sex work tend to focus on the negative aspects and risks associated with the profession (Bucardo, Semple, Fraga-Vallejo, Davila, & Patterson, 2004; Gorryet al., 2010). Women working in sex businesses face elevated levels of psychological stress compared to individuals in other professions (Weitzer, 2009).

The study of sex work is complex and challenging due to various legal, social, and ethical factors, which can hinder research efforts. However, due to the complexity and sensitivity of studying sex work, it can be challenging to obtain representative samples and reliable data. Factors such as the hidden nature of the profession, fear of legal repercussions, and mistrust of researchers may contribute to underreporting or difficulties in recruiting participants.

According to the Samaritan Society of Mizoram, the number of Female Commercial Sex workers ever registered in Mizoram till January 2022 was 1014 and the number of validated clients was 226. And the age gap between them was 16-53 years. In many places, including Mizoram, commercial sex workers can be categorized as street-based or home-based workers. Street-based sex workers operate in public spaces such as streets, parks, or other open areas, while home-based sex workers may work from their residences or in establishments like cheap hotels or thatched houses on the outskirts of towns. Though there were women sex workers in all districts of the state, the majority of them 90% were working in the capital-Aizawl.

Be it is whatever the factor of engaging in sex work, given the mentioned theoretical backgrounds, provided relevant studies about the psychosocial problems, and the current scenarios of sex workers, the present study was framed to serve the research gap especially for the present targeted group to provide valuable insights into the psychosocial challenges faced by sex workers and contribute to understanding their mental health needs.

The present study entitled *"**Locus of Control on Resilience, Depression and Stress: A Study of Female Commercial Sex Workers in Aizawl City**"* aimed to study the level of mental health conditions among Female Commercial Sex Workers in

Aizawl City. The study focused on some of the factors of mental health such as locus of control, resilience, depression, stress and psychological Satisfaction with life.

It was hypothesized that there will be a significantly different level of Resilience, Depression, Stress and Satisfaction with life among the groups (External Female Commercial Sex Workers; Internal Female Commercial Sex Workers; External Females Non Sex workers and Internal Females Non Sex Workers). It was expected that Female Commercial Sex Workers will have significantly higher scores on Depression and Stress but lower scores on Resilience and Satisfaction than Female Non Sex Workers. It was also expected that there will be a significant positive relationship between Locus of Control, Depression and Stress, and Resilience and Satisfaction with life whereas Locus of Control, Depression and Stress will have a negative relationship with Resilience and Satisfaction with life. It was also hypothesized that there will be a significant independent effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life.

To achieve the research objective, 200 adult female comprising of 50 Female Commercial sex Workers with External Locus of Control (External Female Commercial Sex Workers; EFCSW) and 50 Female Commercial sex Workers with Internal Locus of Control (Internal Female Commercial sex Workers; IFCSW). To compare with the FCSW, 100 Female Non Sex Worker (FNCSW) comprises 50 Female Non Sex Worker with an External Locus of Control (External Female Non Sex Worker; EFNSW) and 50 Female Non Sex Workers with an Internal Locus of Control (Internal Female Non Sex Worker; IFNSW) who were working in private / Non-Governmental Organizations (NGOs) and has been working in the organization more than 1 year to 4 years were also screened out using the Rotter's Locus of Control Scale (Rotter, 1966)

Four psychological scales were used to measure the variables of interest:

i) Rotter's Locus of Control Scale (Rotter, 1966), ii) Resilience Scale (RS; Gail M.Wagnild and Heather M. Young, 1993), iii) The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985), iv)The DASS-21 (Lovibond & Lovibond, 1995).

Subject-wise scores on the specific item of the scales were separately prepared and analyzed to check their psychometric adequacy for measurement purposes across the samples. The psychometric adequacies of the behavioral measures were analysed by employing SPSS 23 (Statistical Package for Social Sciences). Firstly, to check the psychometric adequacy of each scale used in the target population included i) Reliability coefficients (Cronbach's Alpha) ii) Descriptive statistics consisting of Mean, SD, Skewness and Kurtosis were included for comparison of the test scores between the groups.

The first objective was to compare the level of Resilience, Depression, Stress and Satisfaction with life among the four comparison groups (i.e. External Female Commercial Sex Workers, Internal Female Commercial Sex Workers, External Females Non Sex Workers, and Internal Females Non Sex Workers). Results indicated that Female Commercial Sex workers with an External locus of Control depicted a lower level of Resilience and Satisfaction with life, however, they depicted a higher score on Depression and Stress compared to the other groups. The impact of sex work on the psychological satisfaction with the life of sex workers can vary depending on various factors such as personal circumstances, societal attitudes, legal frameworks, and support systems available.

In the context of female commercial sex workers, the combination of an external locus of control and the specific challenges associated with their profession may contribute to higher levels of depression and stress. The commercial sex work industry is often characterized by factors such as social stigma, legal and safety concerns, and potential exploitation, which can exacerbate feelings of helplessness and contribute to a sense of powerlessness over one's life circumstances. Perceiving a higher level of internal control can contribute to resilience by fostering a proactive and determined mindset, leading to better mental health outcomes when facing challenging situations (Grob et al., 1995; Leontopoulou, 2006).

The second objective was to examine the significant difference between Female Commercial Sex Workers and Female Non Sex Workers on Resilience, Depression, Stress and Satisfaction with life. Results revealed that Female Commercial Sex Workers had significantly higher scores on Depression and Stress but

lower scores on Resilience and Satisfaction than Female Non Sex workers. These finding is consistent with the results of previous studies on the quality of life, emotional health, and resilience among female sex workers have indeed indicated lower overall well-being compared to the general population (Wonget al., 2006). Studies also show that the mental status of FCSW differed due to work settings, nationalities as well as their propensity for ill mental health (Rössler et al., 2009).

Female commercial sex workers may face various psychosocial stressors, including financial instability, interpersonal conflicts, and a lack of social support networks. These stressors, combined with an external locus of control, can increase the risk of developing mental health issues such as depression and elevated levels of stress. Studies done by (Deering et al., 2014; Li Q et al., 2010) found that FCSW face increased levels of key risk factors for mental disorders, including financial stress, low education, inadequate housing, violence, alcohol and drug use, STIs including HIV, and stigma and discrimination, which may help explain the higher prevalence of mental health problems in comparison with the general population.

The third objective was to study the relationship between Locus of Control, Stress, Depression, Resilience and Satisfaction with life. The results revealed a significant positive relationship between Locus of Control, Depression and Stress, and Resilience and Satisfaction with life whereas Locus of Control, Depression and Stress have a negative relationship with Resilience and Satisfaction with life.

Research has shown a correlation between an external locus of control and poorer mental health outcomes, including higher levels of depression, stress, and lower levels of resilience and life satisfaction. Factors such as stigma, social marginalization, and lack of legal protections can contribute to increased stress and lower mental well-being among sex workers. Sex work can involve challenging working conditions, vulnerability to violence and limited access to healthcare, and societal discrimination, all of which can affect mental health outcomes. These external factors can contribute to a heightened sense of lack of control and increase the likelihood of experiencing mental health challenges. Perceptions of internal locus of control refer to an individual's belief that they have control over the events and outcomes in their life. This belief is associated with empowerment, as it is thought to contribute to a sense of

personal agency and the belief that one can influence their circumstances (Zimmerman, 2000).

While it is difficult to make broad generalizations about any specific group of individuals, including Female Commercial Sex Workers, individuals with an external locus of control may experience lower resilience and life satisfaction. The concept of locus of control has been linked to resilience, which is the ability to bounce back or adapt positively in the face of adversity or challenging situations. Research suggests that individuals with an internal locus of control are more likely to exhibit higher levels of resilience. This is because they perceive themselves as having more control over their circumstances, which can lead to a greater sense of empowerment, problem-solving skills, and a proactive approach to dealing with challenges (Masten et al., 2001; Dipayanti et al., & Rotter, 1954).

Studies explain that when individuals with an external locus of control experience a problem and get social support from others, their level of resilience will increase (Dalal, 2000 & Stewart, 2011). FCSW arise from their negative feelings toward themselves and poor living and working environments. Evidence in exposure to trauma, greater Internal Locus of Control has been positively associated with the ability to resiliently adapt to situations (Frazier et al., 2011).

Additionally, individuals with an internal locus of control tend to be hardworking and persistent in their endeavors. They believe that their efforts can make a difference more likely to invest time and energy in pursuing their goals. This strong work ethic can contribute to resilience by enhancing perseverance and determination when faced with adversity (Grant et al., 2007).

The fourth objective was to examine the independent effect of ‘Commercial Sex Work’ and ‘Locus of Control’ on Resilience, Depression, Stress and Satisfaction with life. The result showed that ‘Commercial Sex work’ and ‘Locus of Control’ had a significant independent effect on all dependent variables.

The nature of the commercial sex work industry can present additional challenges and stressors that may impact overall life satisfaction. These can include social isolation, physical and emotional risks, economic instability, and lack of social

support. Such circumstances can contribute to a lower sense of well-being and satisfaction with life.

Resilience, depression, stress and satisfaction with life are complex psychological factors that can be influenced by a multitude of variables, including personal experiences, social support, and individual coping strategies. It is challenging to attribute specific effect sizes solely to commercial sex work, as these factors interact with and influence each other. Resilience conceived as a successful adaptation to challenging internal or external stressors predicts future psychological problems, such as depression, anxiety and stress (Connor & Davidson, 2003). The Resiliency Model (Richardson et al., 1990) stresses the difference between the disruptors of psychological balance, or "stressors" and the outcome of maladaptive coping mechanisms, such as symptoms of anxiety, depression and stress-resilience being a significant moderator or buffer between these psychological variables (Liu et al., 2014). Research on resilience stresses that it is a crucial factor in the study of life crises or transitions, operating as a potentially protective factor against psychological distress (Jayalakshmi & Magdalin, 2015).

The fifth objective was to there will be a significant interaction effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life. The result revealed that there was a significant interaction effect of 'Commercial Sex Work' and 'Locus of Control' on Resilience, Depression, Stress and Satisfaction with life. In the context of female sex workers, those with an internal locus of control may believe that they have chosen or have control over their involvement in sex work. They may perceive their choices and actions as the primary factors influencing their work and its consequences.

Sex workers with an internal locus of control may believe that they have chosen their profession and have control over their work conditions and decisions. They may be more likely to view themselves as active agents in their lives, which could contribute to their resilience and satisfaction with life. On the other hand, sex workers with an external locus of control may feel that they are forced into the profession or that external factors dictate their choices and outcomes. This perception of limited

control over their circumstances may increase their vulnerability to depression, stress, and lower satisfaction with life.

Limitations of the study

The present study acknowledges several limitations which need to be addressed but are not able to include in this study due to time limitations. First, the sample size used in the study was not large enough to effectively represent the targeted population which may specify not big enough to generalize to the whole targetted population.

Another limitation of the study is that a more systematic and comprehensive empirical cross-examination of FCSW responses such as conducting qualitative interviews, longitudinal studies, or employing mixed-methods approaches to gain a more in-depth understanding of the issue.

Sex work is an underground or hidden profession, and high taboo in many regions, including Mizoram. The transient and secretive nature of the work makes it challenging to locate and establish contact with sex workers. This can lead to difficulties in recruiting a representative sample and capturing the diversity within the population.

Collecting data from sex workers can indeed present several challenges. Sex workers may face heightened risks during the pandemic due to the nature of their work and the potential for close physical contact with clients. As a result, they e reluctant to share information or participate in data collection activities due to concerns about their safety and privacy which required a longer time to collect data.

The study could not include more independent variables which were assumed to be a reason for commercial sex work and more dependent variables which are assumed to be a consequence of Commercial sex work due to the limitations which were mentioned.

Suggestions for further studies

The inclusion of more demographic information to get valuable insights into the factors that contribute to why individuals enter the profession of sex work and potential underlying factors that influence their decision to engage in sex work would provide comprehensive factors and status of Commercial Sex Workers with comprehensive information and its complexities.

Bigger samples and a wider range of participants covering non-registered female sex workers like call girls to have more information for understanding the sex industry in Mizoram. It will help to capture the diversity of experiences and challenges faced by sex workers and their specific needs.

Further research in this area required close relationships with the participants with whom the participants can share their identities, experience, problem, the reason for joining commercial sex work, and so on.

Significance of the study

The analysis of the socio-demographic variables provided important information regarding the status and possible causes for Commercial Sex work such as age, sex, education level, marital status, parent's occupation of the samples, family size, number of siblings, monthly income of the family, house living condition, duration of service, parent's marital status of the sample, type of shift in a day, duration of the working hour in a day, which not yet done in the targeted population.

The results of the study illustrated revealed a significant difference among the four groups- Female Commercial Sex Workers in Mizoram had a higher mental problem compared to Female Non Sex Workers, Female Commercial Sex Workers had significantly higher depression and stress compared to Female Non Sex Workers whereas a lower resilience and satisfaction with Life which may be taken as the high need of psychological cares by the FCSW. The results may explain that the Female Commercial sex workers regardless of personality (internal or external Loc) had a higher mental problems personality.

The results provided the significant difference between the FCSW and FNSW on resilience, stress, depression and satisfaction with life which demonstrated that FCSW had higher depression, stress whereas lower resilience and satisfaction with

life; which indicated that the FCSW were more in need including psychological cares and intervention.

The results provided a significant positive relationship between stress and depression, resilience and satisfaction with life, whereas both stress and depression had a significant negative relationship to resilience and satisfaction with life. Accordingly, the FCSW had higher depression and stress but lower resilience and satisfaction with life than FNSW in this study.

The independent effect and interaction effect of 'Commercial Sex Works' and 'Locus of Control' was elucidated by this study, and may be utilized to make a strategy for the prevention, intervention, and/or rehabilitation of commercial sex workers.

In conclusion, the study contributed to the existing academic literature about "Locus of Control on Resilience, Depression and Stress: A Study of Female Commercial Sex Workers in Aizawl City" where the 'Locus of control' and " Commercial Sex Work" effect on Resilience, Depression and Stress by highlighting the difference between (i) External and Internal Locus of control groups, and (ii) Female Commercial Sex Workers and Female Non Sex Workers; (iii) Relationship between the psychological variables- Resilience, Depression and Stress; overall results displayed the poor mental health of Commercial sex workers than Non Sex Workers along with an Externally control than Internally Control among the samples which were not available in the existing academic literature, and much needed to understanding for designing prevention of sex work, and rehabilitation to Female Commercial Sex Workers.

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