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RESEARCH ARTICLE

Openness Without Safety? Negotiated Visibility, Stigma, and Well-Being Among Female Sex Workers Living in Local Communities

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Abstract
Female sex workers (FSWs) often manage a concealable, stigmatized identity, yet some are known within their neighborhoods. Using Interpretative Phenomenological Analysis (IPA), this study examined how five Indonesian FSWs (35–45 years) living in Central Java made sense of "living openly" and mental health as emotional, psychological, and social well-being. "Living openly" was defined as negotiated openness: at least some community members (e.g., neighbors, informal leaders, and/or family) knew participants' work status, while operational details were deliberately withheld. Participants were recruited via snowball sampling and completed in-depth interviews in Indonesian; excerpts were translated into English for reporting. Idiographic accounts converged in four cross-case themes: (1) boundary work that eased the burden of secrecy without requiring total disclosure; (2) emotional relief coexisting with vigilance as stigma resurfaced through gossip, moral judgment, harassment, and safety concerns; (3) psychological well-being sustained by time–space separation between work and home, privacy management, selective trust, and meaning anchored in caregiving roles; and (4) social well-being built through routine participation and visible contribution to community activities under conditional acceptance. The findings position openness as a continuing social practice through which well-being is reconstructed amid persistent stigma and structural vulnerability. Implications highlight harm-reduction norms, safe spaces, and family support.

Keywords: mental health; female sex workers; negotiated openness; community participation; stigma.

INTRODUCTION

Women engaged in sex work routinely navigate intersecting structural vulnerabilities–criminalization or quasi-criminalization, economic precarity, gendered violence, and exclusion from social and health institutions–that collectively intensify psychosocial stress and constrain access to care (World Health Organization [WHO], 2022). In Indonesia, national and programmatic documents have estimated that the population size of sex workers reaches the hundreds of thousands, underscoring the public health and social significance of understanding their lived experiences in specific local contexts (United Nations Population Fund [UNFPA], n.d.). Within this landscape, stigma remains a central mechanism through which disadvantage is produced and reproduced. Stigma is not merely an individual attitude; it is a multi-level social process that involves labeling, stereotyping, separation, and status loss enacted through power relations (Link & Phelan, 2001). For women in sex work, stigma can be amplified by moral judgments, community surveillance, and institutional discrimination–often culminating in social withdrawal, limited help-seeking, and chronic psychological burden (WHO, 2022).

The mental health burden among sex workers is consistently documented across settings. Recent syntheses indicate elevated risks of depression, anxiety, post-traumatic stress symptoms, and psychological distress, driven by cumulative exposures to violence, economic insecurity, and stigmatizing social environments (Martín-Romo et al., 2023; Millán-Alanis et al., 2021; Deering et al., 2014). Importantly, these outcomes do not arise solely from the work itself, but from the structural and relational conditions under which sex work is performed and socially interpreted, including the ways stigma constrains safety, dignity, and access to supportive resources (Treloar et al., 2021; Link & Phelan, 2001; Deering et al., 2014). In this regard, mental health research with sex workers requires analytic attention to the social ecology of everyday life–family dynamics, neighborhood norms, peer and community networks, and institutional encounters–rather than relying on individualizing explanations (Treloar et al., 2021; World Health Organization, 2022).

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A pivotal yet under-theorized dimension of this ecology is "openness" about engagement in sex work. Classic stigma scholarship distinguishes between discredited identities (visible) and discreditable identities (concealable), emphasizing that concealment and disclosure are strategic responses to anticipated stigma, enacted to reduce harm but often accompanied by psychological costs (Goffman, 1963; Link & Phelan, 2001; Pachankis, 2007). Contemporary disclosure frameworks further conceptualize disclosure as a decision-making and coping process shaped by goals (e.g., safety, support, authenticity), anticipated reactions, and context-specific risks (Chaudoir & Fisher, 2010). For sex workers, disclosure is rarely a binary "open vs. closed" condition. Instead, many practice negotiated or selective disclosure–being known to certain trusted individuals while maintaining boundaries in other spheres–to manage safety, livelihood, and family roles (Treloar et al., 2021; Chaudoir & Fisher, 2010). Accordingly, "living openly" should be framed as a continuum of community-recognized visibility: a sustained condition in which engagement in sex work is known by at least some members of the local community (e.g., neighbors, informal leaders, or family), while still involving deliberate boundary-setting around details, space, and relational access (Treloar et al., 2021; Pachankis, 2007). This framing is essential to avoid an unintended assumption that openness equals total disclosure.

Openness is also a high-stakes decision. In many contexts, being known as a sex worker may heighten exposure to discrimination, harassment, reputational harm, and threats to physical safety, including violence and coercion (WHO, 2022; Deering et al., 2014). Yet openness may simultaneously reduce the psychological strain of secrecy, enable access to social support, and facilitate more stable engagement with health and community systems–especially when local relationships include elements of reciprocity, acceptance, or harm-reduction norms (Treloar et al., 2021; Chaudoir & Fisher, 2010). This paradox–openness as both risk and potential resource–suggests that mental health among sex workers who live openly is best understood through an analytic lens that integrates stigma processes, disclosure management, and the relational conditions of community life (Link & Phelan, 2001; Treloar et al., 2021).

To strengthen conceptual precision, this study adopts a positive mental health framework that treats mental health as more than the absence of disorder. Keyes' s mental health continuum distinguishes flourishing and languishing across emotional well-being (positive affect and life satisfaction), psychological well-being (e.g., autonomy, purpose, personal growth), and social well-being (e.g., integration and contribution) (Keyes, 2002, 2005). This framework is compatible with contemporary definitions that emphasize functioning, meaning, and the capacity to cope productively amid stressors (Galderisi et al., 2015; World Health Organization, 2022). For marginalized populations, including sex workers, a Keyes-informed lens is particularly useful because it enables inquiry into how individuals build (or struggle to build) well-being in the presence of persistent stigma and constrained structural conditions, rather than restricting analysis to symptoms alone (Keyes, 2002, 2005; Link & Phelan, 2001).

Despite growing literature on stigma and health among sex workers, prior work has predominantly centered on populations who conceal their identities or on service access outcomes, leaving limited understanding of women who are openly known within their neighborhoods and how they sustain mental health in everyday community life (Treloar et al., 2021). The current manuscript' s original introduction highlights this gap and positions openness and community participation as potentially consequential for emotional, psychological, and social well-being. Building on that foundation, a refined gap statement is warranted: what remains insufficiently explained is how women who live openly negotiate disclosure boundaries, manage stigma-related risk, and mobilize relational resources (family, peers, and community structures) to maintain or reconstruct well-being across Keyes' s three domains–particularly in local Indonesian settings where communal norms, religious practices, and neighborhood governance can shape both acceptance and surveillance (Treloar et al., 2021; Keyes, 2002, 2005).

This study was preceded by a formative preliminary exploration that included initial conversations/interviews with openly known women engaged in sex work (March 2023–April 2025). To avoid methodological ambiguity, the preliminary phase should be explicitly framed as pilot/formative work used to refine the interview guide, recruitment pathways, and safety procedures, and it should be clearly distinguished from the analytic sample and the primary data collection period (reported in the Methods section). This clarification is important for transparency and for preventing readers from misinterpreting the preliminary material as part of the main dataset.

Accordingly, the purpose of this descriptive phenomenological study is to explore and describe the dynamics of mental health among female sex workers who live openly within their local communities in Central Java, using Keyes' s framework as an organizing lens. Specifically, the study aims to (a) elucidate how openness is practiced as negotiated visibility and boundary management, (b) examine how community responses and participation in local social structures shape emotional, psychological, and social well-being, and (c) identify the role of family meaning–particularly motherhood and responsibility for children–as a potential anchor for resilience and identity reconstruction amid stigma. By integrating stigma and disclosure theory with a positive mental health framework, the study seeks to contribute a more nuanced, context-sensitive account of openness as both risk and resource, with implications for community-based harm-reduction supports and safer, non-stigmatizing pathways to well-being.

MATERIALS AND METHODS

Methodological approach and reporting standard

This qualitative study was conducted using Interpretative Phenomenological Analysis (IPA) as the primary methodological umbrella to examine how women engaged in sex work make sense of "living openly" within their local communities and how these meanings relate to emotional, psychological, and social well-being. IPA was selected because it is explicitly idiographic, emphasizes depth of analysis within cases, and is rooted in phenomenology and hermeneutics–making it well suited to exploring meaning-making under conditions of stigma, relational risk, and identity negotiation (Smith et al., 2009). In line with the IPA commitment to the double hermeneutic, the analytic goal was not a purely descriptive thematic catalogue but an interpretative account of participants' lived experience and the researcher' s analytic engagement with those accounts (Smith et al., 2009). To strengthen

transparency and publication readiness, the Methods section was prepared to align with established qualitative reporting recommendations, including interview-based reporting guidance (Tong et al., 2007) and broader standards for reporting qualitative research (O′Brien et al., 2014), as also recommended in widely used qualitative design references (Creswell & Poth, 2018).

Participants, and inclusion/exclusion criteria

Eligible participants were adult women who self-identified as female sex workers and reported living openly within their local communities, with inclusion criteria of ages 35–45 and Indonesian as the primary interview language. The age range was intentionally selected to strengthen interpretability of openness as a sustained and negotiated social position: mid-adulthood is often characterized by longer community embeddedness and more stable social roles (e.g., caregiving responsibilities, neighborhood participation), which can shape both disclosure boundary management and the social consequences of visibility. This narrowing also reduces developmental heterogeneity that could confound comparisons in how openness is enacted and experienced, supporting the idiographic and contextual aims of IPA (Smith et al., 2009; Creswell & Poth, 2018). Exclusion criteria included inability or unwillingness to provide informed consent and severe cognitive or psychiatric conditions that would preclude meaningful participation or increase risk during interviewing, consistent with ethical expectations for qualitative work with vulnerable populations (Creswell & Poth, 2018; Tong et al., 2007).

Table 1. Participant Characteristics (N = 5)

Participant (Initial)	Age (years)	Occupation	Place of Origin
Participant 1 (P)	45	Female sex worker	Purworejo
Participant 2 (Y)	42	Female sex worker; homemaker	Bandungan
Participant 3 (D)	39	Female sex worker; freelancer; homemaker	Semarang
Participant 4 (N)	36	Female sex worker; karaoke guide; homemaker	Salatiga
Participant 5 (I)	37	Female sex worker; Peer Leader (AIDS outreach educator); homemaker	Salatiga

Operationalization of "living openly" and recruitment strategy

In this study, "living openly" was conceptualized as negotiated visibility–a context-dependent condition in which engagement in sex work is known (to some degree) by people in the participant′s community and shapes everyday social interactions–rather than implying total disclosure to all community members. This operationalization aligns with phenomenological attention to lived meanings and boundary management in real-world contexts (Smith et al., 2009; La Kahija, 2018). Recruitment used snowball sampling initiated through community contacts and peer referrals, which is commonly used for stigmatized and hard-to-reach populations while prioritizing safety and feasibility (Creswell & Poth, 2018). To minimize undue influence within chain referral, invitations emphasized voluntariness, the right to decline without consequence, and independence from any services or community relationships.

Screening for "severe psychiatric conditions" and participant safety

To apply the exclusion criterion related to severe psychiatric conditions, a brief eligibility screening was conducted before interviewing, focusing on the participant′s capacity to provide informed consent and to participate without undue risk. Screening relied on (a) self-report regarding acute psychological crisis, recent psychiatric hospitalization, or severe symptoms that could impair participation (e.g., disorganized thinking, acute psychosis, imminent self-harm intent), and (b) the interviewer′s observational assessment of comprehension and stability during the consent process, consistent with ethical practice in qualitative interviewing (Tong et al., 2007; O′Brien et al., 2014). If acute distress or safety concerns emerged, the interview was paused or discontinued, and the participant was offered information for locally available psychosocial support services. These procedures were documented as part of the study′s audit trail to support transparency and ethical accountability (Lincoln & Guba, 1985).

Data collection procedures

Data were collected through face-to-face semi-structured interviews in participants′ local areas in Central Java, with each interview lasting approximately 50–60 minutes. Interviews were conducted in private, participant-approved locations and scheduled to minimize visibility and potential social risk. Participants were informed they could pause, skip questions, or withdraw at any time without justification, consistent with best practices for interview-based qualitative research (Tong et al., 2007; O′Brien et al., 2014). With permission, interviews were audio-recorded and supplemented by contemporaneous field notes and analytic memos to capture contextual information relevant to idiographic interpretation in IPA (Smith et al., 2009). As a culturally appropriate appreciation token, participants received a small non-monetary gift after the interview; the type and approximate value were selected to acknowledge time without creating undue influence, consistent with ethical guidance for research with vulnerable populations (Tong et al., 2007; O′Brien et al., 2014).

Ethical approval and protections for a vulnerable population

The protocol received approval from the Faculty of Psychology Research Ethics Committee, Universitas Muhammadiyah Malang (E.6.m/318/KE-FPsi-UMM/V/2025). Given participants′ heightened vulnerability to stigma exposure, ethical safeguards prioritized confidentiality, minimization of harm, and autonomy. Data were de-identified at transcription, and contextual details with potential for deductive disclosure in small communities were masked. These protections reflect core expectations for trustworthy qualitative research and ethical rigor, including safeguards emphasized in interview reporting guidance (Tong et al., 2007), qualitative reporting

standards (O'Brien et al., 2014), and foundational trustworthiness frameworks (Lincoln & Guba, 1985).

Interview guidelines

The semi-structured interview guide was developed using Keyes's mental health continuum model as a sensitizing framework to explore emotional, psychological, and social well-being without forcing responses into predetermined categories. Consistent with IPA, questions emphasized lived experience and meaning, using open prompts and follow-up probes to clarify how participants interpreted community reactions, disclosure boundaries, and coping resources across daily life contexts (Smith et al., 2009). The guide and interviewing approach were iteratively refined through reflexive consideration of how questions shaped participants' meaning-making, consistent with qualitative design principles (Creswell & Poth, 2018).

Sample size rationale

The final analytic sample comprised five participants, consistent with IPA's idiographic commitment and emphasis on depth over breadth (Smith et al., 2009). Recruitment concluded based on the principle of information power, whereby sample adequacy is determined by the study aim, sample specificity, quality of dialogue, and analytic strategy–rather than statistical representativeness (Malterud et al., 2016). This approach supports the study's goal of generating a nuanced, context-sensitive interpretative account rather than population-level estimates.

Transcription, translation, and data management

Audio recordings were transcribed verbatim and checked against recordings to ensure accuracy, with transcripts stored securely under restricted access. Because interviews were conducted in Indonesian, excerpts used in an English-language manuscript should be translated using a transparent procedure (e.g., forward translation by a bilingual team member with review by a second bilingual reviewer) to preserve meaning equivalence, especially for culturally specific expressions. Such documentation is consistent with reporting expectations for qualitative research and enhances transparency for international readership (O'Brien et al., 2014; Tong et al., 2007).

IPA analytic procedure

Analysis followed established IPA stages: repeated reading for immersion, detailed initial noting (descriptive, linguistic, conceptual), development of emergent themes within each case, clustering into superordinate themes per case, and cross-case patterning while preserving idiographic nuance (Smith et al., 2009). Coding and theme development were documented through an audit trail of analytic decisions, including memoing and iterative refinement of theme labels, to support an auditable chain of evidence (Lincoln & Guba, 1985; Smith et al., 2009). Where applicable, analytic decisions were discussed through peer debriefing or inter-review to enhance interpretative rigor and reduce unnoticed assumptions, consistent with recommended qualitative quality practices (Tracy, 2010; O'Brien et al., 2014).

Trustworthiness, reflexivity, and clarification of prior claims

Credibility and trustworthiness were strengthened through reflexive journaling, systematic documentation of analytic decisions, and active searching for disconfirming evidence (negative case attention) to test and refine emergent interpretations (Lincoln & Guba, 1985; Tracy, 2010). Member checking, when used in IPA-oriented work, was treated as a check on resonance and factual accuracy of summarized accounts rather than as a requirement for participants to "validate" interpretative claims; procedures (who was contacted, what was shared, and how feedback influenced analysis) should be reported explicitly to meet reporting expectations (O'Brien et al., 2014; Tong et al., 2007). Importantly, the study avoided overstating "triangulation" or "prolonged observation" unless these were supported by concrete practice; instead, the design can be accurately described as data-source enrichment through interviews supported by field notes and analytic memos, with clear documentation of the number and duration of encounters to maintain precision and credibility (O'Brien et al., 2014; Tracy, 2010).

RESULTS OF STUDY

An analysis of the five participants' narratives indicates that mental health among women engaged in sex work who live openly within their local communities is not formed automatically. Rather, mental health is constructed through three domains of well-being articulated by Keyes (2002): emotional well-being, psychological well-being, and social well-being. Across domains, the core finding is that "living openly" primarily operates as negotiated openness (managed/selective openness): the community may "know" a participant's occupational status, but detailed information is intentionally restricted and regulated as a protective strategy. One participant articulated this boundary-setting explicitly: *"I usually withhold detailed information from neighbors. They know I'm a sex worker, but they don't know where I work, when I work, or how it happens. So it's enough that they just know the basics" (Participant I)*. The same participant linked selective disclosure to stigma prevention and rumor control: "If too many people know, it becomes gossip... they ask where I work, what hours, and then the story gets twisted" (Participant I). Similarly, another participant described limiting informal neighborhood communication because of perceived "curiosity" and narrative distortion–"*Neighbors like to be nosy... once they know, they make up stories... I rarely communicate... I go to [community activities]... but I don't tell personal stories or anything else" (Participant Y)*–and emphasized that even in the work setting, some matters remained intentionally private: "*There are secrets too... but not everything has to be told" (Participant Y)*. Taken together, these accounts position openness as boundary work: participants permitted social recognition while restricting operational details, personal history, and family-related information to reduce exposure to gossip and residual stigma.

Negotiated openness was also enacted through role/identity management and spatial–temporal separation between work and private life. One participant described "code-switching" in presentation: "*The way I dress... is different from at home... my appearance is different too,*" while also setting firm limits on where work could occur: "*I*

don′t want my rented room or this boarding house to be where I work; if I meet someone, it has to be outside or at a hotel.″ Another participant similarly reported adjusting return times and everyday "normality cues" to avoid neighborhood suspicion: "*Usually I just come home at dawn or in the morning… I also bring groceries from the market, so it looks like I just went shopping in the morning.″* Importantly, the findings also clarify why participants did not frame openness as uniformly safe: one participant recalled feeling unsafe when a local man repeatedly came to her lodging at night–"*Yes… there was someone from around here who often came to the boarding house… at night [knocking on the door]… I felt… a little afraid″*–highlighting that acceptance could coexist with situational insecurity.

Emotional well-being

Within emotional well-being, the results show that post-openness experiences did not move in a single direction toward improvement; instead, they were shaped by two concurrent currents: relief as the burden of concealing identity decreased, and persistent emotional instability triggered by residual stigma, relational dynamics, and safety concerns. Participant P described openness as a shift from "*holding things in″* to feeling relieved because she was treated more humanely–"*they treat me like a friend, even like family.″* However, this relief did not fully protect her from emotional vulnerability when social acceptance was interwoven with unwanted sexual attention, producing discomfort and interpersonal conflict– "*Some residents want me though they have wives…″*. For P, emotional well-being appeared as "*earned calm,″* yet remained readily disrupted by power dynamics and social boundary pressures.

Participant Y conveyed a flatter and more pragmatic affective tone: openness did not change her emotions dramatically– "*I feel indifferent; relations with people are just normal″*. She continued to participate in communal activities–"*If there is an event, we help… when people pass away we attend the funeral″* – but positioned emotional distance as a form of protection. For Y, "stability" did not indicate the absence of pressure; rather, it reflected a strategy of normalizing the situation and managing social involvement in a functional way.

Participant D illustrated that openness did not automatically restore emotional safety. She continued to carry a persistent fear of social judgment– "*I still feel quite afraid…″* – and her emotional experience was easily "wounded" when teasing came from close relationships– "*Sometimes close friends bully and tease me… it still hurts″*. For D, openness appeared as a condition to be endured: she attempted to join community activities, yet fear and hurt remained a stable emotional backdrop.

Participant N narrated an emotional trajectory moving from fear toward greater relief as she began to "blend in"– "*At first I was scared… but now I mix with them″*. At the same time, she reported residual stigma from those close to her through derogatory labels–"*they once called me derogatory names″*. Thus, for N, emotional well-being emerged through repeated negotiation: social acceptance increased emotional lightness, but the "trace" of stigma continued to demand emotional endurance.

Participant I emphasized that openness improved her emotional state because she was less alone and could participate more freely in social activities, yet she still needed vigilance: "*It feels better than being alone, although I still have to be careful… some accept, some talk behind your back″*. She also acknowledged simultaneity in her experience–support alongside hurt–"*Some hurt, some give me encouragement″*. For I, emotional well-being appeared as a "fragile balance," maintained through social caution and selective relationship choices.

Across cases, the dominant pattern indicates that relief after openness was not uniform and depended strongly on relational context. For P, N, and I, openness reduced the psychological pressure of secrecy and created opportunities to feel "recognized." In contrast, Y′s emotional tone remained largely neutral, while D′s fear persisted. This underscores that openness is better understood as a trigger for context-dependent emotional shifts rather than a universal emotional "cure." Across all cases, participation in communal activities functioned not merely as social engagement, but as a mechanism to cultivate belonging, maintain routine, and resist isolation. Interpretively, "joining activities" became a way to build positive emotion through experiences of inclusion–while also negotiating social position without relying on explicit verbal affirmation.

The primary emotional challenges were not "stigma" as an abstract concept, but stigma as a daily relational experience: teasing from close contacts (D), derogatory labeling (N), gossip and backtalk (I), and unwanted sexual attention with conflict potential (P). Idiographically, these experiences clarify why emotional well-being after openness was often ambivalent: relief was present, yet vigilance and sensitivity to social relationships remained active. Participant Y described relatively low emotional stress because the local environment framed the situation as "normal." This pattern suggests that emotional well-being is shaped not only by the decision to be open, but also by how the community "reads" that openness–whether as a moral deviation subject to strict surveillance or as a socio-economic reality that is tolerated.

Psychological well-being

Within psychological well-being, the five participants primarily described an ongoing process of reconstructing self-evaluation, sustaining role functioning (family–work), and maintaining agency in decision-making amid social acceptance that remained uncertain and conditional. For participant P, psychological well-being appeared to be built through two main sources: (1) feeling "useful" through community involvement, and (2) the presence of an emotionally safe support figure. P rated her life satisfaction as relatively high and linked it to being "better than before" and to perceived usefulness in the community: "*For me personally, I′d say I′m satisfied… I′d rate it 7/10… I can also be useful to the community here″*. She also framed social involvement as evidence of self-worth (being present and helping neighbors): "*As for the community, it′s good… I have community activities… for example, if someone is sick, I visit them…″.* P′s emotional support was selective; she named one trusted person with whom she could share concerns and receive advice: "*I do have someone here… I trust him… that 'Kakang' …″*.

Participant Y presented a firm self-as-agent narrative–independence was not merely a choice, but a long-established identity: "*Since a long time ago… I′ve handled everything on my own… I don′t really like it when people interfere in my life″ (Participant Y)*. Openness and social involvement appeared to strengthen her confidence and personal growth: "*I became more confident… I was invited to a campus before… and from that I became even more confident″ (Participant Y)*. In evaluative terms, Y rated her

life satisfaction as high (8/10) and framed it as a pragmatic comparison between past hardship and her current capacity to meet family needs: "*Um, 8... before, even eating was difficult... now I can buy rice... I' m grateful... even though I sell my body, I' m still grateful that I can provide for my family...*" *(Participant Y).*

For participant D, psychological well-being was most evident as the capacity to manage dual roles and structure daily rhythms to remain functional. She established work–family boundaries through clear time allocation: "*During the day I take care of my child first... then at night I work as a sex worker*" *(Participant D).* At the same time, D emphasized her position as the sole decision-maker in her life, reflecting autonomy but also the burden of personal responsibility: "*I decide everything by myself... I don' t want people interfering... because if anything goes wrong, I' m the one who loses*" *(Participant D).*

Participant I described changes in psychological well-being as an identity shift: fear of being known moved toward social courage, accompanied by a reframing of herself as someone who still has value. This narrative was particularly strong because I articulated an explicit "before–after" contrast: "*I used to feel insecure a lot... now that I' m open... I' ve learned to be braver... I join PKK... I feel useful... it makes me more confident... mentally I also feel stronger*" *(Participant I).* However, her evaluation of life satisfaction reflected realistic ambivalence (6/10)–there was gratitude, but fatigue and constraints remained salient: "*Maybe I' d rate it 6... sometimes I' m tired... but I' m still grateful... the children can go to school...*" *(Participant I).* I also perceived social acceptance as conditional: "*I feel accepted... but of course there are still people who are judgmental...*" *(Participant I).*

Participant N viewed openness as a catalyst for improved self-perception: "*It' s better... before, I wasn' t confident... now I' m more confident*" *(Participant N).* Yet the openness she practiced was not total; N emphasized a selective strategy–she restricted information based on context and need: "*I don' t talk about it... in detail... if someone wants to know... then I tell them*" *(Participant N).* The most salient form of psychological protection was the protection of family space: "*At home... I focus on my child... I don' t bring guests... the house is my privacy with my child*" *(Participant N).* In her life evaluation, N reported low satisfaction (3/10), signaling a gap between "*being able to endure*" and "*feeling well*": "*On a scale of 1 to 10, I' d give it a 3...*" *(Participant N).*

Across cases, the most consistent pattern was that psychological well-being strengthened when participants had socially demonstrable roles (attending community activities, helping neighbors, being present at key social moments). These roles functioned as identity validation: participants were not only "known" for their occupational status, but also "*recognized*" for their contributions. Participant I expressed this directly–although negative labeling persisted, contribution still generated a sense of value: "*Even though my job is... seen as degrading... I can still contribute.*" A similar pattern appeared in participant P' s account, linking life satisfaction to being beneficial to others*:* "*I can also be useful to the community.*" Interpretively, "*being useful*" operated as a psychological bridge from a stigmatized identity toward a more functional, self-acceptable identity.

Another key finding indicates that openness did not automatically imply the disappearance of boundaries. Rather, well-being appeared more stable when participants could regulate what was disclosed, to whom, and to what extent. Participant N described information selection *("not... in detail")* and disclosure based on request ("*if someone wants to know... then I tell them*"). This frames openness as an adaptive relational strategy–sufficient to reduce the burden of concealment while still protecting psychological safety.

In several cases, the firmest boundary was the separation of family space from the work sphere. Participant N positioned the home as a private domain and rejected bringing "*guests*" into that space. Participant D structured boundaries primarily through strict temporal organization (daytime for childcare, nighttime for work). Interpretively, these boundaries were not merely behavioral rules; they functioned as self-protection that preserved caregiving/family roles, preventing identity from being fully absorbed into occupational identity.

Autonomy emerged as a dominant theme with dual meaning. For participant Y, autonomy was an identity *("doing everything myself")* and a rejection of others' intervention. For participant D, autonomy felt more like a survival mechanism–she insisted on making her own decisions because she also bore the consequences *("if anything goes wrong, I' m the one who loses").* Thus, autonomy can be read as protective independence: it helped participants maintain control, while also signaling limited space for sharing decision burdens.

Life satisfaction appraisals varied sharply: Y (8/10), P (7/10), I (6/10), and N (3/10). This variation indicates that "*feeling better*" after openness was not necessarily equivalent to "*feeling satisfied*" with life overall. Interpretively, satisfaction ratings appeared more closely tied to the ability to meet basic needs, economic stability, and children' s educational continuity (e.g., Y and I referenced sufficiency and schooling). Within the lived-experience frame, openness could improve aspects of identity and social relations, but it did not automatically lift the structural burdens that anchored participants' evaluations of whether life felt satisfying.

Social well-being

For social well-being, idiographic accounts suggested that post-openness social functioning involved "*negotiating a place*" in the community through contribution, participation, and norm compliance–rather than becoming passively "*accepted.*" For P, involvement in communal celebrations functioned as a way to build a reputation as a cooperative and "*useful*" community member, including hands-on assistance through completion: "*I helped with wedding receptions... I stayed until everything was finished*" *(P).* For Y, acceptance felt like familial relatedness, but was also framed as coexistence supported by local socio-economic ties: "*Neighbors see us like friends or family... acceptance becomes important for everyone*" *(Y).* For D, social participation was not only "*joining activities*," but also legitimizing a safer social role grounded in her identity as a mother/community member and reinforced through being recognized as a volunteer: "*I contribute as a housewife... I was even invited... to be a health volunteer...*" *(D).* For N, involvement took a more formal form (leadership/education), making openness a source of visibility as well as social responsibility: "*I show my role as a PKK leader... I was invited to give HIV outreach...*" *(N).* Meanwhile, I showed a pattern of contributing "as much as possible but consistently" to preserve social connection and a sense of acceptance: "*I try to contribute according to my ability... Being involved makes me feel accepted*" *(I).*

Across cases, the main pattern indicated that social integration was negotiated integration: contribution and participation served as "*social evidence*" to counterbalance a stigmatized identity, yet acceptance often remained conditional and not fully knowable–as D stated, "*I do not know what they truly think… they seem more accepting, although only some of them" (D)*, and I underscored acceptance ambivalence: "*Some still look down on me. I just try to blend in and stay involved" (I)*. Accordingly, social well-being in these findings is best understood as social connectedness paired with self-regulation: participants actively read the community's safety boundaries and maintain harmony through norm compliance, as reflected in Y's account: "*wearing revealing clothes in public is not allowed… Village meetings are also mandatory" (Y).*

DISCUSSION

This study extends understanding of mental health among female sex workers who live openly within their local communities by showing that openness is best understood as negotiated visibility rather than total disclosure (Goffman, 1963; Link & Phelan, 2001; Pachankis, 2007; Treloar et al., 2021). In participants' accounts, being "open" reduced the psychological load of secrecy and enabled fuller participation in everyday community life, which supported moments of relief, self-revaluation, and social contribution (Chaudoir & Fisher, 2010; Pachankis, 2007; Treloar et al., 2021). At the same time, openness did not eliminate stigma; instead, it reconfigured stigma into more situational forms–gossip, moral judgement, interpersonal friction, and safety concerns–that could re-trigger emotional instability and vigilance (Goffman, 1963; Harris et al., 2025; Link & Phelan, 2001; Platt et al., 2018). This core pattern aligns with the manuscript's central claim that emotional, psychological, and social well-being can improve after disclosure while remaining vulnerable to residual stigma and insecurity (Beattie et al., 2020; Martín-Romo et al., 2023; World Health Organization, 2021).

Positioned against the broader literature on sex work and mental health, these findings are consistent with evidence that sex workers' psychological distress is strongly shaped by stigma exposure and structural vulnerability, and that mental health cannot be reduced to individual coping alone (Beattie et al., 2020; Harris et al., 2025; Martín-Romo et al., 2023; Platt et al., 2018; World Health Organization, 2021). Importantly, this study clarifies that "benefit" is not a uniform endpoint of openness; instead, openness creates a new social arrangement in which acceptance, neutrality, and rejection can coexist, requiring ongoing interpretation and adjustment (Chaudoir & Fisher, 2010; Goffman, 1963; Treloar et al., 2021). In this sense, mental health appears less as a stable state and more as a dynamic equilibrium that participants actively maintain through boundary work, selective trust, and routine participation in communal roles (Goffman, 1963; Pachankis, 2007; Treloar et al., 2021).

A central tension–critical to avoid an overly positive discussion–is that openness functioned simultaneously as a resource and a risk. On one hand, disclosure can support dignity and belonging because it reduces concealment strain and permits more authentic social contact, a pattern consistent with disclosure-process perspectives emphasizing both potential gains and costs of revealing a concealable stigma (Chaudoir & Fisher, 2010; Pachankis, 2007). On the other hand, visibility can increase exposure to judgement, harassment, and relational threat, making emotional safety contingent on local norms, gendered power relations, and community moral surveillance (Beattie et al., 2020; Harris et al., 2025; Platt et al., 2018; World Health Organization, 2021). Participants' reports of being treated "like family" while also encountering unwanted attention, hurtful teasing, or persistent fear illustrates how openness can improve social access while leaving intact the conditions that reproduce stigma–meaning that psychological relief and insecurity may be experienced in parallel rather than sequentially resolved (Goffman, 1963; Link & Phelan, 2001; Treloar et al., 2021).

Within emotional well-being, the study indicates that relief after openness is not simply "feeling better," but an experience of being less burdened by concealment and more recognized as a person (Chaudoir & Fisher, 2010; Pachankis, 2007). However, emotional stability remained fragile when stigma resurfaced in interpersonal interactions (e.g., mocking from close contacts) or when safety felt uncertain (Harris et al., 2025; Martín-Romo et al., 2023; Platt et al., 2018). This suggests that emotional well-being after openness is maintained through continuous appraisal of whom to trust, how to respond to micro-aggressions, and how to remain socially present without becoming emotionally exposed (Goffman, 1963; Link & Phelan, 2001; Treloar et al., 2021). Therefore, the emotional trajectory is better interpreted as regulated openness: participants sought the emotional benefits of recognition and connection while minimizing the emotional costs of overexposure in a stigmatizing environment (Chaudoir & Fisher, 2010; Pachankis, 2007; Treloar et al., 2021).

For psychological well-being, participants' narratives suggest a meaningful shift in self-perception: openness created space for self-acceptance and a sense of usefulness, yet internalized stigma did not disappear (Kaya et al., 2025; Chaudoir & Fisher, 2010). This duality is consistent with contemporary findings that self-stigma can remain an active determinant of mental health even when external circumstances improve (Kaya et al., 2025). The most consistent psychological mechanism across cases was boundary management–time, space, privacy, and role separation–used to protect family identity and reduce spillover of occupational stigma into home life (Chaudoir & Fisher, 2010; World Health Organization, 2021). Autonomy also emerged as a double-edged foundation of well-being: it strengthened agency and decision ownership, but it also concentrated responsibility and emotional load on the individual, particularly where structural supports are limited and stigma constrains help-seeking (Platt et al., 2018; World Health Organization, 2021). In other words, "independence" functioned as both empowerment and necessity–supporting control in daily life while limiting opportunities to share burdens (Winter et al., 2024; World Health Organization, 2021).

One of the strongest and most specific contributions of this study is the way children and family roles operated as a durable source of meaning and an identity anchor under stigma. Participants framed caregiving and children's futures as the reason to endure, self-regulate, and continue seeking acceptance without escalating conflict, particularly in contexts where disclosure can intensify scrutiny and moral judgement (Chaudoir & Fisher, 2010; World Health Organization, 2021). This meaning system did not merely motivate; it also reorganized identity by offering an alternative moral narrative: being a responsible mother/caregiver who provides, protects, and plans, even when social legitimacy remains conditional (Winter et al., 2024; Platt et al., 2018). Recent synthesis work on sex work

and parenthood similarly emphasizes that parenting roles shape sex workers' decisions, risk management, and self-understanding, often becoming a core pathway to resilience and identity continuity under social marginalization (Winter et al., 2024). The present findings sharpen that insight by showing how, in an "open living" context, family-centered meaning helps participants tolerate ambiguity—acceptance that is partial, stigma that is intermittent, and well-being that must be actively maintained—rather than resolved once-and-for-all through disclosure (Chaudoir & Fisher, 2010).

The study's theoretical contribution lies in detailing how complete mental health in this context is assembled through (1) emotional relief that coexists with vigilance, (2) psychological agency built through managed boundaries and selective autonomy, and (3) social integration achieved through participation and contribution despite conditional acceptance (Chaudoir & Fisher, 2010; World Health Organization, 2021). Rather than treating disclosure as a single turning point, the findings characterize it as a continuing social practice—negotiated visibility—through which participants balance authenticity, safety, and belonging in everyday interactions (Chaudoir & Fisher, 2010). This strengthens the manuscript's IPA-consistent emphasis on meaning-making: openness is not only an event that happens to participants, but an experience they continually interpret, adjust, and operationalize in daily social life, especially when stigma exposure remains situational and relational (Kaya et al., 2025; Winter et al., 2024).

Implications should be framed realistically and aligned with harm reduction rather than broad moral prescriptions. First, community responses matter: stigma-reduction efforts are likely to be most feasible when embedded in practical coexistence norms (non-violence, privacy respect, anti-harassment) rather than demanding full moral agreement, because conditional acceptance can still support safety while reducing everyday harms (Platt et al., 2018; World Health Organization, 2021). Second, safe spaces and peer-based support can help participants sustain emotional regulation and reduce isolation without forcing total disclosure, particularly where confidentiality concerns and enacted stigma deter formal help-seeking (World Health Organization, 2021; Winter et al., 2024). Third, family-oriented support is essential: interventions that strengthen caregiver coping, parenting stress management, and trusted-family communication may be especially impactful because family roles are central to meaning and resilience (Winter et al., 2024). Finally, health and social services should prioritize confidentiality, non-judgmental access, and violence-prevention pathways consistent with public-health guidance on key populations (World Health Organization, 2021), because the benefits of openness will be undermined if visibility increases exposure to harassment or service discrimination (Platt et al., 2018; World Health Organization, 2021).

Several limitations constrain generalization. The findings are grounded in a specific local context and a small sample recruited through snowball procedures; participants may share social networks and norms that shape both openness and community responses. The age range in this sample is relatively narrow (mid-adulthood), and experiences of openness may differ for younger sex workers or those with different work settings and mobility patterns. In addition, living "openly" is inherently context-dependent; what counts as openness, and what risks it carries, may vary substantially across communities. Future work would benefit from comparative designs across localities and age cohorts, as well as longitudinal approaches to examine whether negotiated openness becomes easier, harder, or simply different over time as economic pressures, parenting demands, and community relationships shift.

CONCLUSION

This study shows that the mental health of female sex workers who live openly within their local communities is neither automatic nor uniformly improved by disclosure. Across participants' accounts, "living openly" was experienced as negotiated visibility—being socially recognized while actively managing boundaries around details, relationships, and private life. This negotiated openness reduced the psychological load of secrecy and enabled fuller participation in everyday community roles, supporting moments of relief, strengthened self-worth, and social contribution. At the same time, openness did not remove stigma; instead, stigma remained situational and relational (e.g., gossip, moral judgment, unwanted attention, and safety concerns), meaning that well-being often appeared as a fragile equilibrium rather than a stable endpoint. A particularly salient finding is that children and family roles functioned as an enduring source of meaning and an identity anchor, helping participants sustain agency and self-regulation even when acceptance was partial and insecurity persisted.

Recommendations should follow directly from these findings and remain realistic. At the community level, the most feasible gains are likely to come from practical coexistence norms that reduce everyday harms—such as non-violence, respect for privacy, and clear social boundaries against harassment—rather than from expectations of full moral agreement. At the interpersonal level, peer-based solidarity and safe spaces can support emotional regulation and reduce isolation without pressuring total disclosure. At the family level, supports that strengthen caregiver coping, parenting stress management, and trusted communication may be especially impactful because family meaning is central to resilience in this "open living" context. For health and social services, the priority is consistent, non-judgmental access with strong confidentiality safeguards and clear pathways for violence prevention and crisis support, because the potential benefits of openness will be undermined if visibility increases exposure to harassment or discrimination.

Finally, these conclusions should be interpreted within clear boundaries. The findings reflect a small, snowball-recruited sample in a specific local context, so transferability is more appropriate than broad generalization. Importantly, dissemination and any advocacy or implementation efforts must be safety-first: confidentiality has practical limits in tightly connected communities, and well-intended interventions can inadvertently increase visibility and risk. Therefore, reporting and programming should avoid deductive disclosure, maintain strict protection of identities and locations, and ensure that participation in any support pathway is voluntary, privacy-preserving, and responsive to participants' own boundary-setting practices.

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DECLARATION

Ethics approval and consent to participate

This study has undergone a formal ethical review and received approval from the Research Ethics Committee of the Faculty of Psychology, with the approval number E.6.m/318/KE-FPsi-UMM/V/2025. The research procedures, instruments and ethical safeguards were reviewed to ensure compliance with established ethical standards for psychological research. In addition to institutional approval, the researchers obtained written informed consent from all participants prior to conducting the in depth research, ensuring that participants were fully informed about the study's purpose, procedures, potential risks, benefits and their rights throughout the research process.

Consent for publication

I give my full consent for this research to be published for academic purposes, and I am willing to offer any necessary support or additional information to facilitate the publication process.

Availability of Data and Material (ADM)

All data and materials used in this study have been properly compiled and are accessible to individuals who require them for academic purposes or future research.

Competing interests

The authors declare no conflict of interest.

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Artificial Intelligence-Assisted Technology

Artificial intelligence tools (ChatGPT) were utilized to assist with language refinement and formatting, under the direct oversight of the authors. The authors assume full responsibility for the accuracy and integrity of the final content.

Authors' contributions

The authors contributed to this study through the design of the research, data collection, analysis, and the development of the final manuscript. These efforts were made possible with the support and assistance of various individuals and parties involved throughout the research process.

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