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THE WHORE PARADOX:
“RATIONAL” CONDOM USE DECISIONS AMONG PROSTITUTES
IN THE CONTEXT OF STIGMA AND PATRIARCHAL BARGAINING

By

Maggie McCandless Stone
B.A., University of Louisville, 1995
M.Ed., University of Louisville, 1999

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A Dissertation Approved on

March 20, 2014

by the following Dissertation Committee:

Ryan Schroeder, Ph.D., Sociology Department, Committee Chair

Patricia Gagné, Ph.D., Sociology Department, Committee Member

Gul Marshall, Ph.D., Sociology Department, Committee Member

Mark Austin, Ph.D., Sociology Department, Committee Member

Richard Tewksbury, Ph.D., Justice Administration Department, Committee Member

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ABSTRACT

THE WHORE PARADOX:

“RATIONAL” CONDOM USE DECISIONS AMONG PROSTITUTES IN THE CONTEXT OF STIGMA AND PATRIARCHAL BARGAINING

Maggie McCandless Stone

March 20, 2014

High-risk sexual activity involved in prostitution is a criminal justice and public health issue heightened by the potential transmission of sexually transmitted infections (STIs) as a result of engaging in certain unprotected sex acts. This constitutes a significant health problem suitable for discourse on social policy. The work adds to the extant prostitution literature by providing an in-depth qualitative examination of female prostitutes resulting in the proposal of a new theoretical framework, *the whore paradox*. The theory provides explanatory insight into the sexual health decisions of prostitutes and has potential applications to other deviant and risk-taking populations. Policy implications include augmenting subsidized drug rehabilitation and harm reduction programs as well as establishing diversion options for prostitution charges that incorporate mandatory sex education programs.

The dissertation is divided into five chapters covering a discussion of the problem, applicable theories, the methods used in data collection, findings, and discussion. Chapter One reviews the extant literature regarding sexually transmitted infections, protective behavior, and prostitution. Chapter Two introduces the applicable

theoretical frameworks including Coleman's Rational Choice Model, Deviance theories, and Patriarchal Bargains. Chapter Three provides an explanation of and rationale for the data collection methods employed. Chapter Four presents the findings thematically, using the narratives of the participants to tell the story. Finally, Chapter Five is a consideration of the findings as they relate to the generation of a new theory, *the whore paradox*, which aims to explain the sexual health decisions made by female sex workers within the context of a gendered society that labels their occupation as deviant.

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CHAPTER I

REVIEW OF TOPICAL LITERATURE

High-risk sexual activity involved in prostitution¹ is a criminal justice and public health issue in the United States that is heightened by the potential transmission of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV). This constitutes a significant health problem suitable for discourse on social policy. This chapter consists of a review of the extant literature relevant to the present study: STIs, condom use, and prostitution. Principally, it provides salient information regarding the unprotected sex acts currently considered high-risk, the prevalence and expense of certain STIs, documented differences between condom use in non-remunerative and remunerative sexual interactions, and why, in the broader context of sexual health, the public should concern itself with risks stemming from prostitutes'² sexual health decisions. A section reviewing prostitution, its history, classifications, and legal implications is also included.

Missing from the scholarship on prostitution to date is a comprehensive assessment of prostitutes' condom use from a solid theoretical perspective. What are the

¹ The author uses the terms *prostitution*, *transactional sex*, *exchange sex*, *sex work*, and *remunerative sex* interchangeably, as do those in the literature.

² The author uses the terms *prostitute*, *(exchange) sex worker*, and *sex exchanger* interchangeably. Distinctions are made regarding other terminology specific to outdoor (e.g., *streetwalker*) or indoor (e.g., *escort*) prostitution.

factors and contexts that influence prostitute's sexual health decisions? The present study's analysis of prostitutes' narrative accounts of their work intends to inform this discourse.

Sexually Transmitted Infections

One way in which STIs are transferred is by engaging in unprotected sex acts with an infected partner. These include activities involving the mouth, rectum, anus, vulva, vagina, and/or penis in which there is contact with infected blood and/or other bodily fluids, such as, prostatic (pre-seminal) fluid, semen, and vaginal secretions. The following factors are considered high-risk for the development of an STI: being between 15-24 years old, African-American, having a new sex partner in the past two months and/or multiple partners (greater than five per year), a history of previous STIs, drug use, recent incarceration, finding sex partners from the internet, contact with prostitutes, and men who have sex with men (MSM) (U.S. Preventive Services Task Force, 2008). The Centers for Disease Control and Prevention (CDC) considers eight major STIs in their prevalence calculations. They are gonorrhea, hepatitis B virus (HBV), herpes simplex virus type 2 (HSV-2), HIV, human papillomavirus (HPV), syphilis, and trichomoniasis. Current estimates report there may be more than 110 million cases of STIs in the United States, resulting in over \$15 billion dollars per year in costs for medical care (2013a).

Of all the STIs, HIV, which is the virus that can cause AIDS (acquired immune deficiency syndrome), is the most concerning. The infection can lead to death because to date there is no known cure (CDC, 2012a). By the end of 2010, it was estimated that there were 1,144,500 persons aged 13 or older in the United States and six dependent areas (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic

of Palau, and the United States Virgin Islands) living with HIV infection, including 180,900 undiagnosed persons (CDC, 2013b). An estimated 15.8% of HIV-positive persons remain ignorant of their status. Because symptoms do not present themselves early on in the disease state, other than at initial onset when there may be flu-like symptoms, many fail to pursue testing, which puts their sexual partners at increased risk of acquisition (CDC, 2013b). Having an STI makes a person more vulnerable to acquiring HIV through sexual contact with an HIV-infected partner, and a person with both HIV and any other STI has an increased risk of spreading HIV to his/her partner(s) through sexual contact (Wasserheit, 1992).

Protective Behavior

The use of protective barriers during sexual contact has been shown to effectively reduce the risk of STI transmission (American Sexual Health Association, 2013; Chambers, 2007). These include dental dams and condoms (male and female) made of latex, polyurethane, or polyisoprene. Similarities and differences exist in the ways in which condoms are perceived and used in non-remunerative and transactional sexual interactions.

Condom use in non-remunerative sexual interactions. Previous literature suggests that partners outside of remunerative sexual interactions are less likely to use condoms than are persons involved in transactional sex (Sherman, Reuben, Chapman, & Liljeston, 2011; Spittal et al., 2003; Weeks, Grier, Romero-Daza, Puglisi-Vasquez, & Singer, 1998; Weissman, Brown, & the National AIDS Research Consortium, 1991; Worth, 1989). Determinants of condom use during non-prostitution sex in the western world tend to be related to age, race and ethnicity, embarrassment, trust, and positive

mood associated with substance use (Albarracin, Kumkale, & Johnson, 2004; Brewer, Muth, & Potterat, 2008; Holmes et al., 2008; Monto & McRee, 2005; Moore, Dahl, Gorn, Weinberg, Park, & Jiang, 2008; Schroder, Johnson, & Wiebe, 2009; Song, Calsyn, Doyle, Davies, Chen, & Sorensen, 2009; Willig, 1995). Prior research has consistently demonstrated correlations between condom use frequency and education (Albarracin et al., 2004; Holmes et al., 2008) as well as marital status (Song et al., 2009) in non-exchange sexual relations. Unmarried individuals with lower levels of education are less likely to use condoms during recreational sexual activity with unpaid partners (Song et al., 2009). Historically, stigma has been identified as a barrier to condom use, particularly as condoms were associated with negative perceptions of sex, such as disease and prostitution (Gamson, 1990; Lupton, 1994; Valdiserri, 1988).

Some research suggests that heterosexual adults tend to equate condom use with issues of trust such that requesting the use of a condom implies either a lack of trust or fidelity (Willig, 1995). A comparison can be made to a form of prostitution known as the girlfriend experience (GFE), where the use of condoms is excluded by definition. Milrod and Monto's (2012) survey research of 567 men who participate in internet-solicited exchange sex described GFE as mimicking a long-term non-remunerative relationship, implying a potential link in protective behaviors between non-transactional and transactional sex.

Condom use by johns. It is critical to assess risk behaviors of johns³ as studies have suggested that they are more likely to carry STIs and engage in high-risk sexual

³ Consistent with the extant prostitution literature and the argot of prostitutes themselves, the author uses the term "john" throughout this paper to refer to men who purchase sex from prostitutes.

activity (e.g., multiple sex partners, unwillingness to use condoms) than are men who do not purchase sex (Decker, Ray, Gupta, & Silverman, 2008). This presents a risk to johns' commercial and intimate sex partners. Interestingly, a 1994 study by McKeganey revealed that while many johns believe that prostitutes are at high risk for HIV, they perceive themselves as low-risk regardless of their sexual transactions with a high-risk group. Numerous studies have investigated johns' assessment of HIV risk and use of condoms during transactional sex encounters (Leonard, 1990; Milrod & Monto, 2012). Multiple variables shape the determination of whether or not a john is agreeable to using a condom, including availability, willingness of prostitute, type of sex act, familiarity with the prostitute, and sexual preferences (Leonard, 1990; Monto, 2001).

Related work in Canada elucidates inconsistent condom use by johns and negotiation strategies that include offering more money to forego condom use (Shannon, Bright, Gibson, & Tyndall, 2007). Some johns go through a selection process to find a prostitute that they believe to be "clean" and harbor a handful of myths that help them decide which situation is least likely to result in contracting infection (Leonard, 1990). Much has been made of the power dynamic between john and prostitute with respect to condom use (Aral & St. Lawrence, 2002; de Graaf, Vanwesenbeeck, Zessen, Straver, & Visser, 1993; Elifson, Boles, Darrow, & Sterk, 1999; Leonard, 1990). A study of East Harlem female sex exchangers by McMahan, Tortu, Pouget, Hamid, & Neaigus (2006) notes that the most frequently given explanations for unprotected sex focused on the preferences of their johns (e.g., he didn't feel like using a condom, condom use would decrease his sexual pleasure), implying that johns may have more impact on the determination of condom use.

Prostitution

Prostitution, defined as exchanging sex acts for remuneration, takes on many forms. Although it has been referred to as the world's oldest profession, hunters and gatherers hold that claim. Reports of remunerative sex exchanges can be found in the history of any civilization with written archives (Bullough & Bullough, 1987). Temples served as the first known locations for such transactions (Sanders, O'Neill, & Pitcher, 2009). Over time Western and non-Western worlds' religious tenets became increasingly opposed to prostitution (Bullough & Bullough, 1987).

Public health crises pushed prostitution deeper into the dark alleys when the transmission of disease was linked, with little medical evidence, to the brothels where Western prostitution had proliferated (Ringdal, 2004). Brothels were shut down or confined to areas now commonly known as red light districts. In the United States, there are legal red light districts in the state of Nevada. Eight of the state's 16 counties currently have at least one brothel in operation. Prostitution outside the confines of those tightly regulated environments is illegal. Nowhere else in the United States is prostitution, now comprising one of the most stigmatized occupations in contemporary society, tolerated by law (Weitzer, 2005).

Prostitution outside of the brothel takes myriad forms, and therefore developing a taxonomy for prostitution is challenging. In addition, because remuneration sometimes occurs in the form of goods (e.g., drugs) or implied promises for later financial benefit as opposed to immediate cash, the distinction between outdoor prostitution (e.g., street work) and indoor prostitution. (e.g., escort, brothel, massage parlor, and bar/exotic dance club) will be utilized as a basis for classifying prostitution types (Weitzer, 2005).

Two notes before the classifications of prostitution are explored. First, indoor and outdoor workers are not restricted to their respective physical environments for the engagement of the sexual transaction. An indoor worker, for example, may occasionally have sex in a public venue out of necessity or by request. Conversely, a sex worker who operates on the street may agree, as part of her transactional contract, to check into an hourly hotel room or crack house. Second, although brothels fall under the indoor label, their special status as a limitedly protected forum, subject to health regulations and coupled with their confinement to Nevada, keep them outside scope of this study.

Strikingly evident in the body of United States sex exchange literature is the overwhelming portrayal of prostitutes as female street workers, the lumpen proletariat of prostitution. This portrayal reflects a common stereotype of a prostitute, but in reality, there exist various types of sex workers (e.g., male, female, intersexed, cross-dressing, transsexual) enacting different sexual orientations and practicing an assortment of sex acts (Calhoun, 1992; Luckenbill, 1986; Ringdal, 2004). Prostitution proliferates globally in both legal and illegal forms; the focus of the present study is limited to illegal prostitution (both indoor and outdoor) by females with male patrons in the United States.

Outdoor prostitution. Outdoor prostitutes, or street workers, are more likely to charge lower fees, be of a racial or ethnic minority, engage in unprotected exchanges, and be HIV positive. The relationship between street prostitution and drug use has been well established in the literature (Elwood, Williams, Bell, & Richard, 1997; Romero-Daza, Weeks, & Singer, 1998; Sherman, German, Cheng, Marks, & Bailey-Kloche, 2006; Weeks et al., 1998). While not all street prostitutes are drug users (Freund, Leonard, & Lee, 1989), obtaining drugs can be a primary motivator for the sex transaction (Sherman

et al., 2006). The highest rates of HIV are found in injection drug using (IDU) street prostitutes (Vanwesenbeeck, 2001). The practice of exchanging sex for money for drugs is not limited to a particular race or ethnicity (Baseman, Ross, & Williams, 1999; Elwood et al., 1997). Of particular interest is how drug use and addiction influence protective behavior in exchange sex. Data collected in The Netherlands demonstrated that female prostitutes reported being more likely to engage in unprotected sex when using drugs (de Graaf, Vanwesenbeeck, Zessen, Straver, & Visser, 1995). The McMahon et al. (2006) study suggests that drug-addicted prostitutes' participation in protective behavior discussions with johns before the exchange is predictive of more consistent condom use unless they are using cocaine at the time of the transaction; the positive impact of the sexual health dialogue is diluted by the use of illicit drugs.

The extant literature indicates a range of risk reduction tactics, (e.g., visual inspection of the genital area, promoting oral sex⁴ over vaginal sex, and maintaining a rotation of regular clients) in addition to condom use by drug-using street prostitutes (Romero-Daza et al., 1998; Weeks et al, 1998). Street prostitutes who reported unprotected sexual behavior explained that they could not afford to lose the customer related to condom negotiations or availability, were experiencing withdrawal symptoms that took precedence over the risk of contracting an infection, trusted regular clients not to carry infection, were caught up in the moment, or were intoxicated (McMahon et al., 2006; Romero-Daza et al., 1998; Shannon, Kerr, Allinott, Chettiar, Shovellar, & Tyndall, 2008; Weeks et al., 1998). Additionally, prostitutes with pimps may have their condom

⁴ This author uses the term *oral sex* throughout the paper, as opposed to *fellatio*, because *oral sex* encompasses a broader range of sexual activities (e.g., *cunnilingus*, *analingus*) than does *fellatio*.

use regulated by the pimp, whereby he controls her access to condoms in order to track her productivity and earnings (Shannon et al., 2008).

Research on outdoor workers, more often the “face” of prostitution, provides the framework for much of what is known about prostitutes’ protective practices. While indoor sex work has not been absent from the conversation (Albert, Warner, Hatcher, Trussel, & Bennett, 1995; Albert, Warner, & Hatcher, 1998; Bimbi & Parsons, 2005; Castle & Lee, 2008; Cunningham & Kendall, 2010; Lee-Gonyea, Castle, & Gonyea, 2009; Lever & Dolnick, 2000; Lucas, 2005; Reuben, Serio-Chapman, Welsh, Matens, & Sherman, 2011; Rocha, Liljeros, & Holme, 2010; Sherman, Lileston, & Reuben, 2011; Sherman, Reuben, Chapman, & Lileston, 2011; Voon, Ciambone, & Vazquez, 2009), the extant literature on prostitution in the United States has tended to focus on street exchanges (Baseman et al., 1999; Elwood et al., 1997; Freund et al., 1989; McMahon et al., 2006; Romero-Daza et al., 1998; Sherman et al., 2006; Weeks et al., 1998).

Indoor prostitution. Indoor prostitutes provide services in a variety of settings and circumstances. While some work for an agency or other establishment, many are independent practitioners (Lucas, 2005). Services are typically delivered in personal homes, hotels, bars/clubs, brothels, and massage parlors (Weitzer, 2005). When a prostitute visits a john at a mutually agreed-upon location (e.g., hotel room, home), it is termed an outcall, whereas incalls involve the john visiting the escort. Weitzer (2005) notes that the public generally views indoor sex work as a more tolerable form of prostitution, but both types are subject to internal hierarchies. Hochschild’s (1983) emotional labor, the effort to attempt to convey and feel a culturally sanctioned emotion for any given situation, is a common reference point in the indoor prostitution literature,

particularly for those who negotiate the boundaries of having regular johns (Lever & Dolnick, 2000; Lucas, 2005; Vanwesenbeeck, 2001; Weitzer, 2005). Some research has shown that condom use is a means by which prostitutes distinguish between transactional sex and intimate sex, with an increased likelihood of protection for transactional sex acts. (Cohen, Alexander, & Wofsy, 1988; Worth, 1989).

Internet solicitation, by both independent and agency escorts, is beginning to gain the attention of researchers (Castle & Lee, 2008; Cunningham & Kendall, 2010; Lee-Gonyea et al., 2009; Rocha et al., 2010; Voon et al., 2009). Likewise, the examination of women who engage in sex exchanges from within the exotic dance industry is relatively new to the field (Maticka-Tyndale & Lewis, 2000; Lewis, Maticka-Tyndale, Shaver, & Schramm, 2005; Reuben et al., 2011; Sherman, Lilleston, & Reuben, 2011; Sherman, Reuben, Chapman, & Lilleston, 2011). In a Baltimore-based study of sex-exchanging exotic dancers, many reported a non-negotiable condom requirement for vaginal and anal sex but inconsistent protective behavior for oral sex. Drugs and alcohol were described as coping mechanisms that facilitated unsafe sexual behavior. Consistent with the extant literature, drug use and financial need resulted in boundary compromise. A relatively new category of indoor prostitutes is known as “half-hookers” or “lite-hooks.” These are typically indoor workers who trade sex for gifts, financial assistance, and/or fame but shun identification as a sex exchanger (Quan, 2009).

Legal implications. Feminist theory, particularly the liberalist view, is a beneficial tool as we ponder the legal consequences of prostitution, as they exist in most of the United States today. Within this framework, liberal feminists propose the contractarian debate: A prostitute sells a service, not her body. It is a private business

transaction. Pateman (1988) argues that a prostitute is an independent contractor, not a wage laborer, who can start or stop a transaction at will. Radical feminists often criticize their liberal counterparts for failing to consider patriarchal power and the coerced, exploitative prostitute-john relationship. The position of radical feminists is that no female can freely enter into a prostitution contract. On the other hand, liberal feminists hold that no one ordinarily enters into a business transaction or contract with a service provider because of who they are personally but rather for their expertise in the services they will provide. Without the legal protections afforded other jobs the prostitute is left at risk (e.g., health, violence) (Nussbaum, 2006). Much of the male domination of women seen in prostitution (e.g., financial and physical abuse by pimps) results from a lack of legal regulation. Personal rights should outweigh concerns for the social good, the liberal feminists maintain, and remedies should seek to free women from the injustices fostered by legally generated and maintained gender biases that favor men over women.

Under the current organization of the vast majority of United States legal systems, prostitution is a criminal act, thus shaping the behaviors of exchange sex workers and limiting their access to resources. Currently some jurisdictions issue citations for prostitution, requiring only that the alleged offender appear in court, pay a fine, and take an HIV test. Alternatives to the current approach by the justice system include legalization, decriminalization, and depenalization (Simmons, 1998). Decriminalization excludes the negative evaluation and the possibility of condemnation to a criminal act, while with depenalization the person declared guilty of the crime may choose to engage in depenalization measures, such as program attendance, in lieu of penalties.

Slippery-slope arguments abound in the debate surrounding the decriminalization of prostitution. If we allow persons to sell their bodies for sexual activities, then to what tribulations might that lead? As Shrage (2006) questions, “if we allow sex to be sold, what else will we allow to be sold?” (p. 243). Likely the product of the transference of cultural fear, feminists are ambivalent about the decriminalization of prostitution and have been slow to mobilize around it. Does it empower women or just create one more female job ghetto? What is clear is this: When prostitution is deemed a criminal act, its serious health implications are not addressed in an advantageous way.

Because prostitutes engage in high-risk sex acts with multiple partners (Albert et al., 1995; Bimbi & Parsons, 2005; Monto, 2001) and have higher than average rates of intravenous drug use (CDC, 2008), unprotected sexual contact with a prostitute constitutes a high-risk sexual activity (Albarracin, Johnson, Fishbein, & Meullerleile, 2001; Albarracin et al., 2004; Albert et al., 1995; Decker et al., 2008; Freund et al., 1989; U.S. Preventive Services Task Force, 2008). Estimates place the number of active prostitutes in the United States somewhere between one and two million (Chen, 2009). This is a substantial population whose sexual health behaviors directly impact their transactional and personal partners. It stands to reason, then, that increasing the frequency of condom usage during sexual activity with a prostitute, one means of reducing the spread of STIs, should be a component of public health policy and programs.

CHAPTER II

REVIEW OF APPLICABLE THEORETICAL FRAMEWORKS

The whore paradox theoretical framework emerged from the data as an amalgamation of Coleman's rational choice theory, deviance theories on stigma and labeling, and patriarchal bargaining from the feminist literature. This chapter discusses relevant portions of each of the contributing theories.

Coleman's Rational Choice Theory

James Coleman (1990) is widely held as being responsible for the integration of rational choice theory into sociological research. Notwithstanding criticisms of its lack of realism and focus on motivational assumptions, the 1990s were notable for an increase in the theory's utilization and prominence in social science disciplines (Hechter & Kanazawa, 1997). The following are examples of how Coleman's model has been in applied in areas such as medical sociology, crime and deviance, and education. Heckathorn and Broadhead (1996) contributed a study of policy analysis and institutional design of AIDS intervention. An ethnographic manuscript of gang behavior was published by Jankowski in 1991. Scholarship on adolescent educational expectations (Morgan, 1998) continues Coleman's own research interest.

Coleman's treatment of rational choice theory views humans as purposive actors who are motivated to make choices based on their own goals and utilities (i.e.,

preferences). In other words, divergent to functional theories, purpose is believed to be inherent in individuals themselves and not in society (Yamaguchi, 1998). Humans are motivated by self-interests to maximize their own utilities and do so by engaging in behaviors they find rewarding and terminating behaviors that are too costly. Actors must also consider opportunity costs (i.e., maximization of benefits must take into account what one might lose by taking a particular route to a goal). Uncertainty activates a secondary motivation to safeguard one's own social status and positive self-image (Coleman, 1990). The theory's economic roots are evidenced by its expectation that the consideration of long-term costs and benefits determines goal-oriented behavior. Contrary to thin economic models, however, Coleman's thick model of rational choice theory assumes individuals consider more than wealth-maximization (Hechter & Kanazawa, 1997). Within Coleman's system, actors' preference hierarchies may include nonexchangeable goods, such as time, information, and approval.

Hechter and Kanazawa (1997) described Coleman's rational choice theory as "inherently a multilevel enterprise" (p. 193) based on micro-macro and macro-micro links. Rational choice explanations may bear similarities to structuralism, but the key difference is in Coleman's application of methodological individualism (Hechter & Kanazawa, 1997). The individual is used as the unit of analysis and those behaviors are then aggregated in order to explain social phenomena (Coleman, 1990). The model, as diagrammed by Coleman (p. 8), takes on the form of a trapezoid, often called *Coleman's bathtub* (see Figure 1). Macrosociological elements (i.e., social structures such as norms and social institutions) that function as the social and material framework for individual behavior are featured on the top corners. The lower level comprises microsociological

elements: expectations about individual utilities and capabilities. Beginning in the upper left corner and following the direction arrows, *macro factor X* places *constraints on actors* who then engage in *rational actions* according to their preference hierarchies, which may result in the development of a new *macro factor Y*.

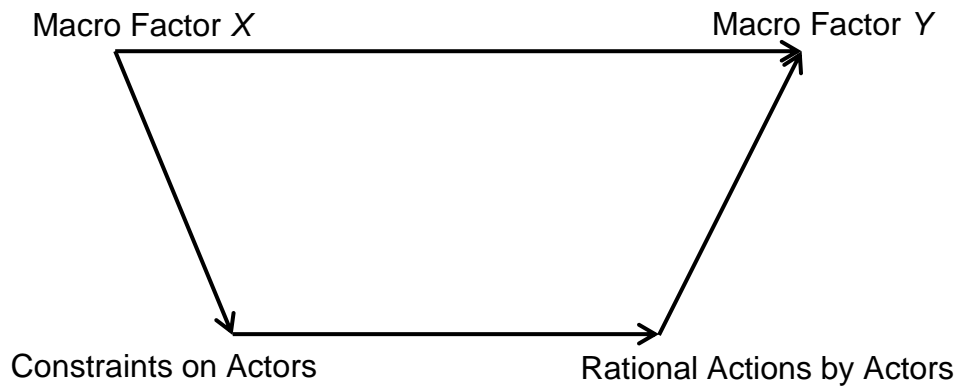


Figure 1. Coleman's Rational Choice Model, (i.e. *Coleman's bathtub*)

An examination of the macro factors allow for additional insight into theoretical application. Norms and social institutions are examples of both *X* and *Y* *macro factors* because they may impact individual behavior as well as develop from it. Effective norms are created when a majority of actors realize a purpose, or utility, for relinquishing control over their own actions in exchange for regulating the behavior of others (Coleman, 1990). When an actor's path is uncertain, her individual decisions may be affected by social norms; she may imitate others because conformity to those norms guarantees her social position in the short term (Coleman, Plank, Schiller, Schneider, & Shouse, 1997). Acting as *X* macro factors, social institutions are additional sources with the potential for restricting individuals' choices via social sanctions. Individual actions are regarded as being shaped by actors' access to resources. Not every individual, however, has equal access to resources, and scarcity of resources may limit an actor's

options. As an example, having access to an adequate amount of accurate information is influential with respect to decision making. Without it, an actor may act rationally within the confines of her knowledge base, but this action may not truly maximize individual utility; when aggregated, however, the actions can still affect macro-level structures. Similar to norms, collective individual behavior may influence, intentionally or unintentionally, the development of existing social institutions (Coleman) and possibly the emergence of new social institutions (Hechter & Kanazawa, 1997).

For example, the preference hierarchy of prostitutes' protective behavior is shaped by their access to resources, both material (e.g., condoms) and informational (e.g., accurate facts about STI risks). Socioeconomic status is a *macro factor X* that may influence the preference hierarchy of prostitutes' protective behavior by placing *constraints* on their access to resources, whether material (e.g., condoms) and informational (e.g., accurate facts about STI risks). The *rational* action taken by women without proper sex education may be not be to use a condom during a high-risk sex exchange because they do not know the risk. Alternately, some prostitutes may not have the financial resources to purchase condoms or the transportation resources to get to a clinic to obtain free condoms. Prostitutes' participation in unprotected high-risk sexual behaviors, when aggregated, influence healthcare, a *macro factor Y*. The billions of dollars spent on STI treatment annually indicate institutional level implications for health departments, the CDC, and the judicial system.

A criticism of Coleman's theory is that while macro-level factors are considered, inevitably bringing the notion of power into play, there is no direct attention paid to power itself. With respect to researching sex work, the exclusion of gendered power as a

factor is a critical failure. The addition of the feminist perspective is necessary as it is integral to understanding the nature of prostitution as it exists in the United States today. Furthermore, given that the data are specific to choices about potentially deviant behaviors (i.e., not using a condom) made by deviant individuals (i.e., prostitutes), Coleman's framework also lacks the consideration of explanatory factors specific to non-normative behaviors.

Theories of Deviance

Labeling theory. The origins of labeling theory can be traced to Durkheim's *Suicide* (1897/1992) and Mead's symbolic interactionism. Next Lemert (1951) began building the foundation for the social construction of deviance. These ideas were picked up by Becker (1963) and developed into social reaction theory by which deviance is described as a social construction rather than a quality assigned to a given behavior. In other words, the behavior itself is not deviant until an authority figure deems it so; the emphasis is always on societal reaction. Thus, primary deviance is the initial step of performing some non-normative behavior. If discovered and labeled as deviant, the individual may accept the label and consider herself different from the majority or view the majority as the true outsiders. The deviant career is characterized by the development of secondary deviance, which involves accepting the label of deviant. Once the person labeled as deviant, in this case as a prostitute, has accepted the label in a way that shapes her ability to live everyday life, then she may begin to rely on deviant means (i.e., prostitution) to earn income. The deviant establishing an affiliation with a deviant support system is the final step of the process.

It is not until Matza's manuscript (1969), however, that labeling theory was formalized. He examined the identity formation of the deviant. The process of becoming deviant is explained as open and sequential. One can a) offend and reoffend or b) offend and not reoffend. In other words, it is possible for a person to be delinquent without being fully committed to a delinquent lifestyle. This process occurs by way of affinity to some prohibited behavior(s), affiliation with people and places that promote said prohibited behavior(s), and signification and apprehension of the offense(s). Matza conceptualized the individual as playing an active role; he attempted to understand the subject's point of view. He does not utilize determinism but rather frames his ideas using neutralization theory.

Matza's (1969) work on neutralization builds on his earlier studies with Sykes (Sykes & Matza, 1957). Their theory is established from four patterns observed in delinquents. First, many delinquents show remorse regarding a deviant act. Second, they may show respect for upstanding (i.e., law-abiding) individuals. Third, they tend to distance themselves from their victims. Finally, they appear to be susceptible to social influence; they are affected by their settings, and they conform. While these neutralization techniques may not completely alleviate the delinquent's guilt, they may be enough to decrease the efficacy of social controls.

Together, Sykes and Matza (1957) proposed five techniques used by juvenile delinquents to rationalize their deviant behavior and neutralize its stigma. These include denial of responsibility ("It's not my fault," the accountability lies with rotten parents, shady friends, or other forces outside the individual's control), denial of injury ("No one got hurt"), denial of the victim ("They got what they deserved," the victim is viewed as

the wrong-doer as in hate crimes or Robin Hood style hijinks), condemnation of the condemner (shifting the blame to those who deem the delinquent's behavior deviant, such as the police, teacher, or parents), and appeal to higher loyalties (the deviant act was necessary for the good of the delinquent's immediate social group).

The process of being labeled deviant combined with the resultant negative stereotypes can erode an individual's self-concept and, ultimately, her behavior. A prostitute may experience feelings of shame and degradation as a result of how she is treated by others aware of her deviant identity (e.g., johns, law enforcement), thus internalizing the negative aspects of the deviant label and behaving accordingly with respect to her sexual health decisions. Goode (1997) argues that even if she does not internalize the deviant label, she may incorporate certain characteristics of it into her self-concept. If her label-consistent behaviors are shame-based, she may develop low self-esteem. Neutralization techniques, which help moderate the negativity, have been validated in deviant sex industry occupations, such as exotic dancing (Thompson & Harred, 1992; Thompson, Harred, & Burkes, 2003; Trautner & Collet, 2010) and prostitution (McCray, Wesely, & Rasche, 2011; Wesely, 2003). Both dancers and prostitutes use these strategies, specifically denial of injury and appeals to higher loyalties, to minimize their risk taking behaviors.

Goffman's stigma. Goffman (1963) defines stigma as "an attribute that is deeply discrediting," (p. 3). Goffman categorized an individual's relationship to stigma as including the stigmatized (stigma), the normal (no stigma), and the wise (normal who are accepted by the stigmatized for their understanding and empathy of the circumstances of those stigmatized). There are three types of stigma: abnormalities of the body, tribal

identities (i.e., membership in a discredited group), and blemishes of individual character (behavior that deviates from social norms). The process of becoming stigmatized follows a predictable path. An individual is perceived as possessing a socially undesirable characteristic, and as a result, her identity becomes spoiled or disqualified. The degree of her immersion in the deviant role influences the extent of the stigma.

Goffman (1963) identifies two levels of stigma: the discredited and the discreditable. In the case of the discredited individual, the stigma is known (i.e., she is “dirty”). An individual who is discreditable has not yet been stigmatized; the discrediting information is unknown. This person chooses to reveal the information or pass as normal by hiding the information. Those who attempt to manage the negative image and maintain their sense of self do so with varying degrees of success.

Informational control is one approach to managing stigma. Dividing the social world, a common strategy employed by those in the sex industry (McCray et al., 2011; Thompson & Harred, 1992; Thompson et al., 2003; Trautner & Collet, 2010; Wesely, 2003) is a stigma management technique by which the individual limits the number of persons with whom she shares the discrediting information. McCray et al. noted that recovering drug-addicted prostitutes pooled their experiences of addiction and prostitution in a way that allowed them to manage the stigma of their former sex work.

In the literature on adolescent sexuality, it has been argued that “slut” is one of the most stigmatizing labels for a young female and has the potential to negatively influence her self-concept. Subsequently her increased sexual behaviors place her at greater risk for infection (e.g., early entry into sexual activity, multiple sex partners) (Brooks-Gunn & Furstenberg, 1990; Orenstein, 1994; White, 1999). This is consistent with Goode’s

(1997) assertion. Victor (2004), however, found that some girls took pride in accepting a stigmatizing identity and assumed labels such as “wigger” in a positive way, thereby neutralizing the negative self-evaluation either by condemning the condemners (Sykes & Matza, 1957) or internalizing the positive attributes of the label. This follows a trend among prostitutes to reclaim the word *whore* as a positive, empowering identity (Almodovar, 2006; Pheterson, 1993). Thus, the potential exists for prostitutes to find positive attributes of their deviant label that they may apply to their self-identity and occupational practices.

Studying prostitution-related behaviors demands the consideration of bodily ownership arguments. Is the human body private property or *qua gift*? Following John Locke’s (1772) reasoning of the body as private property a person can use and enjoy it as she chooses, up to and including its destruction or sale. In mainstream United States culture, there is an expectation that the body should be treated as *qua gift*, meaning that the body is an entity given to a person with the expectation that she will safeguard its wellbeing; ownership is likened to stewardship. Actively engaging in risky health practices violates this norm and subjects the person to stigmatization.

In recounting exotic dancers’ decision-making processes regarding service provision in the context of the club setting, Wesely (2003) wrote that patrons’ offers of additional financial compensation forced dancers to make split-second decisions about the extent of their physical interaction with each customer, often leading to fluid body boundaries that were variable by customer. Some women described expanding their repertoire of behaviors to include physical contact (from touching to oral sex) that they would not have initially considered as part of their work. Similarly, a prostitute without a

clear sense of occupational boundaries (perhaps because they are not well thought out or because in rejecting the label of prostitute, they fail to consider or prepare for the perils of their work), may violate the societal expectation of protected sex when presented with inducements. Strictly from a health perspective, the prostitute has already been discredited by engaging in an occupation that involves having multiple sex partners thus placing her sexual health, and the health of others, at risk. This can be compared to the obese individual who is seen over-indulging at a buffet; the person already bears the stigma of health endangerment and knowingly engages in an act that violates additional societal norms of bodily care. For the prostitute, failure to use a condom exemplifies a deviant individual behaving deviantly. If, like the exotic dancer, her boundaries are fluid, she may make condom use decisions on a case-by-case basis. These decisions would be driven by the utility maximization calculations described by the rational choice model. Those who take ownership of the deviant identity and reject the associated stigma, however, may establish an informed, consistent set of boundaries.

While Wesley's (2003) participants highlight the financial reasons for reconstructing boundaries within a deviant occupation, it is conceivable to combine ideas from the stigma and labeling literature with Coleman's thick model of rational choice when considering how decisions are made and fluid body boundaries are shaped and reshaped. Hence, a rejection of stigma and acceptance of secondary deviance may, using Wesley's terminology, negate the fluidity of body boundaries by creating a space in which the female feels empowered to engage active strategies. Conversely, operating under the shame associated with the stigma of deviance leads to more spontaneous

decision making. While those calculations are still rational, they are more passive in nature, resulting in fluid body boundaries.

Sex work in the United States occurs within the context of a patriarchal society, necessitating the additional consideration of a framework that includes gendered power as it affects perceptions of stigma as well as calculations of utility involved in making rational choices about one's bodily safety and health.

Feminist Theory

Each feminist camp has a different take, some more diametrically opposed than others, on the societal origin of inequality. Radical and liberal accounts are two polarized camps with respect to the sex industry (Chapkis, 1997). The former takes the stance that prostitution is a manifestation of male domination that legitimizes and enforces the lesser status of women by entwining sex, economics, and subjugation (Overall, 1992), whereas the latter faults legal systems as the source of female oppression, arguing that lack of autonomy and subjection to patriarchal dominance are realities for other services provided by lower class women (e.g., domestic servant, factory worker) (Nussbaum, 2006). Sex-positive feminism, on the other hand, locates power within the individual rather than societal patriarchy and views sex work as a liminal site (Egan, 2006). While this view acknowledges women's subordinate position in society, it also recognizes that women can find ways to resist and manipulate their position through sexual freedom. Socialist feminism, citing income and wealth disparity, a segregated labor market, status inferiority (e.g., marginalization and stigmatization), and Hochschild and Machung's (2003) *second shift* (i.e., unequal division of familial labor), purports that women's oppression is caused by class conflict. Poststructural feminism emphasizes the discursive

nature of identities, particularly gendered ones, such as prostitution; power is held by a deceptively male standard that is cleverly presented as neutral but is, nonetheless, masculine. That which does not conform (i.e., the feminine) is oppressed and dominated. Standpoint theory acknowledges that prostitutes, as a marginalized group, possess a special knowledge of the world allowing them to challenge existing male-biased conventions (Smith, 1987). Feminist theory, with its varied stances on gendered power, provides a backdrop for the study of prostitutes' lived experiences. Whereas all the feminist theories focus on the gendered divisions of power that inform studies of prostitution, condom use within prostitution is best framed by patriarchal bargaining (Kandiyoti, 1988).

Patriarchal Bargaining. Kandiyoti (1988) asserts that patriarchal societies require women to employ different strategies, or patriarchal bargains, in order to resist oppression. These guidelines regulate transactions between males and females. She claims that, like other social norms, they are socialized and thus become an unconscious part of our social interactions and impact rational choices. Patriarchal bargaining focuses on two ends of a continuum of such interactions: *less corporate* and *more corporate*. The distinctions between the two ends can be applied to sexual health decisions made in the context of prostitution.

Less corporate is used to describe examples of bargaining Kandiyoti (1988) observed influencing the interaction of men and women in areas of sub-Saharan Africa. There, women (specifically, mother-child units) existed in a state of relative autonomy in a cultural environment due to their willingness to raise obstacles where patriarchal influence encroached on access to their own income-generating means. In one region,

(the Mwea irrigated rice settlement in Kenya), women deserted their husbands when lack of access to their own growing plots and to their husbands' resources became limited. In Gambia, parameters granted women either wages for their contribution to husbands' earnings or else access to a plot for growing their own swamp rice. Women in yet another sub-Saharan region, a strong observance of Islamic seclusion protects women from presumptuous demands from husbands, and the women are free to trade baked goods they make.

In clear contrast is the entailment of stronger female subjugation, and thus the greater imbalance in patriarchal bargaining power in cultures Kandiyoti cites as *more corporate* or fitting the paradigm of classical patrimony. In such cultures, overt means to exert power for their own good do not exist; rather, a system in which women are wholly subsumed by familial, male-centered obligations places them within a much narrower band of choices. The alternatives for the women here are not whether to operate independently, either by abandoning the marriage or finding income through another source. Instead, women under a classic patrimonial system are empowered only to the extent that deference to tradition helps secure the essence of the patrimonial arrangement. Recent legal happenings in Uganda illustrate the *more corporate* bargain. In 2004, a feminist attempt to pass legislation prohibiting spousal rape was met with extreme resistance; parliament contended that the greater evil came from wives who deny sex to their husbands (Goldberg, 2009).

Women negotiate with themselves whether they want to be *less corporate* (active) or *more corporate* (passive) when it comes to their intended outcome. These strategies are evident in the dichotomous sexual health decisions of prostitutes whereby the

consistent enforcement of condom use illustrates an active strategy and the agreement to forego condom use a passive one. The Cult of True Womanhood epitomizes patriarchal culture; women should be submissive, domestic, pious, and pure (Welter, 1966).

Prostitutes are deemed neither pure nor pious by patriarchal societies, and those who choose to embody the deviant label can be *less corporate* in their employment of an active approach to sexual health decisions.

Allowing oneself to feel shamed and degraded by her occupation as a prostitute, however, demonstrates the acceptance of stigma, a product of the patriarchal values inherent in the Cult of True Womanhood. For these prostitutes, marked by inconsistent protective sexual behaviors, engaging in active strategies may be more likely when they do not have a pressing need. When the need is urgent (e.g., getting high immediately to counteract withdrawal symptoms or obtaining money in order to pay bills), they may passively trade their health for the opportunity to meet their given need. Some prostitutes have internalized a patriarchal norm that the man is responsible for providing condoms and act passively in this regard. If the john fulfills his societal obligation and has a condom, then one is used; otherwise, she passively accepts an unprotected exchange.

Women take an active or passive role in their safety strategies. Many are more observant and aware of potential threats when walking in an unfamiliar territory, reflecting the patriarchal value that they are endangered objects. An equivalent scenario in prostitution occurs with regulars or established johns. A prostitute's deference to a regular's request to forego condom use illustrates a passive bargain by which she replicates a non-remunerative relationship through reciprocal trust. She may use passive

strategies with unfamiliar johns as well (e.g., looking for indicators of “cleanliness”) to determine if she could go without sexual protection if requested.

Power in United States society is gender based and rooted in a patriarchal system. Nowhere is this more apparent than in the occupation of female prostitution. Whether the prostitute is viewed as empowered or dominated, those states are undeniably shaped by gendered power. Given that context, Coleman’s rational choice theory falls short due to its failure to address power. Neither does it take into account factors related to deviant behavior and stigma. Thus, while providing an excellent basis for considering humans as rational actors that maximize a wide range of utilities not limited to merely financial gain, a consideration of stigma and feminist frameworks, in conjunction with rational choice, holds much potential for a more complete explanation of human behavior. With condom use among prostitutes, specifically, an integration of the three perspectives provides a more thorough and nuanced framework for understanding sexual health decisions that can be used as the basis for further theorizing and public health policy.

CHAPTER III

METHODS

The current project is an idiographic study of female prostitutes' protective behaviors during high-risk exchange sex acts with johns in light of their existence as rational actors, their deviant label, and their reaction to the stigmatized nature of their work in the context of patriarchal bargaining. The principle contribution to the literature of the current study lies in a theoretically-informed examination of prostitutes' reasoning behind condom use decisions.

Sampling

The sample included 35 women. Participants ranged in age from 19 to 62 years; most were in their 20s. All but two of the subjects were active prostitutes, and those not currently engaging in sex work had only recently left the industry. There were 27 Caucasians, four African-Americans, two Latinas, one Native American, and one Other (self-identified as French/Latina). Over half of the participants had at least a high school education, and the majority of women were single (either divorced or never married).

I employed nonprobability sampling, a common method when researching a criminal, difficult to reach population (Davidson & Layder, 1994). Initially, with the cooperation of a local police department, sampling was purposive and derived from two sources: citations and informants. As women were cited for prostitution, my police

contacts asked if they were willing to speak with me upon completion of police paperwork, ensuring it was understood that participation in no way impacted their past or present legal issues. Those who were willing and met inclusion criteria were given the option to participate in the interview at that time or schedule an appointment at their convenience. Nineteen participants were identified in this way. Not all potential participants agreed to be interviewed or met the inclusion criteria. Two declined to participate and four were detained on other charges (e.g., possession of drugs, invalid identification) and, therefore, were not suitable for inclusion. Consideration was given to the possibility of selection bias, but there was no reason to believe that those particular candidates differed in a meaningful way from the rest of the sample. The officers extended the research participation invitation to their confidential informants, prostitutes who had previously been arrested or cited by law enforcement but now provided the department with intelligence (usually drug related) for remuneration. Six of these women, all of whom were approached, agreed to participate. Via snowball sampling, I acquired ten additional participants, referrals from colleagues or other women in the sex industry. Interviewing continued until theoretical saturation had been reached (i.e., no new information or properties of the patterns were emerging) (Glaser & Strauss, 1967).

A precedent for small sample size in qualitative work has been established in the literature (Creswell, 1998; Guest, Bunce, & Johnson, 2006; Morse, 1994). Morse suggested that samples for grounded theory studies should include a minimum of 35 participants, whereas Creswell argued that 20 to 30 participants were adequate for thematic development in such studies. Guest et al. used data from their qualitative study of female sex workers and HIV in Western Africa to conduct a separate systematic

analysis of theoretical saturation with a purposive homogenous population finding evidence to support that saturation can be reached using a sample as small as 12.

The nature of the sample is noteworthy. When researching prostitutes, it is common for samples to be drawn from a singular, convenient location, such as a rehabilitation center. This results in many samples consisting of primarily drug-addicted street prostitutes. This sample's composition offsets the typical overrepresentation of the more easily accessed street worker, criticized by Wahab (2003). While I make no claims of representativeness, this study draws its participants from a more spontaneously occurring milieu. Employing a variety of theoretical frameworks allows for a thorough consideration of micro- and macro-sociological issues while situating them within the context of non-normative behaviors. The results of the study are not intended to be generalized to the population at large but rather are meant to provide a thorough consideration of the experiences of the participants of this study. As such, the study's recommendations are intended to inform criminal and health education policies by being integrated into the curricula of STI and HIV prevention programs and local justice policy.

Participants were broadly categorized as indoor or outdoor prostitutes. Indoor prostitutes provide incall and outcall services. They advertise primarily via websites (e.g., *Craigslist*, *Backpage*) as escorts, lingerie models, or therapeutic massage providers, posting provocative descriptions and photos, which may or may not be of the actual service provider. Typically, the advertisements include a phone number by which the john can contact the worker to arrange an appointment by calling or texting. Many indoor prostitutes maintain a list of regulars. A regular is a john who has an established history of transactional sex with the prostitute. The indoor classification also includes

massage parlor workers and exotic dancers who engage in exchange sex with patrons. Outdoor prostitutes, often called street and survival sex workers, advertise their services in person by walking the streets and generally work a particular area, or set of streets, known as a track. They rely on obtaining business via three sources: cruising, regulars, and online rating websites. When a john drives through an area or on a known track in an attempt to locate a prostitute for sex, it is called cruising. Street prostitutes' regulars locate them by cruising, keeping a pre-arranged date, or making phone contact. Online rating sites, such as *USASexGuide* or *TheEroticReview*, differ from advertising websites used by escorts. On these websites, johns (referred to as hobbyists in this context) post reviews of their experiences with prostitutes and direct other johns to recent or current locations of street prostitutes in a given area.

Data Collection

Between April 2012 and July 2013, I conducted interviews with 35 adult female indoor and outdoor sex workers in a Southern metropolitan area, amassing over 16 hours of face-to-face interaction. In addition to conducting interviews, I reviewed police records for several of the confidential informants who agreed to be interviewed. Participation in the interview was voluntary, and no remuneration was provided. I only reviewed records of those who agreed to participate. Inclusion criteria were recent or current occupation in the sex industry, being at least 18 years of age, absence of overt indicators of drug/alcohol intoxication, and lack of intention to harm self or others. Subjects were assessed according to The American Psychiatric Association's (2000) criteria for substance intoxication as delineated in the Diagnostic and Statistical Manual, 4th Edition, Treatment Revision (DSM-IV-TR): slurred speech, incoordination, unsteady

gait, psychomotor agitation, aggression, extreme pupillary dilation or constriction (not in response to light levels), confusion, sedation, and/or impaired attention and concentration. Any person deemed dangerous (e.g., violent, resisting arrest, verbally threatening) was not eligible for interview.

A semi-structured interview protocol (see Appendix C), intended to be in-depth, evolved over the course of the fifteen months of data collection as participants' contributions were allowed to refine and expand the questions asked. Generally, topics included demographics, occupational history, subjective responses to occupational labels, experience of stigma, deviant identity and stigma management, exchange sex services provided, influence of drugs and alcohol on work-related choices, influence of environmental settings on work-related choices, as well as protective behaviors and the factors influencing those decisions.

The study was approved by the University of Louisville Institutional Review Board (IRB). Because of the criminal nature of the participants' work, great care was taken to protect their identities up to and including the procurement of verbal informed consent instead of written so that names could not be linked back to the cases. Caution was exercised even when assigning interaction codes to prevent discovering participant names through public police citation records. Identifying data were not solicited. All names were substituted with pseudonyms chosen by the participants. Interviews were conducted in spaces that afforded auditory privacy. Per IRB request, participants held the researcher's audio recording device in order to have control over what was recorded. Interviews were digitally recorded and transcribed verbatim. Transcriptions were then

checked for accuracy and sanitized of any inadvertently revealed identifying data. Audio files were deleted upon completion of transcription.

Entrée. Two key hurdles to data collection were gaining access to this difficult-to-reach population, initially achieved through forming a working relationship with a local police department, and very quickly establishing rapport with participants in the interview setting. Through a mutual colleague, I established contact with a guide from a local police department who worked in the division responsible for investigating prostitution complaints made by residents or hotel owners/guests. In the investigated area, prostitution is a misdemeanor charge resulting in a citation similar to a speeding ticket. Upon obtaining clearance from the police department to accompany the unit during their undercover work, but prior to collecting data, I engaged in three scouting expeditions with their unit for the purpose of determining the feasibility of my proposed data collection plan (e.g., appropriate site conditions for interviewing participants, my physical safety and emotional preparedness for the work, officers' willingness and ability to tolerate my presence). I scouted both indoor and outdoor locations before commencing research. Throughout the 21 months that I shadowed the police unit (from August 2011 when I made first contact to May 2013 for my final undercover detail), I had numerous opportunities to get to know the officers during lunches, record reviews at their office, and the time while we waited for prostitutes to return calls or show up for an appointment. I relied on front stage work (e.g., modifying my speech patterns and language, assuming a very casual style of dress) and disattending (e.g., erosion of visibility by time and by display of no symbolic detachment) to achieve *invisible researcher* status (Berg, 2009).

Prostitutes recruited after receiving a citation were sometimes distressed by the police contact or hesitant about potential legal implications of talking to me. Few wanted to acknowledge their tribal identity as prostitutes. Even when caught in the act of agreeing to a sex exchange, they tried to manage stigma in order to avoid being discredited. Foregoing protective behavior may be construed as a blemish of individual character, which adds an additional layer of discredibility. Often I found that participants, in an effort to divide their social world, initially lied or minimized their stigmatizing practices. Enacting Goffman's (1963) role of the wise, I used my previous counseling experience in rapport building, reflecting their content of feeling in order to alleviate their concerns before, and sometimes during, the interview. When that was not enough to peel back all of the defensive layers, motivational interviewing was employed.

Motivational interviewing (Miller, 1983; Rollnick, 1995) is a practice in substance addiction interviewing in which the interviewer asks the participant about their discreditable behaviors in increasing increments, projecting acceptance of said behaviors. Thus, the interviewer does not allow the respondent's denial answers to deter the line of questioning regarding the discrepancies between the behavior and the narrative account. The technique takes finesse and close attention to the participant's paraverbal presentation. Persistence is required but must be tempered by delicateness so that the subject's cooperation is not lost. The technique allows the interviewee to admit marginally acceptable information and move on to ownership of higher stakes behavior. For instance, when initially queried, many participants endorsed using a condom during sex. I followed up by asking about condom use specifically during oral sex. If a participant responded that she used a condom for oral penetration, I inquired about how

she induced an erection. Some participants stated johns already had erect penises or that manual stimulation was utilized, but quite often participants admitted at this point that some oral stimulation was provided without a protective covering. Questions were parceled out over the course of the interview and presented in an accepting, non-judgmental way in order to allow participants to feel comfortable providing socially undesirable information.

The setting. I observed, by way of video and/or audio surveillance, ten detective-prostitute interactions during the course of scouting and data collection. Observations were conducted from a secure surveillance area that was physically separated from the operation site. In seven of the details, police officers were able to incorporate into their script a proposition of increased financial compensation for a high-risk sex act (vaginal, anal, or oral) without a condom. Therefore, the findings do not merely rely on self-report but rather, in some cases, are supported by observations and police records, which were beneficial in verifying the reliability of the data.

Indoor details. The indoor details varied by incall and outcall. Incalls entailed visiting a prostitute at a hotel room, residence, or massage parlor. Outcalls, in which the prostitute came to a hotel room for the transaction, were more common and provided the opportunity for audio and video surveillance. An outcall detail was typically scheduled in an eight to twelve hour block and could yield from one to six completed undercover operations. Location of hotels varied. The police procured two hotel rooms, usually adjacent. One room was designated as the undercover detail room and the other as the technical (or “tech”) room. When full recording equipment was available, the detail room was set up with a microphone on or near the television or its stand, a touch lamp

equipped with a hidden camera on a bedside table that provided a view of the bed and the entry door, a smoke detector equipped with a hidden camera mounted to the wall opposite the bed to provide an alternate view of the bed, and an alarm clock equipped with a hidden camera on the alternate bedside table for third view of the bed and floor space in front of it. The detail room was made to look lived in with rumpled sheets, a suitcase, partially-emptied beverages, and towels scattered on the floor near the bathroom. The technical room housed three to eight officers. Sometimes a technology specialist was present. This room held the monitoring equipment. Officers sat on chairs, sprawled out on beds, and walked around the room. The mood was typically casual and jovial.

The following description is representative of a typical outcall experience. Officers scanned websites, primarily *Backpage* and *Craigslist*, calling women known to be prostitutes with potential information about local drug activity or those whose advertisements suggested that they were under 18 (e.g., the photos posted were youthful in appearance, the use of tag lines such as “barely legal”) in order to build a human trafficking case. Once the undercover officer was able to make phone contact and schedule an appointment with a prostitute, he waited in the detail room for her. This process (calling, making an appointment, and waiting) could take several hours. The undercover often met the prostitute at the hotel room door in some state of undress. After chatting and sometimes physically touching (e.g., hugging, rubbing of arms or shoulders), the undercover began negotiating an agreement to pay cash for a penetrative sex act. Usually the prostitute undressed, got in bed with the undercover, and some amount of physical contact (often a massage) ensued before she agreed to the transaction. At that

time the undercover identified himself as a police officer, handcuffed the suspect, and notified the other officers to enter the detail room, which they did while displaying their badges. The undercover explained the charge to the prostitute while the others searched her belongings. After securing that there were no weapons present and she possessed a valid identification card, an officer removed the handcuffs and allowed her to dress. As long as there were no outstanding warrants or other charges, they cited and released her.

Outdoor details. The outdoor details involved cruising for possible street workers. Although I was able to interview a number of street prostitutes for the study, none of them were identified through these details; they were all either informants or referrals. For a full-scale outdoor detail, there were no fewer than three vehicles. One agent was undercover, usually driving an undercover pick-up truck and dressed in coveralls, a threadbare, sweat-stained long-john shirt, and a baseball cap with a fake ponytail. The other officers (two to five agents from the unit) split up in other undercover backup vehicles. All were in communication via radio. Using *USASexGuide*, they looked for johns' postings of local prostitution activity and cruised the identified areas. Potential prostitutes were visually detected by a lack of purposefulness in ambulation, sloppy clothing, absence of a purse, direct eye contact with oncoming traffic, and response to car horns. After backups obtained a visual on the potential prostitute, the undercover agent attempted to solicit her services. Upon successful completion of the proposition, backup officers joined the undercover to assist with citation paperwork or detainment.

Interview setting. Interviews took place in a multitude of different environments. I interviewed women in their homes, hotel rooms, regular's home, and cars. Those

settings were the easiest to control for privacy and comfort. I drove around a local track with two street prostitutes who wanted to be able to show me streets, people, and landmarks as they discussed them. That was a fruitful venture that enriched my understanding of their world and lived experience. Most of the hotel rooms where participants stayed and conducted incalls were treated as temporary spaces, but several kept their pets (cats or small dogs) with them and one clearly lived in her hotel room on some semi-permanent basis. She had redecorated the bathroom with Hello Kitty décor. The bedroom was adorned with artwork, photographs, personal furniture, and a four-foot high stack of bed linens and towels. One participant met with me in a conference room on university campus. Against my recommendation, another requested we talk over dinner at a crowded restaurant, which was uncomfortable due to the subject matter we discussed in a public venue and disastrous when I attempted to transcribe her recorded interview. Massage parlor workers were interviewed in private rooms at their salon.

The most difficult interview setting to negotiate was the undercover indoor detail, be it incall or outcall. Both required that I find a space that afforded physical and auditory privacy but, per IRB requirements, from which I could be heard if I needed to call out for help. These scenarios were tested during scouting, and it was determined that two options met the prerequisites: an unused room (detail or technical) with the adjoining door left partially open and the bathroom with the door left partially open. When interviewing a participant in a hotel room, most sat on the bed, and I sat on the alternate bed or a chair. Interviewing in the bathroom takes a bit more finesse, tolerance, and sense of humor. I gave the participant her choice between standing or sitting on the edge

of the tub or on the toilet. If she stood, so did I. If she sat down, I, too, took a seat in the other position, even if it meant conducting the interview from a toilet seat.

Data Analysis

The constant comparative method, consistent with grounded theory (Charmaz, 2006; Glaser & Strauss, 1967), was employed in data analysis. My initial coding was done word-by-word to establish themes and patterns related to participants' sexual health decisions. I then moved to incident-by-incident coding to compare within and between cases. I followed with a focused coding, to make decisions about the most salient codes, axial coding to develop broad categories from the subcategories, and finally worked to develop the substantive codes into a meaningful theory through theoretical coding.

According to Blumer (1954), sensitizing concepts give the researcher initial ideas to ask questions and pursue concepts during data analysis. They provide a loose agenda to the study; in essence, they are a starting point. Analysis of the data proceeded using several sensitizing concepts: rational decision making, feminist theories about gendered power's impact on negotiations, and the stigma associated with deviant labeling.

First, I found repeated evidence of rational decision making. Participants in the study consistently described calculating costs and benefits as if the process will maximize their advantage. Drawing on Coleman's Rational Choice Model (1990), I allowed for the consideration of more than simply wealth maximization. I considered participant's inclusion of non-monetary factors such as trust, time, and information.

Next, included in the interview guide was what I initially believed to be a simple question about their subjective responses to occupational labels. For many respondents, the discussion of this topic resonated deeply. In my initial coding, I noted their

exploration of the nuances of labeling and its resultant stigma that I had not considered. Comparing the cases through incident-by-incident coding, I began to see a common thread among the decision-making process of those who felt stigmatized that differed from those for whom stigma was not verbalized. Stigma, as it was expressed by the majority of the women interviewed, was directly related to their rejection of secondary deviance (Becker, 1963) or refusal to accept the label of prostitute.

Finally, there must be a consideration of context. The study of prostitution is incomplete without a consideration of the gendered power at its root. The stigma-directed nature of sexual health decisions was often framed in the context of social inequity and greatly resembled Kandiyoti's (1988) notion of patriarchal bargaining.

CHAPTER IV

FINDINGS

In this chapter, the findings are reported according to three categories of protective behaviors during transactional sex: 100% condom use, less than 100% condom use, and 0% condom use. Ten participants report consistently providing protected services 100% of the time for all penetrative sex acts (oral, vaginal, and anal), regardless of circumstance and john. Nineteen participants fall into the less than 100% condom use classification, meaning that in the course of their work they have engaged in some form of high-risk sex transaction. Typically, this behavior varies according to sex act, situational context, and john. Four subtypes were identified: *intermittent*, *oral only*, *oral plus intermittent*, and *regulars*. For the *intermittent* group, protection takes the form of variable condom use. The *oral only* group will consistently provide some amount of oral sex (from utilizing oral stimulation for the sole purpose of inducing an erection to achieving ejaculation) without a condom but requires protection for all other penetrative sex acts. The third group, *oral plus intermittent*, is a hybrid of the first two classes; they routinely provide oral without a condom and in some instances will also provide other unprotected services. Finally, the *regulars* subset restricts unprotected behavior to transactions with their established johns. Six participants report that they never use

condoms in their work due to limiting their transactional sex activity to non-penetrative acts, such as manual stimulation.

Prostitutes across the sample described engaging in cognitive processes that involve weighing the risks and benefits of protective behaviors during exchange sex. These decisions were rational in nature. In other words, although participants did not present their decision making as cost-benefit analyses, their reasoning was framed in a manner consistent with that type of logic. After an initial consideration of each rational theme, the data were interpreted in light of stigma (whether prostitutes' acceptance or rejection of the deviant label impacted their rational choices) and the influence of gendered power on the negotiation of condom use.

Rational Choices

Condom use in prostitution is conceptualized as a maximization of utility. The task then becomes determining the specific utilities and analyzing the preference hierarchy. Even though every participant verbalized health (i.e., concern about STIs) as a major consideration when making a decision about protective behavior, in the majority of the sample, this utility was outweighed by competing factors: perceptions of cleanliness, financial need, drugs, and trust. In the analysis, three primary rational categories were identified with respect to health decisions in transactional sex work: *interpersonal*, *situational*, and *personal*.

Interpersonal. *Interpersonal* factors include perceptions of cleanliness, elements of trust, GFE, and the john's perceived business value. Numerous facets of hygiene may be considered. Prostitutes list criteria for both external and genital cleanliness. Samantha, a 30 year-old Caucasian escort who routinely performs oral sex without a

condom and estimates that she agrees to vaginal sex without a condom approximately twice per month, summarizes her views on external cleanliness, “You can look at a guy and just see that he’s clean cut, well-groomed. He’s not showing up with dirty fingernails, bad breath.” External indicators that a john is clean, however, go beyond basic sanitation. Prostitutes list criteria for both external and genital cleanliness attire, vehicle, and race. Lulu, a 30-year-old Caucasian street prostitute whose protective behavior is intermittent and varies by interpersonal and situational dynamics, provides a typical profile of a clean john that relies heavily on stereotyping:

Clean guys...looked like a lawyer, wore collared shirts, smelled good and clean. I paid attention to their car too. That’s real important. You didn’t want nobody in a beat up old car.... I never did it with no black men either. The majority of the black men they got AIDS, so you gotta be careful of that out on the street.

Susan, a 46-year-old African American survival sex worker who traded sex for money and drugs, is far more skeptical about using external indicators to estimate cleanliness:

The thing is, I’m grateful I didn’t get any STDs behind anything I did, even when I wasn’t protected or they weren’t protected. I was real lucky because I know a lot of people who did have things like that. I know this one girl, she wound up having full blown AIDS and she was still running around cuz the guys didn’t know it. I’m lucky I didn’t get a hold to none of the guys that she had done. So I’m grateful for that. Cuz you know, like with her, the outside might look good, but the inside might be rotten. Like an onion. I just picked some out of my bin the other day. They looked good on the outside and then you cut into them and they all brown and rotted and you gotta throw them away.

Over half of the participants describe performing informal visual inspections of the genitalia as a component of the process of determining whether a john was clean.

Faith, a 19-year-old indoor prostitute, may or may not examine the area. “Depends on what it looks like. I’m serious about it, but I don’t try to like embarrass them. I look for smells, bumps, looking nasty. He has to look, clean and normal or I don’t mess with that.” Gretchen, a 62-year old Caucasian escort who prefers to perform oral sex without

a condom, explains how this factors into her decision making regarding service provision and condom use:

I take a close look at his penis and the surrounding area. I am looking for bumps or sores or spots or a rash. If I see anything that doesn't look right to me, he gets a condom and a hand job after I've rinsed my hands with alcohol. If I get any argument about it, I remind him that I advertise as full body sensual massage, and I am not obligated to suck his dick at all.

Some sex acts are perceived as being cleaner than others. Specifically anal sex is a service that many say they will not provide at all or may only consider if using a condom. Destiny, a 30-year-old Caucasian street prostitute with variable protective practices, provides her view on the topic, "I'm ...not really an anal girl. It's dirty, dirty trickin'. Definitely need a condom for that shit." Additionally, digital penetration of the vagina or anus is regarded as unclean. "One thing I'm a big stickler about, and a lot of working girls are, is fingers because fingers can have, like, cuts on them and touching inside a girl you...could get a blood disease. You know, that's a no-no," says Vicky, a 25-year-old Caucasian escort who initially endorsed consistent use condoms but by the end of her interview acknowledged initiating oral sex without a condom as well as engaging in routine unprotected exchanges with a regular for increased financial compensation. Vivian, a 28-year-old Caucasian exotic dancer who engages in exchange sex with club patrons, agrees, "What I hate is when they try to stick their fingers up your pussy or in your ass. Fingers are nasty. They oughta have a dispenser of hand sanitizer back there in the couch room just for that purpose." Angie, a 25-year-old Caucasian escort who endorses a strict policy of condom use, reports an increase in johns' requests to receive anal and prostate stimulation:

I don't like doing that, but you get used to it. You gotta wear gloves though. Oh God, you *have* to! Try it sometime, and you'll see what I'm talking about. You

have to wear a glove. I mean, if you have long fingernails, you'd get shit under them.

In terms of trust, participants in this study value the duration of the relationship and frequency of contact, familiarity, and personal attributes when determining which johns they consider regulars. Estimates for how long it takes to achieve this status vary by participant, ranging from a long weekend to routine contact over two years. Sara, a 23-year-old Caucasian street prostitute who forgoes condoms with her regulars but is “basically 100% covered” with random johns, describes the variability in her regular client rotation, “It’s so weird because I’ve been with one of my regulars for almost four years and we still use a condom....Now Aaron I’ve been seeing for about two or three years and we don’t.” According to Vicky:

I had a regular and I’d known him about 2 years...once we stopped using a condom, we never went back to using one. But with everybody else, yeah, I still used one. But with him it became a regular thing between me and him....He was a regular for two years so I trusted him....It was built up to. He didn’t just ask me one time and I agreed, you know? And I figured if he had something, I’d have known it by then.

Melanie, a 22-year-old French-Latina exotic dancer with variable protective behaviors, says she stopped using a condom with her first regular john when, “I’d known him for a few months altogether.” Several participants identify regulars by familiarity or how well they know them. Abby, a 30-year-old Caucasian escort who acknowledges performing oral sex on regulars without a condom, says, “I’ll usually do it without a condom if I know them really well. I just have to get a feel for the guy.” Melanie reports that on a recent weekend spent with a new john she learned so much about him that she might be willing to forego the use of a condom the next time she sees him.

Trust, as it is presented by several of the participants in this study, is reciprocal. Destiny makes this argument. “First of all, I trust that he’s clean. Plus how would it look if I started asking him to use a condom? It’d look like *I* had something.” As Vicky explains:

He’s married, you know, and I know I took that leap of hope that his wife wasn’t cheating on him too and didn’t have the same kind of agreement with somebody else because then, you know, you’ve got all that. Just like he took a hell of a leap of faith assuming that I didn’t do that with anybody else because I’m sure there’s girls out there who do that.

Similarly, Jane, a 25-year-old Caucasian exotic dancer who generally sees only regulars and, with one exception, provides them with unprotected services, says, “I invest a lot of work in these guys, in getting them to trust me, in getting to know them well enough that I trust them.” She contrasts her condom use with regular versus random johns, noting that she has used a condom when engaging in vaginal sex with a john as part of a bachelor party. “It’s in my best interest,” she reasons, “because I don’t know him from Adam.” Her regulars, however, she describes differently. “They’re my friends....I can’t say that I used condoms with any of them... I trust all of them. I know each one well.” Melanie elaborates, “It just seemed like if I kept insisting that he use one, he’d think either a) I didn’t trust *him* or b) he shouldn’t trust *me*.”

A recurrent theme is the assumption that a john’s personal attributes (e.g., marital, residential, occupational, and socio-economic status) are tantamount to trustworthiness. Married men with families and a house are viewed as healthier and more stable. Melanie says most of her clients are “decent guys with jobs and families.” According to Gretchen, “My clients tend to be comfortably middle-class married men who have pretty good health consciousness....To some degree I count on them to know whether or not

they have a social [*sic*] disease and to take some responsibility for it.” Regarding her regulars Jane explains, “I know their legitimate information like where they live, where they work, current and past relationships, likes and dislikes, just who they are as a real person.”

Several participants in the sample defined GFE as perpetuating the illusion of a real romantic relationship in which the interactions are more like dates, and there is an expectation that condoms will not be used. When asked about GFE, Janet, a 21-year-old Latina escort who only offers covered services and even puts condoms on her sex toys replied, “No, no, no, no! GFE is like uncovered services. Not my cup of tea.”

According to Jane:

I’ve never used condoms with either one of [my regulars] no matter what we’ve done, and that’s how it’ll stay....That’s something a *whore* would do. When you’re into a guy and in a relationship with him and know he’s clean, you don’t go asking him to suit up, do you?

Melanie describes her first transactional sex relationship as “a weird kind of boyfriend-girlfriend relationship” that falls in line with both GFE and half-hooking (Quan, 2009).

She met Tom at the exotic dance club where she worked and soon began engaging in an exchange sex relationship with him:

He always gave me money, but I never agreed to *do* anything for the money. He was nice and it was really fun most of the time, so I didn’t mind and I never thought of it as being paid to have sex with him.... I just told myself that maybe this was how rich guys treated their girlfriends.

Regarding protective behavior within the context of this relationship she says, “At first we [used condoms]. I insisted. But time passed and he would ask and ask me not to.

Finally I just caved.” Many refer to their client appointments as “dates.” Vivian elaborates that “sometimes [I’m] just a hot girl to hang out with. I make them feel good

about themselves.” In line with the half-hooker criteria she states, “Nobody pays me for sex per se, but I’ll get them to do things for me, ‘loan’ me money that I know I never have to pay back, drive me around, buy me things... That’s just how it works.”

According to Faith, “it’s not only, like, about sex. It can be like a date. You hang out. You’re spending time with them.”

Some participants value a john’s business enough to disregard issues related to sexual health, and others do not. Susan was relatively selective about the clients with whom she engaged in unprotected transactions and for them required no additional fee. She gauged the likelihood that a john was “a threat” by age and repeated business, usually two or three visits.

There was a couple older gentlemen, older as in older than me and I was in my 30s, so they were in their 40s. I’d sit up there and think they was ok cuz a lot of the older gentleman can’t get it up. Old cats, most *older* people usually they get a main person, and that’s what I wound up with.... It wasn’t only the sex and the drugs, sometimes just the conversation. A lot of older men have erectile dysfunction, so they may not want to actually have sex. They just want you to sit up there and talk to them and try to rub on them and get them hard.

...I sat up there and gave them the sense that I *love* them cuz, you know if you can make somebody believe that you love them, that you enjoy they company, they gonna give you a little bit more. You use everything that you can to make them feel safe and secure in your company to make sure they keep on feeding you. It’s like feeding a stray cat. The more you give me, the more I’m going to allow you to take advantage of me and the more I’m going to try to take advantage of you. So you think it’s a win-win situation, but in the end when you done ran out of money and dope and I’m tired cuz my knees is tired, my back is tired, or my mouth is tired, you know, what do we have left? What is really left? Thank you. Goodbye. Take a shower, put fresh clothes on, keep on going until the next one comes along and then the next one.

In Destiny’s case the reasoning for placing a great deal of significance on the value of a transaction was also financial but without the forward thinking employed by Susan, who recognizes the potential for other customers. “I can’t afford to lose that

money....I've tricked for as little as seven dollars.” Jane fears losing business should she offend a john by requiring a condom or inquiring about health-related matters. When asked whether she discussed sexual health matters with any of her regulars, she responds, “You mean like asking any of them if they had the clap? Yeah, I’ll bet that’d go over well. Nope, definitely cutting down on doing that these days. I’d lose too much business.” Others place less importance on the individual transaction and are willing to forfeit work over condom use disputes. Angie states, “If someone doesn’t like it [using a condom], I just won’t do it with them.” Similarly, Cindy, a 29-year-old Caucasian escort who reports providing protected services only, says, “If a guy gets difficult, I don’t deal with him.” Lulu expects the provision of unprotected services to double her fee per sex act. Those who are unwilling to pay are told to “keep going...get your stuff and good bye.’ Less than double was like...well, it was kinda like a put-down.”

The assessment of whether a john is “clean” is an interesting *interpersonal* component of cost-benefit analysis. “Clean,” as it is used to refer to a john, is a moniker for infection-free that considers genital indicators of the presence of infection (e.g., sores) and external estimates of the likelihood that a john is infection-free because he looks like he takes care of himself, is of a particular race, and/or appears to have financial resources. Anal sex and digital penetration are repeatedly recognized as “dirty” services that are engaged in only with protection or avoided altogether. Trust, a crucial element for participants involved in unprotected transactions with regular clients, is measured differently by participants with variable appraisals for how long and with what frequency a john must be seen in order to be considered a regular. Reciprocity, however, is a consistent aspect of trust; each participant who discusses trust agrees that it is a matter of

her trust in the john as well as his trust in her. Similar to the notion that external appearance can be equated with infectious status, is the idea that a john's personal attributes are indicators of trustworthiness. GFE, described by participants as including unprotected services, is sometimes tied to trust.

Situational. *Situational* factors, such as availability of condoms, concealment of evidence, drugs, financial inducements, and negotiations, are key to the decision-making process. Prostitutes who provide condoms are more likely to insist upon their use. Brianna, a 29-year-old African American escort who reports providing protected services only and refused the undercover detective's financial incentives (an offer of \$100 additional payment) for sex without a condom, is an example of the power of agency. "Yeah, I bring my own, so when I get undressed and we're in bed I just hand it over, like, 'Here you go.'" Conversely, those who assume johns are responsible for providing condoms take the risk that one will not be available, ensuring one of two outcomes: a lost transaction or an unprotected exchange. Destiny, who acknowledges engaging in unprotected high-risk exchange sex when motivated by drugs or with a regular, describes her take on condom provision. "Shit! That's their job....Some guys have them. Some guys don't.... If that mother fucker don't have a condom, then they shouldn't be out there looking to buy pussy or head, you know?" Providing another street perspective, Sara contributes:

Lately I haven't been carrying them with me. Sometimes I've gone to the Family Planning Center...because they'll give them to you....But I will tell you that I know that is a major problem as far as the girls on the street are concerned. They don't carry them.

Melanie correlates condom use with availability. "It depends on if he's got them or not. A lot of guys aren't that prepared."

In some situations, specifically in the case of transactional sex within an exotic dance club setting, the use of condoms may leave an undesirable trail of evidence.

Melanie explains:

You do have to be careful that you aren't...leaving evidence. I'd rather we used one because it keeps the cum controlled, not splattered everywhere. But I've done it in the club without a condom. When that's the case, he has to pull out and cum in his pants. If there's a condom involved he has to pocket it. Either way it's a pain. Hide the condom or hide the cum.

Some dancers make the case that carrying condoms on the club floor is either impractical or impossible and could draw unnecessary attention. When asked about protection,

Vivian explains the particular difficulties of prostituting in an exotic dance club, "Where am I gonna carry something like that? Second, I'm not looking to get caught in the club.

That would take time and draw too much attention. You gotta be discreet."

Drugs impact exchange sex in a variety of ways. Some prostitutes report that when working while high or in withdrawal their likelihood of condom use decreases.

According to Destiny, whether or not she insists on protection is drug related:

How fucked up am I, and how bad do I need the money? I know about AIDS and infections, and I for sure don't wanna catch one, you know? I mean, I'm not stupid and I ain't got a death wish, but if I'm drunk or high, then that just doesn't even cross my mind, you know? I'm either too fucked up to care or I need the money for my next fix too bad to care. I hate to put it like that, but it is what it is....It really is more about me and my state of mind....When I'm not fucked up or desperate, then I got more control, you know? Then I got the power to say, "Strap up or get up, mother fucker!"

Vicky's assessment of her arrangement to provide unprotected services to a regular in exchange for additional remuneration is similar.

Back then, I was looking to make more and more, for one to get high, and for two I just didn't have the consideration for my life. I didn't look at things the way I do now. I wasn't clear-headed....I mean really it depends on the girl's state of mind and how strong she is.

As explained by Sara the need for money to buy drugs may override the need to provide protection:

The only thing [drug-addicted prostitutes] care about is getting that next rock. And if they need twenty dollars to buy a rock, then they will spend every bit of that twenty on drugs rather than buy condoms....They will choose the drugs over buying condoms. The drugs are basically more important to them than their health or their life.

An exception to the typical response comes from Monica, a 24-year-old Caucasian escort who reports using protection for all high-risk exchange sex acts. She describes protective behaviors as being contingent upon the need to maintain her sexual health in order to continue making money to buy drugs. "If I catch something, then I can't work. If I can't work, I can't make no money. No money, no drugs."

While some prostitutes' acceptance of financial inducements is drug driven, others report needing the money to pay bills and make daily purchases. Samantha clarifies her reasoning and limits:

There'll be times when somebody offers you quite a bit of money to do it without condoms, then I might....It depends on how busy I've been. If I haven't had a lot of clients and I'm hurting for money. Like right now my electric is due, so, you know, that makes a difference. It would be not a lot, like I told [the undercover detective] a hundred dollars extra.

One prostitute in the sample, Kiki, a 21-year old African American escort who reports using condoms with all of her johns, situates her protective behaviors within the context of her relationship with her pimp, Ronald. Although she has been offered more pay to provide sexual services without a condom, she says, "I couldn't do that; Ronald would be mad."

Yet another *situational* factor is the negotiation process regarding the use of condoms during exchange sex. Prostitutes choose whether to exercise agency through

proactively introducing the topic of condom use. Echoing the sentiments of several women in the sample Destiny insists, “Don’t none of them *want* to use a condom.” Lulu expresses agreement, “I gotta tell you, the johns I picked up always seemed to ask. I don’t know what other girls would tell you, but that’s the truth of it.” Samantha automatically assumes that a condom will be used. “They have to specifically ask if they don’t wanna use one” before she will engage in negotiations regarding financial remuneration. Brianna takes a more forceful stance:

A lot of guys don’t like condoms....I still do what I do, you know? I put it on. I gotta be in charge. I can’t let them know I’m scared. I gotta be like, “Look, I *need* you to put the condom on.” But you be more fierce in talking to them and they’ll do whatever you ask them to do....You gotta be in control....Usually when I tell them how it is, they always go along with it.

Participants utilize different strategies for dealing with johns who do not want to use condoms. Destiny reports that she has asked a john to “go get one and come right back.” Abby will sometimes threaten a persistent john. ““If you say that one more time, I will put on two condoms.’ That shuts them up pretty quickly.” Cindy says, “I’ll always try and pull the ‘maybe in a few more sessions’ to keep them coming back until they...catch on that I will never let that happen.” Several others redirect the client with alternative options. Marilyn, a 28-year-old Caucasian escort who agreed to an undercover detective’s offer for an extra \$150 to engage in unprotected anal sex, insists, “I would have tried to talk myself out of it and done something else where he wouldn’t have lasted as long to do it.” Gretchen has a more assertive attitude:

I do not have intercourse unless I want to, and I like for it to be my idea. So I will say something along the lines of, “That’s lovely and I know something even better, let’s do this,” and I’ll distract him with some sensual thing.

Situational factors span a range of topics, exerting influence over protective behavior. When participants take responsibility for providing condoms and have established scripts for managing or negotiating the transaction to ensure condom use (e.g., assumption of use, initiation of conversation regarding use), they are far more likely to engage in a successfully protected transaction. In this sample, concerns regarding storage and disposal of condoms are exclusive to sex workers in exotic dance clubs. Participants relate drug intoxication and withdrawal to unprotected behavior. The need for money to buy drugs is a common theme, particularly among the outdoor workers in the sample. Other participants agree that they, too, are willing increase their fee by foregoing condom use but report financial needs unrelated to drugs (e.g., food, bills).

Personal. Comprising the *personal* theme are considerations regarding health and STI myths. Prostitutes who use condoms place a higher value on their sexual health and express an understanding of the ramifications of STIs, including HIV/AIDS. “There are guys that will say, ‘I’ll pay you extra if we don’t use one,’ but it’s not worth it to get AIDS or nothing. That extra hundred isn’t gonna help me five years from now when I’m dying,” reasons Angie. Even though she practiced inconsistent condom use, Susan echoes Angie’s concerns regarding AIDS but on a more personal level. “I wanted to try to be safe because my brother died of AIDS.” Similarly, Niveah, a 25-year-old Caucasian escort well-known to the police department for having a console full of condoms and dental dams, takes pride in offering only protected services. “I don’t do anything unprotected...I can’t afford to, you know? It’s my life. You know what I’m saying? That’s priceless.” Cindy’s perspective is that “this is a business and I am a

service provider. I take my health seriously. We're talking about pregnancy, infection. There's no reason to take those risks." According to Janet:

There's just a lot of diseases and a lot of nasty people out there that do this with girls and they don't get tested or anything. And I don't think that the money is worth, you know, sacrificing my life in any kind of way.

Sonya, a 27-year-old Caucasian street prostitute, carries an assortment of condoms, anti-bacterial wipes, and cleansers in her purse.

Yeah, maybe some people think I'm crazy or OCD or whatever. You can laugh your ass all the way to the clinic on that one cuz I'm not catching shit, you hear me? I work this block, the dirty South, and I'm crazy for swapping dong bags? I don't think so. I'm gonna use one when I suck it and another when I fuck it. Period.

Brianna is motivated by fear:

I'm too afraid I'm gonna catch an STD or something, so I put condoms on, like, every time...I know I can't get pregnant cause I got enough going on, you know, so I gotta protect against that. But I know, too, that I can't afford to be catching something that I gotta take care of or that may kill me.

Kiki describes how she must think about the sexual health of not only herself but also the other women associated with her pimp, such as his other prostitutes and wife:

We can't afford to be bringing back no diseases. Like, Ronald has sex with us, ok? Can't nobody afford to have something because then we all gonna catch it. Plus we have to think about his wife too. Nuh-uh. It's not worth it. He says we all gotta use condoms.

The previous comments have focused on johns whose status is unknown. Jane has a regular who admits to having genital herpes:

I'm always real careful with him. I don't let him get his mouth near me. I don't care if he's got sores or not. I'm not taking no chances. I won't give him head. I will fuck him but only with a condom on and that's it. I feel like I'm being safe about it. I mean, he's a [medical professional] so he's on whatever medicine he's supposed to be on for outbreaks and stuff. I can honestly say I've never seen a sore on him.

Participants who engage in unprotected exchange sex often recognize, although sometimes too late, the risk they are taking. Gretchen admits:

The one time I made an exception [and didn't use a condom for vaginal penetration], I got trichomoniasis and had to go to the clinic....I do understand that I'm taking a risk. I try to mitigate that by going to the clinic every six months for my tests....I *have* contracted bacterial vaginosis, yeast infections, and trich on this job. All have been successfully treated.

Abby understands the potential danger of engaging in unprotected oral, up to but not including ejaculation, with her regulars, "I know it's just as unsafe because there's pre-cum or whatever....I do get tested regularly. I do the blood testing so it's a little bit more accurate. I get tested once every two weeks." For Lulu unprotected exchange sex had dire consequences:

I ended up contracting herpes. I just found out about it and was worried that one of my kids might have it, that I might have given it to them, but thank God I did not.... I'm really lucky I didn't catch AIDS.

Prostitutes who provide unprotected services are also more likely to endorse STI myths than those who do require condoms. Numerous participants in this study verbalized beliefs in erroneous information regarding practices believed to decrease the risk of contracting STIs. Several of these were similar to ideas expressed by South Florida drug addicts surveyed by Metsch, McCoy, Miles, & Wohler (2004). Practices mistakenly assumed to be safe include having unprotected sex with regulars and healthy-appearing ("clean") johns, not allowing the john to ejaculate in the vagina or mouth with little to no concern regarding pre-seminal fluids, and the use of cleaning methods to mitigate infection. Brandy, a 42-year-old Caucasian massage parlor worker, offers her clients "hot towels that are in 380 degrees so they kill any germs or anything." Samantha says:

I always start with the oral so his penis is right in my face so a lot of stuff you see about STDs says that unless there's a major outbreak then it's not transferrable or whatever so I look for that, for signs of outbreaks.... I don't let anyone cum inside me.

Jane, Vivian, and Vicky collectively summarize the frequently voiced belief that oral sex involves no risk. When asked why she does not use condoms for oral, Jane replied, "There's no reason to really. I don't swallow." Vivian purports that performing oral on a man is "proven to be safe without a condom" and a woman receiving oral is "harmless." Even though Vicky performs genital inspections, her insufficient knowledge about STI exposure results in her making precarious choices. "You don't *wanna* suck a raw area, you know, maybe I'll suck it once or twice, but I'll always end up putting a condom on it because, you know, the semen to me seems like there's infection." Other methods by which some participants try to reduce risk include using antibacterial sanitizers and avoiding contact with the ejaculate. Even though she routinely performs oral sex without a condom, Gretchen trusts that "at fewer than 10 clients per week I am in the low volume category and that also lowers my exposure, I think." Niveah, however, remains doubtful that condoms provide enough protection:

The shit that I'm worried about is the shit Ajax won't take off.... I keep a barrier between him and me. I mean, I keep my hand down there even though I use a condom anyways. I don't like to touch them.

Likewise, Susan reasons

If there were things wrong with their *things*, I wasn't doing them....even *with* a condom. Everything that looks good ain't good. Like a bran muffin looks good, but you bite into it, and it's not what it looked how it would taste. You know? But if something looks bad already. If it's got a spot on it, you don't wanna sit up on it. You know? It's like molded bread. I already know I ain't eating that. Don't matter how hungry I am. I be like, "Uh-huh, why's your mold oozing?" That's ok. That's ok. You have to think about the long terms of it. If you go down on somebody that has anything wrong with it, even if it looks pretty, it could be like a Venus flytrap. Looks *real* good until it opens up and gets you.

You never think of a penis like that, but it's true. You never know what's on the inside of it.

Participants in the sample all express some degree of knowledge regarding sexual health issues as well as concerns regarding the risks associated with their occupation. Health concerns consist of pregnancy, the personal cost of contracting an STI, and the collective costs of spreading an STI to others. Internalization of inaccurate health information, or STI myths, contributes to high-risk behaviors. For example, numerous participants do not believe that oral sex is associated with increased STI risk and continue to practice it without consideration of protection.

Stigma and Secondary Deviance

Rational choices are not made in a vacuum and, for the participants of this study, were influenced by their experience of stigma and acceptance or rejection of secondary deviance. However, the application of rational choice theory alone necessitates an analysis of prostitutes' utilities as they impact the action taken without contemplating the underlying reasons for those preferences. This renders the exclusive use of Coleman's rational choice theory inadequate for analyzing prostitutes' sexual health decisions. Stigma and gendered power are key components that must be factored into the analysis.

Trickin': Justifying primary deviance through alternative terminology. Lulu, like many of the participants, expresses cognitive dissonance about labeling and her struggle regarding acceptance or rejection of stigma. Initially she states, "I'm not ashamed of what I did. I'm really not. They can call me whatever they want. Doesn't change who I am. I'm not a bad person." But later in the interview she expresses anger toward a cop who once referred to her as "a known whore." In Lulu's eyes, describing her work with the verb "tricking" was completely acceptable, but tying her identity to a

noun (“whore”) was discrediting. Similarly, while Cadence, a 24-year-old Caucasian escort, acknowledges being a prostitute, she is more comfortable describing the action than the occupational title. “It’s just, you know, a girl’s way of making money. Is it prostitution? Yes, I guess that is what it would be. I call it hustling.”

Sara was visibly displeased by the use of the word “prostitute” during her interview.

It’s kind of like embarrassment. It’s shame....It’s just like something that you don’t like to talk about...that you keep to yourself...you don’t want anybody to know. And you sure don’t *ever* use the word prostitute....Like maybe you would say “get money,” [or] “tricking.”

Melanie describes the shame she experiences from discredibility.

I would never admit to anyone what I do there [transactional sex in the exotic dance club]. It’s easy to do while you’re speeding, while you’re in that environment, but on the outside, in the real world it feels...talking to you about it makes me feel dirty. So it’s a conflict, an internal conflict, for me because I’m ok doing it while I’m doing it, but afterward I’m...I guess I’m ashamed. Ashamed that I *do* it. Ashamed that it’s easy for me *to* do it. Ashamed that I like the money. Ashamed that I get off on the power.

When asked how she felt about the occupational label of prostitute, Melanie responded, “Ashamed and mortified. Let’s just stick with ‘dirty girl.’ A prostitute is a drug using addict that walks the street.” The idea that the label prostitute is synonymous with streetwalker is echoed by Faith, who advertises her services online. When asked what she calls her work, she stated, “I guess I would say, like, escorting. I thought prostitutes just stood on the street and waved to people who drove by.” As a package handler at a large distribution center, occasionally her two identities intersect, which can be “embarrassing sometimes....When people see you on *Backpage* and then see you in public and try to say something to you. That’s awkward.”

Even though Vivian acknowledges participating in transactional sex, she emphasizes, “I’m a *stripper*,” and reasons that she cannot carry condoms as a practical matter of the inability to conceal them in the exotic dance club. When I asked Mary, a 27-year-old Caucasian indoor prostitute who had agreed to provide unprotected services to an undercover detective, to define the work she did for a living, she replied without hesitation, “Degrading.”

Susan employs the neutralization technique described by McCray et al. (2011) to explain how her addiction to drugs made it possible for her to escape the acknowledgment of the label prostitute.

Nope. I just [snaps fingers] did it. It was just like, it was just like he’s got something I want, you know? It’s a tit for tat situation, you know. He’s giving me. I’m gonna give him. Even Steven. And I didn’t think about it, throughout the whole time, even when I was out on the street, I never thought about it like it was prostitution. You know, I never thought about it as prostitution until I got sober....They finally broke me to until I actually admitted that I was ho’in’, that I was actually prostituting myself for drugs because I really didn’t think about it like that. I’m getting something and so he’s getting something. It was just a transaction type of thing, so I never really thought about it through. I never, because I think if I had really thought about it through, the shame, guilt, and remorse would have actually made me not do it, but then my addiction kept me doing it. That’s what it was; it was all about that addiction. It was about feeding that habit. At that point I wasn’t feeling like I was doing anything wrong because it was just sex. You know? Sex didn’t seem like it was such a bad trade.

Jessica, a 24-year-old Caucasian escort, also frames her sex industry work as part of her addiction but simultaneously makes an appeal to higher loyalties when explaining her identity conflict about transitioning from half-hooking in an exotic dance club to working as an outcall prostitute:

What do I call my work? Um...I don’t know...I guess, um, making a living [laughs]. That’s what everybody who works does, right? They make money. You do what you have to do to survive. But, it was easier when I was a stripper. Then, not that I walked around advertising that I danced, but then it was easier to swallow, you know? I was afraid for, like, my family or someone like that to find

out where I worked, but even if they did, that didn't automatically make me a whore. I mean, yeah, I did trick out of the club. That's how all this came about. I got hooked on pills and paying for more and more of those led to hooking....Anyway, this work is a necessary evil that helps me pay for my other necessary evil.

Callie, a 23-year-old Latina massage parlor worker was tearful throughout her interview. She admitted to performing oral sex without a condom during four-hands work, a massage given to one person by two massage parlor workers simultaneously, and was very concerned about her husband discovering her occupation. Being able to limit the sexual transaction to oral services allowed her to justify unprotected contact and shun the label of prostitute:

If he knew what I did for a living, how I make the money I bring home, he would never stay with me. I would do anything to keep him from finding out. I feel [sobs]...I feel dirty, but this is the only way I know to make the amount of money we need. I thought if I didn't have sex, real sex, with guys that made it, not really ok, but I could live with it.

Whores: The positive impact of secondary deviance. Conversely, consider how the following participants exercise agency through their acceptance of secondary deviance. According to Angie, "I think you just adapt....It's hard to explain; it's just one day you're like, you hear the word [prostitute] and you're not bothered by it." When asked if that changed the way she thought of prostitution as a career, she responded, "Yeah...I do separate myself from the street work, the dirty girls. I do safe work [meaning] condoms." Niveah institutes a mandatory condom requirement for all penetrative sex acts with all clients, even regulars.

Oh, I could care less what you call it. I mean, people are like, "I'm an *escort*." [snorts] Oh, ok, so you're a glorified hooker. If you're a hooker, say you're a hooker....You should be proud to be what you are. That's just how I am. I'm a fucking hooker....There's girls going home with guys from bars for \$12 in drinks....And then you wake up...hungover, broke, and, you know, did you use protection? Were you careful?...So you run more risks doing that than doing what

I do. And that's why when people say to me, "You're a ho," I say, "No, baby, I'm a pro. Don't get it twisted."

Exemplified by Niveah's statement is the idea that accepting stigma could possibly lead to more protected sex. This has an interesting correlation with the literature on non-remunerative sex and the perception of condoms as stigmatizing, potentially indicating a promiscuous lifestyle (Dahl, Darke, Gorn, & Weinberg, 2005; Hillier, Harrison, & Ware, 1998; Sacco, Rickman, Thompson, Levine, & Reed, 1993; Wilson, Jaccard, Endias, & Minkoff, 1993). Even though most people recognize condoms for their positive benefits, they may still experience what Dahl et al. term *attitudinal ambivalence*, meaning they have competing beliefs or feelings about them. While they recognize the positive health benefits of condoms, they still may not like certain aspects associated with condom possession or use (e.g., expense, inconvenience, stigma). The ambivalent attitude is easily influenced by a person's assessment of the situation and context. Prostitutes who accept their deviant occupation may experience less attitudinal ambivalence about condoms and hence are more comfortable carrying and using the tools of the trade.

Patrice, a 37-year-old Caucasian indoor sex worker who requires condoms for all high-risk sex acts, defines her occupation as "an escort" and has no difficulty accepting the deviant label. "I do what I do. I been doing it a while. So, no, there's no shame in my game." In her eyes the difference between escort and prostitute is "a fine line. Most people...know what you mean, but it's just like a more proper way of saying it. It's a safer way, especially when you don't know who you're talking to."

Participants who feel stigmatized by their participation in sex work are less likely to require consistent condom use for high-risk sex acts. Instead, when making a decision

regarding protective behavior, they go through a process of calculating their utility, which is situated in the context of a patriarchy. By contrast, those who accept secondary deviance are consistent in their enforcement of sexual health boundaries, requiring protection for all high-risk sex acts.

Gendered Power

In previous research on gendered experiences, such as those encountered by exotic dancers (Barton, 2006; Lewis, 2000) and women who have had cosmetic surgery (Gagné & McGaughey, 2002), authors have noted the conflicting nature of individual empowerment versus group exploitation. While a prostitute's individual agency may be expressed through setting and maintaining condom use standards with clients, this is only possible through the acceptance of the inherent societal power discrepancy by which the privileged male commodifies the female. A prostitute uses her body as a sexual object that may be used for some fee. In doing so, she makes a trade-off: promoting her personal agency at the expense of reinforcing structural gender inequalities (McCray et al., 2011). Thus, the previous consideration of rational choices, as they are shaped by stigma and secondary deviance, are made within the broader context of hegemonic social norms.

Jane's explanation of her relationship with a long-time regular with whom she does not use condoms illustrates some facets of the bargaining process as it intersects with her ambivalence of secondary deviance.

He likes the companionship and the sex without the commitment of a relationship. He knows it's no strings. He don't have to listen to my bullshit. I'm always fixed up when I see him. I make it all about him, and that's what he likes....I would never under any circumstances have a sexual relationship with this man in my real life. He's old, bald, and fat...there is zero attraction for me. Also, I could never be in a relationship that is all about the dude. I have emotional needs too, so this

is just not real. You know? It's work. I don't like to admit it because then what does that make me?....A whore. But if I don't think about it, then maybe I'm one step up from a whore. I've never sucked dick to pay my rent, you know? I'm a stripper, who still tells everybody I'm a waitress. I'm a stripper with weirdo "boyfriends."

Susan situates the transaction between prostitute and john within the context of a traditional, heterosexual non-remunerative relationship.

Most people in a relationship, you know, you don't think of them as using condoms, so if that was something that could help me keep the guy coming back, then I'd use it. But only, like I said, the older ones that were regulars and didn't seem like a threat. With any kind of game that you play, you have to learn how to play it. It's role play, you know? You want that person to come back and see you so you have to make sure that person feels comfortable in your presence. And then you establish a rapport, you know. Maybe they start bringing you something special: a bottle of liquor or beer, a chicken dinner from anywhere, maybe a little bit of extra money in your pocket.

For Jessica, who previously discussed her discomfort with accepting the identity of a prostitute, the bargain begins with the gendered assumption that the man is responsible for providing condoms and is influenced by not only her avoidance of secondary deviance but also elements of utility maximization (e.g., STI myths, addiction, financial need). The exotic dance club setting in which she began her work actually afforded her more power in the transaction.

In the strip club you're kinda limited as to what you can do, but also I just was, I don't know, that was different. That's before I really got into the whole online thing and meeting guys out with the intention of getting paid for sex. Right? So it was more like if a guy asked for something extra, I'd negotiate a tip, but honestly that was so, so different. I mean, the guy is already there in front of you. You have a sense of how much money he's got on him, if he looks clean, if he seems safe and not too pervy, and also what you could get away with at the time. So there's a bunch of stuff to think about real quick but behind it all is how bad do I need the money? It was just pills then, but those aren't free and I still had regular bills, so every shift I worked I had a sense of how much I needed to make. Some guys were just gross and I was like, no way. That's the bad thing now, is that I don't know what's gonna show up at the door [shudders]. Before it was almost like I had a little more control because we'd get so far and I could always stop if I didn't want to and move on to the next one....I don't go buy [condoms].

That's kind of the man's place to get them, isn't it? They're the ones using them. But I know there are things I could catch so I make them wear a condom when we have sex....if he doesn't have any then I'll offer to do something else, blow him or jerk him off....I don't use them for oral....I didn't know I could catch something that way.

Susan also described her work out of a crack house as providing a security that indirectly impacted her transaction negotiations and ability to say no to unprotected activities if she so chose.

Send them to the next one. There's, in a house, there's always somebody who wanna do it if you don't wanna do it. If there's three women in the house, there's always gonna be that one that's gonna do the kinky stuff. Somebody that likes it rough and ready, somebody that like it up the butt, somebody that likes extreme sex. There's just always gonna be that one that is just, whatcha call it, is plain. You know? They all kinds.

She did not worry about turning down a john "because there was always gonna be another one coming down the track. Guaranteed."

Vicky says that additional remuneration was not the only reason she agreed to forego condom use with her regular. "Then I wouldn't use condoms with a lot of the guys that I see because they'll offer." Her decision, fueled by drug addiction, involved patriarchal bargaining.

So we had discussed the whole thing. It was built up to. He didn't just ask me one time and I agreed, you know? And I figured if he had something, I'd have known it by then. I had gotten tested too....That was in my drug days that I agreed to do that with [him] for \$300....Now that I'm level-headed, there's no way I'd do it at all, no matter how much....If the girl is a drug addict and she's weak minded, then yeah, the guy has the power cuz all he has to do is offer the right amount of money...enough money for her to get high. Um, but if the girl's level-headed, then the girl has the power.

The data support that participants are less likely to use condoms with regulars, and the key components outweighing health concerns were trust and adherence to social norms regarding long-term intimacy (i.e., that foregoing condoms is equated with non-

remunerative relationships). In the case of the GFE data collected, the question becomes, would insisting upon condom use terminate the transaction and can the prostitute afford that financial loss? At this point, the prostitute's decision has been simplified to the valuation of health versus money, still influenced by her access to informational resources and the unspoken bargain that is shaped by structural gender inequalities. Others who suffer from addiction may prioritize money for drugs over maintaining their health.

Participant accounts document female prostitutes' struggles to navigate a highly gendered, stigmatized, and health-risky occupation. With every high-risk sex transaction, they are challenged by an opportunity to make a potentially life-altering decision, whether they recognize it as such or not. In doing so, within the context of their existing environment, gendered social location and deviant identity, they balance *interpersonal*, *situational*, and *personal* components.

Whether prostitutes engage in active or passive bargaining is a product of their acceptance or rejection of stigma. Those who reject stigma and embrace secondary deviance utilize active strategies, the outcome of which is condom use during transactional sex. Those who accept stigmatization view themselves as objects and bargain passively, resulting in variable condom use during remunerative sex exchanges. The internalized patriarchal norms are a previously unconsidered part of the preference hierarchy in rational choice decision making, adding an additional layer of complexity to Coleman's model. The present study uses narratives from indoor and outdoor prostitutes about their exchange sex condom use in order to construct a more complete framework

for understanding the sexual health decisions among prostitutes that combines elements of rational choice, stigma, and patriarchal bargaining.

CHAPTER V

DISCUSSION

The prostitution literature includes ample research exploring condom use in transactional sex, but there remains a dearth of material regarding the explanatory factors involved in prostitutes' sexual health decision making. The present study contributes to the extant literature by positing a new theory that aims to overcome that deficit. Rational choice theory assumes humans will act in ways that maximize their benefits and minimize their costs. Coleman (1990) expanded the theory to include so-called *thick* factors that were not of a monetary nature, but even after adding factors like time and trust, the theory has no substantial way to account for societally structured inequalities, nor does it allow for a thorough consideration of issues specific to stigmatized behaviors and groups.

Participants in the present study were classified by consistency of condom use behavior during transactions. Ten reported that they used a condom with every john during penetrative acts. Nineteen had variable condom use during transactions (*intermittent, oral only, oral plus intermittent, and regulars*). For six of the participants, who restricted their work to non-penetrative acts, no condoms were used during their transactional activity. All of the women interviewed who engaged in high-risk sex acts with johns endorsed some amount of protective behavior resulting from active decision-

making processes consistent with a rational choice model (i.e., cost-benefit analysis). Varying combinations of *interpersonal*, *personal*, and *situational* factors were described as means by which a decision about condoms was made. Participants' protective behaviors differed by acceptance of the deviant label prostitute. Those who rejected the deviant label, substituted alternate terminology (e.g., 'tricking', 'making money'), utilized neutralization techniques, and expressed feelings of shame engaged in variable condom use practices as their rational choices were made through a series of *more corporate* gender-scripted bargains (e.g., trust, GFE, the value of the john's business). Women who accepted secondary deviance viewed condoms as a crucial component of their legitimate profession. Their decision to use condoms at all times exemplified the *less corporate* bargain in that they were not willing to compromise their protective behavior; sexual health (their own and that of others) was the primary rational preference considered in utility maximization.

The Whore Paradox

The theoretical framework, and its name, developed from a participant's response to whether she used condoms during transactional sex activity: "That's something a *whore* would do." Jane's inflection on the word *whore* was laden with judgment and exemplified the stigmatization with which women in the profession of prostitution are faced, even by in- group members. For some the word *whore* is disquieting, offensive even, as it connotes dishonor and unworthiness of the woman to whom it is applied. Pheterson (1993) wrote, "Given the social loading of the word *whore*, it is not surprising that linguistic tensions would exist among prostitutes as well as among non-prostitutes" (p. 47). In the prostitution and sex worker rights movement, however, *whore* is being

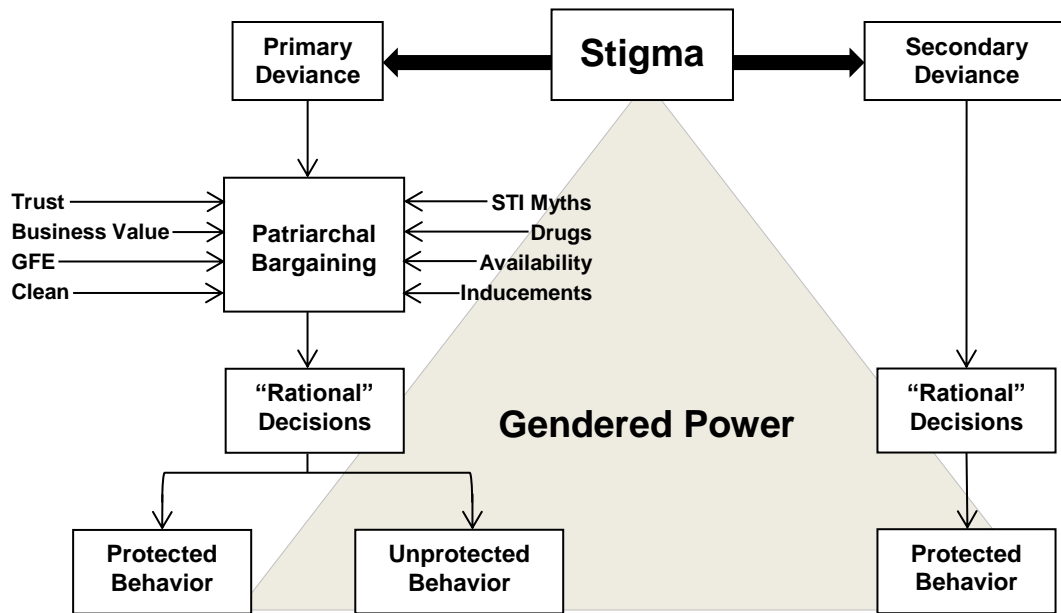
reclaimed. During 1985, in Amsterdam, the *International Committee for Prostitutes' Rights'* first assembly was dubbed *The World Whores' Congress*. Thus the word *whore* was deliberately selected when penning a name for this framework as it simultaneously reflects both responses to the stigma with which prostitutes are faced, from within and without their occupation: the shame and subjugation experienced by those who reject the label as well as the freedom and autonomy that comes from accepting secondary deviance regardless of the application of any label. The paradox is that in United States society, prostitutes are judged negatively regardless of the path they take. One prostitute lives in shame, as society expects her to, consequently making decisions that expose her and others to sexual health risks. In order to shun that subjugation and subsequently engage in safer health decisions, the other prostitute must accept a deviant label that has been crafted according to the norms of a society marked by gender inequality.

This study elucidates factors present in prostitutes' sexual health decisions during exchange sex within a theory that considers both their deviant occupation and gendered social location. *The whore paradox* (see figure 2) is based on two assumptions: Societal power in the United States is gendered, and humans are rational actors. These assumptions impact and are reflected by each component in the model. Dominant society stigmatizes women who engage in sex for remuneration, and the acceptance or rejection of stigma is crucial to the sexual health decisions of prostitutes. Accepting the stigma of being a prostitute leads to secondary deviance, evidenced by a deviant career. Rejecting the stigma is a process by which prostitutes continue to commit acts of primary deviance but actively engage strategies of negating the discreditability associated with being a prostitute. Tomura (2009) has documented a similar contrast in neutralization strategies:

women on one end divide their social world trying to hide the discrediting information and on the other value the merits of their occupation. Both responses have implications for sexual health practices under the umbrella of structural inequality. Essentially, those who accept stigma engage in safer sex than those who do not.

With her statement, “That’s something a *whore* would do,” Jane echoed the sentiment of the many participants who did not accept the deviant label or identity and exhibited more flexibility, hence risk, in their condom use decisions. Some women, like Jane, resisted any form of identification with prostitution; although as a stripper, she was willing to identify herself as a part of the sex industry. Others avoided labels altogether using only verbs to describe their work. For example, Lulu was comfortable with talking about her work as “tricking” but found all nouns for her occupation offensive. Here, *the whore paradox* finds its mate in the sex worker who bears the shackles of stigma and attempts to conform to a bargaining system in which the male has assumed greater power to impact sexually protective behavior. Categorically, these women actively incorporated multiple *personal*, *situational*, and *interpersonal* factors into their preference hierarchies as they negotiated with johns regarding the protection of their own sexual health. Nevertheless, those who accepted the deviant label without shame or regard to stigma, like Niveah’s attitude that she is “a pro” not “a ho,” make a rational calculation that is void of outside influences, including structural inequalities. Hence, *the whore paradox* reflects this confluence of stigma and gendered power as it shapes rational decision making.

In the context of *the whore paradox*, we can liken the self-granted empowerment of those employing the *less corporate* bargain, such as the sub-Saharan African women



of Mwea, to the prostitutes who, as a result of accepting secondary deviance, operate sufficiently free of stigmatization and enforce condom use. Separateness unties the women from weights that would otherwise submerge their ability to self-direct and self-protect.

Figure 2. *The Whore Paradox Model*

Applications of the Model

It is not only in the context of prostitution that *the whore paradox* can find potential. Many behaviors that have accrued the pallor of stigma present their stigmatized participants with the choice either to embrace the fact of the ongoing nature of their conduct or to deny it and as a result fail to enlist the ameliorating power of a *less corporate* patriarchal bargain. *The whore paradox* has the potential to be applied to other sexual health decision makers, deviant groups, and risk-engaging populations, such as male prostitutes, MSM, sexually promiscuous individuals, exotic dancers, drug users, and runaways, among others.

Wesely (2003) presented exotic dancers' body boundaries as fluid. Perhaps that fluidity, an illustration of passive maneuvering, is exclusive to dancers who feel stigmatized. Under *the whore paradox* model it is possible to imagine that exotic dancers who accept the secondary deviance of their occupation are inclined to engage in active strategies by which they set firm limits and do not allow for fluid body boundaries. Similarly, a woman with multiple sex partners (concurrently or consecutively) faces stigmatization stemming from the Cult of True Womanhood patriarchal norms: she is labeled "sexually promiscuous" or "slutty." Her condom use strategies, active or passive, may be explained by the reasoning set forth in *the whore paradox*.

The theory also has implications for the MSM community. The MSM cruising community, for example, is stigmatized not only by the general public but also specifically by the gay community, largely due to the health risk of multiple-partner anonymous sex (Tewksbury, 1996). Men who have sex with other men but are ashamed of their primary deviance and try to conceal their behavior may engage in passive strategies when making sexual health decisions (e.g., avoiding HIV testing and considerations of status, looking for "cleanliness" indicators, allowing availability of condoms to determine whether an exchange is protected).

Contributions to the Literature

The primary contribution of the present study is its introduction to the literature of *the whore paradox*, an explanatory theory of female prostitutes' sexual health decision-making that has the potential to be applied to other groups. Additionally, while acknowledging the underlying male power inherent in a transaction conducted within a patriarchal society, this study shifts the focus from examining johns' power in the

condom use decision-making process to female prostitutes' appraisals of the risks and benefits of protective behavior. Also of note is the nature of the sample. Participants are a mix of indoor and outdoor prostitutes with varied drug histories (i.e., from abstinence to IDU). It offers some insights into the relatively new category of indoor prostitutes known as "half-hookers" or "lite-hooks" who trade sex for gifts, financial assistance, and/or fame but shun identification as a sex exchanger (Quan, 2009). The data show that a number of factors previously identified as contributing to unprotected behavior in outdoor prostitutes (e.g., drugs, regulars, misinformation, and financial need) apply to indoor workers as well. New elements are introduced to the prostitution literature on protective behavior including concerns regarding leaving evidence and the reciprocal nature of trust.

Implications for Future Research

Several considerations for future research present themselves. Chief among them is the potential application of *the whore paradox* to other populations. An investigation of the relationship between condom use and motivations for occupational entry as well as the length of time spent in the sex industry might reveal noteworthy patterns. Few participants in this study discussed violence as a part of their occupational life, but the extant literature has established violence against prostitutes as a serious problem (Romero-Daza et al., 1998; Shannon et al., 2008). Future expansion of this research should directly probe the topic of violence and its potential relationship to sexual health decisions. With only a few exceptions, little has been done to examine sex exchanging exotic dancers (Lewis, Maticka-Tyndale, Shaver, & Schramm, 2005; Maticka-Tyndale & Lewis, 2000; Reuben et al., 2011; Sherman, Lilleston, & Reuben, 2011; Sherman,

Reuben, Chapman, & Lilleston; 2011). Finally, in 2005, Weitzer recommended the need for additional research on gay male prostitutes. Since that time, the CDC has estimated that from 2008 to 2010 alone, the number of new HIV infections among the MSM population increased 12%, suggesting a need to study condom use decision making in gay male prostitutes (2012b).

Limitations

The findings of this study should be considered in light of its limitations. The sample is small (although I have provided rationale for its realization of theoretical saturation), ethnoracially homogenous, and nonrandomly selected. Outdoor prostitutes are under-represented. Interviews are reliant on self-report, so responses may reflect social desirability bias. When possible, I tried to mitigate this bias by comparing participants' verbal accounts to my observation of their behaviors in response to undercover officers as well as to police records of prior investigations. Additionally rapport building and motivational interviewing techniques were used.

Thoughts on Prostitution as a Crime

Under the current organization of the vast majority of the United States' legal systems, prostitution is a criminal act, thus affecting the behaviors of sex workers and limiting their access to resources. Deeming prostitution a criminal act complicates addressing its health implications in an advantageous way. Currently some jurisdictions issue citations for prostitution, requiring only that the alleged offender appear in court, pay a fine, and take an HIV test. Some parts of the United States (e.g., Dallas, TX; Hartford, CT; Phoenix, AZ) already have "prostitution courts," similar to John Schools, that offer diversion options to prostitutes (Shively et al., 2008). The proliferation of STI

myths endorsed by participants in this study indicates a need for sexual health education, which could be added to the consequences of a prostitution charge. This is envisioned as a mandatory course in which STI risk within the context of exchange sex is discussed specifically.

Ericsson (1980) recommends *sound prostitution* in which prostitutes would practice a voluntary, legal occupation that is free from stigma. Sound prostitution's requirement of entry by free will is important to the necessary creation of boundaries for the profession that take into account inexorable economic conditions. Mandates, such as the law requiring condom use and routine STI testing for licensed brothel workers in the portions of Nevada in which prostitution is legal, have been positively correlated with condom use (Albert et al., 1998). The media reflects a growing trend toward attempts to normalize condom use. Prostitutes who require protected sex with regulars contribute positively to the transformation of the social norm regarding condom use acceptance within the context of a long-term relationship.

The link between drug use/addiction and unprotected exchange sex is well-documented in the extant literature. Women who work as prostitutes are highly unlikely to have medical insurance that will cover the necessary treatment, illustrating the need for more subsidized drug rehabilitation programs. Harm reduction programs that distribute condoms should continue their outreach efforts as this study has shown that, particularly in drug-addicted street prostitutes, availability of condoms is an issue. Interventions at these levels are critical to improving prostitutes' choices regarding protective behaviors.

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APPENDICES

Appendix A

IRB Approval Letter



INSTITUTIONAL REVIEW BOARDS

University of Louisville
MedCenter One, Suite 200
501 E. Broadway
Louisville, Kentucky 40202-1798

Office: 502-852-5188
Fax: 502-852-2164

To: Schroeder, Ryan
From: The University of Louisville Institutional Review Board (IRB)
Date: Wednesday, February 08, 2012
Subject: Approval Letter

Tracking #: 11.0728
Title: The Price of Health: Prostitution, Condom Use, and HIV
Approval Date: 1/11/2012 12:00:00 AM
Expiration Date: 1/10/2013 12:00:00 AM

This study was reviewed by the full board on 01/11/2012 and approved contingent upon changes to the study documents. The changes were received and reviewed by expedited review on 01/29/2012. This study now has final IRB approval from 01/11/2012 through 01/10/2013.

Documents/Attachments reviewed and approved:

- Stone Schroeder Brief Protocol, dated 01/13/2012
- Preamble, dated 01/13/2012
- LMPD signature memo, dated 12/15/2011
- LMPD letter, dated 12/20/2011
- Interview Guide with Informed Consent script, Clean, 01/13/12
- Interview Script (Draft), dated 01/03/2012

This action will be reported promptly to the IRB at a scheduled full Board meeting.

Site Approval

If this study will take place at an affiliated research institution, such as Jewish Hospital/St Marys Hospital, Norton Healthcare, or University of Louisville Hospital, permission to use the site of the affiliated institution may be necessary before the research may begin. If this study will take place outside of the University of Louisville Campuses, permission from the organization should be obtained before the research may begin. Failure to obtain this permission may result in a delay in the start of your research.

Privacy & Encryption Statement

The University of Louisville's Privacy and Encryption Policy requires such information as identifiable medical and health records; credit card, bank account and other personal financial information; social security numbers; proprietary research data; dates of birth (when combined with name, address and/or phone numbers) to be encrypted. For additional information: <http://security.louisville.edu/PolStds/ISO/PS018.htm>.

1099 Information (If Applicable)

As a reminder, in compliance with University policies and Internal Revenue Service code, all payments (including checks, gift cards, and gift certificates) to research subjects must be reported to the University Controller's Office. Petty Cash payments must also be monitored by the issuing department and reported to the Controller's Office. Before issuing compensation, each research subject must complete a W—9 form.

For additional information, please contact the Controller's Office at 852—8237 or contro1l@louisville.edu.

The following is a NEW link to an Instruction Sheet for BRAAN2 "How to Locate Stamped/Approved Documents in BRAAN2" if your item was submitted on or after 5/17/10:

<http://louisville.edu/research/braan2/help/ApprovedDocs.pdf/view>

Please begin using your newly approved (stamped) document(s) at this time. The previous versions are no longer valid. If you need assistance in accessing any of the study documents, please feel free to contact our office at (502) 852—5188. You may also email our service account at hsppofc@louisville.edu for assistance.

Best wishes for a successful study. If you have any questions please contact the HSPPO at (502) 852-5188 or hsppofc@louisville.edu.

Thank you.



Board Designee: Quesada, Peter

Once you begin your human subject research the following regulations apply:

1. Unanticipated problems or serious adverse events encountered in this research study must be reported to the IRB within five (5) work days.
2. Any modifications to the study protocol or informed consent form must be reviewed and approved by the IRB prior to implementation.
3. You may not use a modified informed consent form until it has been approved and validated by the IRB.
4. Please note that the IRB operates in accordance with laws and regulations of the United States and guidance provided by the Office of Human Research Protection

(OHRP), the Food and Drug Administration (FDA), the Office of Civil Rights (OCR) and other Federal and State Agencies when applicable.

5. You should complete and SUBMIT the Continuation Request Form eight weeks prior to this date in order to ensure that no lapse in approval occurs.

Letter Sent By: Block, Sherry, 2/8/2012 10:28 AM

Full Accreditation since June 2005 by the Association for the Accreditation of Human Research Protection Programs, Inc.



Appendix B
Informed Consent Letter

<p>UNIVERSITY OF LOUISVILLE INSTITUTIONAL REVIEW BOARD</p> <p>Date Approved <u>2/28/2012</u> Valid Thru <u>1/10/2013</u></p>
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THE PRICE OF HEALTH: PROSTITUTION, CONDOM USE, AND HIV

January 13, 2012

Dear Subject,

You are being invited to participate in a research study about exploring the sexual health of prostitutes by answering the interview questions regarding your sexual health. Because the questions are of a personal nature there is a mild risk of psychological discomfort from your participation in this research study. Participating in the study cannot impact your legal standing in any past, ongoing, or future criminal case. The information collected may not benefit you directly but will help inform social policy in policing and HIV prevention. A copy of the sanitized transcript (i.e., all identifying information will be removed) from your interview will be stored at Lutz Hall on Belknap Campus at the University of Louisville. The interview will take approximately 10-15 minutes time to complete and will be recorded and transcribed.

Individuals from the Department of Sociology, the Institutional Review Board (IRB), the Human Subjects Protection Program Office (HSPPO), and other regulatory agencies may inspect these records. In all other respects, however, the data will be held in confidence to the extent permitted by law. Should the data be published, your identity will not be disclosed.

Taking part in this study is voluntary. By answering my interview questions you agree to take part in this research study. You do not have to answer any questions that make you uncomfortable. You may choose not to take part at all. Even if you decide to be in this study, you may stop taking part at any time.

If you have any questions, concerns, or complaints about the research study, please contact: Dr. Ryan Schroeder, (502) 852-8010.

If you have any questions about your rights as a research subject, you may call the Human Subjects Protection Program Office at (502) 852-5188. You can discuss any questions about your rights as a research subject, in private, with a member of the Institutional Review Board (IRB). You may also call this number if you have other questions about the research, and you cannot reach the research staff, or want to talk to someone else. The IRB is an independent committee made up of people from the University community, staff of the institutions, as well as people from the community not connected with these institutions. The IRB has reviewed this research study. If you have concerns or complaints about the research or research staff and you do not wish to give your name, you may call 1-877-852-1167. This is a 24 hour hot line answered by people who do not work at the University of Louisville.

Sincerely,



Ryan D. Schroeder, Ph.D.



Maggie B. Stone, M.Ed.

Revised 02/16/12

Appendix C

Interview Protocol

My name is Maggie Stone. I'm a student conducting research at the University of Louisville that explores the sexual health of prostitutes. I know that a lot of guys go to prostitutes and in general a lot of people have sex without a condom. I'd like to ask you some questions if you're agreeable. There are some things you should know before agreeing to talk to me.

First, your participation in this study is strictly voluntary. You can answer all, some or none of my questions. We can stop the process at any point and the police will tell you what you need to do next. Second, if you choose to participate, your information will remain confidential. I will not report identifying information, such as your name, etc. Second, participation has no influence on your legal standing in this, or any other, criminal case. In other words, from a legal standpoint answering my questions today cannot hurt or help you. Third, you won't get paid or otherwise compensated for participating in the study. Fourth, some of the questions I will ask may seem personal or bring up issues that make you uncomfortable. Again, I want to stress that you do not have to answer any questions that make you feel this way. Finally, I cannot interview you if I believe that you are under the influence of any substance.

I would like to record, and later transcribe, our conversation today. I will give you control over the recording device so that you have control over what is recorded and what is not.

Do you agree to participate in this study? If so, please say back to me the risks and benefits I just explained. Here is contact information for the University of Louisville, the university's Institutional Review Board (IRB), and the principal investigator.

1. What's your highest level of education?

2. How long have you been in this field?

Potential Probes

a. *Only elite/only street?*

3. What other kinds of jobs have you held?

Potential Probes

a. *Occurrence & duration?*

b. *Overlapping prostitution?*

4. Current employment status?

5. How do you feel about being called a prostitute?

Potential Probes

a. *Trying to get at cognitive dissonance idea*

6. Tell me about the sex acts you're typically asked to perform

Potential Probes

a. *Consideration of risk (increased or decreased?)*

b. *Does location matter? – Convenience*

c. *Does time of day matter? – Concealment*

7. **When you have oral sex with a customer, approximately what percentage of the time do you use a condom?**
8. **When you have vaginal sex with a customer, approximately what percentage of the time do you use a condom?**
9. **When you have anal sex with a customer, approximately what percentage of the time do you use a condom?**
10. **How often do you ever bareback with a customer?**

- a. **For which sex acts?**

Potential Probes

- i. *Oral?*
- ii. *Vaginal?*
- iii. *Anal?*
- iv. *Who typically brings up the topic? You or customer?*

- b. **Is risk a consideration?**

- c. **How do you make the decision of whether or not to bareback with a customer?**

Potential Probes

1. *He looks clean?*
2. *He offers extra money?*
 - a. *If so, how much extra do you need?*
 - i. *Is willingness to bareback for extra money dependent upon situational context?*
 1. *Need for money*

2. *Need for drugs*

3. *Do you consider the value of your health?*

4. *Intoxicated (alcohol)?*

5. *Intoxicated (drugs)?*

11. How much do you charge to bareback with a customer?

CURRICULUM VITA

Maggie B. Stone, M.Ed.

Department of Sociology, 122 Lutz Hall
University of Louisville
Louisville, KY 40292
maggie.stone@louisville.edu

EDUCATION

Ph.D. Applied Sociology

University of Louisville, Anticipated Completion May 2014

M.Ed. Counseling Psychology & Personnel Services

University of Louisville, 1999

B.A. Psychology, Minor in Social Sciences

B.A. Music

Summa cum Laude, University of Louisville, 1995

PROFESSIONAL POSITIONS

Graduate Research Assistant, August 2013 to present

Graduate Teaching Assistant, July 2010 to July 2013

Adjunct Instructor, March 2008 to June 2010

Business Owner, January 2003 to present

Licensed Psychological Associate/PASRR Evaluator, May 1999 to May 2005

Sex Offender Treatment Program Psychology Intern, August 1998 to May 1999

TEACHING EXPERIENCE

University of Louisville, Louisville, KY

August 2010 to current

Preparing and teaching courses independently

- Research Methods (303) – Summer 2013 (1), Fall 2013 (1), Spring 2014 (1)
- Social Statistics (301) – Spring 2012 (1), Fall 2012 (1), Spring 2013 (1)
- Diversity and Inequality (323) – Fall 2011 (1), Summer 2012 (1)
- Introduction to Sociology (201) – Fall 2010 (2), Spring 2011 (2), Summer 2011 (1)

Assisting faculty with courses

- Seminar in Statistics I (609) Fall 2011 (1)
- Social Statistics (301) Fall 2011 (1)

ITT Technical Institute, Louisville, KY

September 2009 to July 2010

- Research Methods (1)
- World Culture (1)
- Social Psychology (4)
- Ethics (1)
- Introductory Psychology (4)
- Group Dynamics (5)
- Professional Development (1)
- Technical Professional Strategies (3)

Sullivan College of Technology & Design, Louisville, KY

March 2008 to June 2010

- General Psychology (7)
- Environmental Psychology (9)
- Conversational Spanish (4)
- Introductory Sociology (4)

SCHOLARSHIP

Publications

Maggie Stone. (2014). Institutional Review Boards and Studying Deviance. In H. Copes and C. J. Forsyth (Eds.), *Encyclopedia of Social Deviance*. Thousand Oaks, CA: Sage.

Maggie Stone. (Forthcoming). "This Could be a Good Avenue for You": Influential Strategies in the Hiring of Exotic Dancers. *Deviant Behavior*.

Professional Papers

Carol Norton, Lauren Heberle, Allison Smith, **Maggie Stone**, and John Vick. (2013). *State of Metropolitan Housing Report 2013*. Center for Environmental Policy and Management. Prepared for the Metropolitan Housing Coalition, Louisville, Kentucky.

Australian Housing and Urban Research Institute. (2011). *Secure occupancy in rental housing: conceptual foundations and comparative perspectives* (AHURI Final Report; no. 170). Melbourne: Australia. AHURI Research Centers.

Papers In Progress

Maggie Stone. The Whore Paradox: "Rational" Condom Use Decisions among Prostitutes in the Context of Stigma and Patriarchal Bargaining. (Dissertation)

Maggie Stone and Ryan Schroeder. "If He Looks Clean":...A Rational Choice Analysis of Condom Use Decisions in Prostitution.

Maggie Stone and Bryan Hamilton. The Criminal Justice System's Biases toward Exotic Dancers.

Richard Tewksbury and Maggie Stone. An Oral History of the House of Ruth.

Papers Presented At Professional Meetings

Maggie Stone. "If He Looks Clean":...Condom Use Decisions in Prostitution. Presented at the 2013 *North Central Sociological Association* conference, Indianapolis, IN.

Maggie Stone. House of Ruth: Proposal for an Outcome Evaluation of a Southern HIV/AIDS Organization. Presented at the 2013 *North Central Sociological Association* conference, Indianapolis, IN.

Maggie Stone, Muhamed Fazlagic, and Rob Shelby. A Proposed Impact Evaluation of United 1996 Futbol Club. Presented at the 2013 *North Central Sociological Association* conference, Indianapolis, IN.

Maggie Stone. "This Could be a Good Avenue for You": Influential Strategies in the Hiring of Strippers. Presented at the 2012 *North Central Sociological Association* conference, Pittsburgh, PA.

Maggie Stone. Wrap it up: Correlates of Condom Use Among Male Patrons of Female Street Prostitutes. Presented at the 2010 *Anthropologists and Sociologists of Kentucky* conference, Columbia, KY.

RESEARCH INTERESTS

- Prostitution
- Sexual Health and Deviance
- Self-targeted Deviance

TEACHING INTERESTS

- Research Methods
- Statistics
- Human Sexuality

GRANTS RECEIVED

Internal Grant Award, Sullivan University, Spring 2014

Graduate Student Council Travel Funding Grant, University of Louisville, Spring 2013

Graduate Student Union Travel Funding Grant, University of Louisville, Spring 2013

Graduate Student Union Travel Grant, University of Louisville, Spring 2012

Graduate Student Union Research Funding Grant, University of Louisville, Fall 2011

ACHIEVEMENTS & HONORS

Grant Writing Academy, University of Louisville, 2013-2014

Graduate Research Assistantship, University of Louisville, 2013-2014

University of Louisville Sociology Department's Outstanding Teaching Award, 2013

Internship, Narcotics Division, Louisville Metro Police Department, 2011-2013

Graduate Teaching Assistantship, University of Louisville, 2010 - 2013

Jules Delambre Student Paper Contest, 2nd Place, A, 2010

Graduate Research Assistantship, University of Louisville, 2009

Graduate Dean Citation, University of Louisville, 1999

SERVICE

Professional Service

Manuscript Reviews for *Contemporary Journal of Anthropology and Sociology*,

Textbook Reviews for *Sociology 13th ed.* (McGraw-Hill), *NYU* (Pearson)

Departmental Service

Sociology Graduate Student Association (SGSA), Member, 2010-2014

SGSA, Vice President, 2011-2012

SGSA, Personnel Committee Representative, 2011-2012

Other Service Activities

Louisville AIDS Walk, Team Captain, 2012-2013

Little Loomhouse (The Lou Tate Foundation), Volunteer, 2008 – current

School of Music Alumni Council, Board Member, University of Louisville, 2007-2012

The Cabbage Patch Settlement House, Inc., Volunteer, 2005 - current

PROFESSIONAL ASSOCIATIONS

American Sociological Association, Member, 2013-2014

Sociologists for Women in Society, Member, 2013-2014

The Midwest Sociological Society, Member, 2011-2014

North Central Sociological Association, Member, 2011-2014

CAREER HIGHLIGHTS

Business Owner

StudioCRS, Inc. and Design4BB Graphics, Louisville, KY

January 2003 to current

- President of architectural & graphics firms located in Louisville, KY.

Licensed Psychological Associate

Seven Counties Services, Inc., Louisville, KY

May 1999 to May 2005

- Conducted Mental Illness and Mental Retardation/Developmental Disability psychological testing, staff in-services, community education and outreach.
- Administrative and supervisory duties, including management of a 12 person staff.

Psychology Intern

Sex Offender Treatment Program, Kentucky State Reformatory (KSR), LaGrange, KY

August 1998 to May 1999

- Counseling, psychological assessments, and parole reports for incarcerated male inmates.