Choice, Circumstance, or Coercion: Prostitution Stigma's Effects on Mental Health Professionals' Perceptions of Sex Workers and Sex Work

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ABSTRACT

Choice, Circumstance, or Coercion: Prostitution Stigma's

Effects on Mental Health Professionals' Perceptions of Sex Workers and Sex Work

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Historically, psychological theory and mental health researchers have viewed sex work as inherently harmful to sex workers and capable of producing negative mental and physical health effects (Sprankle et al., 2018). Moreover, research focused on clinicians' expectations for sex workers in therapy has not specifically examined clinicians' attitudes toward sex workers or sex work as separate concepts (Benoit et al., 2015; Koken, 2011; Ma et al., 2017). In addition, mental health professionals may not view sex work as legitimate work because of the virtual lack of evidence-based theoretical frameworks for guiding therapy for sex workers, and, therefore, may use prostitution stigma as a substitute for theory (Krumrei-Mancuso, 2017; Williamson & Cluse-Tolar, 2002). The present study investigated the extent to which mental health professionals' expectations of sex work and sex workers were related to prostitution stigma and their perceptions of sex workers' overall mental health and evaluations of sex work as decent work. In particular, the study investigated the extent to which mental health professionals stigmatized the work of sex workers. Mental health professionals ($N = 201$) read a clinical vignette and completed an online survey containing a demographic information sheet, the Attitudes Toward Prostitutes and Prostitution Scale (Levin & Peled, 2011); (c) the Decent Work Scale (Duffy et al., 2017), (d) the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1986), and (e) the PTSD-8 (Hansen et al., 2010). Results from

multivariate multiple regression analyses supported that when mental health professionals held higher levels of stigma towards sex work and sex workers, they may diagnose the client with higher levels of PTSD symptoms. Further, the results supported that endorsement of a feminist orientation moderated the relationship between sex work stigma and diagnosis clients' PTSD avoidance symptoms. The discussion included methodological limitations and implications for research and practice.

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Chapter 1

Introduction

Sex work, which is colloquially referred to as "the oldest profession," is a source of income for between 1% and 4% of adults in today's global market (Benoit et al., 2017; Vandepitte et al., 2006). In the United States, sex work historically and currently is a highly charged and debated topic, as evidenced by ongoing legal, social, and stigma related actions towards sex workers (Ward & Roe-Sepowitz, 2009). Though sex workers make up a considerable proportion of the labor force of the world, several studies suggest that sex workers may need mental health services, in part due to prostitution stigma. *Prostitution stigma* is defined as society's derogatory labeling, stereotyping, and discrimination toward sex workers, which reduces sex workers to inaccurate stereotypes and generalizes the negative perceptions of them as people to their work (Benoit et al., 2017; Link & Phelan, 2001; Koken, 2012; Koken et al., 2004; Pheterson, 1990; Scambler, 2007).

Possible treatment-related stereotypes are inherent in mental health, specifically, psychoanalytic, feminist, and neo-abolitionist/radical feminist theoretical orientations. These include assuming that sex work is coerced work and, therefore, sex workers are traumatized, exploited victims of childhood abuse, from low-income families, have inadequate skills, and/or use illegal substances (Benoit et al., 2015). If mental health service providers hold such perspectives, then prostitution stigma may influence how they diagnose sex workers as clients as well as the career-related services that they provide to sex workers. Yet very little is known about mental health professionals' perceptions of sex workers even though research suggests that sex workers may not seek

therapy because they fear that service providers may engage in prostitution stigma (Chakrapani et al., 2009; Ghimire et al., 2011).

Historically, mental health research has excluded the role of prostitution stigma and its effects and only viewed sex work as inherently harmful producing negative mental and physical health effects (Sprankle et al., 2018). Given the virtual lack of evidence-based theoretical frameworks for guiding therapy for sex workers, mental health professionals may be unable to view sex work as legitimate work and may perpetuate prostitution stigma as a consequence (Krumrei-Mancuso, 2017; Williamson & Cluse-Tolar, 2002). Further, in this study, the word sex work and sex workers are used intentionally because the more inclusive terminology highlights the economic and labor aspect of the sale of sexual services and attempts to mitigate the stigma associated with terminology such as prostitute or sex trafficked (Kotiswaran, 2001). For this study, we recognize and understand the diversity and heterogeneity of work within the commercial sex industry, and as such, we classify sex workers in a broad umbrella term to capture the experiences of mental health professionals because supposedly, mental health care providers might be engaging with people who do a variety of types of sex work. Although some sex workers may experience traumatic events and exploitation, there is very little research that differentiates involuntary, coerced, and circumstantial sex work from voluntary and consensual sex work. Therefore, it is not clear what types of interventions and treatments are most appropriate for what types of sex workers or whether mental health care providers make clinical evaluations and diagnoses based on prostitution stigma regardless of the nature of their clients' sex work. Of note, the above perspective is situated in a decriminalization framework, which is often in opposition by

those politically classified by the end-demand or neo-abolitionist framework, which will be highlighted later.

Theoretical Perspectives on Sex Work as Applied to Mental Health Professionals

The theoretical debates about sex work usually concentrate on women and their position within the sex industry (Pitcher, 2013). On one extreme is the abolitionist perspective, which argues that all sex work is non-consensual and is a re-enactment of exploitative patriarchal power (Farley, 2004). On the other end of the spectrum are those that argue individuals enter the sex industry for a variety of reasons, which have yet to be fully understood within the mental health field. However, within mental health, three theoretical perspectives have been proposed to guide clinical interventions with sex workers, specifically (a) psychoanalytic (Caprio & Brenner, 1961; Freud, 1905), (b) liberal feminist and neo-abolitionist/radical feminist (Bindel, 2017; Levin & Peled, 2011), and (c) decency of work or labor right-to-work (Vanwesenbeeck, 2017). Though each of these theoretical perspectives is often thought of as fringe, esoteric, or outdated, many of their theoretical arguments can still be observed in more contemporary theories (Fonagy, 2012). Further, many researchers have noted that the conflation between sexual exploitation and sex work often muddy theory and treatment interventions (Vanwesenbeeck, 2001); as noted by Herzog (2008) in general, there are attitudinal disparities in the general public about survivors of sexual exploitation, which is difficult to separate from values of mental health professionals. An example of this conflation of sexual exploitation and sex work can be observed in Okech et al.'s (2018) methodology.

The first two theoretical perspectives focus on the intrapsychic characteristics of sex workers that lead them to engage in sex work, whereas the latter theoretical

perspective focuses on the work itself. While the first two theoretical orientation may not have the substantial following within the mental health community, these theories and intervention recommendations are broad spanning and often are found in more contemporary theoretical perspectives.

Intrapsychic Theories

Psychoanalytic theorists argue that women who engage in sex work are essentially developmentally fixated at the phallic and anal stages and consequently are unable to control their pleasure-seeking drive. Lack of self-control allegedly results in engaging in sexuality and performing sexual acts in nonnormative or non-feminine ways (i.e., through sex work). Liberal feminists contend that women engage in sex work because of lack of economic choice and substance use, while radical feminist often cites sexual deviance and male domination of women or girls (Bindel, 2017). If health professionals ascribe to any of these perspectives, maladaptive personalities, or dysfunctional environments, the basic principles might be inherent in mental health services related to their diagnoses of sex workers.

Work Theory

There are essentially two work perspectives that offer opposite perspectives on the nature of sex work, neo-abolitionist feminism, and psychology of work theory. The key argument of the neo-abolitionist feminist perspective is that sex work is inherently a manifestation of male violence and aggression that preys upon the most vulnerable individuals in society (Bettio et al., 2016). Proponents of the neo-abolitionist lens argue that sex work, rather than other life circumstances, is intrinsically traumatizing and cite a

variety of symptoms identified by researchers (e.g., dissociation, substance abuse) to support their position (Krumrei-Mancuso, 2017; Lazarus et al. 2012; Villano et al. 2004).

In contrast, the psychology of working theory (PWT; Duffy et al., 2016) uses the International Labor Organization definition of decent work as to how the person/worker feels about work rather than how others perceive it. PWT is consistent with the labor right-to-work perspective which describes decent work primarily in terms of structural factors (e.g., safe working conditions, fair pay; MASWAN, 2018; Spankle et al., 2017). Therefore, according to Duffy et al., decent workers may be defined in terms of potentially positive personality and interpersonal characteristics of the (sex) worker, such as (a) self-determination, (b) survival and power, and (c) social connection. Decent (sex) work may (a) provide a source of income, (b) enhance the workers' personal worth, and (c) provide workers the freedom to set their own schedules (Krumrei-Mancuso, 2017). By using PWT to conceptualize the nature of sex workers' relations to their work, clinicians can begin to understand the sociocultural factors that underlie sex workers' work choices rather than assuming that they are all necessarily victimized or maladjusted.

The Study

If mental health professionals engage in prostitution stigmatization, they risk creating clinical environments in which sex workers may come to believe that they deserve violence, bias, and discrimination and that such factors are an inevitable part of sex work (Lyons et al., 2017; Sallmann, 2010). When sex workers fear the judgment of mental health care providers, they do not engage in services (Benoit et al., 2016; Lazarus et al. 2012). For example, Bungay et al. (2013) reported that sex workers often chose not to disclose their occupation because of fear that health care providers would become

fixated on their own assumptions about the sex workers' occupations rather than on the sex workers' presenting problem(s).

The research focused on clinicians' perceptions of expectations for sex workers in therapy has not focused specifically on their attitudes toward sex workers or sex work as separate concepts (Benoit et al., 2015; Koken, 2011; Ma et al., 2017). The study sought to investigate the extent to which mental health professionals' perceptions of sex work and sex workers are influenced by prostitution stigma and the extent to which it relates to their perceptions of sex workers' overall mental health and evaluations of sex work as decent work. In particular, the study investigated the extent to which mental health professionals stigmatize the work of sex workers. Developing an understanding of whether mental health professionals' attitudes towards sex workers and sex work are biased is essential for providing quality mental health care for sex workers and training for mental health care providers.

Chapter 2

Review of Literature

It is important to understand whether or how prostitution stigma is manifested among mental health professionals. Prostitution stigma may inform mental health professionals' clinical conceptualizations of sex workers; it might also affect their perceptions of the work of sex workers. Either bias focused on the workers or bias directed towards their work would ultimately lead to a lower or misguided quality of therapy or career services offered, perhaps regardless of the sex workers' presenting problem(s) (Chakrapani et al. 2009**)**. Carter and Dalla (2006) stated that sex workers are a highly stigmatized population that needs mental health treatment and interventions. According to Herman (2004), sex work itself is a subject that is rarely discussed among mental health professionals in any training or clinical context. Moreover, virtually no research has examined mental health professionals' views of sex workers from a research perspective.

Therefore, the purpose of the study was to investigate whether prostitution stigma influences mental health professionals' perceptions of the mental health of sex workers and their work. In support of these questions, I provide (a) an overview of prostitution stigma (Pheterson, 1993), (b) present implications of prostitution stigma for mental health professionals' views of sex workers (Benoit et al., 2016; Chakrapani et al. 2009; Vanwesenbeeck, 2001), and (c) a rationale for sex work as decent work (Harcourt et al., 2005; Shannon et al., 2014). Whenever it is possible, I use psychological theories to discuss the relevant issues because existing research tends to be atheoretical (Brannigan & Van Brunschot, 1997).

Prostitution Stigma

Although research has rarely focused on mental health professionals' use of prostitution stigma as opposed to sex workers' perceptions of their use, stigma more generally is a widely used concept in the mental health fields and is often associated with negative health outcomes (Beniot et al., 2015). Goffman (1963) defines stigma as operating to label individuals that offend the norms of society by not what they do but what they are. According to Link and Phelan (2001), *stigma* is defined as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination and must occur in relationships in which one party has power over the other. According to this definition, if mental health professionals have power over their clients who do sex work, they might express negative behaviors and thoughts when treating them consistent with prostitution stigma as previously defined.

Empirical Studies of Stigma

Much of the research on prostitution stigma has focused on the health care needs of sex workers (Scambler & Paoli, 2008; Valera et al., 2000; Wahab, 2004). Importantly, researchers continue to seek to identify key barriers to adequate health care and mental health care access for sex workers, the lack of which they attribute to health care providers' potential belief in prostitution stigma (Cohan et al. 2006; Kurtz et al., 2005; Lazarus et al. 2012; Scambler & Paoli, 2008; Wahab, 2004). Thus, some studies have investigated sex workers' experiences with or expectations of care providers as barriers.

In the only study to measure prostitution stigma and its association with barriers to health care directly, Lazarus et al. (2012) conducted structured interviews of female street-based sex workers ($N = 252$), who were recruited from a community-based HIV

prevention research project. Their independent variable was prostitution stigma, which they defined as sex workers' hiding their involvement in sex work from family, friends, and community members. The dependent variables were agency barriers to accessing health care (e.g., limited hours of operation, long wait times, not knowing where to access services, language barriers, and poor treatment by providers). After adjusting for confounding variables (e.g., education level), they concluded that prostitution stigma was associated with sex workers' experiencing barriers to health care. However, their operational definition of prostitution stigma was based on the sex workers' attitudes and behaviors and perceptions of agency barriers rather than mental health professionals' adherence to prostitution stigma.

In a qualitative study, Whitaker et al. (2011) investigated illegal substance-using sex workers perceived and internalized stigma from frontline workers (doctors, nurses, and social workers). Their sample was current and former street-based female (n=31) and male (n=4) sex workers. The sex workers reported that when accessing substance use prevention services, they were treated as "dirty and undeserving of respect" by frontline workers.

In a study that is also relevant to the question of identifying mental health professionals as barriers to care, Wahab (2004) interviewed adult female sex workers (*N* = 6), who worked as escorts, street-based providers, and erotic dancers. She found that the sex workers reported experiencing mental health professionals as viewing and treating them as helpless victims and, therefore, they felt a loss of agency over their survival choices, which included feeding their children and protecting themselves from harm. Although Wahab's study did not investigate prostitution stigma specifically, it is

notable that sex workers were reporting disempowering experiences perceived as being perpetrated by mental health professionals.

To understand the barriers to sex workers' access to care, Kurtz et al. (2005) conducted a mixed-method study using surveys and interviews with female, street-based sex workers (*N*=586). Many of their participants were homeless (42%), had not completed high school (43%), were using crack cocaine (73%), and reported having experienced childhood sexual abuse (53%). Kurtz and colleagues reported that 60% of sex workers needed acute services, such as shelter, fresh water, transportation, crisis intervention, drug detoxification, and mental and physical health care. Nevertheless, sex workers perceived structural barriers (e.g., not being the programs' target population, travel costs, and mental health professionals' office hours) rather than mental health professionals' biases.

Summary

Despite researchers' inferences from studies of treatment barriers that mental health professionals engage in prostitution stigma, none of the limited studies has investigated mental health professionals' attitudes about sex workers (Wahab, 2004). Although restricted access to mental health facilities may result from prostitution stigma, there is no evidence that mental health professionals create or control institutional and individual treatment barriers (e.g., travel costs, office hours) that have been previously studied (Kurtz et al., 2005). Sex workers have reported hiding their occupations to receive non-judgmental treatment from providers (Lazarus et al., 2012), but there are potentially many reasons why a sex worker might not be obtaining adequate care.

Therefore, it is important to understand the role of prostitution stigma in mental health professionals' treatment plans for sex workers.

Theories of Prostitution Stigma in the Mental Health Field

Essentially two theoretical perspectives have contributed to prostitution stigma in the mental health field: (a) psychoanalytic theory and (b) feminist theory. To the extent that mental health service providers received training according to either of these theoretical frameworks, one can safely assume that they would express treatment goals consistent with their professional training. In addition, they might share the socialized views of society toward sex workers, especially women.

Psychoanalytic Theory

Most psychoanalytic perspectives have a common belief that all sex workers are women or girls and that there is something pathological about someone who wants to engage in sex work. Psychoanalytic theories focus on the presumably pathological internal characteristics of female sex workers and, in doing so, have helped shape prostitution stigma for mental health professionals who use the theories as acknowledged or unacknowledged theoretical frameworks.

Freud (1905) put forth the argument that women who engaged in sex work were unable to internalize feelings of shame because they were fixated in early childhood developmental stages (i.e., anal and phallic stages) and had inadequate socialization that resulted in an inability to control their impulsive pleasure-seeking drives. Accordingly, the pleasure-seeking drive led women to engage in sexual deviance that prevented them from engaging in "normal" sexual pleasure and relationships. Another psychoanalyst, Abraham (1942), put forth the argument that women who engaged in sex work had an

inability to repress animalistic urges (e.g., lust or aggression). Also, Lampl-de Groot (1928) diagnosed women sex workers as having extreme cases of Electra complexes, which was a psychoanalytic conception of young women competing with their mothers for their fathers' attention.

In the 1950s and 1960s, the psychoanalytic perspective shifted the common explanations of women sex workers from inappropriate expressions of heterosexual urges to the repression of homosexual urges. During this time, it was hypothesized that women who engaged in sex work needed to repress female lesbian inclinations through hyperactive heterosexual activities (Caprio & Brenner, 1961).

In sum, psychoanalytic theorists pathologized the involvement of women or girls engaging in what theorists presumed were non-normative sex practices. The three overarching theoretical principles that have characterized psychoanalytic theory's conceptualizations of sex workers are (a) they are not able to control their pleasure-seeking drives; (b) the women's pleasure-seeking is an expression of their animalistic urges; and (c) sex workers' development of human sexuality results from fixations at early psychosexual stages or repressed lesbian inclinations. These principles might affect how mental health professionals diagnose sex workers' presenting problems.

Liberal and Radical Feminism

Feminist organizations, in both United States and Great Britain, had a focus on sexual slavery or White slavery, which was considered the sexual trafficking of White women being tricked by foreign men (Jews, Chinese, Italians, etc.) (Bromfield, 2016). This allowed for a narrative that presumed that White women needed saving and rescuing from their captors. Further, there are accounts of a feminist during the progressive area

that conflated individuals who were doing sex work with those who were being trafficked. Bromfield draws parallels between this historical perspective and modern feminism and policy initiatives such as TVPA and other Human Trafficking policies. Moore (2015) reviewed the literature and found that most U.S. based NGOs that combat trafficking, many using feminist principles, interchange terms like trafficking with sexual exploitation, prostitution, and porn to bolster the number of supposed trafficking individuals.

Because of radical and liberal feminist theoretical assumptions, mental health researchers began to investigate sexual trauma as the primary reason for female's entry into the commercial sex industry (Vanwesenbeeck, 2001). During the 1970s women's movement, liberal feminism, which focused on employment, sexual reproduction, sexuality, and family, helped change and shape a new narrative of sex workers in which women's sexual experiences were shifted away from pathological personality factors as causative to emphasizing negative environmental, social, and personal experiences (Levin & Peled, 2011). Radical feminists' explanation of sex work was that it is a power struggle between women as objects and men as people who own objects, thus making sex work a version of slavery, regardless of whether the woman has entered the work voluntarily (Barry, 1995). According to the radical feminist perspective, sex work can only be transactional and is inherently violent (Bindel, 2017).

Based on the conceptualizations of sex work as exploitative, researchers in the 1970s and 1980s continued to associate sex workers with mental illness (e.g., addiction to illegal substances) and dysfunctional environments (e.g., neglectful families and parental abuse) (Arnold et al., 2000; Carter, 2003; Farley et al., 2003; Gur, 2004). Liberal and

radical feminism have shaped contemporary thoughts and research on sex workers' experiences. Their views of sex work as resulting from traumatic personal or environmental conditions exclusively has skewed the type of research focused on sex workers. Nevertheless, regardless of the specific type of feminist theory from which hypotheses have been derived, each of them assumes that individuals engage in sex work because of the domination of women or girls by men and/or sex work as inherently traumatic.

Current Continuum of Mental Health Services

Currently, mental health interventions attempt to provide interventions to individuals who enter the sex industry through the circumstance or choice. Those who are coerced into sex work are not the focus of this study; however, adequate services should be provided to those individuals. For an overview of these services, see (Hammond & McGlone, 2014; Roe-Sepowitz et al., 2014). Researchers cite sex workers may have the following needs: (a) services for those who have experienced violence, (b) substance use, (c) homelessness, (d) low self-esteem, (e) harassment from police and communities, (f) interaction with the criminal justice system or incarceration, and (g) negative experiences accessing medical, legal, or mental health services (Pitcher, 2013). However, of note, most research has been conducted on street-based workers, so it is unclear if these needs are true for all sex workers (i.e., brothel-based, escorts, web-cammers) who may have entered through choice and circumstance (Sanders, 2004). For individuals who have entered the commercial sex industry out of choice and circumstance, there are few if any mental health services available beyond social service, community-based outpatient, and criminal justice diversion programs (Preble et al., 2016). In part, mental health services

are difficult to obtain because of individual, relational, structural, and institutional barriers that prevent sex workers from exiting the industry (Baker et al., 2010), as well as lack of adequate harm reduction programs (Mayhew & Mossman, 2007; Whose Corner).

Examples of exiting programs are SAGE (now closed), and Veronica's Voice and their services include counseling, case management, street outreach, prostitution offender remediation, prostitution diversion programming, and medical intervention. Programs, such as SAGE and ROSE, also are survivor run programs that help to address the social, political, and economic difficulties that many clients face (Hotaling et al., 2004; Roe-Sepowitz et al., 2014) and are often operating from a harm-reduction standpoint that offers flexibility in the delivery of service than traditional providers (Roe-Sepowitz et al., 2014). One component of formal exiting programs is that individuals recognize or concede that sex work is a form of sexual exploitation (Davis, 2000). While this a well-intended value of many intervention programs, it often leaves those who do not wish to identify as a victim looking for alternative services (Wahab, 2002). Most exiting programs often only cater to street-based sex workers or incarcerated sex workers. While these individuals do need services, they are not the only profession of sex workers that may like to exit the industry. Most exiting programs operate from a harm-reduction framework that is in the theoretical lineage of psychodynamic theory and further, housed in radical and liberal feminism that suggests that any exchange of sex for services is a form of exploitation, circumstance, or domination (Kennedy et al., 2007). An example of a program that attempts to operate outside of this model is YANA, where "staff members are strong proponents of women's rights to self-determination, and they provide the

women with services they need without any expectation that they desist from prostitution." (Wiechelt & Shdaimah, 2015, pp. 173).

Summary

Psychoanalytic theory and liberal and radical feminism each present negatively biased theoretical explanations of sex workers and sex work. While some are exiting programs, peer-run, and rooted in harm-reduction in attempts to decrease stigma, at the core, there are still assumptions about the explanations of those who engage in sex work (Wiechelt & Shdaimah, 2015). Such explanations might contribute to prostitution stigma in the mental health field(s). If so, one might expect mental health professionals' diagnoses to focus on uncovering sex workers' pathology and/or depraved environments.

Mental Health Diagnosis

Much of the research has investigated sex workers' dysfunctional environmental experiences of trauma and violence, which are described by liberal and radical feminist theory. Many researchers report that sex workers experience higher rates of physical and sexual abuse from clients, partners, managers, and during childhood than the general population (Lutnick et al., 2015; Nixon et al., 2002; Sallmann, 2010; Valera et al., 2000). However, studies often are vague about their sampling methodologies, and their results are used to generalize across types of sex work and workers. Perhaps more importantly, for the study, no research has investigated mental health professionals' diagnostic assessments. Instead, current research has focused primarily on diagnosing sex workers' histories of violence and related trauma and substance abuse.

Violence and Trauma

The prevalence of violence towards sex workers is difficult to estimate, in part due to methodological and ideological issues that bias sex work research (Vanwesenbeeck, 2001). Supposedly, approximately two-thirds of sex workers suffer from PTSD-related conditions (Farley et al., 2003). Farley and Barkan (1998) investigated sex workers' histories of violence and prevalence of PTSD by using the PTSD Checklist and a 23-item questionnaire that queried physical and sexual violence histories. In a survey of mixed-gender sex workers (*N*=130: 75% were female, 13% were male, and 12% were transgender) of unspecified type of sex work, Farley and Barkan found that 86% of the individuals interviewed met criteria for PTSD. They concluded that sex workers experience high levels of violence when engaging in sex work. The interviewers in Farley and Barkan's study knew some of the participants and asked specific questions to elicit potentially traumatic events from them. Therefore, the results were likely skewed in a direction that supported the assumption that sex work is traumatizing for sex workers. Further, Farley and Barkan queried about physical and sexual violence histories, not necessarily the sex workers experience within sex work.

Rössler et al. (2010) investigated the correlates of poor mental health of sex workers across a range of occupations. The sample included female providers who worked in the following contexts: outdoors, in studios, cabarets, bars, and parlors, and as escorts (*N* = 193). Rossler et al. reported that the most prevalent correlates of mental health challenges for outdoor sex workers involved violence (within and apart from sex work), but this was not the case for sex workers who worked in brothels, salons, or cabarets. Across the sample, higher rates of mental health challenges were associated

with poor working conditions, the psychological struggle of leading a double life, and experiencing shame and guilt from prostitution stigma.

Chudakov et al. (2003) mixed-method study supports Rössler et al.'s (2010) findings that different forms of sex work have different mental health challenges. Chudakov et al. investigated a variety of factors related to individuals' decisions to do sex work (e.g., types of sexual activities, use of condoms, work satisfaction, and psychological symptoms). Their sample consisted of brothel-based female sex workers (N =55), all but two reported engaging in voluntary sex work. They screened participants for PTSD (PCL checklist) and depression (CES-D). Chudakov et al. found that only 17% of the sex workers met the criteria for PTSD.

In contrast, McCarthy et al. (2014) examined predictors of employment in sex work in comparison to other occupations. The occupations included: escorting and street-based sex workers (n=212), those employed in the food and beverage industry (n =204), and those working in salons (n =179). The variables used to compare employment choices were several environmental and family characteristics (e.g., family economic insecurity and work history), as well as childhood and adolescent experiences of trauma. McCarthy et al. found that sex workers' levels of stress, depression, PTSD, and alcohol use were higher than they were for individuals in the serving and styling industry, but these factors were often associated with childhood disadvantage. Thus, it may be argued that they had little to nothing to do with sex work as an occupation.

In sum, the evidence regarding violence and trauma as related to sex workers is inconclusive. Rates of PTSD in cited research have varied from nominal to high. However, methodological flaws prevent attributing symptoms to violence experienced

during sex work because researchers do not seem to have asked about occupational violence in their studies of sex workers or what type of sex work was being engaged in when the sex worker experienced occupational violence.

Substance Use

The use of illegal substances is frequently offered as either a consequence of working in exploitative occupations or an inducement of the entry (Farley & Kelly, 2000). Some researchers and literature have found correlations between sex workers' backgrounds and the use of substances (Rash, Burki et al., 2016; Scambler & Paoli, 2008)**.** Yet virtually none of these types of studies have focused on the sex workers' other mental health concerns.

One study that investigated substance use and mental health was conducted by Jiwatram-Negron and El-Bassel (2015) investigated whether women who trade sex (*n*=94) reported poor mental health, substance use, and incarceration histories relative to women who were not trading sex (*n*=294). The sample was recruited from either a couples-based HIV/STI prevention program or an individual-based prevention program among low-income, HIV negative, drug-using heterosexual couples. Jiwatram-Negron and El-Bassel (2015) found that 90% of the women, who traded sex for drugs, used crack cocaine as compared to 68% of women who did not trade sex for drugs. Further, Jiwatram-Negron and El-Bassel reported that women trading sex had a pattern of poor mental health, which included 46% reported being hospitalized for mental health issues in their lifetime versus the 24% of women who did not trade sex. Also, women who traded sex reported higher psychological distress on the Global Severity Index than women who did not trade sex. This may indicate that mental health concerns play a role

for individuals who have experienced incarceration, use substances, and trade sex for money, but in what environment is unclear.

In a study investigating the etiology of women's involvement in sex work and substance abuse, Potterat et al., (1998) studied female sex workers (*N*= 237, *n* = 193; street-based providers, *n* = 20; non-street-based providers, *n* = 20; unknown), who were known to the authors to have exchanged money or drugs for sex. The sex workers were sampled from an agency that conducted free STI testing, and the comparison group (*N*=407) consisted of women from the same STI clinic who had not engaged in sex work. The groups were compared using nonparametric methods of nine questions that assessed the age when each participant engaged in the first penile sexual encounter, substance use, and sex work history. The women who used the clinic services came voluntarily or were mandated by court order. Potterat et al. reported that the only significant difference between the two groups was that 86% of the sex workers reported regular substance use, and 66% of them reported using non-injectable substances before engaging in sex work. Potterat et al. concluded that there is a complex link between substance use and entry in sex work. Though the study attempts to elucidate the connection between substance use and sex work entry, there is still is no clear link as to why sex workers may use substances at higher rates than the general population, or if they do, what other correlates may impact this etiology.

Summary

If mental health professionals make treatment decisions based on the research that is currently available to them, they may be relying on biased and methodologically flawed research. Methodological flaws include questionable sampling procedures, lack of

comparison groups, broad generalizations that do not differentiate between types of sex work, and lack of exploration of the mental health of sex workers generally. Some research does indicate that some sex workers do experience higher rates of PTSD (Farley & Barkan, 1998), substance use (Potterat et al., 1998), and poor mental health (psychiatric hospitalizations and overall mental health functioning) compared to those who do not engage in sex work (Jiwatram-Negron & El-Bassel, 2015). Yet, in addition to the obvious methodological flaws in existing studies, perhaps the most serious flaw is that researchers have not investigated how mental health professionals diagnose or treat sex workers in therapy. Therefore, it is not possible to determine whether their therapy interventions are influenced by prostitution stigma.

Sex Work as Decent Work

Much of the theoretical and empirical literature does not differentiate between sex workers and the work they do, in part because of the methodological challenges of research on sex work, the illegal nature of sex work in most countries, and the theoretical frameworks of psychoanalytic, radical, and liberal feminism. These issues may result in career psychologists and mental health professionals having unassessed biases about sexuality, sexual practices, and the selling of sex for money (Burnes et al., 2012). Nevertheless, many sex workers and related organizations have called for the decriminalization of sex work or the right-to-work for sex workers, and they have advocated for decent work conditions (e.g., Amnesty International, 2016; American Civil Liberties Union, 2014; Open Society Foundation, 2012; Sex Workers Out Reach Project - USA, 2018; and World Health Organization, 2012). Yet there have been virtually no calls

for the training of mental health professionals that focuses on overcoming prostitution stigma as it potentially affects their perceptions of sex work.

The Nature of Sex Work

Pheterson (1993) theorized that mental health professionals are not aware of the different impetuses for sex work, which are important to acknowledge because often sex workers who are trafficked and those engaging in sex work out of choice or circumstance are not always differentiated in theory or research. *Trafficked* individuals are people who are compelled to perform sex work or other labor through force, fraud, or coercion (Trafficking and Victims Protection Act: TVPA; U.S. Department of State, 2010). *Consensual sex work* is defined as any adult individual of any gender consenting to exchange sexual services for money or goods (Amnesty International, 2016). Researchers have not investigated whether mental health professionals react similarly and negatively to sex workers regardless of the type of work in which they engage (e.g., street worker, escort) or the level of coercion involved (e.g., trafficked, consensual).

Psychology of working theory (PWT; Duffy et al. 2016) has the potential to help frame theoretical and empirical research on sex work that does not use prostitution stigma as an underlying assumption. PWT conceptualizes decent work in terms of satisfactoriness of physical and interpersonal working conditions (e.g., work hours that allow for free time and adequate rest, organizational values that complement family and social values, and access to adequate health care) (Duffy et al. 2016, p. 130), as well as personality characteristics associated with decent work (e.g., self-determination, work fulfillment, and well-being). Of these proposed dimensions of decent work, the personality characteristics seem most relevant to the work of mental health professionals.

Indicators of Sex Work as Decent Work

Wahab (2004) conducted a participatory inquiry that investigated how female sex workers (N=6) define their work and agency as it applies to their lives and profession. The participants worked as escorts, street-based providers, and erotic dancers. Wahab reported that the women described entering the sex work industry as a choice to engage in a wider range of employment options. For example, the participants stated that sex work allowed them to survive, have secure financial means, job flexibility, safe work environment, and work that satisfied social relationship connections with other sex workers. Wahab provides a clear example of how sex work can be decent work across a wide range of sex work occupations.

Further, there have been several research studies on how sex work provides an adequate income and a livable wage. For example, Blissbomb (2010) wrote an autoethnography about her experiences as an indoor sex worker. She highlights how sex work was able to provide her with the financial security that allowed her to have full-time work, while also doing activism work that did not pay a livable income. Another study that looked at sex work as a source of financial stability was conducted by Bayer et al. (2014). Bayer et al. conducted a semi-structured interview with male sex workers (N = 40, n = 23; low-income urban primarily outdoor sex worker, and n = 17; middle-income suburban primarily internet-based sex work). Participants reported that their motivation for engaging in sex work included basic survival of food and shelter (low-income urban sex workers) to housing stability, post-secondary education, gym membership, and money for leisure activities (middle-income suburban sex workers). Both Blissbomb and Bayer et al. studies suggest that sex work can provide financial security and, in some

instances, provide financial means to pursue other purposeful and meaningful activities (e.g., activism work, post-secondary education, leisure activities).

There is a debate about the amount of income sex workers make; however, a study conducted by Edlund and Korn (2002) found that most female sex workers earn considerably more income than low-skilled workers. Further, Deering et al. (2011) reported that the median weekly income for street-based workers who were younger than 25 was between $200-$800, with an average of 6 clients. Unfortunately, the weekly median income for street-based workers over 25 dropped to $100 to $500, with an average of 6 clients.

To highlight how some sex work can enable individuals to have control over their work conditions, Sanders, Connelly, and King (2016) investigated internet-based sex workers (N=240) work conditions. There sample included 82% female, 12% male, and 4% transgender, mostly escort workers. 91% of the participants in the survey described their work as flexible, 66% described it as fun; and 56 % found their work rewarding. Further, 80% of participants reported deciding how long to work and felt like they could refuse clients. However, 76% of the participants reported that their income could be unpredictable at times due to client cancellations. Internet-based sex workers appear to have a high level of control over their work conditions, which, according to PWT, leads to work satisfaction.

Sex work can also facilitate safe interpersonal connections with clients and other sex workers. Bernstein (2007) conducted an ethnographic study of middle-class female erotic dancers and escorts (N=15). She investigated how technology has facilitated a change in the sex work industry and interpersonal connection. Bernstein reported that the

participants used technology (e.g., online marketing and websites) to increase physical safety through the ability to sell sexual services by screening clients and by facilitating community and camaraderie among sex workers. Thus, technology was able to facilitate connections with clients by creating a "bounded emotional, authentic experience explicit in an economic contract" (pp. 482) similar to a client paying a therapist.

In sum, sex workers have reported that sex work does provide livable wages, physical safety, and interpersonal connections with clients and other sex workers. However, this research is limited and is based mostly on indoor sex work. Researchers need to continue to understand how mental health professionals may hold biased attitudes towards sex work as decent work regardless of the type of work a sex worker pursues.

Personality Characteristics of Sex Work as Decent Work

Vanwesenbeeck (2017) highlights how framing and acknowledging sex work as decent work supports the self-determination of sex workers and reduces prostitution stigma among service providers. Sex workers report that they engage in sex work for the following reasons: it (a) enhances their personal worth; (b) permits self-determination; and (c) it provides the freedom to set their own schedules while allowing (f) the excitement and fun of sex work (Krumrei-Mancuso, 2017).

To illustrate how sex work supports self-determination, Wahab (2004) conducted a participatory inquiry that investigated how female sex workers (N=6) define their work and agency as it applies to their lives and profession. The participants worked as escorts, street-based providers, and erotic dancers. The sex workers in this study described how they choose their professions because it allowed for agency and self-determination by allowing the role flexibility of being nurtures, performers, and educators. In addition, the

sex workers also highlighted how the exchange of sexual services for money allowed for agency and negotiation of boundaries, which supported the participant's self-determination.

Sex workers report that sex work enhances their personal worth, including self-esteem. For example, Benoit et al. (2018) in a mix-method study investigated the effects of sex work on sex worker's sense of self among a gender diverse population of sex workers (N=218), including 76% identified as women, 17% as men, and 7% as another gender. The type of work the participants engaged in was 21% were street-based workers in the past year, and the remaining 79% were categorized as having worked in an indoor setting. One hundred forty-six sex workers talked about how self-worth was an important internal value that they held. Of those 146 participants, 58% reported that sex work bolstered their sense of self. Participants reported that sex work helped them feel confident, felt a sense of accomplishment, and felt more beautiful, feminine, and powerful. Like most work, sex work provides the potential to promote positive self-worth.

Indeed, some sex workers report enjoying, having fun, and being excited by their work. Bayer et al. conducted a semi-structured interview with male sex workers (N = 40, n = 23 low-income urban primarily outdoor sex worker and n = 17 middle-income suburban primarily internet-based sex work). For the male sex workers that were able to screen clients, there was also an association with being satisfied with the work, enjoying the work, and feeling good about their work. Finally, sex workers are reporting that there are flexibility and excitement in their work. Blissbomb (2010), in an autoethnography, talks about the financial and emotional rewards of negotiating boundaries and services,

management skills, scheduling, sales and finance, phone and webpage skills, active listening, being able to relate with diverse clientele, health awareness, creating rapport, and using one's body sensuality and desirability for employment.

Summary

Due to prostitution stigma and biased research, mental health professionals may be unaware of the benefits that a person may glean from working in the commercial sex industry, some of which are consistent with the tenets of PWT. Depending on the type of sex work, many sex workers feel that their work promotes self-determination, work fulfillment, and well-being. Nevertheless, it is important for mental health professionals to understand the complexity of sex work, the differing types of sex work, and the positive and negative factors of differing types of sex work.

Statement of the Problem

In sum, the existing literature suggests that mental health professionals may have different perspectives towards sex workers and sex work based on their theoretical orientations. Yet few studies or theoretical articles have focused on whether mental health professionals stigmatize sex workers and/or if prostitution stigma affects their clinical work with sex workers. Most studies that have explored prostitution stigma have been from the perspective of the sex workers (Benoit et al. 2017; Bettio et al. 2016; Koken, 2012; Sallmann, 2010) or have proposed theoretical arguments about the nature of prostitution stigma generally (Ma et al. 2017; Vanwesenbeeck, 2001). Overall, understanding the degree to which mental health professionals stigmatize sex work and sex workers is important for determining whether it is necessary to create interventions and training that decrease prostitution stigma (Herman, 2004; Lennon et al., 2014).

In the present study, it was assumed that men, women, queer, and transgender individuals across race and ethnicity participate in the commercial sex industry for a multitude of reasons (Burnes et al., 2012; Sanders, 2005). Some enjoy sex work, some feel ambivalent about sex work and engage in it for survival or out of circumstance, and some are coerced and hate sex work. For the purposes of the current study, I used sex workers as a broad umbrella term to explore the attitudes of mental health professionals because mental health care providers may have opportunities to provide services to people who do a variety of types of sex work.

Prostitution Stigma and Mental Health Professionals' Attitudes towards Sex Workers

Some qualitative research indicates that sex workers report experiencing prostitution stigma from mental health professionals, but relevant studies are limited in number and quality (Bayer et al. 2014; Rossler et al. 2010). Theoretical discussions, empirical research, and sex workers' reports suggest a need for further examination of mental health professionals' actual beliefs about sex workers. Unfortunately, investigations of mental health professionals' prostitution stigma are often left out of scholarly research (Benoit et al., 2017; Scambler, 2007); thus, little is known about how or whether this stigma operates.

Mental Health Professionals' Assessment of Mental Health

Given that mental health professionals may attend to sex work research that is methodologically flawed, it is important to understand how prostitution stigma affects their clinical judgment or assessment. Moreover, their exposure to psychoanalytic or feminist theories during their professional training may also affect their perceptions of

sex workers. Although sex workers have reported instances of prostitution stigmatizing by mental health professionals (Chakrapani et al., 2009; Sprankle et al., 2017), it is unclear if mental health professionals do indeed hold views related to prostitution stigma and if such attitudes influence their clinical judgment of sex workers regardless of their type of sex work.

Mental Health Professionals' Attitudes Toward Sex Work

Prostitution stigma possibly influences mental health professionals' views of sex work by conflating stereotypes of sex workers with their work. Most of the literature on sex work has focused primarily on street-based or outdoor sex work and rarely has included the array of other forms of sex work (Weitzer, 2005). Researchers hypothesize that prostitution stigma may be perpetuated by mental health professionals because they lack adequate training and information about the nature of different forms of sex work (Herman, 2004; Weitzer, 2017). This lack of information may be due to mental health professionals' theoretical orientations, being exposed to methodologically flawed research, and unfamiliarity with the principles of decent work.

Sex Work as Decent Work. No empirical research has been conducted on whether mental health professionals believe that sex work can be decent (Vanwesenbeeck, 2001). It is possible that individuals who work from clinical orientations other than psychoanalytic theory or radical and liberal feminism may have beliefs about sex work that are not rooted in prostitution stigma. It also may be true that mental health professionals who hold stereotyped views of sex work may practice from clinical orientations aligned with psychoanalytic or feminists theories.

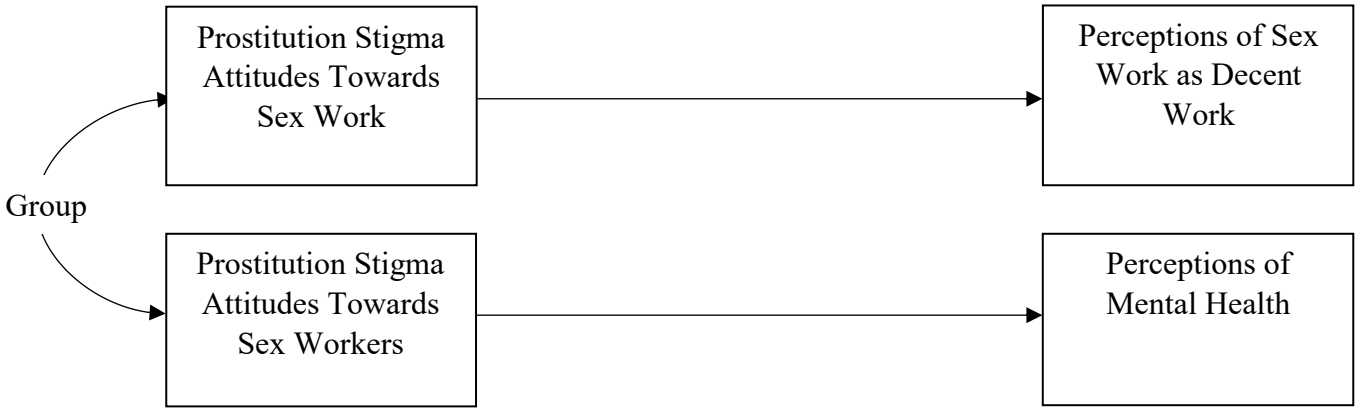
Proposed Conceptual Model

The paucity of research regarding mental health professionals and their attitudes towards sex workers and sex work, the current study sought to understand if types of work (i.e., escort, street-based sex worker, and accountant) differ between mental health professionals' attitudes towards sex work and sex workers (Figure 1). Further, this study sought to explore the relationship between prostitution stigma and mental health professionals' attitudes toward sex work as decent work and the diagnostic impression of sex workers, as illustrated in Figure 2. Finally, this study sought to explore whether mental health professionals' theoretical orientation moderates the relationship between prostitution stigma and mental health professionals' diagnostic impressions of sex workers and mental health professionals' attitudes of sex work as decent work (Figure 3). The following hypotheses were tested:

Hypotheses

Hypothesis 1. Mental health providers' levels of stigmatizing of sex work or sex workers would differ significantly between the accountant, escort, and street-based worker conditions. Specifically, mental health providers would perceive the street-based worker group more negatively than the escort group and the escort group more negatively than the accountant group (Figure 1). Support for hypothesis 1 is based on the lack of mental health research that does not differentiate the types of sex work (Blissbomb, 2010). Further, support for hypotheses 1 is that researchers hypothesize that prostitution stigma may be perpetuated by mental health professionals because they lack adequate training and information about the nature of different forms of sex work (Herman, 2004; Weitzer, 2017).

Figure 1. *Model Mental Health Professionals Beliefs in Prostitution Stigma and Effects on Perceptions of Sex Work and Mental Health*

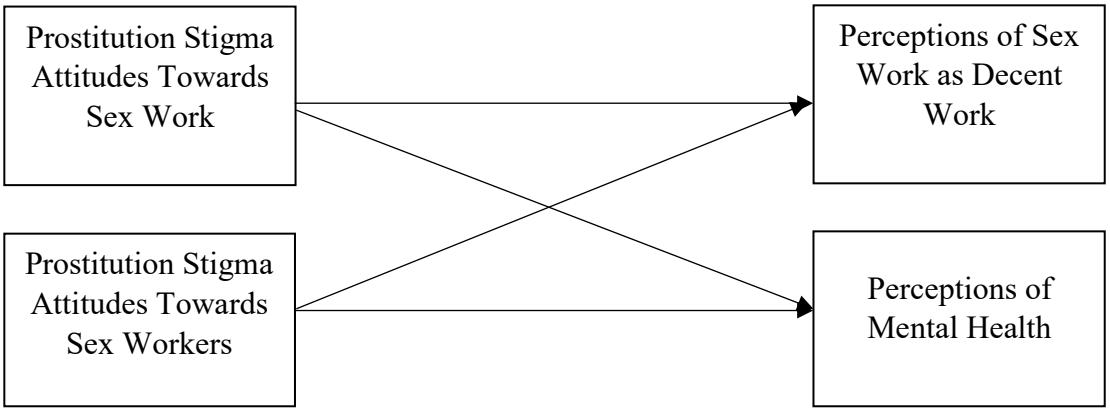


Hypothesis 2a. Mental health providers' levels of stigmatizing sex work or sex workers would predict higher levels of mental health concerns (PTSD, Anxiety, and Depression). Support for hypotheses 2a is that researchers hypothesize that prostitution stigma may be perpetuated by mental health professionals because they lack adequate training and information about the various types of sex work, which in some cases may lead to higher levels of violence and systemic oppression (Farlay et al., 2003; Potterat et al., 1998), and in some cases may lead to higher levels of enjoyment, control, and stability (Benoit et al., 2018; Blissbomb 2010; Sanders, Connelly, & King, 2016). See figure 2.

Hypothesis 2b. Mental health providers' levels of stigmatizing of sex work or sex workers would predict lower levels of expectations for decent work characteristics (i.e., Safe Working Conditions, Access to Healthcare, Rest and Free Time, and Values). Support for hypothesis 2b is drawn from the literature based on the fact that the majority of mental health research has been conducted on street-based providers, which expose

individuals to higher levels of risk (i.e., housing instability, substance use, violence). Sex workers who work as escorts, web-camming, erotic dancer, there is evidence that they enjoy their jobs and find the self-determination and income to be fulfilling (Bayer et al., 2014; Connelly & King, 2016); however, there is little evidence that mental health providers have access to this knowledge. Thus, mental health professionals may hold stigmatizing beliefs about sex work or the nature of sex workers. See figure 2.

Figure 2. *Conceptual Model Mental Health Professionals Beliefs in Prostitution Stigma and Effects on Perceptions of Sex Work and Mental Health.*

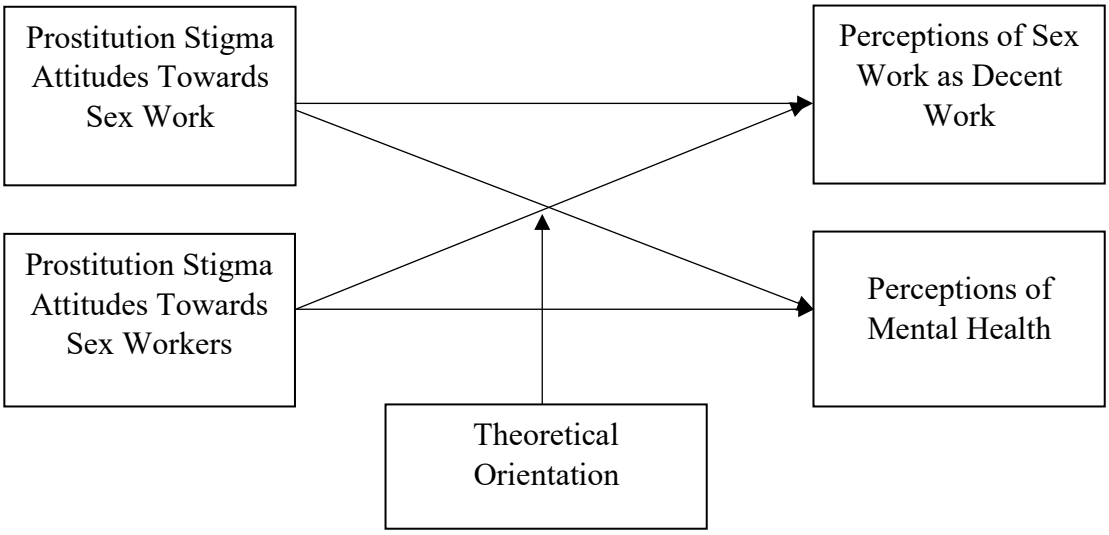


Hypothesis 3a. The relationships between mental health providers' levels of stigmatizing of sex work or sex workers and mental health concerns (i.e., PTSD, Anxiety, and Depression) would be moderated by theoretical orientation (psychoanalytic, feminist, and behaviorist). Support for this hypothesis is based on the lack of research on individuals who engage in different types of sex work, and that mental health professionals are socialized through mental health theories and society to have negative and stigmatizing attitudes towards sex workers (Benoit et al., 2015; Vansweensbeck, 2001). Further, support for hypothesis 3a is drawn from the theoretical literature on

prostitution stigma and from the research literature that suggests that mental health professionals do stigmatize mentally ill clients (Rossler et al., 2010).

Hypothesis 3b. The relationships between mental health providers' levels of stigmatizing of sex work or sex workers and decent work variables (i.e., Safe Working Conditions, Access to Healthcare, Rest and Free Time, and Values would be moderated by theoretical orientation (psychoanalytic, feminist, and behaviorist). Support for hypothesis 3b is drawn from the fact that there is no research on the understanding of sex work as decent work.

Figure 3. *Moderation Conceptual Model Mental Health Professionals Beliefs in Prostitution Stigma and Effects on Perceptions of Sex Work and Mental Health*



To operationalize prostitution stigma, I used the Attitude Toward Prostitutes and Prostitution Scale (APPS), which assesses mental health professionals' social attitudes towards sex workers and sex work (Levin & Peled, 2011). The construct of decent work was operationalized using the Decent Work Scale (DWS: Duffy et al., 2017), which is a scale used to measure the five components of decent work. To assess the degree to which

mental health professionals' diagnosed their clients with depression, anxiety, and/or PTSD, I used two scales: the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1986) and the PTSD-8 (Hansen et al., 2010). Theoretical orientations were operationalized by asking mental health professionals to indicate on 7-point scales how closely aligned their beliefs were with each of a list of orientations. Three different vignettes (i.e., escort, street-based sex work, and accountant) were used to operationalize the three types of work.

Chapter 3

Participants

Participants in this study were mental health professionals (N = 201), who ranged in age from 22 to 72 years (M = 36.64, SD = 12.45). Table 1 provides a summary of the participants' self-described demographic characteristics. Most of the sample identified as female (76%), heterosexual or mostly heterosexual (60%), White (74%) and of White American, European, or European American (63%) ethnicity. In terms of education, participants primarily identified as having a Master's degree (63%) and with a third reported working as a social worker, therapist, or clinician (37%). Participants primarily reported their clinical experience as either 4 to 6 years (30%) or 1 to 3 years (28%). The majority of the sample (67%) reported that they had never worked with a sex worker.

Table 1

Demographic Information ($N = 201$)

	N	%
Race		
Black or Black African	10	5
White	148	74
Asian or Asian American	17	9
Latinx	7	3.5
Biracial/Multiracial	7	3.5
Middle Eastern	3	1.5
Not Answered	9	4.5
Ethnicity		
African American, African, Caribbean	6	3
European or White American	126	63
Middle Eastern	5	2.5
Jewish	14	7
Asian or Asian American	14	7
Spanish/Latinx	17	8.5
Native American	1	.5
Not Answered	18	9
Gender		
Female	154	77
Male	35	17
Transmasculine	3	1.5
Genderfluid, Gender Nonconforming, Gender Queer	7	3.5
Not Answered	2	1
Sexual Orientation		
Pansexual, Bisexual, Fluid, or Queer	50	25
Asexual	1	.5
Gay	14	7
Heterosexual	120	60
Lesbian	13	6.5
Not Answered	3	1.5
Years in Clinical Practice		
1 to 3 Years	57	28
4 to 6 Years	60	30
7 to 10 Years	29	14
Over 10 Years	54	27
Any Experience with Sex Workers		
Yes	66	33
No	134	67

Measures

Participants were asked to complete the following measures: (a) a demographic questionnaire; (b) the Attitudes Toward Prostitutes and Prostitution Scale (Levin & Peled, 2011); (c) the Decent Work Scale (Duffy et al., 2017), (d) the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1986), and (e) the PTSD-8 (Hansen et al., 2010).

Demographic Questionnaire. I designed a demographic questionnaire to collect data about the participants' age, race, ethnicity, gender, sexual orientation, education, occupation, theoretical orientation, and previous experience working with sex workers (Appendix A). These variables were used to describe the participants and assess theoretical orientation in subsequent analyses.

Attitudes Toward Prostitutes and Prostitution Scale. The Attitude Toward Prostitutes and Prostitution Scale (APPS) is a 29-item measure that assesses mental health professionals' social attitudes towards prostitutes/sex workers and prostitution/sex work separately (Levin & Peled, 2011). The APPS was specifically designed to examine the attitudes of social workers and social work students. In the present study, the APPS was used to assess for certain general assumptions about sex workers (See Appendix B).

The two subscales of the APPS are (a) attitudes towards sex workers (14 items) and (b) attitudes towards sex work (15 items). The subscale assessing attitudes toward sex workers measures clinicians' endorsement of whether sex workers make a choice or are forced to engage in sex work (e.g., "prostitutes are unable to get out of the situation they are in"), as well as whether clinicians perceive sex workers as socially deviant or socially normative (e.g., "most prostitutes are drug addicts"). The subscale assessing clinicians' attitudes towards sex work measures the extent to which they perceive sex

work generally as socially normal or socially deviant (e.g., “prostitution damages society’s morals”). Mental health professionals responded to items using 5-point rating scales, ranging from 1 (“fully disagree”) to 5 (“fully agree”). Item responses were summed to yield scores for the two subscales. Higher scores indicate that participants held more stigmatizing attitudes towards sex workers and sex work

Levin and Peled (2011) conducted a study of social science college students (*N*=159) and found Cronbach alpha reliability coefficients for their responses of α = .81 for scores on the entire scale, α = .73 for the responses on the attitudes towards sex workers, and α = .73 for the responses to the attitudes toward sex work. Levin and Peled’s study suggest that 73% to 80% of the variability in participants’ responses could be due to consistent responding; thus, suggesting that the sample perceived the items as measuring a construct consistently.

In the present study, Cronbach alpha coefficients for participants’ responses for the attitudes towards sex workers' responses were α = .64, and for the attitudes towards sex work, it was α = .71. To improve the reliability estimates, I examined inter-item responses and dropped items that were negatively correlated within the subscales. In addition, I removed items that did not appear to measure the intended construct in this sample (e.g., prostitution is important for teaching teenage boys about sexuality) or that appeared to not be relevant in a U.S. American cultural context (e.g., through prostitution, pretty girls can find a husband). After removing the above items, I retained 10 of the original 15 items of the sex work scale, and 7 of the original 14 items of the sex worker scale. The revised Cronbach alpha coefficients were α= .89 for the responses on

the attitudes towards sex work and α=.75 for the item responses on the attitudes towards sex workers subscales.

Levin and Peled (2011) also conducted construct validity and convergent validity studies of scores on the APPS scale. Construct validity was assessed using Categorical Principal Component Analysis with varimax rotation to determine whether there were two distinct subscales: (a) attitudes towards sex workers and (b) attitudes towards sex work. The authors evaluated convergent validity by correlating college students' (*N*=159) social science scores and scores on the Illinois Rape Myth Acceptance Scale. High scores on the Rape Myth Scale indicated a negative correlation with the APPS, which suggested that participants, who were more accepting of rape myths, perceived sex work as a form of victimization, rather than a product of choice.

Decent Work Scale. The Decent Work Scale (DWS; Duffy et al., 2017) is used to measure five components of decent work according to Blustein's (2013) psychology of working theory. It is a 15-item measure that assesses whether the external properties of a specific job support employees' needs (e.g., has safe working conditions, access to health care). In the present study, this measure was used to investigate whether mental health professionals' perceived sex work as decent work. Example items from the scale are "I feel emotionally safe interacting with people at work," "I am not properly paid for my work," and "I have no time to rest during the week" (Appendix C).

The five subscales of the DWS are: (a) Safe Working Conditions, which measures the degree that a work environment is physically and emotionally safe; (b) Access to Healthcare, which measures the degree to that healthcare is accessible through one's job; (c) Adequate Compensation, which assesses the perception that one's pay is acceptable;

(d) Free Time and Rest, assess the degree that individuals are able to have time and rest outside of work and measures the degree an individual feels overworked, exhausted, and fatigued; and (e) Complementary Values, which assess the degree that the work values of one's job aligns with one's community and family values (Duffy et al., 2017).

The DWS is designed to be a self-report scale. In the present study, I modified it to be a clinician-rated scale by changing "I-statements" to clinician statements. For example, the item, "I feel emotionally safe interacting with people at work," was modified to read, "the client feels emotionally safe interacting with people at work," The scale items were administered on 7-point Likert-type scales ranging from 1 (strongly disagree) to 7 (strongly agree). Higher scores on each subscale and the total scale are indicative of higher levels of decent work.

Duffy et al. (2017) conducted an exploratory factor analysis and confirmatory factor analysis study of mostly full-time working adults (*N*=589). The estimated Cronbach alpha internal consistency for the responses of the five, three-item subscales (Safe Working Conditions, Access to Healthcare, Adequate Compensation, Free Time and Rest; and Complementary Values) and the response for the total scale were as follows: Safe Working Conditions (α = .79), Access to Healthcare (α = .97), Adequate Compensation (α = .87), Free Time and Rest (α = .87), Complementary Values (α = .95), and the Total Scale (α = .86).

In the present study, the Cronbach alpha reliability estimates for responses to the five, three-item subscales and the total scales, were as follows: (a) Safe Working Conditions (α = .77), (b) Access to Healthcare (α = .98), (c) Adequate Compensation (α = .49), (d) Free Time and Rest (α = .70), and (e) Complementary Values (α = .65). Given

the low alpha coefficient for scores on the Adequate Compensation subscale, it was not used in subsequent analyses.

Duffy et al. (2017) conducted an exploratory factor analysis to assess construct validity and found a five-factor model that accounted for 65.2% of the item variance and was consistent with their theory. Duffy et al. also assessed the convergent validity of the DWS with scores on five other instruments. Specifically, the Safe Working Conditions subscale positively correlated (r = .40) with the measure of general Job Safety; the Access to Health Care subscale positively correlated (r = .35) with the Health Care Satisfaction Survey; the Adequate Compensation subscale was positively correlated (r = .70) with Pay Satisfaction measure; the Free Time and Rest subscale was negatively correlated (r = -.60) with Occupational Fatigue scale; and Complementary Values subscale was positively correlated (r = *.76)* with Workplace Fit scale. These correlations suggest strong convergent validity, thus conceptually related to similar scales.

Mental Health. Mental health professionals' mental health assessment of the client in the vignette was assessed with the HADS and the PTSD-8.

Hospital Anxiety and Depression Scale (HADS). The Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1986) are used to identify anxiety and depression among clients in psychiatric and non-psychiatric settings, but in the present study, providers used it to diagnose analog clients' symptoms. The scale consists of two subscales (anxiety and depression) that are broken down into a total of 14 items, which is defined by a series of symptoms that measure both anxiety and depression. Example items were: (a) "I feel tense or "wound up," (b) "I get sudden feelings of panic," and (c) "I laugh and see the funny side of things." HADS can be used as a clinician-rated scale,

and the items were adapted to be used by clinicians. Thus, items were modified to describe clinicians' expectations rather than clients' self-descriptions of symptoms (e.g., the "client feels tense or "wound up") (The providers responded to items using 4-point frequency scales, ranging from 0 (Not at all) to 3 (Most of the time). Higher levels indicated higher levels of anxiety and depression (Appendix D).

Bjelland, Dahl, Haug, and Neckelmann (2001) reviewed 747 papers that had used HADS to assess the reliability and validity of responses to the HADS scale. They found that in the 747 papers (sample sizes ranging from N = 20 to 6,165), reliability coefficients for responses on the HADS anxiety subscale ranged from $\alpha = .68$ to $\alpha = .93$ and for the HADS depression subscale, they ranged from $\alpha = .67$ to $\alpha = .90$.

In the present study, alpha coefficients for participants' responses on the HADS anxiety subscale and the HADS depression scale were $\alpha = .68$ and $\alpha = .67$, respectively, The reliability alphas suggest that 68% to 67% of the variability in the participants' responses to the scale was due to consistent responding. Furthermore, Bjellan et al. (2001) assessed concurrent validity evidence for the HADS with the General Health Questionnaire ($r = .80$) and the Beck Depression Inventory ($r = .61$).

PTSD-8. The PTSD-8 (Hansen et al., 2010) is a scale derived from the Harvard Trauma Questionnaire to assess symptoms of PTSD. It is an 8-item scale that assesses for intrusive, avoidance, and hypervigilance symptoms that are associated with PTSD. An example item is "client feels on guard." The scale items were rated on 4-point frequency scales with anchors ranging from 0 (Not at all) to 4 (Most of the time). Higher levels indicated symptom severity related to PTSD (Appendix E).

Hansen et al. (2010) conducted two studies, one on Danish individuals who were in traffic accidents (*N*=1710) and another on rape survivors (*N*=305). The estimated Cronbach alpha internal consistency of the responses for the PTSD scale was α = .83, and the second study was α = .84. The reliability alphas suggest that 83% to 84% of the variability in the participants' responses to the scale was due to consistent responding. In the present study, the Cronbach alpha reliability of responses for the PTSD8 scale was α = .97, and for the subscale that measured intrusive symptoms, the Cronbach alpha was α = .96, for avoidance the α = .96, and for the hypervigilance subscale the α = .84. Concurrent validity was assessed by comparing it to the Trauma Symptom Checklist (TSC); for the first study, the correlation was .58, and for the second study, it was .78, both of which indicate high concurrent validity with other trauma scales.

Experimental Conditions

In the present study, I used an experimental between-groups analog design to investigate mental health professionals' beliefs about prostitution stigma and their impact on clinical diagnosis and views of work stress. There were three conditions to which participants were randomly assigned. The conditions were (a) a control group, in which participants read a vignette about an accountant (*n*=47); (b) a sex-worker group, in which participants read a vignette about a sex worker who works as an escort (*n*=77); and (c) a sex-worker group, in which participants read a vignette about a sex worker who worked outdoors (*n*=77). The accountant group had a lower number of participants because many of the participants randomly assigned to the accountant group did not complete at least 90% of the survey. Looking through the responses, it appears that most (84%) of respondents did not move beyond reading the vignette.

Vignettes

Each of the three vignettes described a female client who is seeking services related to concerns about a family member and the client's work. The manipulation in each group consisted of changing female client's type of work (i.e., accountant, street-based sex worker, and escort). The vignettes were approximately one double-spaced page in length. Each vignette was divided into four sections: (a) basic identifying data. (b) concerns about a retired parent, (c) employment and school history, and (d) social supports. Each vignette was designed to reflect the same constellation of adjustment disorder symptoms, but overall the level of severity of the psychopathology was ambiguous (Appendix E). The participants were instructed to read the vignette closely as they would be asked questions about it later in the survey.

Positionality

I (the principal investigator) find it imperative to discuss my positionality and the possible influences it may have on my interpretation of the data given the sensitive nature of the study. I am positioned and view the world through several lenses that include being White, queer, and genderqueer. I grew up in a small, rural, farming community and attended a small Catholic school from K-12th grade. During these formative years, I understood that many farmers in the area used migrant labor to support and maintain their agricultural businesses. However, I understood that those farmers who conducted their farming business in this way were unethical in terms of the religious community in which I grew up. For example, the belief/value that hard work should be rewarded with equitable pay, and by not providing equitable pay, you would somehow be in conflict with your values.

While attending college, also in a White, rural, farming community, there was an organization called Coalition Against Trafficking in Women, which had several programs devoted to labor trafficking in the area. I became interested in the organization and began to do activism work with the organization to help identify those who had been labor trafficked. While in graduate school, I again became interested in individuals who had been commercially sexually exploited. There were many presentations and trainings in the Northeastern Law School focused on deconstructing the terms "sex work," "prostitution," and "sex trafficked" that influenced me. I came to believe that those who enter the commercial sex industry do so for a myriad of reasons, including economic and financial necessity, coercion and oppression, expression of sexuality, survival, circumstance, and psychological well-being.

In addition, my graduate education and clinical experiences in mental health have been influences. I have worked in community mental health as a clinician providing therapy to those who identify as sex workers. In these clinical sessions, individuals helped shape my perspective on potential interventions for those who are sex workers. Currently, I am working on a doctorate in Counseling Psychology and have maintained a middle-class economic position. This status has allowed me to engage in advocacy and activism work with a local chapter of sex workers called SWOP-Boston. This advocacy and activism work again has influenced my positionality and views on sex work and sex workers. Accordingly, during the study, I was mindful and intentional throughout the data analysis process so that my biases ideally did not influence the interpretation of the data. I monitored my potential biases by communicating with my advisor and discussing the data analyses. This communication allowed me to reflect upon how beliefs and biases

were possibly influencing my interpretations, as well as allowing space for my advisor to raise concerns.

Procedure

The survey was approved by the Boston College Institution Review Board (IRB) with Approval Number 19.175.01e. All participants were recruited through internet sampling methods, which included email distribution via listservs and targeted emails to local mental health organizations. Notices were also posted to Facebook on profiles that have a substantial number of mental health professionals, such as the American Psychological Association (APA) pages, including the Facebook profiles for APA Graduate Students (APAGS), and the Society of Counseling Psychology. The rationale provided in the recruitment posts and emails stated that I was trying to assess how mental health professionals understand the impact of work on mental health. All surveys remained confidential, and all data were collected anonymously. The majority of participants were community mental health agencies and were outpatient service providers. Exclusion criteria included individuals who did not complete at least 90% of the survey.

The survey was built in Qualtrics. Information in the emails and the Facebook posts contained an email link to a Qualtrics survey. The opening page consisted of the consent form, and only those who agreed to participate were permitted to move forward. The Qualtrics survey began by randomly assigning participants to one of the three clinical vignettes. The participants were directed to the vignettes, which they had the opportunity to read before moving onto the surveys. After reading the vignette, the participants were directed to move forward to a page of questions. To obtain their initial

reactions to the client vignettes, participants were not allowed to go back and read the vignette again. Participants were asked to complete the DWS, PTSD-8, and HADS. After the participants had completed those portions of the survey, they were administered a demographic survey and the attitudes toward prostitutes and prostitution scales.

Participants had the option to enter a raffle for one of two $50 gift cards at the end of the survey. The link directed them to a web-based form where they could enter their email address. Information collected on the raffle page was stored in a secure database separate from the database containing participants' responses to the survey and were destroyed after the electronic raffle prizes were sent.

Chapter 4

Results

Data Preparation

To prepare the data for subsequent tests of hypotheses, I examined the data for missing values and violations of assumptions underlying the intended analyses.

Missing Values

I used SPSS Statistics 25.0 to examine the data for missing values. The data downloaded from Qualtrics contained 383 respondents. I removed participants (n = 116), who originally consented to participate in the survey, but did not answer any of the survey questions. I removed participants (n = 67), who completed less than 90% of the survey questions. I conducted a Missing Data Analysis in SPSS 25 for the remaining participants' responses (N = 201); only .2% of their data were missing. I conducted multiple imputation analyses using the Markov Chain Monte Carlo (MCMC) method with five iterations to replace the missing data because all of the missing data were assumed to be missing at random (Kline, 2016).

Testing Multivariate Multiple Regression Assumptions

The assumptions for multivariate multiple regression analysis are that the vector of error variances follow a normal distribution and that the variance and covariance matrices for variable distributions are homogeneous (Johnson & Wichern, 2007).

Data Normality. I examined all scale score distributions for skewness and kurtosis patterns. Skewness and kurtosis give insight into whether the data are normally distributed. Specifically, skewness indicates the symmetry of the data around sample means, and kurtosis is the measure of the tails relative to the rest of the score distribution (Kline, 2016). All of the subscale scores were within the skewness range of -2.00 to 2.00,

which indicates nearly normal distributions of scores. In addition, all of the subscale scores were within a kurtosis range of -1 to 1. Further, I examined the histograms of all the variables. All scales and subscales, except for PTSD variables, appeared to be normally distributed. Given the near-normal distributions and the symmetry of the data for most of the variables, I considered the data acceptable for subsequent data analyses.

Multicollinearity. Multicollinearity or highly correlated predictor variables may lead to Type II (i.e., failure to reject the null hypothesis when it should be rejected). To examine for multicollinearity, I checked tolerance values and variance inflation factors (VIF) for all subscale scores (PTSD, Depression, Anxiety, Decent Work, and Prostitution stigma), none of which was significant. I conducted Pearson correlation analyses among subscale scores, which are summarized in Table 2. For the most part, within scales, subscale scores intended to measure similar constructs were related, although not necessarily strongly or in expected directions. Thus, evidence for convergent validity is mixed. APPS subscales of stigma towards sex work and stigma towards sex workers were highly positively correlated (r = .74) for the entire sample. All of the PTSD scores were significantly positively correlated as follows: intrusive symptoms with avoidance (r = .90), intrusive symptoms with hypervigilance (r = .84), and hypervigilance with avoidance symptoms (r = .85). Interestingly, depression was slightly negatively correlated with anxiety (r = - .25). In addition, the DWS subscales' inter-correlations were small, and mostly did not significantly correlate with each other. For example, the subscale scores for rest and free time were not significantly correlated with any other DWS subscale.

Table 2

Correlations Among Predictors and Criterion Variables for the Total Sample ($N = 201$)

	1	2	3	4	5	6	7	8	9	10	11
1. SWer	**.75**										
2. SW	.74**	**.89**									
3. Anx	.03	.07	**.68**								
4. Dep	.04	-.08	-.25**	**.67**							
5. Saf	-.01	-.08	-.18**	.15*	**.77**						
6. Hea	-.01	.02	-.05	-.01	.06	**.98**					
7. Rel	.11	-.04	.09	.12	-.01	-.11	**.70**				
8. Val	-.04	-.07	-.17*	.14*	.19**	.14*	-.01	**.65**			
9. Int	.15*	.21**	.38**	-.11	-.25**	-.05	.02	-.31**	**.96**		
10. Avo	.11	.19**	.42**	-.15*	-.26**	.01	.03	-.28**	.90**	**.96**	
11. Hyp	.17*	.26**	.42**	-.12	-.23**	-.07	.01	-.31**	.84**	.85**	**.84**
Mean	15.04	22.49	8.61	8.31	12.34	9.91	13.24	10.91	1.97	1.22	1.46
SD	3.74	7.35	3.25	2.11	2.58	3.58	1.99	2.35	3.28	1.93	1.87

** $p < 0.01$. * $p < 0.05$.

Note: 1. SWer = APPS Stigma towards sex workers; 2. SW = APPS Stigma towards sex work; 3. Anx = HADS Anxiety; 4. Dep = HADS Depression; 5. Saf = DWS Safety; 6. Hea = DWS Access to Healthcare; 7. Rel = DWS Relaxation and free time; 8. Val = DWS Complementary values; 9. Int = PTSD Intrusive Symptoms; 10. Avo = PTSD Avoidance; 11. Hyp = PTSD Hypervigilance. Cronbach alpha coefficients are reported for each subscale along the diagonal line in bold font.

Further, I conducted Pearson correlation analyses among the interaction terms for theoretical orientation and prostitution stigma variables (Appendix H). In the correlation matrix for theoretical orientation and prostitution stigma, most of the interaction terms were either strongly (r = .89) or moderately (r = .28) positively correlated with each other. Further, I conducted a multiple regression among the interaction terms to examine the tolerance and variance inflation factor (VIF). For tolerance, the interaction terms were between .78 and .03, suggesting the values closer to zero are multicollinear. Plus, the variance inflation factor (VIF) for the interaction terms were between 1.21 and 28.88, suggesting those above two were multicollinear. The results of the tolerance and the VIF indicate that the interaction terms were multicollinearity, which may have increased the likelihood of results that were not statistically significant.

Preliminary Analyses

I analyzed whether theoretical orientations significantly predicted stigma towards sex work and stigma towards sex workers. I conducted a MMRA in which the independent variables were the seven ratings of theoretical orientations (i.e., psychoanalytic, self-psychology, relational psychoanalytic, humanistic, feminist, CBT, and behaviorist) and the dependent variables were sex worker stigma and sex work stigma. See Table 3 for correlation results and Table 4 for the MMRA results. Theoretical orientations were rated on a scale from 1 to 7, with low ratings indicating strong endorsement.

The correlation analysis revealed that many of the theoretical orientations were significantly related to other similar theoretical orientations. For example, psychoanalytic orientation was positively correlated with self-psychology (*r* = .38) and relational

psychoanalytic theory (r = .40). Also, feminist theoretical orientation was moderately positively correlated with humanism (r =. 53) and had a small positive correlation with CBT (r = .22). Expectantly, there were some theoretical orientations that were negatively related to theoretical orientations that were based on different epistemologies. For example, CBT and behaviorist theoretical orientations were negatively associated with psychoanalytic theory, self-psychology, and relational psychoanalytic theories.

Table 3

Correlations among Theoretical Orientations for the Total Sample (N = 201)

	1	2	3	4	5	6	7
1. PA	--						
2. SP	.38**	--					
3. RP	.40**	.35**	--				
4. Hum	-.04	.22**	.33**	--			
5. Fem	-.12	.06	.26**	.53**	--		
6. CBT	-.27**	-.10	-.25**	.11	.22**	--	
7. Beh	-.21**	-.05	-.22**	.03	.07	.67**	--
Mean	3.99	3.81	4.22	4.19	4.73	4.33	4.29
SD	1.63	1.42	1.58	1.63	1.64	1.91	1.63

** $p < 0.01$. * $p < 0.05$.

Note: 1. PA = Psychoanalytic; 2. SP = Self-Psychology; 3. RP =Relational Psychoanalytic; 4. Hum = Humanistic; 5. Fem = Feminist; 6. CBT = Cognitive Behavioral Theory; 7. Beh = Behaviorist.

The MMRA revealed that the overall model for sex work stigma as predicted by theoretical orientations was not significant, $F(8, 193) = 1.52$, $p = .16$ with an $R^2 = .08$, which indicated that no theoretical orientation significantly predicted sex work stigma. However, the variance explained by the overall model for sex worker stigma as predicted by theoretical orientation was statistically significant at $F(8, 193) = 2.69$, $p = .01$ with an $R^2 = .14$. Specifically, the theoretical orientations that significantly predicted sex worker stigma were feminist (t (199) = -2.40, $p < .01$, $B = -.12$) and behaviorists (t (199) = 2.59, $p < .01$, $B = .08$).

Interestingly, feminist was negatively associated with sex worker stigma, and behaviorism was positively associated with sex worker stigma. Thus, a stronger feminist theoretical orientation was related to lower levels of sex worker stigma, but higher levels of behaviorist orientation were associated with higher levels of stigmatizing sex workers. Consequently, in addition to the originally proposed theoretical analyses, the subsequent analyses included the original theoretical orientations suggested by my analysis of theoretical literature (i.e., feminist and psychoanalytic) plus the behaviorist theoretical orientation.

Table 4

Summary of Theoretical Orientation as Predictors of Providers' Stigma towards Sex Work and Sex Workers (*N*=201)

Predictor Variable	SW Stigma		SWer Stigma	
	B	t	*B*	t
Psychoanalytic	-.05	-.32	-.07	-1.52
Self-Psychology	.004	.22	-.08	-1.02
Relational	.02	.31	.05	1.63
Humanist	.006	.55	.02	1.03
Feminist	-.03	-1.40	-.12	-2.40*
CBT	.12	.41	-.06	-1.11
Behavioralist	.07	1.55	.08	2.59*

Note: * = p < .01. SW = Sex Work; SWer = Sex Workers.

Tests of Hypotheses

I used SPSS 25 to conduct the analyses of variance (ANOVAs) to test the first hypothesis. I used STATA 15 to conduct the multivariate multiple regression analyses (MMRA) to test the second hypothesis. MMRA is an appropriate statistical analysis when there are multiple independent variables and multiple dependent variables. To test the third hypothesis, I used hierarchical multiple regression analyses. ANOVA, MMRA, and hierarchical regression analyses are all stepdown analyses such that one examines successive steps in the analysis if the preceding step is significant**.**

Hypothesis 1. Mental health providers' levels of stigmatizing of sex work or sex workers will differ significantly between the accountant, escort, and street-based worker conditions. Specifically, mental health providers will perceive the street-

based worker group more negatively than the escort group and the escort group more negatively than the accountant group.

To test this hypothesis, I conducted two ANOVAs. In both ANOVAs, the independent or predictor variable was the group experimental condition (i.e., escort, accountant, or street-based worker). The dependent or outcome variables were stigmatizing sex work and sex workers as measured by the APPS. Higher scores on the APPS scales indicate higher levels of stigma towards sex work and sex workers.

For the first ANOVA in which the dependent variable was stigma towards sex workers, neither the means for escorts (M=14.93, SD=3.76), street-based workers (M=14.93, SD=3.72), nor accountants (M=15.40, SD=3.77) differed significantly (F(2, 198)= .28, p = .75, d = .10). Similarly, for the second ANOVA with the dependent variable of stigma towards sex work, neither the means for escorts (M=22.44, SD=7.35), street-based workers (M=21.91, SD=7.48), nor accountants (M=23.55, SD=7.19, d = .23) differed significantly (F(2, 198) = .73, p = .48,).

These findings indicate that the service providers' levels of stigmatizing did not differ significantly according to the type of work of the three groups. Also, examinations of correlations among the variables indicated that correlations were in similar directions for the sex worker conditions. Therefore, given these findings, subsequent analyses were conducted separately with the total sample consolidated across the three conditions and the sex work groups consolidated (i.e., escorts and street-based).

Hypothesis 2a. Mental health providers' levels of stigmatizing sex work or sex workers will predict higher levels of mental health concerns (PTSD, Anxiety, and Depression).

To test this hypothesis, I conducted two MMRAs, one using the aggregated sex-worker vignettes and one using the total sample. The independent or predictor variables were stigma towards sex work and stigma towards sex workers. The dependent or outcome variables were PTSD symptoms (i.e., Avoidance, Intrusion, and Hypervigilance) as measured by the PTSD-8 and anxiety and depressive symptoms as measured by the HADS. For PTSD symptoms, Anxiety, and Depressive symptoms, higher scores indicated higher levels of symptomology. See Table 5 and Table 6 for means, standard deviations, and a summary of the results of the statistical analyses.

Stigma and Perceived Mental Health Symptoms in the Combined Sex Worker Condition

The MMRA for the combined sex worker group tested whether mental health professionals' stigmatizing beliefs towards sex work predicted mental health concerns. Attitudes towards sex work significantly predicted PTSD Intrusive symptoms (F (1, 153) = 4.06, $p < .05$; $R^2 = .02$), PTSD Avoidance symptoms (F (1, 153) = 4.01, $p < .05$; $R^2 = .02$), and PTSD Hypervigilance symptoms (F (1, 153) = 8.95, $p < .001$; $R^2 = .05$). Further, examination of regression coefficients indicated that providers' sex work stigma attitudes were positively associated with their expectations with regard to PTSD Intrusive symptoms (t (153) = 2.02, $p < .05$, $B = .17$), PTSD Avoidance symptoms (t (153) = 2.00, $p < .05$, $B = .16$); and PTSD Hypervigilance symptoms, (t (153) = 2.99, $p < .001$, $B = .24$).

Thus, when mental health providers reported higher stigmatizing beliefs towards sex work, they also associated higher levels of intrusive thoughts, avoidance of trauma, and hypervigilant orientations with the occupation(s) of sex work. However, mental

health professionals' stigma towards sex work was not a significant predictor of their anxiety or depression expectations (Table 5).

The MMRA that tested whether mental health professionals' stigmatizing beliefs towards sex workers significantly predicted mental health concerns about sex workers indicated that only the model for PTSD hypervigilance symptoms was significant (F (1, 153) = 4.35, $p < .05$; $R^2 = .03$). This finding suggests that providers' stigmatizing beliefs about sex workers' were positively related to beliefs that sex workers manifest PTSD Hypervigilance symptoms (t (153) = 2.09, $p < .05$, $B = .24$). However, as summarized in Table 5, mental health professionals' stigma towards sex workers was not a significant predictor of PTSD intrusive symptoms, PTSD avoidance symptoms, anxiety, or depression.

Stigma and Expected Mental Health Symptoms in the Total Sample

The MMRA for the total sample tested whether mental health professionals' stigmatizing beliefs towards sex work predicted expected mental health concerns disregarding the three types of work portrayed in the analog. In the regression model, attitudes towards sex-work significantly predicted PTSD Intrusive symptoms (F (2, 199) = 9.02, $p < .001$; $R^2 = .04$), PTSD Avoidance symptoms (F (2, 199) = 7.44, $p < .001$; $R^2 = .04$), and PTSD Hypervigilance symptoms (F (2, 199) = 14.78, $p < .001$; $R^2 = .07$). Furthermore, examination of regression coefficients indicated providers' attitudes toward sex work were significantly positively related to their diagnoses of PTSD Intrusive symptoms of (t (153) = 3.00, $p < .001$, $B = .21$), PTSD Avoidance symptoms (t (199) = 2.73, $p < .001$, $B = .19$), and PTSD Hypervigilance symptoms (t (199) = 3.84, $p < .001$, $B = .26$). Therefore, when their stigmatizing beliefs towards sex work were high, so were

their diagnostic expectations regarding all three PTSD symptoms. However, mental health professionals' stigma towards sex work was not a significant predictor of their expectations about anxiety or depression.

The MMRA for the total sample tested whether mental health professionals' stigmatizing beliefs towards sex workers predicted mental health concerns disregarding the type of work. In the regression model, attitudes towards sex workers significantly predicted PTSD Intrusive symptoms (F (2, 199) = 4.71, $p < .05$; R^2 of .02) and PTSD hypervigilance symptoms (F (2, 199) = 6.10, $p < .05$; R^2 of .03). These findings indicate that when providers held higher stigmatizing beliefs towards sex workers' they expected high levels of PTSD Intrusive (t (199) = 2.17, $p < .05$, $B = .15$) and PTSD Hypervigilance symptoms (t (199) = 2.47, $p < .05$; $B = .17$). However, mental health professionals' stigma towards sex workers was not a significant predictor of PTSD avoidance symptoms, anxiety, or depression.

Summary

For both sets of MMRA analyses (i.e., the sex worker combined condition and the total sample), the results supported the hypothesis that when mental health professionals' stigmatizing attitudes towards sex work were high, so were their expected levels of PTSD symptoms for the clients. Furthermore, both MMRA analyses provided some support for the hypothesis that, when mental health professionals held stigmatizing beliefs towards sex workers, they expected higher levels of PTSD hypervigilant symptoms for the portrayed clients. However, there was no support for the hypothesis that mental health providers would expect higher levels of depression and anxiety for sex work and sex workers.

Table 5

Summary of Multivariate Multiple Regression Analysis (MMRA) Using Stigma towards Sex Work and Sex Workers to Predict Mental Health Symptoms for the Combined Sex Worker Conditions ($N = 154$)

Predictor Variable	Dependent Variable	M SD	F	R^2	B	*t*
Sex Work Stigma						
	PTSD Intrusion	1.85 (3.12)	4.06 *[a]	.02	.17	2.02*
	PTSD Avoidance	1.16 (1.80)	4.01*[a]	.02	.16	2.00*
	PTSD Hypervigilance	1.46 (1.87)	8.95 ***[a]	.05	.24	2.99***
	HADS Anxiety	8.36 (3.23)	.33[a]	.002	.05	.56
	HADS Depression	8.43 (2.12)	.85[a]	.005	-.07	-.92
Sex Worker Stigma						
	PTSD Intrusion	1.85 (3.12)	2.65[a]	.02	.13	1.63
	PTSD Avoidance	1.16 (1.80)	1.31[a]	.008	.09	1.14
	PTSD Hypervigilance	1.46 (1.87)	4.35*[a]	.03	.16	2.09*
	HADS Anxiety	8.36 (3.23)	.30[a]	.002	.05	.55
	HADS Depression	8.43 (2.12)	.23[a]	.001	.04	.49

Note: [a]= *df = (1, 153). * = p < .05; ** = p < .01; *** = p < .001.*

Table 6

Summary of Multivariate Multiple Regression Analysis (MMRA) Using Stigma towards Sex Work and Sex Workers to Predict Mental Health Symptoms for Sex Work in the Total Sample ($N = 201$)

Predictor Variable	Dependent Variable	M (SD)	F-	R^2	B	t
Sex Work Stigma						
	PTSD Intrusion	1.97 (3.28)	9.02 ***[a]	.04	.21	3.00***
	PTSD Avoidance	1.22 (1.92)	7.44 ***[a]	.04	.19	2.73***
	PTSD Hypervigilance	1.46 (1.87)	14.78 *** [a]	.07	.26	3.84***
	HADS Anxiety	8.61 (3.25)	.91 [a]	.004	.07	.96
	HADS Depression	8.31 (2.11)	1.16 [a]	.005	-.07	-1.08
Sex Worker Stigma						
	PTSD Intrusion	1.97 (3.28)	4.71* [a]	.02	.15	2.17*
	PTSD Avoidance	1.22 (1.92)	2.51 [a]	.01	.11	1.59
	PTSD Hypervigilance	1.46 (1.87)	6.10* [a]	.03	.17	2.47*
	HADS Anxiety	8.61 (3.25)	.14 [a]	.0007	.02	.38
	HADS Depression	8.31 (2.11)	.38 [a]	.002	.04	.62

Note: [a]= *df = (2, 199). * = p < .05; ** = p < .01; *** = p < .001.*

Hypothesis 2b. Mental health providers' levels of stigmatizing of sex work or sex workers will predict lower levels of expectations for decent work characteristics (i.e., Safe Working Conditions, Access to Healthcare, Rest and Free Time, and Values).

To test this hypothesis, I conducted two separate MMRAs, one for the sample only with the mental health providers' reactions to the combined sex worker vignettes

and one with their reactions to the total sample. The independent or predictor variables in both analyses were stigma towards sex work and stigma towards sex workers. The dependent or outcomes variables were Decent Work (i.e., Safe Working Conditions, Access to Healthcare, Rest and Free Time, and Values) as measured by the DWS. For the DWS subscales, higher scores indicated higher levels of perceptions of decent work. See Appendix I for Table 7 and Table 8 for means, standard deviations, and a summary of the results of the MMRA for the combined sex worker condition and the total sample.

The MMRA tested whether mental health professionals' stigmatizing beliefs towards sex work and sex workers predicted their expectations about decent work. Mental health professionals' stigma towards sex work and sex workers was not a significant predictor of decent work characteristics for either the combined sex worker vignettes or the total sample. In sum, the hypothesis was not supported.

Hypothesis 3a. The relationships between mental health providers' levels of stigmatizing of sex work or sex workers and mental health concerns (i.e., PTSD, Anxiety, and Depression) will be moderated by theoretical orientation (psychoanalytic, feminist, and behaviorist).

To test this hypothesis, I conducted five hierarchical multiple regression analyses. Specifically, five models were run; in step one, all predictors (Sex work stigma and sex worker stigma) and moderators (theoretical orientation) were entered. In step two, all interaction terms involving the theoretical orientations and the two stigma predictors were used to predict the dependent variables (i.e., PTSD, Anxiety, and Depression).

Hypervigilance. For the dependent variable PTSD hypervigilance, the regression model main effects accounted for a small amount of variance $R^2 = .07$ ($F(5, 195) = 3.23$,

p =.008). For step two, the interaction terms were entered, and accounted for a Δ R^2 = .04 (F(11, 189) = 2.13, p =.02). The change in variance was small and not statistically significant. Thus, the relationship between sex work and sex worker stigma does not vary significantly across theoretical orientation beliefs. See Appendix J for Table 9 for an overview.

PTSD Intrusion. For the dependent variable PTSD Intrusion, the regression model main effects accounted for a small amount of variance R^2 = .02 (F(5, 195) = 1.94, p =.08). Step two, the interaction terms, accounted for a small amount of variance, Δ R^2 = -.01 (F(11, 189) = 1.31, p =.22). The change in variance was not statistically significant, nor were the main effects. Thus, the relationship between sex work and sex worker stigma does not vary significantly across theoretical orientation beliefs. See Appendix J for Table 10 for an overview.

PTSD Avoidance. For the dependent variable PTSD Avoidance, the regression model main effects accounted for a small but significant amount of variance R^2 = .05 (F(5, 195) = 3.72, p =.008). The interaction terms entered in the second step accounted for Δ R^2 = .01 (F(11, 189) = 2.13, p =.02). The change in variance was small. Specifically, the feminist orientation moderated the relationships between sex work stigma and PTSD avoidance (t = -2.17, p < .05) and sex worker stigma and PTSD avoidance (t = 2.33, p < .05). Thus, as those who agree stronger with a feminist orientation, the relationship between sex work stigma and PTSD avoidance increases. However, as those who strongly agree with a feminist orientation, the relationship between sex worker stigma and PTSD avoidance decreases. See Appendix J for Table 11 for an overview.

Anxiety. For the dependent variable anxiety, the main effects for the regression model accounted for a small amount of variance R^2 = .02 (F(5, 195) = .85, p =.51). The interaction terms accounted for Δ R^2 = .05 (F(11, 189) = 1.10, p =.35). The change in variance was small and not statistically significant. See Appendix J for Table 12 for an overview.

Depression. For the dependent variable depression, the main effects for the regression model accounted for a small amount of variance R^2 = .03 (F(5, 195) = 2.48, p =.03), which was significant. Next for step two, the interaction terms were entered, and accounted for small change in variance, Δ R^2 = .02 (F(11, 189) = 1.59, p =.10). See Appendix J for Table 13 for summary statistics.

Summary

For all of the hierarchical regression analyses, the main effects of depression and PTSD avoidance were statistically significant. For the interaction terms, the results only supported the hypothesis that feminist theoretical orientation moderated the relationship between PTSD avoidance and mental health professionals' stigmatizing attitudes towards sex work and sex workers. Essentially, the relationship between PTSD avoidance and stigmatizing beliefs towards sex work and sex workers varied depending on whether the mental health clinician endorsed the feminist theoretical orientation. The feminist theoretical orientation-by-stigma interaction accounted for 5% more of the variance in the degree to which mental health providers diagnosed the clients with PTSD avoidance symptoms than the model without the moderator term.

There was no statistical support for the regression models that included the moderating interaction terms for theoretical orientation and prostitution stigma on the dependent variables of PTSD hypervigilance, PTSD intrusion, depression, or anxiety.

Hypothesis 3b. The relationships between mental health providers' levels of stigmatizing of sex work or sex workers and decent work variables (i.e., Safe Working Conditions, Access to Healthcare, Rest and Free Time, and Values will be moderated by theoretical orientation (psychoanalytic, feminist, and behaviorist).

To test this hypothesis, I conducted five step-wise multiple regression analyses. Specifically, five models were run, in step one, all predictors (Sex work stigma and sex worker stigma) and moderators (theoretical orientations) were entered, and in step two, all interaction terms were entered. The dependent or outcomes variables were Safe Working Conditions, Access to Healthcare, Rest and Free Time, and Values as measured by DWS.

Working Conditions. For the dependent variable safe working conditions, the regression model accounted for a small amount of variance $R^2 = .03$ ($F(5, 195) = 1.37$, p =.23). When the interaction terms were entered, they accounted for $\Delta R^2 = .03$ ($F(11, 189) = 1.27$, p =.24). The change in variance was small and not statistically significant. See Appendix K for Table 14 for an overview.

Healthcare. For the dependent variable access to healthcare, the regression model accounted for a small amount of variance $R^2 = .01$ ($F(5, 195) = .59$, p =.70). The interaction terms accounted for $\Delta R^2 = 0$ ($F(11, 189) = .98$, p =.98) indicating no change in explained variance. See Appendix K for Table 15 for an overview.

Values. For the dependent variables values, the regression models accounted for a small amount of variance R^2 = .04 (F(5, 195) = 1.76, p =.12). The interaction terms did not have additional variance to the model, Δ R^2 = .03 (F(11, 189) = 1.26, p =.24). See Appendix K for Table 16 for an overview.

Rest. For the dependent variable rest and free time, the regression model accounted for a small amount of variance R^2 = .02 (F(5, 195) = .64, p =.66, which was not significant). The interaction terms did not account for significant variance, Δ R^2 = .03 (F(11, 189) = .87, p =.56). See Appendix K for Table 17.

Summary

For all of the hierarchical regression analyses, the main effects indicated that there were no significant results. For the interaction terms, the results only supported the hypothesis that psychoanalytic theoretical orientation moderated the relationship between Rest and Free Time and mental health professionals' stigmatizing attitudes towards sex work. Essentially, the relationship between Rest and Free Time and stigmatizing beliefs towards sex work varied depending on the combination of mental health clinicians' psychoanalytic theoretical orientation and sex worker stigma. The psychoanalytic theoretical orientation-by-stigma interaction accounted for three percent of the variance in the degree to which the mental health provider understands a person's capacity to have rest and free time than the model without the moderator term.

There was no statistical support for the regression models that included the moderating terms of theoretical orientation and prostitution stigma as predictors of the dependent variables of access to safe working conditions, healthcare, and values.

Overall Summary

In summary, hypothesis one was not supported as the results indicate that mental health providers' level of prostitution stigma did not differ significantly between the control group and the two sex worker conditions (escort and street-based worker). Hypothesis 2a was partially supported as the MMRA results indicated that there was a relationship between prostitution stigma towards sex work and PTSD symptoms. However, for hypothesis 2a, this study did not find the support that there was a relationship between prostitution stigma towards sex work or sex workers for anxiety or depression. Hypothesis 2b was not supported as the results indicate that there is no relationship between prostitution stigma and decent work.

There was limited support for hypothesis 3a that theoretical orientation moderated the relationship between prostitution stigma and diagnosis of PTSD, anxiety, or depression, though there was evidence for feminist orientation moderating the relationship between PTSD avoidance and mental health professionals' stigmatizing attitudes towards sex work and sex workers. Finally, there was no evidence to support the hypothesis 3b that providers' prostitution-stigma attitudes would be related to their evaluations of sex work as decent work, but psychoanalytic orientation moderated the relationship between rest and free time and mental health professionals' stigmatizing attitudes towards sex work.

Chapter 5

Discussion

Historically, mental health research has excluded the role of prostitution stigma and its effects on how therapists regard sex workers and their work. Some argumentation and research suggest that sex workers do not use mental health services because they fear that mental health workers' perceptions of sex workers are biased and stigmatizing (Benoit et al., 2016; Bungay et al., 2013; Lazarus et al. 2012). Mental health providers may view sex work as inherently harmful and likely to produce adverse mental and physical health effects (Sprankle et al., 2018). Given the virtual lack of evidence-based theoretical frameworks for guiding therapy for sex workers, mental health professionals may be unable to view sex work as legitimate work and may use prostitution stigma to guide their assessments of sex workers as a consequence (Krumrei-Mancuso, 2017; Williamson & Cluse-Tolar, 2002).

Nevertheless, there seems to be no evidence obtained from therapists themselves as to whether or how prostitution stigma affects their perceptions of sex workers or sex work. Therefore, the current study investigated the relationship between mental health professionals' expectations of sex work and sex workers and the influence of prostitution stigma on their expectations. In particular, the current study investigated whether or how mental health professionals' attitudes of prostitution stigma were related to their expectations of the mental health status of sex workers as clients as well as their evaluations of sex work as decent work.

The current study was guided by the following research questions: (a) Do mental health providers' attitudes of prostitution stigma differ between street-based workers and

escorts? (b) Is there a relationship between prostitution stigma and mental health concerns, and is this moderated by theoretical orientation? (c) Is there a relationship between prostitution stigma and decent work, and, if so, (d) is this relationship moderated by theoretical orientation? In the following sections, I discuss the findings related to these research questions, limitations of the study, and research and counseling implications.

Comparisons of Prostitution Stigma by Type of Sex Work

Prostitution stigma possibly influences mental health professionals' views of sex work by conflating stereotypes of sex workers with their work regardless of the type of sex work. Most of the literature on sex work has focused primarily on street-based or outdoor sex work and rarely has included the array of other forms of sex work (Weitzer, 2005). In the present study, different types of sex work and a control condition were portrayed by vignette clients. The results from the present study did not support the hypothesis that mental health providers' levels of stigmatizing sex work or sex workers would vary across experimental groups (i.e., street-based, escort, and accountant). The lack of significant differences between therapists' stigmatizing of different types of sex workers relative to each other and relative to the control condition (accountant) may suggest several different explanations.

One possible explanation for the lack of between-group differences is that sex work and sex workers are rarely discussed among mental health providers (Herman, 2004); thus, providers may not have knowledge of the different types of work or different types of safety concerns in the different types of sex work. Another possibility is that mental health providers had limited clinical experience with sex workers and, therefore, were attempting to imagine themselves in a situation that they had never knowingly

experienced. In the current study, 33% of mental health professionals reported having previous clinical experience with sex workers. Consequently, therapists may not have had enough knowledge to differentiate among the vignettes, and thus, the group manipulation may not have been adequate enough to elicit their actual feelings about sex workers. It may behoove future researchers to conduct research with mental health providers who are familiar with sex work and sex workers.

Further, the terminology used in the vignettes of the present study may have been problematic because it supposed some familiarity with terms such as "street-based worker," "escort," and "sex worker." I chose to use the words sex work and sex worker to acknowledge the labor perspective, which understands sex work as real work. However, the perspectives of the Nordic model and the anti-trafficking model may be better known by mental health providers. Given this possibility, mental health providers may not use the terminology of sex work or sex works, or they may be unfamiliar with such terms. If so, future researchers may want to use more commonly used terms, such as prostitutes, prostitution, sex trafficked, or commercial sexual exploitation, to investigate whether terminology may change outcomes.

Methodological problems also may have accounted for the lack of between-group differences. First, of the 383 potential participants who started the survey, only 53% completed it. Thus, it is unclear why 116 participants did not complete one questions of the survey (rates per group were: n = 29 for the street-based group, n = 31 for the escort group, and n = 38 for the accountant group) or why 201 participants chose to complete the study. One hypothesis for the high dropout rate from the accountant condition may be that not all mental health providers view career counseling as mental health counseling,

nor are they trained to do it (Blustein, 2013). Although it is not possible to determine why participants dropped out, perhaps mental health providers with less experience or with higher levels of prostitution stigma were uncomfortable with the topic of the research.

Secondly, there was no manipulation check in the present study. Consequently, it is possible that the manipulation of the different types of sex work was not strong enough for participants to perceive them, which may have led to confounding variables and a lack of statistical significance. Future researchers should include manipulation checks into their research. Manipulation check questions that might be included are: (a) what type of work did the client participate in? or (b) what was your initial reaction to the vignette client's work?

Nevertheless, since the mental health workers did not appear to differentiate between the two sex worker conditions and the accountant condition, I conducted analyses using only the sex worker conditions as well as the sex worker conditions plus the accountant condition (i.e., total sample, N = 201). This analytic procedure was an attempt to differentiate between mental health effects between the sex worker group and the total sample. McCarthy et al. (2014), who looked at the mental health effects of sex workers and those in customer service industries, used a similar approach.

Prostitution Stigma and Mental Health Concerns

Given that mental health professionals may be exposed to sex work research that promotes anti-sex worker biases, it is important to understand how prostitution stigma may affect their clinical judgment or assessment. Some support was found for hypothesis 2a that when mental health professionals hold stigmatizing attitudes towards sex workers and the sex-work profession, they are more likely to expect higher levels of PTSD

symptoms. The results from the MMRAs, both in the sex work conditions and the total sample, supported the hypothesis that when mental health professionals held stigmatizing attitudes towards the sex work profession, their expected levels of clients' PTSD symptoms were high. Also, both MMRA analyses provided some support for hypothesis 2a that, when mental health professionals held stigmatizing beliefs towards sex workers, they expected higher levels of PTSD hypervigilant symptoms for the portrayed clients. More specifically, for both the total sample and the combined sex work group, expected PTSD hypervigilance and PTSD intrusive symptoms were associated with providers' higher levels of sex work and sex worker stigma. Thus, hypothesis 2a was partially supported in that there were relationships between the level of mental health professionals' stigmatizing beliefs towards sex work and sex workers and PTSD diagnostic impressions.

According to Farley and Barkan (1998) and Farley et al. (2003), almost two-thirds of sex workers experience PTSD symptoms. Farley and Barkan's research may indicate a high prevalence of PTSD symptoms among sex workers; thus, it makes sense that mental health professionals would be primed to relate PTSD symptoms to sex work and sex workers. On the other hand, the current study suggests a relationship between providers' sex worker stigma and expected client PTSD symptoms, even though the vignettes were written to portray a client with adjustment disorder. This suggests that mental health professionals may be using stigmatizing beliefs by diagnosing sex workers with PTSD symptoms regardless of their presenting concerns.

The current study found some evidence that theoretical orientation moderated relationships between prostitution stigma and mental health symptoms. For mental health

professionals, stronger beliefs in feminist theory moderated the relationship between PTSD and stigmatizing attitudes towards sex workers and sex work. Specifically, the hierarchical regression analysis indicated that the participants who agreed with a feminist orientation had a stronger positive effect on the relationship between sex work stigma and PTSD avoidance symptoms and a stronger negative effect on sex worker stigma and PTSD avoidance symptoms. Further, the analysis indicated that the scores of participants who endorsed a feminist orientation were strongly related to the relationship between stigmatizing beliefs towards sex work and PTSD avoidance. Thus, hypothesis 3a was partially supported.

Some feminist theories continue to view sex work as inherently traumatic (Arnold et al., 2000; Carter, 2003; Farley et al., 2003; Gur, 2004a). Given that some feminist theories view sex work as inherently traumatic, it is not surprising that feminist orientation had an influence on PTSD diagnostic impressions. Nevertheless, multicollinearity among the interaction terms used in the analyses may have obscured the moderation effects of other theoretical orientations, which potentially contributed to the lack of statistical significance of the various models. In future research, I should standardize the variables comprising the interaction terms to determine whether multicollinearity can be reduced.

The MMRA analyses to test the relationships between service providers' attitudes toward sex work stigma and depression and anxiety were not supported for either the total sample or the combined sex-work sample. However, there has been some research that suggests a link between anxiety (Chudakov et al., 2002) and depression (Chudakov et al., 2002; Moen, 2014) among sex workers. Perhaps clinicians were not aware of such

linkages. Alternatively, if they did not perceive the vignettes as intended, the diagnosis may just not have been relevant to them. Moreover, though there have been researchers who hypothesize a link between depression and stigma (Benoit et al., 2015), this relationship did not occur in the present study.

Prostitution Stigma and Mental Health Providers' Beliefs about Decent Work

No empirical research has been conducted that investigates mental health professionals' beliefs about whether sex work can be decent work (Vanwesenbeeck, 2001). This study was an attempt to discover whether there was any relationship between mental health professionals' beliefs about sex work and their sex-work-stigma attitudes. The current study did not find support that prostitution stigma predicted beliefs about decent work or whether stigma and decent work were moderated by theoretical orientations. This lack of a significant finding may indicate that future researchers need to continue to deconstruct the relationship between sex workers and sex work, as much of the theoretical and empirical literature does not differentiate between sex workers and the work they do.

Furthermore, the absence of support for the relationship between sex work stigma and decent work may also indicate mental health providers' lack of understanding about the specifics of sex workers' occupations. Lastly, the absence of support for the relationship between sex work stigma and decent work may indicate that sex work stigma does not influence mental health professionals' understanding of work or sex work. As sex workers increase the call to move towards decriminalization of their work within the legal system, it will become more important for mental health professionals to understand the link between sex work and clinical and therapeutic implications.

Limitations

Several potential limitations should be considered when interpreting the current study's findings. They can broadly be categorized into the following domains: (a) research design; (b) measurement; and (c) sampling.

Research Design Issues

The primary limitation of this study is whether the manipulation check of the control group (accountant) versus the experimental groups (i.e., street-based and escort vignette groups) worked. As previously discussed, the study did not include a manipulation check to confirm that the participants knew to which group they had been assigned. Further, although each participant was randomly assigned to the control and experimental groups, which was a positive aspect of the design, there was no way to check on participants' attention levels throughout the study for any of the conditions. It can be beneficial to check online surveys as some participants often have a tendency to ignore instructions and skip over written content (Oppenheimer et al., 2009) if questions are redundant or ask participants to answer questions using a particular format (e.g., Please answer this question by clicking on 5 – strongly agree).

A second design limitation may have been the order in which the online items were presented to the participants. The survey was attempting to investigate sex work stigma as the primary construct (i.e., predictor variables). Yet stigma was not assessed until the end of the survey. In part, stigma was not assessed until after the participants read the vignettes so as not to prime the participants' potential stigma towards sex workers or sex work. Thus, it might not have been possible to assess the association between the vignette, the service providers' exposure to the Attitude Toward Prostitutes

and Prostitution scale (Levin & Peled, 2011), sex work and sex worker stigma, and the criterion variables (i.e., PTSD, Anxiety, Depression, and Decent Work).

A final research design issue relates to whether mental health providers felt comfortable using diagnostic criteria when assessing clients for the first time. The mental health professionals in the present study might have been wary of diagnosing clients with symptoms of PTSD, anxiety, or depression without having adequate knowledge of the client's context, environment, and history. For example, this study used scales that were designed to be correlated with DSM diagnostic criteria; however, there may be potential difficulties with only using DSM diagnosis. If mental health professionals approach diagnosis using a transdiagnostic model (i.e., to diagnosis across or through existing categorical diagnoses to go beyond them to produce better classification (Fuasr-Poli et al., 2019)) this may have confounded the diagnosis of PTSD, Depression, and Anxiety in the study. Further, if the participants were not familiar with DSM criteria (i.e., participants who may be early career professionals), in which case, the scales may not have adequately measured the participants' understanding of mental health difficulties as it related to the vignettes. Thus, future research may consider adding questions to the survey, which assesses the level of familiarity with the PTSD, Depression, or Anxiety diagnoses.

Measurement Issues

There were also limitations to some of the scales (APPS and DWS) used to measure some of the conceptual constructs in the present study. I modified some of the measures, which potentially may have created reliability and validity issues. For example, the Attitude Toward Prostitutes and Prostitution scale (Levin & Peled, 2011) was

originally developed to measure social workers' prostitution stigma in Israel. Thus, there may have been cultural and societal differences in the ways that the U.S. participants interpreted the items relative to Israelis. I opted to modify the questionnaire to use the items that were relevant to American and Canadian understandings of sex work and to drop items that were negatively correlated with the intended subscales. For example, I dropped the item, "prostitution is important for teaching teenage boys about sexuality" because it was negatively correlated with other items on the subscale Attitudes Towards Prostitutes. Another example of a dropped item was "through prostitution, pretty girls can find a husband." I dropped it because it did not appear to be relevant to the United States' cultural context.

After dropping five items from the Attitudes Towards Prostitutes subscale and seven items from the Attitudes Towards Prostitution subscale, the reliability coefficients for each subscale increased from $\alpha = .64$ to $\alpha = .89$ for the Attitudes Towards Prostitutes subscale and from $\alpha = .71$ to $\alpha = .75$ for the Attitudes Towards Prostitution. Thus, the deletions made the subscale scores more reliable than they were in the original study. Nevertheless, it is not possible to tell whether the revised scale(s) better represented the constructs that the present study was designed to measure. Moreover, because of the modifications, it is not possible to compare scores of the sample with Levin and Peled (2011) original sample. Consequently, evidence of the validity of the measures' scores is limited. Yet the modifications may suggest how future versions of the Attitude Toward Prostitutes and Prostitution scale (Levin and Peled, 2011) might be modified for use in the US.

Another measurement concern was the Decent Work scale (Duffy et al., 2017). Though DWS is a broad assessment of participants' beliefs about decent work, it is unclear whether it was appropriate for analyzing sex work. For example, the Access to Healthcare subscale may not have appropriate if mental health professionals' did not perceive the vignettes about sex work and the clients within the vignettes having access to traditional benefits of employment (i.e., insurance, 401K). Another explanation for the measurement concern in the present study is the reliability coefficients for some of the subscales (e.g., Access to Healthcare and Adequate Compensation). In the present study, the analysis indicated that participants' answers to the items in the Access to Healthcare were highly correlated ($\alpha = .98$), thus, raising concerns about the validity of the subscale. Further, in this study, the Adequate Compensation subscales' Cronbach reliability coefficient ($\alpha = .49$) was low, thus indicating that participants' responses to the items measuring the construct were heterogeneous. Low correlation among the items potentially created noise, which potentially led to Type II errors (i.e., rejection of a true hypothesis) when used in the analyses.

Finally, another potential limitation is the way theoretical orientation was measured. Theoretical orientation was measured using Likert-type scales, ranging from strongly agree to strongly disagree, in which the service providers rated their agreement with respect to each of seven different theoretical orientations (i.e., psychoanalytic, self-psychology, relational psychoanalytic, humanistic, feminist, CBT, and behaviorist). However, using a single broad umbrella question to measure theoretical orientations may provide very little information about adherence to specific theoretical tenets within the theory that would lead to positive or negative stereotyping of sex workers by mental

health professionals. Perhaps a scale that assessed theory-related biases more directly would have provided more useful perspectives with respect to sex work. It is also possible, given that each mental health worker provided scores on all of the theoretical orientations, that profile analysis might have yielded different results from those obtained with multiple regression analyses. Perhaps providers do not use one orientation rather than another, but instead use them interactively.

Sample

For the current study, an initial sample of 383 participants agreed to participate in the study by signing the informed consent. However, the final count of who actually completed the survey was only 201. The attrition rate for the study was 48%, with the majority of individuals not completing one question beyond the informed consent. For each group, the vignettes were presented after the informed consent. Individual participants may not have felt they could complete the survey questions with the information given in the vignettes as each experimental group had between a 42% to 44% dropout rate. One consequence of this high dropout rate was that there were not enough participants for me to test my conceptual model by means of structural equation modeling (SEM) as I had originally intended. Moreover, statistical power for the multivariate analyses generally was affected by the relatively small number of participants.

Another potential limitation pertains to sampling bias as the study directly investigated the attitudes and beliefs of highly educated individuals within the mental health profession. This makes it difficult to generalize mental health professionals' attitudes towards sex workers within the system of mental health more broadly, as the mental health field encompasses other individuals beyond therapists (n = 25),

psychologists (n = 47), and social workers (n = 57). Furthermore, because the survey was administered online, it might not have been accessible to mental health workers who were hearing or visually impaired. The survey might also have been inaccessible to low-income providers without access to computers or the spare time to participate in my study as well as individuals who might have felt uncomfortable using technology to complete surveys.

Implications for Future Research

A number of research directions can be inferred from the current study. First, researchers should begin to work towards creating a scale to measure sex work stigma as it is expressed in the context of the United States as views about sex work and sex workers vary throughout the world. For example, some countries have decriminalized sex work, whereas some other countries have criminalized sex work. Sex-work laws may have an impact on mental health professionals' thoughts about decent work and diagnosis. Specifically, the legal and cultural landscape in the United States invariably has influenced the way that sex workers are perceived in society, but perhaps not among mental health professionals. The legal landscape in the United States has a history of criminalizing individuals who trade money or substances for some types of sex acts, which implicitly indicates that there is something either morally or legally wrong with the sale of sex (Ward & Roe-Sepowitz, 2009). Therefore, future sex-work stigma scales might incorporate items involving endorsement of the relevant law as well as religious beliefs about sex work.

Researchers may also work towards refining the Counselor Perception of Prostitution Scale (CPPS) by Millner (2010) to include beliefs about sex work as real

work. Millner's (2010) CPPS scale is designed to measure unintentional and intentional bias toward prostitution/commercial sex work and attempts to determine whether respondents perceive the work as intrinsically harmful or as an expression of women's sexuality and empowerment. Although the CPPS scale appears to mirror the debate in society about whether sex work is traumatizing or an expression of sexuality, it perhaps still leaves out the bias and stigma by which sex work is not perceived as work or as a form of invisible labor. The current study, in part, was investigating whether mental health professionals' viewed sex work as real work; but Millner's CPPS scale may be appropriate to use in further investigating bias or sex work stigma within the mental health field due to the CPPS focus on parts of prostitution stigma (i.e., trauma and sexual empowerment).

Furthermore, it may benefit researchers to conduct qualitative research focused on how mental health providers understand the types of work sex workers participate in and the types of stereotypes that mental health professionals may hold towards sex workers. It might also benefit researchers to conduct qualitative research with mental health professionals who have previously worked with individuals who have entered the sex work industry either by choice, circumstance, or coercion to begin to understand the developmental trajectory of sex workers and their therapists. Further, future researchers should investigate how institutional barriers (e.g., wait times, building locations, session length) may contribute to prostitution stigma. The present study did not investigate service providers' perceptions of institutional barriers with the possible exception of those inherent in the Decent Work scale (Duffy et al. 2017). Therefore, it is not clear from the results of the present study of how mental health providers incorporate such

factors in their work. The creation of a scale based in the United States' cultural context will help researchers to understand the relationship between therapists' stigmatizing attitudes toward sex workers and sex work.

Secondly, researchers should continue to work towards understanding mental health professionals' perceptions and assumptions about sex work. Although the current study found no significant relationships between decent work and sex work stigma, it may behoove researchers to conduct qualitative research on mental health professionals to determine how they understand the various types of sex work. Further, future researchers should continue to examine the different effects of demographic variables and types of professional training (e.g., school counseling, social work, mental health counseling). Future research should begin to examine the role of therapists' beliefs to ascertain whether a therapist's religious beliefs affect diagnostic impressions or expectations about sex work.

Additionally, future researchers should continue to attempt to understand if there is a relationship between sex workers, prostitution stigma, and trauma so that they can provide more useful mental health information to providers. The current study found evidence of a relationship between sex worker stigma and PTSD symptoms, as reported by service providers, even though the clinical vignettes were not written to include PTSD symptoms, which may be resulting in inappropriate clinical interventions. Researchers should begin to focus on different types of sex work that may be differentially associated with the frequency of PTSD symptoms (e.g., street-based work versus escort) (Rossler et al., 2010; Sanders, 2004; Wahab, 2004).

In addition, future researchers should continue to examine the role of theoretical orientations and their relationship to sex work stigma and diagnostic impressions. The current study found some evidence that feminist orientation moderated the relationship between sex work stigma and diagnostic impressions. Specifically, researchers should begin to focus on identifying or deconstructing the mechanisms within feminist theories that may have led to the association of trauma with those who do sex work for therapists in the present study.

Counseling Implications

The current study's findings may have several possible implications for counseling when working with sex workers. First, the results suggest that sex work stigma towards sex work and sex workers may affect PTSD diagnostic impressions, even if the client is not presenting with symptoms of PTSD. It is important for mental health providers to understand the role of their own sex work stigma when working with sex workers, specifically if the sex worker is not reporting symptoms of trauma.

Implicitly, the results might also indicate that mental health providers do not receive training that allows them to obtain adequate knowledge about the experiences of sex workers or the multiple occupations within sex work. As a starting point, agencies and hospitals that work with sex workers and employ mental health professionals could offer training opportunities for staff with the goals of deconstructing sex work stigma and increasing therapeutic knowledge of potentially traumatic experiences that sex workers may or may not have had.

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Appendix A

Demographic Questionnaire

1. What is your age (fill-in)?

2. What race do you identify as (fill-in)?

3. What ethnicity do you identify as (fill-in)?

4. What gender do you identify as (fill-in)?

5. What is your sexual orientation (fill-in)?

6. What is your highest educational degree (drop-down)? (High School Diploma, Bachelor Degree, Master's Degree, Doctoral Degree, or Other)

7. Do you have any post-graduate training related to mental health (e.g., psychoanalytic training, trauma certificates, etc.)? (fill-in)

8. What is your occupation (fill-in)?

9. What professional licenses do you hold (fill-in)?

10. How many years have you been doing clinical work (including practicum, internships, fellowships) (drop-down)? (1 to 3 years, 4 to 6 years, 7 to 10 years, Over 10 years)

11. Do you have any clinical experience working with sex workers (yes or no)?

11a. If yes, what type of work was the individual involved in (drop-down) (Street-based sex work, escorting, pornography model, exotic dancer, web-based or camming, or other)?

12. On a scale from 1 (Strongly Agree) to 7 (Strongly Disagree) rate the following theoretical orientations alignment with your own: Psychoanalytic Theory, Self-Psychology, Relational Psychodynamic Theory, Humanism, Feminism, Cognitive-Behavioral Theory, Behavioral Theory, and Post-Modern Theories.

Appendix B

Please rate the following items on a scale from 1 (Fully Disagree) to 5 (Fully Agree).

Questions	1 Fully Disagree	2 Disagree	3 Unsure	4 Agree	5 Fully Agree
Prostitution is the trafficking of women	1	2	3	4	5
Most prostitutes are drug addicts	1	2	3	4	5
Prostitution is forcing undesired sexual behavior	1	2	3	4	5
Prostitution is important for teaching teenage boys about sexuality*	1	2	3	4	5
Prostitutes earn a lot of money*	1	2	3	4	5
Prostitution allows women who practice it to actualize their sexual fantasies*	1	2	3	4	5
Prostitution increase drug use in society	1	2	3	4	5
Most prostitutes are morally corrupt	1	2	3	4	5
Without prostitution, more women would get raped*	1	2	3	4	5
Most prostitutes are ugly	1	2	3	4	5
Prostitution damages society's morals	1	2	3	4	5
Prostitutes spread AIDs	1	2	3	4	5
Prostitution is a violation of women's human dignity	1	2	3	4	5
Prostitutes enjoy controlling men*	1	2	3	4	5
Women become prostitutes because they were not properly educated	1	2	3	4	5
Prostitution provides men with stress relief*	1	2	3	4	5
Prostitution is a form of violence against women	1	2	3	4	5
Prostitutes like sex	1	2	3	4	5
Many prostitutes are students who prefer a convenient, profitable job*	1	2	3	4	5
Prostitutes are victims of drug abuse	1	2	3	4	5
Prostitution is a way for some women to gain power and control*	1	2	3	4	5
Women choose to be prostitutes*	1	2	3	4	5
Prostitution is a form of rape in which the victim gets paid	1	2	3	4	5
Women choose to be prostitutes*					
Prostitution harms the institution of marriage*	1	2	3	4	5
Most prostitutes only work as prostitutes for a few years to get settled financially	1	2	3	4	5
Prostitutes are unable to get out of the situation they are in	1	2	3	4	5
Prostitution is a way to empower economically disadvantaged populations	1	2	3	4	5
Through prostitution, pretty girls can find a husband*	1	2	3	4	5

Note: * indicate questions that were dropped in the analysis.

Appendix C

Please respond to the following items on a scale from 1 (Strongly Disagree) to 7 (Strongly Agree)

Sex workers feel emotionally safe interacting with people at work						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
At work, sex workers feel safe from emotional or verbal abuse of any kind						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
Sex workers feel physically safe interacting with people at work						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
Sex workers get good health care benefits from their job						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
Sex workers have a good healthcare plan at work						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
Sex workers employer provides acceptable options for healthcare						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
Sex workers are not properly paid for their work						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
Sex workers do not feel that they are paid enough based on their qualifications and experience						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
Sex workers are rewarded adequately for their work						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
Sex workers do not have enough time for non-work activities						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree

Sex workers have no time to rest during the workweek						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
Sex workers have free time during the workweek						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
The values of sex workers work to match their family values						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
Sex work values align with their family values						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree
The values of sex work match the values within the sex workers community						
1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Unsure	5 Slightly Agree	6 Agree	7 Strongly Agree

Appendix D

Circle the number that best represents how the client has been feeling in the last week.

0 = Not at All	1 = From time to time, occasionally	2 = A lot of the time	3 = Most of the time

1. Client feels tense or “wound up”	0	1	2	3
2. Client still enjoys the things they used to enjoy	0	1	2	3
3. Client gets a sort of frightened feeling as if something awful is about to happen	0	1	2	3
4. Client can laugh and see the funny side of things	0	1	2	3
5. Worrying thoughts go through the client’s mind	0	1	2	3
6. Client feels cheerful	0	1	2	3
7. Client can sit at ease and feel relaxed	0	1	2	3
8. Client feels as if they are slowed down	0	1	2	3
9. Client gets a sort of frightened feeling like “butterflies” in the stomach	0	1	2	3
10. Client has lost interest in their appearance	0	1	2	3
11. Client feels restless as if they have to be on the move	0	1	2	3
12. Client looks forward with enjoyment to things	0	1	2	3
13. Client gets sudden feelings of panic	0	1	2	3
14. Client can enjoy a good book or radio or TV program	0	1	2	3

Note: Anxiety scale: Items 1, 3, 5, 7, 9, 11, 13. Depression scale: Items 2, 4, 6, 8, 10, 12, 14.

Appendix E

The following are symptoms that people sometimes have after experiencing, witnessing, or being confronted with a traumatic event. Please read each one carefully and circle the number that corresponds best with your clients' experience.

0 = Not at All	1 = Rarely	2 = Sometimes	3 = Most of the time

1. Client has recurrent thoughts or memories of the event	0	1	2	3
2. Client has felt as though the event is happening again	0	1	2	3
3. Client has recurrent nightmares about the event	0	1	2	3
4. Client has sudden emotional or physical reactions when reminded of the event	0	1	2	3
5. Client avoids activities that remind them of the event	0	1	2	3
6. Client avoids thoughts or feelings associated with the event	0	1	2	3
7. Client feels jumpy or easily startled	0	1	2	3
8. Client feels guarded	0	1	2	3

Appendix F

Vignette 1

Luca is a 28-year-old who presents to therapy with concerns about work and worrying about her mother's transition to retirement. She self-referred to therapy.

Luca reports growing up in a lower-middle-class family with access to decent schools. Luca reported attending some community college when she was 18, but found it unfulfilling. Currently, she works as an accountant in a large urban city. She describes her job as repetitive, requiring a consistent structure, and organizational and interpersonal skills. She says that she finds it sometimes stressful to interact with many people on a daily basis, and the long working hours and budgeting constantly are challenging.

Luca's mother has been struggling with her relationship with Luca since she retired about a year ago. Luca has periodically been missing family dinners and her mother no longer calls as often. Luca's family consists of her father, mother, and one other sibling. She describes their family as close and supportive. She reported feeling worried about her parents and stated she "has had trouble concentrating at work." Luca also reports feeling guilty that she is unable to help her mother more because she is usually busy working. Luca reports that she has a handful of friends, but often has limited time for her friends because of her work schedule. She also reports being in a romantic relationship with her partner of 3 years. She describes their relationship as supportive and validating. Luca describes her days as normal. She attends work every day, eats three meals a day, and sleeps fine. Luca reports that she has been feeling "stressed lately and would like to learn better ways of coping."

Vignette 2

Luca is a 28-year-old who presents to therapy with concerns about work and worrying about her mother's transition to retirement. She self-referred to therapy.

Luca reports growing up in a lower-middle-class family with access to decent schools. Luca reported attending some community college when she was 18, but found it unfulfilling. Currently, she works as a street-based sex worker in a large urban city. She describes her job as repetitive, requiring a consistent structure, and organizational and interpersonal skills. She says that she finds it sometimes stressful to interact with many people on a daily basis, and the long working hours and budgeting constantly are challenging.

Luca's mother has been struggling with her relationship with Luca since she retired about a year ago. Luca has periodically been missing family dinners, and her mother no longer calls as often. Luca's family consists of her father, mother, and one other sibling. She describes their family as close and supportive. She reported feeling worried about her parents and stated she "has had trouble concentrating at work." Luca also reports feeling guilty that she is unable to help her mother more because she is usually busy working. Luca reports that she has a handful of friends, but often has limited time for her friends because of her work schedule. She also reports being in a romantic relationship with her partner of 3 years. She describes their relationship as supportive and validating. Luca describes her days as normal. She attends work every day, eats three meals a day, and sleeps fine. Luca reports that she has been feeling "stressed lately and would like to learn better ways of coping."

Vignette 3

Luca is a 28-year-old who presents to therapy with concerns about work and worrying about her mother's transition to retirement. She self-referred to therapy.

Luca reports growing up in a lower-middle-class family with access to decent schools. Luca reported attending some community college when she was 18, but found it unfulfilling. Currently, she works as an escort in a large urban city. She describes her job as repetitive, requiring a consistent structure, and organizational and interpersonal skills. She says that she finds it sometimes stressful to interact with many people on a daily basis, and the long working hours and budgeting constantly are challenging.

Luca's mother has been struggling with her relationship with Luca since she retired about a year ago. Luca has periodically been missing family dinners, and her mother no longer calls as often. Luca's family consists of her father, mother, and one other sibling. She describes their family as close and supportive. She reported feeling worried about her parents and stated she "has had trouble concentrating at work." Luca also reports feeling guilty that she is unable to help her mother more because she is usually busy working. Luca reports that she has a handful of friends, but often has limited time for her friends because of her work schedule. She also reports being in a romantic relationship with her partner of 3 years. She describes their relationship as supportive and validating. Luca describes her days as normal. She attends work every day, eats three meals a day, and sleeps fine. Luca reports that she has been feeling "stressed lately and would like to learn better ways of coping."

Appendix G

You are going to read a brief vignette. Imagine yourself as the therapist who has been assigned to work with this client, and this is your first meeting together. The client is beginning to describe the reasons for coming to therapy. Please pay attention as you will be asked several questions about the vignette.

Note: Used with Permission from Holzapfel, J

Appendix H

Correlations Among Interaction Terms for Theoretical Orientation and Prostitution Stigma and Mental ($N = 201$)

	1	2	3	4	5	6
1. PSYxSWer	1					
2. FEMxSWer	.17*	1				
3. BEHxSWer	.14*	.38**	1			
4. PSYxSW	.89**	.19**	.13	1		
5. FEMxSW	.16*	.87**	.33**	.37**	1	
6. BEHxSW	.12	.37**	.88**	.28**	.53**	1
Mean	59.63	70.45	64.98	89.17	106.01	97.40
SD	29.09	28.97	30.80	48.41	51.02	51.53

Note: 1. PSYxSWer = Interaction term for psychoanalytic theory and sex worker stigma; 2. FEMxSWer = Interaction term for feminist theory and sex worker stigma; 3. BEHxSWer = Interaction term for behavioralist theory and sex worker stigma; 4. PSYxSW = Interaction term for psychoanalytic theory and sex work stigma; 5. FEMxSW = Interaction term for feminist theory and sex work stigma; 6. BEHxSW = Interaction term for Behavioralist theory and sex work stigma.

Appendix I

Table 7

Summary of Providers' Stigma towards Sex Work and Sex Workers as Predictors of Decent Work Criteria in the Combined Sex Work Condition (*N*=154)

Predictor Variable	Dependent Variable	M *(SD)*	*F*-test	R^2	*B*	*t*
Sex Work Stigma						
	Safe Working	12.25 (2.48)	1.00 [a]	.006	-.08	-1.00
	Access to Healthcare	9.16 (3.73)	.0001 [a]	.000	.001	.01
	Values	14.81 (3.05)	.69 [a]	.004	-.06	-.83
	Rest and Free Time	10.87 (2.35)	.35 [a]	.002	.04	.60
Sex Worker Stigma						
	Safe Working	12.25 (2.48)	.02 [a]	.0001	-.01	-.15
	Access to Healthcare	9.16 (3.73)	.07 [a]	.0005	-.02	-.28
	Values	14.81 (3.05)	1.16 [a]	.007	-.08	-1.08
	Rest and Free Time	10.87 (2.35)	2.12 [a]	.013	.12	1.46

Note: [a]= *df = (2, 153).*

Table 8

Summary of Providers' Stigma towards Sex Work and Sex Workers as Predictors of Decent Work Criteria in the Combined Sex Work Condition (*N*=201)

Predictor Variable	Dependent Variable	M *(SD)*	*F*-test	R^2	*B*	*t*
Sex Work Stigma						
	Safe Working	12.34 (2.58)	1.08 [a]	.005	-.07	-1.04
	Access to Healthcare	9.91 (3.58)	.12 [a]	.0006	.02	.35
	Values	14.82 (3.01)	1.02 [a]	.005	-.07	-1.01
	Rest and Free Time	10.91 (2.31)	.01 [a]	.0001	.008	.12
Sex Worker Stigma						
	Safe Working	12.34 (2.58)	.03 [a]	.0002	-.01	-.18
	Access to Healthcare	9.91 (3.58)	.02 [a]	.0001	-.01	-.14
	Values	14.82 (3.01)	.30 [a]	.001	-.03	-.55
	Rest and Free Time	10.91 (2.31)	1.02 [a]	.005	.07	1.01

Note: [a]= *df = (2, 199).*

Appendix J

Table 9

Summary of Regression Analysis Using Stigma towards Sex Work and Sex Workers to Predict PTSD Hypervigilance Symptoms Moderated by Theoretical Orientation

	Predictor Variable	B	t
Step 1		.58	.67
	Sex Work Stigma	.30	2.93**
	Sex Worker Stigma	-.05	-.52
	Psychoanalytic	-.07	-.99
	Feminist	.14	.20
	Behavioralist	-.43	-.60
Step 2		2.14	.72
	Sex Work Stigma	.40	.78
	Sex Worker Stigma	-.32	-.62
	Psychoanalytic	-.12	-.40
	Feminist	-.33	-1.14
	Behavioralist	.05	.19
	Sex Work Stigma * Feminist	-.54	-1.14
	Sex Work Stigma * Behavioralist	.81	1.85
	Sex Work Stigma * Psychoanalytic	.41	.80
	Sex Worker Stigma * Feminist	.85	1.69
	Sex Worker Stigma * Behavioralist	-.84	-1.63
	Sex Worker Stigma * Psychoanalytic	.41	.80

Note: * = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Table 10

Summary of Regression Analysis Using Stigma towards Sex Work and Sex Workers to Predict PTSD Intrusion Symptoms Moderated by Theoretical Orientation

	Predictor Variable	B	t
Step 1		.90	.57
	Sex Work Stigma	.22	2.01*
	Sex Worker Stigma	-.02	-.20
	Psychoanalytic	-.06	-.82
	Feminist	-.45	.65
	Behavioralist	-.13	.89
Step 2		.77	.14
	Sex Work Stigma	.75	1.43
	Sex Worker Stigma	-.41	-.78
	Psychoanalytic	-.12	-.38
	Feminist	-.18	-.63
	Behavioralist	.22	.81
	Sex Work Stigma * Feminist	-.92	-1.92
	Sex Work Stigma * Behavioralist	-.43	-.82
	Sex Work Stigma * Psychoanalytic	.002	.005
	Sex Worker Stigma * Feminist	.96	1.86
	Sex Worker Stigma * Behavioralist	-.43	-.82
	Sex Worker Stigma * Psychoanalytic	.08	.15

Note: * = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Table 11

Summary of Regression Analysis Using Stigma towards Sex Work and Sex Workers to Predict PTSD Avoidance Symptoms Moderated by Theoretical Orientation

	Predictor Variable	B	t
Step 1		.60	.66
	Sex Work Stigma	.24	2.30*
	Sex Worker Stigma	-.08	-.72
	Psychoanalytic	-.04	-.42
	Feminist	-.03	-.42
	Behavioralist	.03	.41
Step 2		1.93	.62
	Sex Work Stigma	.75	1.43
	Sex Worker Stigma	.63	-1.21
	Psychoanalytic	-.20	-.63
	Feminist	-.31	-1.05
	Behavioralist	.21	.78
	Sex Work Stigma * Feminist	-1.05	-2.17*
	Sex Work Stigma * behaviorist	.44	.97
	Sex Work Stigma * Psychoanalytic	.93	.21
	Sex Worker Stigma * Feminist	1.20	2.33*
	Sex Worker Stigma * behaviorist	-.61	-1.16
	Sex Worker Stigma * Psychoanalytic	.11	.21

Note: * = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Table 12

Summary of Regression Analysis Using Stigma towards Sex Work and Sex Workers to Predict Anxiety Symptoms Moderated by Theoretical Orientation

	Predictor Variable	B	t
Step 1		7.96	5.16***
	Sex Work Stigma	.10	.97
	Sex Worker Stigma	-.03	-.30
	Psychoanalytic	.03	.50
	Feminist	.06	.91
	Behavioralist	-.10	-1.38
Step 2		1.89	.35
	Sex Work Stigma	.14	.27
	Sex Worker Stigma	.38	.71
	Psychoanalytic	.45	1.41
	Feminist	.40	1.35
	Behavioralist	-.17	-.62
	Sex Work Stigma * Feminist	-.91	-1.88
	Sex Work Stigma * Behavioralist	.62	1.37
	Sex Work Stigma * Psychoanalytic	.34	.78
	Sex Worker Stigma * Feminist	.35	.68
	Sex Worker Stigma * Behaviorist	-.43	-.81
	Sex Worker Stigma * Psychoanalytic	-.76	-1.44

Note: * = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Table 13

Summary of Regression Analysis Using Stigma towards Sex Work and Sex Workers to Predict Depression Symptoms Moderated by Theoretical Orientation

	Predictor Variable	B	t
Step 1		9.84	9.93***
	Sex Work Stigma	-.23	-2.21*
	Sex Worker Stigma	.20	1.93
	Psychoanalytic	-.17	2.30*
	Feminist	-.06	-.97
	Behaviorist	-.08	-1.23
Step 2		13.60	4.02***
	Sex Work Stigma	-.33	-.64
	Sex Worker Stigma	-.14	-.26
	Psychoanalytic	-.77	-2.43*
	Feminist	-.03	-.16
	Behavioralist	-.20	-.75
	Sex Work Stigma * Feminist	.34	.72
	Sex Work Stigma * Behaviorist	-.26	-.59
	Sex Work Stigma * Psychoanalytic	.05	.12
	Sex Worker Stigma * Feminist	-.35	-.68
	Sex Worker Stigma * Behavioralist	.38	.72
	Sex Worker Stigma * Psychoanalytic	.65	.68

Note: * = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Appendix K

Table 14

Summary of Regression Analysis Using Stigma towards Sex Work and Sex Workers to Predict Safe Working Conditions as Moderated by Theoretical Orientation

	Predictor Variable	B	t
Step 1		13.97	11.39***
	Sex Work Stigma	-.12	-1.20
	Sex Worker Stigma	.06	.60
	Psychoanalytic	-.01	-.23
	Feminist	-.15	-2.20*
	Behavioralist	-.002	-.03
Step 2		5.67	1.36
	Sex Work Stigma	-.004	-.008
	Sex Worker Stigma	.75	1.42
	Psychoanalytic	.27	.85
	Feminist	.29	.99
	Behavioralist	.42	1.54
	Sex Work Stigma * Feminist	-.93	-1.77
	Sex Work Stigma * Behavioralist	.46	1.02
	Sex Work Stigma * Psychoanalytic	.04	.10
	Sex Worker Stigma * Feminist	.002	.004
	Sex Worker Stigma * Behavioralist	-.93	-1.77
	Sex Worker Stigma * Psychoanalytic	-.35	-.67

Note: * = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Table 15

Summary of Regression Analysis Using Stigma towards Sex Work and Sex Workers to Predict Access to Healthcare Moderated by Theoretical Orientation

	Predictor Variable	B	t
Step 1		9.61	5.59***
	Sex Work Stigma	.07	.72
	Sex Worker Stigma	-.07	-.68
	Psychoanalytic	.07	1.06
	Feminist	-.06	-.93
	Behavioralist	.05	.77
Step 2		10.51	1.77
	Sex Work Stigma	.04	.09
	Sex Worker Stigma	-.14	-.26
	Psychoanalytic	-.03	-.09
	Feminist	-.09	-.31
	Behavioralist	.09	.34
	Sex Work Stigma * Feminist	.11	.23
	Sex Work Stigma * Behavioralist	-.07	-.15
	Sex Work Stigma * Psychoanalytic	-.01	-.03
	Sex Worker Stigma * Feminist	-.06	-.12
	Sex Worker Stigma * Behavioralist	.005	.009
	Sex Worker Stigma * Psychoanalytic	.14	.25

Note: * = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Table 16

Summary of Regression Analysis Using Stigma towards Sex Work and Sex Workers to Predict Values Moderated by Theoretical Orientation

	Predictor Variable	B	t
Step 1		11.21	10.243***
	Sex Work Stigma	-.09	-.88
	Sex Worker Stigma	.05	.48
	Psychoanalytic	.10	1.48
	Feminist	.02	.32
	Behavioralist	-.14	-1.99*
Step 2		15.79	4.22***
	Sex Work Stigma	-.45	-.85
	Sex Worker Stigma	-.15	-.28
	Psychoanalytic	-.41	-1.28
	Feminist	.05	.18
	Behavioralist	-.41	-1.51
	Sex Work Stigma * Feminist	.61	1.27
	Sex Work Stigma * Behavioralist	-.09	-.20
	Sex Work Stigma * Psychoanalytic	-.01	-.03
	Sex Worker Stigma * Feminist	-.56	-1.10
	Sex Worker Stigma * Behavioralist	.41	.79
	Sex Worker Stigma * Psychoanalytic	.60	1.14

Note: * = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Table 17

Summary of Regression Analysis Using Stigma towards Sex Work and Sex Workers to Predict Rest and Free Time as Moderated by Theoretical Orientation

	Predictor Variable	B	t
Step 1		13.50	9.35***
	Sex Work Stigma	-.11	-1.00*
	Sex Worker Stigma	.16	1.52
	Psychoanalytic	.02	.28
	Feminist	.06	-.68
	Behaviorist	-.05	-.68
Step 2		11.41	2.32*
	Sex Work Stigma	-.53	-1.01
	Sex Worker Stigma	.66	1.23
	Psychoanalytic	.12	.38
	Feminist	.01	.03
	Behavioralist	.66	1.23
	Sex Work Stigma * Feminist	.08	.18
	Sex Work Stigma * Behavioralist	-.30	-.66
	Sex Work Stigma * Psychoanalytic	.87	2.01*
	Sex Worker Stigma * Feminist	-.01	-.01
	Sex Worker Stigma * Behavioralist	-.02	-.04
	Sex Worker Stigma * Psychoanalytic	-.90	1.69

Note: * = $p < .05$; ** = $p < .01$; *** = $p < .001$.