Mapping Therapists' Clinical Decision-Making with Clients Engaged in the Sex Trade: A Thematic Analysis

By

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Abstract

Understanding how therapists engage in clinical practice with clients in the sex trade is essential to improving the quality and accessibility of mental health care for this stigmatized population. Sex trade is a widespread phenomenon encompassing sex work, commercial sexual exploitation, and sex trafficking. Individuals in the sex trade experience pervasive stigmatization, which contributes to adverse mental health outcomes and barriers to affirming mental health care, including, but not limited to, judgment and pathologization from providers (Antebi-Gruszka et al., 2019; Gerassi et al., 2019; Grittner & Walsh, 2020; Kurtz et al., 2005; Pederson et al., 2019). However, how therapists engage in clinical practice with clients in the sex trade has been understudied. The present study sought to address this gap by interviewing 20 licensed mental health practitioners with experience working with clients in the sex trade. I used thematic analysis (Braun & Clarke, 2006) to address the following analytic questions: 1) How do therapists perceive the emergence of sex trading in clinical practice? 2) How do therapists address clients' sex trading in clinical practice? Based on extant literature, I focused on salient clinical moments (responding to disclosure, navigating terminology, and determining the focus of therapy) and areas of clinical content (stigma and safety). A central finding of this work is that unique therapist and client contributions informed participants' clinical decision-making. Therapist contributions included previous personal and professional exposure to the sex trade, frameworks informing conceptualization, and awareness of personal attitudes and biases. Client contributions included past experiences with and current expectations related to disclosing sex trading, experiences in the sex trade, and how the client made meaning of their experiences. Findings are also discussed in the context of foundational clinical skills and psychotherapy processes. Finally, implications for clinical training, practice, and future research are discussed.

Chapter 1: Introduction

Sex trade is a widespread phenomenon and encompasses sex work, commercial sexual exploitation, and sex trafficking, which are engaged in by a heterogeneous group of people (e.g., race, class, gender, indigeneity, ability). Approximately 46 million women (i.e., 1.5%) engage in the commercial sex trade industry worldwide (Benoit et a., 2018). Within the United States, results from two large national surveys suggest that 12-13% of trans individuals have participated in the commercial sex trade at some point in their lives (Grant et al., 2010; James et al., 2016). Estimates of sex trafficking prevalence within the United States remain a source of continued debate. Roughly 1,000 sex trafficking survivors per year are officially recognized within the justice system, while estimates from social service providers are closer to 100,000-300,000 instances of sex trafficking (Nichols, 2016). However, all estimates are likely underestimations given the methodological challenges of gathering data related to criminalized acts and limited prevalence estimates among men, transmasculine, and nonbinary individuals (Bungay et al., 2016; Jones, 2020).

Defining Sex Trade

Sex trade(s) refer to sexual acts that are exchanged for compensation. *Sex work* commonly describes adults who trade sex voluntarily (i.e., in the absence of force, fraud, or coercion), in the presence of alternatives, and/or as independent workers acting with agency over their labor and commercial exchanges (Kurtz et al., 2005; Lazarus et al., 2012). Others expand the definition of sex work to encompass people who enter into the sex trade in order to meet their basic needs and in a context of constrained choices (Benoit et al., 2019; McCarthy et al., 2014). *Commercial sexual exploitation (CSE)* is sex trade that occurs due to a vulnerability or contextual factor being exploited. For example, preexisting vulnerabilities include but are not

limited to poverty, age, addiction, intellectual disability, citizenship status, and homelessness (Benoit et al., 2019). Among adults, federal law defines *sex trafficking* as occurring when an individual 18 or older is induced by force, fraud, or coercion to perform a commercial sex act (22 U.S.C §7102). Within this context, a commercial sex act is defined as any sex act for which an individual receives or is given something of value. Among minors, federal law defines sex trafficking as occurring anytime a minor engages in commercial sex, regardless of the presence or absence of force, fraud, or coercion. Throughout the remainder of this proposal, my use of "sex trade" refers only to adults engaging in commercial sex. A focus on the experiences of minors is outside the scope of the present work.

Individuals who trade sex have varied experiences of agency, coercion, and victimization (Gerassi & Nichols, 2017). However, dominant perspectives on the sex trade often view agency and victimization as discrete and dichotomous categories where, for example, the presence of agency indicates the absence of victimization and vice versa (Gerassi & Nichols, 2017; Nichols, 2016). This is important to consider because broader societal beliefs about the sex trade, perpetuated by forces like the media and policy, can be internalized and enacted by mental health providers. For example, Wolf (2019) cautions that some therapists may "…overlook the reality that choice and circumstance often overlap, and those who have been involved in the sex industry by force have often navigated the full spectrum of these concepts…." (p. 7). In this work, I want to hold space for the idiosyncratic, fluid, complex, and overlapping ways adults who trade sex can experience agency, coercion, and victimization. For example, after reaching 18 years of age, youth who continue to engage in the sex trade may be exploited or transition into consensual sex work and no longer be considered sex trafficking victims. Alternatively,

individuals who see themselves as consensual sex workers may come under the control of a pimp and be viewed as entering into the context of sex trafficking.

In the present work, I am utilizing Gerassi and Nichols' (2017) Continuum of Agency to Victimization to make sense of sex work, CSE, and sex trafficking as overlapping categories that individuals can move between (See Figure 1). Gerassi and Nichols (2017) position sex workers at one end of the continuum, indicating the presence of agency and options and the absence of exploited vulnerabilities. At the center of the continuum rests CSE, where buyers and traffickers exploit vulnerabilities. On the other end, sex trafficking involves commercial sex induced through force, fraud, and coercion among adults and any commercial sex among minors. Importantly, agency, coercion, and victimization can occur at any point along this continuum (Gerassi & Nichols, 2017). Sex workers who use their agency and choose to engage in commercial sex are still at risk of coercion and victimization in their interactions across systemic, institutional, and interpersonal levels. Similarly, trafficked and exploited individuals can enact their agency through any number of actions ranging from seeking help to making decisions necessary for survival (Gerassi & Nichols, 2017). In addition to defining the sex trade and understanding the central tenets of this framework, it is crucial to attend to the unique risks that can be faced across the continuum.

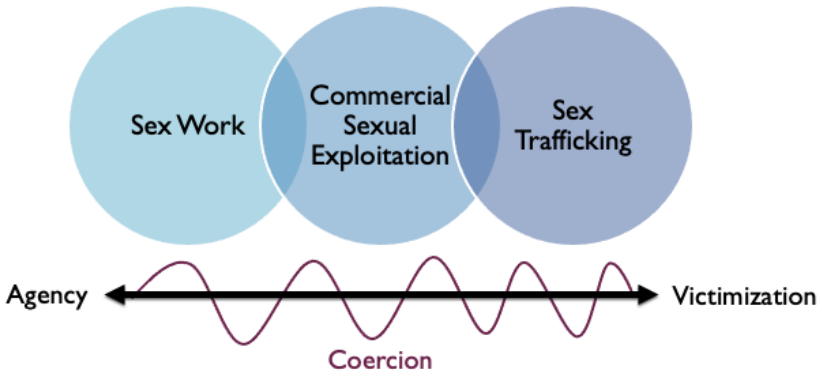
Client Focus

I focus on individuals who trade sex in this study because they, their mental health, and their ability to access affirming care and spaces of healing matter. I will discuss the risks and stigma associated with the sex trade. Stigma is the assignment of inferior status and judgment to individuals and groups based on a social attribute or mark that distinguishes them from others (Goffman, 1963). Stigma impacts individuals' self-concept and social interactions as they

experience exclusion, discrediting, judgment, and shame (Benoit et al., 2018; Wolf, 2019). Stigmatizing attitudes can also become embedded in and reinforced by laws and policies (Wolf, 2019).

Figure 1

Agency-Victimization Continuum



Note: Source (Gerassi & Nichols,2017)

For example, Link and Hatzenbuehler (2016) write that stigma plays an important "role in the distribution of life chances, influencing health through the production of disadvantage and the induction of stress." Individuals involved in the sex trade experience high levels of stigma because they are "seen as 'symbolically dirty,'… stereotyped as irresponsible, criminal or vectors of disease and are treated as a threat to self or public" (Benoit et al., 2019c, p. 2). This exposes them to public shame, social estrangement, state monitoring, and police harassment (Grittner & Walsh, 2020). Sex trade stigma also influences health, behavior, and well-being, with significant negative implications for mental and physical health among people who trade sex (Benoit et al., 2018; Corrigan, 2004; Grittner & Walsh, 2020; Kurtz et al., 2005; Link & Hatzenbuehler, 2016). The stigma associated with the sex trade is omnipresent and often

intersects with other forms of oppression (e.g., White supremacy, heterosexism, transphobia, ableism, colonialism) (Benoit et al., 2018; Gerassi et al., 2019; Lyons et al., 2017).

Previous research has identified stigma as a critical factor impacting the quality and accessibility of services provided by mental health professionals (Koken, 2012; Lazarus et al., 2012; Quinn & Chaudoir, 2009). Even if services are accessed, clients who trade sex may encounter judgment, invalidation, and pathologization from providers (Antebi-Gruszka et al., 2019; Gerassi et al., 2019; Grittner & Walsh, 2020; Kurtz et al., 2005; Pederson et al., 2019). Individuals who trade sex may fear and expect their therapist's attitudes and beliefs to reflect those found in society. Because trading sex is a concealable identity, clients can cope with stigma by concealing sex trading within the therapeutic relationship (Koken, 2012; Quinn & Chaudoir, 2009). This self-protective approach may hinder a therapist's understanding of their client's lived experience regardless of whether presenting concerns are related to the sex trade. Concealment can also limit a therapist's ability to support clients navigating risks related to the sex trade (e.g., engaging in supportive harm-reduction conversations) (Antebi-Gruszka et al., 2019). The potential risks related to the sex trade are also notable.

Risks associated with the sex trade include but are not limited to, experiencing discrimination across systemic, institutional, and interpersonal levels (Nadal et al., 2014). For example, people who trade sex face a heightened risk of violence and harassment. Grittner and Walsh (2020) tie this back to stigma, writing that "many sex workers identify stigma as intertwined with pervasive beliefs that sex workers are personally to blame or deserve the violence and discrimination they experience" (p. 1673). Compounding factors include being unable to seek recourse within the criminal justice system if clients become violent or refuse to pay (Lyons et al., 2017); being unable to provide proof of income (e.g., a W-2) (Nadal et al.,

2014); and facing employment and housing discrimination (Nadal et al., 2014; Shaver et al., 2011).

At the same time as emphasizing the risks and stigmatization faced by people in the sex trade, it is also important to note that sex workers experience both tangible and intangible benefits from their work (Pederson et al., 2019). Therefore, therapists need to be willing and able to explore what their clients gain through the sex trade (Antebi-Gruszka et al., 2019; Bloomquist & Sprankle, 2019; Wolf, 2019). In my literature review, I primarily focus on risks and challenges that may be experienced within the sex trade to underscore the importance of mental health care being affirming and accessible. At the same time, it is essential to recognize the potential negative clinical implications of therapists overlooking and invalidating the benefits their clients might experience in the sex trade or the needs that might be met through the sex trade. In this study, I focus specifically on therapists given their central role in either empowering and supporting or harming and pathologizing this vulnerable population.

Provider Focus

I hope to better understand whether and how providers make sense of their clients' experiences of trading sex within a complicated landscape of agency, coercion, and victimization (Gerassi & Nichols, 2017). My focus on providers is motivated by an understanding of the power-differential inherent in providing mental health services where providers are placed in a position of power relative to the clients they serve (Feminist Therapy Institute, 1999). From this position of power, therapists' attitudes and biases can manifest implicitly or explicitly within their clinical practice and have implications for client care, healing, and well-being. Indeed, prior research has demonstrated the influence of therapists' attitudes and beliefs on clinical judgment and behavior, which may affect the therapeutic process and outcomes (Tao et al., 2015). In order

to mitigate harmful clinical practices and the perpetuation of bias, therapists are tasked with not only building self-awareness around their attitudes and biases but also gaining relevant knowledge and understanding (Tao et al., 2015; Sue, Arredondo, & McDavis, 1992; Vera & Speight, 2003).

The importance of engaging in self-reflective practice and continuing education is underscored for therapists serving clients who hold marginalized or stigmatized identities and experiences (e.g., sexual and gender minorities, racial and ethnic minorities, persons with disabilities, economically marginalized). Because mental health care providers live in a society that stigmatizes and marginalizes their clients, they are subject to the same internalized negative attitudes and biases in our culture. In order to hinder harmful practices, professional associations such as the American Psychosocial Association have developed guidelines for practitioners working with particular populations to facilitate the provision of efficacious and affirming mental health care. Individuals who trade sex face significant social stigmatization and marginalization, yet guidelines for providing affirming services to this population are limited (Antebi-Gruszka et al., 2019; Task Force on Trafficking of Women and Girls, 2014). Mental health providers have a critical responsibility to ensure that they are aware of their attitudes and biases surrounding the sex trade.

Given this population's vulnerability and the pervasive impact of stigma on them, my main purpose in this investigation has been to better understand the clinical landscape of sex trade in therapy. I focus on mental health care providers because their perspectives have significant implications for client care. The role of therapists is vital to consider when working with vulnerable populations. We can also begin to appreciate the ways in which therapists can either perpetuate or disrupt stigma processes within the therapeutic relationship. Addressing the

role of stigma in the lives of individuals who trade sex can help us to understand some of the unique challenges these clients navigate.

By attending to how sex trade related content emerged and was addressed by therapists in sessions, I sought to gain insight into how therapists understand their clinical practice with clients who trade sex. These research efforts have been guided by the following main research questions: 1) How do therapists perceive the emergence of sex trading in clinical practice? 2) How do therapists address clients' sex trading in clinical practice? My intention is that findings from this work will be utilized to inform clinical training and practice for this underserved group.

Chapter 2: Review of the Literature

In this chapter, I present a review of the literature base informing my thinking as I began this study. The first section provides the conceptual context for the study by discussing stigma as it may be experienced by individuals who trade sex and perpetuated or counteracted by therapists. The second section situates the study within the context of scholarship related to therapists' attitudes and their impact on clinical practice. The final section addresses three dominant frameworks for understanding the sex trade that have been elucidated in previous scholarly work.

2.1. Defining Stigma

In the context of the sex trade, stigma has implications for individuals' working conditions, personal lives (i.e., isolation, rejection), physical and mental health and well-being, discrimination when seeking social services, and violence, hostility, and harassment from family, friends, clients, and the criminal justice system (Benoit et al., 2018; Benoit et al., 2019; Grittner & Walsh, 2020; Koken, 2012; Lazarus et al., 2012; Quinn & Earnshaw, 2013; Sprankle et al., 2018; Weitzer, 2018). Stigma involves the societal devaluation of an individual's identity,

attribute, or behavior (Goffman, 1963). Goffman (1963) writes that "we believe the person with a stigma is not quite human" but rather a "tainted, discounted one." Stigma may be attached to a visible or concealable attribute, controllable or uncontrollable, or to a person's group membership, appearance, or behavior (Major & O'Brien, 2005). Stigma involves using power and the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001). Link and Phelan (2014) offer a framework for understanding stigma that shifts away from the historical emphasis on inter- and intrapersonal experiences, instead focusing on the broader social function of stigma. Here stigma is viewed as serving the aims of stigmatizers through maintaining dominant social norms and attempting to control those who deviate from the norm (Link & Phelan, 2014). Stigma maintains dominant social hierarchies and power structures by "keeping people down," "keeping people in," and "keeping people away" (Link & Phelan, 2014). For a review of theoretical frameworks and mechanisms underpinning stigma, see Herek & McLemore, 2013; Link & Phelan, 2001; and Major & O'Brien, 2005.

2.1.1. Stigma Processes

Looking at both distal and proximal factors is one way to understand how individuals are impacted by stigma (Meyer, 1995; 2003). Distal factors include prejudice events such as experiences of discrimination, violence, and environmental factors (e.g., policies). For example, individuals who trade sex experience high rates of discrimination and violence both within and outside the context of the sex trade (Deering et al., 2014; Shaver et al., 2011). Incidents of harassment, discrimination, and physical or sexual violence are often under-reported to the police (Nadal et al., 2014; Sausa et al., 2007). Individuals who trade sex hold a legitimate fear that law enforcement will dismiss their concerns outright (Lyons et al., 2017) or that law enforcement

will perpetrate physical and sexual violence against them by coercing them into engaging in sexual acts under threat of arrest (Benoit et al. 2019).

Proximal factors include individuals expecting rejection, anticipating adverse events (which may contribute to hypervigilance), internalizing stigma, and coping through concealing one's stigmatized identity or experience (Meyer, 1995; 2003). Indeed, individuals who trade sex navigate social stigma and prejudice, internalized stigma, and challenging choices related to concealing and disclosing involvement in the sex trade (Bloomquist & Sprankle, 2019). Koken (2012) qualitatively explored how sex workers (N =30) perceived sex work stigma and what strategies they used to manage the impact of stigma on their lives. Many of the women Koken (2012) interviewed anticipated rejection from family and friends if they disclosed sex trading. As such, they opted to cope by concealing their involvement in the sex trade rather than face potential blame, shame, and judgment (Koken, 2012). However, coping with stigma by relying primarily on concealment was often linked to increased social isolation and decreased social support.

Dynamics related to concealment and disclosure have implications for help-seeking behavior when individuals who trade sex anticipate providers' judgment and harmful treatment (Benoit et al., 2019; Quinn & Earnshaw, 2013). For example, street-based sex workers (N = 252) in Canada identified occupational sex work stigma (i.e., concealing sex work status from friends, family, and their community) as a barrier to health care as individuals faced decisions about whether or not to seek care and whether or not to disclose trading sex (Lazarus et al., 2012). Furthermore, actual experiences of judgment, blame, and invalidation from staff and providers have been identified as contributing to sex trading clients prematurely disengaging from social services (Gerassi, 2020). This underscored the importance of individuals who trade sex having

access to quality, affirming, and inclusive mental health care. Mental health care providers are thus tasked with examining their own beliefs, assumptions, and biases and acquiring continued education and training to ensure the provision of competent care to individuals who trade sex (Hendricks & Testa, 2012). At the same time, it is essential to consider unique factors that may contribute to mental health care providers' biased perspectives towards sex trade. Beyond broader social stigma, the field of psychology has its own unique historical roots related to sex trade stigma.

2.2. Sex Trade and Psychology

During the early nineteenth century, Western psychologists were interested in uncovering the origin and correlates of sex trade (e.g., mental age, personality structure, and family of origin conflict) (Agoston, 1945; Mateer, 1920). Sex trade was framed as a form of delinquency, a vector for the spread of venereal disease, and "a social evil dependent upon many factors" (Mateer, 1920, p. 410). Researchers were driven by a quest to uncover what could lead someone to engage in commercial sex and identify what could be done at the individual or societal level to steer someone away from a path deemed devastatingly undesirable. An underlying assumption in this psychological scholarship was that pathology or moral failure drove people into sex trade and that these people then required a savior to pull them free. Such perspectives on sex trade (i.e., pathologization, savior complex) can still be seen today (Nichols, 2016).

As psychologists developed assessment tools aimed at measuring personality, psychopathology, and cognitive abilities (e.g., Wechsler Adult Intelligence Scale, Minnesota Multiphasic Personality Inventory, Rorschach Inkblot Test), researchers used such instruments to compare individuals in the sex trade (e.g., "call girls," "streetwalkers") to samples of matched controls (Exner 1977). Such research intended to uncover the probability of psychopathology

among sex workers. Unfortunately, this research also perpetuated the narrative that only pathological, broken individuals would enter the sex trade. Researchers continue to explore experiences of violence, abuse, and early victimization as predictors of or risk factors for entry into the sex trade, with particular attention to childhood sexual abuse (Silbert & Pines, 1981; Vanwesenbeeck, 2001). Theoretical, political, and practice debates about how to conceptualize and address the sex trade are still ongoing (Nichols, 2016). Today scholars make a connection between the stigma attached to sex trade (with an appreciation for its specific roots within psychology) and the barrier to mental health services faced by this population (Bloomquist & Sprankle, 2019; Koken, 2012; Lazarus et al., 2012; Rayson & Alba, 2019). At the outset of this study, I sought to understand how therapists in the contemporary environment made meaning of clients in the sex trade and how social perspectives might be internalized and enacted by clinicians in their work with clients who trade sex.

In addition to understanding the roots of attitudes towards sex trade in psychology, my research was informed by scholarship related to pathologized work more broadly. Some, though not all, adults who engage in the commercial sex trade self-identify sex trade as their work or occupation (Gerassi et al., 2019). Scholars in vocational psychology have studied the phenomena of "dirty work," which is defined as work perceived as "degrading human dignity" on a social, physical, or moral basis (Terksova & Agadullina, 2019). Workers in "dirty jobs" are subject to dehumanization and discrimination and are perceived as tainted by their work (Terksova & Agadullina, 2019; Valtorta et al., 2019). While all workers engaged in dirty work may be perceived negatively, those who engage in morally dirty work (i.e., rather than physical or social) are subject to the greatest disdain (Ashforth, Kreiner, & Clark, 2007). In a cluster analysis study within an Italian context, lay people (n = 126) rated 27 occupations on scales reflecting physical,

social, and moral taint. Notably, participants in this study rated "prostitutes" highest on physical, social, and moral taint compared to the other 26 occupational groups (Valtorta et al., 2019). Given that therapists may be subject to the same biases and attitudes present within broader society (i.e., held by lay people), it may be the case that they inadvertently pathologize this work.

Conversely, therapists could be less likely to pathologize this work, whether due to preexisting attitudes or training experiences. However, research has yet to explore therapists' experiences working with individuals under the broad umbrella of "dirty work" (i.e., rather than a specific occupation such as sex work). Future research could also provide insight into clients' experiences under this umbrella. For example, it is unclear whether and how sex workers' experiences as clients are similar to others who engage in "dirty work." Following, I will survey the literature on how therapist beliefs and implicit bias may influence their perspective on clients.

2.3. Attitudes

Mental health professionals' implicit and explicit attitudes about clients' identities and experiences influence clinical decision-making and the therapeutic process (Eubanks-Carter & Goldfried, 2006; Hayes & Erikson, 2000; Mohr et al., 2009; Sabin et al., 2015; Schechinger et al., 2018; Snowden, 2003; Weber, 2020). Understanding the impact of therapists' attitudes is essential to inform efforts to improve the quality and accessibility of mental health care through education and training. Considering the influence of therapists' attitudes is particularly important in clinical practice with clients who experience marginalization or stigmatization, such as individuals who trade sex. This population is often overlooked despite research documenting disparities in the quality and accessibility of mental health services among individuals who trade sex within the United States (Antebi-Gruszka et al., 2019; Gerassi, 2020; Kurtz et al., 2005;

Lazarus et al., 2012; Wolf, 2019). Literature related to mental health care and the sex trade has tended to focus more on clients than the therapists providing care. More research is needed to explore therapists' attitudes toward the sex trade. Because the sex trade is stigmatized, literature on therapists' attitudes toward clients who experience stigma and hold marginalized identities will be explored.

An attitude can be broadly understood as "an individual's propensity to evaluate a particular entity with some degree of favorability or unfavorability. Evaluation refers to all classes of evaluative responding, whether overt or covert…" (Eagly & Chaiken, 2007, p. 583). Attitudes are attached elements of a person's world, such as a person, group, object, behavior, policy, etc. Scholars have proposed various models to inform our understanding of attitude formation, maintenance, and change processes (Jain, 2014). For example, Eagly and Chaiken's (1998) ABC model posits that attitudes are comprised of affective (i.e., feelings towards an entity), behavioral (i.e., intentions towards an entity), and cognitive (i.e., beliefs an individual holds about an entity) components. An individual's tendency to evaluate an attitude object positively or negatively is informed by the tone of previous experiences with or knowledge of that object. At the same time, the specific context (i.e., time, place, space) in which a person encounters an attitude object can influence how a person responds (Eagly & Chaiken, 2007). Results from a meta-analysis by Glasman and Albarracín (2006) suggest that attitudes are more likely to predict behavior when an attitude is easy to access and recall and stable over time. Attitudes are more predictive individuals' behavior when they have experience with the specific attitude object and believe their attitude is correct (Glasman & Albarracín, 2006).

2.3.1. Therapists' Attitudes

Research has demonstrated that therapists' attitudes and beliefs impact their clinical judgment and behavior. Prior work has specifically examined therapists' attitudes in the context of race (Abreu, 1999; Katz & Hoyt, 2014; Snowden, 2003), gender identity and sexual orientation (Biaggo et al., 2000; Eubanks-Carter & Goldfried, 2006; Hayes & Erikson, 2000; Mohr et al., 2009; Mohr et al., 2013; Sabin et al., 2015; Thompson et al., 2019), relationship orientation (Herbitter, 2020; Schechinger et al., 2018), and, only very recently, sex trade (Weber, 2020). Therapists' attitudes are necessary to consider given the role mental health professionals can serve in supporting clients experiencing, coping with, and resisting stigmatization and marginalization. In light of therapists' role, accompanied by its inherent power and responsibility, part of the critical work of therapist education lies in helping therapists to understand how their beliefs, attitudes, and biases influence their clinical practice. This is just one facet of training that has been central to the movement toward developing a culture of competency in psychology. The competency movement has not only influenced training programs, broadly (Fouad et al., 2009) but also the development of best practices for working with populations that have been historically underrepresented, underserved, or harmed within the field (Vera & Speight, 2003). Competencies have been developed to train and equip psychologists with specific knowledge, skills, and attitudes facilitative of both efficacious treatment and reducing disparities in treatment-seeking and outcomes (American Psychological Association, 2003; Sue et al., 1992).

One prominent example of practice guideline development within psychology can be seen in the movement toward multicultural competency within psychotherapy (Imel et al., 2011; Tao et al., 2015). Additional examples include the development of practice guidelines and best practices for psychologists working with clients who identify as transgender or gender

nonconforming (American Psychological Association, 2015) and who identify as lesbian, gay, or bisexual (American Psychological Association, 2011). This pair of guidelines is an example of competencies developed to promote affirming and inclusive clinical practice with populations that had been historically stigmatized. However, guidelines for mental health professionals working with sex workers have only recently been developed (Antebi-Gruszka et al., 2019). In the absence of sufficient education and training, providers may hold stigmatizing attitudes towards those with stigmatized identities and experiences (e.g., individuals who trade sex), which may be expressed explicitly or implicitly (Boysen & Vogel, 2008; Boysen, 2009; Hall et al., 2015; Kolmes et al., 2006; Rayson & Alba, 2019).

Snowden (2003) explained that providers' attitudes have implications for service provision across various practice domains, including therapeutic alliance, case conceptualization, and diagnosis. Providers may also over-pathologize unfamiliar behavior and minimize mental illness by misattributing symptoms that reflect cultural beliefs or practices (Snowden, 2003). A prominent example of pathologization within psychology and the subsequent movement towards depathologization centers around the kink community and those engaged in BDSM (i.e., bondage, discipline, dominance, submission, and sadomasochism). Early psychological theories of normative and deviant sexuality fueled the emergent perspective on BDSM sex practices as pathological or the result of sexual trauma (Brown et al., 2020; Burnes et al., 2017; De Block & Adriaens, 2013). The perceived connections between 1) BDSM practice and pathology, trauma, and complications during early childhood and 2) the inaccurate conflation of nonconsensual sexual violence and consensual BDSM were used to justify the, since contested, association with paraphilic disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013; Brown et al., 2020; Burnes et al., 2017).

Kink-identifying clients report encountering therapists who engage in pathologization and stigmatization by assuming BDSM practices are the result of previous physical or sexual trauma, attempting to convince their clients to cease their BDSM practices, and conflating consensual BDSM with physical or sexual violence (Kolmes et al., 2006). Research aimed at understanding therapists' perspectives on BDSM and a push towards depathologization has facilitated the development of trainings and best practices to support therapists in offering affirming services to clients in this population (Burnes et al., 2017). Notable parallels between the treatment of BDSM and sex trade within the field of psychology offer a potential roadmap toward increasing the affirming services for clients who trade sex. However, a gap remains in our understanding of therapists' perspectives on the sex trade and how they engage in clinical practice with this population. While therapists' perspectives on the sex trade remain understudies, research has explored the impact of therapists' attitudes and biases when working with other groups facing social stigma. More specifically, this body of research examines providers' perception of psychopathology, perceived salience of clinical issues, and diagnostic impressions.

2.3.2. Perceived Salience of Clinical Issues

Research suggests that sexual stigma and bias may be enacted through providers over- or under-estimating the salience of clinical issues related to a client's stigmatized sexual identity or behavior. Schechinger and colleagues (2018) explored consensually nonmonogamous (CNM) individuals' (N = 249) helpful and harmful experiences in therapy. Results suggested that many CNM clients "perceived their therapists to be suggesting or implying that CNM was the cause or result of CNM clients' presenting concern… Rather than acknowledging how societal stigma may be causing or amplifying the problem, some therapists appear to be implying that CNM is

the problem" (p. 887). CNM clients experienced their providers as making their sexual identity a central clinical issue when being CNM was not a presenting concern and ignoring the role of stigma. In their analogue study Mohr and colleagues (2009) presented psychologists (N = 108) with a clinical vignette of a male client who was either bisexual, gay, or heterosexual. Psychologists who read about a bisexual client overestimated the clinical relevance of issues that were unrelated to the client's stated presenting concerns and, instead, prioritized clinical issues reflective of bisexual stereotypes (i.e., sexual orientation, intimacy, sexual dysfunction, and identity development). The authors noted that their results might reflect providers' holding stereotypes about sexual minority clients generally rather than having a positive or negative evaluation of the group (Mohr et al., 2009).

Therapists working with clients who trade sex may also be vulnerable to under- and overestimating the salience of clinical issues related to the sex trade. Antebi-Gruszka and colleagues (2019) describe clinical errors within their guidelines for working with clients who engage in sex work (CSW). The authors note that therapists may find themselves exoticizing or voyeuristically focusing on clients' involvement in the sex trade. Alternatively, therapists might respond by altogether avoiding and insufficiently addressing involvement. Antebi and colleagues (2019) argue that "over- or under-emphasizing their previous or current engagement in sex work and its relation to mental health and well-being may constitute incompetent mental health care" (p. 6). These guidelines converge with findings from a Delphi exploring the knowledge, skills, and attitudes sex workers desire in therapists (Pederson et al., 2019). Participants wished that therapists would avoid assuming sex workers were in therapy to talk about their involvement in sex work, particularly when they perceived their presenting concern as unrelated to sex work. Participants also voiced concerns regarding therapists blaming sex work for issues in a client's

life that existed well before they entered the sex trade (Pederson et al., 2019). It is important to note that this was an exploratory study with a sample (n = 8) that consisted exclusively of individuals who identified as "voluntary sex workers." Of note, this study's sample was predominantly white and, as such, was under-representative of key groups within the population who face the greatest risks within the sex trades (i.e., trans women, people of color, persons with disabilities).

2.3.3. Diagnostic Impression

Stigma and bias also influence providers' diagnostic impressions. For example, to explore how implicit bias might influence clinical diagnosis, Eubanks-Carter and Goldfried (2006) conducted an analogue study examining the impact of clients' sexual orientation on psychologists' (N = 141) diagnoses. When presented with a diagnostically ambiguous clinical presentation, psychologists were more likely to diagnose gay and bisexual clients with Borderline Personality Disorder (BPD). Eubanks-Carter and Goldfried (2006) hypothesized that this might be due to pathologizing social narratives and stereotypes linking same-sex attraction and borderline personality structures, particularly within psychoanalytic traditions. Alternatively, the authors posed that their findings could be reflective of participants anchoring in stereotypes of gay and bisexual men as feminine and their perceptions subsequently being impacted by the association between women and BPD diagnoses (Eubanks-Carter & Goldfried, 2006).

Interestingly, despite finding that psychologists were more likely to diagnose gay and bisexual clients with BPD, psychologists concurrently reported positive explicit attitudes towards LGBTQ+ individuals (Eubanks-Carter & Goldfried, 2006). This result is consistent with findings from a systematic review that highlights a discrepancy between therapists' explicit and implicit bias (Boysen, 2009). Perhaps unsurprisingly, therapists often report little explicit bias in self-

report measures at the same time as demonstrating implicit bias on the basis of race and sexual orientation (Boysen, 2009).

Similarly, Weber (2020) conducted a vignette study investigating the relationship between mental health professionals' (N = 201) attitudes toward sex work and their perception of sex workers' mental health. This study utilized a vignette portraying a client with adjustment disorder who was either a sex worker or an accountant. Mental health professionals were more likely to diagnose the hypothetical client with symptoms of posttraumatic stress disorder (PTSD) when the client was a sex worker rather than an accountant. Weber (2020) found that higher levels of stigmatizing attitudes toward the sex trade were associated with a greater likelihood of diagnosing PTSD symptoms. The author suggested that providers may have internalized stigmatizing attitudes about sex workers, which shaped their expectations and influenced their diagnostic impression. Weber (2020) noted that this might be due to common narratives linking sex work and trauma, as well as research suggesting that nearly two-thirds of individuals who trade sex experience PTSD symptoms (Farley & Barkan, 1998; Farley et al., 2004). Of note, only 67% of the sample reported prior experience working with clients who traded sex. Without more developed schemas, providers without prior clinical experience may have relied more heavily on stereotypical beliefs (Weber, 2020). These results highlight the importance of continued research to understand how providers make sense of sex trade and engage in clinical practice with clients who trade sex.

2.3.4. Perceptions of Psychopathology

When clients hold a stigmatized identity, therapists' perception of psychopathology, degree of empathy, and willingness to work with these clients can be subject to bias (Boyson, 2009; Hayes & Erikson, 2000; Snowden, 2003). Much of this insight has been established in the

context of implicit bias surrounding sexual minority individuals. For example, Hayes and Erikson (2000) conducted a vignette study with 425 psychologists and found that hypothetical gay male HIV-positive clients were perceived as holding lower levels of psychological functioning based on Global Assessment of Functioning (GAF) scores. In addition, providers in this study demonstrated less empathy and less willingness to work with clients who were gay. Hayes and Erikson's (2000) findings support a relationship between providers' attitudes and their clinical judgment when working with clients with stigmatized sexual identities. In addition, the authors explored the degree to which providers perceived their clients as responsible for contracting HIV. They found that "clients were held more responsible for causing their problems not simply as a function of their behavior but also in direct proportion to therapists' prejudicial attitudes" as measured using a homophobia scale (Hayes & Erikson, 2000, p. 76). This may suggest that providers' perception of their client's fault or blameworthiness versus victimization could affect their clinical impressions.

In contrast to the findings above, Biaggo and colleagues (2000) presented psychologists (N = 422) with a vignette of a depressed client who was either heterosexual, lesbian, or gay. Participants were asked to rate the degree to which a range of mental health diagnoses were present or absent (e.g., personality disorders, psychotic disorders, mood disorders, anxiety disorders, and substance use disorders). Participants also provided their clinical impression across relevant domains (e.g., social functioning, need for medication, level of impairment, functioning in intimate relationships). Biaggo and colleagues (2000) found no significant differences in participants' diagnoses. However, participants rated hypothetical gay and lesbian clients as functioning better in their significant relationships. Gay and lesbian clients were perceived as more motivated for therapy and having a greater need for medication (Biaggo et al.,

2000). The authors offered that the latter two findings could be due to providers perceiving gay and lesbian clients as experiencing heightened distress or psychopathology compared to heterosexual clients. Thompson and colleagues (2019) found no significant difference in providers' ratings of clients' level of psychopathology based on sexual identity. Within their vignette study of 257 mental health professionals, providers rated hypothetical lesbian and heterosexual clients similarly on measures of depression (PHQ-9) and anxiety (GAD-7) symptomology, which were adapted from patient-rated to provider-rated measures (Thompson et al., 2019). Similarly, in an analogue study of clinical perceptions and reactions, Mohr and colleagues (2009) found no differences in provider-rated Global Assessment of Functioning (GAF) scores for hypothetical clients who identified as bisexual, gay, or heterosexual.

When making sense of these contrasting findings, it is important to consider how therapists' attitudes towards LGBTQ+ individuals shifted over the past two decades. Within the context of sociocultural movements and concerted efforts to improve mental health providers' competence when working with sexual minority clients, we can see evidence of the alterable nature of attitudes. The rationale for focusing on therapists' attitudes and perspectives in the proposed study is rooted in an appreciation for this malleable nature of attitudes. In expanding our understanding of how societal attitudes are internalized and enacted by therapists, my hope is that more generative perspectives can emerge to better serve clients who trade sex.

2.4. Conceptual Foreground

At the outset of this study, my thinking was informed by distinctions scholars have drawn between liberal feminist, radical feminist, and intersectional feminist perspectives on the sex trade (Nichols, 2016). These frameworks for understanding the sex trade have emerged from the synthesis of decades of scholarship across disciplines (e.g., social work, sociology, public health,

and criminology) (Nichols, 2016). It is important to note that all perspectives addressed below condemn sex trafficking. Broadly, feminist approaches also aim to eradicate forms of sex and gender inequality. However, the way they conceptualize inequality and mechanisms of change differ. For example, some advocate for the abolition of all forms of sexual commerce, and others advocate for the continuation of some forms of sexual commerce while still criminalizing sex trafficking. I explore points of convergence and divergence among the perspectives below. Each framework attempts to explain the sex trade's existence and continuation, holding divergent views of agency, and victimization, emphasizing shared vs. idiosyncratic experiences, and the role of the government in regulating commercial sex (Nichols, 2016). Academic, political, and public discourses surrounding the sex trade are infused within these theoretical frameworks. Not only do they impact the experiences of individuals who trade sex, but they may reflect views held by mental health providers.

2.4.1. Radical Feminist

The radical feminist perspective centers on explaining sex and gender inequality emerging from misogynist, patriarchal systems that create and perpetuate the subjugation of women to men within society. Nichols (2016) notes that this perspective may be understood as "'essentialist' feminism because it homogenizes and focuses on the common experiences of women and girls" (Nichols, 2016, p. 26). Radical feminists view women in the sex trade as being treated as subordinates and sexual objects, only serving men's sexual gratification. Indeed, prostitution is regarded as "paid rape." The existence of the sex trade is intimately tied to victimization and violence against women outside the context of the sex trade, which is seen as modeling acceptable ways of treating women. That is, if it is acceptable for men to purchase sex (i.e., victimizing women) and treat women poorly in the context of the sex trade, it will

inevitably lead to men acting violently across multiple domains. For example, Cotton and colleagues (2002) found a positive correlation between undergraduate students' acceptance of rape myths (e.g., attitudes that normalize sexual violence, for example, "he couldn't help it," "she really wanted it") and prostitution myths (i.e., attitudes and beliefs that "justify the existence of prostitution"). Based on their findings, the authors argued that "prostitution myths… contribute to a social climate that exploits and harms not only prostituted women, but all women" (Cotton et al., 2002).

Radical feminists regard sex trafficking, sex work, and other forms of sexual commerce (e.g., acting in porn, stripping) as indistinct (Nichols, 2016). By maintaining the equivalence of sex trafficking and sex work, radical feminists may ignore, erase, and invalidate the experiences of sex workers who perceive themselves as using their agency to engage in the sex trade. Agency is viewed as being denied to *all* women through 1) the objectification of women in sex trade and 2) sexual commerce being condoned or sanctioned by the state. Radical feminists believe that all who engage in sexual commerce are victims and contend that this victimization extends to all women and girls. As such, it is not uncommon for those who hold a radical feminist perspective to be proponents of the abolition of all forms of sexual commerce.

2.3.2. Liberal Feminist

The liberal feminist perspective centers on women's right to choose and use their agency when deciding whether and how to engage in sexual commerce. This perspective argues that "the choice to participate in sexual labor should be present and used if individuals choose" (Nichols, 2016, p. 25). Proponents of the liberal feminist perspective typically use the language of "sex work" rather than "prostitution" to describe individuals who voluntarily engage in the sex trade. Agency is viewed as the presence of an individual's ability to choose to engage or not engage in

sexual commerce. There is also an acknowledgment that choice may occur within the context of constrained options. Victimization occurs when individual choice and agency are denied or removed through force, fraud, coercion, or exploitation. Choosing to engage in the sex trade is viewed as counter to traditional morals that justify controlling women's sexuality and their role in society more broadly. The liberal feminist perspective acknowledges that engaging in commercial sex can be a source of empowerment and healing for some individuals while arguing that the presence or absence of empowerment does not determine the validity of someone's choice to engage in sex work (Wolf, 2019). Actions taken by the state (i.e., an embodiment of White cis-hetero-patriarchy) aimed at regulating the sex trade are viewed as impinging on women's choice and agency over their bodies (Nichols, 2016). Liberal feminism centers on agency and individual choice, which may ignore or overlook experiences of victimization.

2.3.3. Intersectional Feminist

The liberal and radical feminist perspectives fail to acknowledge the experiences of men, transgender, and gender-diverse individuals in their analyses (Sawicki et al., 2019). Further, they largely ignore, rather than center, the impact of intersecting systems of oppression and inequality (e.g., racism, nativism, classism, sexism, cisgenderism, heterosexism) on individuals' experiences in the sex trade (Nichols, 2016). Intersectionality emerged from the experiences, scholarship, and activism of Black feminists and women of color. It was first termed by legal scholar Kimrelé Crenshaw (1989), who described how Black women's experiences were uniquely informed by the combination of racism and sexism. She articulated how the impact of racism and sexism as separate and distinct failed to capture reality in Black women's experiences. Sociologist Patricia Hill Collins (1990) introduced the matrix of domination, writing of "a system of interlocking race, class, and gender oppression," the oppressive

structures' mutual dependency on one another, and a need for "greater attention to how they interconnect…" (p. 222). Intersectionality emerged with a "promise for understanding and challenging dynamics of power, privilege, and oppression" (Moradi & Grzanka, 2017, p. 500), and over time many who use it have been critiqued for depoliticizing and diminishing it (Grzanka, 2020; Shin et al., 2017).

Scholars within counseling psychology developed guidelines to foster the stewardship of intersectionality by emphasizing intersectionality as a field of study, analytic strategy, and critical social justice praxis (Moradi & Grzanka, 2017). In addition, a distinction has been made between weak and strong approaches to intersectionality in scholarship and clinical practice (Dill & Kohlman, 2011). A weak approach to intersectionality focuses on diversity and multiple social identities while ignoring systems of oppression (Dill & Kohlman, 2011; Adames et al., 2018). A strong approach to intersectionality names and critiques the interlocking relationships between structural forms of oppression and how they impact individuals (Dill & Kohlman, 2011; Adames et al., 2018). In the context of this study, I sought responsibly utilize an intersectional framework. Within the context of my interview protocol, I aimed to use my growing understanding of strong and weak intersectionality (Dill & Kohlman, 2011; Adames et a., 2018) to uncover whether and how providers considered the impact of structural forms of oppression on their clients and their clients' intrapersonal understanding of their identities, respectively, within the context of the sex trade.

Unlike radical and liberal feminist perspectives, intersectional feminists staunchly reject the notion of a singular, common experience among all women and emphasize how sex/gender inequality manifests differently according to the impact of interlocking structural systems of privilege and oppression (Crenshaw, 1989; Collins, 1990). The intersectional perspective breaks

from the outdated understanding of gender as binaried and stagnant. Instead, this perspective challenges a binaried conceptualization of gender by seeing gender as fluid and existing on a continuum that individuals can identify along or outside of. In doing so, intersectional feminists create a frame to hold and understand the experiences of not only men but also individuals who are trans, nonbinary, and gender diverse, along with how they are impacted by systems of inequality and oppression within the sex trade. This perspective actively engages with the impact of socially enforced gender norms on all individuals. Intersectional feminism contends that we cannot eliminate one form of oppression (e.g., sex/gender inequality) without also struggling to abolish other forms of oppression, which are inherently bound in a mutually reinforcing relation to one another (e.g., racism, cissexism, ableism, classism) (Collins, 1990). Approaches that only attend to sex/gender inequality and claim to focus on shared experiences among "all" women are viewed as only uplifting White, cisgender, heterosexual women (Nichols, 2016).

Nichols (2016) writes that "intersectional feminist perspectives are not as commonly used to examine sexual commerce, at least in the United States" (Nichols, 2016, p. 28). However, the experiences of individuals entering the sex trade are heavily influenced by the systems of inequality and oppression that an intersectional framework allows to be interrogated to move towards systemic change. The intersectional perspective creates a frame for understanding the social context and conditions (i.e., social systems of power, oppression, and privilege) surrounding entry into the sex trade, experiences during, and pathways towards exiting the sex trade. Nichols (2016) writes that "women and girls as well as those of marginalized races, lower classes, undocumented, or LGBTQ* status may be more likely to engage in sexual commerce due to lack of options in a society that marginalizes these identities; that is, sex work can be used as a survival strategy…" (p.29). Radical feminists are critiqued for advocating for the abolition

of what is, for some, a critical survival strategy while often failing to address the context of constrained options or offering viable alternatives.

At the outset of this study, distinctions drawn between liberal feminist, radical feminist, and intersectional feminist perspectives on the sex trade informed my thinking (Nichols, 2016). With this as my conceptual foreground, I sought to identify which views my participants' perspectives most closely aligned with and how they informed what was centered or overlooked in therapy (i.e., their approach). However, as I engaged in interviews with my participants, I quickly learned that my understanding of their approach to clinical practice would be constrained if I did not allow for the expansion of my own perspective about what could inform my participants' approach to clinical practice with clients in the sex trade. In what follows, I describe my qualitative approach and highlight ways I addressed my positionality throughout my work.

Chapter 3: Methodology

The purpose of my research was to gain insight into how therapists understand their clinical practice with clients who trade sex. I did so by exploring therapists' perceptions of how sex trade related content emerged and was addressed in sessions. I used qualitative thematic analysis in order to address the following analytic questions: 1) How do therapists perceive the emergence of sex trading in clinical practice? 2) How do therapists address clients' sex trading in clinical practice? My intention is that findings from this work will be utilized to inform clinical training and support therapists in working with this underserved group.

3.1. Philosophical Assumptions

To better understand mental health providers' clinical practice and decision-making with individuals who trade sex, I used a qualitative research approach. Qualitative research is uniquely positioned to allow researchers to uncover how people perceive their experiences,

construct their world, and what meaning people attach to their experiences (Merriam & Tisdell, 2016). Creswell (2018) writes that the meanings sought through such research "are varied and multiple, leading the researcher to look for the complexity of views" (p. 89) as opposed to seeking out a singular answer. In this way, seeking and building understanding is inductive rather than deductive. Given this study's focus on the perception and experiences of therapists who work with clients in the sex trade, a qualitative methodology is best suited to the task. The lack of research on this topic, demonstrated in Chapter 2, further supports the importance of qualitatively building knowledge to address the literature gap.

A range of philosophical assumptions and epistemologies inform researchers engaged in qualitative inquiry, and these must be made explicit. Broadly, qualitative researchers draw on frameworks such as social constructionism, critical theory, and postmodern theory. These frameworks differ in how they conceptualize reality, view the purpose of research, and which qualitative methods they fit with (Merriam & Tisdell, 2016). As I engaged with the present study, I held a social constructionist epistemological stance. Social constructionism views meaning as created through dynamic interactions individuals have with others in their world, which are informed by the social and historical norms surrounding them (Creswell & Poth, 2018). Researchers seek to understand how participants perceive or experience a phenomenon rather than explain the phenomena being studied (Constantino, 2008). In my research, I used the perspectives of my participants to understand clinical practice and decision-making with clients who trade sex. Social constructionism contrasts with positivism, which assumes that a true, objective, and stable reality exists and is knowable through observation and measurement. Social constructionist researchers understand that their lived experiences, identities, and cultural knowings influence their interpretation and the meaning they co-construct by interacting with

participants. The qualitative researcher is the primary instrument for data collection, analysis, and interpretation. As such, I attended to my subjectivity throughout each stage of the research process in order to foster trustworthiness in my work. I did so through memoing, consultation with my chair and others in my interpretive community, and consistently checking my interpretation of findings against my data. In addition, I made my positionality explicit at different points in my research and writing process in order to bring my own assumptions and biases to the fore in addition to empowering my readers with this knowledge as they engage with my findings (See 3.7. Positionality and Appendix E: Original Positionality Statement). As a person with training in psychotherapy and clinical supervision, I utilized my contextual knowledge as I engaged in data collection, analysis, and interpretation.

3.2. Strategy of Inquiry

The present study utilized a basic qualitative approach. According to Merriam and Tisdell (2016), basic qualitative studies are most appropriate when researchers are interested in focusing on the following: 1) How people perceive and interpret their experiences, 2) how people construct their worlds, and 3) what meaning people attach to their experiences. A basic qualitative approach is justified when using an inductive approach is necessary due to the exploratory nature of the investigation and the prior limited work on which to build in this area (Corbin & Strauss, 2015). The basic qualitative approach was deemed appropriate given the intention to understand how therapists understand their work and clinical decision-making with clients engaged in the sex trade.

3.3. Procedure

Therapists with experience working with clients who have traded sex were recruited online. For inclusion in this study, therapists needed to meet the following criteria:

1. 18 years of age or older.
2. Currently practicing as a licensed mental health professional within the United States: Licensed professional counselors, licensed mental health counselors, licensed clinical mental health counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychologists, licensed rehabilitation counselors, and licensed clinical rehabilitation counselors.
3. Provided counseling to a minimum of 3 adult clients who have disclosed trading sex or who were at risk of sex trafficking.
4. Willing to participate in a 60–90-minute interview.
5. Had access to the Internet and email.

Therapists were recruited through purposeful sampling, specifically criterion sampling. Using purposeful sampling allowed for a sample of participants who could offer rich information and describe their perspectives and experiences in depth. This sampling method allowed for the emergence of an in-depth understanding of a phenomenon or experience (Merriam & Tisdell, 2016) rather than statistical generalizability. I used criterion sampling (Creswell & Poth, 2018; Palys, 2008) because it allowed for the inclusion of only participants who met specific inclusion criteria. This sampling method is best suited for studies where all participants must have a specific, shared experience (i.e., working with clients who have traded sex). By using this sampling method, I had a greater ability to ensure the quality of my data and gather rich, descriptive, and relevant information from my participants. At the same time, the potential benefits of using criterion sampling were counterbalanced by challenges related to recruiting within a narrow sampling frame. As such, I used snowball sampling by asking participants if they knew of others who may meet the inclusion criteria or if they were willing to share

recruitment materials within their formal and informal professional networks (Creswell & Poth 2018).

I sought to recruit therapists who worked with clients across the continuum of agency. To do so, I used multiple methods of online recruitment. I sent my recruitment email (Appendix A) and flyer (Appendix B) to individual therapists, group practices, and social service agencies throughout the United States. In order to find potential participants, I searched terms and tags such as "therapy," "therapist," "psychologist," "psychotherapist," "counseling," and "mental health" on directories such as the Human Trafficking Hotline Directory and Polyamory Friendly Professional Directory and directories offered by Survivors.org and the Adult Performer Advocacy Committee. In addition, I contacted individual mental health organizations whose therapists seemed likely to meet inclusion criteria (e.g., Pineapple Support, an organization providing therapy to individuals who work in the adult film industry) and asked for my materials to be emailed to their therapists. Throughout the recruitment process, I made an effort to reach therapists who worked predominantly with sex trafficking survivors or sex workers along with therapists who worked with clients spanning the continuum of agency to victimization.

I sent therapists who agreed to participate in the study a link to my Qualtrics questionnaire. The measure included the study's IRB-approved informed consent with additional information about the research and participation. Therapists were allowed to ask follow-up questions at any point in the process. Therapists provided their consent to participate electronically, through Qualtrics, and verbally before the start of each interview. The Qualtrics measure also included demographic questions (Appendix C). All interviews were conducted over Zoom (with or without video per participant preference) and using a semi-structured interview guide (Appendix D). Interviews lasted approximately an hour but ranged from 45-80 minutes.

Following each interview, I engaged in memo writing to capture initial impressions, emergent questions, and perceptions of and reactions to participants. All interviews were audio recorded, uploaded directly from Zoom to a UW-Box Folder, and deleted from Zoom. Digital recordings were password protected and later deleted following transcription. I used Zoom's automatic transcript feature to generate initial interview transcripts. I then deidentified and quality-checked all transcripts to ensure accuracy. Therapists were assigned participant identification numbers to protect their privacy. For the present document, I generated pseudonyms to increase readability.

3.4. Interview Guide Development

I conducted interviews using a semi-structured interview guide (Appendix D) developed for this study. Before beginning interviews, I pilot-tested the interview guide with a graduate-level therapist. Pilot testing led to alterations to the initial interview guide, which resulted in my placing a greater focus on exploring how sex trade emerged in therapy, how therapists approached their clinical practice, and how their approach changed over time. Changes to the interview guide included reframing questions focused on the impact of stigma and therapists' assumptions. I added prompts inquiring about therapists attending to identity and sociocultural context, navigating differences in terminology, and the degree to which sex trade was an explicit focus in therapy. Given the exploratory nature of this study and the inductive nature of the basic qualitative approach, I revised the interview guide in response to themes emerging through data analysis (See "Emergent Questions" in Appendix D).

3.4. Participants

A total of 20 participants took part in individual interviews between August 2021-December 2021 (Table 1). Participants ranged from 27 to 62 years old ($M = 38$, $SD = 9.5$). Regarding gender identity, participants were asked both "How would you describe your

gender?" and "Which term(s) do you use to describe your gender?" In response to the first, the majority of participants identified as cisgender women (n = 11), six identified as nonbinary, and three identified as cisgender men. Of note, when responding to the second question regarding gender identity, eight participants selected terms reflective of gender diversity. Regarding sexual identity, the majority of therapists identified as LGBQ+ (n = 15), with 8 participants specifically identifying as queer. The remaining participants (n = 5) self-identified as straight. The majority identified as white (n = 18), two identified as Black, and two identified as ethnically Latinx.

Table 1

Sample Information (n = 20)

Race	
Black, Latinx, and Mixed-Race[1]	3
White[2]	17
Age	
25-34	9
35-44	7
45-54	3
55-64	1
Sexual Identity	
LGBQ+[3]	15
Straight	5
Gender Identity	
Cisgender woman	11
Trans, Nonbinary, and Gender- Nonconforming	6
Cisgender man	3
Years in Clinical Practice	
0-5 years	6
6-10 years	10
More than 10 years	4
Type of Licensure	
Social Work	12
Counseling	5
Marriage and Family Therapy	2
Art Therapy	1
Psychology	1

Note.
[1]"Black, Latinx, Hispanic, and Mixed-Race" were combined to maintain confidentiality
[2]"White" indicates White and non-Hispanic
[3] "LGBQ+" encompasses bisexual, gay/lesbian, pansexual, and queer

Participants' clinical experience as licensed mental health providers ranged from 2-20 years (M = 8.5, SD = 4.94). The majority of therapists were licensed social workers (n = 12) and, of note, only one was a licensed psychologist. The majority of participants practiced large cities (n = 15), with the remaining participants working in small cities or towns (n = 4) or the suburb of a larger city (n =1). None practiced in rural communities. Participants were licensed in the following states: California (n = 3), Florida (n = 1), Georgia (n = 3), Illinois (n = 2), Indiana (n = 2), Iowa (n = 1), Maine (n = 1), Massachusetts (n = 1), Michigan (n = 2), Missouri (n = 3), New York (n = 5), South Carolina (n = 1), Texas (n = 1), and Washington (n = 1). Five participants were licensed in multiple states.

Participants were also asked about the number of clients they worked with who had traded sex (Table 2). Participants Marian, Evelyn, and Tanya were considered outliers due to the large number of clients they saw (i.e., 300, 70, and 75, respectively), which were outside the upper fence of the interquartile range. The remaining 17 participants saw 3-50 clients who traded sex (M = 13, SD = 12). The majority of participants worked with sex trading clients who spanned the continuum of agency to victimization (n = 9) or were sex workers (n = 7). Of note, only a minority of participants worked predominantly with sex trafficking survivors or individuals who experienced CSE (n = 4). Participants were also asked whether they had previously attended trainings addressing the sex trade, sex work, and/or sex trafficking. The vast majority (n = 18) reported participating in some sort of training in the past. However, one participant had not, and one was unsure. While I did not explicitly ask participants about any personal experience with the commercial sex trade, roughly a quarter of participants (n = 6) voluntarily disclosed their personal experience with the commercial sex trade. Four participants identified explicitly as having experience as sex workers, and one noted having experienced a

trafficking incident. Three participants reported being connected to the sex trade in other ways, including working on the production side of the adult film industry or having a family member or spouse who was a sex worker.

Table 2

Therapist Clinical Training and Practice

Pseudonym	Pronouns	Caseload[1]	Sex Trading Clients	Practice Setting(s)
Abby	She/her	Sex Work	6	Private Practice
Kiah	-	Mixed	10	Private Practice
Sofia	She/her	Mixed	20	Private Practice
Tessa	She/her	Mixed	12	Private Practice
Marian	She/her	Sex Trafficking/CSE	300	Community Health Center
Evelyn	She/her	Mixed	70	Private Practice
Daria	They/them	Sex Work	23	Private Practice
Eliza	She/her	Sex Trafficking/CSE	10	County government, Rape Crisis Center
Alisha	She/her	Mixed	50	Private Practice, Residential Sober Living
Marty	They/them	Sex Trafficking/CSE	3	Private Practice
Hazel	She/her, They/them	Sex Work	6	Private Practice
Rebecca	She/her	Mixed	10	Private Practice
Willow	She/her	Sex Work	5	Private Practice
Rue	They/them	Mixed	15	Private Practice
Charlotte	She/her	Sex Work	5	Private Outpatient Clinic
Tanya	She/her	Sex Trafficking/CSE	75	Nonprofit Social Service Agency
Kevin	He/him	Mixed	30	Residential Treatment Center
Kai	They/them	Sex Work	5	Private Practice
Quinn	He/him/his	Sex Work	8	Private Practice
Darren	He/him/his	Mixed	8	Community Health Center

*Not*e.

[1] Therapists were asked to describe the types of sex trade their clients engaged in. Responses were coded as "Sex Work," "Mixed," or "Sex Trafficking/CSE." "Mixed" indicates a participant worked with clients spanning the continuum of agency to victimization (i.e., sex workers and people who experienced commercial sexual exploitation or sex trafficking).

Participants were asked about their theoretical orientations (Table 3), and the five most frequently endorsed theoretical orientations and approaches were Person-Centered (n = 13), Strengths-Based Therapy (n = 11), Multicultural Counseling (n = 10), Feminist Therapy (n = 9), and Psychoanalytic/Psychodynamic (n = 9).

Table 3

Therapist Theoretical Orientation

Theoretical Orientation	Count
Person-Centered	13
Strengths-Based Therapy	11
Multicultural Counseling	10
Feminist Therapy	9
Psychoanalytic/Psychodynamic	9
Narrative Therapy	8
Cognitive Behavioral Therapy	7
Emotion Focused	7
Integrative Therapy Approach	6
Solutions-Focused Therapy	6
Existential-humanistic Therapy	5
Other: Somatic	5
Family Therapy	4
Other: Attachment-Focused	3
Acceptance and Commitment Therapy	3
Cognitive Therapy	3
Behavioral Therapy	2

Note. Theories endorsed only once included: Internal Family Systems; EMDR; mindfulness-oriented, rooted in Health at Every Size and social justice; Harm Reduction Therapy; Brainspotting; Relational Cultural Therapy; Rational Emotive Behavior Therapy

3.5. Risks and Benefits

There were no direct benefits to participants. However, it was expected that results from this study could provide new insight into clinical practice with clients who trade sex and offer specific recommendations for training and clinical practice. Such recommendations could support therapists in improving their work with clients in the sex trade. In the interest of contributing to therapists' growth and development, I asked participants if they would like to be invited to a virtual group discussion of my study's findings. All participants consented to be contacted regarding this meeting.

For participants, there were no anticipated risks or discomfort related to discussing their clinical practice with clients in the sex trade. No participants disclosed concerns throughout the course of their participation. I conducted interviews in a private room in my home in order to limit the risk of a potential breach of confidentiality. Because participants were being directly

asked to speak about their work with therapy clients, they were directed to avoid using clients' names or to use a pseudonym to maintain their clients' confidentiality.

3.6. Data Analysis

This research aims to explore the clinical landscape of sex trade in psychotherapy. Specifically, my research was guided by the following main research question: How do therapists understand their work with clients engaged in the sex trade? When proposing this research, I initially developed a list of theoretical codes I intended to use to engage in deductive analysis of my data. However, after completing participant interviews and immersing myself in the data, I decided I no longer wanted to impose my original theoretical codes onto the data. I saw the ways in which attempting to fit my data within a pre-existing framework would significantly constrain my findings and would be antithetical to the exploratory nature of my work. I consulted with my interpretive community and engaged in memo writing related to this decision, which was made before analyzing my data.

Instead, I used thematic analysis to identify, analyze, and define themes across participant interviews (Braun & Clarke, 2006). The purpose of thematic analysis is to identify themes (i.e., salient patterns in the data) that address a research question or speak to a particular issue by facilitating the organization, detailed description, and interpretation of data (Braun & Clarke, 2006; Maguire & Delahunt, 2017). Thematic analysis is a flexible approach that can be applied across epistemologies and areas of inquiry (Braun & Clarke, 2006). It is an appropriate method when researchers aim to understand participants' perceptions and experiences (Braun & Clarke, 2006). As detailed below, I engaged an inductive approach to analysis, which involved identifying themes emerging from and closely tied to the data without attempting to constrain the data to fit into a preconceived coding framework (Braun & Clarke, 2006). Inductive coding is a

data-driven approach that is appropriate when researchers decide to allow for the evolution of research questions throughout the coding process. While I took an inductive approach to data analysis, my knowledge of the literature related to psychotherapy, the sex trade, and stigma and personal assumptions informed my use of thematic analysis. Below I describe how I used a range of strategies to attend to my subjectivity.

Braun and Clarke's (2006) thematic analysis is a six-phase approach. The phases include:

- Phase 1: Familiarizing yourself with the data
- Phase 2: Generating initial codes
- Phase 3: Searching for themes
- Phase 4: Reviewing themes
- Phase 5: defining and naming themes
- Phase 6: Producing the report

Phase 1

During the first phase, I immersed myself in the data by listening to all twenty interviews to quality-check the transcripts. Then, following transcription, I reread each interview twice. While quality checking and rereading transcripts, I took notes recording emergent meaning, patterns, and ideas for initial codes that I could return to in later phases of analysis.

Phase 2

During the second phase, I coded individual transcripts to identify as many potential themes as possible within the data. Each meaning unit was able to be coded with multiple codes. I coded interviews using Dedoose, a qualitative analytic software. As part of an iterative coding process, I periodically reviewed codes at this stage to identify those that I could rename, nest, or were redundant and I could merge. For example, the initial code "Responding to [sex work] like

any other job" was nested under and later merged with the code "Normalizing sex trade" because I conceptualized the former as an example of a strategy therapists used to normalize sex trade. I documented these analytic decisions in the description of each code to capture why a given code was renamed, nested, or merged. In addition, I utilized a "miscellaneous" code for data that did not seem relevant to my research questions at the time but that I wanted to retain for future analysis. As new codes emerged throughout this phase, I periodically returned to previously coded transcripts to identify any relevant data reflecting the new code. After I coded all interviews, I moved into Phase 3 of the analysis.

Phase 3

I reviewed my codes during the third phase and searched for meaningful themes across participant interviews. At this stage, I started nesting my initial codes within Dedoose to capture emergent themes. I periodically exported a list of all codes into a Word document to continue grouping codes into categories while also memoing my rationale for the decisions I made along the way and then returning to Dedoose to make the resulting changes reflect in my coding. For example, during this phase, "Normalizing sex trade" was nested under the emergent "Clinical Interventions" theme that I developed to capture behaviors therapists reported engaging in during their sessions.

Phase 4

After identifying candidate themes, I began refining and re-coding as necessary. My intention at this stage of analysis was to learn which of my initial themes 1) were not themes (e.g., due to having insufficient data or capturing data that was too heterogenous), 2) needed to be combined, or 3) needed to be separated into distinct themes. Here I reread all sections of the interviews for each central theme to determine whether a coherent story emerged within the data

extracts. When incongruence emerged, I decided whether the data extract did not fit the theme or if the theme needed to be modified. I wrote notes capturing my analytic decision-making process, which allowed me to think through and articulate my rationale for deleting, merging, or separating themes.

Phase 5

During the fifth phase, I engaged with the data to refine, define, and name themes in ways that aligned with the story emerging from the data contained within each theme. At this stage, I gathered all interview extracts related to a specific theme into a Word document to organize them into a story related to the study's overarching research questions. As I began crafting this narrative and identifying illustrative quotes, I reflexively returned to all extracts for a given theme to ensure my interpretation and emergent narrative were rooted in and reflective of the data. Given my subjectivity, informed by theory, knowledge of related literature, and personal experiences, this step was essential, particularly as the sole researcher. On several occasions, I identified discrepancies between my emergent narrative and what was reflective of the data, made a note of my opinion, and revised accordingly.

Phase 6

Chapter 4 reflects the final phase of my analysis, where exemplar quotes are integrated within the analytic narrative flowing from the study's research questions. At times, relevant literature is incorporated into the final report of the analysis to help frame findings within a broader context, whether in the field or socioculturally. Throughout the process of writing my findings, I was attentive to whether and how I might be prioritizing quotes from some participants more than others. Here again, I returned to the data in order to note whether I was

missing important, particularly divergent perspectives reflected in my data, so that they could be integrated.

3.7. Positionality

As the sole researcher in the current study, my unique background and experience with this study's content area matter as the data have been interpreted through my subjectivity. Biases and subjectivity are inevitable components of all research endeavors (Schweber, 2006). Tending to such subjectivity in the context of one's research is essential in implementing a rigorous qualitive research methodology. I began this by acknowledging my positionality in the present investigation. At the time of writing, I am an advanced doctoral student in counseling psychology. Particularly relevant to my interpretation, I am a white, cis woman, emergently in relation to queerness. I have no lived experience in the sex trade. However, some of my beloved friends are sex workers. My disciplinary background is in counseling psychology and conducting research with individuals involved in the sex trade and the mental health, medical, and social service providers positioned to provide care for this population. Given my clinical focus, it is likely that I was especially attentive to issues of clinical importance in the data collection and analysis process. Further, my social justice, anti-oppression, and liberation-oriented values have resulted in taking care and intentionality within data gathering, data analysis, and the creation of this manuscript.

Regarding reflexivity, I noted several personal assumptions and biases before and during my coding. First, I assumed participants' perspectives on the sex trades would be relatively fixed and align with theoretical frameworks described by Nichols (2016; i.e., liberal feminist, radical feminist, and intersectional feminist perspectives). Second, I assumed participants' perspectives on the sex trades would have a somewhat deterministic relationship with their clinical approach

to working with clients in the sex trades. Third, I assumed participants who described their perspective on the sex trades as more closely aligned with radical feminism (i.e., all sex trade is inherently victimizing) would be more likely to impose their perspective on clients, hold pathologizing views of their clients' sex trading, or push clients to exit the sex trades. Fourth, I assumed that a participant's perspective on the sex trades would align with whether or not they believed individuals should have a right to choose to engage in the sex trades. Next, I assumed that, given my greater familiarity with sex work relative to CSE and sex trafficking, I would be more likely to agree with the perspectives and clinical approaches described by participants who worked primarily with sex workers. I discuss how I attended to these assumptions in the trustworthiness and discussion sections below.

3.8. Trustworthiness

Objectivity is typically the understood standard for goodness in quantitative research methodologies, which seek to control for human error and allow for the generalization of one's findings. However, this is not the case for qualitative methodologies which typically seek to particularize aspects of individual experience and self-understanding (Wright, 2012). As such, it has been important for qualitative researchers to articulate alternative standards for goodness in such work (Peshkin, 1993). Lincoln and Guba (1985) proposed trustworthiness as one such standard for determining goodness. I approached my research intending to cultivate trustworthiness. Lincoln & Guba (1985) articulate how researchers can establish trustworthiness in qualitative research by addressing a study's degree of credibility, transferability, dependability, and confirmability. In addition to my own reflexive practice of checking my interpretation against the data and careful attention to the influence of my assumptions, I routinely consulted with my dissertation chair about all aspects of data coding, interpretation,

and theme building to establish credibility. Further, my findings build on existing research and scholarship, thus corroborating my findings and conclusions. To ensure transferability, I have intentionally utilized a purposeful criterion sampling frame and gathered relevant contextual data about participants' clinical practice, experience with clients in the sex trade, and the context in which they practice. (e.g., clinical practice setting, city size, region of the country). Such data has allowed me to contextualize my findings and promote readers' ability to judge the applicability of my findings. Dependability has been demonstrated by critically and rigorously examining the extent to which my assumptions and biases have impacted the entire research process, thus adding richness and sincerity to my memoing. Ongoing engagement and rigorous review by my dissertation chair has, and review by my dissertation committee will foster my study's dependability. In addition, my findings are interwoven with ample participant quotes to illustrate the degree to which my interpretation reflects the perspectives my participants expressed. Additional research related to this study in the future will aid in ensuring my study's dependability. Lastly, I will present findings from this study to participants prior to publication in order to engage in a member checking. I will hold a synchronous, virtual presentation of findings to my participants where they will be invited to ask questions and share their perspectives with one another and myself. Following the presentation, I will invite participants to share additional thoughts or feedback with me. Participants who would like to provide feedback, but are unable to attend will be sent slides and consulted on an individual basis in order to ensure their perspectives are heard and can be integrated into future publications and research.

Chapter 4: Results

The purpose of this research has been to explore the clinical landscape of sex trade in psychotherapy. Specifically, this research has been guided by the following main research

question: How do therapists understand their work with individuals engaged in the sex trade? The following analytic questions were used to frame my analytic process:

1) How do therapists perceive the emergence of sex trading in clinical practice?
2) How do therapists address clients' sex trading in clinical practice?

In this chapter, I will summarize the findings of my investigation by presenting themes that emerged from interviews with therapists in this study.

4.1. Emergence and Addressing of Sex Trade

I asked participants a series of questions related to sex trade and how they navigated moments when content related to sex trade emerged within the clinical context. I asked participants to describe how their clients disclosed their history of sex trading for the first time, how participants typically responded in session, and the conditions under which their approach might differ. Next, I address how participants navigated similarities and differences in how they and their clients would define or describe their clients' sex trading and how they addressed discrepancies if they emerged. Finally, I share findings that speak to how participants navigate the degree to which sex trade was a focus in therapy.

4.1.1. Initial Disclosure

Clients face a choice about whether and how to disclose a history of sex trading within the context of therapy. Previous research highlights barriers and facilitators to disclosure (Benoit et al., 2019; Lazarus et al., 2013; Pederson et al., 2019; Quinn & Earnshaw, 2013) along with potential positive and negative consequences that can accompany a provider's response (Gerassi, 2020; Pederson et al., 2019). In this section, I address how sex trade first emerged in therapy. I asked all participants how they typically learned about their client's involvement in the sex trade for the first time. Participants described learning in several ways; however, the majority of

participants first learned about their clients' experience with the sex trade during an individual session early in the course of therapy, including at intake. Two participants (i.e., Darren, Rue) noted working with clients who only felt comfortable sharing their experiences with trading sex later in the course of therapy. In addition, two participants (i.e., Hazel, Marian) recounted working with clients who started doing sex work for the first time while partway through a course of therapy. These two cases specifically involved clients who lost employment due to the COVID-19 pandemic and started creating sexual content online (i.e., on Only Fans) to earn an income.

Two participants (Charlotte and Daria) had the unique experience of working with clients who disclosed their history of sex work prior to intake. These clients disclosed on their intake paperwork when providing occupation and income information or when the intake form included a specific question about trading sex. When asked what contributed to these early disclosures, Charlotte (she/her) reflected how she had,

> …found that because I have so explicitly marketed myself a sex worker affirming; people tend to bring it up in their, the initial email that they send to me. Rather than it being something that's like I see somebody a handful of times and they're like, "By the way…" it tends to be more something that's brought up before we even meet in person.

A fifth of participants indicated that they or their group practices marketed themselves as sex work affirming. Participants were not specifically asked about their marketing, so this may be an underestimation particularly given participants were primarily recruited using directories and other public-facing materials. Examples of affirming marketing included using language related to sex work or sex trade on their websites or being affiliated with directories for affirming therapists. In addition to presenting as sex work affirming, some participants indicated their

public-facing materials also highlighted their work with LGBTQIA+, kinky, and nonmonogamous clients.

The conditions under which disclosure occurred varied partly based on the type of clinical setting where participants worked (e.g., private practice, community mental health, residential facility). Unlike in other settings, a client's history of sex trading was implied when they received services from programs or agencies specifically serving people in the sex trade. Seven therapists in this study had current or past experience working in programs, residential facilities, or agencies specifically serving clients who had experienced commercial sexual exploitation, sex trafficking, or were at risk of sexual exploitation. Evelyn (she/her) described how prior knowledge of a client's sex trading impacted her work as she shared,

> [clients] kind of know coming in like they definitely they know that "Okay, something about my experience aligns with this whole thing that you do." And so, in most cases, that has kind of broken the ice, I guess, in some ways.

When services were contingent on a client's history with commercial sexual exploitation or trafficking, clients were no longer in charge of deciding whether or not their therapist knew about their involvement with the sex trade.

While the majority of participants worked with clients who disclosed trading sex during an early session, a minority of participants noted divergent experiences, including clients disclosing prior to intake or later in therapy, clients getting involved in the sex trade during the course of therapy, or having a history of trading sex implied based on the practice setting. Regardless of how therapists learned about their client's experience, participants next faced a decision about how best to respond to their client's disclosure.

4.1.2. Responding to Disclosure

In addition to inquiring about how sex trade initially emerged in the context of therapy, I asked all participants to describe how they responded when a client disclosed. I initially anticipated that participants' responses would vary partly according to the type of sex trading their client disclosed (i.e., sex work, commercial exploitation, sex trafficking). However, my assumption was often disconfirmed as a greater degree of variation emerged than I initially anticipated. My assumption was challenged when participants who had similar caseloads (i.e., primarily sex workers or sex trafficking) took different approaches from one another. On occasion, participants described utilizing a flexible approach, which allowed them be responsive to each client's unique needs. Upon reflection, my initial expectation was also partially informed by an assumption that participants' perspectives on sex trade would more explicitly inform their approach to clinical work with this population. As such, I was surprised on several occasions to learn a participant's perspective on sex trade later in the interview after hearing about their clinical approach. In such cases, I noted my surprise while memoing. Below, I address how participants responded to sex trading disclosures in session.

Following a client's first disclosure of trading sex, the majority of participants expressed their intent to demonstrate empathy and positive regard by responding nonjudgmentally and using interventions such as validation and affirmation. The content integrated in participants' responses ranged from addressing the difficulty of finding a sex work affirming therapist and naming the risk involved in disclosing something criminalized and stigmatized to acknowledging the traumatic nature of a client's experience. How participants decided to respond appeared to be informed by the manner in which their clients disclosed (e.g., mentioned in passing, loud and proud, or subtly alluded to), how clients described framed their sex trading (e.g., a painful experience, a vocation, or an accessible way to make money), and the participant's perspective

on the sex trade. Participants also reflected on how their approach to responding to disclosures changed over time.

For example, Evelyn (she/her) worked predominantly with clients who engaged in survival sex or had been sex trafficked, though she worked with a few sex workers. In the context of working with clients who experienced coercion and victimization, she described how she tried to respond to her clients,

> with empathy, with compassion, and validating their experience. I think it's huge. Just "I'm sorry for what happened to you, and I believe you." And creating space that is safe and supportive for people to feel like they can share whatever they've been through and know that that is not going to be met with judgment… I think sometimes people feel like, "Are you still going to be my therapist if I tell you this?"

Evelyn's response appeared informed by an understanding that her clients might fear being met with blame, disbelief, or perhaps even abandonment. Participants who worked primarily with sex workers also described responding nonjudgmentally. However, despite having a similar intent, the content of their non-judgmental response looked somewhat different. For example, in their work with sex workers (i.e., full-service escort, camming), Hazel (she/they) shared how they,

> respond in probably a very similar way to how someone were to disclosing to me that they were a lawyer or a teacher or whatever. So I ask them about their job, do they like their job, what are some of those stressors that come with their job, is their job the reason that they're coming to see me? "No." Okay, cool. Well, maybe it'll come up at some point in time, but then maybe not… I have come at it from a very open and non-judgmental place and ask the same kinds of questions that I would ask to anyone disclosing to me what they do for work.

For Hazel, demonstrating nonjudgment following a client's sex work disclosure involved normalization ("like any other job"), actively inquiring about her client's experience in the sex trade, and assessing whether sex work (i.e., their job) was part of the presenting concern. Darren (he/him) shared a similar approach in his work in community mental health with a mixed caseload of clients across the continuum (e.g., survival sex work, stripping, escorting, phone/video-based erotic services). When clients first disclosed, he would,

> …take it in like most everything else. You know, it's it's a part of their experience… Sex work is work; it's a very valid means of taking care of oneself. And so I would say generally I just validate and kind of take it in like most things that someone might be describing to me early on… doing my best to be non-judgmental, supportive.

Darren implied that he would respond similarly to sex workers and non-sex workers sharing something early in therapy. At the same time, he noted how he might specifically validate sex work as work and a reasonable means for meeting one's needs. Sex work was not the only thing that might be validated following a disclosure. Kai recounted how they explicitly named and validated the difficulties clients face when finding affirming mental healthcare.

> I mean, "It's an honor to be here, to be trusted." You know and it's bullshit that like… Empathy around like, "I wish it didn't have to be that way. I'm so honored to be here with you. And I wish you were able to choose a therapist based off like what you actually want to be talking about." (Kai, they/them)

In their response, Kai acknowledges how people who trade sex may prioritize finding a therapist who specializes in working with sex workers rather than prioritizing working with a therapist whose focus is related to their specific presenting concern (e.g., anxiety, eating disorders, substance use). Similarly, in their work with clients across the continuum of agency to

victimization, Rue (they/them) described validating their client's decision to seek a sex work affirming therapist,

> I usually affirm like, "I'm really glad that you were, that you sought out a therapist who could understand what you're talking about and understand like when you're talking about issues related to work and also not make it about work when you're not talking about work."

At the same time as affirming their client's choice, Rue also decided to explicitly address potential fear their clients might hold about therapists over-emphasizing sex trading or perhaps pathologizing their work. In his work with sex workers, particularly gay men, Quinn (he/him) described how, "Initially, I always make sure to immediately thank them, to be grateful for them opening up and sharing something that is so heavily stigmatized. I want to always recognize the courage of that…" Quinn, who shared his own history in sex work, explicitly addressed the impact of stigma on his clients, acknowledged the inherent risk involved in disclosing, and reflected back their strength.

Asking Follow-Up Questions. When asked how they responded to a client's sex trade disclosure, participants also reflected on their decision about whether and how to ask questions and learn more about their client's experience in the sex trade. This section addresses both clinical considerations participants articulated and how they described their responses to clients. Tessa (she/her) walked through her approach to this decision in her work with clients who ranged from "boutique full service" workers to those doing "traditional street work,"

> Often when sex work comes up initially, the the content is not around sex work; the content is around a presenting issue that we're talking about in general… And so, in addition to focusing on just having a receptive holding space, I typically keep going with whatever this presenting issue is...

In general, Tessa prioritized addressing her client's presenting concern rather than transitioning the session to focus more on her client's sex trading the first time it came up. At the same time, she went on to describe how she conceptualized the initial disclosure as "a testing moment." At that moment, she saw her clients assessing her response to determine if they would feel comfortable and safe exploring sex work later in therapy. Tessa's (she/her) decision to respond to disclosures in this manner was informed by working with clients who had stories about therapists who would immediately begin "checking about their safety, checking about like the nitty-gritty of the work." Tessa came to view directly assessing for safety and probing for further detail after a sex trading disclosure as demonstrating "a lack of trust in that person's boundaries or ability to make their own decisions. So um, got to avoid that." In contrast to what Tessa described, in her work with sex workers, Willow (she/her) shared how she would typically ask,

> what that experience is like for them or what it's even like to share that experience with me… "What's that been like for you?"… Because it tends to come back up… I also like to talk about just like who like – "Is this something you share with people?" Like, "How do you? Who do you feel safe telling this to?" "Are you safe?"

Willow decided to gather information by inquiring about her client's safety in addition to being curious about her client's other experiences with disclosure. In addition to using information-gathering questions, Willow also attended to the process of disclosure within the therapeutic relationship. In his clinical practice with sex workers, Quinn (he/him) shared how he might follow with a client's disclosure by asking,

> "How did you feel about that," right? I definitely try to stay away from assuming that it's traumatic. I think my own bias comes in here where I assume that it's not traumatic in a

> way. And so I try to be careful of that… I haven't yet experienced this, but, um, for a percentage of people, it could be if they were trafficked or victimized in some way. So I try to look for my own bias there and just see how, what it meant to them.

Quinn observed how his approach was informed by personal assumptions and the scope of his clinical practice with clients in the sex trade. In contrast to Quinn's open-ended questions, Evelyn (she/her) recounted responding to sex trading disclosures by saying, "Do you want to talk more about that? Do you identify that as something that's traumatic? And if so, maybe it would be worth talking through more" Evelyn explicitly asked her clients close-ended questions following a disclosure. Rather than assume her clients would tell or demonstrate to her whether or not their experience in the sex trade was traumatic, Evelyn asked.

Assessing How Clients Disclose. Attending to how clients shared their sex trading for the first time also offered potentially clinically relevant information. In this section, I address how participants attended to the process of disclosure to inform clinical hypotheses. Darren illustrated this clinical dynamic as he shared how, following a disclosure, he would be

> …listening of just like how they describe it, sort of any like shift or change in tone or affect. How are they disclosing it? Is it something where it feels like maybe there's more here? Or is it something that they are, again, sort of loud and proud and and that's not, no difficulty talking about it at all? I think just listening for those things and just kind of maybe taking some mental notes. But usually, early on, I don't I don't make it a point that "Oh, we need to pry, or we need to dig into this further." I mean, it's part of their life just like anything else.

As Darren attended to his client's nonverbal cues, his approach was also informed by a sense of pacing and a recognition that he could follow up in the future. In her work with clients engaged

in stripping, full-service work, adult film, trading sex for as needed, or doing street work, Tessa (she/her) attended to shifts in her client's tone and nonverbal behaviors. In addition, her theoretical lens informed what she attended to as clients shared their experiences. When a client disclosed, Tessa described

> …having a receptive like kind of positive regard while keeping the, keeping assumptions about the emotionality of that statement very neutral. Because regardless of what I'm, I'm sensing and the way they presented it, especially sometimes when people say things like very proudly, really very kind of performatively positively. To go with that, it's actually a good idea to stay neutral because it's possible that was a defense mechanism for whatever negative aspect they need to bring up right then.

Tessa leaned into her theoretical lens to develop clinical hypotheses regarding her client's disclosure. She found it helpful to track potential defense mechanisms activated during when discussing their sex trading.

One participant was attentive to the function of the disclosure in session and used their hypotheses about this to inform how they responded in the moment. Marian (she/her) reflected specifically on her work with a client who lost employment due to the COVID-19 pandemic and subsequently started "started the Only Fans with her two roommates." Marian (she/her) tried to "really validated the economic crisis and the need to stay physically safe and how, 'Oh, the three of you are a pod. Like this is a way your pod can have enough money for groceries...'" Marian went on to describe how she attempted to align her response with her client's need at that moment despite her reaction to the client starting to engage in the sex trade. She noted, "I was startled at how I felt. Like I knew it was going to be a bad deal and wanted to stop it somehow."

Marian demonstrated her ability to adapt her response depending on her client's story and need. She shared,

> …other times, people need us to hear that it's dangerous. In my practice I'm in now, I often hear about people's former sex work when they're sort of processing trauma… And that's the bulk of the stories that I hear in this practice is retrospectively people being like, "This was this thing that happened that was really scary. Can you hold it in context for me?"

Marian tailored her response after assessing "the purpose of the disclosure or what's the need in the moment." Her contrasting examples illustrated the flexibility and responsiveness of her approach with different clients. In addition to varying depending on the client, several participants spoke about how their responses changed over time.

Response Changing Over Time. In this section, I address two participants' self-reflection on changes in how they attend to clients' disclosure. Participants also considered factors that contributed to their development, particularly exposure to more clients in the sex trade, greater clinical experience, and increased clinical self-efficacy. For example, Hazel (she/they) shared how early in their work with sex workers, when clients disclosed,

> … my response was like, "This is really cool, I am so happy that you found this work that that empowers you," whatever the narrative that I had had. I, I feel like I had more curiosity around the work itself and around the person's connection to the work and, at times like, probably focused on the work more than I needed to. Where I had assumed that it was part of the story and it wasn't a part of the story.

When reflecting, Hazel noted how their clinical approach and interventions might have been driven more by their curiosity and personal perspective on the sex trade than by their client and

what was, in retrospect, clinically indicated. When asked about any differences in their clinical approach since sex work has become less sensational for them, Hazel shared,

> … I think the more that I have just normalized it as like this is just a career that some people choose, and for some people, it is really empowering, and for some people, it isn't. It, for some people it's just a job. And as I moved into that place, I have been more curious about the person and less curious about the work.

With more experience, Hazel learned that their clients could relate to their experience in the sex trade in more diverse ways. Marian (she/her) also reflected on how her clinical approach changed throughout her career. However, compared to Hazel, she described having a more "judgmental" attitude towards the sex trade when she started working with clients who trade sex. Importantly, Hazel worked primarily with sex workers (i.e., full-service escort, camming), whereas Marian worked primarily with clients engaged in survival sex (i.e., exchanging sex for drugs). Marian described how early in her career as a social worker if a client were to make comments such as, "Oh, I can't go out with my friends this weekend because I have other responsibilities," "My boyfriend is really upset because there are periods of time I can't talk to him," or "I have income and I have *income* and this goes on paper, and *this* doesn't" she

> …would hear that stuff and be like oh, that's something that person wants to hold out of relationship with me; they want that private. And I felt that was a boundary I should just respect. And now I'm just curious! "Oh, tell me what has happened over the weekend?" or "Where does that money come from? And so, if I can be curious, people can can share a little more. And I think they see the curiosity as not being scared…

When asked what contributed to her approach changing over time, she shared,

> The stigma got less for me. I think I was less judgmental about sex work. And I was like, because before I thought, "Oh, you must be ashamed of that. I need to protect that. And and that's a thing that you don't want to talk about right now."

Marian described how initially, her attitude towards sex work and a belief that her clients would feel judged if she followed her clinical curiosity and asked follow-up questions.

Taken together, participants illuminated a range of approaches when responding to a client's first time disclosing a history of sex trading in the context of therapy. The majority of participants intended to express empathy and positive regard toward their clients by embodying a nonjudgmental stance that integrated the use of validation and affirmation. Variation emerged regarding whether and how participants decided to ask follow-up questions related to their client's sex trading. The manner in which clients disclosed (i.e., the process, nonverbal cues, etc.) emerged as a potentially relevant source of clinical information. Lastly, two participants reflected on how their approach to responding to disclosure changed throughout their clinical practice.

4.1.3. Navigating Terminology

Language matters because it can be reflective of and perpetuate stigmatizing attitudes. The language and terminology therapists use may be a cue clients attend to in order to determine the degree to which they feel comfortable addressing in therapy moving forward (Pederson et al., 2019). I asked participants whether they encountered discrepancies between how they and their clients would define or describe their clients sex trading and how they addressed discrepancies if they emerged. Participants in this study varied in their perception, having either a shared language to discuss sex trade with their clients or encountering discrepancies.

Participants who decided to disclose their own lived experience as current or former sex workers described themselves as often having a shared language with their clients regarding sex work. For example, Daria (they/them) noted, "I was a sex worker for decades prior to being a therapist, so I'm familiar with what it used to be and what it is now." Daria saw how their own experience as a sex worker contributed to a breadth and depth of knowledge and familiarity that they could bring into their clinical practice with sex workers. Despite feeling generally familiar with their clients' language, several of the five participants with personal experience as sex workers described continuing to learn new terms from their clients. For example, Charlotte (she/her) illustrated how she learned when clients whose sex work experience varied from her own:

> I find that I oftentimes use language that I'm familiar with, and sometimes that has changed because it's been many years since I've done that… I see that more with clients who I have who are non-binary, specifically in terms of the language that they use for themselves and the types of services that [they're] providing.

Charlotte found her knowledge and vocabulary extending at times when working with gender-diverse clients engaging in sex work differently than she had. Charlotte's comment highlights the importance of understanding the nuance and variation among clients who may fall under the broad "sex worker" umbrella. Relevant terms may vary not only over time and depend on the type of services a sex worker provides but also when clients are members of smaller communities of sex workers, which may be connected through a shared identity. In contrast to others with lived experience, Quinn noted, "I've never seen an incongruence in the way that I view the work and they do."

Half of my participants encountered differences in the terms they and their clients used. For example, when working with a client who Rue (they/them) thought of as doing "escorting," Rue learned that their client referred to herself as a "full-service provider." When faced with discrepancies, Rue noted, "I just go with the client's language. And I also try to make sure I understand their language. That I'm not just assuming what we mean if I'm not sure." Rather than assume the meaning of a given term, sought clarification before integrating it into sessions, even if it was "a little funny for me to adjust" to the client's preferred term.

Rue described how they translated their approach when working with clients who engaged in "survival sex or street-based work, who don't identify as sex workers and would not use that language. And actually would not identify it, particularly as a job at all, so much as something that they're just doing right now…" Similar to before, Rue mirrored their clients' language while still being "careful like not to refer to what they're doing as a sex worker or or to them as sex workers even though that is how I think of folks in my mind." Rue described their ongoing process of catching their own perspective or bias and, rather than imposing their view, centered their client's subjective experience and perspective.

On its face, choosing to check in with a client and ask a question like "What does that mean for you" (Kiah, she/her) may seem like a clear decision in the face of differences in language. However, Kiah highlighted a potential barrier for therapists as she recounted advice from a clinical supervisor, "If you're not really sure what somebody's talking about, you should go look it up later. You shouldn't make them teach you." Despite her supervisor's advice, in her work with clients across the continuum, Kiah resolved to clarify the meaning of her clients' language so that she could "incorporate it with an awareness of what they mean," which aligned with her value of "really trying to push my own stuff aside and instead, be able to like sit and

hold those terms that they use and really start to understand them better." Kiah highlighted one of the tensions therapists faced between trying to avoid burdening their clients with the task of educating their therapist while also taking a humble stance by being curious and mindful of personal assumptions.

In addition, clarifying the meaning of specific terms clients used to describe themselves or their sex trading, a small number of participants noted instances when their client's language seemed clinically relevant, potentially warranting a clinical intervention. For example, in their work with clients who engaged in survival sex or experienced CSW or trafficking, Marty (they/them) described their general approach to navigating,

> I try and match language as long as I don't feel like it's self-deprecating or harmful to them. But I also don't want to be like the lady coming in and try and tell them what word to use, right?

For Marty, one of the clinical indicators for potentially exploring terminology in session was their sense that the term was negatively impacting their client. At the same time, Marty highlighted the importance of avoiding taking a patronizing or paternalistic stance. When asked what factors they weigh when deciding whether and how to intervene, Marty shared,

> First and foremost, is the clinical picture, right? If it's not going to be helpful, if I don't feel like it's clinically appropriate, I'm just not going to do it. What creates that clinical picture, then right, is the next question. So, of course, it has to do with kinda like baseline stability, capacity to feel strong emotion without becoming too dysregulated. And also like how far along we are in the, in our therapeutic relationship. I certainly wouldn't want to do something like that in the beginning…

The strength of the therapeutic relationship, the clinical relevance, and the client's ability to stay emotionally regulated guided Marty's decision to address language with clients. Similarly, Evelyn (she/her) heavily weighed the strength of her therapeutic rapport when deciding whether and how to address how her clients described and defined their experiences in the sex trade. Evelyn described her clients broadly as "people [who] self-identify as a sex worker or a prostitute or "I was exploited.'" She noted that her clients included people who experienced familial trafficking or were in a boyfriend-pimp dynamic. With some clients, she shared the federal definition of sex trafficking. When asked about factors that informed her clinical decision, she described how

> …the primary goal would be to help them gain a better understanding of their experience and conceptualize it in a way to then move through and move forward in healing. And if someone finds that justice could take place through the legal process in that aspect, then that can be useful in that capacity as well...

When asked about her approach to presenting the federal definition of sex trafficking to her clients, she shared,

> … I'm never presenting it as "this is what happened to you," but saying this is "based on what you've shared with me, it sounds like your experience might align with this; what do you think?" And then we talk about that.

Evelyn went on to describe how her clients have responded,

> …some people say, "Wow, that is really what happened to me" and "Yeah, I was sex trafficked," and they can sometimes take on that label, but most clients do not initially view their experience in that way…"

While she did not provide the federal definition for sex trafficking, Eliza also talked with clients about potentially reframing how they defined or described their sex trading. Similar to Evelyn, Eliza shared that some of her clients were open and receptive to her intervention. However, Eliza shared how "other clients just definitely brushed me off or like 'Yes me, and I know that it's not getting through." One challenge with accounts like this is not knowing how clients received interventions like these as relevant and appropriately challenging or potentially as clinical misses.

Tanya reflected on a dynamic more specific to working with individuals who have experienced CSE or sex trafficking. For example, she worked with clients through a community-based agency that partnered with a residential faculty for women who had experienced commercial sexual exploitation. In her clinical context, Tanya described explicitly asking her clients, "How would you like to be referred?" and having a dialogue with clients that centered their agency in choosing how others could describe them and their experience. Tanya felt this was important, in part, because

> …a lot of them really hate any kind of language around "victim" or "victimhood." So we very quickly, you know, moved out of using that language… So you know, usually it's just a conversation of like, "How does 'survivor' feel to you?" "What, what would you like me to use?" And then I, I'm always upfront if I'm not comfortable like using something, "I'm not going to use that language.

In addition to illustrating her approach to navigating language with clients, Tanya subtly highlights how language and terminology are relevant outside the therapeutic dyad context. Indeed, it needs to be addressed to at the level of the program or agency that is engaging clients.

To summarize, participants in this study varied in their perception of having a shared language to describe their clients' sex trading versus encountering discrepancies. This variation was present among both participants who had lived experience in the sex trade and those without lived experience. Half of my participants recounted moments when they navigated differences in their and their clients' terminology. Participants illustrated a range of approaches to navigating discrepancies, including asking for clarification and mirroring language. In addition, three participants recounted instances when they engaged in clinical interventions related to the language their clients used to describe their experiences in the sex trade. These participants also highlighted specific factors that informed their decision-making about whether and how to intervene.

4.1.4. Determining the Focus of Therapy

Prior research related to sex workers' experience in therapy shed light on potential concerns clients may hold about therapists assuming they are in therapy to talk about their involvement in the sex trade or assuming their mental health and well-being would be better if they exited the sex trade (Pederson et al., 2019). Given this context, I asked participants how they navigated the degree to which sex trade was a focus in therapy. The majority of participants described their approach as "client-centered." A client-centered approach often involved concentrating on the client's stated presenting concern. For example, in her work with clients across the continuum of agency to victimization, Evelyn described her approach, "If they're engaging in sex work and they're here to talk about their dog dying like that's what we talk about. We don't talk about sex work unless that's what they want to talk about." Willow (she/her) shared a similar perspective about letting clients decide when to bring sex trade up in session and also noted, with regard to common presenting concerns, that "their anxiety, their

depression, their concerns; they're going to be there whether or not they're working in the sex trade." Willow makes an implicit distinction, similar to Evelyn's explicit one, between presenting concerns and a client's experience in the sex trade.

One participant embedded her rationale for taking a client-centered approach in her understanding of how sex trade stigma can impact therapists' treatment of individuals who trade sex. Charlotte (she/her) described her approach as reflecting her intent to counter harmful approaches to addressing sex trade in therapy. Indeed, Charlotte shared her perception that among therapists, "… there's a lot of like savior complexes when it comes to people who provide sex services. And so people will choose to sort of pathologize that rather than seeing it as a career choice for many, many people." Charlotte shared how they explicitly communicate their belief that "…just because you are a sex worker doesn't mean you need therapy, and it doesn't mean that you like need therapy focused on being a sex worker." However, as Charlotte went on to note that sex workers are not the only clients whose experience or identity has been pathologized,

> I feel the same way with with if I'm doing if I'm meeting with someone who needs like a letter of support for any sort of like trans health care. It's like just because you're trans, you don't need to come to therapy. And so, like, you can come in here and will get your needs met, and I'm not going to force you to be here.

Charlotte described taking a similar approach when working with clients from other groups pathologized in mental health fields. When determining the focus of therapy in their work with sex workers Abby (they/them) aimed to ensure "there's no rescuing, there's no shaming, there's no questioning whether this is really what they want to do with their lives." Their approach was

informed by their beliefs about sex work, noting, “it can be very feminist and revolutionary to take control of that part of their lives,” and that,

> by presenting that degree of acceptance and support for what they choose to do, they come to me for their other mental health issues. They’ve got trauma from childhood or anxiety issues or depression or bipolar disorder or whatever. And they just need somebody to do that clinical practice with who isn’t going to constantly be drawing their attention back to their work and saying, “Well wouldn’t it get better if you didn’t do this?”

Abby viewed their affirming stance towards sex trade as reducing barriers to addressing their client’s presenting concerns and exploring sex trading when clinically indicated and aligned with the client’s concerns. Indeed, having an affirming stance towards the sex trade did not preclude Abby from exploring the challenges their clients faced in the sex trade,

> …one person that I have who who really doesn’t like the work she does. She’s doing it because she has other obstacles in her life. Can we solve those obstacles so that she can go into a field of work that makes enough money to support her and is not something she hates? But in the meantime, I’m going to do my best to teach her to not shame herself and not judge herself.

When working with a client who wanted to exit the sex trade, Abby addressed their client’s sex trading not only by working to reduce external barriers to leaving the sex trade but also by intervening around the client’s internalized sex trade stigma. Determining the focus of therapy with clients who want to exit the sex trade, Kai (they/them) noted, “… we’re not here to drive our own agendas. If a person wants out of the life and wants assistance getting out of life, they will tell you that. You don’t need to plant that seed.”

Taking a client-centered approach when discussing sex trade presented challenges at times. Alisha (she/her) worked for an agency focused on helping women who had experienced "sexual exploitation" and "commercial sexual exploitation," whose clients often referred to themselves as "in the life." Among her clients, she described how typically "one of their goals that they come in with is like that they they do not want to work in sex work, related to like the stigma and the violence they've experienced." The challenge arose for Alisha in her work with one client who "…wanted to continue sex work, but also wanted to work on other things." She went on,

> …it was definitely a challenge at the time, I remember because it was different than what I had been taught previously. And so I learned a lot about like sitting in that tension of saying, "Okay, yeah that's not, that's not your goal. And what, what are the things that we are working on? And how do I, how do I support you and work with you on those things.?"

This case was particularly challenging because she had more experience working with clients who wanted to exit the sex trade. In addition, she attributed some of her difficulty with this case to her perspective on the sex trade. Specifically, "wrestling with" her own "assumption that if someone had other options, they would choose other options." Alisha highlights how a therapist's client-centered approach could differ depending on the client.

Participants spoke about the importance of being able to discuss content related to sex trade within the context of therapy sessions. Marian (she/her) primarily worked with people engaged in survival sex or exchanging sex for drugs and money while working in strip clubs. When asked how she navigated whether and how to focus on sex trade in sessions, she shared,

> I think part of my role as a clinician with them that's different is to be like fiercely open to having the conversation. Like she might be, or he might be talking about sex work with

> other folks, but probably not able to link it to all the complexity of life. And so actively being open to people connecting my sex work with this other thing that's complicated, and also there's this other thing that's complicated that isn't always connected to my sex work; like I can have trouble with my boyfriend, and it's not about my sex work.

Marian viewed a central component of her role as a therapist as providing a unique relational experience even when compared to other relationships where her clients may be comfortable talking about their sex work. Marian highlighted the importance of being willing to explore whether and how parts of a client's life or distress were related to or impacted by their sex work.

Participants also spoke about their experiences processing clients' painful and challenging moments in sex trade. In their work with clients across the continuum, Rue (they/them) described how they continue to "follow the client's lead" when talking with clients about difficult experiences. However, they also cautioned that "…if [clients are] talking about a specific situation that was stressful or scary or whatever, that you're staying with them on talking about that specific situation and not trying to generalize it to their work in general." Similar to Marian, Rue saw value in being able to talk about the breadth of experiences a client may have in the context of sex trade while also avoiding jumping ahead of a client and overgeneralizing from one specific negative experience.

In addition, a small number of participants conceptualized their client's sex trading as a core domain where their presenting concerns emerged. For example, Kai (they/them) worked at a private practice with "queer and trans folks and fat folks with eating disorders and complex trauma and sex workers of any kind at all" but also had prior experience working with people who had experienced sex trafficking. They described their general approach with sex workers as

"…like in work with everybody else like; I'm very pro just like being with what comes into the room." They went on to describe how,

> …sometimes it is shit that involves their, their work. Usually, when it comes up, it's mistreatment by a manager at a club or some snide words from a customer, body comments, and the felt need to make their body look a certain way, which is usually in contradiction to the work that we've been doing.

Kai described how content related to sex trade connected to the primary focus of their clinical work. For example, exploring their client's experience in sex work allowed Kai to identify ways their client's experience in sex trade might contribute to maintaining their distress.

In addition to being conceptualized as a domain where clients' presenting concerns may be maintained, sex trade was also seen as part of clients' lives where they could practice skills, make changes, and have new experiences. Tessa (she/her) described her work with a client with borderline personality disorder, sharing,

> We were working on and reflecting on her automatic thoughts in certain situations. We were working on communicating her needs, hearing other people's needs, and tuning into like herself instead of kind of going into overdrive or auto-drive. So when we talked about sex work, it was often for her an easy place to kick into "I'm a bad bitch, and I'm in control of the situation, and I know what I'm doing." And once you establish a good relationship of respect where she knows that I'm not questioning anything about her agency to be a sex worker, then the conversations around sex work are often "How are you playing out, you know, your presenting issues?"

Tessa saw sex work as part of her client's life where she could practice developing interpersonal effectiveness and emotion regulation skills. At the same time, Tessa saw building trust and a

strong therapeutic rapport as foundational to addressing sex trade, given how her clients might anticipate judgment.

When deciding whether and how to focus on sex trade in sessions, a tension between over-emphasizing and under-emphasizing sex trade emerged for two participants. In his private practice, Quinn (he/him) worked with gay men who "mostly kind of consensual sex work, escort work." He describes the tension he navigated,

> I'm always trying to walk the line of like not over-emphasizing sex work within the clinical work. Trying to look to a patient to kind of guide there while also not under-emphasizing it, right? And particularly if a patient's more avoidant. I mean, I really try to follow the patient's lead, perhaps to a fault sometimes… perhaps I collude in avoidance sometimes.

Quinn generally found a client-centered approach helpful when striving to avoid over- or under-emphasizing sex trade. However, he recognized limitations in relying too heavily on his clients due to potential hesitance or avoidance related to discussing sex trade. He recognized there might be moments when it would be important and clinically relevant to stretch outside his tendency towards focusing less on sex trade. When asked how he moved towards a more balanced approach, Quinn went on,

> So you know, sometimes it's just probing gently to bring it up and just saying… "I know we haven't talked about your sex work. It's something I don't want to over-emphasize in our work together, and I don't want to under-emphasize it either. So maybe we can, you know, spend a little time talking about it, just getting a general history." You know, motivations, a lot of the feelings surrounding it, exploring again a lot of the the stigma or shame and how they protect themselves from that, but also just from clients.

Quinn described how he might explicitly name his desire to avoid over- or under-emphasizing sex trade while actively inviting his clients to share their experience. Darren addressed this tension as he observed how some therapists potentially under-emphasize sex trade by treating it "like any other job." He continued,

> It's making me think about like race… I don't want it to be this like, "I don't see color." Like no, race affects us… And so, even with sex trade or sex work, it's not as if, like, "I just think of everybody the same." Like, no, it is different… I probably do lean in more around their relationship to it then maybe someone who works for corporate whatever or just has like a desk job… Like certainly approaching it with the same care and compassion and also, I think, like, leaning into really listening and hearing the nuances because, because I know it is different and talked about in society differently and experienced for folks differently than a conventional 9-5 job.

Darren drew a parallel between the impact systemic racism and the conditions surrounding the sex trade as he reflected on ways his approach may differ when working with clients in the sex trade.

In sum, participants strove to embody a client-centered approach to determining whether and how sex trade was a focus of sessions. At times participants described making explicit statements to communicate their desire to not overly focus on their client's involvement in the sex trade and, instead, center their stated presenting concerns. One participant highlighted a challenge they encountered when working with a client who intended to continue in the sex trade, which was different from the participants' prior experience focusing on supporting clients interested in leaving the sex trade. Participants noted the importance of addressing content related to the sex trade, particularly when sex trade was conceptualized as a domain where

presenting concerns were playing out. Finally, two participants noted a tension between over- and under-emphasizing the sex trade in sessions.

4.2. Clinical Content

I asked participants a series of questions grounded literature related to sex trade. Participants were asked whether and how they saw their clients impacted by sex trade stigma impacted. They were then asked how they intervened in sessions related to stigma. Themes emerged related to internalized stigma, the impact of stigma on clients' relationships, and stigma as a barrier to accessing care. In addition, participants were asked to share about instances when they felt concerned about potential risks or coercion their clients were experiencing. They were then asked to describe their clinical approach to addressing potential red flags.

4.2.1. Stigma

Given the deleterious effects of sex trade stigma (Benoit et al., 2018; Benoit et al., 2019; Grittner & Walsh, 2020; Koken, 2012; Lazarus et al., 2012; Quinn & Earnshaw, 2013; Sprankle et al., 2018; Weitzer, 2018), I was curious to learn how therapists conceptualized the impact of stigma on their clients. As such, I asked all participants to reflect on their views and explore how they might intervene in session to address the influence of stigma on their clients' lives and presenting concerns. As participants reflected on whether and how they addressed sex trade stigma in the context of their sessions, three-quarters of participants spoke of their clients' experiences with internalized stigma. A third of participants reflected on how stigma impacted clients' interpersonal relationships. Participants also spoke of stigma's impact on their client's experiences accessing medical and mental health care.

When discussing stigma, two participants explicitly described integrating additional frameworks into their understanding of the impact of stigma in their clients' lives. Specifically,

Quinn (he/him) named the Minority Stress Model, and Tessa (she/her) described explicitly integrating an intersectional lens, which allowed her clients "identifying themselves as like at some intersections of oppression." In sessions, Tessa saw drawing on intersectional frameworks as "really powerful," particularly when working with clients she perceived as "drawn towards like some social analysis."

Broadly, participants saw stigma as having a pervasive, multifaceted impact on their clients. Kai (they/them) reflected, "…it touches fucking everything." As they elaborated on their clinical approach to addressing stigma in sessions, Kai integrated their clinical expertise in treating eating disorders, noting parallels in the expansive impact of sex trade stigma and eating disorders. However, at the same time, Kai distinguished between sex trade stigma and eating disorders, noting, "sex work can similarly touch everything else, but we're not trying to change that they're doing sex work." When asked how they addressed stigma in sessions, they described being cautious of constantly naming the stigma, noting, "at what point is it more frustrating to hear me say that?" At the same time, Kai described the conditions under which they might explicitly name the role of stigma,

> Like at the beginning, relationally, it's important for them to know that I know. And sometimes, maybe there have been a couple of instances where stuff has happened, and maybe they're not seeing it, and I'll call that out, but for the most part, we both know.

Kai saw value in explicitly demonstrating their understanding of sex trade stigma rather than assuming their clients would intuit their perspective. They also viewed naming stigma as a means for building rapport early in the therapeutic relationship.

Similar to Kai, Daria (they/them) viewed stigma as having an expansive impact on the sex workers they worked with. Prior to sharing about stigma's impact their clients, Daria

reflected on their own positionality as a former sex worker, “Well it’s hard it’s really hard for me to speak about [stigma] without speaking about my own experience with that having sort of hindsight from before and how it feels different now.” Consistent with literature related to the consequence of sex trade stigma, Daria highlighted the impact of stigma on risk and safety, interpersonal relationships, and issues of disclosure, discrimination, and negative mental health implications. They described how clients with life experience in the sex trade/sex work,

> …have to be hypervigilant for their safety and they have to be very careful about who they talk to about their jobs and the kind of work that they do. …depending on their like social location there can be a lot of housing insecurity. Even with like the most privileged sex workers there tends to be some housing insecurity because people worry about getting outed or treated badly, discriminated against, evicted, things like that.

Daria noted how sex trade stigma touches all individuals in the sex trade while also making clear that the consequences of stigma are unequally distributed based on how systems of power, privilege, and oppression impact an individual. Daria then reflected on the relationship between clients” strategies for surviving sex trade stigma and their mental health.

> … there’s just a lot of kind of hypervigilance and self-censorship that has, that heightens anxiety or depending on the person if they’re a tendency for depression or whatever the things are it can exacerbate those kinds of symptoms.

In addition to noting the impact of stigma on mental health, participants also reflected on factors they saw impacting their client’s unique experience of stigma, including age and how their client made meaning of their sex trading. For example, when asked about the impact of sex trade stigma, Kevin reflected on his experience running a residential facility and programming for women, both minors and adults, whose experiences in the sex trade ranged from “voluntary so to

speak…to kind of typical like pimp-operated trafficking with street prostitution… Some kind of escort service, strip clubs, survival sex, being chained in a dungeon for 20 years." Kevin made use of hyperbole to illustrate how he saw age influencing clients' experiences of stigmatization,

> …the younger you are, the more we care. And so if I if I share an article on Facebook about somebody raping a baby, people are going to freak out right and, and they should. But yeah, the older, the older you get, it doesn't seem as bad, and people don't care as much, or there it's easier for them to put some level of responsibility or blame… And so definitely as soon as they become an adult, it's just gonna, it's kind of a "victim, victim, victim, victim, victim, okay you're whore." And so it is just like just all of a sudden like, "You're, you're a prostitute, and you're disgusting."

Kevin's comment reflected a view of stigma as influencing perceptions of people who trade sex as being responsible and to blame for any risk, violence, and discrimination they might face within the context of the sex trade. Kevin noted how he viewed this stigma as contributing to barriers to funding services for adults in the sex trade as opposed to minors. I address additional factors (e.g., race, size, and gender) that may account for the unequal impact of sex trade stigma in a later section on Identity and the Impact of Systems.

Two participants considered the relationship between stigma and clients' pathways into or relationship with the sex trade. As she reflected on her work with clients who experienced commercial sexual exploitation, Tanya (she/her) posed a wonder,

> …I don't know, in terms of stigma like how do you, how do you separate it from maybe somebody who identifies as a sex worker by choice versus somebody who was maybe trafficked as a minor and is now engaged in sex work because it's all they know?

While Tanya saw the potential for differences in her clients' experiences of stigma depending on their pathway into sex trade, she did not offer suggestions about how this might manifest. Regardless, she saw her role as supporting clients in "peeling back the layers… to help alleviate some of the stigma." Rather than focus on the impact of clients' pathways into sex trade, Evelyn (she/her) saw distinctions in how her clients made meaning of their sex trading, noting how

> …clients take on the identity of "I am a sex worker" or "I am a prostitute" or "I am a trafficked person." "This is who I am" versus a belief that "This is something I experienced." "I engaged in prostitution to survive," "I was a sex worker to survive, and now I am something else."

As she reflected on the impact of stigma on her clients across the continuum of agency, Evelyn proposed that sex trade stigma might impact how a client related to sex trade,

> Yeah, so there's a lot of cultural shame that is put upon people who have engaged in sex work, whether by choice or circumstance or coercion… And I think some of that also contributes to if someone really kind of takes on this identity of "this is who I am" versus "this is something that I did."

Evelyn described how relating to sex trade as an identity may bring clients into greater contact with essentializing, dehumanizing beliefs about people who trade sex, "Because in media in particular, someone when someone is labeled a prostitute, that is who they are. There is no other humaneness about them…" When asked how she intervened in sessions around issues of stigma, Evelyn described a pillar of her approach as delving into her client's belief system by "…talking about how maybe the cultural beliefs or beliefs of their family or things that their family or friends or partners have said, how that has impacted them." And then engaging in dialogue exploring whether and how their beliefs are beneficial, "And if not, let's see if there's a way that

maybe we can shift this belief to be something that is more healthy and beneficial for you and your autonomy and choice." Themes related to the impact of cultural and familial beliefs about sex trade on stigma emerged as participants reflected on how such beliefs were internalized by their clients.

Internalized Stigma.

Content related to internalized stigma emerged during interviews with three-quarters of participants. Broadly, when participants spoke of internalized sex trade stigma, they addressed its impact on their clients and how they addressed it in sessions. The majority of participants used the term "internalized stigma," though two also referred to "internalized whorephobia." Participants described using diverse interventions to address their clients' internalized stigma. For example, Quinn provided a snapshot of interventions he used to help clients begin addressing internalized stigma and shame by looking to "disentangle what society tells us from what we believe." He shared,

> I do a lot of work surrounding values… a lot of work on self-compassion… more insight-oriented work we can do of, "Where did you learn to be ashamed by this," right? Either again through kind of societal, ideological, or institutional stigma to the more interpersonal, right? "How did you learn from your parents growing up that this wasn't okay?" But then also maybe some more kind of behavioral interventions in terms of self-compassion and changing self-talk. Sometimes even some parts work, like talking to ourselves. Just more narrative, kind of identifying dominant beliefs, name the problem.

Quinn drew interventions from a wide range of theoretical approaches when addressing internalized stigma among sex workers in his private practice. While working in community mental health work with clients who engaged in street-based sex work, Rue (they/them) saw

clients with “a lot of internalized stigma and a lot of shame about their work,” which left clients “feeling like, like it was hard for them to kind of interact with people, with other people who weren’t in their community.” When I asked how they intervened in sessions, they shared the importance of validation (i.e., “Not trying to pretend it doesn’t exist”). Rue emphasized,

> …always coming back around to like the stigma being the problem and not the clients’ work being a problem in the relationships. This like this distance isn’t caused by this work, this distance is caused by like the feelings about this work that are influenced by outside factors, right?

Rue approached stigma in sessions by validating the ways it impacted their clients’ lives, particularly their relationships, and working to defuse sex trade stigma from sex trade itself. When asked to reflect on how they were personally impacted by working with clients in the sex trade, Rue shared about how supporting their clients working through internalized stigma,

> …has furthered my own healing process there around internalized stigma that I have about my own history of sex work… the more that I’m in this space of being affirming and empowering and supportive and just kind of the opposite of stigmatizing, the more that, the more I do that for other people, the more I also have that for myself.

As a former sex worker, Rue revealed how they were uniquely impacted by the process of supporting clients in working through their internalized stigma.

While most participants spoke explicitly about different types of stigma (e.g., social, internalized) and their impact on clients, this distinction appeared less clear for one participant. When asked whether and how she saw stigma impacting her clients, Eliza (she/her) shared, “I think that stigma affects them more when with like working with other systems and not necessarily like internally for themselves...” Like other participants, she saw the adverse effects

of stigma on her clients (e.g., “interacting with law enforcement is not a pleasant experience, especially for sex workers”). However, she went on,

> I think for themselves, I don’t know. I mean I, my experience could be completely off base in that I just don’t feel like they’re as affected by the stigma of society about it as they are like your own guilt and shame about it.

Eliza seemed to see her clients’ feelings of guilt and shame related to their sex trading as distinct from and, potentially, uninformed by more distal forms of stigma. When asked to expand on what she meant, she continued,

> There’s like the occasional person that I’ve talked to that, like like I said before, is like empowered by it. And that definitely could be a trauma response for themselves as well. But I think for the majority of people, they don’t want to be doing this. And they, they have a lot of shame about it and don’t want to tell people about it. And I think that that internal conflict is really difficult. Versus like that’s about themselves internally, versus like the stigma that other people might have.

Eliza’s perspective on internalized stigma diverged from that of other participants in that Eliza did not appear to view clients’ beliefs and attitudes about their sex trading as directly influenced by stigmatizing attitudes held by others. At the same time, she was one of many participants who noted the impact of sex trade stigma on clients’ interpersonal relationships.

Impact on Relationships.

A third of participants remarked on the impact of stigma on their clients’ interpersonal relationships, particularly with family and romantic or sexual partners. Participants varied in how they discussed the impact on relationships, whether as a broad clinical context or as content addressed in treatment. As broader clinical context, the presence or absence of disclosure,

specifically with family, emerged in relation to a client's psychosocial history. When addressed in therapy, participants recounted working with clients grappling with decisions about whether and how to disclose their sex trading to family and romantic or sexual partners.

Family. A fifth of participants remarked on the impact of sex trade stigma on their clients' familial relationships. In doing so, the majority focused on issues related to disclosure and the consequences of the presence or absence of disclosure. For example, Evelyn noted their client's feelings related to disclosing, "So oftentimes people don't feel comfortable sharing that they have engaged in sex work, whether that was a trafficking situation or by choice, with their families because of the shame and stigma that exists." In their work with clients across the continuum, Evelyn observed a relationship between sex trade stigma and social isolation that contributed to barriers for people wanting to leave the sex trade. They noted how stigma and resulting isolation "…makes it harder and harder for folks who want to get out of that situation to get out because their sense of belonging is with the people who are in that work." In contrast, as Darren reflected on how stigma impacted his clients' relationships, he viewed familial relationships as less of a focus in sessions than the potential impact on clients' dating lives. He attributed this to working with clients who tended to be,

> …either they're, like, it's none of their [family's] business, and they just have no desire to go there with their family or or it's a part of their past. And again, whether or not their family knows they're they're like this this is irrelevant to sort of get into with family.

Darren illustrates how issues of disclosure may arise in sessions as part of a client's background or story, while not being actively addressed in sessions. Charlotte recounted her work with a particular client that exemplified how issues of disclosure were sometimes actively addressed in sessions. She described working with a client who,

> …really struggles with her parents' perceptions of her being lazy and not working. And them being like unaware that she does actually work very hard and is financially successful and like lives a very stable life because of the work that she does… But she has sort of battled with like, "Which perception am I more willing to sit with right now?"

When asked to describe her approach to clinical intervention, she shared,

> I try to approach that from a place of like, "Do you have a goal to tell family members or is this something that like we want to work more on acceptance of having these sort of dichotomies in your life? Or that like this is something that is a big part of your life and your family's a big part of your life and those things don't mix. And so, trying to help people identify sort of where they fall on that continuum and then supporting that… But it is, I do typically try to figure out with people sort of what what they think is important around disclosure or lack of disclosure.

Charlotte took an open, exploratory approach to assess whether and how her clients' goals related to disclosure.

Romantic Relationships. When asked to describe how they saw their clients impacted by sex trade stigma, a fifth of participants noted the impact of stigma on their clients' dating and intimate relationships. Participants recounted clients' past challenging experiences, ongoing challenges in relationships, and concerns about what would happen in future relationships. In her work with clients spanning the continuum of agency, Evelyn observed that some of her clients had partners who "…feel comfortable and fine with their significant other engaging in sex work or having a history of being that. But I think it's probably fewer people who have said, 'This is fine, this is something that I'm comfortable with.'" In addition to noting the range of experiences her clients shared, Evelyn reflected on a more specific dynamic as she explained,

> I've heard quite a few people share challenges that will come up especially in like strip clubs... Especially that narrative for partners who have someone who is working at a strip club where maybe at times they're fine with it, but then they'll put kind of these restrictions on them saying like "I'm okay with you doing this, but not this with customers."

In describing how her clients' partners asked them to negotiate boundaries around their work, Evelyn is perhaps alluding to the unique context of working in a strip club where workers may provide indirect sexual services (Sanders et al., 2018) while also potentially having the option to engage in full-service sex work. Tessa shared how sex trade stigma was used in the context of conflict in her client's relationship.

> My trans male client, his partner was a trans woman through like the years that I knew both of them. They were both doing sex work. And if they got into a bad enough fight, his girlfriend would whip out that he presents as a woman sometimes in ways that were really weaponized. And not factor in at all that he's only doing that for sex work. And, like she's a sex worker and still the stigma was strong enough where she's like I can use this against him if I really need to.

Tessa highlighted how sex trade stigma could impact relationships even when more than one member of the couple was a sex worker. In addition to coming up concerning current relationships, a few participants noted ways sex trade stigma contributed to their clients' concerns about dating and future relationships. For example, Darren recalled supporting clients who were navigating,

> …reservations about disclosing to a partner or someone they might be seeing or interested in for fear there's going to be judgment or criticism or they won't want to date someone who's in the sex trade or a sex worker. Yeah I've definitely heard about that from clients.

Darren perceived his clients as worrying about being judged or even rejected by prospective romantic partners.

Impact on Access to Medical and Mental Health Care.

Extant research suggests that sex trade stigma is a significant to physical and mental health care for individuals in the sex trade (Bloomquist & Sprankle, 2019; Koken, 2012; Lazarus et al., 2012; Rayson & Alba, 2019). Consistent with this research, a fourth of participants commented on the negative impact of sex trade stigma on their client's ability to access necessary medical and mental health care services. Participants described how clients shared in session their fears and worries about what could happen in a clinical encounter and processed harmful interactions. For example, Kai (they/them) had clients share experiences with providers who would "…hear sex work and then the only thing they can see is like 'Oh you're a sex worker that's a problem, we got to get you out of the life' or whatever, which is bullshit." Kai's comment illustrated how they perceived such comments as harmful to their clients. They described their stance as "a clinician that works with marginalized folks who need medical care. I am pretty rowdy about acknowledging that, in a lot of ways, these systems are fucked up."

Participants noted a range of approaches to addressing stigma as a barrier to care, including sharing resources, building a network of affirming providers (e.g., psychiatrists, primary care providers), and, at times, educating providers working with their clients. Darren noted that access to affirming care was an issue for his clients despite working in a large city. When asked how he responded when clients shared concerns about what they might encounter, he responded,

> Validate, I mean, first of all, right? …It's very often rooted in real-life experiences, not just in some sort of projected catastrophizing happening, but actual experiences they've had in

other places… And then exploring the options from there and where they want to take it. Because if maybe it is something that it is really critical and like needs to be done. And maybe not, maybe maybe less so, and they they decide, "Uh, I'm not going to bother. This feels like too much to to handle right now." So just really meeting them where they're at.

Darren described using a client-centered approach, validating his clients' concerns, and exploring their options. At the same time, he made clear that the importance or medical necessity of the services his clients were seeking could influence his approach.

4.2.2. Safety, Risk, and Coercion

An individual's entry into the sex trade may be due to preexisting vulnerabilities being exploited or through force, fraud, and coercion (Benoit et al., 2019; Nichols, 2016; Sanders et al., 2018). Within the context of the sex trade, individuals face an increased risk of discrimination, harassment, and physical or sexual violence (Lyons et al., 2017; Nadal et al., 2014; Sausa et al., 2007; Shaver et al., 2011; Stenersen et al., 2022). At the same time, harm often goes under-reported due to additional risks associated with engaging with the criminal justice system, such as dismissal, blame, harassment, or sexual coercion (Benoit et al., 2019; Lyons et al., 2017).

Given this context, I wanted to learn how participants navigated moments when they perceived indicators of potential risks or had concerns for their client's safety. How content related to safety emerged in sessions, clinical considerations participants noted, and participants' responses are intertwined within this section. Variation emerged in what participants saw as potential indicators, the frameworks they used to make sense of their client's experiences, and how they viewed their role when intervening. Participants reflected on different types of safety, including physical, sexual, and emotional safety. Participants also illustrated approaches to addressing safety that ranged from nondirective to direct.

The majority of participants described taking an open, direct approach when talking with clients about safety. For example, in her work with sex workers providing a range of online and in-person erotic services, Charlotte, who had a history of sex work, shared, “My approach for good or for bad is to be pretty transparent about what’s going on in my head. Um, where if I have a concern, I will say it.” In such moments, she noted how she might say, “This is coming up for me, and I’m curious if that feels accurate to you?” After voicing her concerns, Charlotte ensured she checked in with her clients and invited their perspective.

Two participants highlighted how their approach to conversations about safety varied depending on how much experience their client had in the sex trade. For example, in their work with sex workers, Hazel (she/they) observed that “the clients that have been doing it for a while have it dialed in.” When asked what how they know these clients have their safety measures “dialed in” Hazel shared,

> They will tell me about how they vet their clients; they will tell me about things that they do or do not do; things they’ll tell me about pretty casually, like how and how often they get tested, things like that. So, with those clients, we talk about safety, like, very briefly. In the same way that I would be like assessing DV in a relationship or assessing alcohol and drug use, you know?

It was not just their client’s breadth of knowledge that indicated a client’s level of experience to Hazel, but also the “casual” manner in which they described routine risk management strategies. In addition, Hazel noted their use of transferable skills when they clarified that talking with clients about safety is not unique to working with clients in the sex trade. Hazel embodied a humble stance as they acknowledged the degree of knowledge their clients possessed compared to their own. Indeed, Hazel noted, "…anything that I could tell them about safety, they’ll tell me

like 18 more things that I'd have forgotten." At the same time, when working with clients who started sex work during the course of therapy, Hazel took a different approach, stating,

> I would ask the same questions around like, you know, "Do you do you feel safe in starting this? What are, what are some questions you might have around safety?" And just kind of opening the door to that and then kind of using my experience with some of the other clients that I've had…

Hazel then shared specific questions they would ask and psychoeducation they might provide regarding physical and emotional safety, while also offering unique considerations for online versus in-person erotic service provision. Sofia (she/her) drew a similar distinction in her approach to working with clients new to the sex trade compared to more experienced sex workers. However, she took a unique approach to address concerns regarding coercion with a client who was new to sex work and creating content on Only Fans. Sofia felt concerned about her client's "…manager, who was very much on the dark and more seedy side of things." She went on to note how the manager was,

> …making money off of her in the way of this, not a partnership, but definitely way of taking advantage of her. Again, because she was young and didn't really know the difference. I feel like she gave into a lot of stuff that, again, just older older, and more wise workers have been able to avoid.

Given her concerns, Sofia decided to intervene. A unique strategy she implemented was connecting her younger client with one of her more experienced sex worker clients. Sofia described her more experienced client as "one of those mentor people" who enjoyed being an "advocate for younger workers." Sofia recognized some of the limitations of her role as a

therapist without lived experience in the sex trade. She also recognized the vital role of community support, which she worked to facilitate.

While most participants described approaching conversations about safety and risk directly, Quinn (he/him) articulated a somewhat different stance toward talking about safety in therapy. He shared, "I really try to avoid any assumptions of safety or not safety, both physically and sexually, too." When asked what embodying this stance led him to do in sessions, he reflected,

> …I rarely ask about like, "Do you use condoms or not?" or I would rarely say things like, "How do you keep yourself safe?" So again, perhaps that's me avoiding a little, but I guess I just try to look for clues as to are there times if they haven't felt safe and just ask, you know if, "How did you feel during this? What came up for you?" And if they indicate any anxiety, then ask, "Did it feel unsafe?" And from there, talk about "How might you keep yourself safer for the future?"

While Quinn intended to avoid making assumptions about his client's safety, he also seemed aware that his clients could sometimes feel unsafe and face risks in the sex trade. As such, he stated his willingness to ask follow-up questions, potentially leading to a more direct dialogue about safety. At the same time, it was unclear what "clues" and signs of "anxiety" served as indicators that would prompt Quinn to assess further.

At times participants' approaches to addressing safety and risk varied depending on other pieces of their client's presentation. For example, Tessa she adapted her approach when working with a trans man who presented as femme only in the context of the sex trade. When she learned that one of his clients was "definitely coercing him just to stay longer than he planned, probably do more than he planned," Tessa grew concerned by how his boundaries were being pushed by

his client (i.e., a perceived red flag). Tessa wanted to assess further; however, she decided to take a less direct approach because he "…had so much shame about [trading sex]. And like really like wanted, wanted it in a box because it wasn't even his body kind of thing." Here, Tessa noted how her approach was influenced by her client's experience of shame intertwined with gender dysphoria he felt in the context of his sex trading. She looked for openings to gently inquire about "his priorities for safety and what are the behaviors that he's engaging into to make that happen." She made clear "…if the content was directly about something that made me worried for his safety, I would ask clarifying questions and then let him determine usually if we're, we're moving on or not." Tessa demonstrated how she navigated a tension between concerns for her client's safety and being responsive to his presentation in session.

When asked about their approach to addressing safety, Rue (they/them) reflected on a particularly challenging case while working at a drop-in community mental health center where they served street-based workers. They recounted working with a client who was accompanied to the agency by "this guy who was exploiting and abusing her." When asked how they reacted, they described making sense of their client's experience as a "…blend of being something like a domestic violence situation and something like a labor exploitation situation…" Drawing on these frameworks led Rue to take an approach that involved,

> …trying to be client-centered and empowering and definitely provide psychoeducation about like options and support that's available. And also work with folks to, like, kind of maximize safety in the moment. And then really be ready to talk about any possibility of getting out of the situation if and when they're ready. But like only in the way that is at their pace… And yeah, it was just the same as as counseling anybody really in a domestic violence situation, and the the forced sex work was just a part of it, just the bigger picture.

Rue found it helpful to rely on various clinical interventions to support their client who was actively being coerced and forced into the sex trade. Eliza (she/her) reflected on her priorities when working with trafficked clients,

> I'm really focused on safety. I want to make sure that, like, it's almost like a harm reduction perspective. Okay, they're not, they're not ready that they want to make any changes, and I support that. And also, how can we ensure safety in what you're doing, you know? So what do not like are there ways that we can increase safety because this can be a dangerous situation… Obviously, with the emotional safety, it is difficult, but I think it's more like the physical safety that like we focus on.

Like others, Eliza noted the importance of talking with her clients about physical safety and sexual health (e.g., knowledge of and access to safer sex materials). However, in the context of working with clients being actively trafficked, Eliza prioritized reducing risks that might accompany accessing mental health services. For example, Eliza described ensuring clients had access to a phone their traffickers did not know about, cautioning clients to avoid keeping appointment cards, and providing ChapSticks with their hotline number on the barcode.

Of note, the majority of participants (n = 13) reported using a harm reduction approach when working with clients who trade sex. Participants described talking with their clients about strategies including the following: Location sharing with a trusted other; procedures for vetting clients; STI prevention and testing; contraception for people capable of pregnancy; setting boundaries with technology when clients engaged in technology-based services (e.g., Only Fans); setting boundaries with clients; and building community with other people in the sex trade.

2.3.1. Identity and Impact of Systems

Systemic oppression heavily influences the conditions under which individuals enter, exist within, and can or cannot exit the sex trade (Gerassi & Nichols, 2017). People who are multiple marginalized and experience identity-based oppression (e.g., racism, cissexism, heterosexism, classism, and ableism) face a heightened risk of sexual exploitation and sex trafficking (Nichols, 2016). At the same time, Black, Indigenous, and People of Color (BIPOC), LGBTQ+, disabled, and other historically marginalized people and communities have deep histories and legacies of healing and collective care (Page & Woodland, 2023). Given this context, I asked participants to tell me whether and how they witnessed sociocultural forces (i.e., identity-based oppression) and identity impacting their clients' experiences in the sex trade. In this section, I integrate findings addressing participants' conceptualization and ways they might respond or intervene in sessions.

In their responses, participants primarily focused on sexual identity (n = 7), gender diversity (n = 7), and race (n = 6) in their responses. A minority of participants explicitly anchored their responses in existing frameworks by naming identity development processes (n = 1), the minority stress model (n = 2), and intersectionality (n = 3). Regarding intersectionality specifically, while only three participants specifically named intersectionality, this does not capture the number of participants whose responses demonstrated a conceptualization informed by intersectionality. For example, Hazel (she/they) conveyed an intersectional conceptualization as they shared,

> I think anytime that a client has multiple pieces of identity that are not fitting within the dominant culture, I think that that the minority stress accumulates. And so if I'm working with a client and they're a sex worker but, they're also queer, they're also a person of color, they are also trans, all of those things are important to think about. …the way that that impacts the work

is that sometimes the sex trade part of things takes a backseat because it's not as important to their identity factors as these other pieces that are seen as "less than" in a lot of environments.

Hazel notes the cumulative impact of systemic oppression on their multiply marginalized clients in the sex trade and how that might inform their clinical approach.

Participants' responses often related to their clients' pathways into, experience within, and ability to exit the sex trade. For example, Darren (he/him) reflected on the impact of systemic discrimination in the context of constrained options his client navigated as Queer and Trans Women of Color, whose sex trading "…was coming out of like survival and like a need because of family rejection, maybe being like thrown out or unstable housing." Similarly, Kiah (she/her) remarked,

> …the more marginalized you are the more likely you're there, which is why it's so high with Trans Women, so high with Black Trans Woman. It's looking out and being like, "Okay, all of these more traditional type jobs aren't available for me and, historically speaking, this has been what my people do…" So not that you won't find people have you know of majority groups within sex trade… I believe there's a strong correlation in the "trapped" part being related to the marginalized identities.

Both Darren and Kiah highlighted the impact of cissexism and gendered racism on their clients' pathways into and barriers to exiting the sex trade. Both participants' remarks illustrate their clients' resourcefulness and reliance on lineages of survival in the face of discrimination. Evelyn (she/her) similarly reflected on the role of discrimination in creating barriers for her clients leaving sex trade as she recounted,

> I think especially clients that I've worked with who identify as LGBTQ, Women of Color in particular, find it more difficult to get out than the white women that I've worked with.

> And some of that is due to racism and injustices within what kind of services are available. Or the services that are available may or may not be a safe space for those individuals to feel welcome to access those services. And there can be mistrust from past experiences of violence and hurt that was inflicted, and that can lead to someone being less likely to choose to try to get out.

Evelyn highlighted how systemic discrimination and violence could be reflected in and perpetuated by social services. In contrast to some participants whose responses centered on challenges or harms experienced by their client, Tessa's (she/her) recounted a range of nuanced experiences among her caseload,

> My [high end] client, it was definitely a piece of like this is how I found my liberation, right? Like very much a foil to a [Jewish] Orthodox upbringing. Both of my clients in film… there did seem to be like an identity supporting aspect of engaging in sex work where it was like, "They want me because I'm a Trans Woman. Like, they want what I'm bringing up and I've had to hide this." Both of them were Latina and had spoken to me about like just the ways in which they still hid in their families, if they had any contact. And so to have a place where they felt seen as themselves was super important, that was a big piece of it. For my client who was stripping there was definitely, we would talk about her identity as a Black woman and what her options were as far as what strip clubs wanted her. And so within like that, that sex work was yet another place for being a Black woman caused limited options.

Tessa's response revealed how an interplay between oppressive dynamics both within and outside the context of sex trade led her clients to find both affirmation and empowerment as well as the perpetuation of systemic oppression within the context of sex trade.

As reflected in the quotes above, participants working with trans, nonbinary, or gender nonconforming clients, named the impact of cissexism on their clients within and outside the context of the sex trade. Two participants specifically noted working with Trans Women who navigated dynamics of fetishization. With regard to working with LGBTQ+ clients more broadly, Rue (they/them) highlighted a unique strength among their queer and gender diverse clients who,

> …all had kind of a process of finding that there's something about them that might not be accepted by everyone around them and deciding that that that's okay or that that's like not going to stop them from living their life or being out or whatever, right? ...And so I think that often can kind of carry over to sex work…

Rue noted their clients' ability to utilize previous experiences navigating minority stress as they then navigated sex trade stigma. Rue contrasted this with what they saw among clients who, while not stated explicitly, they implied were cishet as they shared,

> …with my street clients in general, that there's more shame and more feeling like they can't tell their family ever. And that they don't have that, they haven't had that process of coming to terms with other people judging them and deciding that they decide how they feel about themselves.

Taken together, participants reflected on both the unique risks and areas of resilience experienced by their LGBTQ+ clients.

Among the six participants who reflected on the influence of racial privilege and oppression, they noted how race-based privilege and oppression were reflected in their clients' relationships and interactions with clients, coworkers, and bosses. For example, Abby (she/her) reflected on a recent session where her client was talking with her

> "…about being a Black Woman and that she just has to work harder. She just doesn't make as much money as the white women do. …she had some white women friends who were also sex workers who were complaining that they weren't doing as well as as they wanted to, but they were also not taking care of their health, being responsible, showing up to appointments on time, marketing themselves effectively. And so my my client was expending herself and expending her energy trying to rescue her friends. And basically what it came down to was "Why are you as a Black woman expending your precious energy to rescue your white friends who have more privilege than you and have opportunity and money fall in their laps that you don't have?" And she really liked that.

Abby's account demonstrated how she conceptualized racial inequity reflected in her client's experience in sex trade across multiple domains (e.g., financial disparities, internalization, interpersonal relationships). Abby also illustrated how she might intervene in sessions by talking explicitly about race and privilege. Drawing on her clinical experiences in both a residential facility for "vulnerable populations" and her private practice work, Kiah (she/her) reflected on the impact of racial discrimination as she remarked,

> How you're treated by the police as well obviously has a lot to do with your identities. And so what may be viewed by one police officer as illegal and problematic and very shameful of "This is what you're doing, we're arresting you for prostitution," rather than arresting the people who are creating these environments and creating these these rings of sex trade very illegally and very, very forced. They're going to be much more likely to be kind of stuck in that and that be used against them. Whereas like a person with more privilege is not going to always be viewed as that. And sometimes even cops being like dismissive of

> it is like “Oh you’re an escort, that’s different in prostitution.” Like, “How? Because I’m white?” Like, probably.

Kiah’s account highlights racial discrimination enacted by law enforcement interacting with people who trade sex. She also alludes to racialized perceptions of different types of sex trading (e.g., escorting vs. prostitution).

Less frequently mentioned aspects of identity included religion (n = 4), size (n = 2), language (n = 1), immigration and refugee status (n = 1), and socioeconomic status (n = 1). Regarding religion, participants noted the impact of regional religiosity (i.e., the Bible Belt) or clients’ religiously conservative upbringings within the context of Christianity, Catholicism, or Orthodox Judaism. The only participant to reflect on the impact of immigration status and language was a clinician (Eliza, she/her) who engaged in clinical practice with people who had experienced sex trafficking. In her specific context, she noted, “We work with a lot of refugees and immigrants… and like language barrier. Or like even when somebody that I was working with and it was like a documentation, her trafficker had her papers and her documentation.” Of note, while not explicitly asked to reflect on their own identities or relationships with systems of privilege and oppression, three participants (Abby, Kai, and Quinn) did so. In doing so, these three white participants specifically reflected how they might be perceived or experienced by BIPOC with whom they were working.

4.3. Assumptions about Sex Trade

Therapists’ beliefs related to their clients’ identities and experiences influence both clinical decision-making and the therapeutic process (Eubanks-Carter & Goldfried, 2006; Hayes & Erikson, 2000; Mohr et al., 2009; Sabin et al., 2015; Schechinger et al., 2018; Snowden, 2003; Weber, 2020). This relationship, paired with my investment in improving clinical practice, led

me to ask all participants to reflect on their assumptions about the sex trade and people who trade sex. In this section, I address participants' beliefs, whether and how their beliefs have shifted over time, and what contributed to the development and transformation of their beliefs.

4.3.1. Expanding Perspectives

In this section, I highlight participants' reflections on their experience with perspective change. Nearly half of my participants observed that their beliefs about the sex trade grew increasingly nuanced throughout the course of their work with clients who trade sex. Participants reflected on their beliefs at the outset of their clinical practice with this population. Perspectives held early on in clinical practice included being pro-sex work, viewing sex trade as a means of survival, or seeing the sex trade as something harmful that should not exist.

Kia (they/them) illustrated what it was like for them as a therapist who held a positive perspective on sex work at the start of their clinical practice. As Kia reflected on their initial "romanticized" view of sex work, they contextualized their belief as stemming from being embedded in,

> …a community of very radicalized folks that are like, "Sex work is real work. I'm a sex worker, I love being a sex worker, I'm so liberated," whatever... And I think I got kind of sucked into that bubble as like, "Oh like, everybody is like pro-sex work." No! What the fuck was I thinking?

Perspectives and experiences Kia were exposed to by members of their community who were, themselves, sex workers informed their initial assumptions about the sex trade. However, Kia subsequently learned from their clients that, in the sex trade, there can be "…a lot of mistreatment, and it's a very harsh reality." When asked to share more about what contributed to their perspective changing, Kai emphasized how their clients' lived experiences were pivotal, "I

think sitting with the shit. Like, the shit that I hear is unbelievable." Kia went on to provide an illustrative example of the "shit" their clients processed in therapy related to the sex trade. Like Kia, Quinn's perspective toward sex work was positive and informed by personal exposure to the sex trade. Quinn described his early assumptions about the sex trade as "…an opposite assumption of many, where it's like, sex work is great, not great, but like it's super legitimate." Over time he learned that "maybe for some people it is traumatic, and you need to honor that, even if a trauma is coming from internalized stigma." However, given his own experiences as a sex worker, he continued to "grapple" with the tension between wanting to "…not invalidate somebody's pain if that's there" at the same time as wanting to "very much honor the healing nature of [sex] work."

Unlike Kai and Quinn, Darren (he/him) previously assumed sex trade was "centered around survival… not necessarily a preferred thing, but an avenue in which folks that are discriminated and oppressed and like unable to support themselves in other ways are making do." Rather than discard his original belief, instead, Darren shared how his perspective expanded to encompass the experiences of clients who "…are living and thriving and sometimes I'm like, 'Oh, you make way more money than me. And I respect your hustle and your business model and I love it.'" Darren described the change in his view on sex work and the sex trade as "a very pleasant shift."

Marty offered an account illustrating the process of perspective change related to beliefs about the sex trade initially centering on exploitation. Marty (they/them) primarily worked with clients engaged in sex trafficking, which they noted as they described how,

> …when I first started out working around human trafficking stuff, I was very adamant that sex work should, it just shouldn't have to exist at all. And I think I've come to be a little

> bit like, well apparently there are some people that enjoy doing sex work and and unless I get to know them really well, I can't decide whether or not they were exploited. They're gonna have to tell me whether or not, like, over time.

Rather than assuming a client's experience was inherently exploitative, Marty began increasingly relying on how their clients made meaning of their experience in the sex trade as exploitative or not. However, they quickly noted some potential limitations to this approach stating,

> … a lot of times a person in an abusive relationship doesn't know they're an abusive relationship. I mean that's just the nature of it. You're in a cult, you might not know you're in a cult. If your boyfriend's a pimp, you might not really frame it that way, right? So it's super complex. I don't know if I've changed that much except to be, I don't know, a little bit less quick to jump on the, "No, you're trafficked!"

Marty drew parallels to various abuses of power and control as they highlighted a concern that their clients might not be able to readily identify instances of abuse and exploitation. At the same time, Marty did note a behavioral change ("less quick to jump") in their approach to addressing clients with sex trading experience. Of note, when Marty described their clients who traded sex, they clarified that they had not yet worked with a client who self-identified as a "sex worker" or wanted to continue their sex trading longer term.

Assumptions about Trauma. When asked about their assumptions about the sex trade, two participants, Evelyn and Rue, described how they previously assumed their clients' experiences in the sex trade would be the "most traumatic" or "worst thing" their clients had experienced. Evelyn shared how this assumption "…continually shifted over time" and clarified, "I do not believe that anymore. Many of the people that I worked with would identify experiences *before* being sexually exploited commercially as more traumatizing." Examples of

earlier experiences included "child sexual abuse" and clients "being kicked out of home" by their families. Evelyn's perspective broadened, and they came to view "…everyone's experience and the way that they process their experience within sex work or a trafficking situation is different and how that affects them is different." Rue (they/them) described a similar change in perspective. They also added that they had learned that "if somebody has had experiences of coercion and exploitation and even if they were like trafficked for years and some terrible situation, not to assume that it was all negative."

Protecting Clients. In response to my question about personal assumptions and how they changed over time, both Rebecca and Kevin reflected on ways they previously tried to offer support for their clients that were driven by some of their discomfort. In her clinical practice, Rebecca (she/her) predominantly worked with "consensual" sex workers but also had experience with clients who had experienced sex trafficking. When asked about assumptions she made about the sex trade, she reflected on how her approach to talking with clients about sex trade initially involved, "I guess cheerleading… without checking in or thinking to check around some of the challenges." When I asked what contributed to her approach, she explained how she believed it stemmed from "…feeling the need to demonstrate support… I want to show support, so I'm not going to necessarily ask as much as I would or should around the like more challenging aspects." Rebecca clarified her early belief that asking clients questions about challenging parts of trading sex would demonstrate judgment. She shared about her current approach now that she has,

> "… moved away from cheerleading to just being more open in my space of like, "How is it working for you right now, how's it not working for you?" Just the way any other job would be, rather than feeling more protective."

When I asked how this change may have impacted her clients, she hoped it would allow "for folks to like be holistically seen and know that they can go anywhere that they want to go. … and bring in the hard parts and bring in the like stigmatized parts and everything else." She initially viewed part of her role as protecting her clients from judgment and avoiding perpetuating stigmatizing beliefs by not asking about difficult experiences in the sex trade. However, she realized that avoiding her own discomfort related to this possibility could deter her clients from addressing challenging parts of their experiences in therapy. When reflecting on what contributed to her change, Rebecca attributed it to increased "comfort and confidence in my skill and in being able to show up with people." Kevin reflected on a similar process of becoming increasingly comfortable with the breadth of his clients' experiences.

In his work with a residential facility for women, Kevin reflected on his early assumptions related to victimization and blame, which contributed to feeling uncomfortable as the women he worked with began taking responsibility for their role in events. He shared,

> One thing that was surprising to me [was] how quickly and easily I guess the the women owned a lot of their own decisions that in some way did position them to be taken advantage of…. I think even saying that, that's a really uncomfortable thing. People don't like that and, and everything is supposed to supposed to be kind of politically correct and and and "These these are victims and it shouldn't matter what you were wearing or where you went if you were drinking or," and those are all true…

Over time, he grew increasingly comfortable engaging in therapeutic dialogue, supporting clients in identifying their choices in a given context and how they may be able to make different choices moving forward. When asked what contributed to his change in perspective, Kevin

attributed it to seeing clients "…continually finding and identifying what what their choices were and and owning those." He went on,

> … I think that's a lot healthier approach because if you're just this poor girl who just continually just gets taken advantage of, well, then there's not really anything you can do different. …you're just screwed, you're going to keep getting hurt for the rest of your life. … if there's something that maybe you are choosing or deciding that seems to be unhealthy, then you have the power to choose otherwise and and then maybe something will be healthier. And so I think that it really it was the that's them taking being empowered to really improve their circumstances…

Kevin and Rebecca recognized how they felt discomfort addressing parts of their clients' experiences in the sex trade. However, over time they learned that their discomfort limited their ability to invite in the breadth of their clients' experience and took steps to change their clinical approach.

4.3.2. Choice and Agency

Three participants voiced assumptions about their client's degree of choice and agency related to their involvement with the sex trade. Eliza (she/her) recounted how earlier in her clinical practice, she "…was under the assumption that [sex trade] was much more of a choice than it really is." Looking back, she believed she was not "…as aware of how their past trauma impacts their current life." She continued,

> Like, even though I have women who say, "I'm choosing this. This is my choice." And I don't want to take that away from them that it isn't, but I don't, I don't always think it is. And I think that, like if, if their life has been different up to that point, I don't know that they would choose that.

Eliza observed that she and her clients might hold different beliefs about her client's degree of agency and the relationship between a client's trauma history and their sex trading. Eliza noted her view that a client's trauma history might delimit a client's ability to choose to engage in the sex trade as she shared,

> … let's say I was working with somebody who did not have a trauma history and they were a sex worker, I think that my perspective obviously would be very different. That would be more of an issue of choice than a lot of the clients I'm working with.

Marian (she/her) shared a similar reflection on her client's agency in the context of entering into the sex trade. She noted, "I really want to listen to people with respect who tell me that they choose to do sex work and that it's empowering for them. And I don't *not* believe that's true. And yet I like worry about people's souls." Like Eliza, Marian reflected on the relationship between her client's history of childhood trauma, sex trade, and agency as she shared, "And I've never heard somebody tell their story about how they chose to do sex work, and it was empowering for them, that I didn't later hear about what their childhood experience of exploitation was. They're so linked…" While not addressing a link between trauma and trading sex like Eliza and Marian, Alisha (she/her) explored her relationship to assumptions about choice as she shared,

> …what I'm wrestling with right now is an assumption that if someone had other options, they would choose other options. That's one of the things that I constantly wrestle with because I think that there's a way that that assumption can sometimes then turn into a judgment around sex work itself.

Rather than being resolute about her assumptions about clients' choices concerning sex trade, Alisha was motivated to actively reflect on and engage with her beliefs.

4.3.3. Sexual and Gender Identity

When asked to reflect on personal assumptions about sex trade, a fifth of participants shared assumptions related to gender and sexual identity. More specifically, they noted beliefs about who engages in sex trade (e.g., cis women, queer people) and how they engage in the sex trade. For example, while working with clients primarily engaged in survival sex, Marian (she/her) observed, "I still struggle to listen for non-feminine presenting people doing sex work." She continued by highlighting how her assumptions about sex workers' gender related to her broader beliefs about sex trade,

> I think it's connected to my bias that I believe that sex work is like fundamentally exploitative, so that the idea that someone who presents as a man could be exploited is still startling to me… I'm old fashion, and I'm like working on my gender norms stuff.

As she reflected on one of the sources of her assumption, Marian drew a connection between her belief that sex trade is inherently exploitative and the belief women and femmes experience exploitation more frequently than men and masc people. In contrast, Tessa (she/her) shared a prior assumption that "…all sex work was like a little queer," which she contextualized, noting, "Oh, I'm a funny example, I was raised by sex workers…" She went on,

> And so I noticed myself bringing those assumptions in and needing to adjust those as like I got feedback about like how very gendered, in like a heteronormative sense, a lot of relationships [in sex work] were. And even like in some contexts, like how very important it is to to be like kind of the idealized straight woman available for a heterosexual relationship.

Learning from her clients about how they navigated gendered expectations and heteronormativity in the context of sex work shifted Tessa's perspective over time.

Charlotte similarly reflected on assumptions about who engages in sex work and how they do so as she noted her early assumptions about "the types of people that were providing sex work… I sort of thought of it as like a 'women's issue' in big quotes." She described how this assumption became more apparent to her as she worked with gender diverse sex workers and learned about "…the intersection of like of gender and sex work. And oftentimes people having to make like compromises about the way that they present to get work, even though it may not be aligned with their gender identity." Similar to how Tessa learned how her client navigated heteronormative expectations, Charlotte learned how clients navigated the influence of cisnormativity and cissexism in the context of sex trade. Charlotte was not the only participant to reflect on the impact of cisnormativity and cissexism on their clients.

In their work with clients across the continuum, Rue (they/them) recounted how there were parts of trading sex that "I like assumed would be the same for different people in the sex trade that I have learned there is more variation of people's experience than I originally knew." When asked about specific examples, Rue reflected on their work with trans and male sex workers who had "totally different norms around screening…" than Rue was familiar from working with cis women. Rue highlighted a poignant learning moment when one of their clients told them, "Screening isn't a thing that I can do because it's not a thing that any other trans male sex workers do in [Large city]. And so why would a client see me if I'm the only one doing that…" Learning involved dynamic interaction between Rue and their clients who were open to correcting them when they got things wrong in session.

4.3.4. Factors Contributing to Change

I explicitly asked more than half of my participants what contributed to their assumptions changing over time, some of which is reflected in the sections above. Eight participants

emphasized the pivotal role their clients' stories played in extending or disconfirming previously held beliefs. For example, Evelyn (she/her) noted shifts that stemmed from "asking and listening to people and believing them." Rather than passively engaging with their client's narrative, Hazel (she/they) her learning process as active and involving "leaning into the lived experience of my clients and taking that at the value in which they were giving it to me and not going based on what textbooks potentially say about things like this." In noting what contributed to changes in her perspectives, Hazel also highlighted the role of educational materials as one potential source for her earlier beliefs about the sex trade. Kiah (she/her) highlighted how the breadth of her clients' experiences contributed to her views changing while working in a residential facility, "…it's interesting going from like 'Oh, this is like horrible' to like sitting with my client who's like, 'Yeah, we went to the like adult video awards event and like how that was really fun and exciting.'" In addition, when asked what contributed to changes in their perspectives, two participants recalled moments when their clients explicitly corrected them, exemplifying how clinical encounters contributed to their beliefs changing over time.

Chapter 5: Discussion

My focus on therapists in this investigation is underscored by an appreciation for the impact of therapists' actions on the clients they serve. Therapists carry a unique constellation of life experiences, personal traits, professional characteristics, and lineages into their work (Hayes & Vinca, 2017; Page & Woodland, 2023; Norcross & Lambert, 2019). In their role, therapists rest in a position of power (Feminist Therapy Institute, 1999) relative to their clients who step into a relationship that holds the potential for care and healing coupled with the potential for harm. Research has illuminated a need for therapists to be better equipped to serve people in the sex trade specifically (Antebi-Gruszka et al., 2019; Gerassi et al., 2019; Grittner & Walsh, 2020;

Kurtz et al., 2005; Pederson et al., 2019). As such, in the present study I sought to uncover how therapists understand their work with individuals in the sex trade. In addition, I explored the clinical landscape of sex trade in therapy by attending to how sex trade related content emerged and was addressed in sessions. Yet how therapists engage in clinical practice with people who trade sex has been understudied, a critical research gap.

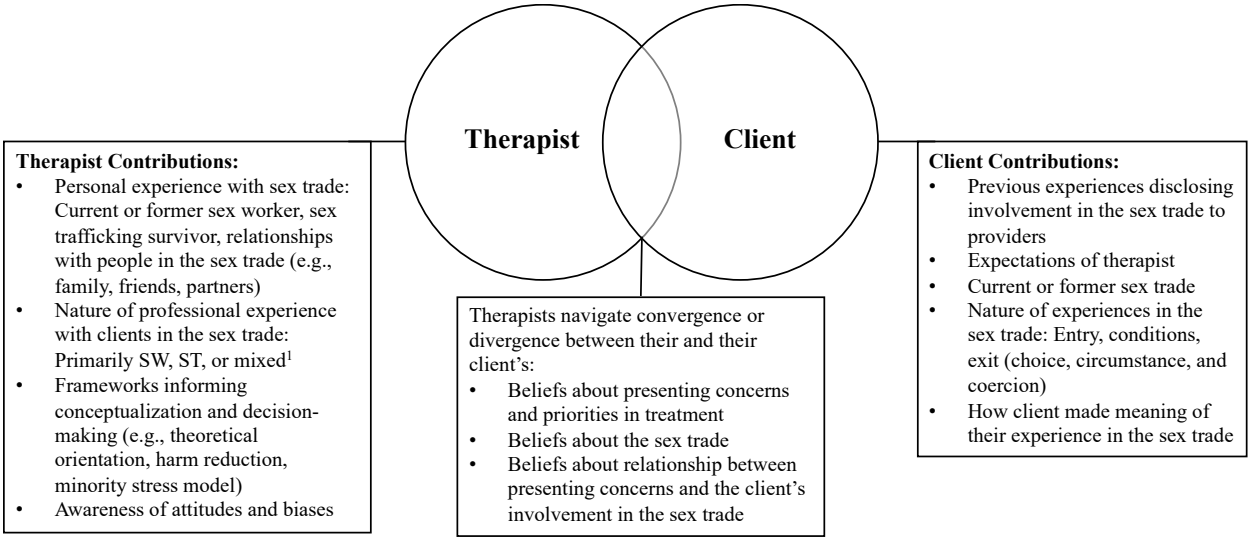
One of my study's primary contributions is its mapping of contributors to therapists' clinical decision-making related to the sex trade in the therapeutic context (Figure 2). My focus on clinical decision-making emerged through my interviews and subsequent analysis. When developing this study, I was interested in learning more about and being able to describe what therapists say and do in sessions with clients in the sex trade. Based on extant literature, I focused on several salient moments (responding to disclosure, navigating terminology, and determining the focus of therapy) and areas of clinical content (stigma and safety). However, my participants' stories led me to recognize the value of exploring the complexity and nuance related to how they *decided* what to say and do in session. As my inquiry developed, I routinely integrated questions prompting participants to reflect on factors that informed their decision-making along with how their approach changed over time and in response to what.

Clinical decision-making is a core competency of clinical expertise aimed at promoting healing and fostering positive clinical outcomes (APA, 2021; APA Presidential Task Force on Evidence-Based Practice, 2006). This dynamic process requires clinicians to "process enormous amounts of data and information, distilling them into coherent diagnostic formulations followed by a logical course of action, which are modified and corrected as new information is gleaned" (Magnavita & Lilienfeld, 2016). Scholars have explored clinical decision-making from the moment-to-moment or more process-oriented level (Ferreira et al., 2017) to higher-level

decisions about assessment, diagnosis, treatment-planning, and treatment implementation (APA, 2021; APA Presidential Task Force on Evidence-Based Practice, 2006; Henriques, 2016). Findings from this study align more closely with clinical decision-making at the moment-to-moment or process-oriented level. A central finding of this work is that participant's clinical decision-making when addressing their client's experience in the sex trade was informed by factors related to the therapist and client (Figure 2).

Figure 2

Contributors to Clinical Decision-Making with Clients Engaged in the Sex Trade



Note: This takes place in the therapeutic context (private practice, community mental health, agency or program targeting people who trade sex).
[1]SW = Sex work, ST = Sex Trafficking, Mixed = Working with clients spanning the continuum of agency to victimization (i.e., sex workers and people who experiences commercial sexual exploitation or sex trafficking).

5.1. Therapist Contributions

Findings from this study suggest several therapist contributions to clinical decision-making with clients engaged in the sex trade. Contributing factors included personal and professional exposure to the sex trade, the use of relevant frameworks, and awareness of personal attitudes and biases. Six participants remarked on how exposure to the sex trade in the context of

their personal lives informed their perspective on the sex trade and their clinical approach. Four participants shared about the influence of their lived experience as sex workers, and one noted having experienced a trafficking incident. Three participants described having personal connections with the sex trade that included previously working on the production side of the adult film industry or having family members, a spouse, or friends who were sex workers. For example, Kia (they/them) reflected on how their attitudes towards the sex trade were initially informed by having a community of "very radicalized folks that are like 'Sex work is real work. I'm a sex worker, I love being a sex worker, I'm so liberated.'"

Similarly, Tessa (she/her) contextualized her beliefs by noting, "Oh, I'm a funny example, I was raised by sex workers…" When reflecting on how they navigated sex trade terminology with clients, Daria (they/them) and Charlotte (she/her) both highlighted how their experience as sex workers informed their approach and decision-making. Findings also suggest that the nature of participants' previous experience with clients in the sex trade (i.e., predominantly related to sex work versus sex trafficking or CSE) informed their subsequent perspective and decision-making processes. For example, Alisha (she/her) illustrated this dynamic when asked how she navigated determining the focus in therapy. She worked almost exclusively with clients who experienced commercial sexual exploitation and was familiar with supporting her clients in leaving the sex trade. She recounted needing to adapt her approach to working with a client who did not intend to leave sex work. As she and her client navigated their beliefs about priorities in therapy, Alisha noted, "…it was definitely a challenge at the time, I remember, because it was different than what I had been taught previously."

The influence of personal and professional exposure to the sex trade on therapists' clinical approaches can be considered in the context of literature addressing clinical decision-

making. Clinical decision-making is multifaceted and has been conceptualized in various ways, highlighting a tension between views that center more intuitive versus more empirically oriented aspects of decision-making (Fox et al., 2016; Henriques, 2016). Magnavita and Lilienfeld (2016) offer an analysis of clinical decision-making anchored in a cognitive psychology framework for understanding decision-making. More specifically, the authors apply Daniel Kahneman's (2011) conception of System 1 (i.e., fast, intuitive, emotional) and System 2 (i.e., slow, deliberate) thinking to the process of clinical decision-making. In doing so, Magnavita and Lilienfeld (2016) note that "clinicians generally and understandably favor System 1 decision making, which is the rapid pattern recognition type necessary for navigating the often-enormous multitude of decisions that are faced on a moment-to-moment basis in clinical practice." Among participants in this study, previous experience may serve as an anchor when making fast, intuitive decisions in session. However, Magnavita and Lilienfeld (2016) caution that "…such intuitions should be guided and double-checked by systematic data." Indeed, an additional consideration informing clinical decision-making was the degree to which participants were aware of the influence of their own attitudes and biases. These therapist considerations are discussed below in the sections addressing clinical responsiveness and attitude change.

Participants' accounts suggest that their conceptualization and subsequent clinical decision-making were at times informed by frameworks such as their theoretical orientation, harm reduction, or the minority stress model. For example, more than half of this study's participants described utilizing a harm reduction framework to inform their clinical practice with this population. Participants such as Eliza recounted how a harm reduction perspective informed her approach to working with clients unwilling or unable to leave a trafficking situation at a given time. Using a harm reduction approach may foster therapists' ability to promote agency in

their work with clients across the continuum of agency. In addition, access to useful frameworks may help therapists organize clinical information and navigate the myriad moment-to-moment decisions in sessions.

5.2. Client Contributions

Several client factors highlighted in this study's findings may be useful for clinicians to be aware of and responsive to in their clinical practice with individuals in the sex trade. The first relates to the nature of clients' previous experiences disclosing sex trading and how clients anticipate others, including their therapist, will respond in the future. Sex trade stigma deleteriously affects the quality and accessibility of mental health care (Koken, 2012; Lazarus et al., 2012; Quinn & Chaudoir, 2009). Participants in this study, particularly those in private practice, explicitly addressed challenges their clients may have navigated to access mental health care. For example, Kai (they/them) shared how they might say to a client, "I'm so honored to be here with you. And I wish you were able to choose a therapist based off like what you actually want to be talking about." Here Kai modeled acknowledging that clients might prioritize working with a sex trade affirming therapist rather than one whose specialty aligns with their presenting concern.

Even after finding a therapist, individuals in the sex trade may anticipate judgment, invalidation, or pathologization from their therapist (Antebi-Gruszka et al., 2019; Gerassi et al., 2019; Grittner & Walsh, 2020; Kurtz et al., 2005; Pederson et al., 2019). In a Delphi study, Pederson and colleagues (2019) interviewed eight sex workers in the United States about the knowledge, skills, and attitudes they believed therapists should hold when working with individuals in the sex trade. Meaning units from interviews were used to create a survey that was sent back to participants twice to identify areas of consensus and disagreement. In the first round

of consensus checking, participants agreed on the following statements: “Therapists should know that sex workers are going to be concerned about their therapist’s opinions surrounding sex work” and “If I got the sense that my therapist was judging me for being a sex worker, I would not see them again.” Findings suggest that some participants in the present study were attentive to their clients’ potential concerns related to disclosing sex trading in session. Quinn (he/him) modeled how he attended to this context in sessions after his clients disclosed, stating, “Initially, I always make sure to immediately thank them, to be grateful for them opening up and sharing something that is so heavily stigmatized…” Comments like Quinn’s also acknowledge the risk inherent in disclosing a concealable identity and their client’s choice to set aside concealment, a commonly used strategy for coping with stigma (Koken, 2012; Quinn & Chaudoir, 2009).

At times participants distinguished implicitly or explicitly between clients who viewed sex trade as part of their identity versus a behavior they engaged in or something they experienced. For example, Evelyn (she/her) made this distinction explicit as she observed differences in her clients who would “take on the identity of ‘I am a sex worker’ or ‘I am a prostitute’ or ‘I am a trafficked person.’ ‘This is who I am’ versus a belief that ‘This is something I experienced.’” Evelyn noted this distinction in relation to clients were impacted by sex trade stigma. The distinction highlighted by Evelyn supports work by Gerassi and colleagues (2019) who qualitatively explored how women (n = 30) made meaning of their identity in relation to their sex trading and how service providers (n = 20) responded to sex trading identities. The authors observed three patterns of meaning making among sex trading participants: 1) Women who engaged in sex trade but did not see sex trading as part of their identity, 2) women who identified as a “prostitute” and viewed this as part of their identity, and 3) women involved in pimp-controlled prostitution who emphasized force and coercion in their

sex trading. Gerassi and colleagues (2019) noted how discrepancies between providers and the women they served contributed to issues and gaps in social service provision. As such, the authors recommended providers recognize complexity in "identities and behaviors of sex trading as well as the fluidity and movement between them." Imposing a limited and inflexible framework for understanding sex trading identities and behaviors may lead to clinical misses. As such, clinicians should be attentive to how their clients make meaning of their sex trading experience and shift their language accordingly.

5.3. Clinical Skills and Psychotherapy Processes

In analyzing findings for how clinicians navigated clinical decision-making as their clients disclosed their involvement in trading sex, I found that most relied on foundational clinical skills and knowledge of psychotherapy processes to inform their ultimate clinical praxis. More specifically, attunement to the therapeutic alliance, clinical responsiveness, schemata refinement, and avoiding discomfort emerged for these participants as criteria utilized to inform their clinical decision-making. Following, I will discuss how each of these psychotherapeutic processes presented themselves in the context of this investigation.

Therapeutic Alliance.

Establishing a strong therapeutic alliance emerged from the findings as an essential component to working with clients who trade sex. This finding is consistent with the dearth of research demonstrating a strong correlation between positive clinical outcomes and the therapeutic alliance, comprised of the therapeutic bond and agreement on the tasks and goals of therapy (Wampold et al., 2017). However, findings from this study also suggest that making clinical decisions aimed at strengthening the therapeutic alliance may be particularly important with working with sex workers. As Kai (they/them) illustrates, "…so my philosophy is like

relationship above everything… And I find that to be especially important with sex workers because I can see in a lot of ways how I can be seen as a scary person, as the enemy." At a relational level, therapists sit in a position of authority and power relative to their clients (Feminist Therapy Institute, 1999). People in the sex trade may anticipate and experience discrimination across systemic, institutional, and interpersonal levels (Nadal et al., 2014), including within the therapeutic relationship, where they may encounter judgment, invalidation, and pathologization from providers (Antebi-Gruszka et al., 2019; Gerassi et al., 2019; Grittner & Walsh, 2020; Kurtz et al., 2005; Pederson et al., 2019).

In addition to highlighting the importance of developing and maintaining the therapeutic alliance, findings also demonstrate participants' clinical decision-making being informed by their assessment of the strength of the therapeutic alliance. For example, Marty and Evelyn both noted how their approach to addressing terminology and language related to the sex trade was informed by an assessment of the strength of their therapeutic alliance. In addition, having a strong therapeutic alliance informed Tessa's decisions about whether and how to address the ways a client's presenting concerns were reflected within the context of her sex trading. The therapeutic alliance is inherently relational and nested within the therapeutic dyad, so there are limits to what can be said what therapist characteristics contributed to the alliance in the absence of client data. At the same time, participants noted their use of relational skills, which Anderson and Hill (2017) define as how therapists "express, receive, and interpret emotional and interpersonal exchanges with the client" (p. 142). More specifically, participants conveyed how they expressed empathy, demonstrated trust for clients, used open-ended questions to foster a client-centered stance, and responded to clients non-judgmentally.

Clinical Responsiveness.

A surprising finding in this study was that the relationship between therapists' attitudes toward the sex trade and their clinical approach was not as deterministic as I anticipated. This finding emerged partly as participants described responding differently to different clients. For example, Marian (she/her) described tailoring her response the first time a client disclosed trading sex with the intent of best meeting their unique needs. The majority of Marian's experience with clients in the sex trade was with individuals whose history with the sex trade was shared while processing trauma. Marian responded to these clients by reflecting back the fear and danger they encountered. However, she recounted needing to adapt her response when one of her clients created an OnlyFans account to cope with financial hardship due to the COVID-19 pandemic. Marian needed to manage her personal reactions ("I knew it was going to be a bad deal and wanted to stop it somehow") to adapt her response appropriately. She tried to "really validated the economic crisis and the need to stay physically safe" for her client. Marian's account illustrates how her clinical approach was informed by her previous experience with clients in the sex trade, her awareness of her biases, and how her clients made meaning of their experience in the sex trade.

One way of making sense of accounts like Marian's is through the framework of appropriate responsiveness, which Stiles and Horvath (2017) define as when therapists "respond to the benefit of their clients, seeking to be aware of their behavior, and adjust it in response to clients' needs" (p. 72). Stiles and Horvath (2017) suggest that both client and therapist factors inform responsive clinical decision-making. Consistent with Heinonen and Nissen-Lie's (2020) distinction between personal and professional therapist characteristics, Stiles and Horvath (2017) note therapist factors such as therapist skills, personal characteristics, and theoretical orientation. The authors propose client factors such as diagnosis, education, stage of life, personal history,

stage of therapy, and moment-to-moment needs in session. Data from this study point to several client factors that may aid therapists in taking a responsive approach when working with clients who trade sex. These factors are addressed in the section above on "Client Contributions."

Elements of appropriate responsiveness can be seen in how participants navigated conversations about safety and risk. Broadly, participants described altering response depending on their comfort asking explicitly about safety and risk, their perception of the message conveyed to clients by questions about safety, their client's tone and nonverbals when talking about, and the presence of explicit indicators such as clients' accounts reflective of being coerced or manipulated. Sofia (she/her), Hazel (she/they), and Tessa (she/her) all described taking a responsive approach when talking with their clients about safety. Sofia and Hazel both emphasized how their approach to talking with clients about safety varied depending on whether a client was new to the sex trade or had substantial experience accompanied by risk management strategies that were "dialed in" (Hazel). In addition, Tessa adopted a less direct approach to addressing potential coercion with one of her clients in response to the shame and gender dysphoria he experienced around his sex work where he presented as femme (i.e., incongruent with his gender).

It is noteworthy that the majority of participants (n = 13) in this study endorsed taking a harm reduction approach (i.e., "meeting them where they're at") in their work with clients in the sex trade. Trans women of color who were sex workers were instrumental in the development of Liberatory Harm Reduction (Page & Woodland, 2023). Perhaps this approach helps therapists anchor themselves in appropriate responsiveness while supporting clients in "action using real-life strategies to reduce the negative health, legal, and social consequences that result from criminalized and stigmatized life experiences such as drug use, sex, the sex trade/sex work… and

other survival strategies deemed morally or socially unacceptable" (Page & Woodland, 2023, p. 88).

In addition to reflecting on how participants could adjust their response in the moment to meet their client's needs, participants also reflected on changes in their attitudes throughout the course of their clinical practice. At the same time, it is essential for findings related to clinical responsiveness to be understood in the context of this study's unique sample. Specifically, given that only four participants worked exclusively with sex trafficking survivors, further research is needed to better understand whether and how clinical responsiveness emerges among therapists working with sex trafficking survivors across practice settings (e.g., trafficking-specific organizations, private practice, and community mental health).

Schemata Refinement.

Findings from this study suggest that participants' attitudes and beliefs about the sex trade tended to grow increasingly complex with greater clinical experience and exposure to clients with diverse backgrounds in the sex trade. Participants whose accounts revealed this process initially endorsed beliefs that ranged from viewing sex trafficking as "a separate world" from that of sex work (Tessa, she/her) or having a "romanticized" view of sex work (Kai, they/them) to seeing sex trade as "centered around survival" (Darren, he/him) or believing that sex work "shouldn't have to exist at all" (Marty, they/them). With increased exposure, these participants learned from clients whose stories disconfirmed or challenged previously held beliefs. This process of developing increasingly nuanced beliefs aligns with understandings of the role of learning and cognition in developing clinical expertise. Stoltenberg and McNeill (2011) write about schema development and refinement in clinical practice as the process whereby overly general schemata (i.e., organized declarative and procedural knowledge) are

applied and do not work as intended, which leads a clinician to set about actively trying to understand why. The refinement process is not automatic and requires clinicians to choose to monitor, evaluate, and then refine their schemata (Schön, 1987; Stoltenberg & McNeill, 2011). Among participants who described their beliefs about the sex trade as relatively static over time, it may be that they either had not yet had a clinical encounter where their schemata did not work as intended or, perhaps, had such an experience but did not choose to interrogate why.

Avoiding Discomfort.

An emergent theme in my data highlighted unintended consequences resulting from strategies therapists used to avoid personal discomfort about potentially perpetuating harmful beliefs about the sex trade and people who trade sex. For example, Rebecca (she/her) initially assumed that asking her clients about challenges they experienced in the sex trade would be perceived as unsupportive and judgmental (i.e., potentially rapport damaging). As such, she adopted an unbalanced "cheerleader" stance when discussing clients' sex trading until she grew more confident in her clinical skills. Kevin reflected on the discomfort he felt when the women he worked with who had experienced ST or CSE took responsibility for their choices related to experiences of coercion and exploitation. Kevin's concern about victim-blaming intertwined with a conflation of responsibility (i.e., making choices that contribute to unintended consequences) and blameworthiness (i.e., intending the outcome). He later recognized how his discomfort impeded his ability to support clients in further developing their personal agency and empowerment. Quinn shared his ongoing desire to "avoid any assumptions of safety or not safety" concerning sex work, which led him to avoid asking routine questions about his client's safety practices except in the presence of explicit indicators of his client's distress or concern.

These accounts suggest participants navigated a tension between wanting to provide supportive, affirming clinical care and avoiding potentially useful clinical interventions due to fear of being perceived as endorsing and enacting stigmatizing, judgmental beliefs. These findings extend previous research suggesting that providers' clinical efficacy may be limited by strategies they use in an attempt to avoid perpetuating harm and judgment. For example, in a collective case study exploring perceived barriers to sex trafficking risk assessment among healthcare providers, Gerassi and Pederson (2021) found that medical providers' desire to be perceived as non-judgmental contributed to a decision to avoid asking patients follow-up questions when routinely assessing for sex trafficking, even in the presence of sex trafficking indicators. The authors highlighted how, among other barriers, providers' assumption that asking patients follow-up questions would appear judgmental may have led to missed opportunities to assess for sex trafficking risk or utilize a harm reduction approach.

For therapists to improve their care, they need to be self-reflective and consider whether and how they are providing care that is helping and facilitating change (Nissen-Lie et al., 2013). As therapists recognize missed opportunities or the emergence of clinical challenges, one way to develop their skills is to engage in deliberate practice (Chow et al., 2015). Deliberate practice is "individualized training activities especially designed ...to improve specific aspects of an individual's performance through repetition and successive refinement" (Ericsson & Lehmann, 1996, pp. 278–279). Deliberate practice can involve activities such as behavioral rehearsal of specific skills (e.g., assessing risk, asking about challenges in the sex trade) and assessing one's performance continuously by seeking client feedback (Rousmaniere, 2016).

5.4. Implications

This investigation offers important clinical implications for therapists working with clients who trade sex across the continuum of agency to victimization (Gerassi & Nichols, 2017). Improving clinical practice with this population matters because individuals in the commercial sex trade face heightened rates of mental health concerns (Cole et al., 2016) coupled with unjust barriers to accessing quality, affirming mental health care (Antebi-Gruszka et al., 2019; Grittner & Walsh, 2020; Kurtz et al., 2005; Pederson et al., 2019). Improving the quality and accessibility of mental health care for individuals in the sex trades is a social justice issue. Therapists should be aware not only of this context when meeting with clients but must also consider the upstream sociocultural conditions surrounding the sex trade that create this context. More specifically, therapists should be attentive to the impact of criminalization, stigmatization, and systems of power, privilege, and oppression on their clients' lives, broadly, and on their experiences within the sex trade (i.e., entry, conditions, and exit).

Findings of this study offer insight into unique client and therapist factors that contribute to clinical decision-making with this population (Figure 2). Regardless of the degree to which therapists hold sex trade specific knowledge the first time they meet with a client in the sex trade, findings highlighted foundational clinical skills and processes that may aid therapists in their clinical practice. First, therapists should be familiar with the factors that comprise the therapeutic alliance (i.e., bond, tasks, and goals) and remain attentive to the development and maintenance of the therapeutic alliance throughout the course of therapy (Wampold et al., 2017). The alliance may be particularly important when working with this population given the harm individuals in the sex trade have experienced from members of the mental health field, in addition to each client's unique history with providers and expectations of their new therapist. Attending to the importance of agreement on the tasks and goals of therapy may also aid therapists in navigating

whether and how to address sex trade in the course of therapy. Therapists should engage in appropriate responsiveness with their clients by attending to the factors outlined in Figure 2 and the paragraph above.

Remaining cognizant of one's own attitudes and biases may aid therapists in navigating potential barriers to appropriate responsiveness. When therapists notice their personal discomfort, concerns about being perceived as nonjudgmental, or feel pulled to use avoidance strategies in sessions for personal benefit, they may benefit from engaging in strategies such as critical self-reflection or professional self-doubt (Nissen-Lie et al., 2013), consultation, and deliberate practice (Chow et al., 2015; Rousmaniere, 2016). Indeed, therapists working with individuals in the sex trade would benefit from remaining attentive to their attitudes towards sex trade and ways they may have internalized stigmatizing beliefs about sex trade or beliefs about saviorism (Panichelli, 2018). In the context of clinical training, clinical supervisors can play a critical role in supporting trainees learning to utilize appropriate responsiveness, critical self-reflection, and deliberate practice. Supervisors' roles may be particularly impactful for trainees working with clients in the sex trade. In addition to encouraging the use of foundational clinical skills, supervisors can model openness and nonjudgment, rather than avoidance, by exploring the supervisee's knowledge of and attitudes toward the sex trades. It is important for supervisors remain attentive to and curious about their own knowledge and belief related to the sex trades as they are ultimately responsible for the care their supervisees' clients receive. Supervisors should be empowered to access resources and consultation to continue expanding their own capacity to support mental health care for individuals in the sex trades.

Emergent findings from this study relate to how therapists can take action outside of the therapeutic relationship to support their clients' mental health and well-being. Therapists may

leverage their positionality by intervening within their sphere of influence to advocate for their clients. Whether in their own agency or practice setting, therapists can engage in dialogue with colleagues who voice stigmatizing or pathologizing views of the sex trade. In addition, with their clients they can be attentive to and willing to inquire about whether and how their clients experience barriers to care with other providers. Therapists can intervene within the therapeutic context by exploring their clients' options and how they might navigate disclosure/concealment or responding to judgmental comments. Therapists should also be empowered to use interdisciplinary skills to advocate for their clients, particularly when coordinating care with other mental health professionals such as psychiatrists. Therapists may also benefit from building referral networks with medical, mental health, and other social service providers with reputations for providing quality, affirming care to individuals in the sex trade.

Participant perspectives highlight how exposure to clients with diverse experiences in the sex trade contributed to the development of broader, more flexible schemata. Therapists should remember that experiences in the commercial sex trade are nuanced. Adults enter the sex trade through choice, circumstance, or coercion (Gerassi & Nichols, 2017); may perceive their experience in sex trade as healing and empowering or traumatic and oppressive (Antebi-Gruszka et al., 2019; Pederson et al., 2019; Sanders et al., 2018); may hold trading sex as part of their identity, an act they engaged in, or something they were forced to do (Gerassi et al., 2019); may experience agency and coercion concurrently (Gerassi & Nichols, 2017); and may fluidly move along the continuum of agency to victimization throughout the course of their time in the sex trade. It is imperative that we continue to adequately equip therapists to work with this population.

In terms of clinical training, findings from this investigation suggest that integrating intersectional, anti-oppressive practice frameworks (Gerassi & Nichols, 2021) into clinical training and practice may promote the quality of mental health care for individuals in the sex trade. Anti-oppressive practice involves "the reflective and critical process of actively challenging domination at an interpersonal and structural level" by tasking providers with "acknowledging their own roles in perpetuating oppression and homogenising experiences in client groups," among others (Gerassi & Nichols, 2021, pp. 30-31). Harm reduction was an additional framework endorsed by the majority of participants in this study. Indeed, harm reduction "recognizes and honors the myriad ways survivors cope, recover, and heal" and has deep roots in the sex trade, which makes it well-suited for clinical work with this population (Page & Woodland, 2023). At the same time, Shira Hassan (2023), a lifelong harm reductionist, prison abolitionist, and author of *Saving Our Own Lives: A Liberatory Practice of Harm Reduction*, gives voice to an essential distinction between harm reduction that has been "co-opted by institutions of public health, social work, and the medical industrial complex" and the practice of Liberatory Harm Reduction. Therapists using a harm reduction framework are encouraged to be curious about where their practice of harm reduction is derived from, who is centered in their practice, and what it upholds.

Social justice values are at the core of counseling psychology (DeBlaere et al., 2019; Singh, 2020). In counseling psychology, we take a strengths-based approach to fostering healing and well-being across the lifespan. We are also advocates and agents for change from the individual to systems level. As such, we are well-positioned to take an active role in improving the quality and accessibility of mental health care for individuals in the sex trades. However, counseling psychology graduate training programs fall short of even providing students with

comprehensive training in human sexuality (Abbot, Vargas, & Santiago, 2023). Following the methodological lead of scholars exploring the current state of training in human sexuality among counseling psychologists (Abbot et al., 2021; Mollen et al., 2020), future research may benefit from exploring whether and how the sex trades are addressed in doctoral programs and pre-doctoral internships.

5.5. Limitations & Future Directions

The present study is not without limitations. First, participants were predominantly white, practiced in large cities, worked in private practice, and had clinical experience comprised of working primarily with sex workers or clients across the continuum of agency. Future studies would benefit from examining the knowledge and clinical practice of therapists working in rural settings and community mental health and residential settings. In addition, research would benefit from continuing to explore the experiences of therapists who primarily work with clients who have experienced CSE or sex trafficking. Second, this work relies on therapists' self-report of their own subjective experience. Accounts of their clinical practice may not accurately reflect the breadth of their interactions with clients. Regardless of whether they were accurate historians of their clinical practice, previous research suggests therapists tend to under-report their level of bias in the context of self-report (Boysen, 2009). At the same time, I believe this exploratory research contributes meaningfully to our growing understanding of therapists' clinical practice with clients in the sex trade. Relatedly, therapists comprise only half of the therapeutic dyad and my analysis cannot speak to how clients experienced their therapists and their therapeutic relationships. Future inquiry may benefit from use of analog methods wherein participants are presented with video recorded stimuli (e.g., a client disclosing sex trading) and therapists' responses are recorded and subsequently coded. Such methods could be particularly useful in

exploring clinical decision-making when therapists work with a client whose type of sex trading differs from that with which they are most familiar. Such methods could also be used to learn more about clinical decision-making among therapists who lack prior knowledge of and clinical experience with individuals in the sex trade. Analog studies would benefit from partnerships with, appropriately compensated, individuals with lived experience in the sex trade.

An additional potential limitation of this study relates specifically to participants' disclosure of personal experiences with the sex trade. While six participants disclosed personal experiences related to the sex trade (e.g., experience as sex workers, experiences with trafficking, or personal relationships with people in the sex trades), their disclosure was not in response to a specific question in the interview protocol. Instead, participants disclosed of their own accord as they provided context relating to their perspectives, experiences, and clinical practice. Given that the interview protocol and demographic questionnaire did not include a prompt regarding personal experience with the sex trades, it is unclear whether the remaining 14 participants had their own experiences. Future research may benefit from integrating questions explicitly asking therapists about their prior exposure to and experience with the sex trades. Lastly, since only one psychologist participated in this study future research would benefit from a specific focus on psychologists' perspectives on the sex trades and clinical practice with clients who trade sex.

Several findings emerged within the present study that were outside to scope of the primary analysis but will be the focus of future analysis. First, participants in this study described addressing vocational issues with their clients across the continuum of agency. Vocational concerns were particularly salient in relation to supporting clients who were interested in exiting the sex trade. Future work will explore how therapists approach these issues with clients in the sex trade. An additional area of future inquiry relates to participants' descriptions of the

professional resources and supports they believed would be useful as they engaged in clinical practice with this population. In addition, two areas of interest emerged that would require future research. First, a few participants noted the influence of the place and space where they practice and its implications on the degree of their professional support they experienced and their clients' own experiences in the sex trade. More specifically, participants noted factors such as being situated in the Bible Belt and large coastal cities, among others. Future research should continue delving into the impact of regional influences and specifically explore providers' experiences in rural settings. Lastly, while participants in this study were asked about their conceptualization of systemic influences on their client's sex trading, this question was not explicitly framed in relation to their clinical approach or clinical decision-making. As such, this line of inquiry should be addressed in future research.

5.5. Conclusion

How therapists engage in clinical practice with clients in the sex trade has been understudied. The present study sought to address this gap by interviewing 20 licensed mental health practitioners with experience working with clients in the sex trade. I used thematic analysis (Braun & Clarke, 2006) to address the following analytic questions: 1) How does sex trade emerge and get addressed by therapists within the context of therapy? 2) How do therapists approach working with clients who trade sex? Based on extant literature, I focused on salient clinical moments (responding to disclosure, navigating terminology, and determining the focus of therapy) and areas of clinical content (stigma and safety). A central finding of this work is that unique therapist and client contributions informed participants' clinical decision-making. Therapist contributions included previous personal and professional exposure to the sex trade, frameworks informing conceptualization, and awareness of personal attitudes and biases. Client

contributions included past experiences with and current expectations related to disclosing sex trading, experiences in the sex trade, and how the client made meaning of their experiences. My hope is that the results of this study will support therapists engaging in clinical practice with this population by pointing them toward important considerations in the context of clinical decision-making, knowledge specific to the sex trade, and foundational clinical skills that should be integrated into practice with clients in the sex trade.

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Appendix A

Recruitment Emails

EMAIL TO ORGANIZATIONS/AGENCIES (*asking to disseminate within organization*)

Subject line: Requesting Assistance: Dissertation Research on Therapy and Sex Trade (& Trafficking)

Dear (NAME),

I am Anna Pederson, M.S. a doctoral candidate at the University of Wisconsin – Madison Department of Counseling Psychology. I'm reaching out because of your role as (ROLE). I learned about (AGENCY) from your listing on (WEBSITE).

I am interviewing mental health professionals who have worked with clients who have traded sex (e.g., engaged in sex work, survival sex, or experienced sex trafficking). Interviews explore how therapists 1) make meaning of sex trade and 2) engage in clinical practice with clients who trade sex. Findings from this study will be used to inform training and clinical practice recommendations for therapists working with clients who trade sex with the ultimate aim of improving services and supports for people who trade sex. Your perspective and those of your colleagues are important.

I would like to invite you to 1) participate yourself and/or 2) share this email and the attached flyer with therapists at your agency. I am happy to answer questions you might have about the study. If you are not the correct individual to ask permission from to pass along my recruitment, please direct me to who that might be.

I am conducting this study as a part of my IRB-approved dissertation research with Dr. Travis Wright as my chair. I look forward to providing participants a presentation and discussion of findings and implications from this study upon completion.

Please feel free to email me with any questions or to be screened for eligibility. I look forward to talking with you.

Thank you,

Anna Pederson, M.S.
acpederson2@wisc.edu
218.590.9809

EMAIL TO INDIVIDUAL PROVIDERS

Subject line: Requesting Assistance: Dissertation Research on Therapy and Sex Trade

Dear (NAME),

I am Anna Pederson, M.S. a doctoral candidate at the University of Wisconsin – Madison Department of Counseling Psychology. I am conducting interviews for my dissertation study and am seeking individuals who meet the following criteria:

- Licensed mental health professionals who have worked with at least 3 adult clients who have traded sex (e.g., engaged in sex work, survival sex, or experienced sex trafficking).

Interviews explore how therapists 1) make meaning of sex trade and 2) engage in clinical practice with clients who trade sex. Interviews are expected to take 50-70 minutes and take place via Zoom.

Findings from this study will be used to inform training and clinical practice recommendations for therapists working with clients who trade sex with the ultimate aim of improving services and supports for people who trade sex. I look forward to providing participants with a presentation and discussion of findings and implications from this study upon completion.

I am hoping you would be interested in participating **OR** know of someone who might meet the criteria! If you are interested, please respond to this email and I will send you the study details. If you know of other practitioners who might be interested, please forward this email to them.

Please feel free to email or call me or my dissertation chair, Dr. Travis Wright (travis.wright@wisc.edu), with any questions or to be screened for eligibility. I look forward to talking with you.

Thank you,

Anna Pederson, M.S.
acpederson2@wisc.edu
218.590.9809

MESSAGE TO GENERAL INBOX

Subject line: Requesting Assistance: Dissertation Research on Therapy and Sex Trade (& Trafficking)

Hi there,

I am Anna Pederson, a doctoral candidate at the University of Wisconsin – Madison Department of Counseling Psychology. I am conducting interviews for my dissertation study and am seeking individuals who meet the following criteria:

- Licensed mental health professionals who have worked with at least 3 adult clients who have traded sex (e.g., engaged in sex work, survival sex, or experienced sex trafficking).

I'm hoping to connect with the person at (AGENCY) who can share this email or the attached flyer with your therapists. I am happy to answer questions about the study. If you are not the correct individual to ask permission from to pass along my recruitment materials, please direct me to who that might be.

Interviews explore how therapists 1) make meaning of sex trade and 2) engage in clinical practice with clients who trade sex. Findings from this study will be used to inform training and clinical practice recommendations for therapists working with clients who trade sex with the ultimate aim of improving services and supports for people who trade sex. Your perspective and those of your colleagues are important.

I am conducting this study as a part of my IRB-approved dissertation research with Dr. Travis Wright as my chair. I look forward to providing participants a presentation and discussion of findings and implications from this study upon completion.

Please feel free to email me with any questions. I look forward to talking with you.

Thank you,

Anna Pederson, M.S.
acpederson2@wisc.edu
218.590.9809

Appendix B

Recruitment Flyer

Appendix C

Informed Consent and Demographic Questionnaire

Informed Consent

University of Wisconsin - Madison
Research Participant Information and Consent Form

Study Title: Therapists' Perspectives on Sex Trade: A Qualitative Inquiry

Principal Investigator: Travis Wright (travis.wright@wisc.edu)
Primary Contact: Anna Pederson (acpederson2@wisc.edu)

Description of the research
You are invited to participate in a dissertation study about is therapists' perspectives on sex trade and their clinical practice with clients who trade sex.

The purpose of the research is to understand how therapists 1) make meaning of sex trade and 2) engage in clinical practice with clients who trade sex.

You have been asked to participate because you are a licensed mental health care professional who has experience working with clients who have traded sex, identified as sex workers, or been sex trafficked.

What will my participation involve?
If you decide to participate in this research, you will be asked to participate in an individual interview. Interviews will last approximately 45-60 minutes and will take place over Zoom (*with or without video per your preference*). I will ask you questions about working with therapy clients with whom you have discussed sex trade (e.g., sex work, survival sex, sex trafficking, etc.).

Prior to completing the interview, you will be asked to complete a demographic questionnaire.

Recording information
An audio recording will be made of your interview. The audio recording will be transcribed by a professional company or approved personnel. The tapes will be kept until transcriptions are received and checked for accuracy.

Are there any risks to me?
The only risk identified in this study is the breach of confidentiality. However, any identifying information shared during the interview process will be removed following interview transcription. You may skip any questions or stop at any time.

Are there any benefits to me?
We don't expect any direct benefits to you from participation in this study. Indirect benefits include the opportunity to inform development of training and advocacy materials that will lead to better supports for people who trade sex.

Following the completion of the study, a presentation of findings and recommendations will be hosted for participants who would like to attend.

How will my confidentiality be protected?

This study is confidential. Neither your name nor any other identifiable information will be published. Electronic data are protected on password protected computers. Only approved personnel will have access to study data.

If you participate in this study, we may quote you directly, without using your name. A pseudonym will be assigned and all identifiable information will be removed/masked.

Whom should I contact if I have questions?
You may ask any questions about the research at any time. If you have questions about the research after you leave today you should contact the Principal Investigator Travis Wright at (travis.wright@wisc.edu or 202.210.5142) or Anna Pederson (acpederson2@wisc.edu or 218.590.9809).

If you are not satisfied with response of research team, have more questions, or want to talk with someone about your rights as a research participant, you should contact the Education and Social/Behavioral Science IRB Office at 608-265-4312.

If you decide not to participate or to withdraw from the study, you may do so without penalty.

Selecting "I consent" below indicates that you have read this consent form, had an opportunity to ask any questions about your participation in this research and voluntarily consent to participate.

- ○ Yes, I do consent
- ○ No, I do not consent

Eligibility

The following questions will determine your eligibility to participate in this study.

Are you **currently practicing as a licensed mental health professional** within the United States?

- ○ Yes
- ○ No

Have you provided counseling to a **minimum of 3 adult clients** who have disclosed trading sex, being a sex worker, having been sex trafficked, or who were at risk of sex trafficking.

- ○ Yes
- ○ No

=

Please estimate **how many clients** have you discussed sex trade, sex work, or sex trafficking with.

Have you ever attended **training(s)** addressing sex trade, sex work, and/or sex trafficking?

- ○ Yes. Please briefly describe:
- ○ No
- ○ Unsure

Demographics

What is your **name**?

What are your pronouns? Please select all that apply

- ☐ She/her/hers
- ☐ He/him/his
- ☐ They/them/theirs
- ☐ Another pronoun (please specify)

What is your **age**?

How do you describe your **gender**?

- ○ Cisgender man (male/man)
- ○ Cisgender woman (female/woman)
- ○ Nonbinary

- ○ Transgender man
- ○ Transgender woman
- ○ Prefer not to answer
- ○ Not otherwise specified (please specify) _____

Which term(s) do you use to describe your **gender**? (*please check all that apply*)

- ☐ Agender
- ☐ Cisgender
- ☐ Demiboy
- ☐ Demigirl
- ☐ Gender fluid
- ☐ Gender nonconforming
- ☐ Genderqueer
- ☐ Man
- ☐ Nonbinary
- ☐ Questioning
- ☐ Transfeminine
- ☐ Trans
- ☐ Transgender
- ☐ Transmasculine
- ☐ Transsexual
- ☐ Two Spirit
- ☐ Woman
- ☐ Another term: _____

How do you describe your **sexual orientation**?

- ○ Asexual
- ○ Bisexual

- ○ Gay/Lesbian
- ○ Heterosexual (straight)
- ○ Pansexual
- ○ Queer
- ○ Not otherwise specified (please specify) _____

How do you describe your **race**? (*please check all that apply*)

- ☐ Asian/Asian American
- ☐ Black/African American
- ☐ Indigenous/American Indian/First Nation
- ☐ Latinx/Hispanic
- ☐ Middle Eastern/Middle Eastern American/North American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Not Otherwise Specified (please specify) _____

How do you describe your **religious views**?

- ○ Agnostic
- ○ Atheist
- ○ Buddhist
- ○ Christian
- ○ Hindu
- ○ Jewish
- ○ Muslim
- ○ Spiritual but not religious
- ○ Not religious or spiritual
- ○ Not Otherwise Specified (please specify) _____

How **important** is religion in your life?

Very Important	Somewhat Important	Slightly Important	Not Important at All	Does Not Apply/Not Religious
○	○	○	○	○

When it comes to **politics**, would you identify yourself as liberal, conservative, or neither?

Strongly Liberal	Moderately Liberal	Slightly Liberal	Neither Liberal nor Conservative	Slightly Conservative	Moderately Conservative	Strongly Conservative
○	○	○	○	○	○	○

The following questions ask about your **education** and **clinical practice**.

What is the **highest level of education** you completed?

- ○ Associates degree
- ○ Bachelor's degree
- ○ Master's degree
- ○ Doctorate degree
- ○ Not Otherwise Specified (please specify) _____

What **type of clinical degree** did you complete? For example, social work, marriage and family therapy, clinical mental health counseling, counseling psychology, etc.

_____

How many years have you practiced as a mental health provider?

_____

What type of **licensure** do you hold?

_____

In which state(s) are you **currently licensed**?

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida

How would you describe your current **practice setting** (*please check all that apply*)

- ○ Academic Health Center
- ○ Armed Forces Medical Center
- ○ Child/Adolescent Psychiatric or Pediatrics
- ○ Community Health Center
- ○ Community Mental Health Center
- ○ Medical School
- ○ Private Practice
- ○ Prison or Other Correctional Facility
- ○ Private General Hospital
- ○ Private Outpatient Clinic
- ○ Private Psychiatric Hospital
- ○ Psychology Department
- ○ School District
- ○ State/County/Other Public Hospital
- ○ University Counseling Center
- ○ Veterans Affairs Medical Center
- ○ Not Otherwise Specified (please specify) _____

How would you describe the **type of community** where you practice?

- ○ Large city
- ○ Small city or town
- ○ Suburb near a large city
- ○ Rural area
- ○ Not Otherwise Specified (please specify) _____

How would you describe your **theoretical orientation** (*please check all that apply*)

- ☐ Acceptance and Commitment Therapy
- ☐ Adlerian
- ☐ Behavioral Therapy
- ☐ Cognitive Behavioral Therapy
- ☐ Cognitive Therapy
- ☐ Emotion Focused
- ☐ Existential-humanistic Therapy
- ☐ Family Therapy
- ☐ Feminist Therapy
- ☐ Gestalt Therapy
- ☐ Integrative Therapy Approach
- ☐ Multicultural Counseling
- ☐ Narrative Therapy
- ☐ Person-Centered
- ☐ Psychoanalytic/Psychodynamic
- ☐ Rational Emotive Behavior Therapy
- ☐ Reality Therapy
- ☐ Solutions-Focused Therapy
- ☐ Strengths-Based Therapy
- ☐ Not Otherwise Specified (please specify) _____

I look forward to providing a presentation and discussion of findings and implications from this study upon completion. **Would like to be contacted when this is scheduled?**

- ○ Yes, please provide your email
- ○ No

Thank you for taking the time to complete this questionnaire!

If you have any questions or feedback, please contact:
Anna Pederson, M.S. (acpederson2@wisc.edu)

Click the arrow below to submit

Appendix D

Interview Protocol

Opening	"This is an interview about your work with clients who have disclosed trading sex or who you may suspected of trading sex. What I'm trying to understand is therapists' perspectives on sex trade and their clinical practice with clients who trade sex. As we're talking, please be sure you don't use anyone full names. You're welcome to use identifiers such as "client, co-worker, boss" or first names only, but not directly identify another person. Do you have any questions for me before we get started?"
Primary Questions	To start us off, can you tell me how you would describe the type(s) of sex trade your clients have engaged in? Follow-up Prompt: Were there ever times when you and your client used different terms to described sex trade? *If so, how did you respond? How did your client respond?**
Focusing Question/ Generating Narrative	Can you tell me about your clinical work with clients who have traded sex? Can you tell me about your work with particular client that best embodies your experience in this area? Follow-up Prompt: How much of a focus was sex trade your therapy? How did you view it as related to presenting concerns? How did it fit into your conceptualization? Can you walk me through how you found yourself in this work or, how did you become interested in this work?
Stigma	How do you think about the impact of sex trade stigma in your clients' lives? Potential Follow-up Prompt: *Can you tell me about your approach to addressing stigma in sessions? How do you intervene when stigma comes up in sessions? How have your clients responded?* Can you tell me about any personal assumptions about sex trade that you've noticed in yourself? Follow-up Prompt: How has this changed over time? *What contributed to the change? What impact has that change had on your clinical approach? How has that impacted your clients?*
Theoretical Questions: Pathways	Based on your work, what have you learned about pathways into the sex trade or how someone might enter? What have you learned about the reasons someone stays? How do you now understand the ways someone leaves or exits the trade?

	How do you think about clients' identities and experiences in this process? How do you think about the role of identity, culture, and context in your work with clients who trade sex?
Theoretical Questions: Victimization	Are there clients where you have been concerned about potential coercion or victimization? Follow-up Prompt: *What did you notice that led you to feel concerned?* How did you respond? How would you respond to a person who holds the perspective that all sex trade is victimization (i.e., sex workers are victims)? How would you respond to a person who holds the perspective that adults can choose/consent to sex work and should have the right to?
Theoretical Questions: Role of Therapist Clinical Support	How do you think about your role as a therapist for clients who involved in sex trade? Potential Prompt: Is this different from how you think about your role with other clients? What sort of supports do you think these clients need? How do you think other mental health providers think about work with clients who trade sex?
Closing	How have you been impacted by your work? What has been transformative for you? Is there anything else that you feel would be important for me to know? What else would be important for me to ask other providers?
Emergent Questions	*What supports do you think therapists working with clients who trade sex need?* *What sources of information have you found helpful when working with clients who trade sex?* *Can you tell me about whether and how you see the place you practice (e.g., region, part of the country) impacting your clients' experiences or your work together?*
*Note: Italics indicate prompts added to the interview guide in response to themes emergent themes.	

Appendix E

Original Positionality Statement

Given the qualitative nature of my research, it is important for my committee to understand how I am positioning myself in relation to my dissertation research. This will aid me in maintaining the methodological rigor of my work, which will require that I understand my subjectivity and its influence on my interpretation.

During my early twenties a few of my closest friends started getting involved in different parts of the commercial sex trade industry. For example, one friend started filming porn with a group of their friends and went on to submit their work (*Nineteen-Eighty Whore*) to a Feminist Porn Festival. Another friend started using websites like *Seeking Arrangements* to facilitate sugar dating with clients. At the same time, commercial sex was never my friends' primary source of income. They held "vanilla" jobs or were students at the same time as being involved in commercial sex. As we talked about their work, my friends would often speak to the sense of agency they felt, revel in bawdy stories, and describe the tangible and intangible benefits of their work. With these friends as my frame of reference, when I thought about sex trade I thought only about sex work (i.e., sex trafficking was far from my mind); how it was a valid, though often stigmatized choice; how it could be empowering; and how it should be decriminalized.

My perspective began to shift when taking a course on human sexuality as part of my Master's in Counseling. In this class, we were asked to meet take a personal sexual history from someone we knew and I asked one of my friends who was a sex worker. At one point during the interview, they described a scary experience with a client that left them with lingering feelings of anxiety in their work. My friend had previously shared that they were engaged in counseling at the time, in part to manage generalized anxiety. However, their therapist was not aware of the

incident that increased the anxiety my friend experienced in their work. When my friend shared about their concerns related to disclosing sex trade, I started to reflect on my own clinical work and role as a therapist.

I began thinking about the role sex work stigma as a barrier to mental health care. I grew curious to know more about what sex workers wanted from therapists and what would increase sex workers' comfort in disclosing sex trade. My curiosity was grounded in my belief that mental health care providers have a responsibility to be aware of the attitudes and biases they carry into their clinical practice. In addition, I believe providers should work to manage the impact of their attitudes in order to facilitate a therapeutic relationship where clients feel able to bring their full selves and not encounter blame, shame, and judgment. I decided to conduct a Delphi exploring the knowledge, skills, and attitudes self-identified sex workers wanted therapists to hold. In the time since collecting and publishing the results of this study, I have a new appreciation for the challenges therapists might face when working with individuals involved in sex trade.

My current perspective is informed by an ever-emerging understanding of the role of coercion and victimization in commercial sex. The conversations I have with my friends in the industry have changed as well. My friends have stayed involved in commercial sex over the past decade, moving through different roles ranging from working for larger adult film production companies, escorting for established agencies, sugaring, and working as an independent full-service sex worker. Over time, they have shared about more instances where they felt exploited (whether by clients or employers) and coerced and we have talked about the ways they manage the risks related to their work. For example, when one friend meets with new clients, she typically drops me a pin with her location and we have an agreed upon time when I should

expect to hear from her to confirm her safety. In addition to learning from friends, my understanding expanded as I engaged in scholarship related to sex trafficking.

I can see how my perspective on sex trade, informed by my knowledge and attitudes, would impact how I thought I should talk with clients about sex trade in a clinical setting. In order to hold a more nuanced perspective, I have had to acknowledges a complicated relationship between agency, coercion, and exploitation. Reflecting on my own experience leads me to wonder about other mental health care providers' perspectives on sex trade and how they work with clients who trade sex.