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Guidelines for mental health practice with clients who engage in sex work

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ABSTRACT

Many mental health practitioners have had or will have the opportunity to work with clients who engage in sex work (CSW). Sex work stigma is pervasive in the general population, and among mental health professionals, including sex and relationship therapists. Such stigma may lead to differential, unfair, and even unethical treatment of CSW. Although there is a clear need for best practice guidelines for mental health practice with CSW, no guidelines have been developed thus far. Therefore, drawing on feminist, multicultural, and sex-positive philosophies, this paper presents ten guidelines that are designed to: (1) address and increase mental health professionals' self-awareness of their own bias about sex work; (2) provide useful information about the multifaceted lived experience of CSW; and (3) offer culturally-appropriate counseling skills and intervention strategies in working with CSW. Acknowledging that multicultural competence is a professional process, rather than an outcome or an end, the guidelines included in this paper are developed with the underlying assumption that all mental health professionals are committed to be sex work-affirming and competent in working with CSW, regardless of therapeutic orientation. The guidelines discussed in this paper are informed by current literature about sex work and people who engage in it.

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Background

Sex work, or the provision of services where eroticism and/or sex (broadly defined) are exchanged for money or goods, is one of the most stigmatized professions globally (Sanders, 2018; Weitzer, 2018). Similarly, sex work stigma is pervasive among mental health professionals, including sex and relationship therapists. Such stigma may result from a lack of appropriate education and training about the unique experiences, needs, and strengths of clients who engage in sex work (CSW). Importantly, sex work stigma among mental health practitioners could be harmful to the therapeutic process in several ways, such as ruptures and premature termination, and

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could eventually lead to differential, unfair, and even unethical treatment of CSW. This is a chief concern for mental health practitioners, and especially sex and relationship therapists, who knowingly or unknowingly, have had or will have the opportunity to work with CSW.

Although there is a clear need for best practice guidelines for mental health treatment with CSW, no guidelines have been developed thus far. Drawing on feminist, multicultural, and sex-positive philosophies, we hereby present ten guidelines that are designed to: (1) address and increase mental health professionals' self-awareness of their own bias toward sex work; (2) provide useful information about the multifaceted lived experience of CSW; and (3) offer culturally-appropriate counseling skills and intervention strategies in working with CSW. It should be noted that this article is not designed to serve as a "sex work 101" or a comprehensive literature review about the clinical experiences of CSW, but rather to provide preliminary directions for affirming and sex-positive therapeutic work with CSW. In this article, we refer to sex work in the broadest sense, inclusive of street sex work, organized sex work in a sex establishment, pornography, stripping and exotic dancing, webcamming, massaging with sexual acts, and telephone sex work, among other practices where sexual transactions take place. These practices can be permanent or temporary, done independently (self-employed) or as an employee, serve as the client's primary or non-primary profession, and be fully voluntary or not. We adopt a continuum-based view of volition regarding sex work where each case of an individual CSW may perceive their engagement in sex work as strictly voluntary to strictly coercive. Although some definitions of sex work only include voluntary and consensual sexual transactions, in this article, we include survivors of human trafficking and other coercive means of entering sex work as CSW.

Acknowledging that multicultural competence is a professional and personal reflective process, rather than an outcome or an end, the guidelines included in this article are developed with the underlying assumption that all mental health professionals are committed to be sex work-affirming and generally competent in working with CSW, regardless of therapeutic orientation, approach, or philosophy. Failure to acknowledge one's bias towards sex work, as well as to foster sex positivity as part of their mental health practice, may result in explicit or implicit discrimination towards and possibly unethical treatment of CSW. Therefore, we contend that all mental health professionals should strive to be sex work-affirming.

Guideline 1: assess for engagement in sex work

CSW come from diverse backgrounds and experiences (Bellhouse, Crebbin, Fairley, & Bilardi, 2015; Shaver, 2005), and thus, theoretically, any client could have engaged in or may currently engage in sex work. Although it may seem unnecessary for some mental health practitioners to assess for engagement in sex work, it is critical to include such assessment not only when working with populations who are placed at greater risk or chance of engaging in sex work, such as transgender women of color (Parsons, Antebi-Gruszka, Millar, Cain, & Gurung, 2018), but also when working with clients who presumably do not have an "apparent reason" to engage in sex

work. In fact, it could be argued that people whose background is not aligned with preconceived (i.e. stereotypical) notions about the background of sex work would be less likely to disclose their engagement in sex work due to anticipated fear of rejection and discrimination. For example, a client that experiences multiple forms of privilege (e.g. white straight male from a middle-upper socioeconomic background) may not be perceived as engaging in sex work, which may make it easier for them to hide it, but also possibly harder to disclose it to their mental health professional if desired. Importantly, assessing for engagement in sex work for all prospective clients normalizes the practice of sex work and conveys an implicit message that the mental health practitioner or agency is interested in being a resource for CSW. Similarly, it is encouraged to include several verbal and environmental cues that signal that the practitioner/agency provide sex work-affirmative counseling services, such as "safe space" stickers or signs that specifically mention sex positivity and the legitimacy of sex work/ers. These cues are best used in moderation so to not overwhelm or create unnecessary pressure on the CSW to disclose their engagement in sex work. Another way of signaling sex-work affirmation could be engaging in advocacy efforts for and events in the broader sex work community. By showing their commitment in this way, mental health professionals can potentially "earn" greater trust from their current and prospective CSW, which may facilitate their sense of safety in disclosing their engagement in sex work.

We recommend assessing for sex work engagement during intake or the initial therapy sessions. This assessment could be made using self-report forms or in-person using the question "have you ever engaged in sex work or exchanged sex for money, shelter, drugs/alcohol, food, or other goods?" It remains unknown whether one method is preferable than the other as some CSW may choose to disclose their previous or current sex work experience in an indirect way using forms, whereas others may feel more safer disclosing such experience in-person, without having a written trace. Although we recommend assessing for sex work experience in early stages of therapy, we believe that for some CSW, it would prove vital to prioritize the establishment of a strong therapeutic relationship before assessing for sex work experience. That is, some CSW may only feel safe to share their previous or current sex work engagement after developing a working alliance with their therapist. This also means that, in some cases, CSW may initially refrain from disclosing their engagement in sex work, and only after feeling reassured about their therapist's unconditional positive regard or lack of evident bias, would feel comfortable disclosing. We contend this change in reporting stems from the CSW's decision to "test the waters" before disclosing and may serve as a preliminary indication for the therapist that the CSW trusts them. Regardless of the timing of the assessment, we encourage mental health practitioners to re-emphasize, verbally or in writing, their commitment to their client's confidentiality, privacy, and general well-being, along with noting that all clients are asked the same question about sex work engagement. This way, clients are less likely to feel that this question was targeted specifically to them.

Additionally, we urge mental health professionals to include specific questions about mental health determinants and experiences that have been shown to be prevalent across diverse samples of CSW, to varying extents. These factors include

socioeconomic status, employment status, income (and especially poverty), sexual orientation, gender identity, discrimination and microaggressions, potentially traumatic events, violence and specifically intimate partner violence, depression, substance use, and negative interactions with the criminal justice system, among other determinants (Parsons et al., 2018; Vanwesenbeeck, 2001). These mental health factors could be assessed at any time during the therapeutic process. We implore practitioners to remain alert of the CSW's responses and emotional reactions in answering the above assessment questions as they may be triggering and challenging to report. Relatedly, we encourage mental health professionals to be as vigilant as possible of their own biases and stereotypes when working with CSW and proceed with caution, especially during the formative stages of the therapeutic relationship when most of the assessment is being conducted (see Guideline 5).

Guideline 2: affirm the client's sharing their engagement in sex work

We find it critical to stress the importance of affirming CSW after they share their prior or current engagement in sex work, so much so that we decided to include it as a separate guideline. Sex work is not only a highly stigmatized practice but could also lead to legal ramifications in certain contexts, which, intentionally or unintentionally, push sex work and CSW to remain hidden and clandestine. This makes CSW a population put at extreme risk for not accessing mental health care services, and when accessing, being more likely to not attend regularly or even terminate prematurely (Beauregard, 2015; Ley, 2017). These potential issues can hamper the therapeutic process or could be perceived by the therapist as a form of resistance on the CSW's end, whereas the underlying reason is anticipated stigma or fear. For these reasons, affirming the client's sharing their engagement in sex work, acknowledging their courage in disclosing, and expressing gratitude for trusting you are crucial steps for the building of a meaningful therapeutic alliance and continuation of treatment. When appropriate and relevant to the individual case of a CSW, we encourage mental health practitioners to think of creative ways to affirm them, including: (1) mentioning their perseverance in engaging in a highly stigmatized profession; (2) noting their resilience and active approach in gaining further control and financial means in their lives; (3) appreciating that they are exercising agency and self-advocacy, and (4) praising their choice and will to engage in mental health care to better their overall well-being. These affirmations could serve as unique moments in therapy where the mental health professional conveys to the CSW their unconditional positive regard, along with empathy and compassion about their specific case and life story. Simultaneously, it is important to monitor the CSW's responses and reactions when being affirmed in case they feel as though their engagement in sex work is overemphasized and given too much attention (see Guideline 4).

In addition to continuously affirming the courage and willingness of CSW to share their personal stories and experiences with their mental health counselor, we urge practitioners to refrain from explicitly suggesting that CSW change their occupation, unless there is a reason to believe that they are in an immediate danger to themselves or others. We caution mental health professionals from letting their biases come in

the way of the therapeutic process by imposing their agenda on their CSW. Excluding instances where suspicion of future self-harm or harm to others arise, any decision regarding possible occupational change should be determined by the CSW solely. In case the mental health practitioner is worried about the potential negative impact of sex work on the health, safety, and overall well-being of their CSW, principles of motivational interviewing could be employed, while emphasizing the CSW's agency and meeting them where they are psychologically (Miller & Rollnick, 2013).

Guideline 3: accept sex work as a legitimate occupation

Most people engaging in sex work, particularly those working indoors (e.g. brothels, from home, webcamming, etc.), conceive their sex work as a profession and career (Murphy & Venkatesh, 2006). And while there are of course differences between sex work and other types of labor (as there are with all jobs), there are certainly similarities as well, particularly to professions which involve interpersonal contact with clients (Brewis & Linstead, 2000; Murphy & Venkatesh, 2006; Sanders, 2005). Thus, it can be worthwhile to examine how a CSW conceives of their sex work. For instance, the ways in which a CSW will create their self-identity are informed by the messages given to them, on individual, interpersonal, and societal levels (e.g. as diseased, dangerous, and immoral, or as a self-employed entrepreneur who does a social good) (Brewis & Linstead, 2000). As such, we suggest to create a space where various discourses can be explored if the CSW wishes.

Additionally, for CSW who present concerns related to their profession, career counseling strategies can be applicable, while prioritizing career-related issues that negatively impact the CSW's mental health. Specifically, it could prove helpful to assess: whether, when, and why the CSW enjoys their work; whether sex work is the CSW's primary job; their business strategies; how the CSW manages their work schedule, including work-life balance (e.g. working only at night, sleep effects, managing friendships/relationships).

One professional issue worth assessing for is social isolation, which can be one of the most harmful psychological effects of sex work, particularly for those that work indoors, and especially when there is no in-person contact (e.g. webcamming and phone sex; Murphy & Venkatesh, 2006). While secrecy due to stigmatization is one cause of this, the hours a CSW works can also be a factor (e.g. at night). Moreover, always being "on call," and as a result not allowing time for self-care or social activities, can also exacerbate this isolation. Furthermore, having to work with commercial clients that, because of stigma, do not always treat CSW or the profession with respect can cause an emotional toll and resentment. Like most service jobs, having to provide satisfactory customer service when being treated unfairly can further exacerbate the CSW's resentment. For instance, when interacting with their commercial clients, CSW may often encounter continuous scheduling changes (i.e. last-minute bookings and cancellations), stressful fee negotiations and bargaining, or people wasting their time communicating with no intention of making an appointment. These challenges seem to be more common among CSW compared to other professionals who also provide a certain costumer service, such as therapists, doctors, or hair

stylists. Thus, CSW are left with little to do but treat their commercial clients nicely and deferentially in order to try to keep their business. Thus, it could be beneficial to help the CSW navigate these issues and their long-term consequences.

Another professional issue that can often arise is the CSW's views on money and how they spend or save it. Research has shown that CSW often view money earned through the trade differently than money earned through the formal economy; and also, that many CSW have a hard time saving money (Murphy & Venkatesh, 2006). Of course, these two things can be related: as the money is quickly earned (and often cash), it may be quickly spent; furthermore, there are practical impediments to saving money (e.g. opening a bank account or credit card) when the money is illegally made (Murphy & Venkatesh, 2006). It is also possible that the CSW (or their partner) views it as "dirty money" due to the stigma surrounding how it was made. Exploring these issues, especially as they relate to longer term career goals, can be warranted.

Guideline 4: do not overestimate or underestimate the significance of engaging in sex work for CSW

The human brain is automatically activated in response to stimuli that are considered unusual or non-normative (Macrae & Bodenhausen, 2000). Since a significant number of mental health professionals do not get to interact often with CSW, they presumably can, willingly or unwillingly, run the risk of "exoticizing" them and focus too much on their past or current engagement in sex work. In contrast, other mental health practitioners can run the risk of not fully considering or even ignoring the impact of their clients' experience with sex work for various reasons, particularly due to stigma and bias against engagement in sex work (e.g. countertransference). For these reasons, we argue that, in working with CSW, 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.

Most counseling approaches hold the fundamental belief that every individual is the expert of their own life. Accordingly, mental health counselors are trained to lead the therapeutic process with curiosity, along with continuous empathy (Corey, 2013). Although we acknowledge that it could be tempting to be driven by curiosity in therapeutic work, we believe it is vital to caution mental health professionals from asking questions out of curiosity that are not necessarily the focus of the therapeutic process. In other words, mental health practitioners are reminded to only focus on and inquire about the aspects of their CSW's work that are pertinent to presenting or identified mental health concern. By that we mean to reinforce the importance of centering the CSW's best interest, rather than satisfying the practitioner's curiosity.

Relatedly, many CSW may engage in therapy for reasons that are not directly related to their sex work experience. Put differently, for many individuals engaging in sex work who seek therapy, sex work is not their main presenting mental health concern. Other CSW may not see the direct or indirect association between a certain psychological state, feeling, thought, or behavior and their engagement in sex work. Therefore, we encourage mental health care practitioners to pay close attention to their CSW's narratives, and explore (rather than indicate) together with them,

whether or not their sex work experience may be related to the specific concern in question. We implore mental health professionals to adopt a social ecological framework when conceptualizing their CSW's presenting mental health concerns and consistently explore the various factors that may contribute to the development and maintenance of that concern, without assuming that sex work experience is certainly related to it (Larios et al., 2009). Instead, after forming hypotheses about the etiology of the CSW's concerns, we recommend posing questions and exploring together with the CSW the potential contribution (or lack thereof) of their sex work experience on their mental health and well-being. Recognizing the complex and multifaceted reality in which CSW exist and tailoring the best therapeutic interventions to their unique needs that might or might not be related to their sex work experience is a critical component of affirming therapy of CSW.

Guideline 5: become self-aware of your own explicit and implicit biases towards sex work

The first step in working in a multiculturally competent manner is self-awareness (Richardson & Molinaro, 1996), and thus, it is critical that practitioners examine their own explicit and implicit biases towards sex work. As is the case when working with any demographic or cultural group that we are not a part of, having a solid base of knowledge about that group—while also acknowledging what we do not know—is important. When possible, we encourage mental health practitioners to try to be open and curious about the client's experience, while at the same time try not to burden them with educating you.

Unfortunately, clinical training programs, even those that stress multicultural competencies, rarely mention sex work (Miller & Byers, 2010). Nor are therapists immune from the moralizing and sex-negativity that permeates our culture (Morrison & Whitehead, 2007; Pheterson, 1990; Vanwesenbeeck, 2001). This is exemplified by much of the research done on sex work during the last century, which focused mostly on HIV transmission, health risks, early victimization, drug use, and personality disorder or pathology. These authors still tend to view sex work through a deviance perspective, similar to how other oppressed groups have been pathologized in the past (gay and lesbian, transgender, kink, polyamorous, among others). The authors would instead be encouraged to view sex work through a work perspective. More recent research shows that many of these earlier views on sex work are stereotypical and incorrect (Pheterson, 1990; Vanwesenbeeck, 2001). Thus, it is often necessary to remain critical of existing scientific knowledge about CSW.

One way we suggest might be helpful in empathizing with CSW is by considering similarities between counseling and sex work. Individuals engaging in sex work often create an alliance with their clients; oftentimes sex work can itself be therapeutic, offering a corrective sexual/intimate experience. Further, as clients are paying for a personal connection in both sex work and therapy, there can sometimes be the worry of whether or not the experience is "genuine." By bringing awareness to these similarities, either explicitly or implicitly, the clinician can better understand the CSW's experience, build a working alliance, and overcome bias.

Awareness and knowledge are only the first steps of multicultural competency. Thus, we recommend discussing possible biases and countertransference in supervision, as well as engaging in experiential activities, such as journaling or the Implicit Association Test. Using cognitive behavioral techniques to unravel cognitive biases by using Socratic questioning, challenging, and reframing may also prove successful. Similarly, engaging in empathy and sensitivity training specific to sex work could be very useful in combating various kinds of bias. Indeed, studies have shown that such trainings were successful in reducing health professionals' bias towards several groups that face stigma and discrimination, such as LGBTQ (lesbian, gay, bisexual, transgender, and queer) individuals and elderly people (Gholamzadeh, Khastavaneh, Khademian, & Ghadakpour, 2018; Teding van Berkhout & Malouff, 2016).

Other opportunities and resources that may prove helpful in exploring biases against sex work among mental health professionals include participating in an advocacy group promoting the rights of CSW, attending events for the International Day to End Violence Against Sex Workers (December 17), International Whores' Day (June 2), or International Sex Workers' Rights Day (March 3), attend a panel/talk about sex work (e.g. AltSex Conference), listening to podcasts about and by sex work/ers (e.g. The Whorecast), engaging with other media and art by CSW, and expanding one's own social and professional network to increase opportunities for contact with individuals engaged with sex work. Lastly, it is important to acknowledge that it is impossible to eliminate all biases completely. Rather, competency in working with CSW (as with all cultures) is a continuous process of awareness of biases and working to reduce them.

Guideline 6: educate oneself about and acknowledge the societal treatment of sex work and its possible harmful effects on the health and well-being of CSW

CSW face multiple and interrelated forms of stigma, including ideological (e.g. perceiving CSW as morally flawed), institutional (e.g. criminalization of sex work), interpersonal (e.g. microaggressions and violence towards CSW), and internalized (e.g. CSW's feelings of worthlessness due to their profession). Stigma scholars have suggested that stigma is a fundamental cause of disease and health inequalities (Hatzenbuehler, Phelan, & Link, 2013; Parker & Aggleton, 2003). Accordingly, we contend that most of the mental health concerns presented by CSW are, at their core, caused by stigma. Thus, we implore clinicians to not only educate themselves about the ubiquitous effects of stigma and discrimination on the mental and physical well-being of CSW, but also acknowledge these effects in their case formulation and treatment plan. Specifically, we recommend incorporating components from theories of social and minority stress which illustrates the trajectory of the stigma-poor mental health relationship (Dohrenwend, 1978; Meyer, 2003).

We fully embrace the viewpoint that CSW are the experts of their own life narratives. Thus, it is vital to listen to the CSW's story, and together with them, identify experiences that may be caused by any form of stigma (including direct and indirect). Similarly, it is also possible that some CSW may not report certain challenges caused

by stigma and oppression, but would nonetheless be affected by them, such as the criminalization of sex work. Put differently, stigma can impact the health and well-being of CSW above and behind their awareness to its existence, as suggested by other research on the detrimental effect of institutional stigma (e.g. discriminatory laws) on the mental health of lesbian, gay, and bisexual individuals (Hatzenbuehler, 2014). Hence, it is the clinician's task to assist their CSW in making the links between stigma and certain experiences, feelings, thoughts, or behaviors as, in some cases, associations to stigma may not be as clear at first glance to CSW.

In addition, we remind clinicians that it is not the CSW's responsibility to educate them about the challenges faced by those engaging in sex work. Clearly, it is important to pay close attention to the CSW's narratives and probe for further clarifications as long as they serve the therapeutic goal at hand. Otherwise, the CSW may feel burdened in educating their clinician instead of feeling heard and taken care of. We implore mental health practitioners to expose themselves to rigorous scientific evidence about sex work stigma and its effects, along with personal accounts (i.e. autobiographies, memoirs) of people who engage in sex work.

Last, from a feminist viewpoint, intervening at the individual level with CSW is insufficient (Enns, 2004). Mental health professionals, and especially those serving CSW, are urged to participate in advocacy, activism, and other direct actions designed to bring about a positive societal change for CSW.

Guideline 7: assess and address clients' internalized sex negativity and sex work stigma

Given the pervasiveness of sex work stigma across numerous interrelated levels, it is perhaps not surprising that many CSW internalize the stigma directed at them. Among CSW individuals, a set of negative beliefs and attitudes towards the practice of sex in oneself and in others is known as internalized sex work stigma or self-stigma. Importantly, internalized sex work stigma is related to a plethora of negative psychosocial outcomes that affect the lives of CSW, including shame, blame, lower self-esteem, depression, and suicidal ideation (Benoit, Jansson, Smith, & Flagg, 2018; Koken, 2012; Logie, James, Tharao, & Loutfy, 2011; Scambler & Paoli, 2008; Queen, 2001). Although research concerning internalized sex work stigma is scant, we can infer from other internalized stigma studies that these findings are only the tip of the iceberg with regard to the deleterious impact of internalized sex work stigma on the health and well-being of CSW.

CSW are bombarded with negative messages and pressures to feel ashamed of their profession, change their career, and remain underground. Such messages are being internalized and can cause great distress to CSW. Therefore, mental health professionals are highly encouraged to challenge their CSW's internalized sex work stigma and sex negativity using feminist therapeutic approaches and philosophies. Specifically, a sociocultural analysis of the internalization process of stigma delineating the progress from ideological to institutional, to interpersonal, and finally to internalized sex work stigma.

Internalized sex work stigma can take many forms, and can be conscious and unconscious. For example, anticipated rejection (i.e. rejection sensitivity) due to sex work engagement is a form of internalized sex work stigma (Herek, 2007). Similarly, being "in the closet" about practicing sex work can also be an indication of internalized sex work stigma. Given the limited research about internalized sex work stigma and concealment, we refer mental health professionals to the current literature about these topics in lesbian, gay, bisexual, transgender, and queer psychology, such as Pachankis (2007).

Furthermore, we believe that when exploring issues related to internalized sex work stigma, it is critical to continuously emphasize to CSW that these issues result from external societal forces. This conceptualization may further normalize the widespread impact of internalized stigma on the well-being of CSW, and can also alleviate feelings of shame and guilt about having such effects. In other words, when CSW recognize that their self-hatred is caused by external factors that were out of their control, they might be better able to overcome these challenging feelings.

Guideline 8: explore clients' conscious and unconscious motivations for engaging in sex work

Exploring a client's motivation for engaging in sex work is paramount. However, it can be quite challenging as the differences between "want," "need," "forced," "survival," or even "trafficking" are not always clear. For instance, some trafficking survivors decide to continue doing sex work of their own free will (Chudakov, Ilan, Belmaker, & Cwikel, 2002). Therefore, we work with the assumption that engaging in sex work is determined by one's wishes and various societal factors (e.g. socioeconomic status and cultural background), except for specific cases of CSW who survived trafficking. As noted above, it can be helpful to adopt a continuum-based view of volition regarding sex work, while carefully listening to a CSW's own reasoning. Furthermore, since initial and current motivations for engaging in sex work can be quite different, we recommend assessing for maintaining factors, barriers, and facilitators. Avoid assuming that sex work is a temporary placeholder for a different/better job unless explicitly noted by the CSW. Moreover, mental health practitioners are encouraged to pay close attention to the painful realities and intense trauma of survivors of human trafficking, while identifying their needs and emphasizing their resilience and strength.

As with most jobs, the primary motivating factor for engaging in sex work is financial (Calhoun & Weaver, 1996). Yet try not to assume that this is the only factor, for if it were, more people of lower SES would engage in sex work. It can be useful to look at Rational Choice Theory when exploring motivations, which states that behavior is governed by the associated rewards and risks, including an assessment of the intensity of the reward or risk, its duration, and the certainty that it will occur (Calhoun & Weaver, 1996).

Furthermore, it can be worthwhile exploring the perceived rewards and risks of sex work for the CSW in order for the CSW to make a better informed decision (i.e. "rational choice"). This can include discussions about positive reinforcements a CSW

might receive from their client on their attractiveness; or conversely, "punishment" a CSW might receive from their client.

We would also encourage MHP to explore unconscious motivations for engaging in sex work. As noted above, research linking sexual abuse or trauma and sex work is tenuous, and correlational at best (i.e. we currently have no rigorous longitudinal data to suggest a causal link) (Vanwesenbeeck, 2001). Nonetheless, some CSW have experienced trauma in childhood, and engaging in sex work could be viewed as a form of coping with this trauma. Thus, examining this unconscious motivation, without pathologizing, is indicated.

It might also be beneficial to explore the CSW's full trajectory in engaging in sex work—past, present, and future aspirations. Is sex work something the CSW views as a lifelong career? If not, is there another career they would like to move into, and how would they? Assess for an "exit strategy." While it is imperative to be careful not to suggest that a CSW *should* eventually discontinue sex work, there are reality-based concerns that could limit the longevity of the work, as is the case with most other bodily labors (e.g. athletes, dancers). Murphy and Venkatesh (2006) argue that viewing sex work as a profession, while beneficial for overall mental health and well-being, can make it harder to leave. Thus, if there is a desire to eventually exit, try to explore concrete steps for doing so (e.g. saving money, educational opportunities).

Guideline 9: identify the cognitive, affective, and behavioral effects of sex work

Earlier research on sex work often showed it to be detrimental to mental and physical health (Vanwesenbeeck, 2001). However, as discussed in Guideline 5, much of this research is biased and methodologically flawed (Vanwesenbeeck, 2001). More current research indicates that CSW are no comparably different than non-CSW in partner status, social support, self-esteem, and general well-being (Romans, Potter, Martin & Herbison, 2001; Vanwesenbeeck, 2001). That being said, there are of course specific cognitive, affective, and behavioral effects of sex work that should be explored in therapy. Sex work is a bodily labor. Thus, it is recommended that mental health practitioners explore the direct and indirect positive and negative effects of sex work on CSWs' body image and self-esteem. Research indicates that feelings of self-worth increase after starting sex work, perhaps due to both explicit and implicit reinforcement on appearance, as well as greater agency (Romans et al., 2001). However, it is possible that this reinforcement will decline with age. As such, it could be helpful to explore what this might mean to the CSW's self-worth and identity.

We would also recommend exploring coping strategies that CSW have to combat the effects of SW. For instance, many CSW try to separate these aspects of their lives, either through physical, temporal or psychological borders. This can include wearing different clothes and makeup, living far from work, keeping emotionally distant at work, and using condoms at work but not at home (Bellhouse et al., 2015). It can also include expressing gender differently when at work than when off the clock: some CSW may "perform" their gender in a particular way (e.g. exaggerating their feminine or masculine characteristics through behavior, speech, or dress) or keep

their true gender identity hidden from clients. While some CSW find this helpful in maintaining emotional well-being, others find it difficult, and it can even lead to dissociation and denial, leading to negative mental health outcomes (Bellhouse et al., 2015).

Furthermore, it is suggested to explore the CSW's coping with exposure to risk. Since the location (e.g. street, brothel, CSW's house) at which the client engages in sex work impacts their exposure to risk, it is critical to assess for location and its associated risks. Relatedly, it would be worthwhile to explore together with the CSW ways to reduce or eliminate such risks. Similarly, while research has often overemphasized the correlation between sex work and drug use, it is a way that some CSW cope with its effects (Vanwesenbeeck, 2001). Thus, we encourage mental health professionals to assess and explore the risks that this might entail.

While it is critical to assess and identify the cognitive, affective, and behavioral effects of sex work when working with CSW, it is equally important to remember that there are many professions that bear cognitive, affective, and behavioral effects. As noted earlier, other bodily labors such as dancers, athletes, and even models can rely on their appearance and physicality for work and are also prone to injury. Careers such as fire fighters, police officers, and construction workers can be equally dangerous. Similarly, mental health professionals can suffer cognitive and emotional tolls, including vicarious trauma and burnout. Hence, when exploring the multifaceted effects of sex work among CSW, mental health practitioners are asked to consider if they would feel the same pull to explore these issues with clients in the professions noted above as way of examining their implicit biases towards sex work.

Guideline 10: explore the effects of sex work engagement on clients' sexual and relational health

There is mixed evidence about the effects of sex work on CSW's romantic and sexual relationships (Bellhouse et al., 2015; Romans et al., 2001). Furthermore, there is quite a wide range in the percentages of CSW in a relationship that do not disclose the nature of their work to their partners (50% to 90%) for various reasons, such as internalized stigma and safety concerns (Bellhouse et al., 2015). Thus, it might be advisable to explore the motivations for and consequences of not disclosing, as well the possible risks of disclosure. Several therapeutic techniques could be used to address the sensitive issues of concealment and disclosure, including exploring unhelpful assumptions and anticipated discrimination—plan, problem solve, role play, and mobilize social support. It could be helpful to think of this in terms of other types of disclosure that a clinician might be more familiar with; for instance, coming out as LGBTQ, or telling one's religious parents that they have a non-religious partner.

Even if the CSW's partner is aware of their sex work, various feelings (e.g. jealousy) can affect the relationship negatively (Bellhouse et al., 2015; Warr & Pyett, 1999). Thus, if the CSW and their partner are willing, it could be helpful to encourage them to explore further, and ultimately, communicate these feelings to each other. Furthermore, stigma surrounding sex work can lead to guilt, shame, and dishonesty between partners, both explicitly and implicitly (Warr & Pyett, 1999). Likewise,

practical matters, such as timing and scheduling (if the CSW primarily works at night), where the sex work is conducted, cleanliness, money, when to have sex, and other similar matters can be hard to navigate for couples. Dyadic/systems interventions regarding communication, emotional expressivity, and power dynamics can be indicated in these instances.

As with many relationships, negotiating issues of sexual desire and arousal between people who engage in sex work and their romantic partners can be complicated. Practitioners might assume that CSW have high sexual drive, or conversely, low sexual drive with their romantic partners after having numerous commercial sex partners. However, people who engage in sex work have differences in sexual desire and arousal just as non-CSW do (Basson, 2000). We urge practitioners to not presume that romantic or sexual issues in the CSW's romantic relationships necessarily result from the nature of their work. Instead, we encourage practitioners to explore with the CSW, and preferably with their romantic partner(s) as well, what and when issues arise, along with the related feelings without assigning blame or cause. Education about the differences in types of arousal—spontaneous and responsive—and the willingness model (Basson, 2000) could be indicated, as might the couples/systems interventions noted above.

Contrary to stereotypes, research shows that condom use during sex work is high, perhaps even higher than that of non-CSW in Western countries (Bellhouse et al., 2015; Vanwesenbeeck, 2001). However, as noted in Guideline 9, as a part of identity work, or separation of selves, some CSW use condoms in commercial transactions, but not with romantic partners (Bellhouse et al., 2015). Exploring this coping strategy, the benefits and risks involved, along with other sexual health concerns, including testing, could be indicated, albeit gently and after rapport has developed, as questions about sexual health can come across as biased and presumptuous.

Conclusion

Sex work stigma is omnipresent, including in mental health care settings. This is concerning, yet not surprising, as most training programs for mental health professionals do not provide specific training about multicultural competency in working with CSW. This also means that even mental health practitioners who consider themselves open-minded and competent in working with diverse population may not be able to provide affirming, respectful, and supportive mental health services to CSW.

Similar to other social groups who face extreme stigma and marginalization, people who engage in sex work can benefit greatly from affirming mental health services. Hence, the guidelines presented in this article are a preliminary step towards promising better mental health care to CSW. It should be noted that although these guidelines cover numerous broad do's and do not do's for clinicians working with CSW, this list is, by no means, exhaustive. Furthermore, it should be noted that not every recommendation included in this article would be relevant to every case.

In formulating these guidelines, it was striking to discover the very limited research evidence about various topics pertinent to CSW, including the effects of internalized sex work stigma, therapy-related experiences of CSW, therapist-CSW

interaction, attitudes towards CSW among mental health professionals (and those in training), and the effects of sex work on CSW's personal romantic and sexual relationships, among others. Future research is warranted to address these gaps.

We hope these guidelines would serve mental health professionals in becoming mental health advocates for CSW.

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