Clinical Bias: Do Counselors' Perceptions of Prostitution Impact Their Work?

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CLINICAL BIAS: DO COUNSELORS' PERCEPTIONS OF PROSTITUTION IMPACT THEIR WORK?

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Abstract

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This study focused on the assessment of counselor perceptions of prostitution and the examination of how perceptions influence counselors' clinical judgments. The preliminary study involved the development of Counselor Perceptions of Prostitution Scale (CPPS) designed to assess counselors' attitudes towards prostitution. The items developed based on the debate in the literature between those who view prostitution as social oppression and inherently traumatizing, and those who believe that prostitution is a self-determined career path were administered to seventy-two counselors-in-training. The measure demonstrated high internal consistency reliability ($\alpha = 0.87$), had a significant negative correlation ($r = -.68$) with the Attitudes towards Prostitution Scale (ATPS) and exploratory factor analysis yielded a unidimensional scale. In the final study, three brief clinical vignettes were used to manipulate the variable of client's engagement in prostitution. Each vignette comprised of a client seeking services for depression while engaging in prostitution, selling marijuana, or working in a department store. One hundred and ninety-eight mental health providers rated their empathy, attribution of responsibility for the cause of and solution to the problem, assessment of client's functioning, and willingness to work with the client in response to the vignette assigned. They also completed CPPS and ATPS. Data was analyzed using multivariate analysis of variance (MANOVA) and canonical correlation analysis (CCA). Overall, results of the MANOVA revealed that empathy was the most significant contributor to the difference between conditions. Contrary to prediction, there was no difference in

empathy for the client engaging in prostitution versus the client working overtime at the department store. However, counselors' demonstrated lower levels of empathy for the client selling marijuana. The CCA revealed that in response to the prostitution vignette, counselors who viewed prostitution as inherently traumatizing and also held accurate beliefs about prostitution were likely to be more empathic and attribute less personal responsibility to the client for solving her own problems. Limitations of this study and implications for counselor practice, education, and future research are discussed.

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CHAPTER 1

Prostitution has frequently been referred to as the oldest profession and sometimes, even the oldest form of oppression (Blustein, 2006; Jones, 2001; Parsons, 2005). In the current global context, prostitution or the commercial sex industry (CSI) comprises of a multibillion dollar global market industry that represents a wide variety of services related to sex and sexuality provided in exchange for remuneration (Farley & Kelly, 2000). Commercial sex businesses typically comprise street prostitution, massage brothels, escort services, outcall services, strip clubs, lap dancing, phone sex, adult and child pornography, child prostitution, video and internet pornography, trafficking and prostitution in tourism (Dalla, 2000; Farley, Cotton, Lynne, Zumbeck et al, 2004; Kramer, 2003). While it is difficult to provide estimates of the number of people in prostitution, it is speculated that over one million people in the United States have worked in prostitution (Miller, 1991) and likely greater numbers have being involved in purchasing services from the commercial sex industry. In 2008, it was documented that over 75,000 people were arrested in the United States for engaging in prostitution (United States Department of Justice, 2008). This is likely to be representative of only a small percentage of people who engage in prostitution.

Prostitution is multi-billion dollar industry world-wide. Despite its enormous economic impact on the sociopolitical infrastructure of any country, it remains one of the most invisible forms of work in the world today, especially with regard to the level of harm it causes to the lives of people engaging in prostitution, impacting physical and psychological health, power, and welfare (Blustein, 2006; Farley, 2003). It may be stipulated that the agent of such an industry is a social and economic system, fueled by power inequities and inequitable distribution of resources, which, systematically denies adequate, accessible, and legitimate economic options for a large number of people, in particular, women (Kalmuss, 2004).

Discourse on prostitution cannot exclude the harm that is an intrinsic part of the experience. Prostitution is multitraumatic with high rates of physical and sexual violence perpetrated against vulnerable people (Dalla, 2000; Farley, 2004). Such vulnerability is commonly a result of gender (Booth, Koester & Pinto, 1995; Piscitelli, 2007), poverty (Aral & Mann, 1998; Barrett & Beckett, 1996; Belcher & Herr, 2005), previous history of sexual assault (Abramovich, 2005; Silbert & Pines, 1983; Vaddiparti, Bogetto, Callahan, Abdallah, et al, 2006), marginalization as a result of one's race or ethnicity (Lever, Kanouse & Berry, 2005; Nelson, 1993), or a combination of these factors (Farley, 2004). An illustration of such vulnerability is demonstrated in a study by Farley and Barkan (1998) who interviewed one hundred and thirty people working in prostitution in San Francisco regarding the extent of violence in their lives and the symptoms of posttraumatic stress disorder (PTSD) they experienced. The results revealed that as children, 57% of these people had been sexually assaulted and 49% physically assaulted. As adults in prostitution, 82% were physically assaulted, 83% threatened with a weapon, 68% raped, and 84% were either currently homelessness or have been so. As demonstrated in this study, these numbers are strikingly high. Other compelling evidence of the vulnerability of women who engage in prostitution is provided by Church and her colleagues (2001) who found that among 240 women in prostitution surveyed, 81% of women working in outdoors prostitution reported experiencing violence by clients where 33% of the women were beaten, 30% threatened with a weapon, 25% choked, 27% vaginally raped, and 9% slashed or stabbed.

Contrary to the argument that violence is restricted to street prostitution, some research demonstrated that violence occurs irrespective of the kind of prostitution that women engage in. For example, Raphael and Shapiro (2004) sought to measure the prevalence of violence perpetrated by customers, managers, pimps, and intimate partners against 222 women in indoor and outdoor prostitution venues in Chicago, Illinois. Their results demonstrated that although

the violence differed in frequency and severity, violence occurred in all forms of the prostitution activities. More specifically, women in outdoor venues reported higher levels of physical violence, while women in indoor venues were frequently victims of sexual violence and were often threatened with weapons. These findings are a strong argument against the public depiction of indoor sex trade activities as harmless and consensual entertainment.

The consequences of prostitution, whether indoor or outdoor, are often poor psychological health (e.g. depression, memory problems and trauma) and suicidality (Farley & Barkan, 1998; Ling, Wong, Holroyd, & Gray, 2007); increased substance abuse and dependence (Ward, Pallecaros, Green, & Day, 2000); poor physical health (e.g. HIV); fragmentation of the self, dissociation, derealization, and depersonalization (Farley, 2003). In addition to the sexual, physical and emotional trauma that is a frequent occurrence in prostitution, people working in prostitution often have a history of childhood physical and sexual abuse (Bagley & Young, 1987; Baldwin, 1993; Dalla, Xia & Kennedy, 2003; Giobbe, 1992; Ratner, Johnson, Shoveller, & Chan, et al, 2003; Silbert & Pines, 1981; Silbert & Pines, 1983; Simons & Whitbeck, 1991; Vanwesenbeeck, 1994). Furthermore, the degree to which the experience of prostitution is traumatizing is enough to evoke the need for mental health services. Therefore, people who engage in prostitution will likely be in need of mental health services regardless of the reasons for engaging in the commercial sex industry (de Schampheleire, 1990; El-Bassel, Schilling, Irwin, & Faruque, et al, 1997).

In a recent awards address at the Annual Convention of the American Psychological Association, Vasquez (2007) defined psychotherapy as a “change process designed to provide symptom relief, personality change, and prevention of future symptomatic episodes and to increase the quality of life, including the promotion of adaptive functioning in work and relationships, the ability to make healthy and satisfying life choices, and other goals arrived at in

the collaboration between client/patient and psychotherapist" (p. 878). Research on successful psychotherapy treatment consistently indicates that the quality of the therapeutic alliance is the most crucial element across different models of psychotherapy (Bordin, 1979; Goldfried & Davison, 1976; 1994; Horvath, 1994; Horvath & Symonds, 1991; Orlinsky, Ronnestad, & Willutzki, 2004; Wampold, 2000).

Counselor bias, whether intentional or unintentional, is a frequent occurrence in psychotherapy practice (Vasquez, 2007). Unintentional bias is commonly the result of the ethnocentric and exclusionary nature of psychotherapy research and practice (Casas, Vasquez, & Ruiz de Esparza, 2002; Center for Mental Health Services, 1998; Morrow & Deidan, 1992; United States Department of Health and Human Services, 2001) as well as natural social cognitive processes (Gaertner & Dovidio, 2000; Guimond, Dambrun, Michinov, & Duarte 2003; Fiske, 2000, Spengler et al, 1990). Clinical bias represented through a psychotherapist's clinical judgments and in session behavior with clients is commonly the result of stereotypes held by clinicians with respect to specific demographic groups to which clients belong (Wisch & Mahalik, 1999). Such bias often interferes with the therapeutic alliance, and partially accounts for high dropout rates and underutilization of psychotherapeutic services among various communities (Vasquez, 2007). Bias in counselor-client interactions during the counseling process also frequently impacts diagnosis, clinical conceptualization, clinical decision-making, and formulation of treatment interventions (Morrow & Deidan, 1992; Robb, 2006).

Clinical bias is often related to specific client variables such as gender, age, sexual preference, social class, and disability type (Strohmer & Leierer, 2000). For example, a study conducted by Rosenthal (2004) demonstrated the effects of client race on the clinical judgment of practicing European American vocational rehabilitation counselors. In this study, participants reviewed case materials depicting either an African American or a European American client.

The results demonstrated that African American clients were judged more negatively than European American clients, when data were collected after minimal initial client information was provided (theorized to be when initial impressions were likely to be more vulnerable to racial stereotypes). This trend persisted even after subsequent information was reviewed, and more definitive judgments were established.

An example of clinical bias related to client's sexual orientation is found in a study conducted by Wisch and Mahalik (1999) who examined the impact that male therapists' gender role conflict, client sexual orientation, and client emotional expression have on clinical judgments made about male clients. The results indicated that therapists' gender role conflict, in combination with client sexual orientation and emotional expression, were associated with therapists' ratings of the male client's prognosis and the extent to which therapists liked, had empathy for, had comfort with, and demonstrated willingness to see the male client.

Another example of client sexual orientation and clinical bias is a study conducted by Hayes and Erkis (2000). These authors provided vignettes depicting a male client with HIV to 425 psychologists. The vignettes varied in terms of the sexual orientation and source of HIV infection. The results revealed that attributions of client responsibility for the cause of the problem were predicted by the source of HIV infection and therapist homophobia. More importantly, the researchers found that the therapists responded with less empathy, attributed less responsibility to the client for solving his problems, assessed the client's functioning to be worse, and were less willing to work with the client when the client's source of HIV infection was other than drugs, when the client was gay, and when therapists were more homophobic.

The literature has clearly delineated different demographic groups where clinical bias may be present such as client race (Bloch, Weicz, & Abramowitz, 1980; Franklin, 1985; Garb, 1997; Luepnitz, Randolph, & Gutsch, 1982), gender (Becker & Lamb, 1994; Broverman,

Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Cook, Warnke & Dupuy, 1993; Garb, 1997), age (Ford & Sbordone, 1980; Perlick & Atkins, 1984; Settin, 1982), socioeconomic status (Franklin, 1985; Luepnitz et al., 1982), and sexual orientation (Gelso, Fassinger, Gomez, & Latts, 1995; Wisch & Mahalik, 1999) just to name a few. We posit in this study that counselor bias extends beyond demographic variables to include aspects of clients' life experiences such as the experience of working in marginalized professions.

Often, counselors are less likely to treat work and work issues as important (Blustein, 2006). Spengler, Blustein, and Strohmer (1990) found that counseling psychologists demonstrated greater preference for working with personal problems in comparison to vocational problems. As a result, there has been little inclusion of literature on clinical bias among counselors who engage in treatment with people who work in marginalized professions, such as prostitution.

Exclusion of work and work issues as part of the dominant discourse in counseling research and practice may function to deny advancement in terms of ethics, morals and social and distributive justice (Blustein, 2006; Richardson, 1993). Therefore, through this study, I seek to break the relative silence that is represented by the gap that exists in psychological literature in terms of how prostitution's status as a marginalized profession predisposes counselors to experience bias when providing mental health counseling to people who engage in prostitution (Farley & Kelly, 2000).

The psychological literature on prostitution has focused largely on HIV or AIDS and to a lesser degree on the physical and sexual violence of prostitution (Farley & Kelly, 2000) while neglecting the emotional and psychological harm which are either direct consequences of prostitution or secondary to the violence and trauma involved in prostitution. Further evidence of this was present when I conducted a search on a major search engine for psychological

literature (viz. Psychinfo) on prostitution. The number of articles or book chapters obtained was 860 when keywords “HIV” or “AIDS” were added to “prostitution” or “sex work” as compared to 158 when the keywords “mental health” or “trauma” were added. It is also important to note that a number of the studies included in these 158 articles/book chapters also included several studies which primarily focused on HIV/AIDS and that a much lesser number exclusively focused on mental health.

This gap in literature may be attributed to several factors. First, the field of prostitution is controversial and there may be reluctance among researchers of being associated with a stigmatized group. Second, several myths exist that promote misinformation about prostitution perpetuating reluctance among researchers and practitioners alike (Cotton, Farley & Baron, 2002). Third, there is ambiguity around the notion of prostitution in light of the polarized debate in the social sciences literature between those who claim that sex work is empowering to women (e.g., Pheterson, 1989) and those who believe that prostitution is an intrinsically harmful experience (e.g. Farley, 2003). This debate is further fueled by media images of people in prostitution. Finally, the specific oppression involved in prostitution and its economic, social, political, and legal implications may serve to evoke shame and stigma among women who seek professional help (Disogra, Mariño, & Minichiello, 2005). Therefore, counselors and psychotherapists may hold perceptions of prostitution that likely influence therapeutic alliance, therapy effectiveness and treatment outcomes with women in prostitution who seek treatment for mental health issues. Such bias is important to understand in order to help counselors create safe and trusting therapeutic relationships with women in prostitution seeking mental health services and also to encourage utilization of available services.

This study is modeled, in part, on the study conducted by Hayes and Erkis (2000) described previously, on therapist reactions to clients with HIV. In this study, I am interested in

whether the client's engagement in prostitution impacts the reactions that counselors have to their clients and whether attitudes held by counselors towards women in prostitution impact counselor bias. The study is an experimental design in which the work that the client engages in is manipulated. In the three conditions conceptualized, the client is presented as having a department store job and as working outside this job to earn extra money. In the experimental condition, the client engages in prostitution for extra money whereas in the two control conditions the client engages in either selling marijuana or working overtime for extra money. The control condition of selling marijuana was added because selling marijuana has similar level of stigma as an illegal activity in comparison to prostitution but is nonetheless different in terms of the threat of harm involved. For the purposes of this study, the components of counselor bias are identified as counselor empathy, attribution of personal responsibility to the client for the cause of the problem and finding the solution to the problem, counselor perception of client's overall functioning and willingness to work with the client. These components are described in greater detail below.

The first of these components is *empathy*. It may be stipulated that in the context of polarized debates, lack of empirical data and the associated social stigma described above, counselors may have difficulty exhibiting empathy towards women who work in prostitution. The second component involves the *attribution of clients' responsibility* for causing their problems and finding the solutions to their problems. Cotton, Farley, and Baron (2002) identified prostitution myths that are culturally supported attitudes normalizing violence against women. Such attitudes include the notion of volition where people believe that women in prostitution have chosen their work and therefore are responsible for the problems that they experience and are responsible for solving their own problems, thereby attributing greater responsibility for the solution to their own problem. A third component of counselor bias may

be the *counselor's perception of the client's overall functioning*. As mentioned before, the majority of psychological research on prostitution is associated with HIV/AIDS. Counselors may be more likely to perceive women in prostitution who are seeking professional mental health services as having a medical condition. Therefore, for the counselor, concern for the client's medical condition may overshadow the psychological issues that the client presents with (Walker & Spengler, 1995). This may generate bias in the counselor's judgment of the clients' problems where counselors may judge women in prostitution to have a lower level of functioning. The final component of counselor bias is identified as *therapists' willingness,* or the lack thereof, to work with women in prostitution. Counselors may be reluctant to work with women in prostitution for many reasons. They may feel ethically compelled not to work with women in prostitution due to the lack of specific training and/or personal discomfort in addressing issues of sex and sexuality in psychotherapy. Lack of willingness may also stem from associated stigma and personal biases.

In sum, in this study, it is expected that counselors who exhibit negative attitudes towards prostitution will demonstrate less empathy, attribute greater responsibility to the client for the cause of the client's problems, attribute lesser responsibility for solution to the problem, judge the client in prostitution to have a lower level of functioning than clients not in prostitution and be less willing to work with the client in prostitution.

Hypotheses

Hypotheses were generated to assess the impact of counselor perceptions of prostitution on all the aspects of counselor bias. The five aspects of counselor bias as outlined before were empathy, attribution of personal responsibility for the cause of and solution to the problem, assessment of client's level of functioning, and willingness to work with the client. The two categories of counselor attitudes were identified to be counselor perceptions of prostitution and counselor beliefs about prostitution. Based on the theoretical and empirical literature outlined above, the following hypotheses were predicted.

(1) Counselors will exhibit greater clinical bias when exposed to a client vignette in which prostitution is used as a means of supplementing income (as opposed to selling drugs or working overtime at a department store). Clinical bias in this study is defined by less empathy for the client, greater attribution of personal responsibility to the client for the cause of and the solution to the problems, lower assessment of client's level of functioning, and less willingness to work with the client.

(2) In responding to the client vignette where prostitution is used as a means of supplementing income, counselors who are more likely to exhibit attitudes towards prostitution which involve perceptions about prostitution as a form of oppression and more accurate beliefs about prostitution, will be more likely to demonstrate more empathy, attribute lesser responsibility to the client for the cause and the solution for the client's problems, be less likely to judge the client in prostitution to have a low level of functioning, and be more willing to work with the client.

CHAPTER 2

Prostitution is a pervasive phenomenon that has historically transcended social, economic, cultural, and political barriers, characterizing it as the oldest profession. Yet, prostitution continues to be elusive and puzzling to those who have attempted to define it. Defined broadly, prostitution involves services related to sex and sexuality rendered in exchange for remuneration either in the form of money or favors. This definition is limited because the idea of services in exchange for money includes women who choose to marry in order to gain a home and a livelihood (Edlund & Korn, 2002). Prostitution may also be defined from the client's point of view. In this definition, prostitution is the act of rendering non-reproductive sex against payment (Edlund & Korn, 2002). In some instances, prostitution is only a temporary informal activity. On occasion, sex is exchanged for basic, short-term economic needs (food, shelter or protection) and may not be a formal, full-time occupation [United Nations Development Fund for Women (UNIFEM), 2005]. In contrast, prostitution is institutionalized (despite being illegal) in the form of the commercial sex industry across the world and one may define prostitution based on what this industry entails.

The commercial sex industry (CSI) is a flourishing industry in the current global market economy. The services included in CSI vary greatly. These services include but are not limited to street prostitution, massage brothels, escort services, outcall services, strip clubs, lap dancing, phone sex, adult and child pornography, child prostitution, video and internet pornography, trafficking, and prostitution in tourism (Dalla, 2000; Farley, Cotton, Lynne, Zumbeck et al, 2004; Kramer, 2003). The prevalence of indoor prostitution (such as escort and massage prostitution) has been identified as being higher than the prevalence of outdoor prostitution (such as street prostitution) in the current context of the United States (Farley, 2005; Weitzer, 2005a). Street prostitution accounts for approximately one-fifth of all prostitution. While indoor prostitution is

much more common, it is less visible. In addition, women dominate the industry, but it also involves men, transgender adults, young people, and children (UNIFEM, 2005). While discourse on men, transgendered adults, and children is important, it is also very complex and beyond the scope of this study.

In 1948, pioneer researchers in human sexuality Kinsey and his colleagues documented that 69% of white males studied had at least one experience with a woman in prostitution (Kinsey, Pomeroy, Martin, & Gebhard, 1953). In more recent years, approximately 15.3% of men are estimated to have had sex with a woman in prostitution (Smith 2006). In the United States, 125,600 people were arrested for prostitution in 1983. This number dropped in 1994 to 98,190 people and in 2008, the number of people arrested for engaging in prostitution was approximately 75, 000 (Meier & Geis, 1997; United States Department of Justice, 2008). As opposed to reflecting decrease in prostitution engagement, this decrease in number of arrests likely reflects a shift in the nature of commercial sex industry with technological advancements occurring in the past three decades. The development of internet technology has likely spurred increased delivery and consumption of sex and sexual services. At the same time, the commercial sex industry remains even more inscrutable and hidden from the public eye. This also makes estimating the number of people engaging in prostitution in the contemporary world, including assessing the degree of violence prevalent, virtually impossible.

This study focuses on women who provide services in the commercial sex industry. Watts and Zimmerman (2002) identified prostitution as one of the eight most prevalent forms of global violence against women. Women make up 90% of the prostitution 'labour force' and men have the purchasing power (Banach & Metzenrath, 2000, p.20). Women in prostitution are an extremely heterogeneous population whose experiences are situated in a myriad of cultural, social, economic, political, and environmental contexts (Surratt, Kurtz, Weaver, Inciardi, 2005).

Attempts to document their experiences have been far from comprehensive and in many instances, such documentation has been used to propagate political agendas.

Debate on the Nature of Prostitution

Ebbinghaus's (1909, p.1; cited in Potterat, Rothenberg, Muth, Darrow, & Phillips-Plummer, 1998) described prostitution as having a "long past but a short history" indicating that despite being the oldest profession, scholarly work on prostitution is minimal. Even a hundred years since Ebbinghaus's quote, prostitution continues to remain shrouded in mystery. Despite the historically pervasive nature of prostitution in all cultures and countries, it remains an elusive, exclusionary and inadequately explored territory in scientific literature, wrought with passionate debates and biased viewpoints (e.g. Farley, 2005; Weitzer, 2005a). There is seldom public or academic interest in the violence that occurs in prostitution which contributes to lack of scientific data. The latter may be attributed to major roadblocks encountered by researchers in fields such as psychology, sociology, and anthropology in their attempts to obtain meaningful information from representative samples of people in prostitution. There are many reasons for these major roadblocks.

First, some authors (e.g. Dalla, Xia & Kennedy, 2003; Overall, 1992; Pheterson, 1990; Watts & Zimmerman, 2002) have claimed that the marginalized status of prostituted women largely accounts for the limited academic interest in or concern for their physical and emotional well-being. Second, prostitution includes a wide variety of activities, and diverse experiences and lifestyles (Chancer, 1993; Monto, 2004; Weitzer, 2005a). Such heterogeneity makes it extremely difficult to capture the full range of experiences of women in prostitution (Pottarat et al, 1998). Third, prostitution is morally condemned in all countries and illegal in many countries. As a result, the work of prostitution is hidden from public view, preventing researchers from access to an appropriate sample. An additional logistical barrier is that there is

lack of funding for studying the wide range of an illegal activity like prostitution (Farley, 2005). Fourth, as a by-product of lack of access to representative populations, data or reports obtained about prostitution tend to be based on incidental, convenience samples, and inconsistent populations (Potterat et al, 1998). Fifth, as Farley (2003) asserts, the voices of victims of prostitution are systematically silenced in the interest and protection of an industry that sanctions power imbalances, oppression and discrimination; whose strategic lack of visibility generates misinformation through media, the exposition of which would result in large-scale social and economic damage. Finally, studies are often biased, reflecting the theoretical standpoint of the researchers. An extreme situation results in ideological fanaticism, which may serve as an impediment to objective scientific inquiry (Weitzer, 2005b). Such ideological polarization is grounded in the passionate debate between the *abolitionists* and *anti-abolitionists*. The nature of this debate is elaborated on in the following section.

The abolitionists versus the anti-abolitionists. The nature of prostitution has undergone several transformations within a rapidly changing context through factors such as globalization, technological advancement, etc. The true nature of prostitution is clouded by intense and passionate debates. In order to gain more clarity on the nature on prostitution, it is important to unpack this discourse. The primary disagreement in the field is between abolitionists and anti-abolitionists (Shah, 2005). Anti-abolitionists have typically been interested in the decriminalization or even legalization of prostitution where abolitionists oppose the same.

Anti-abolitionists. The *anti-abolitionist approach* finds its roots in the harm reduction model of confronting social issues and human rights abuses that are intrinsic to prostitution (Sullivan, 2005). In *legalization*, the state or country regulates the industry permitting some forms of prostitution, while others, such as street prostitution, remain criminalized (Sullivan, 2005). The *decriminalization approach* advocates that prostitution and prostitution-like

activities be completely withdrawn from the criminal code and be treated in the same way as other legitimate commercial activities. More importantly, both *legalization* and *decriminalization* permit prostitution to be recognized as legitimate (legal) jobs and pimps and brothel owners as legitimate and legal business operators.

Such moves towards legalization are based on the assumptions that a regulated industry could contain the rampant growth of the highly visible brothel and street prostitution trade, eliminate organized crime, end child prostitution and sex trafficking, and promote public health by preventing venereal diseases such as AIDS. Most importantly, legalization of prostitution is considered to be the solution to the rapid escalation of global sex trade and trafficking. According to the U.S. Department of State's Trafficking in Persons Report (2008), the numbers of people trafficked ranges from 600,000 to 800,000, mainly for sexual exploitation. The International Labour Organization has estimated that these figures expand to between two million and four million when intra-country trafficking is included (ILO, 2005). The primary expectation through legalization and decriminalization of prostitution is that by legitimizing prostitution as a form of work, harmful work practices and oppression will be minimized. For example, brothel and escort agency owners will be subject to the same occupational health and safety standards of international labour laws applied to workers in the mainstream labour force, (Sullivan, 2005). There is also an understanding that prostitution could be practiced under circumstances of relative safety, security, freedom, hygiene, and personal control (Overall, 1992; Weitzer, 2005a).

Abolitionists. In contrast, *abolitionists'* view of prostitution endorses the belief that violence is intrinsic to the nature of prostitution and that the expectations outlined by the anti-abolitionists are unrealistic and frequently subject to failure (Gamache & Giobbe, 1990, Hughes, 2004, Jeffreys, 1997, MacKinnon, 1993). While social stigma and invisibility add to the

oppression, these are not in and of itself the primary cause of violence and human rights violations. According to the abolitionists, prostitution can never be a legitimate business, even if legalized, because it will always be associated with crime, corruption, poverty, mass sexual exploitation and human trafficking. In fact, decriminalizing or legalizing prostitution would normalize and regulate practices which are human rights violations, and which in any other context would be legally actionable (like sexual harassment, physical assault, rape, captivity, economic coercion) or emotionally damaging (like verbal abuse; Farley, 2005). These authors believe that the commercial sex industry exploits to its advantage the fact that most women and children who are in prostitution come from the most oppressed and vulnerable groups in society.

The abolitionists highlight many reasons for their argument. First, legalization intensifies the commodification of women's bodies and greatly expands the illegal, as well as legal, sectors of the industry. Second, prostitution becomes an intrinsic part of public life, gets integrated into the State tourism industry and ameliorates the support of financial institutions towards the industry (Sullivan, 2005). Third, there are minimal opportunities for self-employment for women in prostitution and limited exit strategies for women who want to leave the work. Fourth, countries in which prostitution is legal but street prostitution illegal have experienced an increase not a decrease in prostitution to commensurate with the overall demand for prostitution sex (Daley, 2001; Sullivan & Jeffreys, 2001). Fifth, sex exploiters indiscriminately traffic women for commercial sexual exploitation, into both legal and illegal brothels, with the former often serving as a safe entry point for the illicit trade. Sixth, there is continued perpetuation of sexual exploitation of vulnerable populations like children, immigrants and people in poverty and people from minority backgrounds (Sullivan, 2005). Seventh, increased tolerance of prostitution requires a steady flow of women and girls to meet the demands of the vastly expanding and lucrative market and sex business interests are quick to devise new forms of sexual exploitation

to ensure continuing profits and meet consumer demands (Sullivan, 2005). Eighth, the abolitionists also believe that attempts to treat prostitution businesses as similar to other mainstream workplaces actually obscures the intrinsic violence of prostitution (such as rape and other forms of trauma) from public view, thereby making it more acceptable. Such violence is entrenched in everyday 'work' practices and the 'work' environment and results in ongoing physical and mental harm for women who must accept that in a legal system such violence is normalized as just part of the job (Farley, 2005; Sullivan, 2005).

The abolitionist perspective, one of which is the 'radical feminist perspective' has been criticized for its reliance upon an essentialist approach and universalism. In particular, the radical feminists' contention that victimization and exploitation are inherent, omnipresent, and unalterable in prostitution has been criticized (Goode, 1997, Rubin, 1993, Weitzer, 2005b). However, there are those who disagree with the assertion that prostitution has never been and can never be organized in a way that minimizes coercion and inequality, and maximizes workers' interests (Goode, 1997).

In reality, the life experiences of women in prostitution are highly diverse, complex and varied allowing for significant support for arguments and counterarguments of the abolitionists and anti-abolitionists. While the abolitionist and the anti-abolitionist perspectives seem polarized, they present with different pathways to the same end. Both perspectives seek to provide people in prostitution with more options, eliminate violence and harmful practices, and accord them with a more dignified way of life. It should be noted that while people adhering to the abolitionist perspective are fairly coherent in their agendas, strategies and concerns, people adhering to the anti-abolitionist position have tended towards discernible, but less strictly defined, internal logic (Shah, 2005). Nonetheless, a relevant by-product of this debate is the question of whether prostitution can be categorized as a form of work or not.

Prostitution or sex work? Based on the above-mentioned debate, academic literature on prostitution has been selective with respect to the language used to depict prostitution. Some feminists find the term *prostitute* to have stigmatizing and degrading associations and instead consider *sex work* to be more appropriate. The term *sex work* is expected to convey the professionalism of the *sex worker* rather than her lack of worth as seen by much of society (Ditmore, 2006). Some go to the extent of claiming that redefining prostitution as sex work is "a preliminary condition for the enjoyment by sex workers of their full human and labour rights" (Bindman, 1997). It is believed that the term *sex work* refers to an income-generating activity or a kind of employment rather than being characteristic of a particular class of women. In fact, women in prostitution often prefer the term sex work (Bindman, 1997).

In response, people adhering to the abolitionist approach to prostitution prefer to use the term *prostituted women* or *women in prostitution* instead of *prostitutes* and *sex work* (Jeffreys, 1997, p. 330; cited in Weitzer, 2005b). Their belief is that the term *sex work* can be misleading because it implicitly denotes the idea of choice and agency, thereby minimizing the violation of human rights that occur through violence, coercion and exploitation (Farley, 2003). These authors' (often referred to as 'radical feminists') claims have been criticized for diminishing the sense of agency that women in prostitution may have by ascribing agency to them only when they either resist being prostituted or when they decide to leave prostitution (e.g. Weitzer, 2005a).

Prostitution as a Form of Work. The abovementioned debate seems to be based on the presumption that the construct of *work* somehow implies agency or volition. I contend with this notion that work necessarily implies volition, agency or in fact, dignity. In contemporary psychological discourse, a meaningful work experience that is actively explored, and freely chosen is frequently associated with the idea of the "grand career narrative" (Savickas, 2005).

The basis of this argument is that people, in general, have the opportunity to explore, manifest and express their interests through their work (Holland, 1997; Super, Starishevsky, Matlin, & Jordaan,1963). However, the ideals of agency, choice, and volition in terms of work are the luxuries of an affluent minority, namely White middle-class individuals living in western society. On the other hand, the majority of the world's population faces systemic barriers to optimal work opportunities that may be an expression of their interests (Blustein, 2006; Peterson & González, 2005). This multitude of barriers that exist in the work lives of individuals are often manifestations of social inequities based on dominant power structures that relate to sexism, classism, racism, heterosexism, ableism, to name a few (Blustein, 2006; Richardson, 1993).

Viewing prostitution as a form of work does not suggest that it is either agentic or honorable. It also does not imply that the violence frequently occurring in prostitution ought to be sanctioned by society. In fact, denying that prostitution is a form of work contributes to the lack of visibility in dominant discourse, which fuels the oppressions related to prostitution. The work in prostitution has typically been characterized by hardship, pain and trauma (Blustein, 2006). In addition, the systemic barriers described above such as race, gender, and social class are more pronounced when prostitution is discussed as a form of work (Han, 2006).

While one may categorize prostitution as a marginalized form of work, it is a form of work, nonetheless (Blustein, 2006). However, prostitution is not just any form of work. It has special aspects that make it more complex than other forms of work. Therefore, any discussion on prostitution as a form of work necessitates an intentional discourse that attempts to understand the nature of the work inherent in the tasks of prostitution. Minimizing the importance of work in the case of prostitution serves to fragment the person's experience, and further perpetuates social inequities (Richardson, 1993).

Work is a central component of people's lives and is intrinsically related to their psychological well-being (Blustein, 2006). The psychology of working perspective (Blustein, 2006) places work at this central position in people's lives. It incorporates all forms of earning a living and not merely those which are an expression of the "grand career narrative". Therefore, it includes marginalized forms of work which are not optimal forms of work but are clear examples of social injustice. The psychology of working perspective provides conceptual scaffolding for understanding the role that work plays in the life of a person engaging in prostitution as a means of earning a living. It is also a helpful framework for understanding the intersecting contextual factors that impact a person's work life and therefore their psychological well-being. Any clinician or therapist who seeks to engage in a comprehensive and empathic treatment of individuals or groups will need to understand the importance and complexity of work in people's lives especially those who engage in marginalized forms of work such as prostitution.

The Psychology of Working Perspective

The field of psychology has historically failed to place adequate emphasis on work and work issues (Blustein, 2006; Richardson, 1993). In fact, work and work issues have remained in the margins of psychotherapeutic discourse and practice. In psychotherapy practice, counselors exhibit bias against attending to work and work related issues in treatment and assessment of clients (Spengler, Blustein, Strohmer, 1990). Unlimited access to an orderly and planful work life is accepted as the norm; this assumption about life may function to protect therapists from confronting the grossly inequitable opportunity structures related to gender, race, and social class that exist in society (Richardson, 1993). Therefore, Richardson (1993) advocated for the development of new paradigms for understanding the complexity and nuances of the role of work in people's lives (Blustein, 2006).

The psychology of working (Blustein, 2006) is one such perspective that seeks to create an inclusive conceptual framework that affirms work as a central component of people's lives while raising awareness among researchers and practitioners alike that most people in this world do not have volition in what they do for a living (Coutinho, Dam & Blustein, 2008). According to psychology of working, work is an integral part of psychological health and well-being. It is closely intertwined with the personal, emotional and relational experiences that people have in daily living (Betz & Corning, 1993; Blustein & Spengler, 1995). In addition, work is a social and cultural construction indicating that the work experiences of people across the world differ, depending on the social, political, economic and cultural context (Fouad & Byars-Winston, 2005). This perspective is grounded on the notion that people work to fulfill their needs, which include the needs for survival and social/economic power, relational connections, and self-determination (Blustein, 2006).

The inclusive framework of psychology of working incorporates all forms of work that do not necessarily fit the traditional idea of careers and jobs. People engage in a myriad of activities to earn a living and not all of them are dignified and honorable forms of work. Marginalized forms of work are frequently the product of social inequities perpetuated within a divisive system. Prostitution as mentioned above is a marginalized, but a legitimate form of work. In fact, it is often a product of social inequities and abuses of power and its lack of visibility on the map of the working world serves to maintain status quo. Therefore, using psychology of working to structure the following discourse, I seek to establish the position that prostitution occupies in the map of the current world of work.

Prostitution as a marginalized form of work. While prostitution may be one of the world's oldest professions, it is also arguably the world's oldest form of oppression. This may be attributed to many reasons. First, prostitution remains the world's most marginalized forms of

work largely because of the lack of visibility due to lack of legal sanction and/or human rights abuses. Such lack of visibility predisposes the lives of the people involved in prostitution to a certain degree of vulnerability associated with the work involved in prostitution. Yet it remains the single highest contributor to world/global economy. It is unaccounted for, untaxed and illegal. Second, prostitution is, more often than not, associated with crime, corruption, poverty, violence, sexual exploitation, and human trafficking (Dalla, 2000; Farley, 2004). Third, language used to refer to women in prostitution is particularly reflective of its oppressive nature. Women who express their sexuality, even if they are not in prostitution, are often referred to by the use of denigrating terms such as *whores*, *hookers*, *tramps*, and *sluts*, to name a few. Fourth, the range of diversity involved in prostitution and prostitution-related activities, while lacking visibility, makes it elusive, oppressive and most lucrative for exploiters. Finally, most people who engage in prostitution often come from marginalized and vulnerable groups in society influenced by race, social class and gender inequities.

Prostitution as a social and cultural construction. The psychology-of-working framework emphasizes the dynamic interactions between multiple levels such as biological, psychological, social, societal, cultural, ecological, and historical contexts that contribute to mental health problems of women in prostitution. There are multiple factors that impact the mental health of women in prostitution. These factors include sociocultural contextual factors that contribute to the vulnerability of women, the developmental level at which women enter prostitution, and psychological factors that contribute to entry into prostitution.

Social Barriers Related to Prostitution. Historically situated systemic barriers and power structures related to gender, race and social class affect the mental health of women in prostitution (Jeffreys, 2008; Wine, 1985).

Gender. Patriarchal societies' grant men higher value than women with explicit and implicit expectations of male dominance in politics, economics, socially (family life) and interpersonal relationships. Such gender norms operate at both the historical and sociocultural level creating power dynamics in all relationships (White & Kowalski, 1998). Power dynamics, then, become enacted at the interpersonal level and result in the internalization of gendered values, expectations, and behaviors within men and women alike. Individual violence is embedded in gendered social and cultural contexts while cultural norms sanction the use of aggression as a tool of the more powerful to subdue the weak. A systemic context that harbors power dominance in a milieu of gender inequalities creates a climate conducive to violence against women – an ultimate manifestation of which occurs on prostitution where men buy sex and are accorded freedom to set the terms within that relationship (Farley, 2005).

Race. Similar oppressive systems characterize race relations in the United States. There is an overrepresentation of minority women in prostitution (Kramer & Berg, 2003). Black women begin work in prostitution, on average, at a younger age than White women (McClanahan, McClelland, Abram, & Teplin, 1999). In one study, it was found that non-street prostitutes were more likely to be White (92%) than were street prostitutes (59%) with greater hazards indicated for the latter (Potterat, Rothenberg, Muth, Woodhouse, et al, 1999). A third study correlating adult rape experiences to prostitution found that women likely to enter prostitution post-rape were likely to be women of color (Campbell, Ahrens, Sefl, & Clark, 2003).

Social class. It is important to note that prostitution generates comparatively more pay than similar low-skill and labour intensive professions (Edlund & Korn, 2002). Even for the worst paid service (such as, street walking) the earnings are multiples of full-time earnings in professions with comparable skill requirements (Edlund & Korn, 2002). Despite being illegal in many countries, this lucrative nature of the work can be alluring to many women, especially

those from lower socioeconomic backgrounds, who have systematically been denied access to other dignified forms of work. In addition, the literature on prostitution has found that women who engage in prostitution tend to have limited educational backgrounds (often not completing high school), struggle with homelessness, and experience limited options for work (Kramer and Berg, 2003; Weisberg, 1985). Therefore, social class is inseparably tied together with prostitution.

Summary. As a consequence of the intersection of gender, race, and social class in prostitution, women experience serious psychosocial stressors and are predisposed to various forms of violence. This has serious bearing on their mental health and safety. While social factors in the form of contextual barriers may set the stage for prostitution, the script to becoming a prostitute is often written by psychological factors (Potterat et al, 1998).

The literature suggests complex and heterogeneous etiological pathways that result in women engaging in the commercial sex industry. Although the possible antecedents to prostitution activity are numerous, characteristics of women engaging in prostitution that have been documented in recent empirical literature include the following: a history of childhood sexual abuse (Bagley & Young, 1987; Silbert, 1980; Silbert & Pines, 1981), childhood physical abuse (Bracey, 1979, 1983; Silbert, 1980, 1982), and leaving home (Bracey, 1979, 1983; Crowley, 1977; Mathews, 1987). Other characteristics that have been identified include poor family functioning (Mathews, 1987; Silbert, 1980), interparental violence (Bracey, 1979; Silbert, 1980, 1982), parental alcohol abuse (Silbert, 1980, 1982), alcohol and/or drug use (Crowley, 1977; Silbert, 1980, 1982), and low self-esteem (Bracey, 1979; Silbert, 1980).

High prevalence rates of incest, early childhood physical and sexual abuse among women who enter prostitution are well documented (Earls & David, 1990; Finkelhor & Browne, 1986, Simons & Whitbeck, 1991, Surratt et al, 2005; Zierler, Feingold, Laufer, Velentgas, 1991). In a

study by Silbert and Pines (1982), three fifths (61%) of the participants reported childhood sexual abuse. This study was replicated in Canada using the same questionnaire on 45 former prostitutes and 45 age-matched controls from the population of Calgary (Bagley & Young, 1987). Their results were similar to those of Silbert's group (Potterat et al, 1998).

The developmental level at which women enter prostitution is of notable significance as well. The average age of entry into prostitution has been identified as thirteen to fourteen (Estes & Weiner, 2002; United States Department of Justice, 2007; Weisberg, 1985). Silbert and her colleagues (1998) found that among 200 street prostitutes interviewed in San Francisco, the mean age of coital debut was 13.5 years. For juvenile prostitutes, the average age of beginning prostitution was 13 years while for an adult it was 18 years - the average being 16-17 years for entry into regular prostitution activity (Silbert & Pines, 1982). From a developmental perspective, early childhood sexual abuse significantly impacts normal developmental pathways presenting serious risk factors to growth and psychosocial adjustment. Stigmatization (shame and self-blame) and internalizing symptoms such as posttraumatic stress and depression, are common among those who have experienced early childhood sexual abuse (Feiring, Simon & Cleland, 2009). In addition, early childhood sexual victimization of women impacts their health, psychosocial functioning, and systemic involvement, predisposing them to engage in illegal activities such as prostitution (DeHart, 2008). In fact, a number of researchers have suggested that one long-term effect of sexual victimization is engaging in prostitution (Bagley & McDonald, 1984; Jehu & Gazan, 1983). In a sample of incarcerated women, Foti (1994) found participants who were sexually abused as children were twice as likely, compared to non-abused detainees, to have engaged in prostitution. These rates are in marked contrast to prevalence studies in the general population that cite figures ranging from 19% to 50% (Bagley & Ramsey,

1985; Finkelhor, 1979; Russell, 1984, as cited in Lung, Lin, Lu, & Shu, 2004). These findings seriously challenge the arguments in favour of volitional engagement in prostitution.

Some other factors such as dysfunctional family unit, discontinuous schooling, high risk of infection with HIV and other reproductive system disorders, unmarried pregnancy (Pajer, 1998), running away from home (Badgley, 1984; Mathews, 1987; Silbert, 1980), homelessness, deviant activities etc. are also found to be significantly related to prostitution (McClanahan, et al, 1999; Simons & Whitbeck, 1991, Surrat et al, 2005). In particular, there is high prevalence of substance use and abuse, whether it precedes or, even coincides with the onset of prostitution. In the Silbert and Pines (1982) study reported above, the authors subsequently reported that nearly all (95%) in their sample had histories of illicit drug use. Of these, 55% reported drug use prior to prostitution entry and 30% subsequent to (15% concurrent with) prostitution entry (Potterat et al, 1998; Silbert, Pines & Lynch, 1982). In a follow of study by Potterat and his colleagues (1998), 66% of prostitutes had used drugs prior to entering prostitution, 18% began both behaviors at the same time, 17% used drugs after beginning to work as a prostitute (Potterat et al, 1998).

The needs of survival, social connections and self-determination. The psychological literature on prostitution is limited, but heterogeneous. In light of the above debate centering on whether prostitution can be categorized as just a job or a violation of human rights, the psychological data collected appears to lopsided in favour of the latter (e.g. Farley et al, 1998; Potterat et al, 1998; Raphael & Shapiro, 2004; Silbert, Pines & Lynch, 1982). On the basis of psychology of working, prostitution can be understood as a marginalized form of work which requires intentional discourse highlighting the oppression, violence and exploitation that is inherent in the nature of prostitution as it exists (not what it could be). According to the psychology-of-working perspective, work is expected to fulfill the three basic needs of people.

These are the need for survival, need for social connection and the need for self-determination. While in an ideal circumstance, all three needs are fulfilled, this rarely happens in marginalized forms of work such as prostitution. In the following, the fulfillment of these needs as they apply to prostitution is elaborated on.

Need for survival. According to the psychology-of-working perspective, working provides the means of obtaining the necessary goods and services to be able to secure food, clothing, and shelter (Blustein, 2006). Closely related to the need for survival and power is the issues of the degree to which a person has control and volition in his/her work life (Blustein, 2006)

Women often engage in prostitution as a means of earning money to obtain social or economic resources that are necessary for survival. It is commonly believed that those engaging in prostitution are consenting adults who freely choose to engage in such an enterprise as a means of earning money. Reality is far more complex. While this may be true for some, most women engaging in prostitution do not have the same privilege (Farley, 2005). For many, it may be the only employment or survival option. In fact, several women are coerced through violence, trafficking, debt-bondage, or the influence of more powerful people to engage in prostitution (Farley, 2003).

While the need for survival may be partially fulfilled, prostitution presents with serious occupational health and safety hazards to those engaging in prostitution which are an intrinsic part of the work involved. There are often serious repercussions for a woman's physical and psychological health and safety either as a direct result of prostitution itself or through a consequent exacerbation of psychological ill-health by engagement in such traumatizing work.

More than 55,000 women are arrested annually in the United States on charges related to prostitution (Taira, Green & Richmond, 1994). At the least, the mere engagement in a

profession that is illegal and socially stigmatizing generates fear (e.g. of legal repercussions) and impacts identity and self-esteem (Brewis & Linstead, 2000). Women in prostitution risk physical and emotional safety when they engage in prostitution (Surratt, Kurtz, Weaver & Inciardi, 2005). There is risk for sexual victimization by customers and pimps (Nixon, Tutty, Downe, Gorkoff, et al, 2002), and for acquiring fatal sexually transmitted diseases such as AIDS (Alegria, Vera, Freeman, et al 1994, Astemborski, Vlahov, Warren, et al, 1994, Inciardi, Pottieger, Forney, et al,1991; McKeganey, 1994, Padian, 1988). Women in prostitution present with very high mortality rates (Potterat, Brewer, Muth, Rothenberg, Woodhouse, et al, 2004). The most striking statistic indicates that women in prostitution have the highest homicide victimization rate of any set of women ever studied (Brewer, Dudek, Potterat, Muth, et al, 2006).

Violence or the imminent threat of violence is very high in prostitution (Nixon et al., 2002) frequently involving rape, mutilations, coercion, threats with weapons and even murder. Farley (2004) asserts that prostitution involves systematic methods of brainwashing, indoctrination, and physical control that are frequently used against women in prostitution. In a study by Farley and Barkan (1998), ninety-two percent of those who are prostituted want to leave prostitution, but find it difficult if not impossible. Although the direct source for this statistic is not available, Sullivan (2005) claims that approximately 75% of women engaging in prostitution in the Netherlands (where prostitution is illegal) desire to leave but are not able to. The psychological impact of prostitution which often includes dehumanizing, objectifying and controlling techniques to keep women in prostitution and prevent women from leaving their work pose similar risks as the development of sexually transmitted diseases (Farley, 2003).

Need for social connection. Feminist perspectives, in particular, relational-cultural theory (Miller & Stiver, 1997), have emphasized that psychological growth occurs through relationships with other people. Growth-inducing relationships are characterized by authenticity

and mutual empathy. Authenticity is the ability to be genuine in sharing one's thoughts and feelings and mutual empathy occurs in relationships where every person has unconditional positive regard and acceptance for the other. The absence of authenticity and mutual empathy in relationships, or the presence of abuse, neglect, and oppression can result in the suppression of innate needs and desires for connection. In addition, relational images of others as abusive, neglectful or oppressive contribute to psychological stagnation.

Work is an aspect of a person's life that can foster human interrelatedness and relational connections (Blustein, 2001; Blustein & Spengler, 1995; Richardson, 1993; Savickas, 1991; Schultheiss, 2003; Swanson, 1995). Ideally, work is a consistent source that provides unique opportunities to people for developing meaningful, authentic, egalitarian and mutually empathic relationships with others often on the basis of common interests and ideologies (Flum, 2001; Schultheiss, 2003). In addition, the relational resources and connections while working foster fertile grounds for work-related satisfaction and optimal performance (Blustein Prezioso, & Schultheiss, 1995; Hall, 1996; Schultheiss, Kress, Manzi, & Jeffrey, 2001).

Work in prostitution creates unsatisfactory conditions for meeting the need for social connections. First, the predominance of internet, video productions, and other technological avenues for accessing the contemporary commercial sex industry often minimizes any relational contact. Second, in venues where there is relational contact, relationships are characterized by rigid and differential power structures. Invariably, women play subordinate roles in relationship to their pimps, to customers (johns or tricks), or to a male-dominated system. Third, the system of crime, oppression and deviance that characterizes the commercial sex industry places women at higher risk for violence and victimization (Dalla, Xia & Kennedy, 2003; Sampson & Lauritsen, 1994).

In the workplace, the sexuality of a woman is the commodity for purchase; her body is the object. While women may exercise a certain degree of control in their work, complete control cannot be dictated by her alone. Also, physical and sexual intimacy may be a part of the work in prostitution but there are limited, if any, opportunities for empathic connections or mutual understanding.

While power differentials and dominance involved in victimization has serious consequences for the individual's sense of agency and self-efficacy, it also affects the perceptions of others in their social world (MacMillan, 2001). The documented high prevalence of early childhood sexual victimization among women who engage in prostitution can result in feelings of worthlessness, alienation and self-abasement for women who later engage in prostitution (Bagley & McDonald, 1984; DeHart, 2008; Foti, 1994; Jehu & Gazan, 1983). Women with life-long patterns of victimization are most at risk for remaining with abusive men and are least likely to expect otherwise. Alternatively, early sexual abuse contributes to the dissociation between emotions and sexual activity which is a frequent coping mechanism used by women who engage in prostitution (Cooper, Kennedy, Yuille, 2001; Harway & Liss, 1999; James & Meyerding, 1977; Ross, Anderson, Heber, Norton, 1990). Disconnections between feelings and experience in the context of relationships characterize inauthentic relationships. It is unlikely that women in prostitution are able to form authentic relationships with her customers or other members of a system in which she has to dissociate in order to earn her daily living.

The primary relationships that characterize the work in prostitution are relationships with other women in prostitution, pimps, employers and customers. Apart from possibly relationships with other women in prostitution, the nature of these relationships is ultimately unidirectional (i.e. they are characterized by victimization and oppression). In all settings of prostitution, women are frequently at risk of physical, sexual or psychological violence, irrespective of

whether they are high-class call girls, strippers or street walkers. This is substantiated by the statistics that highlight the high occurrence of suicide and homicide among women in prostitution. Violence from pimps, strangers, and clients is a commonly reported phenomenon in prostitution (Maher, 1996; Raphael & Shapiro, 2002). In an unexpected finding, Dalla, Xia & Kennedy (2003) found that women in their study who engaged in street prostitution experienced violence in the streets as much as in intimate relationships. Not only were the women subject to multiple forms of bodily injury by clients, they experienced greater and more severe violence from intimate partners.

Authenticity, mutual understanding and opportunities for psychological growth through relationships are practically non-existent for women in prostitution. While this may seem mostly true for outdoor prostitution, indoor prostitution is similarly structured on the basis of a system which treats women's sexuality as a commodity for purchase.

***Need for self-determination*.** The working context can provide unique opportunities for genuine self-expression, great life satisfaction and immense psychological growth. Under ideal circumstances, work can satisfy the need for *self-determination* (Blustein, 2006; Deci & Ryan, 1985; Ryan & Deci, 2000). This concept is based on Self-Determination Theory (SDT) proposed by Deci and Ryan (1985; Ryan & Deci, 2000). When work is self-determined or *intrinsically motivated,* it provides an outlet for a person's interests and generates satisfaction, pleasure and enjoyment. More often than not, work is *extrinsically motivated* i.e. driven by external rewards such as remuneration, comforts, satisfying others. Under certain conditions, extrinsically motivated work can become internalized into one's motivational and value system. The conditions that are required for an extrinsically motivated activity to become *self-determined* include a) *autonomy* i.e. opportunities for exercising volition and control over one's work life with little external regulation, b) *relational support* i.e. opportunities for forming meaningful

connection with others in the working context and c) *competence* i.e. opportunities for success or feelings of mastery in a given job or work (Blustein, 2006).

As suggested by some aspects of the debate between the abolitionists and the anti-abolitionists, the question of whether prostitution provides opportunities for self-determination is debatable. Using the psychology of working framework described above, I argue that self-determination is rarely possible in prostitution. While some authors (e.g. Pheterson, 1989; Weitzer, 2005b) suggest that prostitution can be intrinsically motivated i.e. through genuine sexual expression, sexual liberation etc., the scholarly literature in the social sciences, particularly in relation to social justice and feminist perspectives, suggests otherwise, tipping the balance against this proposition. The pathways to prostitution demonstrate that women frequently enter prostitution for extrinsic rewards such as monetary gain, flexible schedule, satisfying a partner's demands, preventing further violence from pimps. It is difficult to imagine that women engage in prostitution to fulfill genuine interests in providing sexual services to others. Psychologically speaking, women use drugs, dissociate and disconnect in order to fulfill their work requirements (Farley, 2003). These strategies raise substantial and critical questions about the notion that prostitution provides life satisfaction and self-expression.

The heterogeneity of prostitution complicates this debate. In some cases, women in prostitution exhibit some degree of autonomy. This may be in the case of high-class "call girls" and women who engage in indoor prostitution where women may exercise some degree of choice in determining their work schedules and negotiating pay. However, it is unlikely that in a male-dominated system, there is no external regulation. In fact, coercion through intimidation, violence, oppression and force in many cases reported characterizes such external control. In addition, the constant threat (including legal repercussions) serves as an external control at work and constricts the choices that women could have in their work. Therefore, it may be argued that

in the current context, opportunities for obtaining autonomy through the exercise of volition and control over one's work life is fairly limited. Second, it may be reaffirmed that relational connections in prostitution are characterized by violence or the risk thereof, limiting opportunities for meaningful connections with others. Finally, there is limited if any opportunities for professional, personal or psychological growth through prostitution and therefore, competence.

In sum, prostitution does not provide opportunities for experiencing fulfillment in the fundamental strivings for survival, developing and sustaining relational connections and establishing self-determined conditions in their lives. While prostitution may satisfy the need for survival among women working in prostitution, it subsequently threatens their physical and/or psychological integrity. There is high stress in work lives and women in prostitution experience serious psychological repercussions arising from their working contexts (Blustein, 2006).

The Impact of Prostitution on Mental Health

Prostitution has serious mental health consequences on the people who engage in it. The literature suggests mental health problems such as depression (Alegria, Vera, Freeman, Robles, et al, 1994; Gibson-Ainyette,Templer, Brown, & Veaco,1988; Pedersen & Hegna, 2000; Plummer, Potterat, Muth, & Muth, 1996; Ross et al., 1990; Rydelius, 1988), anxiety disorders including posttraumatic stress disorder, (Brown, 1979, de Schampheleire, 1990, Farley & Barkan, 1998, Silbert & Pines, 1983, Surratt, et al, 2005), dissociative disorders (Ross et al., 1990), psychosis (Miller & Finnerty, 1996), personality disorders (Brody, Potterat, Muth & Woodhouse, 2005; Warren, Burnette, South, Chauhan, et al, 2002), other psychopathology (de Schampheleire, 1990; Gibson-Ainyette et al., 1988), substance abuse (Poterrat et al, 1998; Silbert et al, 1998), and suicidality (Ling, Wong, Holroyd, Gray, 2007). From this myriad of

psychological issues, it is apparent that women in prostitution are in need of mental health services.

The data enlisted above undoubtedly support the claim that mental health treatment is essential in successfully intervening on behalf of prostituted women (Carter & Dalla, 2006). However, minimal information exists in the counseling literature related to knowledge about the violence that occurs in prostitution or effective counseling techniques for working with women in prostitution. Professional counselors are often ill-equipped, academically and experientially, in addressing the diverse needs of women in prostitution who have typically experienced life-long patterns of victimization, substance addiction and continued self-destructive behaviors (Carter & Dalla, 2006). In addition, the lack of focus on work and work issues by counselors serves to remove focus from the nature of victimization that women experience in their working contexts.

The psychology-of-working perspective is based to a large extent on the argument that it is the moral and ethical obligation of clinicians and researchers to include work and work issues in psychological practice. According to Blustein (2006), "*psychotherapy represents the application of psychological research and theory to the task of helping individuals deal with problems of a diverse nature, including, but not limited to physical health, mood, interpersonal problems, psychiatric illnesses, family concerns and conflicts, adjustments to trauma, work-related problems, and related mental health issues*" (Blustein, 2006, pp. 248).

Clinical Bias in Counseling

Treatment in psychotherapy is largely a function of subjective clinical judgment of the psychotherapist (Garb, 1998). The idea that clinicians' personality and experiences impact the manner in which they work with their clients has been present since the inception of counseling as a profession. As early as 1910, Freud introduced the construct of countertransference as

comprising the analyst's unconscious reactions (unresolved neurotic conflicts) to the patient (Freud, 1958; Tyson, 1986). As a result, he viewed countertransference as an impediment to effective treatment. Stemming from his work, later psychoanalytic and psychodynamic theorists accounted for bias and prejudice through a pathologized view of specific people (e.g. authoritarian personalities; Christie, 1991). In the decades to follow, the concept of countertransference has been broadened to include both the counselor's unconscious and his/her conscious reactions to the client (Bernard, 2005; Tyson, 1986). Countertransference reactions are now believed to be inevitable in the dyadic relationship between the therapist and the client.

Countertransference is often an umbrella term used to describe counselor reactions to clients (Watkins, 1985). A more specific category of countertransference comprises bias (Wisch & Mahalik, 1999). Bias is a more specific term that involves an interpretive judgment that a given response is unfair, illegitimate, or unjustifiable, in the sense that it goes beyond the objective requirements or evidence of the situation (see Brewer &Brown 1998, Fiske 1998, Turner & Reynolds, 2001). In the counseling context, bias implies inaccurate clinical judgments by a mental health professional based on his or her stereotyped notions about a client (Wisch & Mahalik, 1999). These stereotyped notions often stem from the client's membership in a particular sociodemographic group (e.g. Black, Jewish, female). In other words, bias of this nature directed towards a particular demographic group comprises of the cognitive process of *stereotyping*, whose attitudinal representation is *prejudice* and behavioral manifestation is *discrimination* (Mackie & Smith, 1998, Wilder & Simon 2001).

Bias is often unconscious and unintentional. Devine (1998) stated that although great advancements have been made in the reduction of overt prejudice, covert prejudice is still evident in society largely because prejudice is similar to a deeply engrained bad habit that can continue to linger despite the best intentions to be unbiased (Tarrant & North, 2004). Social

psychological research (e.g. Dovidio et al., 2002) has documented how unintentional bias produces barriers to university admissions, employment, and advancement of well-qualified members of ethnic minority groups. While people may perceive themselves to be egalitarian, they are subconsciously not so. Dovidio et al. (2002) demonstrated in a series of studies that contemporary racism among White Americans is subtle, often unintentional, and unconscious. Many White Americans often give off negative body language (less eye contact, voice tone not as warm or natural) in response to those different from themselves. White Americans who demonstrate these behaviors report not being aware of this negativity. In addition, members of ethnic minority groups were equally aware of negative attitudes toward them in those studies that examined these interactions (Dovidio et al, 2002).

Unintentional bias threatens therapeutic alliance. Psychotherapists frequently experience unintentional bias in their work with clients or patients who are culturally different from them (Vasquez, 2007). Greenwald and Banaji (1995) suggested that societal structures influence cognitive judgment and lead to implicit attitudes and unconscious effects. Human social structures have compounding effects on people's cognitive structures and ultimately on their social attitudes and beliefs about others. The way society constructs societal representations of groups (based on race or occupation e.g. prostitution) affects the social order and has a tremendous impact on the identities of individuals in various groups which include ethnic minorities and the White majority; people who engage in marginalized forms of work as well as those who do not.

Unintentional bias identified in social psychological research is commonly a part of the psychotherapist/client interaction (Gaertner & Dovidio, 2000; Garb, 1998). In fact, unintentional bias partly accounts for high dropout rates and underutilization of psychotherapeutic services by people from marginalized and oppressed backgrounds (United States Department of Health and

Human Services, 2001). In particular unintentional bias interferes with the therapeutic alliance between client and psychotherapist, rendering treatment interventions ineffective (Vasquez, 2007).

Theories of Social Cognition and Intergroup Bias

The field of social psychology has been remarkably informative for the field of counseling (Heppner & Frazier, 1992; Stoltenberg, McNeill, & Elliott, 1995). Extensive research on attitudes, social cognition, interpersonal relations, intra- individual judgment processes and decision-making, personality and group processes, and individual differences have been crucial to the development of the fields of psychotherapy, career counseling, assessment, supervision, rehabilitation, and psychopathology (e.g. Garb, 2005; Garb, Lilienfeld, & Fowler, 2008; Neville, Heppner, & Wang,1997; Quimby, Wolfson, & Seyala, 2007). More specifically, research in the area of social cognition has been most informative to the constructs of countertransference, clinical judgment, bias and prejudice (Fiske, 2004b).

Social cognitive theory and bias. *Social cognition* is the study of how the individual processes social information within a social or cultural context (Huitt, 2006; Sternberg, 1994). The idea that bias is inevitable in social situations was first conceived and emphasized at the time of the cognitive revolution in psychology of the 1960s and 1970s. In particular, the metaphor of the mind as an information-processor (see Broadbent, 1958; Berry, 2002) took precedence and social cognition came to be viewed as a sufficient explanation for bias. Therefore, categorization, stereotyping, judgments and bias fall under normal cognitive processes (Fiske, 2004b). This stems from the notion of schemas or knowledge structures that exist in the mind comprising of beliefs, theories, and information stored in memory. Schemas contain clinicians' implicit theories of personality, psychopathology and assumptions regarding different sociodemographic groups.

Clinicians frequently make judgments based on these knowledge structures which predispose clinicians to exhibit cognitive bias (Garb, 1998). *Cognitive biases* are types of errors that people commonly make. One particular example of biases is confirmatory bias. *Confirmatory bias* occurs when clinicians seek or recall information that can confirm, but not refute, a hypothesis. For example, a clinician may hypothesize that a woman in prostitution made an active and well-informed choice about engaging in prostitution and may seek information that confirms this hypothesis. As a result, the clinician may ignore information that does not support his/her hypotheses, interpret ambiguous information as supporting his/her hypotheses, or may not consider whether information could support an alternative hypothesis that women may not have freely chosen to work in prostitution (Garb, 1998).

Intergroup bias. Another type of bias that frequently occurs in the context of social relationships like psychotherapy is intergroup bias (Hewstone, Rubin & Willis, 2002). Intergroup bias comprises of the social cognitive processes of stereotyping (cognition), prejudice (attitude), and discrimination (behavior) which contribute significantly to errors in clinical judgment (Garb, 1998; Mackie & Smith 1998; Wilder & Simon, 2001). Intergroup bias refers generally to the systematic tendency to evaluate one's own membership group (the in-group i.e. people who engage in dignified forms of work) or its members more favorably than a nonmembership group (the out-group i.e. people who engage in prostitution; Hewstone, Rubin & Willis, 2002). More precisely, this group-serving tendency can take the form of favoring the in-group (in-group favoritism and/or derogating the out-group (out-group derogation). Intergroup bias can be both explicit and implicit and typically operates outside of conscious awareness, nevertheless distorting clinical judgments (Dovidio & Gaertner, 2004). Intergroup bias is the result of the strong, innate tendencies of an individual towards s*ocial categorization* i.e.

categorization of objects and people into groups, and *ingroup favoritism and outgroup derogation* i.e. prefer things (and people) that (who) are familiar and similar to the ingroup.

Social categorization involves categorizing people as belonging to particular groups (such as racial, ethnic, gender). In social situations, people invariably categorize others on the basis of salient cues (like race, gender, age), recruit associated stereotypes, trigger emotional prejudices, and launch discriminatory behavior (Fiske, 2004). For example, people confuse women with other women or Blacks with other Blacks (Taylor, Fiske, Etcoff, & Ruderman, 1978), providing evidence of immediate categorization into in-group and out-group by gender and race (Fiske, 1998). Therefore, people commonly hold stereotypes or prejudices towards their own in-groups and out-groups. A corollary of such categorization involves accentuating differences of out-groups (assumption of outgroup homogeneity) and underestimating differences within groups ("They all look or act alike"; Ackerman, Shapiro, Neuberg, & Kenrick, 2006).

Social categorization involves *Ingroup Favoritism and Outgroup Derogation* where the individual favors one's ingroup and is denigrating towards one's outgroup. For example, in one study, a variety of rapid yes–no judgments (Is x a word? Could a person ever be x? Is x good or bad?) revealed patterns favoring people's own groups (Gaertner & Dovidio, 1986). That is, when first primed with 'us', people respond faster to positive words (e.g., intelligent is a word, can apply to people, or is good) than when primed with them. The same pattern holds for replacing us and them with specific ingroup–outgroup primes, such as white and black (Fiske, 2004a). When clinicians work with women in prostitution, they may view themselves as in-group, possibly as people who chose dignified forms of work and their client in prostitution as choosing prostitution and therefore, similar to all other women in prostitution. Research on intergroup bias demonstrates a predominance of a mild form of in-group favoritism, rather than

out-group derogation (see Brewer 1999, 2001). Positive bias towards one's ingroup is often an unconscious and automatic process e.g. positive evaluation of in-group pronouns (e.g. us) is stronger than generalized negative evaluation of out-group-pronouns (e.g. them; Otten & Wentura 1999, Perdue, Dovidio, Gurtman, Tyler, 1990). However, what is most pertinent to this study is the presence of out-group derogation. Out-group derogation may be characterized in subtle ways (such as aversive racism or racial microaggression; Dovidio & Gaertner, 2004; Sue et al, 2007) with the absence of positive sentiments, not necessarily, the presence of strong, negative attitudes, towards out-groups (e.g., Dovidio & Gaertner 2000, Pettigrew & Meertens 1995, Stangor, Sullivan & Ford, 1991). Out-group derogation can also involve derogation, hostility, and antagonism in the presence of strong emotions or threat (Brewer 2001, Doosje et al. 1998, Mackie & Smith 1998, Mummendey & Otten 2001). In the counseling context, it may be speculated that when working with women in prostitution, clinicians may experience both the absence of positive sentiments as well as the possible strong negative attitudes towards women who provide sex in exchange for money.

The Continuum Model of Impression Formation. In our struggle to understand, predict and control our social world, forming impressions of others is helpful. In a clinical setting, this is of utmost importance. The counselor has to form initial impressions that guide formulation of interventions and facilitate treatment. The *Continuum Model of Impression Formation* (CM; Fiske & Neuberg, 1990; Fiske Lin, & Neuberg, 1999) provides one theoretical framework within social psychology for person perception. According to this model, social perception occurs along a continuum from more categorical to more individuated impressions. When perceivers encounter social group members, they see them initially in terms of master statuses (such as, age, race and gender; Fiske, 1998) that activate cognitive (stereotypic) and affective (prejudiced) responses. But motivated and informed perceivers like therapists can

move along the continuum to form more nuanced, individuated impressions. The type of information that allows a more nuanced impression includes the person's idiosyncrasies: personality, accomplishments, skills and preferences (likes and dislikes). Particular judgments of preferences, for instance, may force one to go beyond the perceived social category to draw on information perceived to be unique to that social group member.

The Continuum Model of Impression Formation captures a distinction between more and less effortful processes of getting to know another person (Fiske & Neuberg, 1990). The model addresses information about others as including readily available categories, such as gender, race, and age, which may be immediately visible, as well as other readily available categories, such as *occupation* (e.g. prostitution), which may be communicated, for example, via verbal labels (Depret & Fiske, 1999). Information that serves as an overarching, organizing category may vary depending on the configuration, but the utilized category provides a framework for understanding other attributes, such as traits or behavior. The model proposes a range of impression-formation processes, from automatic initial categorization, to category reconfirmation, to intermediate processes that balance categories and attributes, to fully attribute-oriented processes, in which the initial category becomes just another attribute.

Information configuration and motivational circumstances determine how far along the continuum perceivers move, from more category-based to more attribute-based processes. Attention to and interpretation of information mediate the underlying processes. The premises of the model have been well supported (see Fiske, Lin, & Neuberg, 1999). For example, perceivers follow more category-based or attribute-based processes, depending on the information configuration (Fiske, Neuberg, Beattie, & Milberg, 1987), the instructions (Pavelchak, 1989), or their own sense of appropriate norms and values (Fiske & von Hendy, 1992).

One core motive determining relatively category-based or attribute-based social perception is interdependence, that is, the degree to which people need each other to further their goals. The continuum model research has emphasized interdependence as a central motivation. The counseling context is characterized by interdependence between the client and the therapist. The client is dependent on the therapist for symptom relief while the therapist is dependent on the client for inferences regarding their presenting concerns and is motivated to keep the client in therapy. While initial categorization is likely to occur, interdependence in the counseling relationship is likely to motivate the therapist to attend to attributes that are inconsistent with the initial categorization. Therefore through the course of treatment, the therapist is expected to use more effortful, attribute based processes of impression formation but initial categorization is likely to be activated upon reading the vignette which as described below will be kept intentionally brief.

Explication of Constructs

Empathy. Theory and research in various areas closely and directly link emotions to evaluations (Talaska, Fiske, & Chaiken, 2008). Zajonc (1980) asserted that emotions precipitate evaluations, bypassing cognition altogether. Mood (non-specific emotion) influences both judgment (e.g., Schwarz & Clore, 1983) and stereotyping (e.g., Park & Banaji, 2000). People automatically evaluate every newly encountered object. Emotion-driven evaluations color their interaction with it (Duckworth, Bargh, Garcia, & Chaiken, 2002). Differentiated emotions toward political candidates predict overall evaluations better than trait descriptions do (Abelson, Kinder, Peters, & Fiske, 1982). Emotions such as fear, hatred, and disgust significantly influence the arousal that often characterizes intergroup encounters (Hewstone, et al, 2002; Smith 1993, Stephan& Stephan 2000). Smith (1993) differentiated milder emotions (e.g. disgust) from stronger emotions (e.g. contempt, anger) most likely to be aroused in an intergroup

context, and linked specific emotions, perceptions of the out-group, and action tendencies (see Mackie, Devos, & Smith, 2000; Hewstone, et al, 2002).

According to the Stereotype Content Model (SCM, Fiske, et al, 1999), stereotypes are typically characterized by ambivalence. Outgroups often fall into two mixed clusters: paternalized groups liked as warm but disrespected as incompetent (e.g., traditional women, elderly people, disabled people) and envied groups respected as competent but disliked as lacking warmth (e.g., Asians, Jews, nontraditional women; Lin, Kwan, Cheung, & Fiske 2005). Outgroups perceived as low in both warmth and competence elicit disgust, an emotion that is not exclusively social, being directed both at people and objects that seem repellant (Rozin & Fallon, 1987). Women in prostitution are likely to be disliked and disrespected and therefore, possibly elicit the emotion of disgust or contempt. Thus, an out-group like prostitution that violates in-group norms (e.g. prostitution is morally wrong) may elicit disgust and provoke avoidance. Stronger emotions on the other hand, instigate greater prejudicial attitudes and discriminatory behaviors which characterize bias (Brewer 2001; Hewstone, et al, 2002).

The context of counseling necessarily evokes the full range of emotions within the counselor from strong to weak. This impacts the ability of the counselor to empathize with the client. In one study, participants demonstrated less emotional and cognitive empathy for a target experiencing distress stemming from an incident reflecting unfamiliar cultural norms (Nelson & Baumgarte, 2004). The authors speculated that this reduction of empathy is mediated by a lack of perspective taking on the part of the observer. These findings suggest that representations of prior experience as well as lack of similarity between self and other can have a negative impact on the ability to mediate perspective taking or empathy on the part of the observer. In addition, Comas-Dıaz (2006) identified cross-cultural encounters in therapy as being frequently rife with "missed empathetic opportunities (as cited in Vasquez, 2007)." These occur when clinician

change topics without addressing or reflecting the client's feelings when the client reports emotional issues. According to Comas- Dıaz (2006), these missed empathetic opportunities are subtle but more frequent when clinicians work with those different from them on the basis of racial, ethnic, gender, sexual orientation, socioeconomic, ideological, and political differences. In this study, I would like extend her hypothesis to marginalized forms of work like prostitution.

Some of the strongest emotional reactions are thought to be elicited by patients who present with past or current experiences of violence, abuse and trauma of a sexual nature (Bernard, 2005; Kadambi & Truscott, 2008). Goldfeld and colleagues (2008) presented psychotherapists with two vignettes indicating one of two types of trauma. The first depicted a client who experienced sexual violence while the other depicted a client who experienced the sudden death of a significant person. Results demonstrated that the vignette comprising of sexual violence was associated with more negative countertransference-related emotional reactions (Goldfeld, Terra, Abuchaim, Sordi, et al, 2008). Prostitution necessarily involves sexual violence, abuse and trauma (Farley, 2003). Therefore, counselors are likely to experience strong emotional reactions (such as anxiety, disgust) to women working in the commercial sex industry which may result in avoidance or possible hostility. These strong emotional reactions may provoke emotional distancing, impair the ability of the counselor to empathize, and negatively impact the therapy.

Cause and solution. In psychotherapy, the additional process of inference occurs due to lack of adequate data that is available to the therapist at the initial meeting. In the vignettes provided, it is expected that the respondent will engage in the process of inference. Inferences require perceivers to mentalize, that is, to consider what is inside another's mind (Baron-Cohen, 1995). This type of mentalizing usually involves observing behavior (engaging in prostitution), knowing the social consensus about the behavior (prostitution is illegal/morally condemned),

knowing the actor's consistency (engages in prostitution on a regular basis) and knowing the actor's distinctiveness in that behavior (prostitution is a profession for this person; Kelley, 1972; McArthur, 1972). In the counseling context, this information is often not readily available. Therefore in order to build alliance, diagnose and attribute causality and responsibility to the client, the therapist must infer most of this information. This process frequently involves extrapolation of data from what is known of the target group of women in prostitution (stereotypes; Fiske et al., 1999). Hence, inferences would be made based on similarity to stereotypes that the clinician holds regarding women in prostitution.

Stereotypes commonly function to provide explanations for disparities between dominant and disenfranchised groups in society. Jost, Burgess and Mosso (2001) and Hoffman and Hurst (1990) suggest that negative intergroup attitudes are rooted in a tendency for people to provide *rationalizations* for social inequalities by invoking intrinsic deficiencies of low status groups. For example, people tend to attribute group traits (such as, African Americans must not try hard enough to succeed) to their negative view of the over-representation of African Americans in poverty-stricken inner cities. According to these authors, people have a natural motivation to view the social system in which they participate as fair and just. To accomplish such a view, one must generate explanations for the low status of certain groups that *blame the group* rather than the system. Attributing blame to the system is likely to call into question the deservingness of the individual's higher social status. This research supports my premise that stereotypes are a way of explaining or rationalizing the disparities in society thereby attributing volition to women in prostitution and subsequent blaming the woman for entering prostitution instead of recognizing and highlighting societal inequities.

Attribution theory and intergroup bias. At an individual level, Weiner's (1985) causal attribution theory assumes that people try to determine why people do what they do, i.e., attribute

causes to behavior. Attribution theory focuses on the conditions under which people exhibit the typical bias of assuming that some stable characteristic, disposition, or attitude of an individual caused his or her behavior. A person seeking to understand why another person did something may attribute one or more causes to that behavior. Attributions are classified along three causal dimensions 1) locus of control (two poles: internal vs. external), 2) stability (do causes change over time or not?) and 3) controllability (causes one can control such as skills vs. causes one cannot control such as luck, others' actions, etc.) Attribution researchers have examined the tendency of people to explain behavior by making correspondent inferences.

At the intergroup context, individuals, as members of salient social categories explain the behavior of in-group and out-group members (Tarrant & North, 2004; Taylor and Jaggi 1974). Attributions at the group level function to serve the in-group i.e. individuals favor members of their own group rather than members of out-groups (Clabby, 2005). Taylor and Jaggi (1974) proposed that group members would attribute the positive behavior of the in-group to characteristics of the group (i.e. they would make internal attributions), and would attribute negative behavior to other sources (i.e. they would make external attributions). Conversely, the negative behavior of an out-group was predicted to be attributed to characteristics of that group (internal attribution), while positive behavior would be attributed to other sources (external attribution; Tarrant & North, 2004). In this study, I hypothesize that clinicians may err on the side of attributing personal responsibility to the client in prostitution for the cause of her problems. Clients' responsibility for solving their problems is closely related to the issue of client's responsibility for the cause of their problems. While attributions of causality on the clinician's part may reflect the client's responsibility for causing the problem, it is likely that the clinician may attribute greater responsibility of the client in solving her own problems.

Most studies in this area demonstrate some support for the predicted effects in a variety of group contexts constituting religion (e.g. Islam and Hewstone, 1993; Joseph, Wetherall, and Stringer, 1997; Taylor and Jaggi, 1974), race (e.g. Greenberg and Rosenfield, 1979; Hewstone and Ward, 1985), gender (e.g. Brady, Trafimow, Eisler, and Southard, 1996; Deaux and Emswiller, 1974), and groups defined by social status (e.g. Hewstone, Jaspers, and Lalljee, 1982). In this study, it is speculated to extend to groups of people who engage in marginalized forms of work like prostitution.

Assessment of functioning. A final component of counselor bias may be related to counselor's judgment of client's overall functioning. Much of psychological research on prostitution is associated with HIV/AIDS (e.g. Choudhury, 2010; Landers & Gruskin, 2010; Shannon & Csete, 2010, Samet, Pace, Cheng, & Coleman, et al 2010; Surratt & Inciardi, 2010). Counselors may be likely to perceive women in prostitution who are seeking professional mental health services as placing themselves at risk of acquiring a chronic medical condition. In addition, clinician's may be aware of the trauma associated with prostitution and may exhibit bias by judging women in prostitution as having a lower level of functioning.

Willingness to work with clients. An important therapist reaction to consider in this study is the therapist's willingness to work with women in prostitution. Counselors may be reluctant to work with women in prostitution for many reasons. Some of these reasons may be ethical. First, it is not uncommon for counselors to have had no specific training regarding sex and sexuality. Wiederman and Sansone (1999) found that close to 90% of doctoral programs in psychology surveyed did not offer a graduate-level course related to sex and sexuality. Second, relevant psychological literature in the area of counseling women in prostitution is sparse. Most studies focus on HIV/AIDS (Farley & Kelly, 2000). In addition to ethical obligations, clinicians may experience personal discomfort in addressing issues of sex and sexuality in psychotherapy.

Research has shown that counselors demonstrate greater negative emotional and cognitive responses when confronted with client's issues with sex and sexuality (Fisher Grenier, Watters, & Lamont et al, 1988). It is not uncommon for clinicians to experience anxiety, shame, and self-doubt. This may be related to the clinician's personal preferences, religious beliefs, prejudices and vulnerabilities regarding the clinician's own and the client's sexuality and the stigma associated with prostitution (Miller & Byers, 2008; Ridley, 2006). Therefore, counselors may feel ill-equipped or experience personal discomfort which results in the counselor feeling ethically obligated to transfer the client to a person with more experience.

Counselor perceptions of prostitution. There has been no research that documents how counselors view prostitution. When working with clients engaging in prostitution, counselors views of prostitution is likely to be impacted by the lack of scientific knowledge on prostitution but mostly, by polarized debates. As mentioned above, the debate is between the abolitionists' and the anti-abolitionists. On one extreme of the debate, sex work is considered to be empowering to women (e.g. Pheterson, 1989) and at the other extreme is the belief that it is an intrinsically harmful enterprise (e.g. Farley, 2003). The logical support and contention for both sides are equally compelling and proponents of each side of the debate are strategic in propagating their passionate agendas. Therefore, perceptions regarding prostitution are likely to be confusing in the face of such ambiguity, dissonance and controversy. Therefore, psychological health care providers are likely to harbour conscious and unconscious opinions of prostitution rooted in their value systems, religious backgrounds and access or lack thereof to particular viewpoints. In turn, counselors' opinions are likely to impact their biases, treatment effectiveness and engagement with their clients who are in prostitution. In essence, counselors who view prostitution as a form of sexual expression and empowerment are likely to view prostitution as another form of work where special considerations may not be necessary to take

into account. On the other hand, counselors who are likely to view prostitution as an intrinsically harmful enterprise may be more likely to anticipate the presence or threat of sexual violence in their client's lives and therefore may engage with the client with a specific focus on these needs.

Counselor beliefs about prostitution. Most attempts at documenting the attitudes that people have towards women in prostitution have been dominated by studies on the attitudes of either consumers or "johns" towards women in prostitution (e.g. Kennedy, Klein, Gorzalka & Yuille, 2004; Monto & Hotaling, 2001; Sawyer, Metz, Hinds & Brucker, 2001) or college students (e.g. Cotton, Farley & Baron, 2001; Evans-DeCicco & Cowan, 2001; RÃ¤sÃ¤nen & Wilska, 2007). There have been no attempts to document the beliefs that health care providers and in particular, counselors hold regarding women in prostitution.

Myths and inaccurate beliefs about prostitution are rampant in the field of prostitution. Some of these myths may be grounded in the prejudicial beliefs fostered within larger social, economic and legal systems that normalize violence against women (Cotton et al, 2002). In their study, Cotton and her colleagues (2002) found that rates of acceptance of rape myths were similar to rates of acceptance of prostitution myths in a college population. The authors theorized that this similarity was based on attributions of responsibility to the victim i.e. the women in the case of prostitution as well as in rape. A study by Miller and Schwartz (1995) prejudicial beliefs normalized and even endorsed rape-related violence in prostitution. In another study (Polk & Cowan, 1996, p. 224; as cited in Cotton et al, 2002), one-third of the participants believed that women in prostitution "love sex, enjoy their work, are proud of their work, have high self-esteem and like being on display."

The dearth of resources available to counselors on sexuality and prostitution creates conditions for the propagation of misinformation regarding prostitution. Therefore, it is possible that many counselors may have received implicit and explicit messages from society that would

make them vulnerable to acceptance of inaccurate beliefs or myths about women prostitution. In addition, if counselors endorse myths about prostitution and consequently hold inaccurate beliefs, they are likely to be less empathic, attribute greater responsibility to women for engaging in prostitution and believe that they would be less likely to solve their problems. In addition, they may be less likely to be willing to work with them and believe that they have lower levels of functioning.

Integrative summary

In sum, the literature on prostitution delineates several characteristics of prostitution. Prostitution is a heterogeneous and complex phenomenon. This implies that there are many forms of prostitution and the experiences of women in prostitution vary greatly depending on the kind of prostitution in which they are engaged. In the current global context, prostitution is a marginalized form of work which is associated with several human rights abuses. Researchers and policy-makers have differed greatly in terms of addressing these human rights violations i.e. either through legalization or abolition of prostitution. Irrespective of these disagreements, one fact remains clear. Women in prostitution are in need of mental health services whether it is a result of traumatic events prior to entering prostitution, through the work of prostitution or in attempting to leave prostitution. In particular, the high risk of violence prevalent in prostitution predisposes women engaging in prostitution to severe mental health concerns. In contrast, comparable mental health services and expertise in working with women in prostitution is negligible.

One of the barriers to accessing mental health services that women in prostitution are likely to experience is counselor bias. As is evident, prostitution evokes disparate reactions from people in general. Its illegal status in society and elusive, provocative nature is likely to influence the manner in which therapists work with women in prostitution who are seeking

mental health treatment. Counselor bias is an ubiquitous phenomenon in the therapy relationship. Clinicians' personalities and subjective experiences impact the manner in which they work with their clients. As a result, clinical bias is a common by-product of the inevitable subjective clinical judgment of the psychotherapist. Bias in the context of counseling women in prostitution first and foremost, arises out of lack of adequate training and experience in addressing the diverse needs of women in prostitution. Bias may also arise out of discomfort while working with victims of sexual trauma and distancing in working with individuals who engage in marginalized forms of work. Finally, bias may arise from dissonance experienced upon receiving contradictory information propagated through media, psychological research, religious institutions etc.

Studies on therapeutic reactions or counselor bias have frequently implemented experimental designs (e.g. Garner, Strohmer, Langford, & Boas, 1994; Meeks, 1990; Mohr, Weiner, Chopp, & Wong, 2009; Murdock, Edwards, & Murdock, 2010; Pfeiffer, Whelan, & Martin, 2000; Stewart, 2004). In a similar vein, the present study used an experimental design to provide illuminating insights into the nature of therapeutic reactions viz. counselor bias when counselors work with clients in prostitution. When counselors exhibit bias, it has been associated with disruptions to the therapeutic alliance. Crucial aspects of the therapeutic alliance are counselors' ability to access empathy, attributions of causality and responsibility, willingness to work with the client and judgments of the client's level of functioning. More specifically, counselors may have difficulty accessing empathy when working with a client in prostitution. In addition, counselors may be likely to attribute responsibility to the client for causing the problem or and also solving the problem that they experience. Counselors may determine the clients' level of functioning to be lesser than it is and may also be unwilling to work with the client. In addition, I believe that if counselor holds attitudes comprising of inaccurate beliefs about

prostitution and perceptions that prostitution is a form of sexual expression for women, they are likely to experience clinical bias.

CHAPTER 3

Participants

Preliminary Study. Seventy-two students participated in the development of the Counselor Perceptions of Prostitution Scale. Of these, sixty-seven also filled out the Attitudes towards Prostitution Scale (Sawyer et al, 2001). The sample comprised approximately 73% female and 27% male. In terms of racial background, approximately 52% of the participants were White and 48% were people of color. Approximately 59% of the sample comprised of counselors- in-training enrolled in the second year in the Masters program in Mental Health Counseling at Boston College, 30% were psychologists-in-training enrolled in doctoral programs in Counseling Psychology and Clinical Psychology residing in the greater Boston area. The remaining 11% did not identify the training program they were enrolled in. All the participants indicated that they were currently working in a clinical placement and of note, approximately 29% of the participants reported that they had currently or previously worked with clients who engaged in prostitution.

Participants were recruited from Masters and Doctoral programs. Some of the participants filled out the data in classrooms while others participated via email distribution of the scales through snowball sampling. I obtained permission from the Director of training of the masters program in mental health counseling at a private university in the northeastern region of the United States to contact the instructors of second-year practicum classes in counseling. I received permission from the instructors to recruit participants from their classes. In the classroom, I announced the study and volunteers were requested to complete the survey during the class break. I responded to questions both before and after the administration of the survey. The volunteers, who agreed to participate, read and signed the consent form and then completed the survey. In addition to this method of recruitment, I also obtained permission from the

Director of training of the Ph.D. program in Counseling Psychology at the same university to distribute the recruitment message via electronic means through the doctoral student listserv. In this message, I included both the recruitment email and the survey as attached documents. Participants who volunteered to participate in the study provided an electronic signature on the consent form and returned both the consent form and the completed survey form via email. All surveys were confidential.

Final Study. Two-hundred and thirty-four psychologists, psychotherapists, mental health counselors, and social workers were randomly recruited through a combination of advertising, listserv distribution and snowball sampling. They were recruited from major hospitals, community mental health centers and outpatient psychological service providers in the Greater Boston Area as well as organizations through the worldwide web, namely, Divisions 17 (Counseling Psychology), 29 (Division of Psychotherapy), 51 (Division of Psychological Study of Men & Masculinity), and 56 (Trauma Psychology) of American Psychological Association, American Counseling Association, and American Mental Health Counseling Association. I obtained permission from the administrators of listservs (please see Appendix C) of the abovementioned organizations to post the recruitment email (please see Appendix E) in the listserv which included the link to the study. I also obtained approval from the Institutional Review Board of a major hospital in the Boston area to recruit participants and permission from the administrators to forward the recruitment email to clinicians. Additional participants who are actively providing clinical services were recruited from listservs of doctoral training programs in clinical and counseling psychology. I contacted the directors of training of the different programs, requesting permission (please see Appendix D) to forward the recruitment email to the listserv of doctoral students. The participants were informed that

five $25 gift certificates to Starbucks Coffee would be randomly provided to five participants in this study.

Each participant was provided with informed consent forms to review (please see Appendix F) before the data were collected. The participants were not informed that the study was on prostitution or counselor bias as social desirability would impact the responses of the participants and confound the results of the study. Instead they were informed that the purpose of the study was to understand the manner in which counselor perceptions influenced their clinical work. Since electronic surveys were being used, special precautions were taken to ensure that the responses of the participants were not retraceable to their internet protocol (IP) addresses. This was done by purchasing a more secure version of the electronic service (survey monkey) and selecting a specific setting on the electronic service used to remove the IP address when participants responded. Finally, the responses of the participants were deleted after downloading the responses from the electronic service.

In order to obtain the optimal number of participants for this sampling pool, a power analysis was conducted. This involved a couple of steps because there are two different types of statistical analyses. The first analyses constituted Multivariate Analysis of Variance where there is a single independent variable and five dependent variables. First, I calculated an average of the effect sizes of similar studies (namely, Hayes & Erkis, 2000; Rosenthal, 2004; Spengler, Blustein & Strohmer, 1990) observed in the literature on counselor bias. I found the result to be a medium effect size based on Cohen's (1992) estimate meeting the criteria for .3. Based on this, I calculated the minimum number of participants required for each of the three cells which was 40. Therefore, the total number of participants required for this section for greater power in the statistical analyses was 120. For the purpose of the second hypothesis, the statistical analyses involved canonical regression analysis methodology. A separate power

analysis was conducted in order to obtain the total number of participants required. Using a similar estimate for effect size meeting the criteria for .3, I calculated the minimum number of participants required for the condition of prostitution to be 80 participants. Therefore, an additional 40 participants was added to those recruited for the prostitution condition in order to conduct statistical analyses with greater power. The minimum number of participants required for adequate statistical power in this study was computed to be 160.

Of the 234 participants, 198 completed the entire survey including the demographic questionnaire. One-hundred and fifty-seven participants were female and 41 were male. Participants ranged in age from 22 to 73 years with an average age of 32.81 years (SD = 10.32). The sample comprised of 160 White Americans, 10 Black American, 10 Latino/Latina American, 8 Asian/Pacific Islander, 1 Native American, 6 Multiracial and 2 participants who self-identified as "Other". In terms of the highest degree obtained, 36 had completed an undergraduate degree, 90 had completed a Masters degree in psychology or social work, 9 were licensed mental health counselors, 4 were licensed marriage and family therapists, 5 were licensed social workers, 38 had completed their doctorate in psychology, 2 were psychiatrists and 6 reported having a highest degree of "other" which in this study likely indicated a professional degree that was not listed among those enlisted above. Of the participants who indicated the number of years that they had been in clinical practice, the range was from 0 – 41 years with the average number of years that the participants had been in clinical practice being 4.73 (S.D. = 6.82) years. Nine participants had no experience in the clinical field, 90 participants had between 1 to 5 years of practice in the clinical field, and 19 had six or more years of practice. Approximately 40% of the sample did not indicate the number of years that they had been in clinical practice. Of those who responded to the previous experience of working with clients engaging in prostitution (78.7% of the respondent sample), 28.4%

indicated that they had previous experience working with people in prostitution while the rest indicated that they had not.

Instruments

The instruments used in this study were the *Demographic questionnaire*, *Interpersonal Reactivity Index* (Davis, 1983), *Cause and Solution Scales* (Karuza, Zevon, Gleason, Karuza, & Nash,1990), *Global Assessment of Functioning Scale* [American Psychological Association (APA), 1994], *Willingness To Work with the Client Scale* (Crawford Humfleet, Ribordy, Ho, & Vickers, 1991), *Client Rating Scales* (Hayes, 1984), *Counselor Perceptions of Prostitution Scale, Attitudes Towards Prostitution Scale* (*ATPS; Sawyer, Metz, Hinds & Brucker, 2001*), and three *clinical vignettes*. These are described in the following sections.

Demographic questionnaire. Ten specific items have been used to identify the participants' sex, age, racial background, nature of clinical site, highest degree obtained, area of specialization, years in practice, theoretical orientation, prior experience working with people in prostitution, and percent of practice devoted to clinical work.

Empathy. The construct of empathy was measured using Davis's (1983) Interpersonal Reactivity Index (IRI). The IRI (Davis, 1983) is a self-report measure that consists of 28 items, measuring cognitive and affective dispositional empathy. Items of this scale are scored along a 7-point continuum from 0 *(strongly feel that this is not true)* to 6 *(strongly feel that this is true).* Higher scores indicate greater empathy. The items were revised slightly, in conjunction with two members of the dissertation committee. The original items applied to the thoughts and feelings of the respondents in a general sense e.g. "Other people's misfortunes do not usually disturb me a great deal." The items were modified to apply specifically to the feelings and attitudes of the respondents toward the client in the vignette which in this study was Miss S e.g. "Ms. S's misfortunes do not disturb me a great deal."

Davis (1983) tested this scale for validity and found it to be a multidimensional measure of empathy that is comprised of four components, namely, perspective taking, fantasy, empathic concern, and personal distress (Badger, Royce & Craig, 2008; Hayes & Erkis, 2000). Cronbach's alpha coefficients ranged from .71-.77 on the subscales demonstrating adequate internal reliability. A review of subscale items by Burkard and Knox (2004) indicated that the Empathic Concern and Perspective-Taking subscales corresponded more directly with conceptual definitions of empathy (i.e., Bohart, Elliott, Greenberg, & Watson, 2002; Ridley & Lingle, 1996), while the Fantasy and Personal Distress subscales did not correspond with well-known conceptualizations of empathy (Constantine, 2001; Hayes & Erkis, 2000). Therefore, for the purposes of this study, the Empathic Concern and Perspective-Taking subscales were the only subscales used. The Empathic Concern subscale was modified to assess the respondent's ability to experience feelings of compassion, warmth, and concern for the client in the vignette (Miss S). A sample item would be "I would have tender, concerned feelings for Ms. S." The Perspective-Taking subscale was modified to asses the respondent's tendency to the client's (Miss S) perspectives and points of view (e.g. "I would find it difficult to see things from Ms. S's point of view").

Attributions of responsibility. The client's responsibility for the cause of and solution to her problems was measured by the Cause and Solution Scales developed by Karuza, et al (1990). These scales were derived from Brickman's *Theory of Responsibility Attributions* which accounted for both the beliefs about or attributions of the cause of the problem as well as its solution (Brickman, Rabinowitz, Karuza, Coates et al, 1982; Karuza, et al, 1990; Wall & Hayes, 2000). The scales were adapted by Hayes and Erkis (2002) to assess counselors' attribution of responsibility to the client in terms of the cause of the problem as well as the ability to solve the problem. The scales comprise of six items with the Cause Scale and the Solution Scale

comprising of three items each (Karuza et al, 1998). The items were rated from 1 *(not at all)* to 7 *(very much),* with higher scores reflecting greater responsibility attributed to the client for the cause of and solution to the problem. Similar to the modification by Hayes and Erkis (2002), the scales were modified in this study to apply specifically to the vignette of Miss S. The cause items reflected respondents' beliefs that the client "is personally responsible for the cause of her problems," "could have avoided the problems that she has," and "could have controlled the cause of her problems." Solution items assessed respondents' beliefs that the client "is personally responsible for creating a solution to her problems," "could overcome her problems alone," and "could control the solution to her problems."

Construct validity evidence has been provided by Hayes and Wall (1998), who demonstrated that clinicians rated clients diagnosed with posttraumatic stress disorder as significantly less responsible for the cause of and solution to a problem in comparison to clients diagnosed with bulimia (Burkard &.Knox, 2004). McCracken, Hayes, and Dell (1997) demonstrated concurrent validity evidence by showing that the Cause and Solution scales correlated positively in predicting directions with the Derived Cause and Derived Solution scales of the Helping Coping Orientation Measure (Michlitsch & Frankel, 1989). Reliability estimates are strong for the Cause Scale and moderate for the Solution Scale. For the Cause Scale, internal consistency has been found to range from .80 to .88 (Hayes & Wall, 1998; Karuza et al., 1990; McCracken, Hayes, & Dell, 1997), and 2-week test-retest reliability has been estimated at .86 (Bailey & Hayes, 1995). In their study, Hayes and Erkis (2002) found the internal consistency estimates for the Cause Scale to be .88. For the Solution Scale, internal consistency has been found to range from .63 to .79, and 2-week test-retest reliability has been estimated at .70 (Bailey & Hayes, 1995; Hayes & Wall, 1998; Karuza et al., 1990; McCracken et al., 1997).

Assessment of functioning. The Global Assessment of Functioning (GAF) Scale was used to measure therapists' judgments of the client's psychological, occupational, and social functioning (American Psychiatric Association, 2000). The GAF scale ranges from 1-100 with higher scores reflecting better functioning. Each respondent rated the client's (Miss S's) overall functioning on a 10- point rating scale in which 1 reflected the GAF range from 1-10 and 10 indicating the GAF range from 90-100. This presentation was chosen for the GAF Scale for ease of administration using the electronic system where respondents were able to select a number instead of leaving the item as an open-ended one.

The GAF scale is a modified version of the Health-Sickness Rating Scale developed by Luborsky (1962). The first adaptation of the Health-Sickness Rating Scale was implemented by Endicott and colleagues (1976) who labeled it the Global Assessment Scale (GAS). They reported interrater reliability coefficients for various populations to be between .61 and .91, with three out of the four studies reporting values of .76 or above. In support of the validity of the GAS, they also demonstrated moderate correlations between GAS scores and a variety of independent measures of psychopathology. A modified version of the GAS first appeared in Diagnostic and Statistical Manual of Mental Disorders III-Revised (DSM III-R) as the Global Assessment of Functioning Scale (APA, 2000). Since then, it has been the fifth component of multiaxial diagnoses of mental disorders and has been utilized to report the clinician's judgment of an individual's overall functioning. Reliability of the GAF Scale has been estimated to be in the .61–.91 range based on the findings of the GAS (American Psychiatric Association, 2000). Moos, Nichol, & Moos (2002) have established validity of the GAF scale through their findings that clinical diagnosis and symptoms are closely associated with the GAF than social or occupational functioning.

Willingness to work with the client. This two-item measure was used to assess therapists' willingness to work with the client depicted in the vignette. The items were revised slightly to apply specifically to the case of Miss S. The items were "How likely would you be to take Miss S on as a client?" and "How likely would you be to refer Miss S to another therapist?" Each item was rated from 1 *(very unlikely)* to 5 (very *likely).* The second item was reverse scored so that higher scores reflected greater willingness to work with the client. These items are adapted from the Professional Contact Questionnaire (PCQ) developed by Crawford et al. (1991). The PCQ is a six-item scale designed to assess the degree of comfort experienced by a mental health professional if he or she were to work with a client (in this study Miss S) in a clinical setting. The authors found that the items discriminated psychologists' reactions to clients with AIDS from their reactions to clients with leukemia. Each item is rated on a seven-point Likert-type scale with bipolar ratings (i.e, 1 = *very strongly disagree,* 7 = *very strongly agree).* Hayes and Erkis (2000) utilized this two-item measure and found that therapists were less willing to work with a client whose source of HIV infection was unknown than with a client who was infected through either blood transfusion or sex. These authors found the correlation between the two items to be .63.

Client rating scales. This additional rating scale comprising of eight 6-point Likert type items were utilized to supplement the other measures and bolster the findings of the study. These ratings related to liking for clients, empathy for the client, comfort with the client, willingness to see the client, client's adjustment, and client's prognosis. The psychometric data that exists on these scales is limited. It is speculated that this may be primarily due to their face validity and simplicity. Nonetheless, studies of clinical judgment bias have used similar Likert type items (Wisch & Mahalik, 1999). These items were originally used by Hayes (1984) where he found counselors-in-training who were high in gender role conflict to be less comfortable

with, feel less empathy for, express less liking for, be less willing to see, and attribute greater maladjustment to a nontraditional male client than low gender role conflict counselors-in-training. Wisch (1997) reported the Global Assessment of Functioning scale (GAF; American Psychiatric Association, 1994) to be significantly related to the adjustment item *(r* = .28, $p <$ .001) and the prognosis item *(r* = .29, $p < .001$). Wisch & Mahalik (1999) found clinicians' ratings of clients using the liking item, empathy item, comfort item, and willingness to see item to be positively significantly related to each other. These results supported the validity of these Likert-type items. In addition, these researchers provided additional psychometric evidence for Client Ratings Scales. In their sample, 20 experienced clinicians completed evaluations of a randomly selected vignette of a client using the eight items two times, two weeks apart. Test-retest reliability for the items ranged from .59 to .81, indicating moderate to high reliability. In this study, clinicians' ratings of clients using the empathy item (item 2) were positively correlated with the Interpersonal Reactivity Index (Davis, 1983; $r = .382$; $p < .01$). The willingness to work item (item 4) was positively correlated with the Willingness to Work Scale (Crawford et al, 1991; $r = .711$; $p < .01$). On the contrary, the assessment of functioning item (item 5) did not have a significant relationship with the GAF scale (APA, 1994).

Counselor Perceptions of Prostitution Scale. Twenty items were constructed to form the content of a scale designed to assess counselors' perception of prostitution. This instrument has been developed in this study to measure participants' views based on the debate related to the question of whether prostitution should be viewed as an expression of sexuality and interests or as a form of social oppression and therefore an intrinsically harmful enterprise. The items constructed for this measure were designed to reflect both sides of the debate about the meaning and implications of prostitution obtained directly from the literature on people's attitudes about prostitution and/or commercial sex work. More specifically, the items were developed by

consulting literature that on one hand, supports the view that sex work is an intrinsically harmful experience (Blustein, 2006; Farley, 2003; Parsons, 2005), and on the other, argues that sex work can be an expression of women's sexuality and therefore, empowering (Pheterson, 1989). The item responses were designed in terms of a 5-point Likert-type scale ranging from strongly disagree to strongly agree and includes reverse-scored items. Higher scores on the scale reflect the respondent's view of prostitution as inherently traumatic and a form of social oppression while lower scores reflect the respondent's view of prostitution as a self-determined career choice.

The items initially were administered to approximately 72 participants who were counselors-in-training with the intention of establishing the reliability and validity of the scale. Details of scale development norms are presented in Chapter 4. Each respondent's item rating choices was scored and the item scores summed to constitute the respondent's total score. The items with the greatest ability to discriminate between highest and lowest scorers on the total score were selected to constitute the scale (Dawis, 1987). The internal consistency reliability of this scale was based on the inter-item consistency estimate obtained from the Cronbach's alpha which in this study was .87 (Cohen & Swerdlik, 2002a).

Beliefs about prostitution. Beliefs about prostitution were measured using the adapted version of *Attitudes Towards Prostitution Scale* developed by Sawyer, Metz, Lewis and Brucker (2001) referenced in Cotton, Farley and Baron (2002) as the Prostitution Behavior Questionnaire (PBQ-A) from the unpublished manuscript of Sawyer et al (2001). The original questionnaire developed by Sawyer and colleagues (2001) was designed to assess the test takers past behaviors with prostitutes, legal history and attitudes and values related to prostitution. Principle component factor analysis investigating construct validity revealed four subscales which are *Inaccurate Beliefs about Prostitutes, Social/Legal Support of Prostitution, Personal Acceptance*

of the Prostitute, Negative Beliefs about Prostitution. Cronbach's *alpha* coefficient analyses testing for internal consistency reliability revealed an overall alpha reliability of the instrument to be .75. In addition, Cronbach's *alpha* for the subscale "*Inaccurate Beliefs about Prostitutes*," was $a = .71$.

In their study, Cotton et al. (2002) implemented an adapted version of this scale to explore the test taker's attitudes about prostitution and prostituted women and measure the extent to which they endorsed myths regarding prostitution. Four of the six items used were items from the Inaccurate Beliefs about Prostitution subscale and these were "Most prostitutes make a lot of money", "Women are prostitutes because they want to be; it's their choice", "Prostitutes enjoy their work"; "Prostitutes genuinely like men". The other two items used were "There is nothing wrong with prostitution" from the Social/Legal Support of Prostitution subscale, and "Prostitutes are victims of pimps" from the Negative Beliefs about Prostitution subscale. Each participant responded to the statement on a 4-point likert type scale. Agreement with each statement indicated endorsement of a myth related to prostitution with the exception of the statement "Prostitutes are victims of pimps", in which case, disagreement indicated prostitution myth endorsement. Cotton et al (2002) found a significant positive correlation (r=.27, p <.0001) between this scale (referenced as *PBQ-A*) comprising of the abovementioned items from *ATPS* (Sawyer et al, 2001) with the Illinois Rape Myth Acceptance Scale (Payne, 1993) which provided support for construct validity of this particular scale. The adapted version of the scale used by Cotton et al (2002) was used in this study as an indicator of inaccurate beliefs about prostitution held by counselors.

Procedure

Preliminary Study. A pilot study was conducted to develop the measure *Counselor Perceptions of Prostitution Scale.* The items of the scale have been constructed on the basis of

literature informing the debate on whether prostitution should be viewed as an expression of sexuality or interests as opposed to a form of social oppression and intrinsically harmful enterprise. The item responses are designed in terms of a 5-point Likert-type scale ranging from strongly disagree to strongly agree and include reverse-scored items. The items were administered to 72 participants. Each respondent's item rating choices was scored and the item scores summed to constitute the respondent's total score.

Clinical Vignettes. Three written clinical vignettes (see Appendix A) were designed for this study, and used to manipulate the vocation of the client (i.e., prostitution, selling drugs and work as a department store clerk). Each vignette described a female client who is seeking services from the participant in the study. The vignettes were approximately three quarters of a single spaced page in length, and took about 5 minutes to read. Each vignette was divided into two sections. The first consisted of basic identifying data, a description of the client's appearance, a brief description of her affect in the session and her presenting concerns. The second section provided a narrative of the client's social, academic, and vocational history and includes her current employment. Each vignette was designed to reflect a constellation of depressive symptoms, but left the overall severity of psychopathology somewhat ambiguous. The details of the vignettes were similar across conditions with the exception of the variables of interest (i.e. vocation). In the prostitution condition, the client was described as working in prostitution as a side job whereas in the control conditions, the client is selling marijuana or as a working overtime in the department store.

The vignettes were administered to 27 students to establish internal consistency and to ensure that they differ in the basic dimensions for the purpose of the study. These students were recruited from the doctoral programs in Clinical or Counseling Psychology at colleges in the greater Boston area through snowball sampling. Each student participant read the vignette

and responded to three likert-type items ranging from 1-9 as well as an open-ended item. The three likert-type items were "To what extent is a client seeking treatment for depression (Ms. S) adequately represented in the vignettes?", "To what extent is each vignette similar to the others?" "To what extent is each vignette different to the other in terms of what the client does for extra money (i.e. she engages in prostitution, she sells drugs or she works overtime)?" A lower score on the response indicated that the vignette is not internally consistent and/or adequately representative of the dimensions being measured. A higher score demonstrated the reverse. The open ended item will comprise of a question "To what extent did you think that the vignettes were adequately representative of the variable being measured. Please elaborate" The information obtained from the responses of the participants was analyzed to determine whether the three clinical vignettes differ across the three conditions along the desired dimensions and presented in Chapter 4.

Final study. Data were collected by electronic means using the survey website www.surveymonkey.com. The surveys were advertised through listservs. Due to the limitations of the website in the ability to randomly counterbalance the measures as planned, six separate links for the surveys were created on the website for random distribution to listservs. There were two surveys for each condition (namely prostitution, marijuana, and overtime). The second version of each survey comprised of a different order of questionnaires in an effort to counterbalance the effect of the measures. Two-hundred and thirty-four participants were randomly assigned to the three groups namely one experimental group, and two control groups and steps were taken to ensure that there were greater number of participants in the prostitution condition. Forty additional participants were assigned to the experimental group i.e. the prostitution condition for the purpose of statistical analyses with regard to the second hypothesis. Each participant read the vignette assigned to them and then

responded to the questionnaires in the order of the following namely, 1) *Interpersonal Reactivity Index* (Davis,1983), 2) *Cause and Solution Scales* (Karuza, et al,1990), 3) *GAF Scale* (APA, 1994), 4) *Willingness To Work with the Client Scale* (Crawford et al.,1991), 5) Client *Rating Scales* (Hayes, 1984), 6) *Counselor Perceptions of Prostitution Scale* (CPPS), 7) *Attitudes Towards Prostitution Scale* (ATPS; Sawyer, et al, 2001) and 8) *Demographic Questionnaire*. The order of administration of the *IRI* (Davis, 1983), *Cause and Solution Scales* (Karuza, et al,1990), *GAF Scale* (APA, 1994), *Willingness To Work with the Client Scale* (Crawford et al.,1991) and the *Client Rating Scales* (Hayes, 1984) were altered in the second set of survey links in order to counterbalance the effect of these measures. Similarly, the order of the *CPPS* and the *ATPS* (Sawyer, et al, 2001) were alternated to counterbalance the effect of these two measures.

In order to ensure random distribution of participants to each of the three groups, the survey links were sent to each listserv in the order in which the links were created (e.g. link 1, link 2 … link 6) and continuing in that order until the data required for each of the groups were adequately collected. Once the minimal number of participants (based on the power analysis described earlier) was obtained for each of the groups, the two links for the prostitution vignette were alternated in their distribution to listservs until adequate number of participants for that condition was obtained (as determined by the power analysis). There was little control over the number of participants that each listserv yielded. This resulted in an uneven number of participants in each group.

CHAPTER 4

The results of this study are presented in four sections. First, the descriptive statistics including the means and standard deviations of all independent and dependent variables are presented. Preliminary analyses conducted to check for the assumptions of the statistical analyses to follow are also presented in this section. Second, the results of the manipulation check of stimulus materials are presented. Third, the results of the preliminary data analysis comprising of the scale construction of the Counselor Perceptions of Prostitution Scale are then presented. In the fourth section, the results of the main analyses of the hypotheses are reviewed; the fourth is then divided into two parts. The first part of this section comprises the multivariate analyses of variance (MANOVAs), which are used to test the first hypothesis of this study along with the results of the post hoc univariate analyses of variance for each of the combinations of the independent variable and dependent variables stated in the hypothesis. The second part of this section comprises the statistical analyses of the second hypotheses using canonical correlational analysis methodology for multiple dependent variables and two independent variables.

Descriptive Statistics and Preliminary Analyses

Means, standard deviations, ranges, minimum and maximums for the dependent variables for each of the three conditions are presented in Table 1. Table 2 represents the data for internal consistency reliability for each of the scales used in this study.

Overall, adherence to random assignment of participants was maintained while distributing the survey links. A preliminary analysis was conducted to assess the effectiveness of randomization i.e. to check if the demographic make-up was similar across the three groups. The results revealed that the groups were relatively similar in terms of sex, race, age, highest degree obtained, years of clinical practice, percentage of practice devoted to clinical work and

experience working with clients in prostitution. The comparisons of these demographic variables between the three groups are presented in Table 29.

Initial analyses were conducted to ensure that the data met the preconditions necessary for conducting MANOVA in testing Hypothesis I. The assumptions for MANOVA are multivariate normal distribution, homogeneity of variance for each dependent variable and variance-covariance matrix, linear relationships among all dependent variables, and absence of multicollinearity among the dependent variables. Examination of the distributions of scores on all the independent and dependent variables revealed that the participant scores on the Willingness to Work Scale revealed moderate negative skewness and moderate negative kurtosis and the participant scores on the GAF Scale exhibited moderate negative kurtosis. The data from these two variables were transformed in order to meet the assumption of normality by taking the square root (k-1) for the scores of the WTW scale and the GAF scale. These transformations resulted in normal distribution of the participant scores on both these scales and were negatively correlated with the original variables prior to transformation. The transformed variables were used in the final analysis. The distributions of all the other dependent variables were found to be roughly normal.

Stevens (2002) asserts that independence of observations is a major assumption in the case of MANOVA, the violation of which is very serious. Independence of observations is also referred to as the absence of multicollinearity. In order to check that the necessary preconditions for this assumption are met, correlational analyses between the means of the dependent variables that comprised counselor bias were conducted. The results of these correlations between each of the dependent variables are presented in Table 3. It is of note that the variable of empathy had significant correlations with both the attribution of cause of the problem variable ($r = 28$; $p < .01$) and the willingness to work variable ($r = .2$ $p < .01$). However, the effect sizes of both these

correlations were low and therefore did not pose a major problem. In fact, correlations between variables that comprise a single construct (in this study, counselor bias) are common and expected to be present in social sciences literature (Stevens, 2002). As an extra precautionary measure, each of these variables was omitted and the MANOVA analysis was conducted. The results were found to be similar to the results obtained when all the variables were used in the analysis. Therefore, these variables are retained in this presentation and are cited in Chapter 5 as a minor limitation of this study. In sum, the assumptions of MANOVA were assessed and found to be optimal for conducting the analysis.

The means and standard deviations obtained in this study from the scales used are compared with those obtained from other studies using the same scales to assess if they are similar. These are presented in Tables 4, 5 and 6. First, the results of the IRI in this study are compared to those of other studies. The reader will note that the means of the subscales of empathic concern and perspective-taking are presented separately from these available studies in Table 4. While Davis (1983, 1994) assessed the different dimensions of empathy separately (i.e. by providing a separate score for each subscale), a global empathy index has been used more frequently in recent studies (e.g., Burkard & Knox, 2004; Burke, 2001; Moriarty, Stough, Tidmarsh, Eger, & Dennison., 2001; Webster, 2002). Based on the latter, I used a single index combining the scores from two of the four dimensions of the IRI (Perspective-Taking and Empathic Concern; Davis, 1983) which I considered most relevant. However, global empathy indices reported from studies using all four scales would not provide accurate comparisons. Therefore, the separate scores for subscales are presented as comparisons for the subscales used in this study. Upon review of the comparisons of IRI scores (Davis, 1983) in this study and other studies, empathy was found to be considerably higher in the present study than in other studies. (Please see Table 4). For this study, the mean for Perspective-Taking was 26.36 as compared to

other studies which were 18.23 (Beitel, Ferrer, & Cecero, 2005), 20.2 (Cusi, MacQueen, & McKinnon, 2010), 17.5 (Spinella, 2005), and 17.97 (Rangganadhan & Todorov, 2010). The mean for Empathic Concern for this study was 28.32 as compared to other studies which were 20.98 (Beitel et al, 2005), 22.2 (Cusi et al, 2010), 20.9 (Spinella, 2005), and 21.33 (Rangganadhan & Todorov, 2010). This may be attributable to the sample which is comprised of mental health service providers. In addition, the original items of the IRI were altered to capture the participants' endorsement of empathy items to Ms. S, the client in the vignette. (Please see Chapter 3 for a more detailed description.) Meanwhile, in the other studies cited, the original items assessed empathy as a trait characteristic of the respondent.

The means and standard deviations of the Cause and Solution Scales (Karuza et al, 1990) in this study are compared to that of four other studies and presented in Table 5. Similarly, the means and standard deviations of the GAF Scale (APA, 2000) in this study are compared to that of four other studies and presented in Table 6. Finally, the means and standard deviations of the Willingness to Work Scale were not available for comparison and therefore are not presented in this chapter. The data presented in these tables demonstrate that the means and standard deviations obtained from the Cause and Solution Scales (Karuza et al, 1990) and the GAF Scale (APA, 2000) are comparable to those of other studies.

Manipulation Check

A manipulation check was conducted for the purpose of examining the question of whether mental health professionals would be able to discern the similarities and differences among the three clinical vignettes used in this study. The rating forms were filled out by twenty-seven students in clinical and counseling psychology. The rating forms were comprised of three questions which are 1) "To what extent is a client seeking treatment for depression (Ms. S) adequately represented in the vignettes?", 2) "To what extent is each vignette similar to the

others?", and 3) "To what extent is each vignette different to the other in terms of what the client does for extra money (i.e. she engages in prostitution, she sells drugs or she works overtime)?". Each of these items was rated on a 1-9 Likert-type scale, with higher scores indicating that the client seeking treatment for depression is adequately represented for the first item, that each vignette is similar to others for the second item and that each vignette differed in terms of what the client did for extra money for the third item. The open-ended item stated "In my study, I am manipulating the independent variable of prostitution. To what extent did you think that the vignettes were adequately representative of the variable (i.e. prostitution vs. no prostitution) being measured? Please comment and/or elaborate". In order to demonstrate that the raters perceived the client's choice of extra work (i.e. prostitution, selling drugs and working overtime) as intended, rating forms and the open-ended question were analyzed for content. A simple examination of means for the ratings was conducted for the first three items. These data, which are presented in Table 7, indicate that depression was adequately represented in the vignettes (M = 8.11; S.D. = 1.013), each vignette was similar to the other (M = 7.41; S.D. = 1.693), and that they differed in terms of the conditions (M = 7.67; S.D. = 1.84). The responses to the open-ended items further supported that the vignettes adequately represented the variables being measured. Examples of responses were "*It clearly seems to make the distinction*", "*Since all other lines were maintained the same, I think this does do a nice job of manipulating the variable*", and "*Yes, I can see you are manipulating that variable of prostitution in the presenting client. You are using the exact same facts and symptoms in the vignette, and only changing your [independent variable](keeping everything else equal).*"

Psychometric Properties of the CPPS

As summarized in chapter 3, this attitude scale was constructed with the purpose of assessing the degree and extent to which counselors view prostitution as being intrinsically

motivated and an expression of self-determined career decision-making as opposed to a form of social oppression and intrinsically harmful enterprise. The items constructed for this measure were designed to reflect both sides of the debate about the meaning and implications of prostitution obtained directly from the literature on people's attitudes about prostitution and/or commercial sex work.

More specifically, twenty items were developed by consulting literature in psychology and other social sciences. The review shed light on a passionate debate that exists between the view that sex work is an intrinsically harmful experience (Blustein, 2006; Farley, 2003; Parsons, 2005), and the view that sex work can be an expression of women's sexuality and self-determination and therefore empowering to people who engage in it (e.g., Pheterson, 1989). The item responses are designed in terms of a 5-point Likert-type scale ranging from strongly disagree to strongly agree and including nine reverse-scored items.

In the preliminary study, the scale was administered to 72 participants who were counselors-in-training with the intention of establishing the reliability and validity of the scale. Each respondent's item rating choices was scored and the item scores summed to constitute the respondent's total score, with higher scores reflecting the perception of prostitution being a form of social oppression and an intrinsically harmful enterprise. The internal consistency reliability of this scale is based on the inter-item consistency estimate obtained from the Cronbach's alpha (Cohen & Swerdlik, 2002a). The Cronbach's alpha coefficient of all twenty items was .85, which suggested moderate-high reliability for the scale. The corrected item-to-total scale correlation for item 12 on the scale which stated that "The term 'prostitution' represents a level of denigration that is not consistent with contemporary work in the commercial sex industry" was -.32 indicating a low and negative correlation with the scale. Therefore, this item was discarded from the scale and the Cronbach alpha coefficient increased to .87. The corrected

item-to-total scale correlations ranged from .25 to .66 (M = .69, SD = .11). In the final study, the revised 19-item scale was administered to 204 participants and yielded an internal consistency reliability of .89 (M = 68.9, SD = 10.58). The corrected item-total correlation ranged from .28 to .66.

In order to establish some initial support for the concurrent validity for the CPPS scale, the total scores were correlated with the total scores obtained on the ATPS (Sawyer et al, 2001). (A more detailed description of the ATPS is available in chapter 3.) In the preliminary study, correlational analysis of the two scales revealed that the CPPS scale was found to have a significant negative correlation (r = -.68) with the score obtained on the ATPS. The negative correlation, as reflected in Table 8, is consistent with theoretical expectations in that high scores on the ATPS reflect more inaccurate beliefs about prostitution and greater endorsement of myths about prostitution and high scores on the CPPS reflect counselors' attitudes towards prostitution as inherently traumatizing and a form of social oppression. In the final study, a similar correlational analysis was conducted and the results were similar in that there was a significant negative correlation between the two scales (r = .66; $p<.01$), as indicated in Table 9.

Finally, exploratory factor analysis methodology was employed to determine whether the items in the scale clustered together to reveal different factors or subscales within the scale. The items of this scale had been designed to reflect a single construct, attitudes towards prostitution. Theoretically, the items were expected to be related to this construct but additional analysis was conducted to check if any of the items organized into clusters. For this purpose, a principal components analysis was conducted. Principal components analysis is a data reduction method commonly used to calculate components by using the variance of the manifest variables (Ford, MacCallum, & Tait, 1986). This is done by transforming the original variables in a new set of linear combinations also known as principal components (Stevens, 2002).

As indicated in Table 10, the Kaiser-Meyer-Olkin measure of sampling adequacy (KMO) was conducted and Bartlett's test of sphericity displayed satisfactory results. The KMO value of .78 is above the minimum of .7 which indicated that the data is likely to factor well. Bartlett's test rejects the null hypothesis ($X^2 = 559.47$; $p < .001$) that the correlation matrix is an identity matrix without too many correlations between the items. Taken together, the results of these tests provided evidence that a principal components analysis (PCA) can be conducted.

The results of the PCA, presented in Table 11, demonstrated that there are five eigenvalues above 1 which according to the Kaiser criterion are the only factors to be retained (Stevens, 2002). Eigenvalues are the variances of the principal components obtained from PCA. In addition, the scree test was conducted. The scree test involves examining the graph of the eigenvalues to check any natural bend or break point in the data (Costello & Osborne, 2005). The scree plot presented in Graph 1 also supports using five factors because the break point occurs in the sixth eigenvalue i.e. the eigenvalues level off from the sixth eigenvalue onwards. The component matrix presented in Table 12 enlists these five factors with their variances.

In order to interpret the five factors, Oblimin rotation with Kaiser Normalizations was used for this study. While Varimax rotation is the most common choice for rotations, oblique methods (unlike orthogonal rotations such as Varimax) allow the factors to be correlated and renders more accurate and perhaps, more reproducible solutions in social science research where correlation among factors is a common occurrence (Costello & Osborne, 2005). The sorted, rotated loadings of the pattern matrix (Table 13) are used to interpret the data. Because an oblique rotation was conducted, the pattern matrix was examined for item loadings, presented in Table 13, and the factor correlation matrix presented in Table 14 were examined for correlations between the factors (Costello & Osborne, 2005). Stevens (2002) recommended that components with four or more loadings above .60 in absolute value are reliable regardless of sample size. As

seen in Table 13, the pattern matrix demonstrated that none of the factors had four or more loadings above .60. This indicated that none of the factors are reliable and therefore cannot be used for interpretation (Stevens, 2002).

A similar analysis was conducted on the data collected for the final study. The results of the PCA, presented in Table 15, indicated that according to the Kaiser criterion, only four factors could be retained because there are four eigenvalues above the value of one (Stevens, 2002). Again, the sorted, rotated loadings of the pattern matrix (Table 16) are used to interpret the data and the factor correlation matrix presented in Table 17 was examined for correlations between the factors (Costello & Osborne, 2005). An examination of the items in the pattern matrix (Table 16) demonstrated maximum loading on the first factor, meeting the criteria for four loadings on items above .60. None of the other factors met this criterion which indicated that there was only one reliable interpretable factor. Although the results were approximately the same, the minimal difference between results of the preliminary study (n = 72) and the final study (n = 204) may be attributed to a larger sample size in the final study (Stevens, 2002).

Main Analyses

Hypothesis 1. The first hypothesis to be tested in this study states that '*counselors will exhibit greater clinical bias when exposed to a client vignette in which prostitution is used as a means of supplementing income (as opposed to selling drugs or working overtime at a department store).*' Clinical bias in this study is defined by less empathy for the client, greater attribution of personal responsibility to the client for the cause of and the solution to the problems, lower assessment of client's level of functioning, and less willingness to work with the client. In order to examine this hypothesis, a multivariate analysis of variance (MANOVA) was conducted.

In this hypothesis, the single categorical predictor variable is represented by the condition of prostitution viz. varied in the three groups to which the vignettes are administered. There are four continuous criteria variables including empathy, attribution of responsibility for the cause of the problem, attribution of responsibility for the solution to the problem, level of functioning and willingness to work with the client represented by the scores obtained on the *Interpersonal Reactivity Index* (Davis, 1983), *Cause and Solution Scales* (Karuza, et al,1990), *GAF Scale* (APA, 1994), and *Willingness To Work with the Client Scale* (Crawford et al.,1991), respectively which together comprise of the dependent variable of the study which is counselor bias. Hence, to evaluate the hypothesis described above, a single MANOVA was conducted to compare the means of the scores of each of the three different groups (comprising of the prostitution condition, the marijuana condition, and the benign job condition) obtained by the participants on the IRI (Davis, 1983), CSS (Karuza et al, 1990), GAF Scale (APA, 1994), and WTWCS (Crawford et al, 1991). The alpha level determined for the purpose of testing this hypothesis is set at .05 for the overall model.

The results for the overall MANOVA conducted are presented in Table 18. The results revealed a significant effect, $F = 3.52$, $p < .01$, yielding a Pillai's trace value of .16, which is significant at the .0002 level. Since Pillai's trace is considered the most robust of the tests (Haase & Ellis, 1987), it is used in this study. In addition, the Partial Eta-squared value is .08, which indicates that approximately 8 percent of the variance in the dependent variable of counselor bias is explained by the independent variable of different conditions.

To follow up on this finding, a series of individual analyses of variance (ANOVA) were conducted on each of the dependent variables that form the synthetic variable known as counselor bias. In order to control for Type I error inflation, the alpha level was set to be more conservative at .025 for this anticipated posthoc pairwise comparisons using ANOVA. As

mentioned previously, these are the variables of empathy, cause, solution, assessment of client functioning and willingness to work as measured by their corresponding instruments. The results, which are found in Table 19, demonstrate that this significant effect of the different conditions on counselor bias was attributable to the variable of empathy ($F = 12.49$, $p < .01$). As demonstrated by the partial Eta squared value, the variable of empathy contributes to .11 or 11% of the variance, as evident in Table 20. Post-hoc evaluations of the pair wise differences (Table 21) demonstrated that the significant differences between the groups were between 1) Group 1 or the Prostitution Condition ($M = 56.48$) and Group 2 or the Marijuana Condition ($M = 52.03$; Mean Difference = 4.456, $p < .01$) and 2) Group 2 or the Marijuana Condition ($M = 52.027$) and Group 3 the Overtime Condition ($M = 55.74$; Mean Difference = - 3.713, $p < .01$). It is important to note that while there was a minor difference in empathy with counselors demonstrating greater empathy for the clients in the prostitution condition ($M = 56.48$) than in the Overtime Condition ($M = 55.74$), there was no significant difference in empathy between them (Mean difference = .74, $p = 1.00$). The individual means of each group are listed in Table 22.

Similar analyses were conducted for the supplementary Client Rating Scales (Hayes, 1984). While the results of the overall MANOVA model (Table 23) were not significant, empathy, again, was the only item which demonstrated significant difference between the groups ($F = 3.346$; $p = .037$). Post-hoc evaluations of the pair wise differences (Table 24) demonstrated empathy was significantly higher for the Prostitution Condition than for the Marijuana Condition and for the Overtime Condition than the Marijuana Condition. There was no statistically significant difference between the Prostitution and Overtime Conditions.

Hypothesis 2. The second hypothesis states that '*in responding to the client vignette where prostitution is used as a means of supplementing income, counselors who are less likely to*

endorse beliefs about prostitution as a form of oppression and tend to endorse more inaccurate beliefs about prostitution, will be more likely to demonstrate bias. Bias is defined as less empathy for the client, greater personal responsibility attributed to the client for the cause and solution to the client's problems, a lower assessment of client's level of functioning, and less willingness to work with the client'. To study the relationship between the set of predictor variables namely counselor perceptions of prostitution and accurate beliefs about prostitution and the set of criterion variables which are empathy, attribution of personal responsibility for the cause and solution to the problems, assessment of functioning and willingness to work, canonical correlation analyses were conducted with the predictors on one side of the model and the criterion variables on the other side. It is important to note that all the variables, both predictor and criterion, were continuous variables.

Canonical correlation provides a mathematical maximization procedure which partitions the total between associations through the use of uncorrelated pairs of linear combinations (Stevens, 2002). The first few pairs of linear combination, known as canonical variates, generally account for the between association. The correlations between the original variables and the canonical variates are used again to name the canonical variates (Stevens, 2002). In this study, the first pair of canonical variates tells us what profile of counselor attitudes and beliefs is maximally associated with a given profile of bias.

The canonical correlation analysis was conducted using the two variables of attitudes towards prostitution and beliefs about prostitution as predictors of the five bias variables to evaluate the multivariate shared relationship between the two variable sets (i.e., attitudes towards prostitution and counselor bias). To assess the overall significance of the analysis, I used the Pillai–Bartlett trace criterion (*V*), which reflects the proportion of the relevant variance in the dependent variables that is explained by the relevant variance in the predictor variables. It is

computed as the sum of the squared canonical correlations (Cohen & Cohen, 1983).The results of the full canonical model, as evident in Table 25, revealed a significant relationship between the two sets of variables with the Pillai's trace value being .35 (F (10, 160.00) = 3.36, p = .001.). The multivariate effect size of the overall model was .174.

The results of the analysis, presented in Table 26, yielded two functions or roots with squared canonical correlations (R^2_c) of .226 for the first function, and .122 for the successive function. Each of the roots obtained yielded specific canonical weights and structure coefficients which provide a means of interpreting the nature of the relationships between the variables (Pedhazur, 1982). The structure coefficients are interpreted in a similar fashion as factor loadings. Structure coefficients (r_s) are the bivariate correlation (Pearson r) between the observed variable (e.g. the predictor counselor perceptions or counselor beliefs) and the synthetic variable that is created as part of the canonical correlation analysis (e.g. counselor attitudes created from all the predictor variables via the linear equation; Stevens, 2002). They inform interpretation by helping to define the structure of the synthetic variable, that is, what observed variables can be useful in creating the synthetic variable and therefore may be useful in the model (Stevens, 2002). They provide information about which of the specific observed variables are useful in creating the synthetic variable and therefore likely to be useful in the full model (Sherry & Henson, 2005). More specifically, in this study, the structure coefficients provide information on the particular variables among the predictor counselor attitudes that are maximally associated with the particular criterion variables that comprise counselor bias.

Collectively, as evident in Table 27, the full model across both roots was statistically significant using the Wilks' $\lambda = .680$, criterion, $F(10, 158.00) = 3.357$, $p < .001$. Because Wilks' λ represents the variance unexplained by the model, $1 - \lambda$ yields the full model effect size in an r^2 metric. Thus, for the set of two canonical roots, the r^2 type effect size was .32, which indicates

that the full model explained about 32%, of the variance shared between the variable sets (Sherry & Henson, 2005).

The dimension reduction analysis enables the researcher to test the hierarchal arrangement of roots for statistical significance (Sherry & Henson, 2005). As noted in Table 27, the full model (Roots 1 to 2) was statistically significant. Root 2 was also statistically significant, F (4, 80) = 2.77, p = .033. The standardized canonical function coefficients and structure coefficients for the first function or root are presented in Table 28. The squared structure coefficients are also presented in the function for each variable.

Given the effects for each of the two roots, the first root was noteworthy in the context of this study (22.6% of shared variance). The second root explained 12.2% of the remaining variance in the variable sets after the extraction of the prior root. Both roots account for a meaningful amount of variability. Given the R^2_c effects for each root, both were considered interpretable in the context of this study and are discussed below. However, some discrepancies in the context of the second root are considered during its interpretation.

Table 28 presents the standardized canonical function coefficients and structure coefficients for Roots 1 and 2. In the first root, the relevant criteria variables were empathy and attribution for responsibility for the solution to the problem. This conclusion was supported by the squared structure coefficients. These variables of counselor bias also tended to have the larger canonical function coefficients. This canonical root was characterized by a moderately high positive loading of Empathy (r = .66) and a moderately high negative loading of the Solution Variable (r = -.68). Furthermore, these variables' structure coefficients of Empathy and Attribution of Personal Responsibility for the Solution to the Problem had inverse signs, indicating that they were inversely related. In terms of the predictor variables, both counselor perceptions and counselor beliefs were primary contributors to the predictor synthetic variable.

These were characterized by a heavy positive loading of counselor perceptions of prostitution (*r* = .870) and a heavy negative loading of inaccurate beliefs about prostitution (*r* = -.958). These loadings indicate that counselor perceptions of prostitution and inaccurate beliefs of prostitution are strongly associated with Empathy and Attribution of Personal Responsibility for solution to the client's problem. It is important to note that these two predictor variables have a significant negative correlation as mentioned before. These results were generally supportive of the theoretically expected relationships between counselor attitudes and bias (for rationale, see Chapter 5).

Moving to Root 2, the coefficients in Table 28 suggest that the criterion variables of relevance were Empathy (*r* = -.58) and Assessment of Functioning (*r* = -.64). The root had a moderate negative loading of Empathy and a moderate negative loading of Assessment of Functioning on one side. In addition, these bias variables had similar directional signs and therefore were positively related on this root. This implies that the more empathy the counselors have, the higher the counselors assessed the level of functioning of the client. As for the attitude towards prostitution predictor variables, Counselor Perceptions of Prostitution (r = .49) was the only dominant predictor with a moderate positive loading. Looking at the structure coefficients for the entire function, it is evident that Counselor Perceptions was negatively related to Empathy and Assessment of Functioning. This is contrary to the prediction described above and is opposite to the first root obtained. It indicates that counselors who perceived prostitution as inherently traumatizing and a form of social oppression demonstrated less empathy and assessed the client in prostitution to have a lower level of functioning.

It is important to note that the second root is interpreted with considerable caution particularly since the structure coefficients were not consistent with other variables and the results of the preliminary analysis in the study. In addition, this root accounted for significantly

less variability than the first root. Counselor Perceptions of Prostitution Scale (r = .49) and Attitudes towards Prostitution Scale (r = .26; Sawyer et al, 2001) demonstrated a positive correlation in the second root. Previous analyses indicated that these two variables have a strong negative correlation. (See section titled *Psychometric Properties of CPPS* in pages 74-75). Also, theoretically, there ought to be a negative correlation between the two variables i.e. the more likely counselors are to view prostitution as inherently traumatizing and a form of social oppression the less likely they are to hold inaccurate beliefs about prostitution. However, the structure coefficient of Attitudes Towards Prostitution Scale (r = .26; Sawyer et al, 2001) was relatively modest and is not used for interpretation in this study. In the first root, the structure coefficients of the two predictor variables were inversely related which is theoretically and statistically supported. In addition, there were directly contradictory results present in the second root when compared to the first root. In the first root, there was a positive correlation between perception toward prostitution and empathy and in the second root there is a negative correlation between these two variables.

These two considerations described in the previous paragraph provide evidence that the second root may be a spurious finding. The second root is nonetheless included in the interpretation and the results of the first root, in particular, are interpreted with caution. These are discussed in detail in the Discussion in Chapter 5.

Summary

Overall, the results of this study demonstrated good norms for the scale developed in this study, lack of support for the first hypothesis and some support for the second hypothesis. First, the preliminary study comprising of the manipulation check confirmed that mental health professionals would be able to discern the similarities and differences between the three clinical vignettes used in this study. Second, the norms of the scale demonstrated moderate-high internal

consistency reliability for the scale, a moderate but significant negative correlation with the ATPS, and no reliable interpretable factors from the exploratory factor analysis. Third, hypothesis 1 which stated that '*counselors will exhibit greater clinical bias when exposed to a client vignette in which prostitution is used as a means of supplementing income (as opposed to selling drugs or working overtime at a department store)' where clinical bias is defined by less empathy for the client, greater attribution of personal responsibility to the client for the cause of and the solution to the problems, lower assessment of client's level of functioning, and less willingness to work with the client* was not supported. In fact, the results were in contradiction with what was predicted in this hypothesis. Counselors demonstrated similar levels of empathy for the client in prostitution as the client working overtime. Counselors demonstrated the least amount of empathy for the client selling marijuana. None of the other dependent variables were significant. The results demonstrated some support for hypothesis 2 which stated that '*in responding to the client vignette where prostitution is used as a means of supplementing income, counselors who are less likely to endorse beliefs about prostitution as a form of oppression and tend to endorse more inaccurate beliefs about prostitution, will be more likely to demonstrate bias. Bias is defined as less empathy for the client, greater personal responsibility attributed to the client for the cause and solution to the client's problems, a lower assessment of client's level of functioning, and less willingness to work with the client'*. The canonical correlation analysis revealed a two canonical roots or functions. The first root had moderate-high positive loadings of empathy and moderate-high negative loadings of attribution for the solution to the problem on one side, and high positive loadings of counselor perceptions of prostitution and high negative loadings of inaccurate beliefs about prostitution on the other side of the root. The second root was characterized by moderate negative loadings for empathy and assessment of functioning on one side, and by moderate loadings of counselor perceptions of prostitution. However, the

second root presented relationships that were inconsistent with the hypothesis and with the findings suggested in the first root. All of these results yielded meaningful information, which are reviewed in depth in Chapter 5.

TABLES

Table 1: Descriptive Statistics of Dependent Variables for All Conditions.

		Prostitution Condition	Marijuana Condition	Overtime Condition	For All conditions
Empathy	Mean	56.48	52.03	55.37	54.69
	Std. Deviation	5.79	6.18	5.60	6.18
	Range	26	27	22	30
	Minimum	42	38	43	38
	Maximum	68	65	65	68
Cause	Mean	8.74	9.06	7.77	8.63
	Std. Deviation	3.35	2.91	2.68	3.08
	Range	15	14	11	15
	Minimum	3	3	3	3
	Maximum	18	17	14	18
Solution	Mean	12.32	12.42	12.60	12.42
	Std. Deviation	2.83	2.69	2.99	2.81
	Range	17	13	17	17
	Minimum	3	5	3	3
	Maximum	20	18	20	20
Global Assessment of Functioning *	Mean	5.72	5.81	5.75	5.76
	Std. Deviation	0.71	0.89	0.69	.77
	Range	3	6	2	6
	Minimum	4	1	5	1
	Maximum	7	7	7	7
Willingness to Work	Mean	11.89	12	12.04	11.96
	Std. Deviation	2.18	1.83	1.89	1.99
	Range	12	8	10	12
	Minimum	2	6	4	2
	Maximum	14	14	14	14

* The GAF rating is based on 1-10 likert type scale with 1 being a GAF rating of 1-10 and 10 being a GAF rating of 90-100

Table 2: Internal Consistency Reliability Data for the Scales use for Dependent Variables.

	Interpersonal Reactivity Index Scale	Cause Scale	Solution Scale	Willingness to Work Scale
Reliability	.69	.82	.49	.74
N of items	14	3	3	2
N	221	224	224	226

* Internal consistency reliability estimates are not available for the Global Assessment of Functioning Scale as this is a single item scale

Table 3: Correlations between the Dependent Variables.

		Empathy	Cause	Solution	Assessment of Functioning	Willingness to Work
Empathy	Pearson Correlation	1	-.281(**)	-.131	.110	.203(**)
	Sig. (2-tailed)	.	.000	.053	.110	.003
	N	221	218	218	214	214
Cause	Pearson Correlation	-.281(**)	1	.305(**)	-.050	-.112
	Sig. (2-tailed)	.000	.	.000	.462	.097
	N	218	224	224	220	220
Solution	Pearson Correlation	-.131	.305(**)	1	.035	.025
	Sig. (2-tailed)	.053	.000	.	.601	.709
	N	218	224	224	220	220
Assessment of Functioning	Pearson Correlation	.110	-.050	.035	1	.107
	Sig. (2-tailed)	.110	.462	.601	.	.111
	N	214	220	220	222	222
Willingness to Work	Pearson Correlation	.203(**)	-.112	.025	.107	1
	Sig. (2-tailed)	.003	.097	.709	.111	.
	N	214	220	220	222	226

** Correlation is significant at the 0.01 level (2-tailed).

Table 4: Interpersonal Reactivity Index Scale (Davis, 1983) subscales means, standard deviations for five samples.

	N		Mean	S.D.	Cronbach's Alpha
This study	221 mental health service providers	PT	26.36	4.09	.59
		EC	28.32	3.42	.62
Beitel, M., Ferrer, E. & Cecero, J. J. (2005)	103 undergraduate students	PT	18.23	4.81	.70
		EC	20.98	4.51	.71
Cusi, A., MacQueen, G. M., & McKinnon, M. C. (2010)	20 middle-aged participants with no known psychiatric history	PT	20.2	5.6	
		EC	22.2	3.2	
Spinella, 2005	49 female community-dwelling participants	PT	17.5	4.7	
		EC	20.9	4.9	
Rangganadhan, A. R., & Todorov, N. (2010)	150 community-dwelling participants	PT	17.97	4.60	.765
		EC	21.33	3.90	.688

Table 5: Cause and Solution Scales (Karuza et al, 1990) means, standard deviations for four samples.

	N		Mean	S.D.
This study	221 mental health service providers	Cause	8.74	3.35
		Solution	12.32	2.83
Hayes & Erkis (2000)	425 psychologists	Cause	3.50	1.76
		Solution	3.93	1.14
Burkard & Knox (2004)	247 practicing psychologists (133 men, 114 women)	Cause	10.62	3.68
		Solution	16.27	2.70
McCraken, Hayes & Dell, 1997	116 college students	Cause	3.84	1.27
		Solution	4.25	1.48

Table 6: GAF Scale (APA, 2000) means, standard deviations for four samples.

	N	Mean	S.D.
This Study	221 mental health service providers	57.23	7.09
Kettmann, et al (2007)	827 clients of a university counseling service (UCS)	63.95	6.81
Høglend et al, 2006	7 Therapist ratings of 100 patients	61.2	6.1
Brand et al, 2009	292 Therapists	50.6	12
Hilsenroth et al 2007	19 therapists assigned to 33 clients	58	6

Table 7: Manipulation Check: means and standard deviations of ratings of the differences between conditions.

	Item 1	Item 2	Item 3
N	27	27	27
Mean	8.11	7.41	7.67
Std. Deviation	1.013	1.693	1.840
Range	3	5	8
Minimum	6	4	1
Maximum	9	9	9

Table 8: Correlation between CPPS and ATPS (Sawyer et al, 2001) in the preliminary study

		CPPS	ATPS
Counselor Perceptions of Prostitution Scale (CPPS)	Pearson Correlation	1	-.683(**)
	Sig. (2-tailed)	.	.000
	N	72	67
Attitudes Towards Prostitution Scale (ATPS)	Pearson Correlation	-.683(**)	1
	Sig. (2-tailed)	.000	.
	N	67	67

** Correlation is significant at the 0.01 level (2-tailed).
Note: Higher scores on the CPPS reflect the respondent's view of prostitution as inherently traumatic and a form of social oppression while lower scores reflect the respondent's view of prostitution as a self-determined career choice. Higher scores on the ATPS reflect inaccurate beliefs about prostitution held by the respondent while lower scores reflect more accurate beliefs about prostitution.

Table 9: Correlation between CPPS and ATPS in the final study

		CPPS	ATPS
Counselor Perceptions of Prostitution Scale (CPPS)	Pearson Correlation	1	-.662(**)
	Sig. (2-tailed)	.	.000
	N	204	204
Attitudes Towards Prostitution Scale (ATPS)	Pearson Correlation	-.662(**)	1
	Sig. (2-tailed)	.000	.
	N	204	204

** Correlation is significant at the 0.01 level (2-tailed).
Note: Higher scores on the CPPS reflect the respondent's view of prostitution as inherently traumatic and a form of social oppression while lower scores reflect the respondent's view of

prostitution as a self-determined career choice. Higher scores on the ATPS reflect inaccurate beliefs about prostitution held by the respondent while lower scores reflect more accurate beliefs about prostitution.

Table 10: KMO and Bartlett's Test for the CPPS in the preliminary study.

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.783
Bartlett's Test of Sphericity	Approx. Chi-Square	559.471
	df	171
	Sig.	.000

Table 11: Eigenvalues obtained from principal components analysis of CPPS in preliminary study.

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	6.132	32.273	32.273	6.132	32.273	32.273	3.694
2	2.037	10.720	42.994	2.037	10.720	42.994	3.029
3	1.604	8.445	51.438	1.604	8.445	51.438	3.544
4	1.247	6.565	58.003	1.247	6.565	58.003	2.927
5	1.202	6.324	64.327	1.202	6.324	64.327	2.797
6	.987	5.197	69.524				
7	.881	4.638	74.163				
8	.717	3.775	77.938				
9	.684	3.601	81.539				
10	.621	3.266	84.805				
11	.536	2.822	87.627				
12	.456	2.400	90.027				
13	.397	2.091	92.118				
14	.339	1.784	93.902				
15	.321	1.691	95.593				
16	.247	1.300	96.894				
17	.217	1.144	98.038				
18	.201	1.059	99.097				
19	.172	.903	100.000				

Graph 1: Scree plot of eigenvalues obtained from principal components analysis of CPPS in preliminary study.

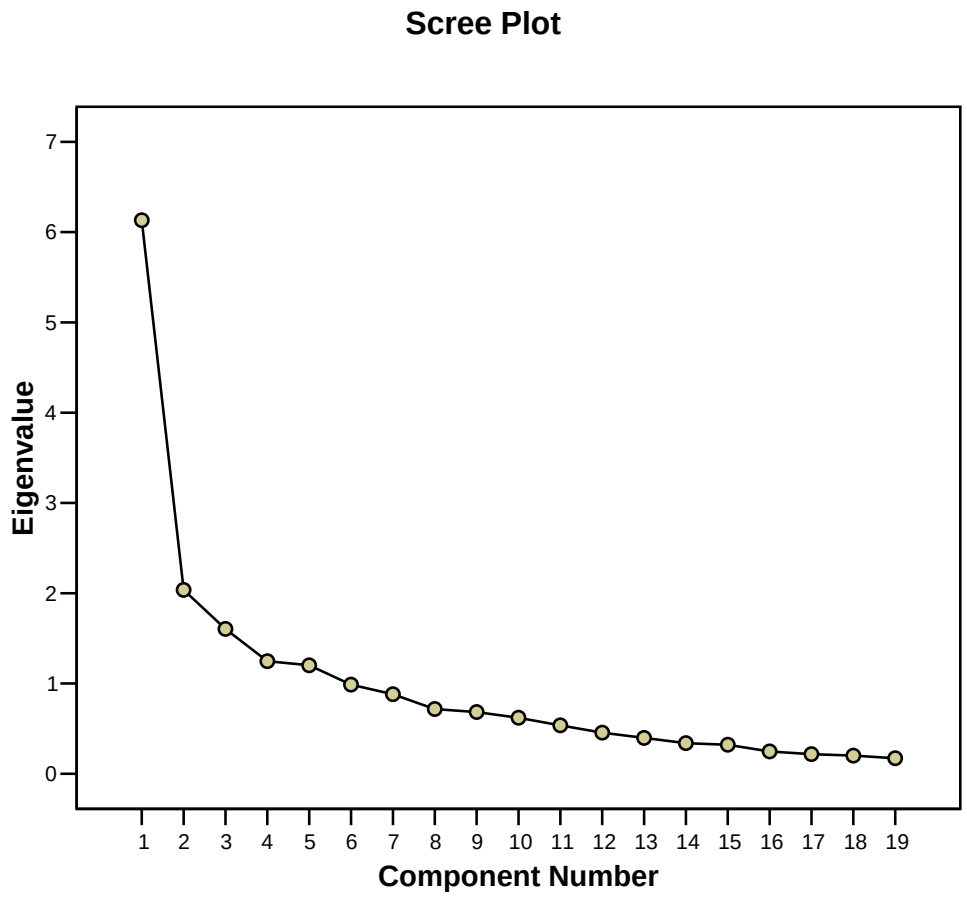

Table 12: Component matrix obtained from principal components analysis of CPPS in preliminary study.

Item	Component				
	1	2	3	4	5
1. I believe that women who work in the commercial sex industry are fulfilling their own aspirations.	.664	.080	-.114	-.276	-.164
2. Women who work in the commercial sex industry have been coerced in this work based on circumstances beyond their control.	.471	.536	.020	.201	.314
3. I believe that women in the commercial sex industry are able to obtain power and control in their working lives.	.450	.167	-.222	-.526	.258
4. I believe that women in the commercial sex industry are severely traumatized by this experience.	.664	.099	.433	-.211	-.290
5. Women working in the commercial sex industry have opportunities to dominate men who need their services	.526	.279	-.374	-.450	.006
6. I believe that women in the commercial sex industry are exposed to violence and degradation.	.588	.242	.490	-.184	-.178
7. I believe that term “sex work” is not an accurate representation in that women do not really have free choice in their choice of livelihood.	.532	.280	-.291	-.013	.407
8. I believe that prostitution is an outmoded concept; women who work in the commercial sex industry are making choices of their own free will about how to earn a living.	.742	.191	-.299	.155	-.079
9. Women working in the commercial sex industry are fortunate to be able to enjoy their work.	.712	-.017	-.127	.028	-.222
10. I believe that prostitution or commercial sex work is an expression of women’s sexuality.	.708	-.088	-.315	.157	-.421
11. Sex work is the more appropriate term to denote volitional employment in the commercial sex trade.	.473	.064	-.295	.332	.055
13. I think that sex work provides a good outlet for women to earn extra money.	.528	-.372	-.240	.354	-.233
14. I think that prostitution is morally wrong.	.483	-.095	.488	-.005	.304
15. I believe that women who enter the commercial sex industry have a hard time leaving it.	.301	.459	.199	.299	-.090
16. I believe that prostitution should be made legal so that women may have more choices.	.522	-.577	-.073	.005	.344
17. I believe that by legalizing prostitution we place women at higher risk of harm.	.552	-.564	.125	-.206	.161
18. I believe that prostitution is the epitome of patriarchal oppression of women.	.513	.222	.251	.390	.365
19. I believe that by legalizing prostitution, women will have greater rights and control over the work that they do.	.591	-.618	.074	.073	.137
20. I believe that the work of women in prostitution is re-traumatizing.	.589	-.025	.415	.012	-.206

Extraction Method: Principal Component Analysis.
a 5 components extracted.

Table 13: Pattern matrix obtained from oblimin rotation of components of CPPS in preliminary study.

Items	Component				
	1	2	3	4	5
1. I believe that women who work in the commercial sex industry are fulfilling their own aspirations.	.282	-.048	.345	-.458	-.082
2. Women who work in the commercial sex industry have been coerced in this work based on circumstances beyond their control.	.012	.143	.058	-.218	.714
3. I believe that women in the commercial sex industry are able to obtain power and control in their working lives.	-.146	-.140	.038	-.774	.035
4. I believe that women in the commercial sex industry are severely traumatized by this experience.	.078	-.037	.825	-.122	-.047
5. Women working in the commercial sex industry have opportunities to dominate men who need their services.	.149	.091	.077	-.783	-.041
6. I believe that women in the commercial sex industry are exposed to violence and degradation.	-.063	.038	.797	-.123	.103
7. I believe that term “sex work” is not an accurate representation in that women do not really have free choice in their choice of livelihood.	.085	-.107	-.191	-.495	.502
8. I believe that prostitution is an outmoded concept; women who work in the commercial sex industry are making choices of their own free will about how to earn a living.	.576	.029	.080	-.282	.275
9. Women working in the commercial sex industry are fortunate to be able to enjoy their work.	.518	-.090	.282	-.192	.018
10. I believe that prostitution or commercial sex work is an expression of women’s sexuality.	.824	-.005	.190	-.106	-.103
11. Sex work is the more appropriate term to denote volitional employment in the commercial sex trade.	.492	-.055	-.163	-.050	.342
Item13. I think that sex work provides a good outlet for women to earn extra money.	.738	-.283	-.020	.185	-.032
14. I think that prostitution is morally wrong.	-.255	-.454	.395	.041	.350
15. I believe that women who enter the commercial sex industry have a hard time leaving it.	.150	.328	.307	.118	.437
16. I believe that prostitution should be made legal so that women may have more choices.	.136	-.807	-.130	-.085	.083
17. I believe that by legalizing prostitution we place women at higher risk of harm.	.035	-.749	.196	-.129	-.124
18. I believe that prostitution is the epitome of patriarchal oppression of women.	.013	-.175	.126	.118	.750
19. I believe that by legalizing prostitution, women will have greater rights and control over the work that they do.	.249	-.766	.097	.081	-.002
20. I believe that the work of women in prostitution is re-traumatizing.	.141	-.144	.656	.088	.060

Extraction Method: Principal Component Analysis. Rotation Method: Oblimin with Kaiser Normalization.

a Rotation converged in 12 iterations.

Table 14: Component correlation matrix of rotated factors of CPPS from preliminary study.

Component	1	2	3	4	5
1	1.000	-.222	.224	-.257	.221
2	-.222	1.000	-.199	.122	-.067
3	.224	-.199	1.000	-.186	.271
4	-.257	.122	-.186	1.000	-.195
5	.221	-.067	.271	-.195	1.000

Table 15: Eigenvalues obtained from principal components analysis of CPPS in final study

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings (a)
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	6.727	35.406	35.406	6.727	35.406	35.406	5.490
2	2.237	11.775	47.182	2.237	11.775	47.182	3.852
3	1.102	5.800	52.982	1.102	5.800	52.982	2.438
4	1.040	5.474	58.456	1.040	5.474	58.456	2.909
5	.938	4.937	63.393				
6	.847	4.459	67.852				
7	.798	4.199	72.051				
8	.716	3.768	75.819				
9	.654	3.440	79.259				
10	.600	3.159	82.418				
11	.555	2.923	85.342				
12	.497	2.615	87.957				
13	.469	2.470	90.427				
14	.438	2.304	92.732				
15	.370	1.949	94.680				
16	.317	1.671	96.351				
17	.286	1.506	97.857				
18	.237	1.248	99.105				
19	.170	.895	100.000				

Extraction Method: Principal Component Analysis.

a When components are correlated, sums of squared loadings cannot be added to obtain a total variance.

Table 16: Component matrix obtained from principal components analysis of CPPS in final study.

Item	Component			
	1	2	3	4
1. I believe that women who work in the commercial sex industry are fulfilling their own aspirations.	.652	-.135	.097	.001
2. Women who work in the commercial sex industry have been coerced in this work based on circumstances beyond their control.	.559	-.344	-.283	-.142
3. I believe that women in the commercial sex industry are able to obtain power and control in their working lives.	.617	-.278	-.178	.068
4. I believe that women in the commercial sex industry are severely traumatized by this experience.	.599	-.107	-.307	.228
5. Women working in the commercial sex industry have opportunities to dominate men who need their services.	.663	-.250	-.048	-.132
6. I believe that women in the commercial sex industry are exposed to violence and degradation.	.488	-.087	.165	.433
7. I believe that term “sex work” is not an accurate representation in that women do not really have free choice in their choice of livelihood.	.642	-.171	-.156	-.174
8. I believe that prostitution is an outmoded concept; women who work in the commercial sex industry are making choices of their own free will about how to earn a living.	.671	-.380	-.083	-.177
9. Women working in the commercial sex industry are fortunate to be able to enjoy their work.	.720	-.175	.247	.009
10. I believe that prostitution or commercial sex work is an expression of women’s sexuality	.735	-.126	.309	-.132
11. Sex work is the more appropriate term to denote volitional employment in the commercial sex trade.	.547	.013	.101	-.488
13. I think that sex work provides a good outlet for women to earn extra money.	.589	-.018	.618	.028
14. I think that prostitution is morally wrong.	.296	.522	.343	.133
15. I believe that women who enter the commercial sex industry have a hard time leaving it.	.418	-.084	-.009	.535
16. I believe that prostitution should be made legal so that women may have more choices.	.556	.674	.006	-.051
17. I believe that by legalizing prostitution we place women at higher risk of harm.	.506	.705	-.261	-.074
18. I believe that prostitution is the epitome of patriarchal oppression of women.	.624	.086	-.055	-.081
19. I believe that by legalizing prostitution, women will have greater rights and control over the work that they do.	.551	.695	-.169	-.069
20. I believe that the work of women in prostitution is re-traumatizing.	.697	.034	-.244	.341

Table 17: Pattern matrix obtained from oblimin rotation of components of CPPS in final study.

Item	Component 1	2	3	4
1. I believe that women who work in the commercial sex industry are fulfilling their own aspirations.	.468	.056	.237	.170
2. Women who work in the commercial sex industry have been coerced in this work based on circumstances beyond their control.	.738	-.051	-.168	.054
3. I believe that women in the commercial sex industry are able to obtain power and control in their working lives.	.578	-.019	-.054	.270
4. I believe that women in the commercial sex industry are severely traumatized by this experience.	.413	.162	-.199	.422
5. Women working in the commercial sex industry have opportunities to dominate men who need their services.	.669	.004	.096	.060
6. I believe that women in the commercial sex industry are exposed to violence and degradation.	.056	-.015	.260	.567
7. I believe that term “sex work” is not an accurate representation in that women do not really have free choice in their choice of livelihood.	.669	.109	-.020	.010
8. I believe that prostitution is an outmoded concept; women who work in the commercial sex industry are making choices of their own free will about how to earn a living.	.789	-.104	.064	.033
9. Women working in the commercial sex industry are fortunate to be able to enjoy their work.	.483	-.006	.408	.188
10. I believe that prostitution or commercial sex work is an expression of women’s sexuality	.528	.043	.479	.034
11. Sex work is the more appropriate term to denote volitional employment in the commercial sex trade.	.604	.212	.233	-.382
13. I think that sex work provides a good outlet for women to earn extra money.	.175	-.008	.762	.127
14. I think that prostitution is morally wrong.	-.305	.488	.406	.122
15. I believe that women who enter the commercial sex industry have a hard time leaving it.	.004	.006	.062	.670
16. I believe that prostitution should be made legal so that women may have more choices.	-.009	.838	.115	.004
17. I believe that by legalizing prostitution we place women at higher risk of harm.	.040	.933	-.171	-.015
18. I believe that prostitution is the epitome of patriarchal oppression of women.	.419	.313	.074	.064
19. I believe that by legalizing prostitution, women will have greater rights and control over the work that they do.	.043	.911	-.068	-.005
20. I believe that the work of women in prostitution is re-traumatizing.	.305	.301	-.119	.542

a Rotation converged in 9 iterations.

Table 18: Multivariate Test of Hypothesis 1.

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.995	8147.998(a)	5.000	207.000	.000	.995
	Wilks' Lambda	.005	8147.998(a)	5.000	207.000	.000	.995
	Hotelling's Trace	196.812	8147.998(a)	5.000	207.000	.000	.995
	Roy's Largest Root	196.812	8147.998(a)	5.000	207.000	.000	.995
Condition	Pillai's Trace	.156	3.518	10.000	416.000	.000	.078
	Wilks' Lambda	.848	3.552(a)	10.000	414.000	.000	.079
	Hotelling's Trace	.174	3.586	10.000	412.000	.000	.080
	Roy's Largest Root	.139	5.776(b)	5.000	208.000	.000	.122

Table 19: Tests of Between-Subjects Effects on Individual Dependent Variables.

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	Interpersonal Reactivity Index	863.247(a)	2	431.623	12.489	.000	.106
	Cause Scale	55.497(b)	2	27.748	2.976	.053	.027
	Solution Scale	6.647(c)	2	3.324	.424	.655	.004
	Global Assessment of Functioning Scale	.051(d)	2	.026	.371	.690	.004
	Willingness to Work Scale	.027(e)	2	.014	.048	.953	.000
Intercept	Interpersonal Reactivity Index	603709.706	1	603709.706	17468.140	.000	.988
	Cause Scale	14563.626	1	14563.626	1561.818	.000	.881
	Solution Scale	31093.876	1	31093.876	3962.003	.000	.949
	Global Assessment of Functioning Scale	438.148	1	438.148	6319.336	.000	.968
	Willingness to Work Scale	555.559	1	555.559	1960.316	.000	.903
Vignettes	Interpersonal Reactivity Index	863.247	2	431.623	12.489	.000	.106
	Cause Scale	55.497	2	27.748	2.976	.053	.027
	Solution Scale	6.647	2	3.324	.424	.655	.004
	Global Assessment of Functioning Scale	.051	2	.026	.371	.690	.004
	Willingness to Work Scale	.027	2	.014	.048	.953	.000
Error	Interpersonal Reactivity Index	7292.290	211	34.561			
	Cause Scale	1967.531	211	9.325			
	Solution Scale	1655.932	211	7.848			
	Global Assessment of Functioning Scale	14.630	211	.069			
	Willingness to Work Scale	59.798	211	.283			
Total	Interpersonal Reactivity Index	650565.000	214				
	Cause Scale	17878.000	214				
	Solution Scale	34478.000	214				
	Global Assessment of Functioning Scale	481.000	214				
	Willingness to Work Scale	651.000	214				
Corrected Total	Interpersonal Reactivity Index	8155.537	213				
	Cause Scale	2023.028	213				
	Solution Scale	1662.579	213				
	Global Assessment of Functioning Scale	14.681	213				
	Willingness to Work Scale	59.825	213				

a R Squared = .106 (Adjusted R Squared = .097)
b R Squared = .027 (Adjusted R Squared = .018)
c R Squared = .004 (Adjusted R Squared = -.005)
d R Squared = .004 (Adjusted R Squared = -.006)
e R Squared = .000 (Adjusted R Squared = -.009)

Note: Higher scores on the IRI indicate greater empathy in the respondent. Higher scores on the Cause Scale indicate greater attribution of personal responsibility for the cause of the problem by the respondent. Higher scores on the Solution Scale indicate greater attribution of responsibility for the solution of the problem by the respondent. Higher scores on the GAF Scale indicate the respondent's assessment of the client as having higher level of functioning. Higher scores on the WTW Scale indicate greater willingness of the respondent to work with the client.

Table 20: Follow-up results of univariate F-tests conducted on individual dependent variables.

Dependent Variable		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Interpersonal Reactivity Index	Contrast	863.247	2	431.623	12.489	.000	.106
	Error	7292.290	211	34.561			
Cause Scale	Contrast	55.497	2	27.748	2.976	.053	.027
	Error	1967.531	211	9.325			
Solution Scale	Contrast	6.647	2	3.324	.424	.655	.004
	Error	1655.932	211	7.848			
Global Assessment of Functioning Scale	Contrast	.051	2	.026	.371	.690	.004
	Error	14.630	211	.069			
Willingness to Work Scale	Contrast	.027	2	.014	.048	.953	.000
	Error	59.798	211	.283			

The F tests the effect of the IV of different conditions. This test is based on the linearly independent pairwise comparisons among the estimated marginal means.
Note: Higher scores on the IRI indicate greater empathy in the respondent. Higher scores on the Cause Scale indicate greater attribution of personal responsibility for the cause of the problem by the respondent. Higher scores on the Solution Scale indicate greater attribution of responsibility for the solution of the problem by the respondent. Higher scores on the GAF Scale indicate the respondent's assessment of the client as having higher level of functioning. Higher scores on the WTW Scale indicate greater willingness of the respondent to work with the client.

Table 21: Mean Differences between Individual Groups on Dependent Variables.

Dependent Variable	(I) Vignettes	(J) Vignettes	Mean Difference (I-J)	Std. Error	Sig.(a)	95% Confidence Interval for Difference(a)	
						Lower Bound	Upper Bound
Interpersonal Reactivity Index	1.00	2.00	4.456(*)	.924	.000	2.227	6.685
		3.00	.744	1.035	1.000	-1.754	3.241
	2.00	1.00	-4.456(*)	.924	.000	-6.685	-2.227
		3.00	-3.713(*)	1.079	.002	-6.317	-1.108
	3.00	1.00	-.744	1.035	1.000	-3.241	1.754
		2.00	3.713(*)	1.079	.002	1.108	6.317
Cause Scale	1.00	2.00	-.319	.480	1.000	-1.476	.839
		3.00	1.016	.538	.180	-.281	2.314
	2.00	1.00	.319	.480	1.000	-.839	1.476
		3.00	1.335	.561	.054	-.018	2.688
	3.00	1.00	-1.016	.538	.180	-2.314	.281
		2.00	-1.335	.561	.054	-2.688	.018
Solution Scale	1.00	2.00	-.241	.440	1.000	-1.303	.822
		3.00	-.442	.493	1.000	-1.632	.748
	2.00	1.00	.241	.440	1.000	-.822	1.303
		3.00	-.202	.514	1.000	-1.443	1.039
	3.00	1.00	.442	.493	1.000	-.748	1.632
		2.00	.202	.514	1.000	-1.039	1.443
Global Assessment of Functioning Scale	1.00	2.00	.036	.041	1.000	-.064	.135
		3.00	.015	.046	1.000	-.097	.127
	2.00	1.00	-.036	.041	1.000	-.135	.064
		3.00	-.021	.048	1.000	-.138	.096
	3.00	1.00	-.015	.046	1.000	-.127	.097
		2.00	.021	.048	1.000	-.096	.138
Willingness to Work Scale	1.00	2.00	.026	.084	1.000	-.176	.228
		3.00	.014	.094	1.000	-.212	.240
	2.00	1.00	-.026	.084	1.000	-.228	.176
		3.00	-.012	.098	1.000	-.248	.224
	3.00	1.00	-.014	.094	1.000	-.240	.212
		2.00	.012	.098	1.000	-.224	.248

Based on estimated marginal means

* The mean difference is significant at the .05 level.

a Adjustment for multiple comparisons: Bonferroni.

Note: Higher scores on the IRI indicate greater empathy in the respondent. Higher scores on the Cause Scale indicate greater attribution of personal responsibility for the cause of the problem by the respondent. Higher scores on the Solution Scale indicate greater attribution of responsibility for the solution of the problem by the respondent. Higher scores on the GAF Scale indicate the respondent's assessment of the client as having higher level of functioning. Higher scores on the WTW Scale indicate greater willingness of the respondent to work with the client.

Table 22: Mean of each group on the individual dependent variables.

Dependent Variable	Vignettes	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Interpersonal Reactivity Index	1.00	56.484	.616	55.269	57.698
	2.00	52.027	.688	50.671	53.384
	3.00	55.740	.831	54.101	57.379
Cause Scale	1.00	8.736	.320	8.105	9.367
	2.00	9.055	.357	8.350	9.759
	3.00	7.720	.432	6.869	8.571
Solution Scale	1.00	12.198	.294	11.619	12.777
	2.00	12.438	.328	11.792	13.085
	3.00	12.640	.396	11.859	13.421
Global Assessment of Functioning Scale	1.00	1.492	.028	1.437	1.546
	2.00	1.456	.031	1.395	1.517
	3.00	1.477	.037	1.404	1.550
Willingness to Work Scale	1.00	1.674	.056	1.564	1.784
	2.00	1.648	.062	1.525	1.771
	3.00	1.660	.075	1.512	1.809

Note: Higher scores on the IRI indicate greater empathy in the respondent. Higher scores on the Cause Scale indicate greater attribution of personal responsibility for the cause of the problem by the respondent. Higher scores on the Solution Scale indicate greater attribution of responsibility for the solution of the problem by the respondent. Higher scores on the GAF Scale indicate the respondent's assessment of the client as having higher level of functioning. Higher scores on the WTW Scale indicate greater willingness of the respondent to work with the client.

Table 23: Tests of Between-Subjects Effects on Individual Dependent Variables on the Client Rating Scales.

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	Liking	1.583(a)	2	.791	1.459	.235
	Empathy	4.887(b)	2	2.443	3.346	.037
	Comfort	1.991(c)	2	.996	1.789	.170
	Willingness to see	.234(d)	2	.117	.152	.859
	Adjustment	.496(e)	2	.248	.308	.735
	Prognosis	.186(d)	2	.093	.151	.860
	Internal attribution	.599(f)	2	.300	.424	.655
	Stable attribution	.001(g)	2	.000	.001	.999
Intercept	Liking	3970.116	1	3970.116	7319.253	.000
	Empathy	5058.760	1	5058.760	6927.725	.000
	Comfort	5644.528	1	5644.528	10141.166	.000
	Willingness to see	5889.864	1	5889.864	7640.850	.000
	Adjustment	2781.083	1	2781.083	3460.893	.000
	Prognosis	3714.020	1	3714.020	6036.112	.000
	Internal attribution	2248.761	1	2248.761	3181.206	.000
	Stable attribution	2624.628	1	2624.628	3782.044	.000
Vignettes	Liking	1.583	2	.791	1.459	.235
	Empathy	4.887	2	2.443	3.346	.037
	Comfort	1.991	2	.996	1.789	.170
	Willingness to see	.234	2	.117	.152	.859
	Adjustment	.496	2	.248	.308	.735

	Prognosis	.186	2	.093	.151	.860
	Internal attribution	.599	2	.300	.424	.655
	Stable attribution	.001	2	.000	.001	.999
Error	Liking	120.417	222	.542		
	Empathy	162.109	222	.730		
	Comfort	123.564	222	.557		
	Willingness to see	171.126	222	.771		
	Adjustment	178.393	222	.804		
	Prognosis	136.597	222	.615		
	Internal attribution	156.929	222	.707		
	Stable attribution	154.062	222	.694		
Total	Liking	4347.000	225			
	Empathy	5535.000	225			
	Comfort	6106.000	225			
	Willingness to see	6444.000	225			
	Adjustment	3131.000	225			
	Prognosis	4089.000	225			
	Internal attribution	2552.000	225			
	Stable attribution	2956.000	225			
Corrected Total	Liking	122.000	224			
	Empathy	166.996	224			
	Comfort	125.556	224			
	Willingness to see	171.360	224			
	Adjustment	178.889	224			

	Prognosis	136.782	224			
	Internal attribution	157.529	224			
	Stable attribution	154.062	224			

a R Squared = .013 (Adjusted R Squared = .004)
b R Squared = .029 (Adjusted R Squared = .021)
c R Squared = .016 (Adjusted R Squared = .007)
d R Squared = .001 (Adjusted R Squared = -.008)
e R Squared = .003 (Adjusted R Squared = -.006)
f R Squared = .004 (Adjusted R Squared = -.005)
g R Squared = .000 (Adjusted R Squared = -.009)
Note: Higher scores on Liking item "how much do you like this client?" indicate greater liking for the client; Higher scores on Empathy item "How much do you empathize with this client?" indicate greater empathy for the client; Higher scores on Comfort item "How comfortable would you feel in dealing with this client?" indicate greater comfort in dealing with the client; Higher scores on Willingness to see item "How willing would you be to take this person on as your client?" indicate greater willingness to work with the client; Higher scores on Adjustment item "How would you rate this client's level of psychological adjustment?" indicate lower adjustment rating for the client; Higher scores on Prognosis item "How would you rate this client's prognosis?" indicates greater prognosis for the client; Higher scores on Internal Attribution item "How much of this client's difficulty would you attribute to causes within herself as opposed to causes external to her?" indicate attribution of causes within the client. Higher scores on Stable attribution item "How much of this client's difficulty would you attribute to stable enduring causes as opposed to unstable transient causes?" indicate attribution of client's difficulties to more stable causes.

Table 24: Mean Differences between Individual Groups on Dependent Variables on Client Rating Scales.

Dependent Variable	(I) Vignettes	(J) Vignettes	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Liking	1.00	2.00	.16	.112	.427	-.11	.43
		3.00	-.02	.128	1.000	-.33	.28
	2.00	1.00	-.16	.112	.427	-.43	.11
		3.00	-.19	.132	.454	-.51	.13
	3.00	1.00	.02	.128	1.000	-.28	.33
		2.00	.19	.132	.454	-.13	.51
Empathy	1.00	2.00	.28	.130	.103	-.04	.59
		3.00	-.07	.149	1.000	-.43	.29
	2.00	1.00	-.28	.130	.103	-.59	.04
		3.00	-.35	.153	.071	-.72	.02
	3.00	1.00	.07	.149	1.000	-.29	.43
		2.00	.35	.153	.071	-.02	.72
Comfort	1.00	2.00	.09	.113	1.000	-.18	.36
		3.00	-.16	.130	.632	-.48	.15
	2.00	1.00	-.09	.113	1.000	-.36	.18
		3.00	-.25	.133	.180	-.57	.07
	3.00	1.00	.16	.130	.632	-.15	.48
		2.00	.25	.133	.180	-.07	.57
Willingness to see	1.00	2.00	.03	.133	1.000	-.29	.35
		3.00	-.05	.153	1.000	-.42	.32
	2.00	1.00	-.03	.133	1.000	-.35	.29
		3.00	-.09	.157	1.000	-.47	.29
	3.00	1.00	.05	.153	1.000	-.32	.42
		2.00	.09	.157	1.000	-.29	.47
Adjustment	1.00	2.00	-.07	.136	1.000	-.40	.26
		3.00	-.12	.156	1.000	-.49	.26
	2.00	1.00	.07	.136	1.000	-.26	.40
		3.00	-.04	.160	1.000	-.43	.34
	3.00	1.00	.12	.156	1.000	-.26	.49
		2.00	.04	.160	1.000	-.34	.43
Prognosis	1.00	2.00	-.04	.119	1.000	-.32	.25
		3.00	-.07	.137	1.000	-.40	.26
	2.00	1.00	.04	.119	1.000	-.25	.32
		3.00	-.04	.140	1.000	-.38	.30
	3.00	1.00	.07	.137	1.000	-.26	.40

		2.00	.04	.140	1.000	-.30	.38
Internal attribution	1.00	2.00	-.12	.128	1.000	-.42	.19
		3.00	-.07	.146	1.000	-.42	.28
	2.00	1.00	.12	.128	1.000	-.19	.42
		3.00	.05	.150	1.000	-.32	.41
	3.00	1.00	.07	.146	1.000	-.28	.42
		2.00	-.05	.150	1.000	-.41	.32
Stable attribution	1.00	2.00	.00	.127	1.000	-.31	.30
		3.00	.00	.145	1.000	-.35	.35
	2.00	1.00	.00	.127	1.000	-.30	.31
		3.00	.00	.149	1.000	-.36	.36
	3.00	1.00	.00	.145	1.000	-.35	.35
		2.00	.00	.149	1.000	-.36	.36

Based on observed means.

* The mean difference is significant at the .05 level.

Note: Higher scores on Liking item indicate greater liking for the client; Higher scores on Empathy item indicate greater empathy for the client; Higher scores on Comfort item indicate greater comfort in dealing with the client; Higher scores on Willingness to see item indicate greater willingness to work with the client; Higher scores on Adjustment indicate lower adjustment rating for the client; Higher scores on Prognosis indicates greater prognosis for the client; Higher scores on Internal Attribution item indicate attribution of causes within the client. Higher scores on Stable attribution item indicate attribution of client's difficulties to more stable causes.

Table 25: Multivariate Test of Hypothesis 2.

Test Name	Value Approx.	F Hypoth.	DF	Error DF	Sig. of F	Multivariate Effect Size
Pillais	.34716	3.36057	10.00	160.00	.001	.174
Hotellings	.42969	3.35156	10.00	156.00	.001	.177
Wilks	.68027	3.35651	10.00	158.00	.001	.175
Roys	.22557					

Note. F statistic for WILKS' Lambda is exact.

Table 26: Eigenvalues and Canonical Correlations.

Root No.	Eigenvalue	Pct.	Cum Pct.	Canon Cor.	Sq. Cor
1	.291	67.787	67.787	.475	. 226
2	.138	32.213	100.00	.349	.122

Table 27: Dimension Reduction Analysis of the two roots identified.

Roots	Wilks L.	F	Hypoth. DF	Error DF	Sig. of F
1 TO 2	.68027	3.35651	10.00	158.00	.001
2 TO 2	.87841	2.76832	4.00	80.00	.033

Table 28: Canonical Solution for Counselor Attitudes Predicting Counselor Bias for Roots 1 and 2.

	Root 1			*Root 2*		
Variable (N=86)	*Coef*	r_s	$r^2_{s\,(\%)}$	*Coef*	r_s	$r^2_{s\,(\%)}$
R^2_c			22.6			12.2
Interpersonal Reactivity Index	.56	.66	43.30	-.49	-.58	33.64
Cause Scale	.08	-.40	15.60	.39	.33	10.89
Solution Scale	-.64	-.68	46.79	-.58	-.35	12.25
GAF Scale	-.29	-.2.0	3.80	-.56	-.64	40.96
Willingness to Work Scale	.41	.40	16.08	-.07	-.27	7.29
Counselor Perceptions of Prostitution Scale	.40	.87	75.70	1.329	.49	24.01
Attitudes Towards Prostitution Scale	-.68	-.96	91.78	1.206	.26	6.76

Note: Coef = standardized canonical function coefficient; r_s = structure coefficient; r^2_s = squared structure coefficient.

** $p < .001$

Note: Higher scores on the IRI indicate greater empathy in the respondent. Higher scores on the Cause Scale indicate greater attribution of personal responsibility for the cause of the problem by the respondent. Higher scores on the Solution Scale indicate greater attribution of responsibility for the solution of the problem by the respondent. Higher scores on the GAF Scale indicate the respondent's assessment of the client as having higher level of functioning. Higher scores on the WTW Scale indicate greater willingness of the respondent to work with the client. Higher scores on the CPPS reflect the respondent's view of prostitution as inherently traumatic and a form of social oppression while lower scores reflect the respondent's view of prostitution as a self-determined career choice. Higher scores on the ATPS indicate respondent's endorsement of inaccurate beliefs about prostitution.

Table 29: Comparisons between groups across demographic factors.

Condition		Sex	Age	Race:	Highest degree obtained	Years of practice	Percent devoted to clinical work	Experience with clients in prostitution
Prostitution	Mean	1.23	33.14	1.62	5.30	5.67	55.62	1.70
	N	83	81	84	83	39	79	84
	Std. Deviation	.423	10.613	1.447	3.642	8.157	25.857	.460
	Minimum	1	23	1	1	0	0	1
	Maximum	2	73	7	12	41	100	2
	Range	1	50	6	11	41	100	1
Marijuana	Mean	1.25	32.25	1.55	4.52	4.56	61.06	1.72
	N	69	68	67	69	64	64	69
	Std. Deviation	.434	9.516	1.197	3.151	6.709	28.821	.450
	Minimum	1	22	1	1	0	0	1
	Maximum	2	61	7	12	30	100	2
	Range	1	39	6	11	30	100	1
Overtime	Mean	1.11	33.07	1.24	4.69	6.62	62.33	1.74
	N	46	45	46	29	42	42	46
	Std. Deviation	.315	11.126	.899	2.817	8.100	26.644	.444
	Minimum	1	23	1	1	0	10	1
	Maximum	2	67	6	10	40	100	2
	Range	1	44	5	9	40	90	1
Total	Mean	1.21	32.81	1.51	4.91	5.46	59.03	1.72
	N	198	194	197	181	145	185	199
	Std. Deviation	.406	10.321	1.256	3.341	7.530	27.110	.451
	Minimum	1	22	1	1	0	0	1
	Maximum	2	73	7	12	41	100	2
	Range	1	51	6	11	41	100	1

Note: Sex of respondent: Female represented by 1; Male by 2; Race represented as 1 for White, 2 for Black, 3 for Latino/Latina, 4 for Asian /Pacific Islander, 5 for Native American, 6 for Multi-racial, 7 for Other. Highest degree obtained is represented as 1 for B.A., 2 for B.S., 3 for M.A., 4 for M.S.W., 5 for L.M.H.C., 6 for L.M.F.T., 7 for L.I.C.S.W, 8 for Psy.D., 9 for Ph.D., 10 for M.D., and 11 for Other. Experience is represented as 1 for Yes and 2 for No.

CHAPTER 5

A close examination of the findings from this study provided important insights regarding clinical bias and counselor perceptions of prostitution. The preliminary analyses focused on the construction of the CPPS Scale, providing evidence for good psychometric data on the scale and demonstrating evidence for construct validity. The main analyses offered some general support for the two hypotheses. The first hypothesis was not supported; moreover, the results were the reverse of what was predicted. Contrary to what was hypothesized, counselors' demonstrated greater empathy for the client engaging in prostitution for extra money than for the client selling marijuana for extra money. The participants demonstrated similar levels of empathy for the client in prostitution as for the client who works overtime for extra money. An unexpected finding emerged from the analysis indicating that counselors demonstrated the least amount of empathy for clients who sell drugs. The results of the analysis for the second hypothesis were generally in support of the a priori prediction. More specifically, the results demonstrated that counselors who hold attitudes towards prostitution as being inherently traumatizing and a form of social oppression, and who hold accurate beliefs about prostitution, are more likely to be empathic towards clients who engage in prostitution and attribute less personal responsibility to the client for solving her own problems.

In the following sections, first, I discuss and interpret the results of the preliminary and main analyses; second, I discuss the importance of the variable of empathy in relation to psychotherapy services provided to women in prostitution; third, I explore the results in light of previous research and theory; fourth, I articulate the implications of this study for theory, research and practice; and, finally, I summarize the limitations of this study.

Interpretation of Results

Preliminary Analysis Scale Construction

The results of the CPPS Scale from the preliminary and final studies suggest good psychometric data for the scale. The Cronbach's alpha estimates indicate that the scale has moderate to high internal consistency reliability, supporting the inference that the items measure the underlying construct. The CPPS Scale was designed to measure a single construct which is counselor perceptions of prostitution. The items were designed to reflect the polarized debate that exists in the literature regarding the nature of prostitution.

Following this, an exploratory factor analysis was conducted. This analysis provided evidence that the items clustered together, primarily into one coherent factor, supporting the inferences that the scale is unidimensional. This implies that it measures a single theoretical construct, namely counselor perceptions of prostitution. More specifically, the CPPS Scale assesses the extent to which counselors view prostitution as inherently traumatizing and a form or social oppression or if they view it as a choice that women make as an expression of their sexuality and self-determined work-based goals.

The results also indicated that the CPPS had a moderate-high correlation with the ATPS (Sawyer et al, 2001), thereby providing some evidence of concurrent validity for the CPPS Scale. To summarize briefly, the ATPS (Sawyer et al, 2001) measures the extent to which the respondents endorsed myths regarding prostitution. A higher score on the ATPS indicates that the respondents endorsed myths regarding women in prostitution and therefore held inaccurate beliefs about prostitution; lower scores on ATPS (Sawyer et al, 2001) indicated that participants have more accurate beliefs about prostitution. Higher scores on the CPPS indicated that participants view prostitution as inherently traumatizing and a form of social oppression which

was correlated to lower scores on ATPS (Sawyer et al, 2001 As such, this finding provides initial evidence of concurrent validity for the CPPS.

Overall, the CPPS Scale responses and results indicated that the scale functioned according to the theoretical expectations of what it was designed to measure viz. counselor perceptions of prostitution vis-à-vis the polarized debate that exists in the social science literature. When considered collectively, these findings provide positive evidence in support of construct validity of the CPPS.

Hypothesis I

The results did not provide support for the first hypothesis; in fact, the results were contradictory to what was hypothesized. The multivariate analysis revealed a significant relationship between the independent variable of work conditions of the client and the dependent variable of counselor bias. Approximately, eight percent of the variance in the dependent variable of counselor bias is explained by the independent variable of different work conditions, yielding a small, but statistically significant effect size. The post-hoc analyses revealed that this significant effect of the different conditions on counselor bias was attributable only to the dependent variable of empathy.

Deeper exploration of the findings revealed that the significant differences were between the Prostitution Condition and the Marijuana Condition, and between the Marijuana Condition and the Overtime Condition. While counselor responses demonstrated empathy in all the conditions, counselors demonstrated the least amount of empathy for the client who was selling marijuana for extra money. The counselors exhibited significantly greater empathy for the client who was working in prostitution than for the client who was selling marijuana. Counselors also demonstrated significantly greater empathy for the client who worked overtime than for the client who sold marijuana for extra money. It is important to note that counselors demonstrated

similar levels of empathy for the client who works in prostitution for extra money as for the client who works overtime for extra money. These results are in direct contradiction to the hypothesis that stated counselors would demonstrate the least amount of empathy for the women in prostitution.

In this analysis, empathy was a major contributor to counselor bias. Empathy has been an important concept in psychotherapy since Freudian psychoanalysis (Bohart & Greenberg, 1997). Empathy offers a way for a mental health counselor to understand the internal experience of the client and convey this understanding to the client (Myers, 2000; Pearson, 1999). It is considered essential to the therapeutic process and has a strong influence on therapy alliance, engagement, and outcome (Burns & Nolen-Hoeksema, 1992; Clark, 2010; Lambert & Barley, 2002; Norcross, 2010). Empathy has been central in counseling across a diverse range of contemporary theoretical orientations with varying degrees of emphasis (Clark, 2010; Cochran & Cochran, 2006). In the counseling and psychotherapy literatures, empathy is widely recognized as a prominent variable in the development of a positive treatment relationship and in particular, to the therapeutic alliance (Feller & Cottone, 2003). Academic literature has provided considerable empirical evidence to support the role of the therapeutic alliance and relationship in therapeutic outcome across different counseling theories (e.g., Botella, Corbella, Belles, Pacheco, et al, 2008; Gelso & Hayes, 1998; Horvath, 2000; Ridley & Udipi, 2002.; Samstag, Muran, Wachtel, Slade, et al, 2008; Shirk & Karver, 2003). In congruence with the literature, the results of this study indicated that empathy, overall, is a crucial element in psychotherapy practice.

An unexpected but crucial finding of this study was the difference in empathy for the client in the marijuana condition as compared to the other conditions. Counselors exhibited the least amount of empathy for the client selling marijuana. While the reasons for these surprising

results remain unclear, they may be subject to some speculation. First, while prostitution and selling drugs are both illegal, the client selling marijuana may be viewed as causing harm to others in society while the client in prostitution may be viewed as placing herself at greater risk of harm. Second, clients selling drugs may elicit strong emotions (e.g. contempt) in counselors causing discomfort and emotional distancing. Third, the client selling marijuana may be seen as having greater control over what she is doing for extra money as opposed to being a victim of circumstances when engaging in prostitution. Consequentially, counselors demonstrated greater empathy for the client engaging in prostitution and the client working overtime than for the client who sells marijuana.

Contrary to the hypothesis, counselors demonstrated a similar degree of empathy for the client who engages in prostitution as for the client who works overtime for extra money. This indicated that counselors did not demonstrate significantly greater or lesser empathy for the client in prostitution. As proposed in Chapter 2, counselors were expected to experience greater emotional distancing from the client in prostitution due to the lack of familiarity with prostitution or from strong emotions elicited in anticipation of the trauma anticipated. These were speculated to contribute to less empathy. However, the results indicate that counselors may be aware of some of the difficulties that women who engage in prostitution face. At the same time, similar levels of empathy for the client in prostitution as the client who works overtime indicate that they may not necessarily be attuned to the specific needs of women who engage in prostitution. This may be attributed to the lack of experience of the counselors in this study of working with clients in prostitution. Finally, the brief information presented in the vignettes may not have been adequate in order to elicit strong emotions about prostitution. .

The results further demonstrated that none of the other variables were statistically relevant to the analyses. Contrary to the hypothesis, counselors did not attribute greater

responsibility to the client engaging in prostitution for the cause or solution to her problems, did not assess the level of functioning of the client to be lesser than the client in the other vignettes, and were equally willing to work with the client engaging in prostitution, the client selling drugs and the client working overtime for extra money. It is possible that counselors may be aware of some of the challenges that women in prostitution face and therefore did not demonstrate greater or lesser bias in terms of attribution of responsibility, assessment of functioning and willingness to work. In addition, therapists may be most likely to pay attention to empathy as a construct over the other variables that were conceptualized to contribute to counselor bias. I elaborate on each of these other variables below.

Attributions of responsibility. The results demonstrated that counselors did not attribute greater responsibility to the client in the vignette for the cause of her problems and did not attribute greater responsibility for the solution to the problem. This may be attributed to a number of reasons. First, there was no specific information provided in the vignettes on the causes of the client's symptoms. In addition, the client's engagement in prostitution appeared late in the vignette which may have generated different responses for causal attributions had it appeared earlier in the vignette. Second, it is possible that counselors may find it easier to modulate biases in their attributions of responsibility towards their clients rather than their biases pertaining to actual clinical judgment of the clients. Third, there is some preliminary evidence with regard to the influence of counselors' theoretical orientation to the manner in which they attributed responsibility to the client for the cause of the problem as well as to the solution of the problem (Hayes & Wall, 1998; McGovern, Newman, & Kopta, 1986). In this respect, the attributions of responsibility may have been less important in this brief vignette depending on the theoretical orientation of the counselors. Fourth, contemporary psychotherapy practice in the managed care world largely focuses on time-limited, and/or solution-focused therapies. This

may predispose clinicians to focus more on solutions rather than on the direct causes of the client's problems (Averill, Ruiz, Small, Guynn, & Tcheremissine, 2003; Burkard & Knox, 2004; Franko & Erb, 1998; Sanchez & Turner, 2003). Finally, literature in multiculturalism has suggested that current models of psychotherapy are largely influenced by European American values which emphasize individual responsibility for cause of the problem as well as improvement in the therapy process (e.g. Sue & Sue, 2003). In this study, the participants were predominantly White. They may be influenced by the values described before, thereby not demonstrating any difference across the three conditions.

Assessment of Functioning. The results further posited that counselors did not demonstrate any difference in the manner in which they assessed the client's level of psychosocial functioning. The Global Assessment of Functioning Scale primarily assesses clients' symptomatology and impairments in the social occupational functioning. It is possible that counselors may have focused primarily on the psychological symptoms of the client. The clients in all three conditions presented with similar symptoms and there was no specific information provided on psychosocial impairments in the vignettes. This may have contributed to the similar assessment of functioning evaluations of the clients in each of the experimental conditions. In addition, it is possible that counselors may not have considered the client's engagement in high risk behaviors (such as prostitution, selling drugs) as important to the assessment of psychosocial functioning. In a similar vein, counselors may not consider engaging in work that is illegal (therefore, generating greater risk) an important aspect of psychosocial occupational functioning of the client. While women who have experienced sexual trauma have significantly poorer psychological outcome in terms of their psychological functioning (Dimitrova, Pierrehumbert, Gatz, & Torrisi et al, 2010), this association may not necessarily have been made by the counselors in response to the brief vignette. In other words, counselors

may not have associated greater psychological trauma with prostitution. Finally, this also may be related to the instrument used. While the GAF Scale was used for assessment, the response format was more akin to a likert-type scale, which may have contributed to variability created by the idiosyncratic rating styles of the individual counselors.

Willingness to Work. Finally, counselors did not demonstrate any difference in their willingness to work with the clients presented in the different vignettes. It is possible that counselors are aware of the issues of women in prostitution and may be inclined to work with them. However, the element of social desirability in response to the vignettes cannot be ruled out as a contributor to the lack of difference between the vignettes, particularly because most of the participants did not report having experience working with women in prostitution.

Hypothesis II

The second hypothesis was studied using canonical analyses methodology to explain the relationships between the predictor and criterion variables. The set of criterion variables for counselor bias were predicted simultaneously from the two predictors, which are counselor perceptions and inaccurate beliefs about prostitution. The results revealed two roots characterized by a significant relationship between the criterion variable of counselor bias and the covariates of counselor perceptions of prostitution and attitudes towards prostitution taken together.

The first root was characterized by a significant positive relationship between the predictors, counselor perceptions of prostitution and accurate beliefs about prostitution and the criterion variable of empathy. There was also a significant negative correlation between the abovementioned predictors and the criterion variable of attribution of responsibility for the solution to the problem. The results of this root demonstrated that counselors who held perceptions of prostitution as a form of oppression and therefore, as inherently traumatizing,

combined with more accurate beliefs about prostitution demonstrated greater empathy for the client in prostitution, and attributed less personal responsibility to the client for solving her problems.

On the other hand, the second root was characterized by a moderate negative loading of empathy and a moderate negative loading of assessment of functioning on one side, and moderate positive loading of counselor perceptions of prostitution. This implies that counselors who view prostitution as inherently traumatizing and a form of oppression demonstrated less empathy and assessed the client engaging in prostitution as having a lower level of functioning. This second root yielded confusing results that directly contradicted the first root. First, inaccurate beliefs about prostitution (Attitudes Towards Prostitution Scale; Sawyer et al, 2001) had a modest loading and had a positive relationship with counselor perceptions of prostitution which was the reverse of the first root. Second, there was a positive relationship between perceptions about prostitution and empathy in the first root, whereas, the second root had a negative correlation between these two variables. In addition to these results, once the variance of the first root was accounted for, the variable called inaccurate beliefs about prostitution was no longer significant in the context of the second root. Finally, the relationship between the variable called 'assessment of functioning' became significant.

These results presented a very curious finding. When this root was examined for interpretation, it revealed that counselors who viewed prostitution as inherently traumatizing, and held inaccurate beliefs about prostitution to a small degree, demonstrated less empathy and assessed the client as having a lower level of functioning. While the relationship between counselor perceptions and assessment of functioning were according to prediction and theoretically consistent, the relationship between counselor perceptions and empathy was not. This made the second root difficult to interpret due to its confusing nature. One possibility is that

this root was statistically spurious and an artifact of measurement error. A second possibility is that the relationships among these variables are highly complex and nuanced, with some inherent contradictions and dialectical relationships that are hard to parse in the linear statistical models used in this study. Naturally, these inferences are speculative and require more in depth assessment which is beyond the scope of this study. Nonetheless, it is apparent that 'inaccurate beliefs about prostitution' is a crucial contributor to the relationship between counselor perceptions of prostitution and empathy. Therefore, the relationship between empathy and counselor perception of prostitution in the first root discussed later in this chapter is interpreted with considerable caution.

Overall, these results were in partial support of the hypothesis which stated that in responding to the client vignette where prostitution is used as a means of supplementing income, counselors who are more likely to exhibit attitudes towards prostitution which involve beliefs about prostitution as a form of oppression and more accurate beliefs about prostitution, will be more likely to demonstrate more empathy, attribute lesser responsibility to the client for the cause and the solution for the client's problems, be less likely to judge the client in prostitution to have a low level of functioning, and be more willing to work with the client.

Empathy was again a strong contributor to counselor bias. The importance of empathy in psychotherapy practice is elaborated in the context of the first hypothesis. As mentioned in Chapter 2, counselors who are likely to view prostitution as an intrinsically harmful enterprise and hold more accurate beliefs about prostitution, likely view prostitution as inherently traumatizing. They are likely to view women in prostitution as victims of social oppression and therefore, will likely be more sensitive to the needs of women in prostitution. They may be more likely to anticipate the presence or threat of physical, emotional, and sexual violence in their client's lives. Empathy is a crucial element in the psychotherapeutic treatment of trauma

(Crenshaw & Hardy, 2007, Lee, 2009; Perkins, 2005). Having a trauma-based approach allows counselors to be sensitive to the shame, blame and stigma associated with prostitution, allowing for greater assessment and treatment of the harmful experiences that have been an intrinsic part of prostitution. They are more likely to understand that certain maladaptive behaviors are a response to trauma, demonstrate knowledge regarding the mental health effects of physical, sexual and emotional violence, and exhibit skills in trauma-specific treatment (Clawson, Salomon, & Grace, 2008).

However, as is demonstrated by the second root, the minimal presence of inaccurate beliefs of prostitution actually reverses the relationship with empathy. Empathy is lower when counselors view prostitution as an intrinsically harmful enterprise but hold inaccurate beliefs about prostitution. Inaccurate beliefs about prostitution involve counselors' belief that most prostitutes make a lot of money, women choose to be in prostitution, prostitutes enjoy their work, prostitutes genuinely like men, there is nothing wrong with prostitution, and that prostitutes are not victims of pimps.

When counselors have more accurate beliefs combined with the view that prostitution is intrinsically harmful, counselors are more likely to view women in prostitution as being the victim of circumstances, with limited agency and considerable difficulty resolving the challenges confronted alone. Counselors are likely to attribute less responsibility to the client for her problems and view her as requiring greater care-giving or assistance in finding solutions to their problems. Therefore, they are most likely to engage with the client with a specific focus on their needs. This informative finding indicates that counselors are likely to be more empathic and inclined to provide more care giving if they view prostitution as inherently traumatizing and a form of social oppression.

As is evident from the second root, assessment of functioning emerged as a potentially important variable in this study. More specifically, counselors who viewed prostitution as inherently traumatizing and a form of oppression are aware of and attuned to the violence and risk-taking associated with prostitution thereby assessing women in prostitution as having a lower level of functioning. These counselors likely consider engaging in work that is illegal and generating greater risk as an important aspect of psychosocial and occupational functioning of the client.

On the other hand, counselors who likely view women in prostitution as agentic and/or as a self-expression of their sexuality and hold inaccurate beliefs about prostitution are likely to treat women in prostitution as experiencing similar issues as other people who seek therapy services, thereby not requiring special attention. They are likely to assign personal responsibility to the client in solving their own problems, thereby believing that they do not require additional assistance and support.

Implications

The results of this study have important implications for counselors, supervisors and researchers in assessing and understanding their bias when it comes to women in prostitution. These implications for counseling practice, counselor education and future research are presented below.

Counseling Practice

The first implication is the importance of empathy in counseling practice. The results of this study emphasize the importance of empathy when working with women in prostitution. While counselors demonstrated greater empathy for the client engaging in prostitution than for the client selling drugs, they did not demonstrate any difference in the manner in which they would treat the client who engaged in prostitution and the client who worked over time. This

indicated that while counselors may be aware of some of the challenges that women in prostitution face, they may not be aware of and therefore may not be sensitive to the specific challenges that the women who work in prostitution face compared to people who do not work in prostitution. For example, counselors need to be sensitive to the shame and blame that is an integral part of the help-seeking process, particularly when an individual engages in prostitution (Snell, 1995; Vogel, Wade, & Haake, 2006). Counselors will likely benefit from more information and training in working with people in prostitution. Therefore, empathy is a very important tool for counselors in developing an effective therapeutic alliance with their clients who engage in prostitution, as with any other client presenting issues in treatment.

Counselor attitudes, perceptions and beliefs about prostitution are very important when working with people who work in marginalized professions like women in prostitution. It is important to note that the attitudes and beliefs that counselors hold about prostitution very likely influence the manner in which they work with women in prostitution. Counselors need to be aware of their beliefs about prostitution and make their attitudes explicit to themselves as they manage their reactions to clients. They also need to monitor for themselves their biases when working with women in prostitution. In addition, it is crucial for counselors to be educated about the needs of women prostitution, dispel myths about prostitution, and be aware of the oppression and potential trauma involved in prostitution. This is likely to help counselors be more empathic, seek supervision regarding issues of countertransference and vicarious trauma, and provide more care giving to clients who engage in prostitution.

An unanticipated but significant finding of this study was that counselors exhibited less empathy for the client selling or dealing with drugs. This is a serious consideration for counselors who provide psychotherapy services to clients who engage in forms of work that are associated with crime; i.e. they need to be aware of their countertransferential bias. If not

attended to, such bias may inadvertently affect other aspects of treatment provided to these clients (e.g. the therapy relationship). It would behoove the clinician to explore the reasons for less empathy and obtain feedback on their reactions in supervision. The therapeutic encounter provides a setting infused with the values of the therapist, the client, and the interaction of their values. It is commonly accepted that counselors, inasmuch as their clients, are influenced by their own values and experiences (Bergin, 1980; Kelly, 1990). Eliciting and clarifying counselor values explicitly or implicitly conveys the counselors' respect for diversity. At times, clients actively engage in behaviors that are discordant with the values of the therapist, such as actions that have the potential to harm themselves or others. Being mindful of such disconnections would enable the clinician to facilitate caring confrontation that serves to alert the client to the consequences of his/her actions.

Another implication for counseling practice is acknowledging the importance of work in people's lives. Work is a major part of clients' lives and clients engage in various forms of work to fulfill the needs for survival, relational connections, and self-determination (Blustein, 2006; for details refer to Chapter 2). Counselors would benefit from being aware of and focusing on work and work issues as an integral part of the therapy process, particularly when the client works in a field that involves great risk and deviates from legal channels. It would be worthwhile for counselors to understand the meaning that clients make from and attribute to their work experiences. In addition, exploring the pathways that lead them to engage in work that is outside social and cultural norms would provide counselors with deep insight into the motivation, strivings, and challenges that compel clients to engage in work that is considered socially deviant. Counselors would be able to facilitate the therapy process by joining their clients in grappling with the personal, social, and economic barriers that clients face as they strive to be creative and productive members of society.

Counselor Education

Based on the results of this study, counseling training programs can provide more training to future clinicians in the area of sex, sexuality, and sexual oppression. This in turn would increase counselors' competence in providing their clients with knowledge regarding safe sex, comfort with sexuality, and identifying sexual abuse and trauma when it occurs. Moreover, this sort of training may help counselors differentiate sexuality from prostitution, which is a distinct aspect of working and social oppression that involves trading sexuality in the market place. In addition, training programs can disseminate greater information and knowledge on different forms of work which deviate from mainstream and socially accepted occupations.

An important implication of this study is the importance of exploring one's biases when providing psychotherapy services to clients from diverse backgrounds and experiences. This would assist counselors-in-training in carefully monitoring one's internal reactions that may consciously or unconsciously interfere with the therapeutic alliance. Awareness and acknowledgment of biases would also assist counselors in becoming more comfortable and competent in providing mental health services to clients who engage in marginalized forms of work such as prostitution.

Supervisors can assist clinicians-in-training by helping them consider the importance of work and work experiences of their clients, particularly those who engage in marginalized forms of work. They can also assist their supervisees by becoming more comfortable in addressing issues of sex, sexuality and sexual trauma. Finally, they can create a nonjudgmental environment in supervision for counselors-in-training to explore their beliefs and attitudes about people who engage in prostitution.

Future research

The results of this study are also crucial to future research. There is a need for more studies in general on factors that influence counselor bias and impede the therapy process. Further inquiry is necessary to study other components of bias that may be involved in the therapeutic process that influences therapy engagement and outcome. There is a need for more studies on empathy and the importance of this component in working with diverse groups of clients based on race, gender, social class, age, sexual orientation and those engaging in marginalized forms of work such as prostitution. In addition, counselor bias and experiences working with people who engage in criminal activities such as selling illicit drugs is an area for further inquiry. More information on the lives, experiences, and motivations of people who engage in such work would provide counselors with greater awareness and knowledge to maintain an empathic stance and resolve impasses.

Most importantly, investigations are necessary to be conducted on prostitution by obtaining information from actual experiences of counselors in working with women in prostitution. Additionally, learning about the experiences of women engaging in prostitution would also shed light on the factors that facilitate or impede access to psychological services. Furthermore, the efficacy of interventions focused on educating counselors on the unique needs of people engaging in prostitution may be an area of expansion of this study. Studies of this nature may provide greater information on components that are responsible for underutilization of mental health services by women in prostitution and also make services provided to women in prostitution more targeted and efficacious.

Limitations

There are several limitations to this study. These are addressed below under the categories of participants, stimulus materials and constructs, statistics and norms of instruments.

Participants

The first limitation relates to the participant pool. The data for this study were collected through electronic methods generating a very selective sample of people who participated in the study. It is possible that those who chose not to respond could have altered the results of this study had they actually chosen to participate. While this is difficult to determine, it is important to note as a potential limitation.

In both the preliminary and final studies, a large number of participants were students enrolled in doctoral programs. Therefore, the results are generalized to the larger population with some caution. Only 25% of the sample identified having experience working with people in prostitution. This lack of experience in three-quarters of the sample may have influenced the results significantly. Related to this, there was also no opportunity for obtaining baseline data for counselors' level of bias related to prostitution prior to administering the vignette. Given the blind nature of the study, this was impossible to ascertain. The remuneration offered to the clinicians may also have affected their motivation in participation and the results may reflect some elements of social desirability.

Stimulus Materials and Constructs

Limitations must also be noted with regard to the stimulus materials and dependent variables. The written vignettes were brief and provided limited information which allowed for maximum control of the conditions of the study. This allowed for the results of this study to be attributable to the actual differences rather than the influence of factors beyond control. At the same time, the analogue design of simulated brief vignettes limits the generalizability of the

results to actual clinical practice. These vignettes excluded information about the psychotherapy process, client presentation in psychotherapy and details of the client's experiences. They also exclude all verbal, nonverbal and interactive cues that characterize actual therapy sessions. Consequentially, counselors were required to make judgments based on abstraction which affect the generalizability of the results of this study.

While the vignettes incorporated specific demographic information related to the client's race (White) and sexual orientation (heterosexual), the specific demographic information regarding the client's social economic status was more ambiguous. The client in the vignette worked in a department store and then worked in prostitution, selling drugs, or overtime for extra money indicating that the client was likely struggling to make ends meet predisposing respondents to believing that that client may not have had choice in terms of the work they engaged in for extra money. Therefore, the respondents' perception of the client's social economic status may have contributed to the reported levels of empathy (and possibly other variables) for the client in the prostitution condition and for the client in the marijuana condition as well.

Some of the constructs used in this study also were limited in terms of their operationalization. Prostitution comprises of a wide variety of sexual services provided in exchange for money. This broad definition of the construct of prostitution may not have been adequately captured by the vignette used in this study. This may have influenced the responses of the participants significantly since each participant may have responded based on their idiosyncratic view of what comprises of prostitution. In addition, the items of the CPPS scale addressed prostitution as a whole. The responses may have varied depending on the type of prostitution that respondents imagined the items addressed i.e. different responses may have been evoked in the context of particular forms of prostitution.

The construct of clinical bias is also limited to specific components, namely empathy, attributions of responsibility, assessment of functioning and willingness to work. This study did not tap into other forms of clinical bias that may pervade a psychotherapy situation. For example, certain countertransference reactions may negatively influence the therapy process and outcome for a client who engages in prostitution. In addition, there may have been other forms of bias that may have confounded the data. For example, the client's gender may have influenced counselor bias. Counselors may have responded differently if the client was male instead of female.

It is important to note that empathy, as a variable, has frequently been used in academic literature as a trait phenomenon and occasionally as a state phenomenon. While this study specifically focused on empathy as a state phenomenon, there was no assessment of empathy as a baseline trait in the counselors. This may have contributed to the skewed data in the empathy ratings provided in response to the vignettes.

Finally, the results obtained in this study were strictly based on self-report of the participants. There may have been elements of social desirability which would not necessarily be prevalent in actual practice in on-to-one sessions. This study did not explore elements of implicit bias of the counselors which may have when working with women in prostitution.

Statistics

The statistics used for the analysis of this main study was the MANOVA procedure. One of the major assumptions of this statistical procedure is the lack of multicollinearity between the dependent variables. In this study, the variables of empathy and attribution of responsibility for cause and between the variables of empathy and willingness to work were correlated as presented earlier. When checked for correlations between these dependent variables, they demonstrated a small albeit significant relationship. As a precautionary measure, separate

analyses were conducted by omitting each of the correlated dependent variables individually. Despite omitting these variables separately, there was no difference in the results obtained. Therefore, all the dependent variables were left in the presentation of the results of the final analyses. However, the presence of multicollinearity among certain dependent variables is cited as a minor limitation of this study.

Another statistical limitation of this study involved the uneven number of participants in each of the conditions. In order to test the second hypothesis, it was necessary to obtain a larger number of respondents for the prostitution condition. There were 91 participants in the prostitution condition, 73 in the marijuana condition and 50 in the overtime condition. The number of participants was adequate in terms of statistical power for interpreting the results of the MANOVA with confidence. While this is a minor limitation, it is nonetheless important to note.

While additional analyses were beyond the scope of this study, further inquiry is warranted in the realm of the influence of different demographic variables on the overall MANOVA model used in this study. While some basic preliminary analyses revealed that the variable of age had some influence on the different between the groups, there needs to be more follow-up in this respect.

Finally, the results of the canonical correlation analysis revealed a second root which was confusing and not theoretically consistent. There were direct contradictions between this root and the first root. In addition, the relationship between counselors' perceptions of prostitution and empathy were particularly difficult to interpret. While the results of both roots were interpreted for the purpose of this study, they are interpreted with considerable caution.

Norms of Instruments

It is essential to note that there is reason to question the reliability and validity of some of the instruments used in this study. First, the GAF scale used was a single item and was modified to a Likert-type response format as opposed to a single number between 1 to100 that counselors are used to reporting as their assessment of the clients social and occupational functioning. Second, the Solution scale yielded a low internal reliability estimate in this study which introduces some unpredictable error into the analyses. Finally, besides the empathy scale, the scales used for each of the dependent variables were short and Likert-type, which may not have adequately captured the complexity involved in attributions of personal responsibility, assessment of functioning and decisions with regard to willingness to work.

Summary and Conclusions

In summary, the results of this study indicated that counselors may be aware of some of the issues that women in prostitution face and thereby exhibit a similar degree of empathy as they would to other clients who do not engage in marginalized professions. The results also indicated that counselors who hold accurate beliefs about prostitution and hold attitudes towards prostitution as being inherently traumatizing and a form of social oppression are more likely to demonstrate greater empathy and provide more assistance and care giving to clients who engage in prostitution. Supplementary evidence demonstrated that counselors who hold perceptions of prostitution as an inherently harmful enterprise also judged the client in prostitution as having a lower social and occupational functioning. Finally, an unexpected result of the study revealed that counselors demonstrated least amount of empathy for the client who sells drugs for extra money.

While the results of this study are presented with some caution and awareness of limitations related to the participant pool, stimulus materials and constructs, statistics, and norms of the instruments, the results have some important implications for counseling practice, research and education. The results underscore the need for counselors to be aware of their perceptions of prostitution and monitor their biases when working with this population. It is recommended that awareness of potential biases would likely improve the therapeutic care that counselors provide to clients in prostitution. These biases could be attended to in training and supervision. In addition, counselors would benefit from knowledge regarding the polarized debates that exist in the literature regarding the nature of prostitution. As a result, counselors would better grasp the myths perpetuated by conflicting ideas, form their own opinions, and recognize the vast range of experiences of people in prostitution while reinforcing the practicality of individualizing mental health strategies to their clients.

It is essential that counselors explore their biases with regard to clients who engage in work that deviate from social norms such as selling illicit drugs and engaging in other criminal activities. Overall, empathy, caring, and the ability to listen well are critical elements in fostering the growth of clients in therapy, even those who may be involved in illegal activities (Masters, 1994). At the same time, counselors are urged to advocate for social responsibility through judiciously challenging their clients on the consequences of their actions to themselves and others in society.

This study is the first step to generating a body of literature focused on providing competent, targeted and sensitive services to people engaged in prostitution. It seeks to understand how counselors' attitudes and beliefs about prostitution influence their work. Future research needs to be conducted on the complex relationship between counselor perceptions of prostitution and the actual experience that women in prostitution have when engaging in psychotherapy.

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Appendix A: Clinical vignettes used in the final study

Vignette 1

Miss S is a 23 year old, single, White American woman straight-identified women who presents in therapy complaining about feeling hopeless and empty and finding her life meaningless. She appears to be of medium height and weight, dressed casually and speaks with soft, low tone. She says “I have not been feeling myself lately”. She reports crying frequently for no reason, not being able to sleep, pervasive feelings of guilt, and having suicidal thoughts. She makes little or no eye-contact through the intake and appears to have tremors. She presents as being depressed, anxious and aloof.

Ms S reports that she was one of six siblings raised in an impoverished neighborhood. After graduating from High School, Miss S began working odd jobs. At present she works as a departmental store clerk. She has little or no time for friends because of her work schedule. At the end of the session, she mentions that in order to sustain herself, she provides sex in exchange for money.

Vignette 2

Miss S is a 23 year old, single, White American woman straight-identified women who presents in therapy complaining about feeling hopeless and empty and finding her life meaningless. She appears to be of medium height and weight, dressed casually and speaks with soft, low tone. She says “I have not been feeling myself lately”. She reports crying frequently for no reason, not being able to sleep, pervasive feelings of guilt, and having suicidal thoughts. She makes little or no eye-contact through the intake and appears to have tremors. She presents as being depressed, anxious and aloof.

Ms S reports that she was one of six siblings raised in an impoverished neighborhood. After graduating from High School, Miss S began working odd jobs. At present she works as a departmental store clerk. She has little or no time for friends because of her work schedule. At the end of the session, she mentions that in order to sustain herself, she sells marijuana.

Vignette 3

Miss S is a 23 year old, single, White American woman straight-identified women who presents in therapy complaining about feeling hopeless and empty and finding her life meaningless. She appears to be of medium height and weight, dressed casually and speaks with soft, low tone. She says “I have not been feeling myself lately”. She reports crying frequently for no reason, not being able to sleep, pervasive feelings of guilt, and having suicidal thoughts. She makes little or no eye-contact through the intake and appears to have tremors. She presents as being depressed, anxious and aloof.

Ms S reports that she was one of six siblings raised in an impoverished neighborhood. After graduating from High School, Miss S began working odd jobs. At present she works as a departmental store clerk. She has little or no time for friends because of her work schedule. At the end of the session, she mentions that in order to sustain herself, she works overtime in the department store.

Appendix B: Informed consent for CPPS

UMA CHANDRIKA MILLNER
LYNCH SCHOOL OF EDUCATION
DEPARTMENT OF COUNSELING, DEVELOPMENTAL,
AND EDUCATIONAL PSYCHOLOGY
CHESTNUT HILL, MA 02467
OFFICE PHONE: (617) 552-4710
E-MAIL: **DAMUM@BC.EDU**

Dear Participant,

You are being asked to participate in a research study related to the development of a scale on counselor perceptions of prostitution. The purpose of this study is to develop a scale that measures attitudes of counselors towards women who work in the commercial sex industry. Participants in this study are students from gradate programs in psychology who are currently in a field placement. The total number of subjects is expected to be approximately a hundred participants. Therefore, you were selected as a possible participant because you are either in the second year of the Masters program in Mental Health Counseling or in a doctoral program in Clinical or Counseling Psychology.You are currently a mental health professional in training and in a placement. We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Procedures

If you agree to be in this study, please fill out the attached survey in the best possible way that you can. You are being asked to rate your attitude towards women in the commercial sex industry. It will take you approximately 10-15 minutes. Please try to complete it in one sitting.

Benefits and Discomforts of Being in the Study

The purpose of the study is to develop a scale measuring attitudes of counselors towards women in prostitution. The benefits of being in this study include increased awareness of your attitudes towards women in prostitution and such awareness can help guide you in your clinical work.

There are no reasonable foreseeable risks. However, since the subject matter is related to perceptions of an illegal activity which embodies social stigma, there may be potential for emotions getting stirred up related to sex and sexuality, discrimination and oppression. If, at any point you do not feel comfortable, the survey can be ended immediately. In such a case, you are invited to share your discomfort or concerns with the investigator or her research advisor.

Please note that there is no payment or reimbursement for participating in the study and there are no costs to you for participating in this research study.

Confidentiality

The records of this study will be kept private. In any sort of report we may publish, we will not include any information that will make it possible to identify a participant. Research records will be kept in a locked file and all electronic information will be coded and secured using a password protected file. Access to the records will be limited to the researchers; however, please note that regulatory agencies, and the Institutional Review Board and internal Boston College auditors may review the research records.

Voluntary Participation/Withdrawal

Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University, the Department you are in and the teacher/s teaching the courses you are enrolled in. You are free to withdraw at any time, for whatever reason. There is no penalty or loss of benefits for not taking part or for stopping your participation. This will not jeopardize grades or risk loss of present or future relationships with the faculty, school or University relationships.

Contacts and Questions

The researchers conducting this study are Uma Chandrika Millner, M.A. and David Blustein, Ph.D. For questions or more information concerning this research you may contact them by email at damum@bc.edu. If you believe you may have suffered a research related injury, contact Uma Chandrika Millner at 617-416-8854 who will give you further instructions. If you have any questions about your rights as a research subject, you may contact: Director, Office for Human Research Participant Protection, Boston College at (617) 552-4778, or irb@bc.edu.

You may retain a copy of this form for your records and future reference.

I have read the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give my consent to participate in this study. I will receive a copy of this form.

Study Participant (Print Name):
Date

Appendix C: Email for administrators of listservs of organizations and agencies

Dear [Administrator Name]

My name is Uma Chandrika Millner. I am a Ph.D. candidate in Counseling Psychology at Boston College. I am currently recruiting participants for my dissertation under the advisement of Dr. David L. Blustein The purpose of our study is to understand the manner in which counselor perceptions influence their clinical work. The participants in the study are mental health professionals who are currently providing psychotherapy services to people with a variety of mental health conditions.

We are writing to request permission to access the listserv [email listing] of the members of your organization [or clinicians who work in your agency]. If the clinicians agree to participate in this study, we would ask them to fill out a survey and in some cases there will be an open-ended response section. The entire process should not take more than 20-30 minutes to complete. We would greatly appreciate your participation and distribution of the electronic study link (either by e-mailing colleagues or via listserv distribution). This study has been approved by Institutional Review Board at Boston College (#10.160.01).

I have attached the recruitment statement and also copied it at the end of this email. Please let me know if you have any questions.

Thank you for your time, consideration and for your assistance in this matter.
Sincerely

Uma Chandrika Millner

Uma Chandrika Millner, M.A.
Ph.D. Candidate in Counseling Psychology
Counseling, Development & Educational Psychology
Boston College
140 Commonwealth Avenue
Chestnut Hill, MA 02467
(617) 416-8854

Appendix D: Email for administrators of doctoral programs

Dear [Administrator Name]

My name is Uma Millner. I am a Ph.D. candidate in Counseling Psychology at Boston College. I am currently recruiting participants for my dissertation under the advisement of Dr. David L. Blustein The purpose of our study is to understand the manner in which counselor perceptions influence their clinical work. The participants in the study include students in doctoral training programs in psychology who are currently providing psychotherapy services to people with a variety of mental health conditions.

We are writing to request permission to forward our survey to the listserv [email listing] of the doctoral students in the Clinical [Counseling] Psychology program at [name] University. If the student agrees to participate in this study, we would ask them to fill out a survey and in some cases there will be an open-ended response section. The entire process should not take more than 20-30 minutes to complete. We would greatly appreciate your participation and distribution of the electronic study link. This study has been approved by Institutional Review Board at Boston College (#10.160.01).

I have attached the recruitment statement and also copied it at the end of this email. Please let me know if you have any questions.

Thank you for your time, consideration and for your assistance in this matter.
Sincerely

Uma Chandrika Millner

Uma Chandrika Millner, M.A.
Ph.D. Candidate in Counseling Psychology
Counseling, Development & Educational Psychology
Boston College
140 Commonwealth Avenue
Chestnut Hill, MA 02467
(617) 416-8854

Appendix E: Recruitment flyer for mental health professionals

Thank you in advance for your interest and participation! Please feel free to forward this e-mail to anyone who would be interested in participating in this electronic survey.

My name is Uma Chandrika Millner. I am a Ph.D. candidate at Boston College and I am currently collecting data for my dissertation under the supervision of David L. Blustein, Ph.D. The purpose of the study is to understand the manner in which counselor perceptions influence their clinical work. You are eligible to participate in this study because you are a mental health professional who is currently providing psychotherapy services to people with a variety of mental health conditions.

Participation in the study will take approximately 20-30 minutes and the data will be collected using a web-based survey. Participation in the study is voluntary, and you may opt out of the study at any time by exiting the survey (exiting the survey even after you begin will automatically delete your responses). In addition, you have the option of entering into a drawing for one of five Starbucks' gift certificates worth $25.00. Please note that the records of this study will be kept private and steps will be taken to ensure that no individual participant is identifiable or traceable to their names or email addresses. In any sort of report we may publish, we will not include any information that will make it possible to identify you as a participant. Please copy the following URL into your web browser or follow the link:

[survey link]

Thank you for your time and help.

Sincerely,

Uma Chandrika Millner

Uma Chandrika Millner, M.A.
Ph.D. Candidate in Counseling Psychology
Counseling, Development & Educational Psychology
Boston College
140 Commonwealth Avenue
Chestnut Hill, MA 02467
(617) 416-8854

Appendix F: Informed consent for final study

Dear Participant

You are being requested to participate in a research study on counselor perceptions. The purpose of this study is to understand the manner in which counselor perceptions influence their clinical work. Participants in this study are mental health professionals who are currently providing psychotherapy services to people with a variety of mental health conditions. You are eligible to participate in this study because you are a psychologist, psychotherapist, mental health counselor, or social worker currently in clinical practice or a psychologist-in-training enrolled in a clinical or counseling psychology doctoral training program. The total number of participants is anticipated to be approximately one hundred and eighty.

If you agree to participate in this study, we would ask you to fill out the attached survey, read the vignette, and respond to a total of seven questionnaires and rating scales. The number of items for each scale ranges from a single item to twenty items. In some cases, there will be an open-ended section for you to respond. The entire process should not take more than 30 minutes to complete.

The benefits of being in this study include increased awareness of your approach to clinical work in relation to some current social issues. Such awareness may improve the manner in which you conduct counseling or psychotherapy. In addition, there are no reasonable foreseeable risks. Any risks that may come up as part of the study are unknown at this time. However, since the material presented is of clinical nature, there may be potential for strong emotions getting stirred up. If, at any point you do not feel comfortable, the survey can be ended immediately. In such a case, you are invited to share your discomfort or concerns with the investigator or her research adviser. Please note that the results of this research may be presented at meetings or in published articles. Please note that there is no payment or reimbursement for participating in the study and there are no costs to you for participating in this research study. If you complete this study, you will be entered in a raffle to earn one of five $25 gift cards to Starbucks Coffee.

The records of this study will be kept private. Each record will be assigned a number to ensure that no individual participant is identifiable or traceable to their names or email addresses. In any sort of report we may publish, we will not include any information that will make it possible to identify you as a participant. Research records will be kept in a locked file in the principle investigator's office; all electronic information will be coded and secured using a password protected file. Access to the records will be limited to the researchers; however, please note that regulatory agencies, and the Institutional Review Board and internal Boston College auditors may review the research records.

Your participation is voluntary. If you choose not to participate, it will not affect your current or future relationships with your academic institution, place of employment or affiliation with any organization. You are free to withdraw at any time, for whatever reason. There is no penalty or loss of benefits for not taking part or for stopping your participation. This will not jeopardize academic or professional affiliation or employment or risk loss of present or future relationships with the administrators, employers, universities, or agencies.

The researchers conducting this study are Uma Chandrika Millner, M.A. and David Blustein, Ph.D. For questions or more information concerning this research, you may contact them by email at damum@bc.edu or blusteid@bc.edu. If you believe you may have suffered a research related injury, contact Uma Chandrika Millner at 617-416-8854 who will give you further instructions. If you have any questions about your rights as a research subject, you may contact: Director, Office for Human Research Participant Protection, Boston College at (617) 552-4778, or irb@bc.edu.

If you agree to participate, please click "NEXT" to enter the survey. Your completion of the measures will serve as your consent to participate.

Thank you
Sincerely

Uma Chandrika Millner

Appendix G: Empathy Scale
(Adapted from Interpersonal Reactivity Scale)

The following statements inquire about your thoughts and feelings in the situation of Ms. S. For each item, indicate how well it describes you. Please read each item carefully before responding. Answer as honestly as you can.

1. I would have tender, concerned feelings for Ms. S.

   ☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

2. I would find it difficult to see things from Ms. S's point of view.

   ☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

3. I would not feel very sorry for Ms. S when she is having the problems described.

   ☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

4. I would try to look at everybody's side of a disagreement in the case of Ms. S before I make a decision.

   ☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

5. When I see Ms. S. taken advantage of, I feel kind of protective towards her.

   ☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

6. I try to understand Ms. S better by imagining how things look from her perspective.

   ☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

7. Ms. S's misfortunes do not disturb me a great deal.

   ☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

8. If I'm sure I'm right about something in working with Ms. S, I wouldn't waste much time listening to her arguments.

☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

9. When I see Ms. S being treated unfairly, I don't feel very much pity for her.

☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

10. I am quite touched by things that I see happening to Ms. S.

☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

11. I believe that there are two sides to every question in this case and try to look at them both.

☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

12. When thinking about Ms. S, I would describe myself as a pretty soft-hearted person.

☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

13. If I felt myself upset at Ms. S, I would try to “put myself in her shoes” for a while.

☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

14. Before criticizing Ms. S, I would try to imagine how I would feel if I were in her place.

☐ Does not describe me well ☐ Describes me a little ☐ Describes me somewhat ☐ Describes me a lot ☐Describes me very well

Appendix H: Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations. Please rate Ms. S on the following scale:

☐ 100-91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

☐ 90-81 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members).

☐ 80-71 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g. temporarily falling behind in schoolwork).

☐ 70-61 Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational or, school functioning (occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

☐ 60-51 Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational or school functioning (e.g., few friends, conflicts with peers or co-workers)

☐ 41-50 Severe symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).

☐ 31-40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

☐ 21-30 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).

☐ 11-20 Some danger of hurting self or others (e .g. suicidal attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

☐ 1-10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

Appendix I: Cause and Solution Scales

In the items that follow, please check the appropriate box for each of the items of the scale below that most accurately reflects the extent to which you agree or disagree with the statement. The scale ranges from "not at all" to "very much".

1. I believe Ms. S is personally responsible for the cause of her problems.

   ☐ Completely Disagree ☐ Mostly Disagree ☐ Slightly Disagree ☐ Undecided ☐ Slightly Agree ☐ Mostly Agree ☐ Completely Agree

2. I believe Ms. S. could have avoided the problems that she has

   ☐ Completely Disagree ☐ Mostly Disagree ☐ Slightly Disagree ☐ Undecided ☐ Slightly Agree ☐ Mostly Agree ☐ Completely Agree

3. I believe Ms. S. could have controlled the cause of her problems

   ☐ Completely Disagree ☐ Mostly Disagree ☐ Slightly Disagree ☐ Undecided ☐ Slightly Agree ☐ Mostly Agree ☐ Completely Agree

4. I believe that Ms. S is personally responsible for creating a solution to her problems

   ☐ Completely Disagree ☐ Mostly Disagree ☐ Slightly Disagree ☐ Undecided ☐ Slightly Agree ☐ Mostly Agree ☐ Completely Agree

5. I believe Ms. S could overcome her problems alone

   ☐ Completely Disagree ☐ Mostly Disagree ☐ Slightly Disagree ☐ Undecided ☐ Slightly Agree ☐ Mostly Agree ☐ Completely Agree

6. I believe Ms. S. could control the solution to her problems

   ☐ Completely Disagree ☐ Mostly Disagree ☐ Slightly Disagree ☐ Undecided ☐ Slightly Agree ☐ Mostly Agree ☐ Completely Agree

Appendix J: Willingness to Work with the Client Scale

In the items that follow, please check the appropriate box for each of the items of the scale below that most accurately reflects the extent to which you agree or disagree with the statement.

1. How likely would you be to take Miss S on as a client?

   ☐ Very Likely Not ☐ Most Likely Not ☐ Somewhat Likely Not ☐ Unsure ☐ Somewhat Likely ☐ Most Likely ☐ Very Likely

2. How likely would you be to refer Miss S to another therapist?

   ☐ Very Likely Not ☐ Most Likely Not ☐ Somewhat Likely Not ☐ Unsure ☐ Somewhat Likely ☐ Most Likely ☐ Very Likely

Appendix K: Client Rating Scales

Instructions: The following are a number of questions regarding the vignette of Ms. S that you just read. Answer each question by checking the box of the number that best corresponds to you answer. Please respond quickly without spending a lot of time on any one question.

1. How much do you like this client?

Very Much					Not at All
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

2. How much do you empathize with this client?

Very Much					Not at All
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

3. How comfortable would you feeling in dealing with this client?

Very Comfortable					Not at All Comfortable
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

4. How willing would you be to take this person on as your client?

Very Willing					Not at All Willing
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

5. How would you rate this client's level of psychological adjustment?

Very Maladjusted					Very Well Adjusted
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

6. How would you rate this client's prognosis?

Excellent					Very Poor
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

7. How much of this client's difficulty would you attribute to causes within herself as opposed to causes external to her?

Entirely Internal Causes					Entirely External Causes
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

8. How much of this client's difficulty would you attribute to stable enduring causes as opposed to unstable transient causes?

Entirely Stable Causes					Entirely Unstable Causes
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Appendix L: Counselor Perceptions of Prostitution Scale

In the items that follow, please check the appropriate box below that most accurately reflects the extent to which you agree or disagree with the statement.

Please note that the term "commercial sex industry" represents work in street prostitution, massage brothels, escort services, outcall services, strip clubs, lap dancing, phone sex, adult and child pornography, child prostitution, video and internet pornography, trafficking, and prostitution in tourism.

1. I believe that women who work in the commercial sex industry are fulfilling their own aspirations.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

2. Women who work in the commercial sex industry have been coerced in this work based on circumstances beyond their control.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

3. I believe that women in the commercial sex industry are able to obtain power and control in their working lives.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

4. I believe that women in the commercial sex industry are severely traumatized by this experience.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

5. Women working in the commercial sex industry have opportunities to dominate men who need their services.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

6. I believe that women in the commercial sex industry are exposed to violence and degradation.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

7. I believe that term "sex work" is not an accurate representation in that women do not really have free choice in their choice of livelihood.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

8. I believe that prostitution is an outmoded concept; women who work in the commercial sex industry are making choices of their own free will about how to earn a living.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

9. Women working in the commercial sex industry are fortunate to be able to enjoy their work.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

10. I believe that prostitution or commercial sex work is an expression of women's sexuality.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

11. Sex work is the more appropriate term to denote volitional employment in the commercial sex trade.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

12. The term "prostitution" represents a level of denigration that is not consistent with contemporary work in the commercial sex industry.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

13. I think that sex work provides a good outlet for women to earn extra money.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

14. I think that prostitution is morally wrong.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

15. I believe that women who enter the commercial sex industry have a hard time leaving it.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

16. I believe that prostitution should be made legal so that women may have more choices.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

17. I believe that by legalizing prostitution we place women at higher risk of harm.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

18. I believe that prostitution is the epitome of patriarchal oppression of women.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

19. I believe that by legalizing prostitution, women will have greater rights and control over the work that they do.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

20. I believe that the work of women in prostitution is re-traumatizing.

☐ Strongly Disagree ☐ Disagree ☐ Uncertain ☐ Agree ☐ Strongly Agree

Appendix M: Attitudes Towards Prostitution Scale

In the items that follow, please indicate the appropriate number using the scale below that most accurately reflects the extent to which you agree or disagree with the statement.

1. Most prostitutes make a lot of money.

   ☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

2. Women are prostitutes because they want to be; it's their choice.

   ☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

3. Prostitutes enjoy their work

   ☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

4. Prostitutes genuinely like men.

   ☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

5. There is nothing wrong with prostitution.

   ☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

6. Prostitutes are victims of pimps.

   ☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Appendix N: Demographic Questionnaire

Please fill out a short demographic questionnaire as the last step of the study.

1. Sex

☐ Male
☐ Female

2. Age

MM/DD/YYYY

3. Race

☐ White ☐ Black ☐ Latino/Latina ☐ Asian /Pacific Islander ☐ Native American ☐ Multi-racial ☐ Other

4. Please write in the nature of clinical site? (e.g.Community Mental Health,Hospital, School, Residential,Private Practice,Consultant, Vocational Counseling, College Counseling, etc). Please indicate if you are currently not in clinical/counseling practice.

5. Highest degree obtained?

☐ B.A. ☐ B.S. ☐ M.A. ☐ M.S.W. ☐ L.M.H.C. ☐ L.M.F.T. ☐ L.I.C.S.W ☐ Psy.D. ☐Ph.D. ☐ M.D. ☐Other

6. If you have an area (or areas) of specialization, please list below.

7. How many years have you been in clinical practice?

8. Which theoretical orientation/s do you adhere to?

☐ Behavioral ☐ Biological ☐ Cognitive Behavioral ☐ DBT ☐ Integrative ☐ Interpersonal ☐ Humanistic-Existential ☐ Eclectic ☐ Systems ☐ Psychodynamic ☐ Psychoanalytic

9. What is the percent of your practice that you devote to clinical work? (Please rate from 0-100)

10. Do you have prior experience working with people in prostitution?

☐ Yes ☐ No

If yes, please share some of your experiences and insights in working with people in prostitution. Please enlist any outstanding questions that you may have regarding this population.