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Understanding the needs of LGBTQ clients and their risk for commercial sexual exploitation: Training community mental health workers

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ABSTRACT

Training on commercial sexual exploitation (CSE) and victimization of lesbian, gay, bisexual, transgender, and queer (LGBTQ) youths can increase awareness among professionals who provide services to this community. This study evaluated the effectiveness of a community-based training program geared toward mental health workers in a diverse metropolitan city. The training provided information about the continuum of sexuality and gender identity, sensitivity when working with LGBTQ clients, LGBTQ clients' risks for CSE, and ways to improve service delivery to this population. Participants' ($N = 64$) knowledge level of these areas was examined prior to the training, immediately thereafter, and in a six-month follow-up. Participants showed an increase in knowledge from pretest to posttest. Follow-up testing on a limited sample revealed scores that were lower than posttest scores, but higher than pretest scores. Overall, through this community-based training, participants gained knowledge about the continuum of sexual and gender identity, appropriate service delivery when working with LGBTQ individuals, and the risk factors for CSE for LGBTQ youths. Participants also reported feeling satisfied with the training approach and format. Implications for future training to enhance mental health workers' competence with LGBTQ victims of sexual exploitation are explored.

Research shows that lesbian, gay, bisexual, transgender, and queer (LGBTQ) youths are disproportionally bullied (i.e., in person and cyberbullied), verbally and physically harassed, and assaulted in schools and other spaces where they are out (Abreu & Kenny, 2018; Kann et al., 2016; Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016). Such hostility has been correlated to lower academic performance and psychological and emotional distress (e.g., suicidal ideation and attempt, depression), among

other detrimental consequences (Abreu & Kenny, 2018; Kosciw et al., 2016). In a recently released national study of sexual minority high school students, LGB students reported higher levels of physical and sexual violence and bullying than their heterosexual counterparts, including being forced to have sex (18% versus 5%) and physical dating violence (18% versus 8%). In this same study, more than 40% of students reported considering suicide and approximately 30% reported attempting suicide in the past year (Kann et al., 2016).

Although studies show that only 5% to 8% of U.S. youths identify as LGBTQ, approximately 40% of these youths experience homelessness (Robinson, 2018). Moreover, compared to their heterosexual and cisgender counterparts, LGBTQ youths experience higher frequency of substance abuse, including alcohol and illicit drugs (Parsons, Grov, & Kelly, 2009; Watson, Goodenow, Porta, Adjei, & Saewyc, 2018; Zhang & Wu, 2017). In addition, teen pregnancy among LGBTQ youths is disproportionally higher when compared to their heterosexual and cisgender counterparts (Boyce, Travers, Rothbart, Santiago, & Bedell, 2018; Charlton et al., 2013). Although these youths are experiencing a range of behavioral and emotional difficulties, they often do not seek treatment from health providers (Barman-Adhikari & Rice, 2011). Reasons include fear of insensitive responses and lack of understanding by mental health professionals (e.g., Black, Fedewa, & Gonzalez, 2012).

Community-based training to address the needs of LGBTQ individuals

Providers across mental and physical health disciplines are called to deliver culturally competent services to diverse and underserved communities, including LGBTQ individuals. When working with LGBTQ individuals, it is crucial for service providers to have knowledge about how systemic oppression, stigma, minority stress, and prejudice contribute to the marginalization of this community (Harper et al., 2013; Mink, Lindley, & Weinstein, 2014; Moe & Sparkman, 2015). Such knowledge allows service providers to implement interventions that promote well-being and healthy development among LGBTQ individuals (Craig, Doiron, & Dillon, 2015; Lee, 2013; Moe, Perera-Diltz, Sepulveda, & Finnerty, 2014). Research has found that workshops and seminars are an effective method of delivering information about LGBTQ issues to helping professionals (e.g., psychology, education, social work; Craig, Dentato, Messinger, & McInroy, 2016; McCabe & Rubinson, 2008; Rutherford, Mcintyre, Daley, & Ross, 2012; Ryan, Broad, Walsh, & Nutter, 2013). Specifically, research has found that in-person trainings have allowed participants to identify ways in which

they can develop and provide LGBTQ-affirming services (Leyva, Breshears, & Ringstad, 2014; Lorenzetti, 2010; Moe & Sparkman, 2015).

Community-based training, or an educational approach implemented in community organizations with the goal of increasing awareness, knowledge, and skills about the needs of a specific population (Craig et al., 2015), has been an effective method of increasing cognizance about issues that affect LGBTQ individuals (Clark, 2010; Rutter, Estrada, Ferguson, & Diggs, 2008). Research shows that community training about LGBTQ-related issues has been effective with different professionals, including law enforcement (e.g., Israel et al., 2017; Miles-Johnson, 2016), school personnel (e.g., Lorenzetti, 2010), and mental health professionals (Rutter et al., 2008). Israel and colleagues (2017) found that an in-person LGBTQ-specific diversity training approach with 120 law enforcement officers effectively allowed participants to better understand their reactions and interactions with LGBTQ individuals. In addition, Craig and colleagues (2015) sought to evaluate the effects of using a community-based training approach to increase knowledge, skills, and self-efficacy of 2,850 multidisciplinary professionals (e.g., educators, psychologists, nurse, social workers) to provide better services to sexual minority youths. This study found that using a community-based intervention was effective in delivering information about the needs of sexual minorities as participants reported an increase in knowledge about sexual minorities. Specifically, participants reported that they intended to speak up at work regarding sexual minority issues, were committed to change policies, and intended to display LGBT-affirmative symbols (Craig et al., 2015).

Commercial sexual exploitation

Commercial sexual exploitation (CSE) refers to a "range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person or in exchange for anything of value (including monetary and non-monetary benefits) given or received by any person" (Office of Juvenile Justice and Delinquency Prevention, n.d.). The U.S. Congress in the Trafficking Victims Protection Act of 2000 (TVPA) defines CSE as any action that is induced by force, fraud, or coercion and in which the person induced to perform the act is under 18 years old. Examples of commercial sex acts include prostitution, stripping, live-sex shows, Internet sex sites, and any sexual activity of a minor that is controlled by a pimp (Cole, Sprang, Lee, & Cohen, 2016). The majority of these victims are runaways, homeless, or displaced from their homes and have used sex to acquire food, shelter, clothing, drugs (if addicted), and other necessities in order to survive (Cole et al., 2016).

CSE claims an estimated 1.9 million children worldwide each year (UNICEF, 2005). A global report conducted by the United Nations Office on Drugs and Crime (2016) illustrates that while the modality of trafficking may vary from country to country, sexual exploitation occurs nearly everywhere. Sex trafficking accounts for more than half of all trafficking reports in the United States, Canada, and Mexico. Furthermore, sex trafficking continues to disproportionately affect women and children. In the United States, it is estimated that between 100,000 and 300,000 children are victims of sex trafficking annually, with many more at risk for CSE (Estes & Weiner, 2001; Lloyd, 2011; Wyler & Siskin, 2010), and these numbers are increasing each year (Ark of Hope for Children, 2017).

LGBTQ individuals and CSE

While the focus of many outreach organizations has targeted heterosexual women who are victims of CSE, LBGTQ youths are also at risk for CSE due to family rejection and systemic factors such as social marginalization and homelessness (Choi, Wilson, Shelton, & Gates, 2015; Cochran, Stewart, Ginzler, & Cauce, 2002; Martinez & Kelle, 2013). Research suggests that existing physical and mental health concerns endured by LGBTQ youths as a result of systemic oppression are exacerbated by CSE (Martinez & Kelle, 2013). For example, compared to their heterosexual counterparts, LGBTQ homeless youths experience significantly higher rates of prostitution (58.7% versus 33.4%; Martinez & Kelle, 2013). Approximately 25% to 35% of boys who are prostituted self-identify as gay, bisexual, or transgender and engage in sexual behavior with older men (Estes & Weiner, 2001). Furthermore, Martinez and Kelle (2013) report that LGBT individuals may face devastating physical and mental health risks as a result of CSE. For instance, LGBT individuals are more vulnerable to sexually transmitted infections (e.g., HIV/AIDS) and higher levels of depression, anxiety, and trauma than their sexual majority peers (Martinez & Kelle, 2013). According to Walker-Rodriguez and Hill (2011), the typical age for boys and transgender youths to enter into CSE is between 11 and 13 years old, with cisgender girls coming in second place with an average between the ages of 12 and 14 years old.

Research shows that transgender youths might be at a particularly higher risk for CSE. One study found that female transgender youths who were homeless were more vulnerable than their cisgender counterparts to sexual exploitation given the stigma and barriers to obtaining jobs and having the ability to have an income (Gwadz et al., 2009). In a study by Bigelsen and Vuotto (2013) of homelessness, survival sex, and human trafficking, transgender youths who participated reported that they had all engaged in "survival sex." While there was no force or coercion involved, they were

trading sex for food, money, or a place to stay. The lack of constructive employment opportunities may serve as a risk factor to CSE among transgender youths. Although at a lower rate than their transgender counterparts, the same study had gay and bisexual/questioning youths reporting instances of CSE (Bigelsen & Vuotto, 2013). Unfortunately, due to the stigma associated with being an LGBTQ individual as well as victimization, CSE is not likely to be reported among these victims.

The present study

This study sought to explore the effectiveness of a three-hour workshop intended to raise awareness of working with LGBTQ individuals in community mental health and their risk for CSE. Content of the training included understanding of sexuality and sexual and gender identity, sensitivity to working with LGBTQ clients, and LGBTQ youths' risk for CSE. Participants included community-based mental health professionals, agency personnel, and students. The in-person, no-cost training took place at an agency that provides services to LGBTQ individuals in a large urban, multicultural city in the southeastern United States. The city is ranked 17 out of United States cites with a LGBTQ population (Newport & Gates, 2015) and was described as the number two "destination city" for CSE in the United States (Dank et al., 2014). Although other studies have reported on the effectiveness of community-based training of LGBTQ issues, to the authors' knowledge this is the first study to report on the effectiveness of training community members about the risk of CSE among LGBTQ individuals. Despite researchers calling for increased CSE training to include the needs of LGBTQ individuals (e.g., Martinez & Kelle, 2013), this remains an unexplored area.

Method

Participants

A total of 64 professionals between the ages of 19 and 71 participated in the training held during a 12-month period of 2016–2017 at an agency specializing in counseling and advocacy services for LGBTQ survivors of victimization. While the training was held at this agency, participants came from this agency and others in the community. Participants represented a variety of professionals within the mental health field and social services as well as students seeking advanced degrees (e.g., counseling, social work, psychology). Participants were grouped into three categories based on their response to the "position" question on the demographic questionnaire: clinical (e.g., case manager, care coordinator, therapist, and advocate), nonclinical (e.g., educational outreach, administration, program analyst,

Table 1. Demographic characteristics of the participants ($N = 64$).

Characteristic	%
Age M (SD)	34.06 (10.77)
Gender	
Female	47
Race/ethnicity	
Hispanic or Latino	88.3
Black or African-American (not of Hispanic origin)	6.7
White or Caucasian (not Hispanic origin)	3.3
American Indian or Alaskan Native	1.7
Language	
English	53.1
Spanish	32.8
Positions	
Clinical	37.1
Student	37.1
Nonclinical	20
Other	5.7
Experience	
Years worked in position	
1–5 years	44.1
>1 year	30.5
5–10 years	11.9
10–20 years	6.8
>20 years	6.8
Degree	
Bachelor's BA/BS	47.4
Graduate degree MA/MS/EdD/PhD	35.1
High school diploma/equivalent	10.5
Associate's AA/AS	7.0
Prior training on CSE	
Yes	23.4
Workshop/training	80.0
Graduate school	10.0
Continuing education workshop	10.0

transportation specialist), and students. The distinction between clinical and non-clinical was that the former had direct contact with clients in their work capacity. Table 1 presents demographic information of the participants.

Procedure

The university's Office of Research Integrity granted approval for this project. Advertisement for the training took place through the agency's e-mail to community partners and postings on social media (e.g., Facebook, Twitter) as well as the website of a partner community agency specializing in victim advocacy and treatment. The community partners were alerted to trainings via e-mail and included agencies such as the various branches of local government, law enforcement, and nonprofit agencies devoted to victim work.

Participants completed a brief questionnaire and a 17-item pretest before engaging in the training. These instruments were developed by the authors for use in this study. The questionnaire gathered basic demographic

characteristics from participants (e.g., position, education, and years of experience). The pretest assessed the participants' prior knowledge of LGBTQ-specific issues and needs, including information specific to the CSE of LGBTQ individuals. The posttest contained the same items and was completed during two time periods, immediately after the training and the follow-up, which was conducted at least six months after the original training date. At posttest, another measure was included to assess CSE self-reported knowledge and skill and to gauge satisfaction with the training. Follow-up was conducted by e-mailing a link to the test to all workshop participants six months following the training. Repeated e-mail reminders were sent once a week for four weeks.

Training

The live training consisted of 52 PowerPoint slides of information and images, divided into several sections. Information was compiled from the current literature on sexuality and CSE among LGBTQ individuals, as well as the fourth author's extensive clinical experience. This included recent research from journals and books and data from a project at the community agency on violence toward transgender Latinos. The three-hour training was intended for service providers working/volunteering in agencies serving LGBTQ clients. The presenter (fourth author) is a licensed mental health counselor with eight years of experience in public health and clinical work with LGBTQ populations. The presenter has also delivered presentations and engaged in advocacy regarding CSE at the local and national level.

The workshop was divided into three main content areas: understanding and working with LGBTQ clients, risk for CSE in LGBTQ populations, and policies and procedures to improve service delivery to LGBTQ clients. The objectives of the workshop included the following: dispel commonly held beliefs/stereotypes about LGBTQ clients, define terms needed to discuss and understand sexuality, sexual and gender identity, and CSE issues in a cultural context (e.g., LGBTQ), risk factors associated with CSE in LGBTQ populations (e.g., survival sex), how to incorporate and execute LGBTQ sensitive services into local community agencies, counseling techniques for serving LGBTQ clients, and challenges to providing services to LGBTQ clients at community agencies.

Measures

LGBTQ sensitivity knowledge questionnaire

This questionnaire was developed by the authors to assess participants' knowledge level of sensitivity to LGBTQ clients' issues in counseling.

The authors developed the measure based on the identified learning objectives and training content. The measure consisted of 17 multiple-choice items and was administered prior to the training, immediately after the training, and in a follow-up (i.e., pre, post, follow-up). The items addressed information on the three content areas (sexual orientation, gender diversity, CSE). Items included "Policies that improve inclusion of LGBTQ youths include … " and "Gender identity, gender expression, and gender roles … ". Scores ranged from 0 to 17, with each correct answer receiving one point. Two-week test-retest reliability for this instrument was .81. The questionnaire also elicited demographic information from participants (e.g., gender, years of experience, current job position).

CSE self-reported knowledge and skill and training satisfaction

This survey was administered at the end of the training. This measure was modified from Ferguson and colleagues (2009) for use with this training. It was used to better assess changes in knowledge of CSE and skill level. Participants rated their perceived level of knowledge of CSE and skill in working with these clients before and after the training using a 5-point Likert scale ranging from none (1) to expert (5). Also, participants rated the CSE training overall using a 5-point Likert scale from poor (1) to excellent (5). In addition, participants rated the relevancy of the training to their jobs also using a 5-point Likert scale from not at all relevant (1) to very relevant (5). During the posttest, participants were also asked to identify three skills they would be better able to use as a result of engaging in the training.

Data analysis

SPSS 24.0 was used to analyze the quantitative data. A paired-samples t-test was conducted to determine whether there was a significant difference between pretest and posttest scores of knowledge of LGBTQ needs. A repeated measure one-way ANOVA was conducted to compare participants' knowledge on the LGBTQ sensitivity knowledge questionnaire in pre-, post-, and follow-up tests.

The open-ended question posed at posttest to participants that solicited three skills acquired through this training was analyzed to find themes. The length of submitted responses ranged from brief phrases to full sentences. The first and second authors read all written responses and coded each response individually. Afterward, both researchers met to discuss individual findings and agree on an initial set of codes. Discrepancies were addressed by both researchers and codes were either consolidated or eliminated, or new codes were created. Coding was reviewed and revised one more time

using input from an independent auditor (the third author). The auditor read the coded data and provided feedback and suggestions for revisions. Revisions were made accordingly, including consolidating, creating new codes, and eliminating codes as needed.

Results

Quantitative analysis

LGBTQ sensitivity knowledge questionnaire

A paired-samples t-test was performed for the entire group ($N = 64$). Posttest scores ($M = 14.73$, $SD = 1.8$) were significantly higher than pretest scores ($M = 10.88$, $SD = 3.6$) regarding participants' knowledge of LGBTQ terms and clinical issues and CSE in this population (t (63) = –8.04, $p <$ .001). The effect size (Cohen's d) is 1.01, which is a large magnitude of difference (Cohen, 1988). Although follow-up scores ($M = 13.2$, $SD = 1.6$) were lower than posttest scores ($p < .05$), they were higher than pretest score ($p < .001$). This indicates that the effectiveness of the training was maintained even after six months.

CSE self-reported knowledge and skill and training satisfaction

A paired-samples t-test was run to evaluate participants' self-reported increase in CSE knowledge before the training ($M = 3.05$, $SD = .90$; demonstrating a "good" level of knowledge), and after the training ($M = 4.00$, $SD = .82$, demonstrating a "sound" level of knowledge). Results of the analysis revealed a statistically significant difference in self-reported knowledge before and after the training, (t (39) = –.64, $p < .001$). The effect size (Cohen's d) is .99, which is a large magnitude of difference (Cohen, 1988).

Qualitative analysis

Twenty-six participants (41% of total sample) provided a response to the open-ended question that asked what skills they felt more confident displaying at their jobs as a result of completing the workshop. The results that follow are based only on these 26 participants. Responses to the open-ended question underscored three areas of information acquisition that participants viewed as most important. First, most participants (73%) identified providing affirming direct services and advocacy as the most important piece of information acquired in the training. Specifically, these participants described learning about the importance of showing empathy, using appropriate language, exploring one's own bias, and advocating for LGBTQ individuals as something they would be better able to do after the training. For example, one participant stated learning about "how to work

with transgender and [other] LGBTQ staff and clients." Second, half of the participants (50%) stated that understanding the different dimensions of LGBTQ identity, including definitions, within-group differences, and LGBTQ-specific needs was an area in which they were more confident. One response that exemplifies this category is, "[I feel comfortable] identifying various populations, definitions, and cultures within the LGBTQ community." Third, participants (23%) shared learning information about CSE among LGBTQ individuals. One participant wrote, "[I learned about] comparing and contrasting CSE-related concepts."

When reporting feedback on the training itself, 86% of participants found the training to be "excellent" or "very good." Ninety-two percent of participants found the training to be relevant to their jobs.

Discussion

There was both a statistically significant change in knowledge scores for participants as well as a self-rated change in knowledge, resulting in participants reporting a "sound" level of knowledge of LGBTQ issues post training. Pretest scores demonstrated that participants scored on average 64% on the measure of knowledge, but upon completion of the training, they scored approximately 87% correct. Since only 23% of the sample had prior training in CSE, there was a need for training on the risks of sexual exploitation for LGBTQ individuals. Participants also reported greater confidence in providing nurturing and affirming responses to LGBTQ clients, and understanding the complexities of LGBTQ identities and the risk for CSE in these populations. In reviewing the objectives of the training, it appears they were met. Overall satisfaction with the training was reported for the vast majority of participants. A great number of participants found the training to be relevant to their clinical work.

Given that the incidence of CSE continues to rise (Ark of Hope for Children, 2017) and that there are physical (e.g., STDs) and mental health consequences (e.g., depression, anxiety; Martinez & Kelle, 2013; Oram, Stoöckl, Busza, Howard, & Zimmerman, 2012) for victims, we posit that CSE is a worldwide public health concern that must be combated at different fronts (Ades, Wu, Rabinowitz, & Bach, 2018; Rothman et al., 2017). In addition, considering that LGBTQ youths report higher incidents of CSE compared to their heterosexual and cisgender counterparts (e.g., Choi et al., 2015; Martinez & Kelle, 2013), it is imperative for personnel who work with LGBTQ youths to pay close attention to this risk in this vulnerable population. Clinical and nonclinical providers and social advocates need increased awareness of the prevalence of the problem and the tools needed for identifying and addressing CSE in order to better serve LGBTQ youths. For

example, an LGBTQ youth might not disclose CSE to their counselor for fear of the counselor's reaction. However, the youth may display risk factors (e.g., homeless) or present with risky behaviors that indicate possible CSE. It is important for mental health staff to initiate this conversation if they believe the youth may be a victim of CSE. Introducing this conversation could communicate to LGBTQ adolescents that they are in a safe space where they will be understood and affirmed (Litam, 2017).

Victims of CSE need specialized treatment services (Donahue, Schwien, & LaVallee, 2018). These service needs are compounded with other mental health and health needs that LGBTQ clients may present. Since LGBTQ clients are not likely to self-identify as victims of sexual exploitation, professionals will need to be astute in asking helping questions that will help the detection of CSE (Chesnay, 2013; Litam, 2017). To the authors' knowledge, no clinical practices or strategies exist to help providers who work with LGBTQ youths address this area of victimization. Helping providers acquire these skills could be included in future training.

The overall findings of this study reveal insights that can be applied to future training and practice. One key finding is the effectiveness of using a community training approach to train service providers about the prevalence and needs of LGBTQ youths related to CSE. In fact, to date this is the first study to use a community training approach to highlight CSE issues among LGBTQ youths. While few participants had previous training in this area, almost all reported the content to be relevant to their work. This suggests that service providers who are in contact with LGBTQ clients need to be well-trained on how CSE issues affect this community and be equipped with the necessary skills to identify and address CSE.

Providing diversity awareness and sensitivity training to established clinicians and students is a critical part of clinical training. Messinger (2013) emphasizes the importance of both staff and student-intern training in sexual orientation, gender identity development, and the impact of social contexts on LGBTQ people. Trainings such as this one will lead to increased awareness of the needs of the LGBTQ population related to CSE so that practitioners who come into contact with them will be better prepared and demonstrate increased sensitivity and understanding.

Limitations

Conducting research in community-based sites has its limitations. Not all participants completed the CSE self-reported knowledge and skill and training satisfaction measure due to it being included on the last page of the materials, which often got overlooked. There may also be some self-

selection bias in the participants attending the workshop as they may be more interested in working with the LGBTQ population. For example, the students at the community agency where the training was held likely selected this training site based on interest in this population and possible prior exposure or experience with LGBTQ persons. While there were increases in knowledge, participants may not improve their clinical skills in working with victims. A longitudinal research design in the future could follow participants and inquire about both their experiences with CSE victims and their practical application of the knowledge from the training. Given the drop in knowledge from posttest to follow-up, innovative ways to provide booster sessions or disseminate information to participants could be developed (e.g., e-mails, links to Web-based trainings). Furthermore, transferability is a limitation. Although this study was conducted in a city with a large percentage of LGBTQ individuals, conclusions should not be drawn about the effectiveness of this training with other professionals who provide services to LGBTQ clients in other cities. Finally, a very small number of participants completed the follow-up despite numerous attempts to engage them.

Conclusion

This study demonstrated that face-to-face training on the needs of LGBTQ youths, including the prevalence and risk of CSE, can lead to an increase in knowledge among community mental health workers. Given the relatively minimal level of knowledge of participants, lack of previous training prior to the training, and the self-reported relevance of this material to participants' work, it is clear that training is needed. Implementing this training for professionals who provide services to LGBTQ individuals is imperative in order to be responsive to the needs of these clients. Understanding the risks that LGBTQ individuals may experience with regard to CSE will help practitioners with early detection in this population and thus facilitate appropriate treatment and service provision.

Funding

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