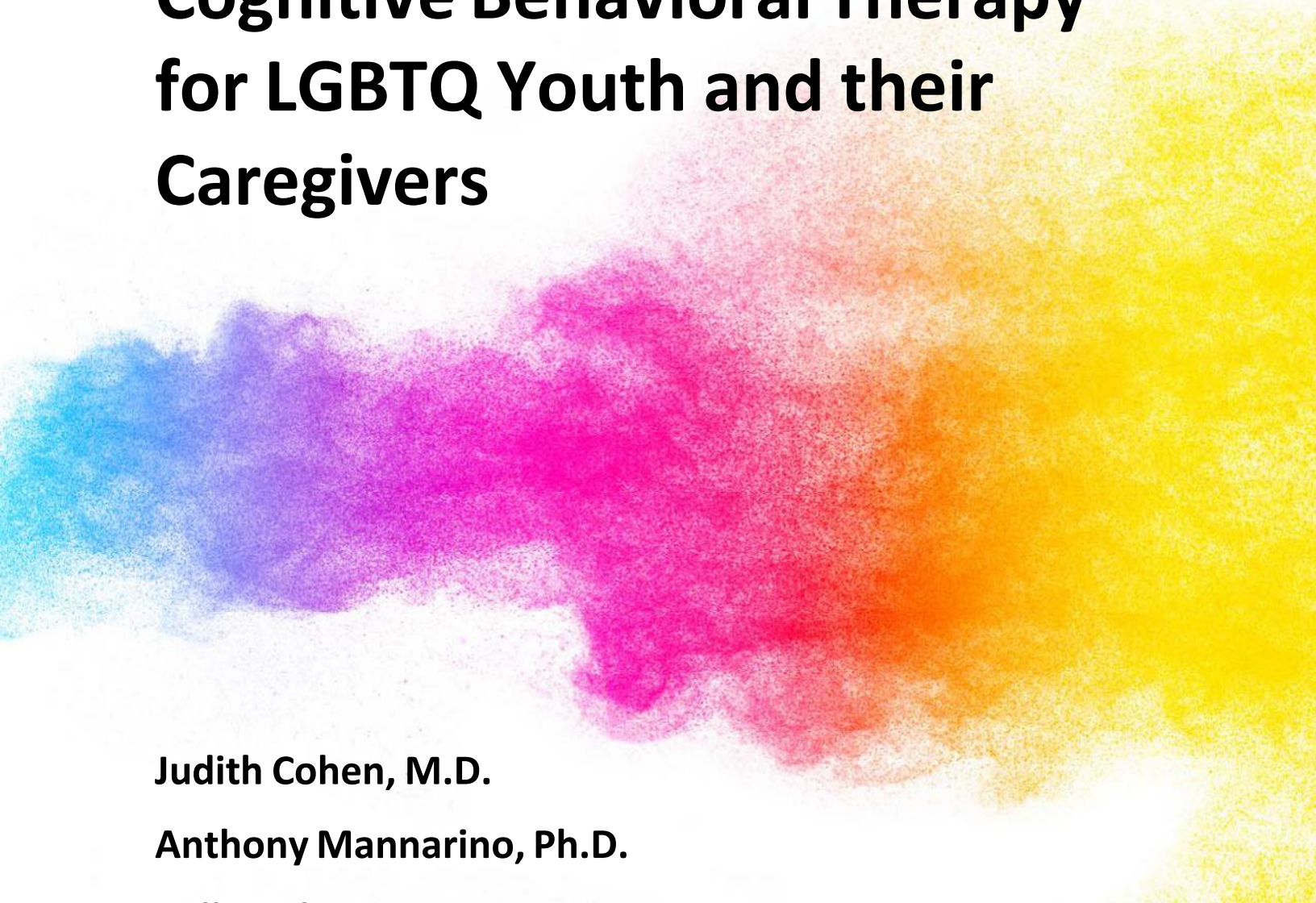


Implementing Trauma-Focused Cognitive Behavioral Therapy for LGBTQ Youth and their Caregivers



Judith Cohen, M.D.

Anthony Mannarino, Ph.D.

Kelly Wilson, LCSW

Arturo Zinny, LPC, M.A.

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FORWARD

This manual addresses strategies for implementing an evidence-based youth trauma treatment—Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)—for trauma-impacted lesbian, gay, bisexual, transgender, queer/questioning and gender diverse (LGBTQ) youth. The information in this manual was developed through a National Child Traumatic Stress Network (NCTSN, www.nctsn.org) Learning Community, initiated through an NCTSN grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to Allegheny General Hospital’s Center for Traumatic Stress in Children and Adolescents. The Learning Community included 32 members from 12 organizations, listed below. Clinicians presented TF-CBT cases during bimonthly calls and provided de-identified data for assessment, after which all participants shared resources about TF-CBT implementation for LGBTQ youth and families and discussed how the TF-CBT model should be modified to incorporate sexual orientation and gender identity issues.

All participants had previously received TF-CBT basic training, and had a working knowledge of how to implement the TF-CBT model for typical treatment cases. The goal of this project was to then apply that knowledge for traumatized LGBTQ youth and their parents or caretaking adults. Users of this implementation manual are similarly assumed to have a working knowledge of the basic TF-CBT treatment model and principles (Cohen, Mannarino & Deblinger, 2017) and of how the model is implemented for youth with complex trauma (e.g., Cohen, Mannarino, Kliethermes & Murray, 2012).

We strongly recommend that therapists complete initial web-based TF-CBT training (available at <https://tfcbt2.musc.edu>), and face-to-face TF-CBT training and consultation calls provided by an approved TF-CBT national trainer (<https://tfcbt.org/training>) prior to implementing the TF-CBT LGBTQ applications described in this manual.”

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Finally, we are enormously grateful for and acknowledge the significant contributions of **Caitlin Ryan, Ph.D., ACSW**, Director of the Family Acceptance Project® (FAP) at San Francisco State University (<https://familyproject.sfsu.edu>), who collaborated with us to integrate FAP’s research findings and intervention approaches from FAP’s family support model into this implementation manual. We also want to acknowledge **Antonia Barba’s** work with Dr. Ryan to align FAP and TF-CBT’s models to strengthen families and improve outcomes for LGBTQ youth.

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INTRODUCTION

Lesbian, gay, bisexual, transgender, queer/ gender diverse (LGBTQ) youth, as well as those who are questioning their identity, experience the same types of traumas as other youth (e.g., child maltreatment, domestic and community violence, motor vehicle accidents, natural disasters, traumatic death and separation, etc.). For brevity and consistency, throughout this manual we will use the term “youth” to refer to children and teens, recognizing that this treatment manual will be used to treat LGBTQ children as young as 3 years old, to transition age youth in their early 20’s; and that parents think of their offspring as “children” regardless of their age. We use LGBTQ as an umbrella term, including diverse sexual orientations and gender identities, understanding that not all words used to self-identify are included in this acronym; however, for the sake of consistency across research and literature we use it as a general term. We note here that other identities not explicitly listed here (e.g., pansexual, genderfluid, gender non-binary, etc.) are still included in this material. We also note here that terminology in the field of sexual orientation and gender identity is continuously evolving and that different cultures and individuals may prefer different terminology (Turban & Ehrensaft, 2017). Throughout this manual we use the term “gender diverse” except when specific studies used different terminology (in which case we use the terminology used in that study). However, individual youth may prefer different terms to identify themselves and therapists should use the individual youth’s preferred terminology and pronouns.

LGBTQ youth are also at elevated risk for experiencing additional traumas that are specifically or in part related to their sexual orientation and/or gender identity. Despite their personal strength, resiliency and courage to face adversity, this places LGBTQ youth at significantly greater risk for cumulative trauma exposure—and for developing the negative mental health and medical sequelae that are associated with multiple traumatic experiences.

For example, according to the Gay, Lesbian Straight Education Network (Kosciw, 2017, et al.) 2017 School Environment Survey (www.glsen.org):

- Almost 90% of LGBTQ youth report being harassed in school related to their sexual orientation or gender identity
- Almost 30% of these students reported being physically harassed at school because of their sexual orientation; roughly 25% reported being physically harassed at school due to their gender identity
- About one in four LGBTQ students reported having been physically assaulted at school during the past year, primarily due to sexual orientation, gender identity and/or expression
- More than 50% of LGBTQ students reported having been sexually harassed in the past year

The 2015 Youth Risk Behavior Survey (YRBS, <http://www.cdc.gov/yrbbs>) documented that, compared to straight youth, LGB youth reported significantly higher prevalence of:

- Bullying at school (LGB: 34.2% vs. straight: 18.8%)
- Electronic bullying (LGB: 28.0 % vs. straight: 14.2 %)
- Being forced to have sexual intercourse (LGB: 17.8% vs. straight: 5.4%)
- Experiencing sexual dating violence (LGB: 22.7% vs. straight: 9.1%)

(Note: This study did not inquire about gender identity.)

Additional traumas that LGBTQ youth may experience related to their sexual orientation, gender identity and/or expression include:

- Hate crimes
- Police or community identity-based violence
- Parental rejecting behaviors that constitute emotional and physical abuse based on the youth's sexual orientation and/or gender identity and expression, often referred to as parental or family rejection (Ryan, 2009; Ryan, 2019c).

The YRBS and GLSEN surveys also documented negative mental health outcomes in LGBTQ youth. Unfortunately, neither of these studies was able to include assessment of disorders such as Posttraumatic Stress Disorder (PTSD) or depression, nor to establish causality between trauma exposure and the reported problems. However, both surveys documented elevated risks for sadness, suicidality and substance use among LGBTQ youth.

For example, the YRBS documented that, compared to straight youth, LGB youth reported significantly higher prevalence of:

- Using alcohol (LGB: 40.5%; straight: 32.1%)
- Using marijuana (LGB: 32%; straight: 20.7%)
- Feeling sad or hopeless (LGB: 60.4%; straight: 26.4%)
- Seriously considering suicide (LGB: 42.8%; straight: 14.8%)
- Attempted suicide (LGB: 29.4%; straight: 6.4)

A recent population-based analysis of 2017 YRBS data from 10 states and 19 large urban school districts on the experiences of transgender students (Johns, Lowry, Andrzejewski, et al., 2019) found that:

- Nearly 2% of students in grades 9-12 identified as transgender
- A significantly higher percentage of transgender students reported violence and victimization experiences compared with cisgender students
- A significantly higher percentage of transgender students reported lifetime use of all substances (except marijuana) compared with cisgender students
- A much higher percentage of transgender students reported suicidal thoughts and behaviors compared with cisgender students:
 - Felt sad or hopeless: 53% of transgender students vs. 20.7% of cisgender males and 39.3% of cisgender females
 - Considered attempting suicide: 43.9% of transgender students vs. 11% of cisgender males and 20.3% of cisgender females
 - Made a suicide plan: 39.3% of transgender students vs. 10.4% of cisgender males and 16% of cisgender females
 - Attempted suicide: 34.6% of transgender students vs. 5.5% of cisgender males and 9.1% of cisgender

Although LGBTQ youth are typically compared to straight youth in these studies, it is important to recognize how stigma, trauma and mental health disparities may differentially impact youth depending on their individual sexual orientation and/or gender identity. Some data suggest that bisexual and transgender youth are at even higher risk than gay or lesbian youth for experiencing stigma, trauma, and/or health disparities specific to their sexual orientation and/or gender identity.

Studies suggest that significant numbers of bisexual youth feel invisible (referred to as “bisexual invisibility” or “bisexual erasure”) and stigmatized by gay and lesbian as well as by straight peers (“double discrimination”), including being stigmatized for being “promiscuous,” “unable to commit” and/or for having problems with relationships (San Francisco Human Rights Commission, 2011; HRC Foundation, 2014). These youth may also feel pressure to “choose” between a straight or gay identity, (i.e., their authentic bisexual identity is questioned or invalidated), and report being less aware than lesbian or gay youth of safe spaces, supportive peers, accepting adults, or organizations that could help them related to their sexual identity issues (HRC Foundation, 2014). This study also found that bisexual youth were less likely than gay or lesbian youth to report that they were “happy” or to be out to family and friends. A recent study showed that for gay and lesbian youth, relationship involvement led to lower emotional distress, but for bisexual youth, relationship involvement led to higher emotional distress (Whitton, et al., 2018). This may be related to results from the National Intimate Partner Violence and Sexual Violence Survey 2010 Findings on Victimization by Sexual Orientation, which documented that bisexual women had significantly higher lifetime prevalence of experiencing rape and sexual violence by intimate partners and by any perpetrator than either straight or lesbian women (https://www.cdc.gov/ViolencePrevention/pdf/NISVS_SOfindings.pdf). In their work with religiously conservative families with LGBT children, the Family Acceptance Project found that bisexual youth experience high levels of pressure from parents to repress or reject their bisexual identity and many hide their identity to decrease family conflict which increases isolation, depression and suicidality (Ryan, unpublished data).

These studies highlight some of the differences within the LGBTQ umbrella, and the importance of understanding the individual youth’s risks for stigma, trauma and behavioral health disparities. Two national studies found significantly higher rates of PTSD among LGBTQ individuals than among their straight and cisgender peers. Russell & Fish (2016) documented a 12-month PTSD prevalence of 11.3% among 16-20-year-old LGBTQ youth, compared to a national annual youth prevalence of 3.9%. Roberts and colleagues (2012) found that LGB young adults were at greatly increased risk for lifetime probable PTSD relative to other young adults, mostly due to higher rates of child abuse. Several studies have shown relationships between various traumatic experiences and the development of PTSD in LGB youth populations, including statistically significant associations between bullying and PTSD (Beckerman & Auerbach, 2014); physical victimization and PTSD (D’Augelli et al., 2006); and sexual orientation-related verbal or physical victimization and PTSD (Dragowski et al., 2011). Roberts et al (2012) documented that among a large national sample of young adults, the heightened risk for PTSD largely stemmed from increased risk of childhood sexual, physical and/or psychological abuse, which in turn was significantly predicted by childhood gender diversity. Smith and colleagues (2016) found that among minority LGB youth, the risk of attempted suicidality was predicted by an interaction of PTSD, depressive and substance abuse symptoms. All of these studies emphasize the importance of assessing youth for trauma exposure and symptoms, sexual orientation and gender identity as well as the full range of mental health problems; and of providing effective, culturally appropriate trauma-focused treatment to youth who have significant trauma-related problems.

Historically, services for LGBT youth focused on protecting them from harm, including from parents who were perceived as rejecting and being unable to learn to support their LGBTQ children (Ryan, 2014). As a result, services typically were provided to LGBT youth individually or via peer support, but rarely included parents (Ryan, 2014; Substance Abuse and Mental Health Services Administration - SAMHSA, 2014). The Family Acceptance Project was founded nearly 20 years ago (Ryan, 2014; SAMHSA, 2014) to establish the field of family intervention with LGBTQ children and youth. FAP’s research has documented the often-critical role of families both in contributing to major health and mental health

risks, and helping to protect LGBTQ youth from harm, and promoting their well-being. FAP's family support model helps practitioners to proactively engage and help families, particularly those who are ambivalent or rejecting of their youth's LGBTQ identity and gender expression—to understand how these reactions contribute to their children's health risks and how supportive behaviors can help to strengthen their family and increase their child's well-being. The goal of FAP's family support approach is not to change families' deeply held beliefs or values, but rather, to align with the families' values to support their LGBTQ children and to reduce the risks of their rejecting behaviors on their children's safety, health and well-being (Ryan & Diaz, 2011; SAMHSA, 2014).

TF-CBT and the Family Acceptance Project are both strengths-based, resiliency-building approaches that view the family and, in particular, the parent or caregivers as potential sources of support for the youth. Both models view cultural values as strengths that the therapist should try to learn about, respect and incorporate into treatment (Cohen, Mannarino & Deblinger, 2017; Ryan, 2014, SAMHSA, 2014). Core assumptions of FAP's approach are consistent with the TF-CBT model and include the following (Ryan & Diaz, 2011):

- Most parents love their children and want them to be healthy and happy; however, their hopes and aspirations for their children are influenced by their culture, religious beliefs and other values that may be at odds with their child's sexual orientation and/or gender identity.
- The therapist should strive to meet the family where they are, by starting at the parents' current level of knowledge, attitudes, expectations and beliefs about their child's sexual orientation and/or gender identity. FAP's framework provides a resiliency-focused, strengths-based approach that supports parents' needs to be heard and understood from the perspective of their culture, values, beliefs and faith traditions. For many parents and caregivers, this is their first experience being able to share their hopes, fears and concerns for their LGBTQ child in a confidential interaction with an empathic nonjudgmental listener.
- Parents who are perceived as rejecting of their LGBTQ children are usually motivated by care and concern to help their children fit in, be accepted by others, be socialized into their cultural world, and be successful in a hetero-normative society that often victimizes, stigmatizes and harms individuals due to their sexual orientation and/or gender identity.
- Practitioners use FAP's research findings, research-based resources and framing to educate parents about how specific family rejecting behaviors impact their LGBTQ child's health and mental health risks and how supportive and accepting behaviors help protect against risk and promote positive outcomes and well-being (Ryan, 2009; Ryan, 2014; Ryan, 2019a, 2019b, 2019c; SAMHSA, 2014).
- Many parents experience their children's sexual orientation and/or gender identity as pulling their child away from the family and as a loss and/or loss of control over their children's positive future. Practitioners should understand that parents experience their lack of knowledge or understanding of their children's sexual orientation and/or gender identity as inadequacy that feels disempowering and shameful. It is very helpful for practitioners to recognize, validate and address these feelings, and emphasize the importance of parental support during TF-CBT as described in this implementation manual.
- FAP's research found that the largest proportion of parents and caregivers are ambivalent about their child's LGBTQ identity, followed by rejecting and then accepting families. When rejecting and accepting behaviors coexist, the resulting ambivalence causes parents to struggle to support their LGBTQ children, leading to increased risk. Education about how family reactions impact LGBTQ youth can improve communication and help parents to better support their LGBTQ youth.

Evidence-based psychotherapies such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) are the first line treatment for youth with PTSD and related difficulties (AACAP, 2010). However, treatment must be tailored to meet cultural, developmental, family and individual needs. This implementation manual provides therapists who are treating trauma-impacted LGBTQ youth with information about how to implement TF-CBT with appropriate modifications in order to facilitate optimal LGBTQ youth recovery from trauma.

Since TF-CBT includes parents or other primary caregivers in treatment whenever possible, this manual also addresses the often-critical issues of enhancing parental acceptance and support of traumatized LGBTQ youth, incorporating the seminal findings, research-based resources and family support strategies from the Family Acceptance Project (Ryan, 2014). See the FAP section below for additional information on the Family Acceptance Project's background and aims. For brevity the term "parent" is used throughout this manual, recognizing that often the primary caregiver for LGBTQ youth whom the therapist is trying to engage in TF-CBT will not be a birth parent but another adult (e.g., grandparent, aunt or uncle, older sibling, foster/adoptive parent, etc.).

Moreover, because FAP interventions may be implemented by a variety of individuals (e.g., nurses, teachers, parent support partners, or parents themselves), the FAP sections in this manual refer to "practitioners" rather than "clinicians."

Integrating Family Acceptance Project's Family Support Model into TF-CBT for LGBTQ Youth

We collaborated with the Family Acceptance Project to include FAP components and procedures in this manual for several reasons. We have followed FAP's research and the development of their family support model with great interest since their initial research was published. TF-CBT does not include perpetrating caregivers in treatment, and we emphasize that this is still the case for caregivers who have perpetrated sexual or physical abuse. However, FAP's research has indicated that transforming family dynamics and increasing affirmation and acceptance can potentially improve depression, suicidality and other trauma-related responses experienced by LGBTQ youth. Based on FAP's research and intervention work, we have modified TF-CBT to include rejecting parents (i.e., those who have been emotionally abusive related to their children's sexual and/or gender identity) in TF-CBT, in situations where the therapist determines that this is clinically appropriate. In cases where the parent's behavior becomes actively unsafe or physically harmful to the child, therapists should take necessary steps to ensure their safety including limiting or concluding the parent's involvement in treatment, involving alternate affirming caregivers, or pausing TF-CBT treatment to implement the FAP model, Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT, www.afcbt.org) or other interventions that also work with perpetrating caregivers.

Moreover, we saw the synergy between these two intervention models and the significant benefits of integrating them. To assist therapists interested in expanding their treatment to include FAP interventions, we have inserted FAP implementation sections at the end of several TF-CBT components and included several FAP resources in the appendix. They contain strategies and tools that therapists may consider for inclusion in work with trauma-impacted youth and their caregivers. Therapists should use their best clinical judgment when selecting interventions and utilize those that are most aligned with their clients' experiences and trauma treatment goals, that have the potential to strengthen the parent-child relationship, and promote youths' safety and well-being. Our pilot data from the TF-CBT LGBTQ Learning Community are promising and suggest the positive impact of integrating aspects of the TF-CBT and FAP models to improve PTSD symptoms for LGBTQ youth. We hope to continue to build on this synergy as TF-CBT clinicians apply this work with LGBTQ youth and families.

INTRODUCTION

[© 2018 Caitlin Ryan – Excerpted from: Ryan, C. (2018). Family Acceptance Project: Working Procedures. San Francisco: Family Acceptance Project]

Family Acceptance Project® – Helping Diverse Families to Support & Affirm Their LGBTQ Children

The Family Acceptance Project® (FAP) is a research, education, intervention and policy initiative that was developed by Caitlin Ryan, PhD and Rafael Diaz, PhD in 2002 to help families learn to support their LGBTQ children to reduce health risks and promote well-being in the context of their families, cultures and faith communities. FAP's work includes the first comprehensive research on LGBTQ youth and families and the first evidence-informed family support model that FAP developed for use in educational and treatment approaches for prevention, wellness and care for LGBTQ children and adolescents (Ryan, 2014).

FAP's family support model is grounded in participatory mixed methods research that studied LGBTQ youth and families in their homes and communities. Among other findings, FAP researchers identified more than 100 specific behaviors that parents and caregivers use to express rejection and acceptance of their LGBTQ children and measured how these behaviors contribute to health risks and well-being. FAP worked with diverse families and LGBTQ youth to develop intervention strategies and research-based resources to help families to decrease rejection and increase support and acceptance for their LGBTQ children. These strategies and resources can be integrated into TF-CBT to support recovery and help reduce risk and promote well-being for LGBTQ children and youth whether or not the child's LGBTQ identity is trauma-related. Moreover, FAP believes that TF-CBT treatment with LGBTQ children and youth will be enhanced and family relationships will be strengthened when practitioners apply FAP's family support approach and resources with all families with LGBTQ children.

All LGBTQ children benefit from family support and even parents and caregivers that are perceived as accepting need to understand how to care for and learn to advocate for their LGBTQ children in the family and in their child's social world. Because most families don't know about FAP's research and how family responses and behaviors affect their LGBTQ children's risk and well-being, many caregivers assume that telling their LGBTQ child they love them or giving them a hug is all their child needs to experience affirmation and validation of their sexual orientation and gender identity. These caregivers may see themselves as accepting while the youth routinely experiences their parent's ambivalence and lack of support, and wonders if their parent will be there for them when they really need them. Routinely, LGBTQ youth will tell FAP practitioners, *"I think my parent cares about me but they don't know anything about my LGBTQ friends, if I have a partner, what I do in the community or at school. They never talk about my LGBTQ identity. So no, they don't accept me."* These feelings are expressed empirically in FAP's research where LGBTQ young people whose parents and caregivers who are moderately rejecting or ambivalent are more than three times as likely to report high levels of depression and twice as likely to attempt suicide compared with LGBTQ peers who report no or low family rejecting behaviors (see Ryan, 2009 for multilingual family education booklets that include simple graphics and guidance for families).

Understanding FAP's family research helps practitioners begin to understand the critical role of family acceptance and support, and the utility of FAP's behavioral approach for helping caregivers to decrease family rejection, dispel myths and misconceptions about sexual orientation, gender identity and expression (SOGIE) and learn to actively support their LGBTQ children—even when they believe that being gay or transgender is wrong.

Practitioners can use any of FAP's strategies and resources in their work with LGBTQ youth and caregivers. Having the support of a parent can be a critical factor in a child's recovery from trauma. When working with LGBTQ youth, practitioners may experience challenges engaging parents in treatment when they are perceived to be rejecting or do not know about their child's sexual orientation or gender identity which may limit actively addressing their sexual

orientation and gender identity in treatment. FAP's model provides effective strategies for supporting and educating parents with the goals of promoting safety, strengthening support, and preventing future traumas from occurring.

FAP components that may be especially helpful for use in TF-CBT include: 1) assessment related to the parent's attitudes, cultural and religious values and knowledge about SOGIE; and assessment of parent and caregiver reactions (accepting and rejecting behaviors) to the youth's SOGIE; 2) psychoeducation to teach the youth and caregiver about specific family accepting and rejecting behaviors that FAP has identified, measured and linked with health and mental health problems and with helping to reduce risk for depression, suicidality, substance abuse and sexual health risks and with increasing self-esteem, overall health and positive relationships; 3) communication and skill building to teach caregivers how to talk respectfully about their child's SOGIE with the youth and others; 4) strategies to build a therapeutic alliance with the caregiver and to align FAP's behavioral framework with the family's underlying cultural and religious values; and 5) teaching and practicing advocacy skills to empower caregivers to stand up for their LGBTQ children when others mistreat them and to advocate for acceptance and affirmation in their child's social world (e.g., safe and supportive schools; welcoming congregations; non-discrimination policies in sports and recreational programs; etc.). As described below, in some cases the parent may also write a brief response to the youth's trauma narrative in which the parent accepts responsibility for their rejecting behavior and shares what they have learned about affirming and nurturing the youth going forward.

ASSESSMENT STRATEGIES

In addition to having training and competence in conducting mental health assessments for traumatized youth, therapists need to consider several unique issues when evaluating and treating traumatized LGBTQ youth.

Confidentiality Issues

Therapists and organizations should be aware of the legal and ethical issues involved in evaluating and treating traumatized LGBTQ youth, including traumas that may be perpetrated by parents related to the youth's sexual orientation and/or gender identity. For example, when assessing the youth's sexual orientation and gender identity, it is important to be aware of who has (or could have) access to the medical records. Parents or legal guardians are able to access medical records of youth younger than 14 years old (specific age may vary according to jurisdiction). As described below, clinicians should inquire about healthy sexuality, sexual orientation and gender identity issues in a developmentally and culturally sensitive manner for all youth. However, in light of: a) the risk of involuntary disclosure of sexual orientation and/or gender identity ("outing") by way of a parent or legal guardian accessing the youth's medical record; b) the possibility that parental maltreatment and/or rejection could occur based on a parent finding out about the youth's sexual orientation and/or gender identity via the youth's medical records; and c) the significant traumatic impact of parental rejection on LGBTQ youth (<https://familyproject.sfsu.edu>), clinicians generally should not record in the medical record information the youth provides about sexual orientation or gender identity, unless the youth is openly out to any parents or legal guardians who have legal access to the medical record, and agrees to having this information included in the medical record.

Assessing sexual orientation and gender identity issues

Therapists should be culturally competent to evaluate sexual orientation and gender identity issues in children and adolescents. This includes therapists gaining increased:

- 1) Self-awareness about one's own attitudes and biases towards LGBTQ youth and towards their families;
- 2) Knowledge about the range of potential sexual orientations, gender identities and expressions;
- 3) Skills and sensitivity for interviewing youth about their sexual orientation and gender identity; including the degree to which, and to whom, the youth has revealed this ("come out") to others;
- 4) Skills and sensitivity for interviewing parents about their perspectives and responses to the youth's sexual orientation and gender identity (and in general, not just related to their youth); and
- 5) Organizational cultural competency around sexual orientation and gender identity, including communicating with others in the organization about the youth's needs (e.g., consistent use of youth's name, pronouns across organizational settings, etc.)

Several NCTSN webinars and information sheets are available to assist therapists in gaining these skills. These include the following:

Safe Places, Safe Spaces: Creating Safe and Welcoming Environments for Traumatized LGBTQ Youth:
<http://learn.nctsn.org/enrol/index.php?id=296>

Empowering Therapists to Work with LGBTQ Youth and Families:
<http://learn.nctsn.org/enrol/index.php?id=231>

Developing Clinical Competence in Working with LGBTQ Youth and Families:
<http://learn.nctsn.org/enrol/index.php?id=229>

Improving LGBTQ Treatment Outcomes Through Integration of Sexual Health:
<https://learn.nctsn.org/course/view.php?id=389>

Welcoming Environments for LGBTQ Consumers in Care:
<http://learn.nctsn.org/enrol/index.php?id=230>

Examples of specific questions that may be used to ask youth about their gender identity and expression are included in Leibowitz et al. (2015, p 594).

In addition to evaluating the youth's sexual orientation and gender identity, it is important to assess factors that may contribute to the LGBTQ youth's identity-related resiliency. These may include a high level of parental acceptance and support, strong social support network among peers, extended family, and/or faith community, and/or involvement in an LGBTQ support group, diversity club or Gender and Sexuality Alliance (GSA) at school. Conversely, it is important to assess factors that may contribute to the youth's risk, for example, family rejection and lack of parental support; the youth's and/or parent's cognitive challenges; the youth's and/or parent's involvement in substance abuse or the presence of a serious comorbid health and/or mental health condition in addition to PTSD or other disorders.

Family assessment in LGBTQ youth

Parents respond to their LGBTQ youth in different ways, depending on their cultural, family, religious, personal and other factors. Many have misinformation and misperceptions about what it means to be

LGBTQ. Many parents perceive LGBTQ identities to be a “choice” or a “lifestyle” that the youth has adopted and that parents often believe will hurt the youth, while others may believe that sexual orientation and gender identity are inborn traits that can’t be changed. Studies show that people who believe that sexual orientation is inborn are more accepting of LGB people. FAP’s research has found that family rejection is typically motivated by trying to help an LGBTQ youth have a good life and protect them from what the family may perceive as an unhealthy or immoral “lifestyle” that will separate an LGBTQ child from their family and cultural world (Ryan, 2014).

In FAP’s family support approach, even rejecting parents can be engaged as partners with practitioners in learning to support their LGBTQ children and ultimately in learning how to advocate for them with the extended family, congregations and social institutions. Guidance on FAP’s assessment approach is included in the FAP section on page 17. Therapists start the family assessment by including parents and caregivers, including those that are rejecting. They meet parents “where they are” to form a therapeutic relationship, understand their concerns about their youth, and engage them in the treatment process to the extent that the clinician determines that this is clinically appropriate. This includes, as part of assessment, asking the parents to share their experiences, hopes, dreams and concerns about their LGBTQ youth. This should include the therapist encouraging parents to describe how they learned about the youth’s sexual orientation and gender identity, their cultural context for understanding the meaning of sexual orientation and gender identity (e.g., “God hates gays”; “People are only female or male, not transgender”; “being bisexual is just a fad”; etc.), as well as their anxiety, fears and concerns about what might happen to their youth because of their LGBTQ identity / gender diversity (Ryan, 2014; SAMHSA, 2014). Through this process, the therapist can join with the parents and understand the underlying basis for the parents’ concerns about their LGBTQ youth, and motivations for their ambivalent and rejecting behaviors. The therapist should validate the parents’ concerns during the assessment, which helps the parents to feel heard and understood. Nevertheless, it is as important not to expose the LGBTQ youth to rejecting comments. Thus, the therapist should assess the parent’s reactions to the LGBTQ youth and the youth’s experiences with rejecting and accepting behaviors separately to document these behaviors initially. (See FAP’s assessment approach on page 17 to learn more about FAP’s initial assessment.) Over the course of treatment, the therapist will discuss family rejection and acceptance individually and with the youth and parent together to help them understand the impact of these behaviors and to support positive behavioral change.

Assessing trauma issues in LGBTQ youth

As noted above, LGBTQ youth are at heightened risk for experiencing traumas that are primarily or in part related to their sexual orientation, gender identity and/or expression, including bullying, physical assault, sexual assault, hate crimes, and parental and other family rejection (e.g., by siblings or grandparents and/or other extended family members). They also experience other common traumas (e.g., sexual abuse, physical abuse, domestic violence, or accidents). Therapists must be aware that these traumas may have a unique impact on or meaning for certain LGBTQ youth based on their sexual orientation and/or gender identity. For example, a girl who felt “different from other girls” from a young age because she liked “boy things,” for years believed that her father had been sexually abusing her rather than her sister as punishment for this characteristic. Father had told her that he was teaching her to be “a real girl.” When she came out to her sister as a lesbian and disclosed the sexual abuse in this context, she was shocked to learn that her father had sexually abused her sister also. This led the girl to great confusion about the sexual abuse and to some degree about its impact on her sexual orientation. The TF-CBT therapist should explore such issues thoroughly during treatment.

Therapists should inquire in detail about all trauma exposures that LGBTQ youth may have experienced in order to have as complete as possible an understanding and timeline of the multiple traumas that many LGBTQ youth experience. Developing a timeline may be particularly useful in eliciting the youth's trauma history (Figure 1). The therapist can use the timeline to help the youth to describe salient events in their life, starting from birth and moving forward up to the present time. The youth is encouraged to highlight different traumas using different colors. For example, if sexual abuse occurred from ages 3-8 years old, the youth could use a marker to denote "sexual abuse" going from 3-8 years on the timeline. The youth should also denote other important events on the timeline. This may include negative events (e.g., placement in foster care; death of a caregiver; running away) or positive events (e.g., coming out; meeting mentors, etc.). However, it is important for therapists to recognize that, like many youth with complex trauma (described below), LGBTQ youth may initially minimize or deny information about their trauma experiences and responses. Unique to LGBTQ youth, this minimization or denial might occur because **disclosing the trauma would entail revealing the youth's sexual orientation and/or gender identity** (or maybe that others will assume the trauma is the cause of their LGBTQ identity). For example, a youth who was sexually abused in a same-sex relationship may not disclose this for fear that this would "out" him as being gay when he was not ready to disclose this: his abusive boyfriend may have threatened that disclosure would lead to this result. There may be additional reasons for LGBTQ youth to minimize or deny trauma experiences, for example, because the youth does not sufficiently trust the therapist to share this information and/or because the youth has come to believe that trauma experiences are "normal." Additionally, therapists should assess patients' interest in accessing gender affirming medical or surgical treatment; one reason that youth may minimize or deny their trauma experiences and/or symptoms may be because they fear that acknowledging these may delay or restrict their access to gender affirming medical or surgical treatment.

Therapists should carefully assess LGBTQ youth for the presence of PTSD symptoms and disorder, while also recognizing that typical of youth with complex trauma, many traumatized LGBTQ youth will initially minimize both reporting their trauma exposures and responses. As with other youth, LGBTQ youth **do not need to meet full PTSD criteria in order to receive TF-CBT**. For TF-CBT to be appropriate, youth should have: 1) exposure to at least one remembered trauma; 2) significant trauma-related symptoms (e.g., PTSD, depressive, anxiety, cognitive, interpersonal, behavioral symptoms) that will be the focus of the youth's TF-CBT treatment determined through the use of clinical interview and at least one standardized trauma assessment instrument such as the UCLA PTSD Reaction Index (RI), the Child PTSD Symptom Scale (CPSS), the Trauma Symptom Checklist for Children (TSCC) or another developmentally appropriate, validated, standardized instrument; and 3) youth's and (if appropriate) parent's agreement to participate in trauma-focused treatment.

Case Conceptualization

Before starting TF-CBT (or any treatment), it is important for the therapist to formulate the information that was obtained during the evaluation into a coherent case conceptualization, and present this information to the youth and parent. Specifically, this information includes how the therapist puts together the information (conceptualization) into a coherent understanding of the youth's problem(s) (diagnosis), and how the therapist proposes to work with the family to address the problem(s) (treatment plan). For TF-CBT (or other trauma-focused) treatment cases, the therapist's conceptualization is that *trauma is a core underlying cause of the youth's presenting problems*. If this is not the case, TF-CBT (or any other trauma-focused treatment) would not be indicated. Therapists should understand that being LGBTQ in and of itself is not a trauma. Most LGBTQ youth are highly resilient; however, due to pervasive societal stigma and prejudice, these youth experience higher rates of trauma exposure than their straight and cisgender peers which leads to higher risk.

Within this trauma conceptualization, the therapist understands the youth's presenting problems— affective (e.g., depression, anger, hopelessness), behavioral (e.g., suicide attempts, school truancy, risky sexual behaviors, running away, substance abuse), cognitive (e.g., self-blame for parental rejection or peer bullying; belief that the world is always or only dangerous; no one can be trusted), social (e.g., withdrawing from peers, affiliating with deviant peers), etc.—as being responses to specific trauma reminders that occur in the youth's daily life and that remind the youth of the original trauma(s). When youth also present with sexual orientation and/or gender identity concerns, the therapist must use clinical judgment about the degree to which these are trauma-related, versus not related to the youth's trauma experiences. For example, a youth whose self-identified sexual orientation suddenly changed after a traumatic sexual assault should be carefully assessed for traumatic impact of the assault in this regard.

It is important to understand that for many if not most LGBTQ youth, traumas are ongoing (e.g., bullying by peers). Particularly with ongoing traumas, trauma reminders are frequent, and the youth's trauma responses also occur frequently if they are not almost constantly present. The therapist explains this to the youth and parent (typically at the assessment) when explaining the rationale for providing TF-CBT (the treatment plan) which will address the youth's problems by developing alternative strategies for managing and responding to trauma reminders.

Conceptualizing the youth's presenting problems in a trauma framework—i.e., as an expected response to frightening, potentially life-or safety-threatening experiences, rather than as a serious mental health problem—is often a relief to LGBTQ youth, and is a highly effective strategy for engaging youth and parents in treatment.

TF-CBT APPLICATIONS FOR YOUTH WITH COMPLEX TRAUMA

Although complex trauma (sometimes referred to as “complex PTSD”, Cook et al., 2003) is not included in the DSM, it is increasingly familiar to child and adolescent mental health clinicians and is proposed for inclusion in the International Classification of Diseases, 11th Version (ICD-11). The proposed ICD-11 criteria for complex PTSD include that: 1) the individual experienced chronic trauma; and that 2) in addition to core PTSD features of intrusion, avoidance and hyperarousal, there must be prominent symptoms of affective dysregulation, negative self-concept, and interpersonal disturbance (Cloitre, et al., 2013). Youth with complex trauma may benefit from trauma treatments that are specifically designed or modified for complex trauma. Complex trauma TF-CBT applications are available (Cohen et al., 2012; Kliethermes & Wamser, 2012; Kliethermes et al., 2013). Many traumatized LGBTQ youth have presentations that are consistent with complex trauma. For these youth, therapists should be familiar with complex trauma TF-CBT applications. Briefly, these include the following:

- 1) Adjusting the length of TF-CBT treatment (from 8-16 sessions for typical PTSD to 16-25 sessions for complex trauma);
- 2) Adjusting the proportionality of TF-CBT phases: specifically, for treating typical PTSD, 1/3 of TF-CBT sessions are spent on each TF-CBT phase. For complex PTSD, up to ½ of the TF-CBT treatment sessions are spent on the initial stabilization phase due to these youth having increased dysregulation and needing more time to start trusting the therapist. The other phases each receive approximately one-fourth of TF-CBT sessions. See Figures 2 (typical trauma) and 3 (complex trauma);
- 3) Recognizing the therapist as a potential trauma reminder since trauma was often perpetrated by caregivers or other attachment figures (for LGBTQ youth, this often relates to parental rejection and peer bullying);

- 4) Safety first: since many youth with complex trauma develop unsafe coping strategies, introducing the Enhancing safety component at the start of TF-CBT treatment and continuing to emphasize this component throughout TF-CBT is critical. This is illustrated in Figure 2;
- 5) Focusing on overarching trauma themes that unify the LGBTQ youth’s chronic/multiple trauma experiences (e.g., “the people who should have protected me, rejected and abused me”; “people like me get bullied or even killed, so it’s not safe to trust anyone,” etc.); and
- 6) Including traumatic grief and separation TF-CBT components at the end of treatment when indicated, since many of these youth experience repeated loss of important attachment figures.

Figure 1: Timeline



Figure 2: TF-CBT Application for Typical PTSD

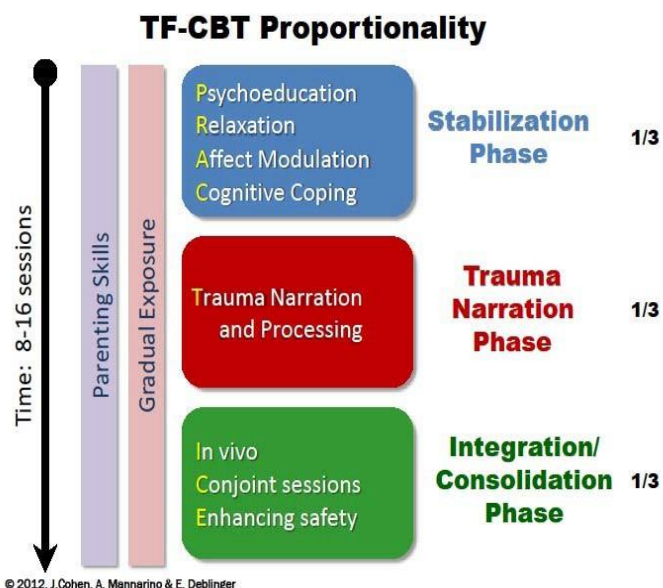
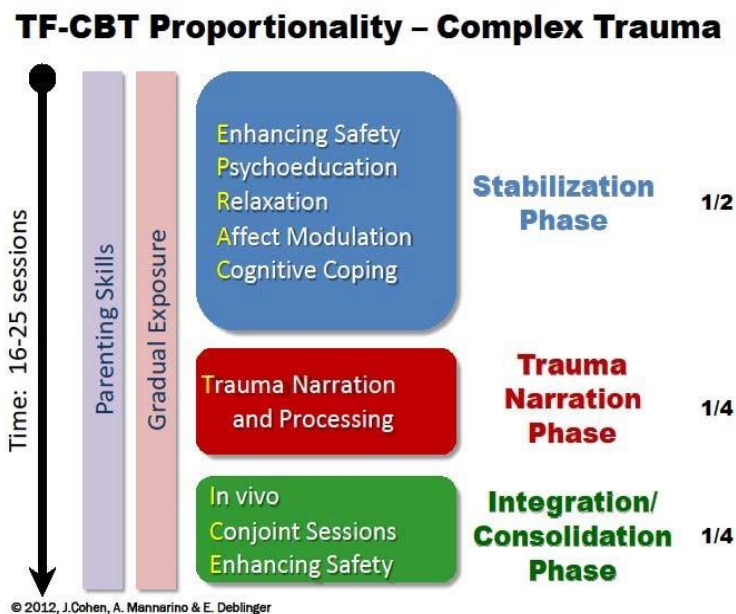


Figure 3: TF-CBT Application for Complex PTSD



However, therapists should also be aware that many youth with complex trauma presentations respond very well to standard TF-CBT treatment without these modifications. A recent study documented that standard TF-CBT treatment provided during 12 treatment sessions using equal proportionality for the three treatment phases led to significant improvement in both typical and complex PTSD symptoms (Sachser et al., 2016) and that the improvement in PTSD was equivalent between youth with typical and complex PTSD (Goldbeck et al., 2015). Clinical judgment should be used in deciding whether to use complex trauma modifications of TF-CBT for a particular LGBTQ youth.

Consistent with the above discussion and with our clinical experience that many LGBTQ youth have complex trauma presentations, we integrate a complex trauma perspective into this implementation manual. Not all LGBTQ youth will present in this manner, so the therapist should make clinical adjustments accordingly. However, because of the frequent need to apply complex trauma modifications for this population we address these issues throughout the implementation manual. Specifically, these may be needed to address acute safety concerns from the beginning and throughout treatment; to manage disrupted attachments between the youth and parents or other caregivers due to interpersonal traumas perpetrated by the caregivers, as well as peer bullying from a young age, threats to their physical integrity, and/or the pervasive and ongoing discrimination and stigmatization coming from multiple sources including family, peers, media, religious organizations, etc. related to the youth's sexual orientation and/or gender identity.

FAP Section #

ASSESSMENT – Family Acceptance Project®

[© 2018 Caitlin Ryan - Ryan, C. (2018). Family Acceptance Project: Working Procedures. San Francisco: Family Acceptance Project]

A core principal of FAP's approach is meeting families where they are. This includes learning about their cultural and religious backgrounds, practices, beliefs, perceptions and misperceptions about sexual orientation and gender identity in the U.S. and countries of origin; literacy levels and language use; and knowledge and experiences with LGBTQ people, including children and adolescents.

FAP does several kinds of assessments to learn about the caregiver's knowledge, attitudes and behavior related to their child's LGBTQ identity and gender expression; and the youth's level of openness about their LGBTQ identity and experiences with family acceptance and rejection.

Youth & Family Questionnaires – Because FAP starts with understanding the parent's and youth's cultural world, FAP incorporates a series of questions on intake forms that ask about the youth's and parent's cultural and religious backgrounds and knowledge and perceptions of sexual orientation, gender identity and expression (SOGIE). These questions can be included in current intake forms or on a separate form. They are open-ended and should be followed by probes to elicit a deeper understanding of how the caregiver perceives non-heterosexual and diverse gender identities in the context of their culture, religion, and interactions with LGBTQ adults in mainstream society and in the caregiver's culture. FAP has included a separate *Youth Questionnaire* and a *Parent Questionnaire* that indicate the order of using other FAP assessment forms (e.g., social support map and gender scale) to make them easier to use. These questionnaires are included in the FAP appendix. When using FAP's model, these assessments are conducted as part of the intake process, as described below. In TF-CBT, these assessments could be completed as feasible during the assessment, to promote confidentiality, enhance safety, and inform the practitioner's approach to working with parents.

Use of Language – FAP works with LGBTQ children, youth, families and caregivers from a wide range of backgrounds. This includes low income, middle class and affluent families, immigrants, non-English speakers, caregivers with lower levels of education, literacy and reduced cognitive ability, and families from all racial and religious groups. Language related to SOGIE is rapidly evolving and typically is generated by the LGBTQ community and by professionals, so terms will likely be unfamiliar to caregivers and may be complex and multisyllabic. For families and caregivers from diverse cultures who are learning about their child's SOGIE and who need to explain this new information to their own families and to cultural and religious leaders, this language is often confusing and may further distance them from their child's vulnerability and humanity.

During assessment, FAP practitioners listen closely to the caregiver's use of language and align with this language in framing intake and follow up questions. Practitioners use this background information in psychosocial education and counseling sessions to ensure that the caregiver understands how to talk about their child or adolescent's sexual orientation, gender identity and expression, and how this relates to child development. Caregivers will continue to learn LGBTQ-specific language as treatment evolves and as they deepen involvement in their child's social world.

Social Support Map – When conducting an assessment, FAP practitioners interview children and youth first to learn about their family experiences and family member's knowledge and responses to their SOGIE. FAP developed a social support map to identify family members, peers and others who are in the child's social world, including those that are sources of support and who know about their LGBTQ identity. This map is used to understand and help build social support for the LGBTQ youth and to help protect the child's confidentiality. Because families need culturally relevant peer support to help them learn to affirm their LGBTQ children, FAP developed a second social support map to help parents and caregivers to identify and expand their social support network, to help support and affirm their LGBTQ child. (These forms are included in the appendix.)

Gender Expectation and Perceptions – FAP developed a simple gender scale to quickly assess the youth’s perceptions of their gender expression and how this relates to the caregiver’s gender expectations and perceptions of the youth’s gender expression. Gender is a core element of identity and social organization and often a source of conflict and rejection for LGBTQ children and youth.

Caregivers often conflate sexual orientation and gender expression. Gender diverse children and youth often experience family rejecting behaviors to extinguish or change both their perceived sexual orientation and gender presentation. Some of these behaviors include physical or verbal abuse and ridicule related to the child’s gender expression and perceived identity; excluding them from family events and activities because of their SOGIE; telling the child they are ashamed of them; trying to change their perceived or known SOGIE; or physically separating from the child in a public space to indicate to others that this child does not belong to them. FAP’s gender scale gives caregivers – including those who might have less education, lower literacy levels and less experience talking about gender – a simple way to acknowledge gender expectations. This enables a youth and caregiver to start to talk about gender and pressure to conform in a neutral, non-threatening way. FAP introduces this scale with the youth and caregiver separately during intake sessions and uses the content later in individual or conjoint counseling sessions. (Copies of these scales are included in the appendix.)

Family Behaviors – FAP assesses the youth’s experiences with family rejection and acceptance throughout the course of care, starting with the initial assessment (done separately with the youth and parent). During the intake assessment, FAP uses its *FAPrisk Screener* – a brief assessment of family rejection and related health risks to quickly determine the level of family rejection and to ask the youth about specific rejecting behaviors and then elicit information on supportive and accepting behaviors that contribute to risk and well-being. FAP has also developed *Youth and Family Assessment Measures* that are used to assess parental growth and change when implementing FAP’s family support model. For this version of the TF-CBT LGBTQ manual, we will use a streamlined process to provide the foundation for increasing family acceptance and support. Clinicians can request access to FAP’s assessment measures that assess growth and change (fap@sfsu.edu).

Introducing Behavioral Content at Intake - Although FAP has done seminal research and family intervention work related to family acceptance and rejection, most youth and caregivers are not familiar with FAP’s work or with the scope of specific rejecting and accepting behaviors that impact their risk and well-being. FAP practitioners use the intake session to take an initial inventory of family reactions to the LGBTQ youth and to start to teach the youth about the range and impact of these behaviors. FAP has found that while many youth know that negative behaviors their caregivers use to respond to them feel bad, they have been socialized to expect these experiences and don’t realize the powerful negative impact that family rejecting behaviors have on their self-concept, health and well-being. Similarly, many LGBTQ youth are surprised to learn the range of family accepting and supportive behaviors that FAP identified and measured and that FAP teaches caregivers to engage in to increase support for their LGBTQ children. Poignantly, when FAP piloted the research measures for their initial survey and asked youth to respond to the full range of rejecting and accepting behaviors that were measured, some LGBTQ youth could not believe that parents and caregivers would respond with *any* accepting behaviors, much less such behaviors as welcoming their LGBTQ friends or partners to their home, supporting their gender expression, standing up for them when others mistreat them because they are LGBTQ or gender diverse or talking with religious leaders to make their congregation more welcoming for LGBTQ people.

Youth Intake – During the youth intake interview after using FAP’s background questions (see appendix), and using FAP’s social support map and gender scale, we suggest that TF-CBT practitioners use FAP’s new public education posters* (that depict family rejecting and accepting behaviors that FAP identified and measured) to help the youth identify these family behaviors and begin to create an intervention map for working with the parents and caregivers.

*The posters have three versions in English and Spanish: 1) a general version on family accepting behaviors and how they help protect against risk and promote well-being; 2) a version on family rejecting behaviors and how they contribute to risk; and 3) a version on family accepting behaviors for conservative settings and communities that substitutes other family accepting behaviors for same-sex dating or expressing support for a youth’s LGBTQ partner which could preclude the posters from being used in these settings.

The posters depict commonly used rejecting and accepting behaviors across cultures. Practitioners might start by asking the youth about experiences with their caregivers:

- *“On a scale of 1 to 5 – with very accepting at one end and very rejecting at the other end – where would you put your caregivers?”*
- Then ask the youth how their caregiver responds to them. Some youth may only answer broadly, so start by asking them about specific rejecting behaviors, using FAP’s family rejection poster as a resource.
 - *“These are some of the ways that parents and caregivers express rejection or disapproval of LGBTQ youth. Have any of these happened to you? If so, how often? Over what period of time?”*
Ask the youth to be specific so you can create an inventory of family reactions.
- Then ask if their caregiver has expressed support or acceptance related to their LGBTQ identity / gender expression. Point to accepting behaviors on FAP’s family acceptance posters and ask if their caregiver has engaged in any of these behaviors. If so, how often? Over what period of time?
- Ask the youth to identify other kinds of parent / caregiver reactions to their SOGIE or LGBTQ identity. And ask how these behaviors felt. *“Was your parent acting this way to try to change, discourage, deny or prevent your LGBTQ identity? Or do you think they were trying to be supportive or affirming?”*

Using this approach, the practitioner creates an inventory of family reactions towards the LGBT youth—including how rejecting or affirming they are—that will be used to process their reactions to these behaviors, individually and in conjoint sessions with their parent during the course of treatment. Practitioners should note parent behaviors that appear especially sensitive for the youth, as well as specific behaviors where the youth’s response feels blunted to address these later in treatment, individually and with the parent.

Caregiver Intake – Initial assessment for caregivers focuses on obtaining background information and building rapport with the caregiver by being encouraging and non-judgmental when asking about knowledge, attitudes, experiences and cultural and religious beliefs related to LGBTQ people. Open-ended questions to assess knowledge and experiences related to SOGIE and LGBTQ people are included in the appendix and can be integrated into routine intake procedures or asked separately. After the practitioner asks SOGIE-related intake questions, they ask the caregiver about their support network using FAP’s caregiver social support map. While the caregiver fills out their map, the practitioner asks about whom they are close to, who they turn to for support and who they can talk with about their child’s LGBTQ identity / gender diversity. Some caregivers have no one they can turn to for support or talk with about their child’s LGBTQ identity. Helping expand the caregiver’s LGBTQ support system to enable them to support their LGBTQ child becomes part of FAP’s intervention goals to help caregivers expand their involvement in their child’s social world and learn to advocate for their LGBTQ child outside the home. After learning about the caregiver’s support system, the practitioner introduces FAP’s gender scale to learn about the caregiver’s gender expectations and experiences related to the youth’s gender presentation and identity (both forms are included in the appendix).

Practitioners should observe the language that caregivers use to describe their LGBTQ children and aim to respond in kind, without using inappropriate language. An important discussion to have with the parent / caregiver either in this session or as soon as possible is to ask them to share their hopes and dreams for their child, to talk about what they understand about their child’s current situation, what their fears and concerns are and how this relates to their cultural and religious values and beliefs (e.g., in some religions, gay people will be separated from their family for eternity, and gender is fixed so transgender identity does not exist in the afterlife).

Although this may seem surprising, few families, especially families of color and those with system-involved children, have been able to openly share their concerns and hopes for their LGBTQ child with a nonjudgmental listener in a

confidential interaction. LGBTQ youth commonly tell their identity stories but many parents and caregivers have few opportunities to talk about these issues with a knowledgeable, empathic listener, particularly a practitioner.

For parents, telling their story is an important step in starting to connect the gaps, identify misconceptions related to what they know about SOGIE and to start to imagine a different future for their child in cultures that some parents fear will never accept them. This also provides an opportunity for practitioners to learn more about how parents are responding to their LGBTQ children, including ways they have tried to change, discourage or support their child's LGBTQ identity. Understanding the parent's / caregiver's perceptions, values and beliefs will help the practitioner identify the types of psychoeducation and support that will promote safety and help the caregiver learn to care for and affirm their LGBTQ child.

After the practitioner helps the caregiver to describe their hopes for their child and to share their fears and concerns related to their child's known or perceived sexual orientation and gender identity, the practitioner asks the caregiver how they have responded to the child's SOGIE, including specific interactions and experiences. This discussion could take a full session since the caregiver might share several stories to explain how they have responded to their child's SOGIE. This phase of assessment is focused on determining the caregiver's knowledge, perceptions and behaviors related to their child's SOGIE and starting to create an inventory of caregiver reactions. Practitioners will help the caregiver to link reactions to their child's SOGIE or LGBTQ identity with risk and well-being once the caregiver begins psychoeducation with the caregiver and separately with the youth – following assessment.

Before FAP practitioners complete the initial youth and family assessment, they administer FAP's *Youth and Family Assessment Measures* that document parent's engagement in specific family rejecting and accepting behaviors, openness to their child's LGBTQ identity and their child's responses. These measures are also used at the mid-point and end of treatment to assess growth and change in helping parents learn to support and affirm the youth's LGBTQ identity. The FAP measures also help educate parents about how their behaviors are affecting their LGBTQ children.

Manual Framework

The remainder of this implementation manual describes clinical applications of the TF-CBT PRACTICE components for traumatized LGBTQ youth and caregivers. For each component, the manual will: 1) provide a brief statement of the goals for that component; 2) briefly summarize typical implementation strategies for that component; and 3) describe LGBTQ implementation considerations and strategies for that component. As noted above, several components also include sections that describe how TF-CBT therapists could incorporate Family Acceptance Project strategies, procedures and resources into those components for appropriate families. All components with the exception of the Conjoint Youth-Parent Sessions are typically provided in parallel individual sessions to youth and parent, respectively, with approximately half of each session being provided to the youth and half of the session to the parent (Cohen et al., 2017).

ENHANCING SAFETY

Goals: The goals of the Enhancing Safety component are to develop developmentally appropriate safety strategies that the youth can utilize in everyday situations, and in response to trauma reminders.

Typical Implementation: In typical TF-CBT, Enhancing Safety is the final treatment component. Youth and parents develop an individualized safety plan that is responsive to the youth's developmental level and personal situation. They may include strategies to address self-destructive behaviors (e.g., running away, suicidal behaviors, self-injury, etc.); body safety education (for younger children) or education about sexual health principles (for older youth); problem solving skills; drug refusal skills; bullying prevention/management skills; and/or other skills as needed. The youth and (as appropriate) parent actively participate in developing and practicing the safety strategies to assure that these are feasible for the youth to use. However, as noted earlier, for youth with complex trauma, this component is provided first and throughout TF-CBT treatment, in recognition that these youth often have significant unsafe behaviors that are a priority to address early in treatment. Despite their resiliency and personal strength, many LGBTQ youth continue to face ongoing and severe traumas. Sadly, this often times results in the development of a complex trauma presentation. Since many, if not, most LGBTQ youth present with complex trauma and often have acute safety issues early in treatment, this component is described first, and the therapist should implement this component first and throughout TF-CBT treatment for youth when it is clinically indicated. Youth with a complex trauma presentation are often involved with other child serving systems, e.g., medical, child welfare and/or juvenile justice systems. It is critical that all professionals working with the youth collaborate to create safe and affirming spaces for LGBTQ youth. If the therapist's impression is that other professionals are not creating such spaces it is important for the therapist to advocate on the youth's behalf to enhance the availability of safe, supportive and affirming professional providers and spaces.

LGBTQ Implementation Considerations: Many LGBTQ youth present with complex trauma, including unsafe coping strategies such as use of illicit substances to manage trauma symptoms, running away, self-injury, suicidality, and other potentially unsafe behaviors. Important considerations for the therapist who is implementing TF-CBT for these LGBTQ youth include the following: a) acknowledge ongoing reality-based threats to the youth's physical and/or emotional safety; b) provide psychoeducation about LGBTQ-specific traumas to connect the ongoing threats to the youth's unsafe behaviors; c) address parental rejection as a potential antecedent to unsafe LGBTQ youth behaviors; d) develop specific safety strategies appropriate to the needs of LGBTQ youth; and e) introduce principles of sexual health specific to the needs of LGBTQ youth.

Acknowledge reality-based threats to the youth's safety: Like other youth with complex trauma, antecedents for unsafe behaviors among LGBTQ youth are often *ongoing traumas*. Specific to LGBTQ youth, these traumas may be related to the youth's sexual orientation and/or gender identity (e.g., parental rejection; peer bullying, which can be both overt and/or covert) and due to homo/trans negativity, heterosexism, bias and other factors. Important adults (e.g., parents, educators, police, etc.) who typically should keep the youth safe may minimize or even deny real ongoing threats to these youths' physical and/or emotional safety. It is therefore important for the therapist to acknowledge the youth's trauma experiences (e.g., a transgender female who experienced parental emotional and physical abuse and peer bullying related to her gender identity), the associated affect, cognitions and behaviors (e.g., anger, hopelessness, running away, school truancy and suicidal ideation), and *the reality basis* for these responses (i.e., fear that being at home or attending school will cause her to be physically attacked). The therapist can then inquire about the youth's unsafe responses to trauma reminders or recurrent traumas. This would typically include obtaining more thorough information about the unsafe behaviors, and detailed information about the antecedents and consequences of the behaviors from the youth and parent, i.e., conducting a detailed functional behavioral analysis of the unsafe behaviors (Cohen, Berliner & Mannarino, 2010).

If appropriate, the therapist can then acknowledge that the unsafe behaviors may have been the youth's best efforts to cope with the trauma in the past, but that these behaviors may not be serving the youth's best interest currently (Cohen, Mannarino, Kliethermes & Murray, 2012). Explore with the youth whether this may be the case, and whether alternative strategies may better serve the youth's needs now. For example, in the past, suicidality may have led to the youth being hospitalized and thus allowed the youth to temporarily escape from a rejecting parent and bullying peers, but now the escalating suicidal acts are putting the youth's health and safety at risk. Can the therapist and youth work together to come up with another strategy that will serve the youth's needs better in the present?

Provide psychoeducation about LGBTQ-specific traumas; connect ongoing threats to unsafe behaviors:

It is helpful for the therapist to make specific connections between the youth's personal trauma experience(s), trauma reminders and trauma responses, including the youth's unsafe behaviors. Tailor this information to highlight the youth's individual symptom presentation and normalize the youth's affective and behavioral responses. For example, the therapist could say something like, "Hearing about your father's rejection and bullying at school, I see why you feel so hopeless and angry", and then proceed to provide psychoeducation (for the above example, this would include information about LGBTQ youth experiences of parental rejection and bullying and common responses including increased suicidality, etc.) FAP educational materials and resources can help LGBTQ youth understand how parent and caregiver responses affect their mental and sexual health, their relationships, self-esteem and sense of the future. Providing this information to parents parallel to the youth is also essential as described below. It may be helpful to provide psychoeducation about the impact of heterosexism and prejudice, including data that LGBTQ youth have higher rates of suicidal ideation related to these experiences, but that this can be significantly mitigated by strong parental support—that is, reframe the youth's response as an understandable response to external stress rather than an indication of mental illness, and explore concrete ways to enlist family and social support to lower the youth's stress. For example, a therapist provided psychoeducation to the parents of a gay teenage boy who complained about former therapists by helping the parents to learn about heterosexism. Through this process, the parents were able to better understand why their son was annoyed and felt so disconnected from the previous therapists when the therapists asked him whether he had a girlfriend. The parents were then able to understand and support his decision to quit therapy with those providers.

Address parental rejection: TF-CBT research has shown the importance of including parents in treating traumatized youth. The Family Acceptance Project has extended our understanding to emphasize the potential value of including parents who reject their LGBTQ youth in treatment (Ryan, 2014). Rather than viewing these parents as perpetrators and simply assuming that the parent does not want the best for the youth or is irredeemable as a potential source of support for the youth, the therapist should start from the belief that rejecting behaviors likely are motivated by concern, fear, desire to protect the youth from harm and to be a "good" parent in the context of the family's cultural and religious beliefs (Glassgold & Ryan, forthcoming; Ryan, 2014). The therapist should therefore, during collateral parenting sessions, explore sources of the parent's concerns about the youth's sexual orientation/gender identity as described in the above FAP Assessment section and provide psychoeducation and other TF-CBT interventions described below (Ryan, 2014), and in the FAP section at the end of the Psychoeducation component.

The therapist should understand that validating motives to protect their LGBTQ child from harm (such as not letting their child have an LGBTQ friend or participate in an LGBTQ support group) during collateral parenting sessions does not mean that they agree with or endorse parental rejecting behaviors. As a result of widespread access to accurate information about SOGIE and positive images of LGBTQ youth and adults, children are increasingly coming out at younger ages and without a period of uncertainty

that characterized the experiences of LGBTQ adults from prior generations (C. Ryan, personal communication, July 26, 2019). Youth who are struggling with their sexual orientation and/or gender identity have a longer time to think about their LGBTQ identity and what this will mean for them and their family. Many parents are unprepared to learn about their child's SOGI because they never assumed that their child might be LGBTQ or because they learned unexpectedly about their child's SOGI in other ways.

Regardless of how parents learn about their child's LGBTQ identity, parents and family members have a parallel "coming out" process through which they become aware of the youth's identity and many parents, in particular, need time to understand and adjust. Parents often have very strong negative emotions (e.g., guilt, fear, shame, anger) and cognitions (e.g., "my child will be murdered if he is transgender," "she will never be happy as a lesbian woman") that contribute to their rejecting behaviors. The therapist should provide psychoeducation to the parent about the impact of parental rejection and how decreasing / stopping rejecting behaviors and increasing supportive behaviors can have a significant impact on reducing hopelessness, suicidality and family conflict.

In FAP's family support model, psychoeducation is an ongoing component to help parents to decrease rejection, increase support and affirmation, and model how diverse families learn to affirm their LGBT children. FAP has developed a range of evidence-informed family education materials, described briefly in the FAP Psychoeducation section and in the Appendix that therapists can use to help parents (and parents and youth conjointly) to learn to increase acceptance and support for LGBTQ children and youth.

After learning how parents respond to their LGBTQ child (through an in-depth assessment that includes identifying family rejecting and accepting behaviors (see FAP Assessment section, page 17-20), therapists start to help the parent to identify more supportive ways to respond to their LGBTQ child and to improve communication skills. This includes modeling, role plays and practicing specific ways for how the parent can interact with the youth in non-rejecting, neutral and/or supportive ways (<https://familyproject.sfsu.edu>). It may be helpful to explicitly state that validating the youth (e.g., "I understand what you are saying" does not mean that the parent is endorsing a "behavior" or "lifestyle" (being LGBTQ) that they are not ready to—or feel they can never—accept. The Family Acceptance Project has developed specific language and framing to help parents understand that they can *support* their LGBTQ child to reduce risk without having to *accept* a "behavior" that they believe is wrong. (See FAP Psychoeducation section and FAP educational materials.)

Develop specific safety strategies appropriate to the needs of LGBTQ youth: The therapist should **engage the youth** in this process by explicitly stating to the youth that the youth's safety is important to the therapist and the parent, and then exploring with the youth how to work together to keep the youth safe. It is important to solicit the youth's input about what needs to change (e.g., ask the youth, "What would you need to keep yourself safe and not engage in the dangerous behavior again?"), keeping in mind that this plan needs to be realistic for the individual LGBTQ youth and parent. It might also be necessary to discuss with the youth their understanding of dangerous behavior. For instance, for some youth, running away or using drugs might present more benefits than potential risks. Challenging such views and providing realistic information regarding threats to their safety may be critical (e.g., being abducted on the streets, shot, stabbed, etc. and exposed to short and long-term negative effects of drugs).

The therapist needs to **negotiate with youth and parent** to develop a safety plan that is feasible for both. For example, one transgender youth's safety plan was that the parents would refrain from saying

negative things about her gender identity. However, the parents were very angry and concerned about their youth's transgender identity and initially refused to consider this proposal. After the therapist focused on the youth's safety, validated the parents' genuine concern about the youth's recent serious suicidal actions, and provided psychoeducation about the impact of parental acceptance behaviors even in the absence of changed parental values, the parents agreed that their number one priority was to keep their child safe from imminent danger or harm. The parents agreed to refrain from making negative comments about the youth's gender identity, even though they could not bring themselves to accept her as a female at this point. They also agreed (albeit quite reluctantly) that if they did not abide by this plan, they would allow the youth to temporarily stay with an aunt who was more supportive. In return, the youth agreed not to engage in suicidal actions/behaviors or running away. Often this requires brief joint sessions with the youth and parent together early in treatment (after the therapist has met with the youth and parent individually) to discuss the safety concerns and agree on safety strategies. In some cases, there are realistic external threats to the youth's safety (e.g. ongoing school bullying; unsafe situations at home or in the community that are contributing to the youth's unsafe behaviors) and that need to be addressed in order to stabilize these youths' responses. The therapist can meet together with the youth and parent in this manner to develop an agreed-upon strategy through which the parent can advocate for the youth and through which the youth's own unsafe behaviors will be minimized.

The therapist should **provide, practice and role play specific TF-CBT coping strategies** that the youth can use in place of their current dangerous behaviors, after identifying trauma reminders that serve as antecedents to unsafe behaviors, i.e., "what situation might lead you to do something dangerous?" For example, the therapist might ask, "When you are feeling hopeless and angry, like when you are being bullied in school, is there anything you could do to calm yourself down and keep yourself safe, instead of cutting yourself?" Early in treatment this will usually consist of relaxation or affective modulation (distraction) techniques, such as taking a walk, listening to music, calling a friend, etc. The therapist should instruct the youth in how to self-monitor and track mood, body tension, and other self-rating tools (e.g., on a 1-10 scale), so that the youth can monitor how these strategies are working. The therapist should ask the youth to track the daily use of these positive coping/safety strategies and tweak these strategies as needed.

The therapist needs to **monitor and tweak the safety plan over time** as needed. The therapist should not be surprised or disappointed if it takes time to replace dangerous behaviors with more positive coping skills, and should be prepared for it to take time for unsafe behaviors to completely stop. Remember that LGBTQ youth with unsafe behaviors have likely developed these strategies over a long time to survive threats they encounter in their daily lives. Showing the youth a few new coping strategies in the therapist's office is rarely sufficient. Therapists need to role play and practice very specific behavioral skills that they want the LGBTQ youth to acquire and use in dangerous situations. This should not prevent the therapist from proceeding with the TF-CBT model— youth likely need time to learn additional TF-CBT stabilization skills in order to develop alternative coping /safety strategies. In most cases, the therapist should move forward with TF-CBT while continuing to monitor safety. The therapist should continue to monitor and tweak safety strategies throughout the course of TF-CBT treatment. As always, youth with **acute suicidality** should be hospitalized if clinically indicated, and may need to be referred to an evidence-based suicide prevention treatment approach (e.g., DBT) prior to beginning a trauma-focused treatment approach such as TF-CBT.

Introduce principles of sexual health appropriate to the needs of LGBTQ youth: The therapist may also introduce principles of Sexual Health, particularly for LGBTQ youth who are engaging in risky sexual behaviors. These are detailed in the webinar <http://learn.nctsn.org/enrol/index.php?id=389> and are described in more detail in Psychoeducation.

PSYCHOEDUCATION

Goals: The goals of TF-CBT psychoeducation are to provide information about, validate and normalize for youth and parent, the impact of the youth's trauma experiences on different domains of functioning and provide information about the value of treatment and hope for recovery.

Typical Implementation: Typically, the TF-CBT therapist provides information about the full range of the youth's trauma experiences and common trauma reactions (including biological, emotional, behavioral, cognitive, social, etc.), connecting these to the youth's personal trauma responses. The therapist also provides psychoeducation about trauma reminders and encourages the youth to start to identify personal trauma reminders. The therapist also provides psychoeducation to the parent in this regard, as well as common parental responses to a child's trauma experiences. Providing information about neurobiology responses to trauma and how treatment can address these (e.g., practicing skills every day reverses these changes) is often helpful for explaining the rationale of TF-CBT to youth and parents. Resources for this include the handout Trauma and the Brain (<https://tfcbt.org/trauma-and-the-brain-handout-mclaughlin-2014/>)

LGBTQ Implementation Considerations: In including information about the impact of the full range of trauma experiences that have impacted that specific LGBTQ youth, the therapist must be careful to balance and include both LGBTQ-specific traumas (e.g., bullying, hate crimes, parental rejection); other types of traumas that may or may not be related to the youth's sexual orientation and/or gender identity (e.g., sexual or physical abuse/assault; community violence, traumatic deaths/separations, etc.), and traumas unrelated to the youth's identity (e.g., motor vehicle accidents, disasters, etc.). Different trauma reminders might yield different trauma responses. The following considerations are important when implementing TF-CBT for LGBTQ youth: a) be nonjudgmental and don't make assumptions; b) be aware of multifactorial influences on trauma impact; c) provide psychoeducation about traumas that differentially impact LGBTQ youth; d) provide psychoeducation specific to traumatized transgender youth; e) provide psychoeducation about the impact of parental rejection; and f) provide psychoeducation about sexual health principles.

Be nonjudgmental and don't make assumptions: It is important for the therapist to not assume the degree to which sexual orientation/gender identity issues are relevant to the youth's traumas and thus to TF-CBT treatment. For some youth, these issues have little or nothing to do with the youth's trauma experiences or responses and for these youth it would likely be off-putting for the therapist to digress from trauma-focused therapy into discussing the youth's presumed issues related to sexual orientation and/or gender identity. In contrast, other youth who have experienced trauma that was overtly due to the youth's sexual orientation and/or gender identity (e.g., parental rejection, peer bullying or hate crime directly related to the youth's LGBTQ identity) may need to address the connections between their trauma experiences and their sexual orientation and/or gender identity.

In either case, it is important to *ask youth for their perception* of what the connection is, if any, between their trauma experience(s) and their sexual/ gender identity, while recognizing that some youth may have maladaptive cognitions related to their identity and/or trauma experiences that may affect the youth's perception in this regard.

For example, a lesbian youth who had internalized familial and societal heterosexism denied that paternal physical abuse or peer bullying was related to her sexual orientation, stating that these traumas occurred because "everyone knew something was wrong with me—I deserved it." She lived in a small rural town, had no LGBTQ friends or positive LGBTQ role models, and had internalized feeling like "a misfit" most of her life. She did not initially connect "being a misfit" to her attraction to girls, nor connect her traumatic experiences to her sexual orientation. She considered herself a misfit because she was different—she didn't look, act or feel like other girls in her family or community and "everyone could tell I never fit in." She said, "I didn't know why I was different until junior high, when I started having crushes on girls." Psychoeducation about the impact of heterosexism and its connection to LGBTQ-specific traumas was very helpful for this youth. In the same way that therapists may not initially know which of their patients have experienced trauma, they may not know which identify as LGBTQ. While many LGBTQ youth are clear on their sexual and gender identity, others may be curious, questioning and/or not yet out. The therapist should be non-judgmental and normalize wherever youth are related to their identity. For all youth (LGBTQ or straight and cisgender), when providing psychoeducation, therapists should strive to provide information, materials and clinical examples that are diverse with regard to sexual, gender, as well as ethnic, racial, religious and other identities.

Be aware of multi-factorial influences on trauma impact: It is important for the therapist to inquire about and provide psychoeducation to youth and parent about how the youth's parents, family, religion, ethnicity, and wider culture view the youth's trauma experience(s), how differences between the youth's and broader culture view of the youth's trauma experiences may impact the youth's responses, and how these are interwoven with the youth's LGBTQ identity. For example, following sexual assault by a male peer, a lesbian teen from a conservative religious family was angry at her parents' focus on her "loss of virginity" and for not understanding her revulsion about sexual violation by a male. Racial, ethnic, religious and other sub-community minority LGBTQ youth often experience "double discrimination" that further increases risk for trauma exposure and symptoms. For example, the U.S. military has a history of discrimination against LGBTQ service members that has likely contributed to higher rates of trauma among LGBTQ than civilian youth. To address these concerns, a new information sheet for parents of military LGBTQ youth is available from the NCTSN at www.nctsn.org/trauma-types/sexual-abuse.

Provide psychoeducation about traumas that differentially impact LGBTQ youth: The therapist should provide psychoeducation to youth and parent about traumas that may differentially impact LGBTQ youth. For example, sexual abuse by same gender perpetrators may lead to "outing" the youth's sexual orientation, or to youth and/or parental confusion about or questioning the youth's sexual orientation (e.g. "Did he pick me to abuse because he knew I was gay?"). Bullying related to the youth's perceived or actual sexual orientation and/or gender identity may lead the youth to develop negative cognitions (e.g., "Why me?" No one will ever accept me for who I am") that the therapist should identify, write down and focus on later in TF-CBT cognitive processing components. Parental rejection related to the youth's sexual orientation and/or gender identity is particularly important to address since it is associated with high rates of mental health problems, and can be significantly impacted through psychoeducation and behavioral interventions. More details are provided below and under Parenting Skills. These resources

may be helpful for youth and parents: <https://familyproject.sfsu.edu/>, www.loveisrespect.org, www.itgetsbetter.org.

Provide psychoeducation specifically for bisexual or transgender/gender diverse youth: Therapists who work with bisexual or transgender youth should be familiar with the research documenting that these youth are at even higher risk than LGQ youth for experiencing stigma, trauma exposure and adverse mental health outcomes. The therapist should provide psychoeducation for bisexual or transgender youth and their parents that acknowledges these risks and also highlights the value of TF-CBT in mitigating these risks through enhancing the youth's resiliency skills and parental support. The following information sheets may be helpful: <https://biresource.org/resources/youth/what-is-bisexuality/>

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/transgender-and-gender-diverse-youth-122.aspx

Provide psychoeducation about the impact of parental rejection: All LGBTQ and gender diverse youth and parents should be assessed for experiences with family rejecting (and accepting) behaviors during the initial assessment. As noted, therapists can use FAP's intervention posters to identify these behaviors and focus on them during psychoeducation for both youth and parents. (See the FAP Assessment section for information on assessing for family behaviors and the FAP Psychoeducation section for information on education and guidance related to these behaviors.) When LGBTQ youth experience parental rejection related to their sexual orientation and/or gender identity, therapists should validate this as a significant trauma and provide psychoeducation on the impact of rejection on their mental health (e.g., FAP's research has shown that parental / caregiver rejection is linked with significantly higher rates of depression, suicidal ideation, suicide attempts and illegal drug use). Family rejection also negatively impacts LGBTQ young people's self-esteem, relationships, life satisfaction, risk for HIV and sexually transmitted infections and sense of the future (Ryan, 2009).

When initiating psychoeducation with parents and caregivers, it is helpful for therapists to lead with education and guidance on the impact of family rejection. Most parents can benefit from receiving information on FAP's research findings and family support strategies, even when parents believe that they accept their LGBTQ child. Often parents have little education and many misconceptions about sexual development, sexual orientation and/or gender identity in children and adolescents, and their cultural context may discourage talking about these topics. This leads to "cultural silence" in which the parents and family do not talk about these issues except perhaps in negative terms (e.g., laughing at disparaging jokes about LGBTQ people, allowing others, including family members, to treat their child disrespectfully without speaking up, etc.). For example, a youth came out to her mother as bisexual, and in an attempt to be protective, her mother said, "Don't tell your father, you know what he's like." The youth experienced this as a message that "My family will never support or accept me.") Silence and secrecy are family rejecting behaviors that are commonly experienced across cultures that FAP has identified and measured in their research and that contribute to serious health risks for LGBTQ young people (Ryan, 2009; Ryan, 2019c).

FAP found that the largest proportion of families respond to their LGBTQ children with ambivalence which still confers significant levels of risk (see Ryan, 2009; e.g., three times as likely to report high levels of depression, and twice as likely to attempt suicide, compared with peers with low or no levels of family rejecting behaviors). Parents that are ambivalent about their children's LGBTQ identity do not realize that their children experience a mix of rejecting and accepting behaviors as rejection and as not being supported by their parents. As FAP's work has demonstrated, many parents, caregivers and

families are often shocked to learn that behaviors they engage in to protect their LGBTQ child are instead causing great harm. Ryan and colleagues have found that many families believe they are protecting their child by isolating and preventing them from being exposed to influences that parents believe are harmful (e.g., LGBT supports), which instead prevents access to the very support their children need to ease their isolation and distress (Glassgold & Ryan, forthcoming; Ryan, 2014; SAMHSA, 2014).

Moreover, many parents that are struggling with their child's LGBTQ identity think they have two options: approve what they see as a harmful "lifestyle choice" which is against their beliefs and they think they can never accept, or actively reject the youth's unacceptable "choice." FAP uses their findings and psychoeducation approach to help parents understand the extremely high cost of family rejection for their LGBTQ child – a 2-8 times greater likelihood of attempted suicide, a 3-6 times greater likelihood of high levels of depression (that increases suicide risk), a 1.5 – 3 times greater likelihood of using illegal drugs or risk for HIV; a much higher likelihood of becoming homeless; fractured families, etc. FAP's multilingual family education booklets, family videos and intervention posters are important research-based resources to show parents and caregivers the powerful impact of rejection, the protective role of family support and messaging to help parents understand that they can align key cultural and religious values by supporting their LGBTQ child to reduce risk without accepting a "behavior" or identity they think is wrong. (See the FAP Psychoeducation section and FAP family education resources for more info on messaging and framing).

The therapist should provide parents with specific examples of respectful language they can use to talk about sexual orientation and gender identity (see Ryan, 2009; SAMHSA, 2014), as many parents do not have such language and/or have generally avoided talking about this topic in their family and culture. (See FAP Psychoeducation section for guidance on talking about their LGBTQ child with parents at different literacy, educational and cognitive levels.) By practicing with parents how to have these conversations, even when they are uncomfortable, the therapist can help parents normalize talking about the youth's sexual orientation and/or gender identity, have these conversations in a more open and respectful way and increasingly affirm and integrate their child's LGBTQ identity into family life. The youth often experiences this alone as more accepting than the parents' prior behaviors. As noted, FAP provides research-based multicultural resources for therapists to increase family communication and support (<https://familyproject.sfsu.edu>), as well as training on using FAP's family support model and research-based resources. In educating parents on FAP's family support framework, the therapist should explain the specific impact of low, moderate and high levels of family rejecting and accepting behaviors on health risks and well-being (Ryan, 2009; Ryan, 2012; Ryan, 2019a, 2019b, 2019c) and help parents understand that small changes in how parents and families respond and interact with their LGBTQ child can make an important difference in the youth's mental health symptoms and increasing connectedness (Ryan, 2014)—even when parents believe that being gay or transgender is wrong. The therapist can give the parent FAP family education booklets, videos and posters on accepting and rejecting behaviors to post in their home and to share with other family members to reinforce positive behavioral change (see appendix). More information about implementing specific parenting strategies with non-supportive parents is described under Parenting Skills and in the FAP Psychoeducation section at the end of TF-CBT's Psychoeducation component.

Provide information about sexual health principles: The therapist should consider introducing sexual health principles during psychoeducation to all youth who have experienced trauma. These skills are particularly important to introduce for traumatized LGBTQ youth who engage in risky sexual behaviors

and are at increased risk for unwanted pregnancy, sexual assault, and sexually transmitted diseases (STD). The six principles of sexual health include the following:

Consent: freely agree to specific sexual activity at a given time *Non-*

exploitation: equal power and control to consent

Shared values: agree that partners want the same things from sexual activities/relationship

Honesty: partners have open, ongoing communication about sexuality

Protection: each partner is safe from HIV/AIDS, STD, unwanted pregnancy, abuse

Pleasure: healthy sexuality feels good

More information about the principles of sexual health is described in the webinar, Improving LGBTQ Treatment Outcomes through Integration of Sexual Health:

<http://learn.nctsn.org/enrol/index.php?id=389>.

FAP Section#

PSYCHOEDUCATION – Family Acceptance Project®

[© 2018 Caitlin Ryan - Ryan, C. (2018). *Family Acceptance Project: Working Procedures*. San Francisco: Family Acceptance Project]

Psychoeducation is a central, ongoing component of FAP's family support model for both the youth and parent and, as needed, the extended family and cultural and religious leaders. FAP practitioners use information learned from assessment about the parent's underlying cultural values and beliefs, knowledge about sexual orientation and gender identity and responses to their LGBTQ child to frame a psychoeducational approach for working with the parent.

Typically, practitioners first teach parents accurate information about SOGIE and how this relates to their child to clarify contemporary understanding of LGBTQ identities and gender diversity, and then explain FAP's research on family rejection and acceptance and how these behaviors contribute to their child's risk and well-being—in language the parent will understand. For some parents, however, learning about family rejecting and accepting behaviors first and how these affect their LGBTQ child may be more helpful, depending on events and family dynamics.

Because LGBTQ issues are commonly discussed online and in the media, parents of children and teens are more aware of sexual orientation, gender identity and LGBTQ identities than previous generations of caregivers, but this does not mean that they understand how these identities are expressed in childhood; that a child or young adolescent can identify as LGBTQ; or that being gay or transgender is an actual "identity." Many parents do not understand that sexual orientation and gender identity are part of normative child development and wrongly believe that a child is too young to know they are LGBTQ. These beliefs are more common among socially and religiously conservative parents who often believe that a lesbian, gay or bisexual orientation only constitutes *attraction* (i.e., same-sex attraction) and is not an *identity*, and that identifying as transgender is caused by confusion, parental permissiveness and psychological problems.

SOGIE Education

In teaching parents about SOGIE and family accepting and rejecting behaviors, FAP uses graphics to help parents understand and talk about these concepts. This includes emphasizing key points, such as talking about how changes in technology and access to information have affected the child's age of self-identifying as LGBTQ and expansion of the underlying knowledge base—and how this enables practitioners and families to understand how best to support and care for LGBTQ children and youth. For example:

- The information age has removed barriers and has increased access to information about SOGIE so children learn about themselves at very early ages compared with earlier generations of LGBTQ adults who did not come out until adulthood or who never shared their LGBTQ identity with others.
- Sexual orientation and gender identity are part of child development. Lack of accurate information and negative images of LGBTQ people have prevented many LGBTQ adults from self-identifying or learning who they were at earlier ages. This is changing, so increasingly, children understand their sexual orientation and gender identity at much younger ages than LGBTQ adults.
- There has been more than 80 years of research on sexual orientation and gender identity so we know a great deal about how to support LGBTQ children, youth and their families and we will use this information to help you and your child.

One of FAP's central messages is to shift how people talk about sexual orientation and gender identity—to move the focus and discussion from *morality to health and well-being* (Ryan, 2014). For example, rather than trying to refute or change a parent's religious beliefs by citing Scripture or religious doctrine, FAP practitioners educate parents about the relationship between family rejecting behaviors with health risks and family supportive behaviors with protecting their child from harm—and align these outcomes with the family's underlying values. Shifting the language and interactions from a specific focus on morality, FAP practitioners reinforce parental norms of helping to care for and protect their child even when the parent believes that being gay or transgender is wrong. This approach is different than approaches commonly used with religiously conservative families in the LGBTQ community that focus on changing the parent's religious beliefs related to homosexuality and gender identity.

Aligning Psychoeducation with Cultural and Religious Values

FAP practitioners have worked with families that range from very accepting to very rejecting of their LGBTQ children. TF-CBT therapists and FAP practitioners view parents as having expertise about their family and children, but also believe that helping parents to support their LGBTQ children can significantly prevent risk, increase well-being and promote positive development. For families that are already supportive, this will take less time. FAP has found that some parents change their behavior immediately once they learn that how they respond to their LGBTQ children is increasing their child's risk. However, many parents believe that they already accept their child's LGBTQ identity and gender diversity, while the child experiences their parent as being ambivalent which still confers risk.

Although reasons for family rejection vary, FAP's research and family intervention work have found that culture and religion are primary reasons for rejecting an LGBTQ / gender diverse child. Part of the reason for doing specific assessment of the parent's knowledge, attitudes and values related to SOGIE and LGBTQ people is to identify family values—including cultural and religious values—that make it more challenging for a parent to support their LGBTQ child and to align FAP's approach with their values to increase family connectedness and support for their LGBTQ child.

For Latino families, for example, the family is typically the cultural core. The cultural value of *familism* prioritizes family cohesiveness over individual needs. At the same time, when a family member is at risk, other family members can mobilize to support them. In using FAP's approach, parent's cultural roles are emphasized to help decrease rejection and increase support for an LGBTQ youth. The father's protective role can be engaged to help an LGBTQ youth who is struggling—even when the parent is angry or ashamed of their child's homosexuality or gender diversity by helping the parent understand the serious health risks for the LGBTQ youth and the impact of specific rejecting behaviors the parent may use to respond to their LGBTQ child. These might include rejecting behaviors such as ridiculing a son's SOGIE, blaming the youth when others mistreat him because he is gay or gender diverse; or excluding him from family events because his gender expression and LGBTQ identity embarrass the family.

FAP practitioners focus on behaviors identified during and after assessment to show how these behaviors contribute to serious health risks for the LGBTQ child, including suicidal behaviors, depression, illegal drug use and risk for HIV

and increasing family conflict, as well as how supportive and accepting behaviors help protect against risk and increase well-being. FAP's research shows the potential impact of high and moderate levels of family rejecting behaviors on serious health risks such as suicide and HIV which is sobering and often shocking for parents who are trying to guide their children, not put them at serious harm. Enabling the parent to understand their LGBTQ child's risk in a cultural frame helps to decrease resistance in addressing the youth's SOGIE and focuses on the parent's role in helping a child who has been harmed by traumatizing experiences.

Similarly, FAP's approach aligns the parent's religious values with FAP's research findings to help the caregiver understand the impact of family rejecting behaviors on their LGBTQ child, including those that use religion to try to change, prevent, discourage or condemn the youth's SOGIE (e.g., making a child pray or attend religious services to try to change or prevent their sexual orientation and gender identity; using religious text or doctrine to discourage or condemn the youth's SOGI; and other rejecting behaviors). FAP's research has found that highly religious families are more rejecting, least accepting and most likely to try to change an LGBTQ child's sexual orientation at home and to take them to a therapist or religious leader to try to change their orientation. Efforts by parents and caregivers to try to change an LGBTQ youth's sexual orientation in the family and taking them to a therapist or religious leader to try to change them are associated with a 2-3 times greater likelihood of attempted suicide and with high levels of depression, lower self-esteem, less social support and significantly lower levels of education and income in young adulthood (Ryan, Toomey, Diaz, & Russell, 2018).

Although many religions reject homosexuality and gender diversity, their doctrines do not differ from underlying values of the major religions which are grounded in mercy, compassion and love. FAP's approach aligns these foundational religious values with FAP's research findings to show how the parent or caregiver can decrease specific rejecting behaviors that contribute to serious health risks like suicide and increase supportive behaviors that foster connectedness and hope without requiring parents to accept an identity they think is wrong. See (Ryan, 2015) for simple framing on supporting religiously conservative parents with LGBTQ children and Ryan & Rees (2012, for how FAP applies its findings to increasing family support for LGBTQ youth in a conservative religious denomination.)

Family Rejecting and Accepting Behaviors

Teaching parents and caregivers about family rejecting and accepting—or supportive—behaviors that parents and caregivers use to respond to a child's SOGIE and explaining how these behaviors contribute to the child's risk and well-being is a primary intervention to help caregivers to decrease family rejection and increase support and acceptance. Many reactions to LGBTQ people are transmitted and reinforced through culture and religion. Parents who engage in behaviors that LGBTQ youth experience as *rejecting*—such as not letting them learn about their LGBTQ identity or preventing them from participating in activities or support groups for LGBTQ youth—believe that these behaviors will help, not hurt, their LGBTQ children. In fact, FAP's research found that parents who engage in these rejecting behaviors are typically motivated by trying to help their LGBTQ “fit in,” have a good life and be respected by others (Ryan, 2009). Many parents are shocked to learn that their behaviors not only contribute to serious health risks and trauma for their LGBTQ child but have undermined their relationship with their child and their child's connection to the family and their faith.

FAP practitioners start to teach caregivers about how rejecting and accepting behaviors contribute to risk and well-being by showing graphics to help caregivers understand the range of family behaviors, how their LGBTQ child experiences these caregiver reactions and how the amount and frequency of these behaviors contribute to health risks / help protect against risk and promote well-being for their LGBTQ child. FAP's education and intervention posters give parents an immediate overview of how these behaviors and their frequency contribute to risk and well-being.

Prior to starting parent psychoeducation, FAP practitioners prepare a list of specific rejecting and accepting behaviors the youth has described during and after the initial assessment, with notes that indicate which behaviors are most frequent and impactful for the youth. Practitioners should include these behaviors in the list of rejecting and accepting behaviors they use in parent education graphics.

In the first FAP psychoeducation session, practitioners describe rejecting and accepting behaviors and show the relationship with health risks and well-being. This enables practitioners to identify other behaviors the caregiver may be using to respond to their LGBTQ child, to talk about the caregiver's intent and to begin to discuss how these behaviors affect their child. FAP teaches the parent to observe how their child responds to these behaviors and to emphasize specific parental behaviors to decrease conflict and increase connectedness and hope for the child that their parent can become more supportive and learn to accept them.

Dealing With Negative Perceptions of Diverse Parents - Practitioners should be aware that LGBTQ youth routinely hear negative messages from other youth in direct interactions and online about how parents respond or are believed to respond to their LGBTQ children. Many of these messages reinforce fears of rejection and assert that parents from specific ethnic, racial and religious backgrounds will not accept their LGBTQ children. These negative messages are widespread and prompted FAP to develop specific educational materials, including booklets and videos that show how diverse families learn to support and accept their LGBTQ children. In working with LGBTQ youth who have not come out to their parents, practitioners should help the youth determine to what extent peer perceptions influence their fear of disclosure vs. how their parent might actually respond. Youth should also be aware that parents often learn about their child's LGBTQ identity from others or from information the parent may find (such as links on the family computer or LGBTQ materials), so being prepared for unexpected disclosure can help the youth reduce stress and develop a plan to minimize family disruption should this occur.

Psychoeducation continues throughout the course of treatment with the parent continuing to learn how to support their LGBTQ child; the parent and child learning to talk about SOGI and about the parent's responses to the youth and the youth's needs for support; and the parent learning about the youth's social world. An important part of FAP's approach is teaching parents how to advocate or stand up for their child when others mistreat them because they are LGBTQ or gender diverse.

Parental Advocacy / Parent's Involvement in Their Child's Social World - Parental advocacy is a key family accepting behavior that FAP researchers identified and measured that helps protect against risk and promotes well-being. Many parents don't know how to advocate for their LGBTQ children, particularly in schools and other institutions where the parent may not understand their child's rights and may be fearful of speaking up to authorities about how their child is being treated. This includes standing up for their child in the family when other family members ridicule their child or speak badly about LGBTQ people in front of them, in the community and in their congregation when others may discriminate against, exclude or reject their child in other ways.

As the parent's support increases, FAP teaches parents and caregivers to learn about and become engaged in their child's social world to help them to support and affirm their LGBTQ child in multiple domains. This may include taking their child to LGBTQ events, volunteering at LGBTQ activities in which their child participates, finding a positive LGBTQ role model to give their child options for the future and welcoming their child's LGBTQ friends and partners to family events and activities. These and other family accepting behaviors show affirmation, strengthen the parent-child bond and provide a supportive foundation to help their child recover from trauma. As noted in FAP's publications, these are also accepting behaviors that help protect their LGBTQ child from harm and promote self-esteem and well-being,

Framing for Parents that Are Struggling

FAP has developed specific framing for helping families that are struggling to learn to support their child' SOGIE:

- *Parents don't have to accept an identity (or behavior) they think is wrong to support their LGBTQ children, to increase connectedness and to help reduce their LGBTQ children's risk. Important family supportive behaviors that help protect against risk and promote well-being don't require a parent to accept an identity they think is wrong: 1) talk with your child and listen to them to understand their experiences; 2) require that other family members treat your LGBTQ child with respect – even when they disagree or think that being*

LGBTQ is wrong; and 3) stand up for your child and advocate for them when other people mistreat them because of their SOGIE.

- *A little change makes a difference in decreasing family rejecting behaviors and in increasing support for their LGBTQ children.* Parents that are struggling with having an LGBTQ child often think in terms of “all or nothing.” This is often expressed as “my child or my faith” or “my child or my culture.” By starting to change rejecting behavior and making small steps that show their LGBTQ child that they care about them and want to help them, parents give their child hope, strengthen the parent-child relationship and begin the journey to affirmative parenting.

FAP Resources for Psychoeducation are included in the FAP appendix.

PARENTING SKILLS

Goals: The goals of TF-CBT parenting skills are to enhance support of the non-offending (non-perpetrator) parent for the youth, and optimize parental skills with regard to recognizing and responding to the youth’s trauma-related difficulties including trauma reminders.

Typical Implementation: Typically, the parenting component is provided to the non-offending parent throughout TF-CBT, with the therapist spending about half of each session individually with the parent and half individually with the youth. During the parent sessions the therapist provides psychoeducation about trauma impact, trauma reminders, and trauma responses to improve the parent’s understanding about the youth’s trauma-related emotional and behavioral problems. The therapist provides specific training in effective parent management techniques (e.g., the use of praise, selective attention, functional analysis of behavior problems, use of behavioral plans, negotiating, etc.) to address the youth’s trauma-related behavioral problems and tweaks these as needed throughout therapy. The therapist provides each TF-CBT component to the parent and practices these so that the parent is best able to support the youth in implementing TF-CBT skills both in daily scenarios as well as in response to trauma reminders (gradual exposure, GE). Resources include a paper on implementing TF-CBT for youth with co-occurring trauma and behavior problems (Cohen, Berliner & Mannarino, 2010), and the National Center on the Sexual Behavior of Youth website for managing sexual behavior problems, available at <http://www.ncsby.org/> (resources available for therapists, parents and youth).

LGBTQ Implementation Considerations: Several implementation considerations arise with regard to the TF-CBT parenting component. These include: a) how to implement the parenting component for LGBTQ youth who have experienced traumas specific to sexual orientation and/or gender identity but the youth have not yet come out to the parent; b) providing the parenting component for youth who have experienced traumas specific to their sexual orientation and/or gender identity; and c) providing the parenting component to youth who experience parental rejection and ambivalence related to the youth’s sexual orientation and/or gender identity. Each of these considerations is addressed below.

Implementing parenting skills when the youth has not come out to the parent: When youth have not come out to their parents, it is highly unlikely that the youth have disclosed traumas related to the youth’s sexual orientation or gender identity, since this would risk “outing” the youth. These parents are

typically seeking treatment for the youth for a reason other than those traumas (e.g., suicidality, school truancy, etc., or for a different type of trauma). As discussed earlier, at the start of treatment it is critical for the therapist to ascertain from the LGBTQ youth: 1) all of the traumas that the youth has experienced including those that may be related specifically to the youth's sexual orientation and/or gender identity, and 2) to whom the youth has come out. If the youth has not come out to the parent(s), this poses some obvious challenges in providing the TF-CBT parenting component. The therapist should not take the youth's decision not to come out to the parent up to this point at face value, but rather, should further explore why the youth has not shared their sexual orientation or gender identity with the parent (e.g., is the youth afraid of being rejected or even fears for their safety; that the disclosure would be a burden to the parents, or that they would be disappointed?) The therapist should explore with the youth these potential risks as well as potential benefits of sharing information about the youth's sexual orientation, gender identity and traumatic experiences (e.g., more closeness with and acceptance of the youth's LGBTQ identity by the parent which results in more authentic relationships). FAP's family education resources, including research-based videos that show how parents move from struggle to support of their LGBTQ children, may be helpful to show youth and parents models of family support (see FAP appendix). Some youth have used these videos to come out to their parents. In some cases the youth may decide to provide additional information to one or both parents about the circumstances of the presenting problem (e.g. "I've been suicidal because I was sexually assaulted by a same-sex peer" or "I'm skipping school because I'm being bullied at school every day"). This information may prompt further discussion which (depending on the degree of parental support or lack thereof) may or may not lead to the youth coming out to the parent. Concurrently, the therapist should try to get a sense of the parent's perspective regarding the youth's LGBTQ status. The youth may have legitimate safety or other concerns which preclude coming out to the parent, and this decision is always the youth's to make.

If the parent already knows or suspects that the youth is LGBTQ; or the parent doesn't know but the therapist assesses that parent will be supportive, the therapist could ask the youth for permission to start a general conversation with the parent about sexual orientation/gender identity and youth's trauma experience(s), explaining that the parent loves and cares about the youth and that the parent's support could be an important source of help for the youth. The metaphor of building a bridge between parent and youth is often helpful (i.e., "It seem that you and your parent are on two sides of a huge chasm now. You can work together to build a bridge between you. Even if the bridge doesn't go all the way across the gap, it may close the distance between you enough to improve your ability to talk to each other, get more support from your parent, etc."). In this scenario, the youth may (or may not) agree to share their sexual orientation/gender identity with the parent, either alone or with the therapist.

If the parent knows, suspects, or doesn't have a clue about the youth's sexual orientation/gender identity but the therapist's clinical impression is that she might not be supportive, the therapist should validate the youth's concern about coming out to the parent and come up with a plan in this regard. For example, they could agree that the therapist will provide psychoeducation about trauma and coping skills, using gradual exposure with regard to the issues of sexual orientation and gender identity until both therapist and youth agree that the parent is able to be either supportive or at least neutral regarding youth's LGBTQ identity. At this point, the youth may feel comfortable coming out to the parent. If this does not happen, the youth will not come out to the parent; in this event, the therapist would not share the trauma narration and processing with the parent. In this scenario the therapist would likely focus future parental and conjoint sessions on developing specific strategies for enhancing parental support of the youth that do not focus on the youth's sexual orientation or gender identity (for example, doing things together that the youth enjoys, enhancing praise, etc.)

If the therapist's impression is that the parent will be actively unsupportive or rejecting of the youth's LGBTQ identity, the therapist should validate the youth's perception of the situation and how difficult it must be to know that despite knowing the parent loves the youth, the parent rejects (or would reject) the youth's sexual orientation and/or gender identity. The therapist may opt to include the parent in therapy (particularly if the therapist believes that the parent knows about or strongly suspects the youth's LGBTQ identity), using the strategies described below related to parental rejection; or may opt not to include the parent in treatment. The explanation could simply be that the therapist believes it would be best for the youth to receive the treatment individually.

The important point of the above discussion is that, while always supporting the youth's autonomy to make the decision about when, how and to whom to come out, it is also important that the therapist and youth not prematurely "give up" on potentially supportive parents. The therapist should remember that youth have had more time to explore and process their sexual orientation/gender identity than their parents, family and friends who all have a coming out process, and parents often need some time to adjust to this new information. As discussed below, it is important for the therapist to explore any opportunities to enhance parental support and decrease parental rejecting behaviors, since the research so clearly shows that these changes have such a profound impact on the mental health of LGBTQ youth.

Provide parental psychoeducation and parenting skills related to LGBTQ-specific traumas: In addition to providing psychoeducation about more typical traumas, it is important for the therapist to help the parent understand the impact of LGBTQ-specific traumas on the youth, and how to support the youth in managing these. (Parental rejection is discussed in a separate section below and in the FAP sections included in this manual.) For example, the therapist should provide information about bullying, hate crimes, sexual and/or physical assault based on the youth's sexual orientation and/or gender identity, and how these traumas have impacted the youth's feelings, behaviors, relationships, self-image, and/or cognitions. In addition to the resources cited earlier in this manual that provide statistics about the higher rates of trauma exposure and symptoms among LGBTQ youth compared to their straight peers (including FAP's publications and materials), the following resources may be helpful:

Facts for Families about Transgender and Gender Diverse Youth

http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/transgender-and-gender-diverse-youth-122.aspx?utm_source=Informz&utm_medium=email&utm_campaign=Annual+Meeting

LGBTQ Youth: Voices of Trauma, Lives of Promise: <http://www.nctsnct.org/products/lgbtq-youth-voices-trauma-lives-promise> (LGBTQ youth describe the impact of different traumas on their lives and how they have recovered)

It Gets Better Project: <http://www.itgetsbetter.org/> Videos by youth and public figures describing their journey of coming out, trauma experiences and how it gets better

In addition to using typical strategies to implement parenting skills in TF-CBT (Cohen et al., 2017), for parents of LGBTQ youth whose traumas are specifically related to the youth's sexual orientation and/or gender identity, the therapist often needs to assist the parent in discussing safety concerns with the youth and advocating for the youth at school, in the community and/or with legal authorities in order to optimally minimize safety concerns and address the youth's trauma responses. For example, if the youth has experienced school bullying, the therapist may (with youth assent and parent consent) contact the appropriate school authorities to develop effective strategies to address this.

Provide specific behavioral strategies for rejecting parents to become more supportive: One of the most common challenges in treating traumatized LGBTQ youth is addressing parental rejection related to the youth’s sexual orientation and/or gender identity. In many cases the parent persistently makes derogatory, harsh comments about the youth’s sexual orientation and/or gender identity to the point that would qualify as emotional abuse (“a persistent pattern of nonphysical behavior that belittles another person”). Name-calling, verbal abuse, ridiculing an LGBTQ youth’s SOGIE or speaking badly about LGBTQ people in front of the youth are among more than 50 rejecting behaviors that FAP measured in their research and that contribute to serious health risks for LGBTQ youth (Ryan, 2009; Ryan, 2019c). The therapist will have ascertained from the youth and parent during assessment and in individual sessions that the parent is engaging in rejecting behaviors and identified the range of these behaviors, especially those rejecting behaviors that are most upsetting for the youth. Including the perpetrating parent is not typically consistent with TF-CBT; however, in the case of parental rejection related to LGBTQ identity, there are very strong data to suggest that even relatively modest changes in parental behaviors can lead to very significant changes in youth outcomes. For this reason, it is very important for the therapist to attempt to provide specific behavioral strategies for rejecting parents. The following steps may be helpful:

- 1) Provide a rationale (psychoeducation) for making small behavioral changes. For example, LGBTQ youth who have accepting parents are 3 times LESS likely to attempt suicide compared with peers who report no or low levels of family acceptance (Ryan, et al., 2010). (<https://familyproject.sfsu.edu>).
- 2) Explore the parent’s concerns about the youth’s sexual orientation and/or gender identity. In most cases the parent’s rejecting behaviors are based on caring, concern and a desire to protect the youth from harm; and a culturally-based fear that the youth’s sexual orientation and/or gender identity will lead to something bad happening to the youth. This concern is also rooted in the misunderstanding that sexual orientation and gender identity are choices that youth make rather than inborn characteristics, and thus, that they can make a different choice to change these. For example, one parent had heard that transgender youth are at high risk for being murdered, and did not want her 16-year-old child to suffer this fate—since she believed that the youth had “chosen” to be transgender, the mother did not want her child to make this “bad choice.” In such cases, validating the parent’s natural concern about the youth is both an important engagement strategy and a critical first step to TF-CBT. After validating the parent’s understandable concerns, and that the parent’s rejecting behaviors are motivated by caring and concern, the therapist can provide psychoeducation (e.g., that gender identity is usually well established by 16 years of age; and that parental rejection is a risk factor for the very things the parent is afraid of, i.e., her child dying by violence such as suicide). The therapist can reinforce the importance of parental support in strongly protecting transgender youth from violence and from negative mental health outcomes. This approach often helps the parent to become more supportive. (See the FAP Psychoeducation section on page 29 for more information on working with families that are struggling with their child’s SOGIE.)
- 3) Explain that the parent can make small changes in *behaviors* without changing their *beliefs or feelings* about the youth’s sexual orientation and/or gender identity. Identify specific rejecting behaviors that are upsetting to the youth (e.g., insisting on using female name and pronouns for a self-identified male). Give specific examples of the *behaviors* that could be changed in order to not overtly reject the youth (e.g.: “Your child has repeatedly told you that he identifies as a male but you continue to call him by a female name and use female pronouns like “she” and “her.” He has said to you and told me that this feels like rejecting “who he feels himself to be.”) Discuss alternative behaviors that the parent would be willing to try instead, that the youth would experience as less rejecting (e.g., “You’ve told me how much

you love and want to help your child. Can you think of any other way to refer to your child that would show this?") If the parent cannot generate alternative behaviors, suggest specific strategies (e.g. "When your child was born you picked the name Jane. Now your child goes by James. Could you call him J for short? And instead of saying "her homework" or "she called", just say "J's homework" or "J called"?").

Practice doing this in the session and tweak any problems the parent has in implementing the behavior (e.g. if parent says it does not feel "natural," validate that it takes practice and attention to change a habitual behavior; the child will notice and deeply appreciate the parents' effort even if they make occasional mistakes in implementing the change). Agree to a specific plan for implementing the strategy (e.g. parents will use the agreed upon name/pronouns consistently during the coming week and the youth and parent will rate how the parent does and how the youth responds to the change. If the parent(s) is (are) able to make this change, the therapist should continue to provide additional specific behavioral strategies for the parental behaviors to become more supportive and less rejecting of the LGBTQ youth. More information about implementing these strategies is available at the Family Acceptance Project's publications, resources and trainings, <https://familyproject.sfsu.edu>).

4) Help the parent to see the impact of their behavioral changes on their LGBTQ youth: Assuming that the youth and parent agree that the rejecting parental behaviors are decreasing and are being replaced by more neutral or (hopefully) supportive parental behaviors, this typically is accompanied by improvements in the LGBTQ youth's self-reported mood and behavioral trauma symptoms. The therapist should be monitoring the youth's safety, mood and behavioral problems on an ongoing basis (for example, asking the youth for weekly self-ratings of mood, sleep, suicidality, etc. on a scale of 1-10; using a standardized self-report instrument or some other method of ongoing monitoring). Through this method, the therapist can track how the youth is responding to the improvements in parental behaviors and provide this feedback to the parent. If there is no improvement in the youth's symptoms, the therapist should explore reasons for this with the youth (for example, are other ongoing traumas in the school or community accounting for the youth's ongoing symptoms?) and address this accordingly. This will likely be more effective with a more supportive parent available to assist in advocating for the youth.

RELAXATION SKILLS

Goals: The goals of TF-CBT relaxation skills are to develop and practice individualized relaxation strategies that the youth can use and parent can reinforce the youth using in a variety of settings to reverse physiological and psychological trauma-related hyperarousal.

Typical Implementation: The TF-CBT therapist typically asks the youth to describe activities the youth finds enjoyable and/or relaxing (e.g., sports, reading, crafts, games, music, etc.), and uses these as a basis for developing a "toolkit" of individualized relaxation strategies the youth can use in a variety of settings (e.g., going to sleep; at school; with friends; with trauma reminders). The therapist usually demonstrates and asks the youth to try some empirically proven relaxation strategies such as focused ("belly") breathing; progressive muscle relaxation; visualization; guided imagery; yoga. The therapist meets individually with the parent, shares the youth's preferred relaxation strategies with the parent, and instructs the parent to encourage the youth to practice these in a structured way for at least 20 minutes each day, and to encourage the youth to use these strategies when trauma reminders occur (gradual exposure, GE). Resources for implementing relaxation strategies with teens include Rays of Calm (Kerr, 2007).

LGBTQ Implementation Considerations: Therapists should be aware of the following issues that may impact the implementation of relaxation strategies differently for LGBTQ youth: a) the impact of heterosexism on hyperarousal; b) balancing relaxation with safety skills; c) the impact of parental fears on supporting youth relaxation skills; d) choosing relaxation skills to decrease body self-consciousness; and e) special considerations for transgender youth.

The impact of heterosexism and stigma on sense of safety and need for hypervigilance: Negative societal prejudices against LGBTQ individuals such as heterosexism, transphobia and stigma may contribute to LGBTQ youth's dysphoria about their sexual and/or gender diverse identity. In combination with trauma (particularly if the trauma was directly related to the youth's LGBTQ identity), these attitudes may contribute to heightened hyperarousal, and to the youth's belief that ongoing psychological and physiological hypervigilance is necessary to assure one's physical safety. From this viewpoint, relaxation strategies are not only unhelpful, but potentially threatening or dangerous. The therapist should inquire about the degree to which the youth holds these views and also ascertain the real safety issues. These must be considered in determining to what degree, and when, relaxation strategies should be used, as opposed to using safety strategies instead. Some youth might find in the therapist's office the first place where they feel enough psychological safety to "let go" and engage in relaxation skills. They might have a few sessions before being able to identify other safe places to generalize this skill.

Balancing relaxation skills with safety skills: LGBTQ youth often face real safety threats. During acute episodes of school bullying, community violence, parental emotional or physical abuse, etc., the youth needs to be alert to danger and use safety strategies to minimize exposure to new traumatic experiences (to the extent that this is feasible). The youth also needs to be able to differentiate between dangerous situations (in which safety strategies should be used) and innocuous situations (in which relaxation strategies can be used, e.g., a youth who goes from "I cannot relax in school at all" to "when I'm at my favorite teachers class I feel safe and I can practice belly breathing"). However, youth with PTSD—and particularly those with complex trauma—often struggle to differentiate between these scenarios, due to overgeneralizing threat, particularly in response to trauma reminders. The therapist should provide psychoeducation about the difference between these, and help youth practice distinguishing between situations that are really dangerous and those that are trauma reminders, while recognizing that this is often a skill that youth only acquire over time, through the use of gradual exposure and developing and processing their trauma narration. The therapist should also provide psychoeducation in this regard to the parent, who can support the youth in using relaxation strategies for innocuous situations at home (e.g., when siblings are yelling but there is no danger or threat to the youth). Routinely practicing relaxation skills in a safe environment can help create a muscle memory that can help the youth make a more accurate appraisal of a threat when triggered.

Impact of parental fears on supporting LGBTQ youth use of relaxation skills: Parental anxiety or fears related to the youth's sexual orientation and/or gender identity may interfere with the parent's and/or youth's ability to effectively utilize relaxation skills. For example, a mother who was afraid that her transgender daughter would be attacked or killed was extremely avoidant of allowing the daughter to leave home. She did not encourage the youth to practice relaxation or other coping skills, because the mother really hoped that her daughter would stay in the "safe" confines of the parental home rather than risk embarking out into the world that the mother feared will lead to dangerous consequences. The therapist should encourage such parents to personally begin to use TF-CBT relaxation skills as one means of decreasing the parent's over-focus on the youth's body issues and thus decrease the caregiver's hyperarousal. Such a parent is also likely to benefit from other interventions such as cognitive processing and affective modulation skills.

Choosing relaxation skills to decrease body self-consciousness: Due to their heightened awareness of sexual orientation and/or gender identity issues, LGBTQ youth may be more self-conscious about their bodies than their straight peers. Relaxation strategies that explicitly focus attention on the youth's bodies, such as focused breathing and progressive muscle relaxation, may paradoxically increase rather than decrease physiological hyperarousal and anxiety if introduced early, since these strategies increase body self-consciousness. For such youth, the therapist may find it more beneficial to initially use distraction relaxation techniques, such as guided imagery, visualization, focusing on sounds, colors and sights. Once these youth gain some mastery with these techniques, they may then feel comfortable trying yoga, focused breathing and other more explicitly physically-focused relaxation strategies. Be aware that some youth may never get to a place where they are comfortable engaging in the kind of relaxation strategies that focus on the body.

Considerations for transgender youth: As described in the introduction, therapists should be aware that transgender youth often experience even more severe stigma and discrimination than other sexual and/or gender minority youth. This could contribute to greater or more ongoing physiological hyperarousal that might be relatively resistant to typical relaxation strategies. For youth whose hyperarousal symptoms are based on real safety threats, implementing safety strategies are likely to be more effective than relaxation skills. Therapists should be conversant with important issues related to gender transitioning; these are discussed in detail elsewhere (e.g., Fraser & Knudsen, 2017). Transgender youth may also be taking a variety of hormones which can have a significant impact on hyperarousal and other anxiety symptoms. As with all youth, the therapist should inquire about all medications transgender youth are taking, have some understanding of how these medications might impact the youth's symptoms, provide appropriate psychoeducation and adjust expectations accordingly for youth and parent.

AFFECT MODULATION SKILLS

Goals: The goals of affect modulation are to provide the youth with vocabulary to describe the full range of affective states, and to provide individualized skills to the youth and parent to modulate negative affective states.

Typical Implementation: The therapist typically provides the youth with affective expression skills through games or activities such as Emotional Bingo for Teens, feelings brainstorm or other games and activities. The therapist also demonstrates and practices with the youth a variety of affective modulation skills tailored for the youth's developmental level and preferences. These may include positive imagery, visualization, mindfulness for teens, ongoing self-monitoring of feelings (rating on thermometer), distraction skills (e.g., activities, social, reading/puzzles, intentionally changing mood via humor, watching a funny movie, etc., positive sensations, social support, improving the youth's ability to read/understand others' affective states (e.g., accurately reading facial expressions), and others. The therapist also encourages youth to use these skills in response to trauma reminders (gradual exposure, GE). The therapist meets individually with the parent to teach the parent these skills and encourage the parent to support the youth in practicing these skills daily, including in response to trauma reminders. Resources for implementing these skills include Emotional Bingo for Teens, feeling thermometer, emotional color wheel, and Ted Talk: Brene Brown: "Listening to Shame"
https://www.ted.com/talks/brene_brown_listening_to_shame

LGTQ Implementation Considerations: Therapists should be aware of the following considerations when implementing affective modulation with LGBTQ youth: a) the impact of heterosexism, transphobia and stigma on LGBTQ youths' depression and anxiety; b) societal and cultural gender roles and expectations related to affective expression; c) the impact of LGBTQ-specific traumas and/or trauma reminders on affective regulation; d) the impact of ongoing parental rejection on affective expression and modulation; and e) not getting stuck when implementing affective modulation skills.

The role of heterosexism and stigma on LGBTQ youth depression and anxiety: It is critical for therapists to be aware that the biggest contributors to negative affect for many LGBTQ youth are societal heterosexism, homonegativity, transphobia, stigma, prejudice and discrimination. In the article Ten Things Transgender and Gender Nonconforming Youth want their Doctors to Know (Turban et al., 2017), these youth state that "If I am depressed or anxious, it's likely not because I have issues with my gender identity, but because everyone else does" (p. 276). A recent study found a direct correlation between passing state policies to support same-sex marriage, with decreasing LGB youth suicide attempts in those states, thus documenting a positive mental health impact of preventing anti-gay discrimination (Raifman et al., 2017); Lambda Legal <https://www.lambdalegal.org/>

Societal and cultural gender roles and expectation related to affective expression: Therapists should be aware of the multitude of expectations that impact LGBTQ youth with regard to how they "should" experience and express emotions; and how trauma further complicates these issues. For example, expectations from our general society that "men don't cry" and how this impacts gay males (e.g., "If I express feelings does this mean I'm a girl not a guy?"); what does this mean for transgender youth (e.g., for a transgender male, "If I cry as a male, am I giving up my male role, does this mean I'm really still a female?"). This further intersects with race and gender expectations (e.g. an African American mother with a history of trauma who raised her daughter to be strong, assertive and empowered to keep herself safe from prejudice and racism; when her daughter came out as transgender, mother said she would have raised a son differently because it's "not safe for a black man in this society to be strong and assertive").

The impact of sexual orientation or gender identity-related traumas and trauma reminders on affective regulation: As discussed earlier, therapists should also be aware that traumas that are perpetrated related to the youth's sexual orientation and/or gender identity (e.g., bullying; parental rejection) are often ongoing with ubiquitous or frequent trauma reminders that recur throughout the youth's daily life. For example, a transgender youth who experienced physical, sexual and verbal bullying at school as well as online bullying, had daily trauma reminders at school and whenever she used an electronic device. As a result, she was anxious, frightened and suicidal during most of her waking hours. Her preferred affective modulation techniques (e.g., listening to music, talking to friends, social media, etc.) did not work because they involved using her iPhone, which reminded her of the threatening texts she received. Her therapist worked with her to develop and practice several "low tech" affective modulation strategies (e.g., written journaling, reading print books, talking in person to mother or friends, etc.) that did not serve as trauma reminders.

The impact of ongoing parental rejection on affect regulation: Ideally at home, traumatized youth can feel safe, supported by protective adults, and free from danger or threat but this is not the case when parental rejection is present. Like other forms of child abuse, when LGBTQ youth live with a rejecting parent, the source of trauma is in the home, and is perpetrated by the adult who is supposed to protect and keep the youth safe from harm. Thus, the trauma is often ongoing, and the parent's negative behaviors and/or attitudes toward the youth (even if not overtly rejecting) often serve as trauma

reminders to the youth, thus triggering affective dysregulation in the youth and presenting challenges to the youth practicing affective regulation skills at home on a regular basis (e.g., a father who belonged to a fundamentalist religion and randomly called his son “sinner, devil” due to his mannerisms not conforming to what is expected for boys). In these situations, the parent typically dismisses or minimizes the youth’s trauma symptoms in relation to parental rejection, does not effectively support the youth’s use of affective regulation skills and thus invalidates the youth’s need to use these skills. Unsurprisingly, LGBTQ youth in these situations struggle to effectively use affective modulation skills. The therapist should continue to work collaboratively with the parents and the youth to increase supportive behaviors while minimizing parental rejecting behaviors using the strategies described above (and in FAP’s Psychoeducation section and FAP appendix). It is also important to emphasize the value of affective expression and modulation strategies for parents who display rejecting behaviors, as these behaviors often express underlying negative overwhelming feelings (e.g., fear, inadequacy, shame, etc.). The therapist should provide basic affective expression and modulation skills to parents, tailoring these to individual parents’ interests and abilities for regular use (e.g., identifying and naming negative emotions; rating negative emotions on a 1-10 scale with 1=least intense, 10=most intense; using ongoing self-monitoring to recognize when an affective regulation strategy needs to be deployed; learning and practicing specific affective regulation strategies such as distraction, removing self from the situation, seeking social support, reading a book, taking a walk, praying, etc.). Helping parents to express and better modulate their negative feelings may assist them in being able to provide more supportive (or at least more neutral and less overtly rejecting) behaviors.

Not getting stuck when implementing affective modulation: Therapists often struggle in moving forward with the TF-CBT model with LGBTQ youth who have complex trauma, because these youth struggle to successfully practice affective modulation skills between sessions, and to gain effective affective modulation skills. Many therapists continue to implement this component, believing that the youth must successfully master affective modulation before moving onto the Trauma Narration and Processing phase of TF-CBT. However, a recent study (Sharma-Patel & Brown, 2016) documented different patterns of improvement in PTSD and affective re-regulation, depending on the youth’s initial level of emotional dysregulation. In youth with **low levels of emotional dysregulation**, PTSD improved steadily during TF-CBT. In contrast, in youth **with high or medium emotional dysregulation**, PTSD only improved after starting the Trauma Narration and Processing phase of treatment. This study thus affirms the importance of therapists not getting stuck in the Stabilization treatment phase, especially for youth with higher levels of emotional dysregulation, because youth will not master affective re-regulation OR experience improvement in their PTSD symptoms until they start the Trauma Narration and Processing treatment component.

COGNITIVE COPING SKILLS

Goals: The goals of TF-CBT cognitive coping skills are to help youth and parents gain mastery in understanding connections among their thoughts, feelings and behaviors; and to gain mastery in replacing inaccurate or unhelpful cognitions related to everyday (i.e., non-traumatic) situations.

Typical Implementation: In typical TF-CBT, the therapist assists the youth and parent in considering whether their everyday thoughts are accurate and helpful, and if not, in developing skills to replace inaccurate or unhelpful thoughts with more accurate or helpful thoughts, in order to feel and act more positively. Certain cognitive styles are associated with higher risk for mental health problems (e.g. individuals who have overly pervasive, permanent, and personalized cognitions are at elevated risk for developing depressive symptoms). The therapist typically introduces the cognitive triangle (connections

among thoughts, feelings, and behaviors) in relation to common scenarios from the youth's daily life that generate negative emotions (e.g., "a friend doesn't say hi to you in school—what do you think, how do you feel, how do you act?"), and through this process, helps the youth to explore whether their thoughts are accurate or helpful (e.g., "I think my friend is mad at me"; "I feel sad and mad—I didn't do anything for her to get mad at me"; "I don't talk to her the rest of the day"). The therapist then assists the youth to develop more helpful and/or accurate thoughts (e.g., "Maybe something upsetting happened to her at home last night; maybe she's worried about a test today") thereby developing more positive feelings ("concerned about my friend; not mad at her") and behaviors ("I'd try to find her and ask if she's okay") in the situation. The therapist encourages the youth to practice this skill regularly and to track how it works. The therapist also introduces and practices these cognitive coping strategies with the parent. Gradual Exposure (GE) is used only with the parent in this component, by starting to explore the parent's maladaptive cognitions related to the youth's trauma experiences. GE is NOT used with the youth in this component, because it is beneficial for youth to engage in trauma narration before attempting to cognitively process trauma-specific maladaptive cognitions. The process of trauma narration facilitates youth in correcting their maladaptive trauma-related cognitions by helping the youth to better clarify and organize their traumatic experiences. Resources for typical implementation for younger children include using the TF-CBT Triangle of Life app (available at Apple Store or Google Play); teen resources include the Thinking Mistakes for Kids (Kliethermes, 2009, available at <https://tfcbt.org/the-what-are-you-thinking-team-kliethermes-2009/>)

LGBTQ Implementation Considerations: In addition to negative cognitive styles and negative cognitions that youth may develop related to their traumatic experiences, LGBTQ youth may have maladaptive cognitions that are based on their experiences with how the world, their family, and/or peers view and treat them. The following considerations may be helpful in implementing cognitive coping with traumatized LGBTQ youth: a) recognizing maladaptive cognitions related to heterosexism, homonegativity, and transphobia; b) addressing maladaptive cognitions related to family and family rejection; and c) addressing maladaptive cognitions related to religion.

Recognizing and addressing maladaptive cognitions related to heterosexism, homo/hetero negativity, and trans/homo phobia: The external world experiences for most LGBTQ youth are generally heterosexist (i.e., favoring heterosexuality over homosexuality, bisexuality, pansexual, asexuality, sexual fluid or other sexual identities) and have a fixed gender-binary (i.e., favoring male/female dichotomy determined by birth gender over bisexual, transgender, gender queer, agender, gender-fluid, two spirit or other gender identities). These experiences may lead LGBTQ youth to develop internalized homophobia/transphobia-related beliefs such as: "I'm screwed up"; "I'm a freak"; "I'm not man/woman enough" ; or overgeneralized negative beliefs based on their heterosexist experiences such as "I'm not represented, heard or seen by anyone"; "No one gets me or understands me"; "No one will like me the way I really am"; " I have to stay away from straight people." The therapist should help the youth to examine the youth's heterosexism-related maladaptive cognitions with regard to pervasiveness, personalization, and permanence, using standard cognitive processing strategies. For example, using the cognitive triangle the therapist could identify the following with a gay youth living in a rural area without other gay peers:

Thought: I don't fit in

Feeling: depressed, angry

Behavior: isolate, self-injure

Using the cognitive triangle, the therapist could then explore alternative ways of thinking about the situation with the youth to develop a new triangle, such as:

New thought: I would fit in if I were around more gay kids and had more supportive peers

New feeling: less depressed, more hopeful

New behavior: look online for other gay kids in my area, LGBTQ pride in my area, or online support

Maladaptive cognitions related to family and family rejection: LGBTQ youth often struggle with concerns about coming out to their family and what the consequences of this will be. A belief such as “My family won’t love me if they know how I really am” may be a maladaptive cognition, but if the parent was exhibiting rejecting behavior after the youth came out, this would provide a reality basis for the belief. The therapist should work with the parent(s) as described above in Parenting Skills, to enhance supportive behaviors and minimize rejecting behaviors. If the parent is rejecting in reality, the therapist should explore more helpful cognitions, for example, asking the youth, “What do you think your parent is really afraid of?” (i.e., encouraging the youth to change the cognition from “My father doesn’t love me” to “My father is afraid that his friends will reject him for having a transgender son” or “My father is afraid I will be seriously hurt or even killed because I am transgender.”) The therapist can then use the cognitive triangle or other cognitive coping strategies to process the meaning of these new beliefs, which although likely still painful, are likely more adaptive and less personal, pervasive and/or permanent than the youth’s original thoughts. Other concerns related to family are more practical, such as concerns of being kicked out of the home, having nowhere to live, etc. When these are present, the therapist needs to work with the family to address safety, enlist other sources of support and if necessary, contact child protection to assure the youth’s safety.

The therapist should also address the parent’s maladaptive cognitions related to the youth’s sexual orientation and/or gender identity. In many cases parental rejection is related to parental caring, concern and fears about dangers related to the youth’s sexual orientation and/or gender identity. As described above, the therapist should start to engage the parents during the assessment in describing their understanding, knowledge, concerns and fears related to the youth’s sexual orientation and/or gender identity. Throughout earlier TF-CBT components, the therapist has been providing psychoeducation about the impact of supportive behaviors and the risks of rejecting behaviors on the youth’s health and well-being, as described above. During this component, the therapist can more directly examine the parent’s concerns about danger and safety, using FAP’s research and framing to document that there is more risk related to parental rejection than from the situations that the parent likely fears (e.g., violence from strangers).

Maladaptive cognitions related to religion: Some parents and other family members cite religious texts as the justification for rejecting their LGBTQ youth (<http://www.rollingstone.com/culture/features/the-forsaken-a-rising-number-of-homeless-gay-teens-are-being-cast-out-by-religious-families-20140903>). Many families (and some LGBTQ youth themselves) believe that LGBTQ individuals are sinners or that they cannot go to heaven. Fortunately, a growing number of religious organizations are taking a stance that supports rather than rejects LGBTQ youth (<https://www.glaad.org/programs/faith>). These are generally based on common principles (e.g., God creates all beings and loves all of his creatures equally; sexual orientation and gender identity are inborn traits). It may be helpful for the therapist to engage a leader or member of the youth’s or parent’s own faith community to address these cognitions. Several resources are available to address religious-based maladaptive cognitions.

The **Family Acceptance Project** has been developing a research-based video series that shows how families integrate culture and religion to support their LGBTQ children, a faith-based series of family education booklets that are Best Practice resources for suicide prevention for LGBTQ youth and a series of prevention and intervention posters on family rejection and acceptance that include a version for use in conservative settings, including those that are religiously conservative: <https://familyproject.sfsu.edu>

Other examples include the following:

Human Rights Campaign and Religion: <http://www.hrc.org/explore/topic/religion-faith> (information for individuals of diverse faith communities)

The Trevor Project: <http://www.thetrevorproject.org/pages/lgbtq-and-religion> (Q&A format)

PFLAG Resources for Muslims: <https://www.pflag.org/resource/faith-resources-muslims>

GLAAD: <https://www.glaad.org/programs/faith>

GayChurch.org: <https://www.gaychurch.org/>: Directory of LGBTQ-affirming Churches, as well as multiple articles about homosexuality and the Bible

Affirmation.org: <https://affirmation.org/>: Mormon LGBTQ affirming organization

The Shame of Religious Families: Homeless LGBTQ Youth: <https://thejesuitpost.org/2014/09/the-shame-of-religious-families-homeless-lgbt-youth/>

As stated earlier, the goals of TF-CBT and FAP parental and family interventions do not aim to change the parent's deeply held beliefs, but rather, to build on underlying strengths and values to improve family communication, decrease rejection and risk and increase support and positive outcomes for LGBTQ children and youth. As such, aligning with the family's values will ideally help to defuse resistance, build an alliance with the parent and immediately shift the focus to decreasing risk and increasing support for their child.

TRAUMA NARRATION AND PROCESSING

Goals: The goals of TF-CBT trauma narration and processing are to assist the youth in developing a trauma narrative about the youth's personal trauma experiences ("speak the unspeakable"); cognitively process these experiences in order to address maladaptive cognitions (making new meaning); and to allow the parent to hear and cognitively process the youth's trauma narration during individual sessions with the therapist, in preparation for subsequent conjoint child-parent sessions.

Typical Implementation: Typical TF-CBT trauma narration and processing involves the therapist guiding the youth in an interactive, trusting process of narrating personal trauma experiences ("speaking the unspeakable"); cognitively processing these traumatic experiences (making new meaning); and sharing the narration and processing with the caregiver during individual sessions, in preparation for upcoming conjoint youth-parent sessions. It is important to emphasize that the product the youth develops (e.g. a written narrative, song, poem, etc.) represents only a small part of that process.

Resources for trauma narration and processing include using timelines or life narratives to guide trauma narration. These may be especially helpful for youth with complex trauma.

Two research papers provide useful resources for therapists who are implementing this component. Dittmann & Jensen (2014) have documented that youth participating in TF-CBT reported that the trauma narration and processing component, while difficult, was the most helpful TF-CBT component. These youth also reported that this component was made easier by having an empathic and supportive therapist. This research confirms earlier results from the TF-CBT developers that more than 85% of youth involved in TF-CBT studies stated that the trauma narration was the best part of the treatment. These results should encourage therapists who are concerned about the difficulty of implementing this component, to keep moving forward. A second study (Yasinski et al., 2016) showed that during the trauma narration and processing component, the caregiver's processing of their own and youth's trauma reactions during TF-CBT treatment predicted significant decreases in youth's internalized and externalized symptoms; and that caregiver support predicted lower internalized youth symptoms. Conversely, caregiver avoidance and blaming the youth during this component of treatment predicted worsening of youth internalizing and externalizing symptoms over follow up. This emphasizes the value of involving parents specifically in the TF-CBT trauma narration processing component, More specifically for LGBTQ youth, it emphasizes the critical importance of TF-CBT therapists working hard with rejecting parents to: a) overcome avoidance about directly addressing the youth's trauma experiences—including those perpetrated by the parent; and b) addressing parental blame of the youth.

LGBTQ Implementation Considerations: Therapists should be aware of the following additional considerations when developing trauma narratives with LGBTQ youth: a) including other traumas, not only those related to the youth's sexual orientation and/or gender identity; b) addressing youth and parent maladaptive cognitions related to trauma as they intersect with the youth's sexual orientation and/or gender identity; c) optimizing parental participation in trauma narration and processing; d) trauma narration and processing to facilitate parental awareness and acceptance of youth's identity and grieving; and e) trauma narration and processing for unsupportive/unaccepting parents. (See the FAP section at the end of this component that describes how the therapist may assist the parent to develop a brief parental response during trauma narration to further support the LGBTQ youth; this would be shared with the youth during the Conjoint Session after the youth's trauma narration has been shared with the caregiver in individual parent sessions.)

Including earlier/other traumas in trauma narration and processing: As with other youth with complex trauma, LGBTQ youth have often experienced multiple trauma types. In some cases, the youth may be avoidant of including earlier traumas (e.g. sexual or physical abuse; domestic violence; important deaths or losses) and/or may believe that these traumas are not relevant to their current symptoms. However, in most cases such interpersonal traumas have contributed to some degree to the youth's current sensitization to danger cues, and thus it is generally helpful for the youth to include these earlier traumas in narration and processing. If it is not feasible to address all of these traumas in detail when developing the trauma narrative, the therapist should use clinical judgment in assisting and guiding the youth to select the most relevant traumas to include, and pacing the development of the trauma narration so that the appropriate amount of time is spent on these respective trauma experiences.

Addressing trauma-related maladaptive cognitions as they intersect with the youth's sexual orientation/gender identity: As described above, a core goal of this treatment phase is identifying and processing the youth's and parents' maladaptive (inaccurate and/or unhelpful) trauma-related cognitions, and replacing these with more accurate and helpful thoughts. For LGBTQ youth and their parents, trauma-related maladaptive cognitions are often interrelated with maladaptive beliefs about

the youth's sexual orientation/gender identity. For example, a transgender girl who was physically and sexually abused by her mother's boyfriend from ages 4-12 years old blamed herself for the abuse because of her underlying transgender identity; she did not disclose the abuse or come out until after the boyfriend left the home when she was 12 years old. Her cognition was that "He could tell I was a girl inside and he was abusing me to punish me; I deserved it because even my mom doesn't love me." The therapist should identify and process such cognitions, and replace them with more accurate cognitions as they relate to both the trauma and the youth's sexual orientation/gender (e.g., "He couldn't have known I was transgender when I was 4 years old, I didn't even know myself. He abused me because he was misusing power and control. He abused my sister too, and she wasn't transgender. My mom is confused about my identity but she still loves me.") Accomplishing this for the youth and parent contributes significantly to optimal resolution of trauma symptoms. The youth's mother was not even aware that the youth attributed the abuse in part to her gender identity; upon hearing this when the therapist shared the youth's trauma narrative with the mother during the mother's individual sessions, the mother (who had been only marginally supportive of the youth's transgender identity), expressed shock, distress, and her own guilt and self-blame regarding the youth's abuse because she had brought the perpetrator into the home. After the therapist helped the mother to process these maladaptive cognitions, the mother said, "I didn't want her to be a girl, but her thinking that the abuse had anything to do with gender identity is just wrong...I love her and I want her to be okay." This illustrates that in many cases, trauma narration and processing of maladaptive cognitions related to trauma and the youth's sexual orientation and/or gender identity can contribute to parents becoming more supportive of the youth in regard to both the youth's trauma experiences and identity issues.

Optimizing parental participation in trauma narration and processing for LGBTQ youth: The therapist should be familiar with the above research findings and strive to integrate this knowledge when sharing and processing the youth's trauma narratives with parents. Specifically, helping parents to cognitively process LGBTQ youths' narrative and express positive support is likely to significantly improve youths' internalizing and externalizing symptoms. Additionally, helping parents to use active coping—that is, encouraging parents to face rather than avoid the reality of the youth's trauma experiences and their corresponding difficult thoughts and feelings during trauma narration and processing; and using cognitive processing strategies to decrease blame of the youth—are most likely to lead to improvement in youths' internalizing and externalizing symptoms.

Trauma narration to facilitate parental acceptance of LGBTQ youth's identity and grieving: As discussed earlier, it is important for the therapist to recognize that parents may be far behind the youth with regard to awareness and/or acceptance of the youth's sexual orientation/gender identity. Engaging in the trauma narration and processing component can help such parents to better recognize the impact of trauma experiences on their LGBTQ youth, see the youth's trauma experiences in a fuller and more accurate light and come to a better understanding and acceptance of their youth's identity. Using a genogram can help LGBTQ youth recognize different family members who are accepting, supportive neutral, and rejecting; and help caregivers to understand the role of the extended family and secondary adversities related to the youth's sexual and gender orientation. This can also facilitate the family's coming out process. The therapist should also recognize that for the parent, full acceptance of the youth's sexual orientation and/or gender identity often may include a grief process in which parents need to acknowledge and experience the loss of their perception of who their child was from conception up until this point in time. For such parents, the trauma narration and processing component can be a very valuable vehicle through which the parents can sort through their own feelings of loss of the child they previously thought they knew, as a way of supporting and allowing the parents to grieve; and helping them to become accustomed to and acquainted with the child that they now are aware that

they have always had. In many cases parents not only end up supporting their youth's LGBTQ identity but go all the way to feeling proud of their resilience and strength and ability to overcome adversity. A new, more authentic, bond is created between caregiver and youth that has a positive impact on both of them.

Trauma narration and processing for rejecting/unaccepting/unsupportive parents: The goals of including parents in trauma narration and processing are to improve the parents' understanding of and empathy for the youth's trauma experiences; to decrease the parents' own avoidance related to the youth's trauma experiences; and to address and correct parental maladaptive cognitions with regard to the youth's trauma experiences. In rare cases, youth may have experienced trauma unrelated to their identity, and the parent may be able to provide support related to the trauma while remaining rejecting, unaccepting and unsupportive of the youth's sexual orientation and/or gender identity. If the youth and therapist agree that this is the case, it would make sense to include the parent in that youth's trauma narration and processing. In most cases, as described above, the therapist will have been working in TF-CBT to enhance the parent's supportive and accepting **behaviors**, regardless of the parent's attitudes towards the youth's sexual orientation and/or gender identity.

Depending on the therapist's clinical judgment and the youth's agreement, if the parent has made sufficient progress in this regard, they may agree that the parent will be able to meet some or all of the above goals, even while they realize that this does not include the parent accepting the youth's sexual orientation and/or gender identity. However, if the parent has not made progress in developing more supportive behaviors, as described above, it is unlikely that the parent will be able to meet these goals. In this scenario, it would likely be counterproductive to include the parent in the trauma narration and processing treatment phase, and indeed, many youth in this situation would be unlikely to agree to share their personal trauma narratives with such a parent, since doing so would provide the parent with more personal information about the youth which the rejecting parent could then use as "ammunition" against the youth, thus further exposing the youth to the parent's rejecting or abusive behavior. In this situation, it would be preferable for the therapist to work with the youth to identify an alternative adult with whom the youth might feel comfortable to share the narrative.

As with other youth participating in TF-CBT, the therapist should not simply introduce an outside adult to the therapy process at this point in treatment. If another adult were to participate in the trauma narration and processing treatment phase with the youth, the youth and parent would need to agree to this, and the therapist would need to spend sufficient time preparing the other adult prior to including that adult in the process. It would likely take at least 2-3 sessions prior to starting this component to educate the adult about TF-CBT and provide information about the youth's trauma, trauma reminders and impact, and introduce the adult to the TF-CBT skills that the youth has been using during the course of TF-CBT treatment. Introducing another adult into this process would therefore require substantial advanced planning. In some cases, another adult will not be available (or the youth will not agree to include another adult). In this rare situation, having a "sharing session" for the youth to share the entire narrative with the therapist will help the youth to have a sense of mastery and a conclusion to the process. While the therapist is developing the trauma narration and processing with the youth, the therapist can continue to work with the parent on enhancing accepting and supportive behaviors, while minimizing rejecting behaviors.

DEVELOPING A BRIEF PARENT RESPONSE TO YOUTH'S TRAUMA NARRATIVE**Family Acceptance Project®**

In TF-CBT, the trauma narrative is a core organizing experience – developed in an interactive process with the therapist and later shared with the parent – to promote recovery from trauma symptomology by integrating trauma experiences into the context of a child's life. In both TF-CBT and FAP the parent-child relationship becomes the vector of change to reduce risk and promote well-being for the child by educating, guiding and empowering the parent / caregiver to learn to support and affirm their LGBTQ child during and after treatment. Parallel to the child's / youth's trauma narrative, the TF-CBT therapist may choose in appropriate cases to work with the parent to develop a brief reconciling parent letter or statement that the parent can share with the LGBTQ youth during the conjoint session after the youth presents their trauma narrative. The goal of the parent's brief response is to provide further support and affirm their LGBTQ child.

During PRAC TF-CBT components, the therapist engages the youth and parent individually to provide psychoeducation about the impact of trauma, explore the meaning it has for the youth and parent, respectively, and identify and practice strategies for effectively beginning to address trauma symptoms. FAP's psychoeducation approach is used to educate parents about their child's SOGIE, to help them identify rejecting and accepting behaviors they use to respond to their LGBTQ child and how these behaviors affect their child's self-esteem, vulnerability, hopelessness or hopefulness, health risks and well-being. Psychoeducation also helps parents and youth understand how trauma experiences interact with the youth's LGBTQ identity and ways to support recovery.

Practitioners can acknowledge parents' beliefs that their child's LGBTQ identity increases vulnerability while helping them understand that parental validation and acceptance of their child's LGBTQ identity is critical to their safety, well-being and trauma recovery. Parents learn to empathize with their child and understand the importance of their role as the central source of support to buffer social stigma and rejection from others. Concurrently, practitioners use FAP's approach to help youth understand how their parents' behaviors have impacted their trauma response and sense of identity. Through individual sessions with the therapist the parent hears the youth's trauma narrative and the parent learns how the youth's LGBTQ identity and trauma experiences intersect, how their parent's behavior has affected them and has shaped their self-perceptions, ability to trust and sense of the future.

Through this work, many parents may have come to recognize missed opportunities to support and affirm their LGBTQ child, as well as behaviors the parent has used to deny, repress, change, discourage or punish the child for their LGBTQ identity and how this has affected their child. With the practitioner's help, during one of the parent's final individual trauma narrative sessions, the parent may choose to create a brief response to the youth's trauma narrative—a personal statement, letter, audio recording or video—that acknowledges how they have disappointed and hurt their child; what they have learned during treatment to support their LGBTQ child; and how they will work to support and affirm their LGBTQ child going forward. FAP's educational materials, such as the family booklets, videos and intervention posters, can help the parent talk about what they have learned in treatment and how they have grown; identify ways for them to help their child, and provide information on how other families have learned to support their LGBTQ children. The therapist prepares the parent to share this directly with the youth in the upcoming conjoint child-parent session during which the youth will directly share their trauma narrative with the parent.

This will be an opportunity for the parent to demonstrate that they have heard their child, that they understand and take responsibility for actions that have been hurtful or harmful, and that they are making a commitment to support their child in ways that are meaningful and responsive to their child's needs. Therapists can guide parents in sharing what they have learned about their past behaviors and acknowledging and apologizing for how they have negatively impacted their child. Parents may share that their behaviors were motivated by love, by trying to socialize their child

to fit into a world they fear would not accept them, or that they were struggling with how to reconcile their child's identity with religious or other cultural beliefs that are important family values. The brief response should conclude with the parent naming the types of support they will commit to provide for their child in the future. This can include effective coping and relaxation strategies identified during PRAC phases of treatment, and for LGBTQ youth, engaging in a range of supportive, accepting and affirming behaviors such as welcoming their child's LGBTQ friends and partners to family gatherings, requiring other family members to treat their child with respect and attending LGBTQ events with their child.

After the parent reads the brief response, the practitioner should process the youth's reactions and support them in responding to the parent. The parent should be coached to invite the child to develop a family support/safety plan with them that will address the child's needs for affirmation and support. The family plan is a mutual commitment to communicate, to support and sustain the healing practices that were identified and practiced during the course of treatment. This is an opportunity for parents to actively show acceptance of their child by practicing what they have learned during treatment. As such, the therapist should empower parents to take an active role in facilitating development of the family support/safety plan with their child.

The plan may include broader issues such as agreement about managing disclosure of the child's LGBTQ identity with the extended family, members of their congregation and cultural group or increasing affirming interactions such as using the child's correct pronouns or chosen name. It may also include plans for how the family will handle potentially triggering situations (for example, a child's need for support in school or in the community), ways to respond to re-emerging symptomology, and identified sources of support. By culminating treatment with developing a family support/safety plan, practitioners increase the likelihood that the family will continue to work together to increase affirmation and acceptance for their LGBTQ child within the family and in their child's social world. Family acceptance provides a critical foundation for helping the child recover from trauma and helping them manage future challenges and adversity that may reanimate vulnerability. #

IN VIVO MASTERY

Goals: The goals of the In vivo Mastery component are to overcome avoidance in real life situations, for those youth who have developed overgeneralized fear and avoidance of innocuous situations. This component is only implemented if the situation is innocuous, i.e., safe. If the situation is not safe, the therapist does not implement this component, but rather focuses on the Enhancing Safety component.

Typical Implementation: In vivo Mastery is the only TF-CBT component that is optional, i.e., this component is only implemented for those youth who develop overgeneralized fear and avoidance of real life situations that serve as trauma reminders that are innocuous, and the avoidance of which involve significant functional impairment (for example, avoiding the use of public bathrooms; not attending school or not sleeping in one's bedroom). The therapist implements this component by educating the youth and parent about the value of overcoming overgeneralized avoidance of innocuous situations; collaboratively developing a fear hierarchy ("ladder") from the least feared to the most feared situations, and through graduated real life ("In vivo") exposure paired with relaxation or other coping strategies, helping the youth to master and overcome avoidance of the feared situations. Parental involvement and buy-in is generally essential to overcoming this type of avoidance, since parents have often been allowing if not enabling the youth to avoid the feared situation. Importantly, since this component typically takes several weeks to successfully complete, the therapist usually begins this component during the stabilization phase (e.g., as soon as the youth has learned relaxation

strategies). This will assure that most youth will complete the In vivo Mastery Component soon after completing the Trauma Narration and Processing treatment phase. Resources for implementing this component include an avoidance hierarchy (fear ladder) for developing the youth's individualized In vivo Mastery plan.

LGBTQ Implementation Considerations: When providing In vivo Mastery to LGBTQ youth, the therapist should be aware of issues that may differentially impact implementing this component for this population. These issues may include the following: a) interactions between trauma experiences and sexual orientation and/or gender identity issues that may complicate successfully completing an In vivo Mastery plan; b) there may be significant ambiguity regarding the safety of situations that the therapist considers to be "innocuous"; and c) parental fears for the youth's safety due to the youth's LGBTQ identity may interfere with implementing this component. These are discussed below.

Interactions between trauma experiences and sexual orientation and/or gender identity issues: For traumatized LGBTQ youth, returning to school, returning to using the bathroom or bedroom, etc. may serve as "double reminders," i.e., not only are these trauma reminders, but they are also reminders of the youth's sexual orientation and/or gender identity, and/or coming out. Depending on the youth's experience of these issues, these interactions may complicate the In vivo Mastery process. For example, a transgender youth who has been beaten up or sexually assaulted in the bathroom may have difficulty using public restrooms due to overgeneralized fears; but public bathrooms may also serve as a trauma reminder of discrimination related to the youth's gender identity more generally. For such youths, bathrooms may understandably serve as a more potent source of overgeneralized avoidance, and thus complicate attempts to gain mastery in using public restrooms. Developing an appropriate In vivo Mastery plan for these youths should emphasize safety, the use of effective coping skills, and engaging supportive adults (parents, educators, etc.) who will advocate for the youth throughout and beyond this process.

Ambiguity regarding safety of "innocuous" situation: The therapist should be careful when determining whether or not a situation is sufficiently "innocuous" to start an In vivo Mastery plan. It may be very difficult to determine the actual safety of home, school or community for LGBTQ youth who often experience intermittent or ongoing threats to their safety. For example, youth are often reluctant to disclose the full extent of school bullying due to stigma, embarrassment and/or shame; even the most supportive parent may not know about the bullying if the youth does not report it, and school personnel often are reticent to fully acknowledge the magnitude of this in their settings. Thus, the extent, severity or frequency of the trauma may go undetected until it is too late, with sometimes tragic consequences (such as when a youth attempts suicide). This ambiguity may magnify the difficulty of mastering avoidance during this component. When there is reasonable doubt with regard to the youth's safety, the therapist should defer this component and focus instead on enhancing safety. For instance, a gay youth who was viciously attacked at a park by 3 older youth due to his sexual orientation refused to go back to parks in his neighborhoods due to the perpetrators being free despite his involving the police department.

Parental fears related to youth's safety: The therapist should be aware that in many instances, parents are fearful for the youth's safety due to the youth's LGBTQ identity. For example, parents of transgender youth may believe that their transgender youth is at high risk for experiencing additional violence if the youth returns to school; and the parents may quote statistics that reinforce their view that such a return would be dangerous, thus supporting their overgeneralized fear and reinforcing the youth's avoidance. In fact, it is not at all unusual for such parents to reinforce the youth's avoidance of the feared situation. Unless the therapist provides clear and supportive psychoeducation about why it would be valuable for

the youth to master avoidance (e.g., the importance of returning to a safe, supportive school environment in order for the youth to gain confidence and courage to face developmentally adaptive tasks), these parents will remain highly likely to undermine the In vivo Mastery plan. Of course, in order to reassure and support parents in this process, the therapist must carefully ascertain the situation and be confident that it is innocuous and not dangerous; if this is not the case, the focus should be on enhancing safety rather than on implementing an In vivo Mastery plan. Despite the real safety concerns for LGBTQ youth in some settings, it is critically important to also emphasize to parents that with parental and peer support, LGBTQ youth are generally highly resilient, and that the goal of TF-CBT is to enhance and build on this resilience.

CONJOINT YOUTH-PARENT SESSIONS

Goals: The goals of conjoint youth-parent sessions are to: a) enhance direct, supportive trauma-focused communication between the youth and parent, including (in most cases) facilitating the youth to directly share the trauma narration and processing with the parent; b) address other trauma-related issues collaboratively with youth and parent (e.g., trauma-related behavior problems; sexual health; safety concerns); and c) transfer direct, supportive trauma-related communication with youth from therapist to parent.

Typical Implementation: During the conjoint youth-parent sessions, the therapist typically facilitates the youth in directly sharing the trauma narration and processing with the parent. Of critical importance is that the therapist has already shared and processed the narrative with the parent during individual parent sessions, while the youth was developing it (or shortly thereafter) during the trauma narration and processing treatment phase. The therapist should never share the trauma narrative in a conjoint session, until the therapist has prepared the youth and parent for this session. At a minimum, this requires that: a) the youth knows that the conjoint session will occur; b) the therapist has previously shared and cognitively processed the youth's narrative with the parent; and c) the therapist has prepared the parent for the upcoming conjoint session. This preparation includes preparing the parent for how to respond to the youth's sharing the narrative, including practicing appropriately supportive parental responses. If the parent is unable or unwilling to provide sufficiently supportive responses to the youth's trauma narrative, the therapist should not proceed with sharing the youth's narrative with this parent during the conjoint sessions.

Alternative strategies for a conjoint youth-parent session are to: 1) identify an alternative adult with whom to share the trauma narration and processing (this requires the youth's assent) and, depending on age, the parent's consent; as well as several sessions of preparatory work to learn about TF-CBT treatment as well as to complete the steps described above to prepare specifically for the conjoint sessions); or 2) include the parent in conjoint session but not share the entire trauma narration during these sessions.

Alternative activities for these conjoint sessions might include: a) enhancing trauma-related communication such as discussing sexual health principles; b) developing a family safety plan; c) addressing ongoing behavioral issues; and d) providing praise for each other related to work accomplished. The youth may also choose to only share the final chapter of the trauma narrative, allowing a sense of mastery and meaningful representation to be shared with the parent.

LGBTQ Implementation Considerations: It is important for the therapist to be aware of several considerations that may arise when implementing the Conjoint Youth-Parent Sessions component with

LGBTQ youth. These include the following: a) enhancing parental support and acceptance related to the youth's sexual orientation and/or gender identity when sharing the trauma narration and processing; b) sharing parent and/or youth cognitive processing related to trauma as it intersects with the youth's sexual orientation and/or gender identity; and c) managing conjoint youth-parent sessions for parents who are not supportive or accepting of the youth's sexual orientation and/or gender identity. Each of these is described below.

Enhancing parental support and acceptance related to the youth's sexual orientation and/or gender identity when sharing the trauma narration and processing: Whether or not LGBTQ youth perceive a connection between their trauma experience(s) and their sexual orientation and/or gender identity, it is helpful for parents to express support related to both during conjoint youth-parent sessions. This is particularly important for those youth who do connect their trauma experiences to their sexual and/or gender identity (since it would be difficult for the youth to believe that the parent was genuinely supportive about one without being supportive about the other). The therapist should address this directly with the parent in individual preparatory session(s) leading up to the conjoint session(s) with the youth and parent together, and as necessary, model, role play and practice appropriately supportive responses for the parent to provide to the youth during the conjoint sessions until the parent is able to provide these to the therapist during the preparatory session(s). If the parent is not able to be appropriately supportive—e.g., a father who, despite his best attempts to support his son, insists that he wouldn't have been sexually abused if he would have been a “real man” based on father's own rigid outlook on gender roles—the therapist may reconsider the value of having the conjoint sessions, or at least restructure these sessions in order to preclude the possibility of having the parent make non-supportive, harmful statements to the youth (i.e., not have the youth share their trauma narration and processing directly with the parent during the conjoint sessions).

Sharing new, adaptive trauma-related cognitions as they intersect with the youth's sexual orientation and/or gender identity: During the course of TF-CBT treatment, LGBTQ youth and parents often have developed new, more adaptive trauma-related cognitions (as described above in the Trauma Narration and Processing component). The therapist should have shared the youth's new cognitions with the parent during the parent's individual trauma narration and processing sessions. During these conjoint sessions, the therapist should also share the youth's new cognitions together with the youth and parent, so that the parent can directly comment and praise the youth for these changes accomplished during TF-CBT treatment. In addition to this, there is also great value in sharing: a) the parent's new cognitions about the youth's trauma experiences; and b) both the youth's and parent's **new trauma-related cognitions as they intersect with the youth's sexual orientation and/or gender identity**. For example, in the case of the transgender youth described on page 45, it was extremely helpful for the youth and parent to share their new cognitions with each other during the conjoint session. The youth shared her new beliefs about the sexual abuse and that her mother still loved her despite being confused about her transgender identity. The mother was able to tell her daughter that the sexual abuse had nothing to do with her gender identity, was not her fault, and that she loved her and would try to support her gender identity despite sometimes struggling with it. This represented a major turning point in their relationship and for the youth's clinical improvement. If the parent has developed a brief response to the youth's trauma narrative, the therapist should facilitate the parent in sharing and processing this during the conjoint session as described above in FAP's section in the Trauma Narration and Processing component.

Conjoint sessions for parents who are not supportive or accepting of the youth's sexual orientation and/or gender identity: When the parent has not displayed more accepting and less rejecting behaviors despite the therapist's ongoing best efforts to implement parental acceptance strategies, the therapist

must decide whether the above goals of conjoint youth-parent sessions can be feasibly met with this parent. In most cases it would not be realistic to believe that such parents would be able to supportively hear the youth's trauma narrative, but there may be some exceptions, and the therapist should make this determination on a case-by-case basis. However, there are many if not most cases in which such parents could supportively engage in other activities (e.g., safety planning, praising youth for progress made, etc.) during a conjoint youth-parent session. The therapist should focus on positive interactions that the youth and parent can engage in, understanding that (particularly for youth who still live with the parents), any positive interactions during a conjoint session can serve as a model for additional positive interactions in the future. Praising parents and youth for any gains and behavioral changes during therapy is important during these sessions, and also models positive ways of the respective family members seeing each other. The therapist should be prepared to cut short a conjoint session if the parent were to become inappropriate or abusive related to the youth's sexual orientation and/or gender identity (or for any other reason). Fortunately, this is an exceedingly rare occurrence and with appropriate preparation and clinical judgment, almost all conjoint sessions proceed in a positive fashion.

ENHANCING SAFETY AND FUTURE DEVELOPMENT—CONTINUED

As noted at the start of this manual, this component is typically the final TF-CBT component. In this manual, it is implemented at the beginning of treatment for youth who have immediate safety concerns, (e.g., youth with chronic trauma exposure with or without complex trauma presentations). As stated in the start of the manual, the TF-CBT therapist should continue to implement the Enhancing Safety component throughout TF-CBT, and should end treatment with this component, assuring the youth and parent are continuing to implement appropriate safety strategies to enhance the youth's optimal adjustment and future development. Some youth and parents may have engaged in developing a joint family support/safety plan during conjoint sessions (as described above in FAP's section in the Trauma Narration and Processing component). This is an excellent strategy for the therapist to facilitate families in planning specific future safety strategies.

At the end of TF-CBT, the therapist should repeat the trauma assessment instrument(s), i.e., UCLA PTSD RI, CPSS, TSCC, that was used at the start of treatment, to ascertain the degree to which this instrument indicates that clinical improvement has occurred (while understanding potential limitations of such instruments in detecting such improvement). It is important that the therapist discuss the results of the post-TF-CBT assessment with the youth and caregiver in order to emphasize the youth's progress during treatment and why TF-CBT treatment is now ending. For youth whose self-report instruments do not reflect improvement but who may have shown other gains (e.g., improvement in adaptive functioning such as decreased self-injury, increased therapy or school attendance, etc.), the therapist should help the youth and parent reflect on these positive changes that have occurred since the start of therapy, and the therapist's observations about how well the youth is using TF-CBT skills (if this is the case) to manage negative emotions, behaviors, and/or cognitions even if this is not reflected in the self-report instrument. The therapist may also find it helpful to review the impact of chronic trauma and to reiterate that, just as traumatic impact can continue after the traumatic experiences themselves are over, the positive impact of treatment can be long-lasting, if the youth and parent continue to practice and implement the skills that they learned. Since trauma-focused treatment may be only one aspect of the youth's needs, appropriate referrals should be made for additional services, as clinically indicated.

SUMMARY

This implementation manual addresses modifications to the TF-CBT model for LGBTQ youth who develop significant trauma symptoms. The NCTSN Learning Community found that generally, complex trauma TF-CBT applications are very suitable for trauma-impacted LGBTQ youth. Highlights of additional specific considerations for this population that are described in detail in this manual include the following (as individually/clinically appropriate):

- Family assessment and psychoeducation that integrates the Family Acceptance Project's (FAP) core assumptions, research findings and strategies, meeting parents where they are to support them to describe their hopes, dreams, concerns and fears related to their youth's sexual orientation and/or gender identity; cultural assessment to prepare to address SOGIE related to the parent's attitudes and knowledge and engaging them in the TF-CBT treatment process
- Recognition of and appropriate safety planning for the realistic threats that may specifically apply to LGBTQ youth in the home, community and/or school
- Psychoeducation about traumas and trauma responses that differentially impact LGBTQ youth, e.g., hate crimes, bullying, sexual assault, and /or parental and family rejection that are directly based on the youth's sexual orientation and/or gender identity; and the critical impact of family support for improving the LGBTQ youth's health and well-being
- Parental interventions specifically related to parental rejection and acceptance, based on FAP's evidence-based research on this topic, and strategies to enhance parental support in order to enhance LGBTQ youth health and well-being
- Selecting appropriate relaxation skills in recognition of the potential that the youth's body may serve as a reminder of traumas related to the youth's sexual orientation and/or gender identity
- Selecting appropriate affect modulation strategies in recognition of ongoing trauma reminders related to heterosexism, homo and trans negativity, and homophobia and transphobia, etc. in the broader environment
- Addressing patterns of maladaptive cognitions related to sexual orientation and/or gender identity in the broader cultural context of heterosexism, homo and trans negativity, and homophobia, transphobia and social stigma
- Integrating trauma issues and conflicts about sexual orientation and/or gender identity into the trauma narration and processing
- Sharing new, more adaptive cognitions of youth and parent related to the youth's trauma and sexual orientation and/or gender identity during conjoint sessions

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APPENDIX 1

TF-CBT with LGBTQ Youth and Caregivers - TF-CBT Checklist Addendum

This addendum was developed to use in conjunction with the TF-CBT Brief Fidelity Checklist (Deblinger et al, 2014), when implementing TF-CBT for trauma-impacted LGBTQ youth.

Prepared by Antonia Barba, LCSW, The Jewish Board

Assessment

Therapists should be LGBTQ affirming and culturally competent and have awareness of legal and ethical issues involved in evaluating and treating LGBTQ youth. Before beginning the model and during the assessment phase, there are additional considerations to make when working with trauma impacted LGBTQ youth, to ensure their confidentiality and safety. These factors may also provide key information about parents' knowledge about and attitude toward their children's sexual orientation and gender identity, which can be used to guide your engagement of the parent in treatment. It is recommended that you include the following components during the assessment phase:

Confidentiality:

- Determine who has or could have access to the youth's medical records (based on your jurisdiction)
- Assess whether all those who have or could have access are aware of youth's sexual orientation and gender identity (SOGI)
- Assess youth's level of openness about their LGBTQ identity
- Assess risk of maltreatment or rejection if parent were to learn of youth's SOGI
- Determine with youth if they agree to have information about SOGI in the medical record

Sexual Orientation and Gender Identity:

- Sexual orientation
- Gender identity and expression
- Healthy sexuality
- Degree to which youth has come out to others involved in their care
- Assess factors that may contribute to youth's identity-related resiliency
- Assess parent's knowledge, attitudes and behavior related to their youth's LGBTQ identity and gender expression
- Assess youth's experiences with family and caregiver reactions, including the presence of specific rejecting and accepting behaviors related to their LGBTQ identity
- Expect that LGBTQ youth may minimize or deny trauma experiences and symptomology for fear of outing themselves
- Assess for presence of ongoing risk factors

The following pages include a list of optional interventions that you may consider for inclusion in your work with trauma-impacted youth and their caregivers. Therapists should use their best clinical judgment when selecting interventions and utilize those that are most aligned with their clients'

experiences and trauma treatment goals, have the potential to strengthen the parent-child relationship, and promote youths' safety and well-being.

Enhancing Safety - Many LGBTQ youth present with complex trauma and have acute safety issues early in treatment. It is suggested that therapists implement this component first and throughout TF-CBT treatment, and log it accordingly on the TF-CBT Checklist. It is recommended that you include and revisit the following components as clinically indicated:

| Component | Session/ Date | Session/ Date | Session/ Date |
|---|------------------|------------------|------------------|
| Acknowledge ongoing reality-based threats to youth's physical or emotional safety | | | |
| Provide psychoeducation about LGBTQ-specific traumas | | | |
| Assess unsafe responses to trauma reminders or recurrent traumas | | | |
| Provide, practice and role play TF-CBT coping strategies | | | |
| Explore and validate parent's knowledge, concerns and fears related to their youth's SOGIE | | | |
| Learn about family's cultural, religious, racial and ethnic background, language, and values | | | |
| Provide parental psychoeducation on the impact of rejecting and accepting behaviors on LGBTQ youth's health | | | |
| Provide youth psychoeducation on the impact of rejecting and accepting behaviors on their health and explore readiness for increased family connectedness | | | |
| Develop safety strategies specific to youth's needs | | | |
| Identify & teach strategies for parents to advocate for youth at home, school and in the community | | | |
| Joint session to negotiate safety plan with youth and caregiver | | | |
| Monitor and adjust safety plan | | | |
| Introduce principles of sexual health appropriate to needs of youth | | | |

Psychoeducation - When providing psychoeducation, it is important to carefully balance and include LGBTQ-specific traumas and other types of trauma that may be unrelated to the youth's identity, and youth and parent perceptions of the relationship between trauma and the youth's identity. It is recommended that you include the following components and considerations as clinically indicated:

| Component | Session/ Date | Session/ Date | Session/ Date |
|--|------------------|------------------|------------------|
| Explore youth's perception of if or what connection exists between their trauma and their SOGI | | | |
| Provide non-judgmental support that normalizes youth's perceptions | | | |
| Utilize psychoeducational materials that represent diverse sexual, gender, ethnic, racial, religious and other cultural identities | | | |
| Provide psychoeducation to youth & parent about traumas that may differentially impact LGBTQ youth | | | |
| Provide psychoeducation specifically for transgender and gender expansive diverse youth | | | |

| | | | |
|---|--|--|--|
| Provide psychoeducation to youth about the impact of their parent's rejecting & supportive behaviors | | | |
| Provide psychoeducation to parent about the impact of their rejecting & supportive behaviors on their child | | | |
| Provide parental psychoeducation on the impact of rejecting and accepting behaviors on LGBTQ youth's health | | | |
| Provide information about principles of sexual health | | | |

Parenting Skills - The parenting component is typically provided to the non-offending parent throughout TF-CBT with the goal of enhancing skills to support their child. Several considerations arise when working with LGBTQ youth who may not be out to their parents, and therefore may not have disclosed traumas related to their identity. It is recommended that you include the following components as clinically indicated:

| Component | Session/ Date | Session/ Date | Session/ Date |
|---|------------------|------------------|------------------|
| <u>If the youth has not yet come out to their parent:</u> | | | |
| Explore why youth has not shared their sexual orientation or gender identity (SOGI) with parent | | | |
| Explore potential risks and benefits of sharing information about SOGI | | | |
| Assess parent's perspective regarding and potential to accept youth's SOGI | | | |
| If parent knows or suspects, or doesn't know but therapist assesses they will be supportive, obtain youth's permission to start general conversation about youth's identity and trauma experience | | | |
| If parent knows, suspects or doesn't know but therapist assesses they might not be supportive, validate youth's concern and create plan for sharing general trauma information and gradual exposure to SOGI | | | |
| If therapist assesses parent will be actively unsupportive or rejecting, validate youth's concern and determine how and if parent can be included in treatment | | | |
| <u>Once youth has agreed to share information about their SOGI with their parent:</u> | | | |
| Provide parental psychoeducation and parenting skills related to LGBTQ-specific traumas | | | |
| Identify and practice using respectful and culturally affirming language parent can use to talk about youth's SOGI | | | |
| Assist parent in talking with youth about safety concerns and ways to advocate for safety at home, school and in the community | | | |
| Provide rationale/psychoeducation for making small behavioral changes to be more accepting of their LGBTQ youth | | | |
| Explore and validate parent's concern about youth's SOGI | | | |
| Identify rejecting behaviors that are triggering to youth and identify small changes in behaviors that can positively impact youth | | | |
| Help parent to self-observe and reflect on the impact of positive behavioral changes on their child | | | |

Relaxation Skills - When identifying and practicing relaxation skills, therapists should be aware of safety issues and trauma triggers that may impact the implementation of relaxation strategies differently for LGBTQ youth. It is recommended that you include the following components as clinically indicated:

| Component | Session/ Date | Session/ Date | Session/ Date |
|--|------------------|------------------|------------------|
| Assess to what degree youth believes psychological and physiological hypervigilance is necessary to their safety | | | |
| Provide psychoeducation about the difference between dangerous situations and trauma reminders to youth and parent | | | |
| Determine when relaxation strategies are safe and appropriate to use as opposed to safety strategies | | | |
| Teach and practice use of TF-CBT relaxation skill with parents | | | |
| Teach youth distraction relaxation techniques that do not call attention to their body and increase self-consciousness | | | |
| Inquire about use of medications including hormones and assess how they may be impacting hyperarousal and anxiety symptoms | | | |

Affect Modulation Skills - Studies show that interpersonal and societal prejudice, discrimination and stigma have a direct negative impact on LGBTQ youth's mental health and symptomology. When identifying affective states and corresponding strategies for modulating affect, therapists should consider including the following components:

| Component | Session/ Date | Session/ Date | Session/ Date |
|--|------------------|------------------|------------------|
| Discuss youth's perceived expectations about how they "should" experience and express emotions based on their gender, sexuality, race, ethnicity, religion and other factors | | | |
| Determine the prevalence of trauma reminders associated with SOGI related traumas | | | |
| Assess the impact of prior & ongoing parental rejection on affect regulation and ability to utilize skills | | | |
| Move onto Trauma Narration phase even though youth has not yet mastered use of affect modulation skills between sessions | | | |

Cognitive Coping Skills - In addition to negative cognitive styles and negative cognitions that youth may develop related to their traumatic experiences, LGBTQ youth may have additional maladaptive cognitions based on the way they have been treated and experienced the world. The following components should be considered when implementing cognitive coping with traumatized LGBTQ youth:

| Component | Session/ Date | Session/ Date | Session/ Date |
|---|------------------|------------------|------------------|
| Use cognitive processing strategies to examine youth's maladaptive cognitions related to heterosexism, homonegativity and gender binary norms | | | |
| Explore alternative ways of thinking about their situation connected to the possibility and presence of increased acceptance and support | | | |

| | | | |
|---|--|--|--|
| Examine maladaptive cognitions related to parents and family | | | |
| Explore helpful cognitions related to parent's possible rationale or motivation for rejecting behaviors | | | |
| Work with family to address safety and enlist alternate sources of support | | | |
| Address parent's maladaptive cognitions related to youth's SOGI | | | |
| Examine maladaptive cognitions related to religion and culture | | | |
| Enlist leader or member of youth or family's faith community to challenge maladaptive cognitions | | | |

Trauma Narration and Processing - While difficult, the trauma narration and processing component can one of the most helpful and significant parts of treatment. In addition to negative cognitive styles and negative cognitions developed related to their traumatic experiences, LGBTQ youth may have additional maladaptive cognitions based on the way they have been treated and experienced the world. The following components should be considered when implementing trauma narration and processing with traumatized LGBTQ youth:

| Component | Session/ Date | Session/ Date | Session/ Date |
|---|------------------|------------------|------------------|
| Include earlier/interpersonal traumas | | | |
| Identify and process maladaptive cognitions connected to negative internalized beliefs about SOGI | | | |
| Validate and process parent's feelings of loss and grief related to their child's identity | | | |
| Assess parent's level of acceptance and ability to participate meaningfully in this phase | | | |
| Discuss and obtain agreement from youth for parent's participation | | | |
| Work with youth to identify alternative LGBTQ affirming adult to participate in this phase | | | |
| Prepare alternative LGBTQ affirming adult to participate meaningfully in this phase | | | |
| Develop brief parent response to youth's trauma narrative | | | |

In Vivo Mastery - The therapist should be aware of issues that may differentially impact or complicate implementing In vivo Mastery with LGBTQ youth. The following components should be considered when implementing cognitive coping with traumatized LGBTQ youth:

| Component | Session/ Date | Session/ Date | Session/ Date |
|--|------------------|------------------|------------------|
| Assess for interactions between trauma experiences and SOGI | | | |
| Include the engagement of supportive and LGBTQ affirming adults in safety plan | | | |
| Defer mastering avoidance when unable to assess safety of "innocuous" situations | | | |
| Assess parent's fears for youth | | | |

Conjoint Youth-Parent Sessions

When facilitating conjoint sessions with LGBTQ youth, the therapist must assess the parent's capacity to respond supportively and affirmatively. When a parent has not displayed less rejecting and more affirming behaviors, despite therapist's best efforts, the therapist must decide how and if the goals of the conjoint session can be met with this parent. The following components should be considered when implementing conjoint sessions with traumatized LGBTQ youth and their parents:

| Component | Session/Date | Session/Date | Session/Date |
|--|--------------|--------------|--------------|
| Prepare and practice LGBTQ supportive and affirming responses with parent | | | |
| Restructure conjoint sessions to limit possibility of parent giving a rejecting response | | | |
| Share brief parent response to youth's trauma narrative | | | |
| Share youth's and parent's new cognitions related to youth's SOGI | | | |
| Coach parent to invite youth to develop a family support/safety plan | | | |
| Jointly develop a family support/safety plan | | | |

APPENDIX 2

Family Acceptance Project®! Resources & Information

The Family Acceptance Project has been developing a range of research-based family education resources and assessment tools to help decrease family rejection and increase family support, and to assess parental growth and change and youth's experiences with parent's behavioral change. These include:

- **Family Education Booklets** – short research-based guidance publications that help parents, caregivers, youth and others understand how family behaviors impact their LGBTQ children; how decreasing family rejecting behaviors can reduce risk and how increasing family supportive and accepting behaviors protect against risk and help promote well-being. FAP's booklets are currently available in English, Spanish, and Chinese, and some faith-based versions, with other versions in development – in print copies and free online. These booklets are designated as a “Best Practice” resource for suicide prevention for LGBTQ youth by the Best Practices Registry for Suicide Prevention. <https://familyproject.sfsu.edu/publications>
- **Family Education Videos** – compelling short documentaries that show the journey of ethnically and religiously diverse families from struggle to support of their LGBTQ children, to give LGBTQ youth and families hope and to show how families learn to support their LGBTQ children. Designed to educate families and LGBTQ young people, for clinical work, community education, and for provider training, these videos are grounded in FAP's research and practice with LGBTQ youth and families and have a discussion guide and educational materials. FAP's most recent video is included in the Best Practices Registry for Suicide Prevention. The videos can be ordered and trailers are available at <https://familyproject.sfsu.edu/family-videos>
- **FAP Intervention Posters** – research-based education and intervention posters in English & Spanish that include a brief introduction, 20-25 family accepting / rejecting behaviors identified and measured in FAP's research, and an infographic that shows how these behaviors contribute to health risks (suicidality, depression, illegal drug use, etc.) or protect against risk and promote well-being for LGBTQ youth <http://familyproject.sfsu.edu/poster>

The posters come in 3 versions: a) accepting; b) rejecting; and c) a version for use in conservative settings, including religious institutions, that substitutes other family accepting behaviors for LGBTQ and same-sex dating which could preclude the posters from being used in these settings. The posters are available free of charge for direct download from FAP's website and can be printed by the user through their agency, institution or a local printer. The posters are most effective when they are professionally printed. The costs for printing one-sided posters are very low, especially when more posters are printed – see FAP's website for printing information - in English (<http://familyproject.sfsu.edu/poster-english>) and Spanish (<http://familyproject.sfsu.edu/poster-spanish>)

The posters range from wall-size to handout size for use in multiple settings and for families to use at home. The posters come with a Poster Guidance that explains their origin, research framework and suggestions for use in prevention, education, assessment and clinical care (<http://familyproject.sfsu.edu/sites/default/files/FAP%20Poster%20English%20Guidance-sm.pdf>)

- **Assessment Tools & Measures**

Assessment Questions – FAP has developed questions to help providers ask about the youth’s and parent’s cultural and religious backgrounds, knowledge and perceptions of sexual orientation, gender identity and expression (SOGIE). These questions can be integrated into an intake form or used separately when initial assessment is done. They are included in this appendix.

Social Support Map – FAP developed a social network map to quickly identify family members, peers and others in the youth’s and parent’s social worlds, including those that are sources of support and who know about their LGBTQ identity. These maps, which are used to understand and help build social support for the LGBTQ youth and parent and to protect the youth’s confidentiality, are included in this appendix.

Gender Expectations and Perceptions Scale - FAP developed a simple gender scale to quickly assess the youth’s perceptions of their gender expression and how this relates to the caregiver’s gender expectations and perceptions. FAP works with parents and caregivers across socioeconomic and literacy levels. FAP’s gender scale gives caregivers – including those who might have less education, lower literacy levels and less experience talking about gender – a simple way to discuss gender expectations. This enables a youth and caregiver to start to talk about gender and especially parent’s pressure to conform to gender expectations in a neutral, non-threatening way. FAP introduces this scale with the youth and caregiver separately during intake sessions and uses the content later in individual or conjoint counseling sessions. Copies of these scales are included in this appendix.

Other FAP Measures – FAP has also developed: 1) a risk assessment scale that quickly enables practitioners to assess for family rejecting behaviors that are predictive of risk and to help LGBTQ youth identify rejecting behaviors that contribute to risk (*FAPrisk Screener*); and 2) measures to assess parent’s and caregiver’s growth and behavioral change from the perspective of both parent and youth during intervention services (*Youth and Family Assessment Measures*). These measures are available from FAP and involve training.

Training – FAP provides training for practitioners and others on using FAP’s family support approach through training hosted by agencies, organizations and institutions. FAP has provided education and training for thousands of families, providers and religious leaders on helping families to support their LGBTQ children and youth (fap@sfsu.edu).

APPENDIX 3
Family Acceptance Project® (FAP) - Youth Questionnaire
 Caitlin Ryan, PhD, ACSW

We have included use of other FAP assessment resources in these background questions to facilitate assessment. These resources are included in the FAP appendix.

These questions will help provide key background information to support the youth's sexual orientation, gender identity and expression, to decrease family rejection and to increase family support. To protect the youth's confidentiality, the clinician may decide not to record answers to some of these questions. Information about the family's cultural and religious background is foundational for FAP's family support approach – as is information about the parent's / caregiver's behavioral reactions to their LGBTQ child or youth.

ID: _____ Youth Age: _____ Date: _____

This information will help us learn more about your family to help increase family support.

LGBTQ IDENTITY

1. How do you describe your sexual orientation?

| | |
|---|--|
| <input type="checkbox"/> Lesbian <input type="checkbox"/> Gay <input type="checkbox"/> Bisexual | <input type="checkbox"/> Heterosexual <input type="checkbox"/> Other (tell us): _____ |
|---|--|

2. How do you describe your gender identity? (check one)

| | |
|---|--|
| <input type="checkbox"/> Transgender <input type="checkbox"/> Gender Diverse <input type="checkbox"/> Gender Binary | <input type="checkbox"/> Gender Queer <input type="checkbox"/> Other (tell us): _____ |
|---|--|

3. Are you questioning your:

Sexual orientation Yes No

Gender identity Yes No

4. How old were you when you first thought you might be lesbian, gay or bisexual? (age): _____

5. How old were you when you thought that you might be transgender? (*age*): _____
6. How old were you when you thought that you might be gender binary? (*age*): _____
7. Does your parent / caregiver know about your LGBTQ identity? _____ *Yes* _____ *No*
8. If so, when did your parent / caregiver learn about your LGBTQ identity? How did they learn about your identity and how did they respond? Has this changed over time?

9. Do your parents know any LGBTQ adults that they think are successful and happy? Do they know other families with LGBTQ children?

Do those families accept and support their LGBTQ family members? What do your parents think of those families?

CULTURE

10. Tell me about your family's cultural, ethnic and racial background.

Are there cultural values that are important to your family?

Tell me about how your parents express those values in your family.

How do those values affect you and your LGBTQ identity / gender expression?

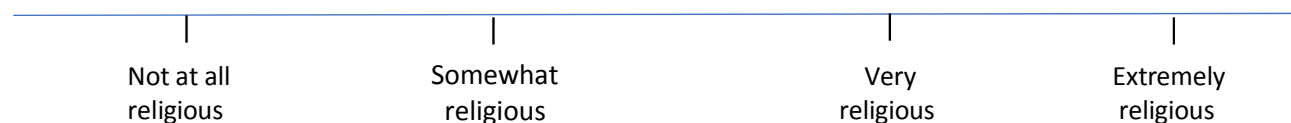
RELIGIOUS BACKGROUND

11. Does your family have a religious background? Tell me about your family's religion.

12. What does your religion say about LGBT people?

13. How religious are your parents?

How RELIGIOUS are your parent(s)? *(circle one)*



14. Are religious beliefs a source of conflict in your family because of your LGBT identity? Tell me about that.

SUPPORT NETWORK

15. Tell me about the peers and adults in your life.

[Practitioner: With youth, fill out FAP social support map]

Who are you closest to?

Who do you turn to for support?

Who knows about your LGBT identity? (Put a star next to their name. Put a circle around people you can talk with about your LGBT identity.)

Who in your family do you wish would be more supportive?

GENDER SCALE

[Practitioner: With youth, fill out FAP gender scale]

16. Tell me about your gender expression and your parents' expectations for how they think you should look, dress and behave).

Using the Gender Scale:

- In the middle of the page, put a "X" on the line that shows how your parents expect you to express your gender (look, dress, behave).
- And on the bottom of the page, put a "X" on the line that shows how you actually express your gender.

Is gender expression a source of conflict with your parents?

How do your parents respond to your gender presentation / identity?

How do you wish your parents would respond to / support your gender identity?

FAMILY REACTIONS

17. Tell me about your experiences with your family:

A. How ACCEPTING are your parent(s) of your LGBT identity? (circle one)

| | | | | |
|-------------------------|-----------------------|-------------------------------|-------------------|------------------------|
| Not at all accepting | A little accepting | Not rejecting or accepting | Very accepting | Extremely accepting |
|-------------------------|-----------------------|-------------------------------|-------------------|------------------------|

B. How REJECTING are your parent(s) of your LGBT identity? (circle one)

| | | | | |
|-------------------------|-----------------------|-------------------------------|-------------------|------------------------|
| Not at all accepting | A little accepting | Not rejecting or accepting | Very accepting | Extremely accepting |
|-------------------------|-----------------------|-------------------------------|-------------------|------------------------|

LEARNING ABOUT YOUR FAMILY'S REJECTING & ACCEPTING BEHAVIORS

[Practitioner: Start to identify how parents and caregivers respond to the youth's sexual orientation and gender identity by having the youth identify and describe their experiences with family rejecting and accepting behaviors, including their frequency and dose (amount and repetition of family behaviors). Read FAP's Poster Guidance - <http://familyproject.sfsu.edu/poster> for background information on the posters.

Show and discuss FAP's family rejection and acceptance posters (<http://familyproject.sfsu.edu/poster>) and explain how family rejecting and accepting behaviors relate to risk and well-being. The posters include some of the common rejecting and accepting behaviors that FAP has identified and measured.

Identifying Rejecting Behaviors – Start with the rejection poster first. Ask the youth if they have experienced any of these rejecting behaviors from their parents or caregivers. Then ask if they have experienced other rejecting behaviors besides those included on the poster. Make a list of the behaviors they describe. Ask which behaviors are most difficult for them to experience.

Identifying Accepting Behaviors – After you have asked about family rejecting behaviors included on the rejection poster, use one of the posters that shows family accepting behaviors to ask the youth about accepting and supportive behaviors. [Read FAP's Poster Guidance to learn more about the posters – <http://familyproject.sfsu.edu/sites/default/files/FAP%20Poster%20English%20Guidance-sm.pdf>].

Ask the youth to identify specific accepting behaviors that they have experienced that are included on the poster and then ask about other family behaviors that their parents or caregivers engaged in to affirm or support them, and how they responded.

Be sure to create a list of rejecting and accepting behaviors to address in other components of care, including behaviors the youth talked about that their parent did not mention.

“The Family Acceptance Project (FAP) has done critical research which shows that how parents respond to their LGBTQ children has a significant impact on their risk and well-being.

FAP has developed education and intervention posters that quickly show how some of more than 100 specific behaviors – like preventing a youth from participating in LGBTQ support groups or making their

child pray or attend religious services to change their LGBTQ identity – contribute to serious health risks, including suicidal behavior, depression, drug use and risk for HIV. FAP’s research also shows that family accepting and supportive behaviors – like standing up for your child when others mistreat them because of their LGBTQ identity or supporting their gender expression – help protect against risk and promote self-esteem, better health and well-being.

Let’s take a moment to look at these posters so you can see how family rejecting behaviors contribute to health risks and family conflict, and how family supportive and accepting behaviors help reduce risk for suicide, depression and substance abuse and build an LGBTQ youth’s sense of self-esteem and positive sense of the future.

We’ll spend time talking about these behaviors during our time together to help your parents understand how important families are in reducing their LGBT child’s risk for major health concerns and teaching parents how to advocate for you and how to increase support in your family.”

Thank you for the information you have shared with me.”

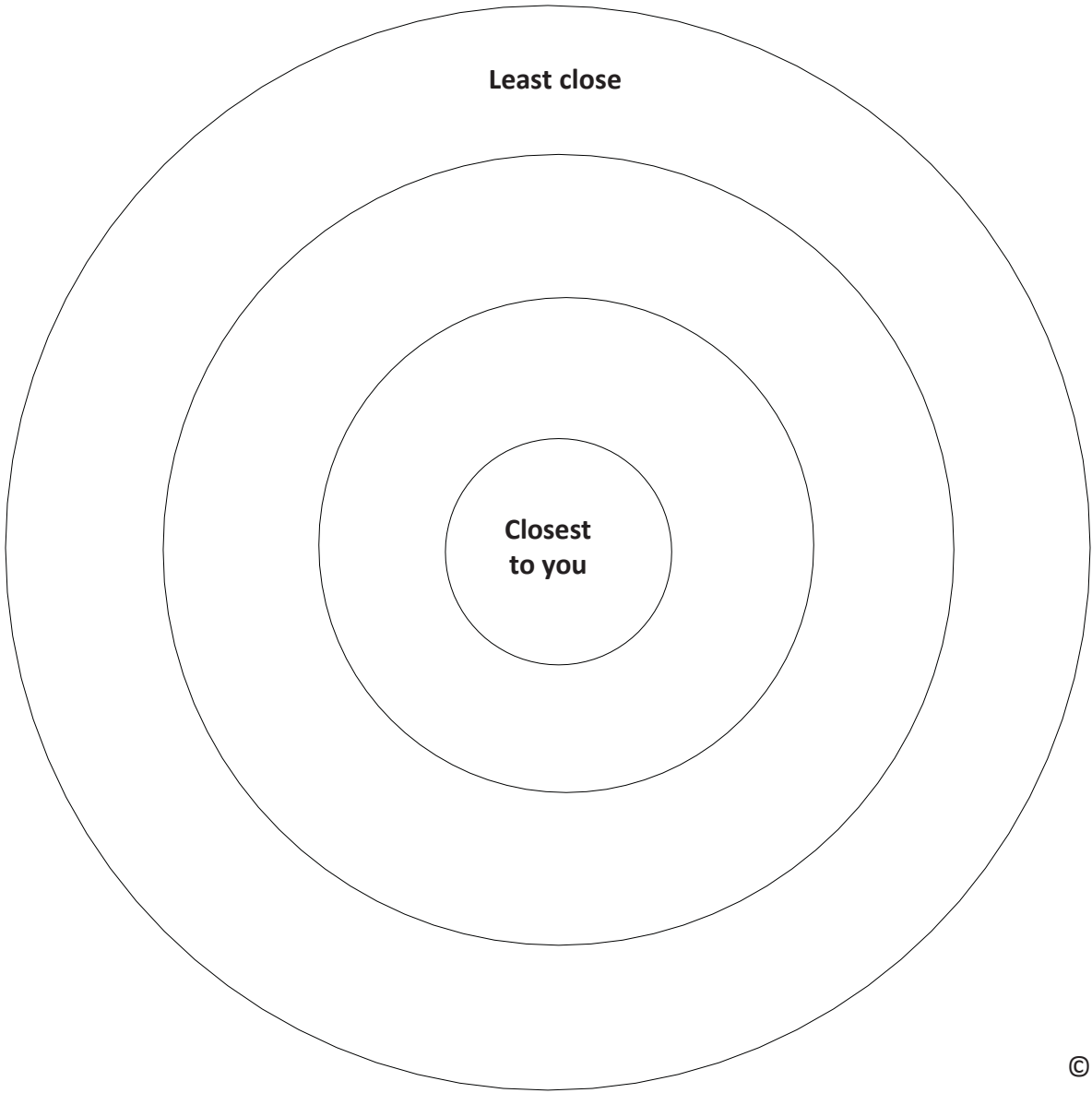
Family Acceptance Project®

SOCIAL SUPPORT MAP - Youth

Name or Case ID: _____

Date: _____

Tell us about the people in your social network (family, friends, etc.) *Put a star next to anyone* who knows about your LGBT identity.* Show on the map people who are closest to you and not as close. Who do you turn to for support? Who do you wish would be more supportive? Put a circle around people you can talk with about your LGBT identity.



APPENDIX 3

Family Acceptance Project® (FAP) - Parent Questionnaire

Caitlin Ryan, PhD, ACSW

We have included use of other FAP assessment resources in these background questions to facilitate assessment. These resources are included in the FAP appendix.

The following questions are intended to be used with parents who know about their child's sexual orientation and gender identity. Practitioners should never "out" or disclose a youth's sexual orientation or gender identity to the parent or caregiver. At times, a youth may ask the practitioner for help to disclose their sexual orientation and gender identity to their parent or caregiver – and this is done with the youth's permission. FAP practitioners interview the youth first during assessment to learn about the youth's sexual orientation and gender identity (SOGI) and to confirm that their parent or caregiver knows about their lesbian, gay, bisexual or transgender (LGBT) identity before discussing the youth's sexual orientation and gender identity with the parent. To protect the youth's confidentiality, the clinician may decide not to record answers to some of these questions.

When parents find out about their child's LGBT identity during treatment, the practitioner can use these questions to learn about the parent's knowledge, attitudes and cultural and religious backgrounds and beliefs related to their child's LGBT identity. Information about the family's cultural and religious background is foundational for FAP's family support approach—as is information about the parent's / caregiver's behavioral reactions to their LGBTQ child or youth.

ID: _____

Youth Age: _____

Date: _____

This information will help us learn more about you and your family to help increase support for you and your child.

LGBT IDENTITY**1. How would you describe your child's sexual orientation?**

| | |
|-----------------------------------|---|
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Heterosexual |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Other (tell us): _____ |
| <input type="checkbox"/> Bisexual | |

2. How would you describe your child's gender identity? (check one)

| | |
|---|---|
| <input type="checkbox"/> Transgender | <input type="checkbox"/> Gender Queer |
| <input type="checkbox"/> Gender Diverse | <input type="checkbox"/> Other (tell us): _____ |
| <input type="checkbox"/> Gender Binary | |

3. Do you think that your child is questioning their:

Sexual orientation Yes No Not sure
 Gender identity Yes No Not sure

4. Do you know at what age your child first thought they might be lesbian, gay or bisexual? (age): _____

5. Do you know at what age your child first thought that they might be transgender? (age): _____

6. When did you learn about your child's LGBTQ identity? Tell me how learned about your child's identity. How did you respond? Has this changed over time?
7. Do your know LGBTQ adults that you think are successful and happy? Do you know other families with LGBTQ children?

Do you know if their families accept and support their LGBTQ family members?
What do you think about those families?

CULTURE

8. Tell me about your family's cultural, ethnic and racial background.

Are there cultural values that are important to your family?

Tell me about how you and other adults express these values in your family.

How do these values affect your child's LGBTQ identity / gender expression?

RELIGIOUS BACKGROUND

9. Does your family have a religious background? Tell me about your family's religion.

10. What does your religion say about LGBT people?

11. How RELIGIOUS are you? (circle one)

Not at all
religious

Somewhat
religious

Very
religious

Extremely
religious

12. Are religious beliefs a source of conflict in your family because of your child's LGBT identity?
Tell me about that.

SUPPORT NETWORK

13. Tell me about other adults in your life.

[Practitioner: With parent, fill out FAP social support map]

Who are you closest to?

Who do you turn to for support?

Who knows about your child's LGBT identity? (Put a star next to their name and put a circle around people you can talk with about your child's LGBT identity.)

Who in your family do you wish would be more supportive? How would you like other family members to support you and your LGBT child?

GENDER SCALE

[Practitioner: With parent, fill out FAP gender scale]

14. Tell me about your child's gender expression and your expectations for how you think they should look, dress and behave).

Using the Gender Scale:

- In the middle of the page, put an "X" on the line that shows how you expect your child to look, dress, behave (express their gender).
- And on the bottom of the page, put an "X" on the line that shows how your child actually expresses their gender.

Is your child's gender expression a source of conflict in your family? Tell me about that.

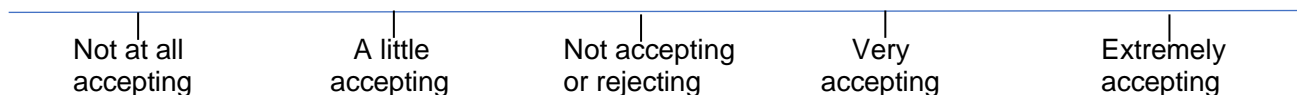
How do you respond to your child's gender presentation / identity?

How would you like to respond to your child's gender presentation / identity?

FAMILY REACTIONS

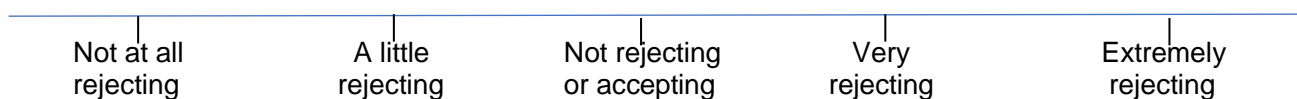
15. Tell me about your experiences with your child:

A. How ACCEPTING are you of your child's LGBT identity? *(circle one)*



[The parent may talk about what "acceptance" means to them and to others in the family. Encourage them to explain what they mean and then let them know that you will talk about this in more detail.]

B. How REJECTING are you of your child's LGBT identity? *(circle one)*



[The parent may describe degrees of “rejection” and what this means to them and to others in the family. Encourage them to explain what they mean and to give examples of times when they or other family members were distressed about their child’s sexual orientation, gender identity and expression and tried to change or discourage their child’s identity and gender presentation. Ask them how their child responded. Let them know that you will talk about this in other sessions.]

LEARNING ABOUT FAMILY REJECTING & ACCEPTING BEHAVIORS

[Practitioner: Show the parent FAP’s healthy futures posters for LGBT youth (<http://familyproject.sfsu.edu/poster>). Start with the rejection poster first. (For more information about FAP’s posters and the Poster Guidance, see Appendix 2).

Use the posters to identify how parents and caregivers respond to the youth’s sexual orientation and gender identity by asking the parent if they have engaged in any of the behaviors on the rejection and acceptance posters. Start with the rejection poster first.

“The Family Acceptance Project (FAP) has done critical research which shows that how parents respond to their LGBTQ children has a significant impact on their risk and well-being.

FAP has developed education and intervention posters (for other educational resources, see appendix 2) that quickly show how some of more than 100 specific family behaviors that FAP identified and measured – such as preventing a youth from participating in LGBTQ support groups or excluding them from family events and activities because they are gender diverse – contribute to serious health risks. FAP’s research also shows that family supportive and accepting behaviors – like standing up for your child when others mistreat them because of their LGBTQ identity or supporting their gender expression – help protect against risk and promote self-esteem, better health and well-being.

Let’s take a moment to look at these posters so you can see some of the ways that parents and caregivers respond to their LGBT children and youth and how these specific family behaviors contribute to health risks and well-being for your LGBTQ child. We’ll use these posters to identify family experiences to help decrease risk, and increase your LGBTQ child’s well-being.

We’ll spend more time talking about these behaviors during our work together.”

Identifying Rejecting Behaviors – Many parents and caregivers are surprised to learn that behaviors they use to try to change or discourage the youth’s LGBT identity and gender expression are experienced as rejection by the youth. This includes behaviors such as not letting their child have an LGBT friend or participate in an LGBT support group or trying to change their gender expression. This is surprising for parents who believe that their behavior is motivated by care and concern for their LGBT / gender diverse child—to help the youth “fit in,” be respected by others and have a good life.

Parents may feel like they need to explain their motives for engaging in these behaviors. Assure the parent that they will have time to talk about their efforts to care for their child during your work together. Right now, your intent is to identify how they have responded to the youth’s LGBT identity so you can learn about their experiences.

After you have asked about parental behaviors included on the rejection poster, ask the parent if there are other ways they have responded to their child or adolescent that the youth may experience as rejecting, denying or trying to change their LGBT identity. Other rejecting behaviors identified by the youth will be addressed when the Practitioner starts FAP’s psychoeducational work with the parent or caregiver.

After you identify family rejecting behaviors, show the parents FAP's acceptance poster (note that there are 2 versions of FAP's acceptance posters, including a conservative version that substitutes other accepting behaviors for support for dating an LGBT partner). Practitioners should determine which acceptance poster to use based on the family's background and intake information.

Applying FAP's Family Support Strategies – Practitioners are encouraged to attend a FAP training and to read FAP's publications, including FAP's family education booklets which are available online and in print copies, to learn more about FAP's family support approach in working with families with LGBT children and youth. This includes approaches to talk about interactions with their child to help parents and caregivers learn to support their LGBT children.

In FAP's family support framework, a little change makes a difference in decreasing family rejecting behaviors and increasing support for LGBT children and youth. In FAP's model, practitioners start where the parents or caregivers are so the goal is not to expect the same outcome for each parent or family but to help each parent learn to increase support and affirmation within their family system. Thus, the parent doesn't have to change, modify or increase all of more than 100 rejecting and accepting behaviors that FAP identified and measured to support their LGBT child. Some parents move very quickly to support their LGBT child, while others need more time to integrate critical health information with underlying values and beliefs.

Identifying Accepting Behaviors – After you have asked about family rejecting behaviors included on the rejection poster, use one of the posters that show family accepting behaviors to ask the parent about acceptance and support for their LGBT child. Ask them to identify specific accepting behaviors included on the poster that they have engaged in, and then ask them to describe other ways they have tried to affirm or support their LGBT child, and to describe how their child responded.

Be sure to create a list of rejecting and accepting behaviors that the parents has used to respond to their LGBT child to address in other components of care, including behaviors the youth identified that their parent did not mention.

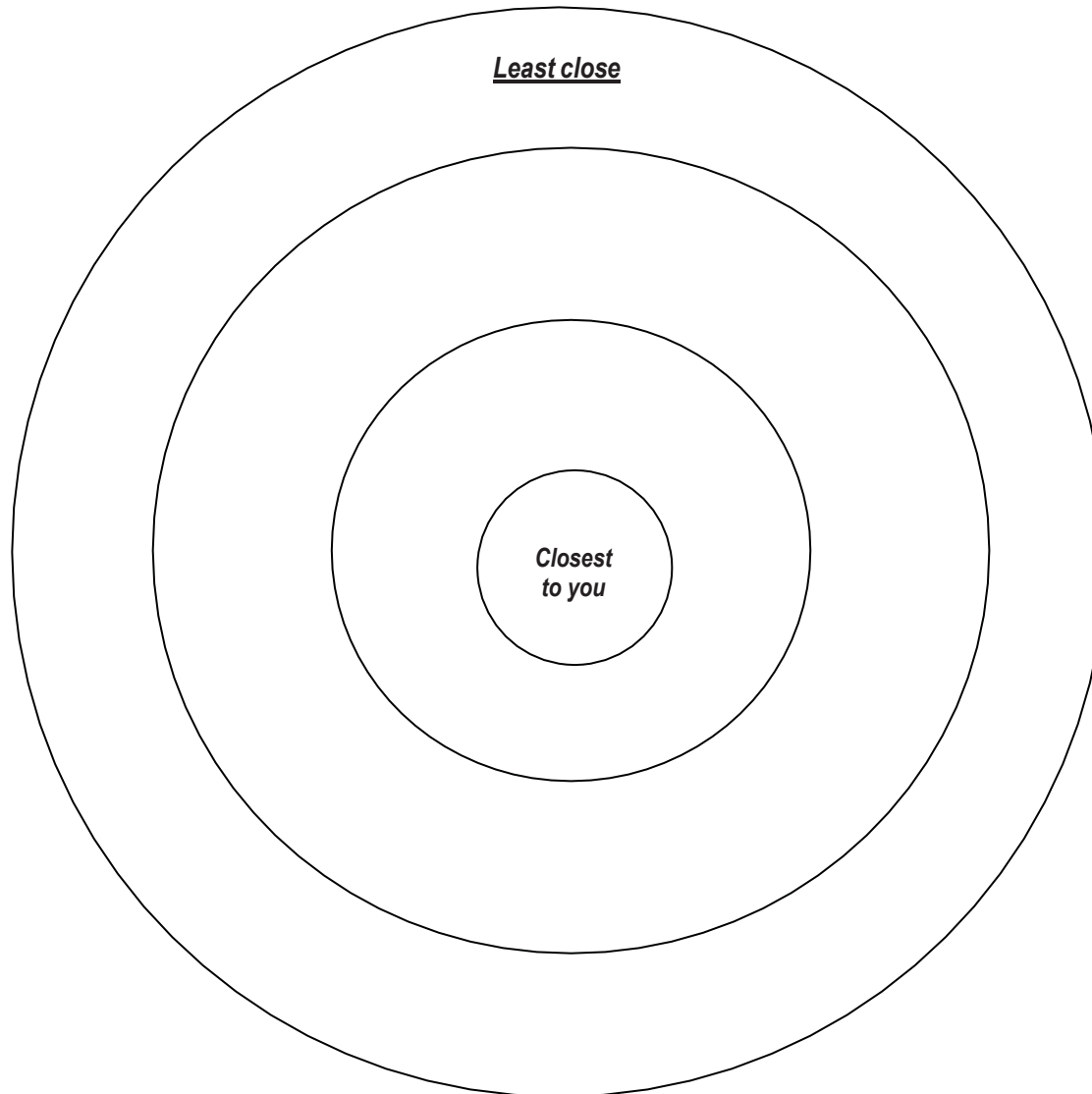
Family Acceptance Project®

SOCIAL SUPPORT MAP – PARENT / CAREGIVER

Name or Case ID: _____

Date: _____

Tell us about the people in your social network (family, friends, etc.) *Put a star next to anyone* who knows about your child's LGBT identity.* Show on the map people who are closest to you and not as close. Who do you turn to for support? Who do you wish would be more supportive? Put a circle around people you can talk with about your child's LGBT identity / gender diversity.



PARENT – YOUR CHILD’S / YOUTH’S GENDER EXPRESSION

Youth ID: _____

Date: _____

People *show* us their gender (being male, female or in between) in ways that range from being very feminine to very masculine

1 2 3 4 5
Very feminine Both feminine and masculine Very masculine

How I expect my Child to Look, Dress, Behave

Put an “x” on the part of the line that best describes **how you expect your child to look, dress, behave** (express their gender identity)

1. How my child looks, dresses and behaves:

1 2 3 4 5
Very feminine Both feminine and masculine Very masculine

How your Child Looks, Dresses & Behaves

Put an “x” on the part of the line that best describes **how your child looks, dresses, behaves** (expresses their gender identity)

2. How my child looks, dresses and behaves:

1 2 3 4 5
Very feminine Both feminine and masculine Very masculine



