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Pepperdine University  
Graduate School of Education and Psychology

DEVELOPING A SUPPLEMENTAL RESOURCE FOR TRAUMA-FOCUSED COGNITIVE-  
BEHAVIORAL THERAPISTS WORKING WITH LESBIAN, GAY, AND BISEXUAL  
ADOLESCENT SURVIVORS OF INTERPERSONAL TRAUMA

A clinical dissertation presented in partial satisfaction  
of the requirements for the degree of  
Doctor of Psychology

by

Paul N. Perales

August, 2017

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This clinical dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirement of the degree of

DOCTOR OF PSYCHOLOGY

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## ABSTRACT

The rates of maltreatment and interpersonal trauma among children and adolescents are astounding. Youth exposed to interpersonal trauma are at increased risk for both short and long-term negative physical, behavioral, and mental health outcomes. Lesbian, gay, and bisexual (LGB) adolescents represent a uniquely vulnerable population. Compared to their heterosexual peers, LGB youth are at increased risk for experiencing interpersonal trauma and sexual violence, including trauma's negative sequelae (e.g., higher rates of PTSD, depression, suicidality, substance abuse, and risky sexual behavior). Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based treatment demonstrating repeated efficacy in treating youth and families exposed to various forms of trauma, including complex trauma. While a breadth of empirical data demonstrates TF-CBT's effectiveness in treating adolescent trauma survivors, additional research suggests that TF-CBT can be culturally modified to enhance its effectiveness and relevance among specific minority populations. Thus, this current study involved development of a supplemental resource manual with culturally sensitive recommendations for TF-CBT therapists working with LGB adolescents. Development of the resource was informed by a review of the literature pertaining to LGB adolescence, interpersonal trauma, and LGB-affirming treatment approaches. Data from this literature review was synthesized and integrated into a supplemental resource manual, which was then reviewed by a panel of three expert clinicians who provided feedback and recommendations via an evaluation form. Results suggested that the resource is a culturally sensitive and useful supplement to the 2006 TF-CBT treatment manual. Strengths, weaknesses, limitations, and recommended improvements are also addressed.

## **Introduction**

Exposure to interpersonal trauma places youth at increased risk for both immediate and long-term mental health impairments. Research of childhood trauma has made clear its adverse effects on the wellbeing and development of youth, including trauma's lifelong impact across various domains of psychological, interpersonal, behavioral, and cognitive functioning. In particular, lesbian, gay, and bisexual (LGB) youth, in comparison to their heterosexual peers, are at increased risk for experiencing not only interpersonal trauma and childhood sexual abuse, but also trauma's negative effects, such as higher rates of posttraumatic stress, depression, suicidality, substance abuse, and risky sexual behavior. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment (EBT) that has demonstrated repeated efficacy in treating youth and families exposed to various forms of trauma, including youth experiencing multiple, chronic, and interpersonal forms of abuse (i.e., complex trauma). While a breadth of empirical data demonstrates TF-CBT's effectiveness in treating adolescent survivors of interpersonal trauma, it should be noted that the majority of the identified and well-researched EBTs for youth have primarily been developed and tested among homogeneous samples of majority group families. As such, further exploration is warranted to determine if cultural modifications of TF-CBT can be utilized to enhance its utility amongst various cultural groups or minority populations, such as LGB youth and their families. Moreover, adapted and modified versions of TF-CBT have been found to enhance the treatment's effectiveness in addressing the unique needs of youth and families from different cultural backgrounds (e.g., Latino, American Indian, and Alaska Native families) and with different developmental needs (e.g., adolescents with complex trauma, children with developmental disabilities). In sum, culturally sensitive modifications to the TF-CBT model or culturally sensitive recommendations for therapists

working with LGB youth could potentially enhance the treatment's acceptability and effectiveness among this population. Helping TF-CBT therapists develop greater awareness of the unique strengths, needs, challenges, and stressors experienced by LGB adolescent trauma survivors and their families, as well as ways to apply and incorporate this knowledge within the TF-CBT treatment model, is hypothesized to increase child and family engagement while decreasing attrition rates. The objectives of the study include:

1. Understanding and exploring the current trauma literature related to LGB youth. More specifically, to understand the prevalence rates, sequelae, and common forms of treatment of interpersonal trauma within this particular minority population.
2. Having a comprehensive understanding of trauma-focused cognitive behavioral therapy (TF-CBT) and ways in which it has been adapted for use with minority populations.
3. Utilizing the knowledge of TF-CBT and issues related to LGB adolescents in order to enhance the TF-CBT model through the development of culturally modified recommendations for clinicians working with LGB adolescents.
4. Strengthening the culturally modified recommendations with the evaluation of experts in each of the following fields: interpersonal trauma, TF-CBT or CBT, child and adolescence, and LGB issues in adolescents/young adults.

### **Prevalence Rates and Effects of Trauma Among Children and Adolescents**

Child and adolescent exposure to interpersonal trauma has been found to increase the risk for both immediate and long-term mental health impairment. Research has shown that traumatic events experienced in childhood are strongly associated with social, psychological, cognitive, and biological impairments (Burns et al., 1998; Cook et al., 2005; Spinazzola et al., 2005). The high prevalence rates of children and adolescents who experience traumatic stressors in

childhood (D'Andrea, Ford, Stolback, Spinazzola, & van der Kolk, 2012) have been extensively studied. It has been found that by the age of 16-years-old, 67.8% of children will experience at least one traumatic event prior to reaching adulthood (Copeland, Keeler, Angold, & Costello, 2007). In the United States alone, the number of adolescents victimized to interpersonal violence is startling; approximately 1.8 million adolescents between the ages of 12 and 17 have been sexually assaulted, 2.1 million severely physically abused as a form of punishment, and 8.8 million reports of witnessing interpersonal violence (Kilpatrick, Saunders, & Smith, 2003). It has also been found that youth exposed to one traumatic event are at significantly greater risk of experiencing multiple traumatic events (Finkelhor, Omrod, & Turner, 2007). Childhood and adolescent trauma exists in many forms, including physical, sexual, and emotional abuse, neglect, community-, peer-, and school-based violence, as well as witnessing intimate partner violence, to name a few (D'Andrea et al., 2012; Gil, 2010). Additionally, studies have found that the severity of trauma symptoms resulting from childhood and adolescent experiences worsens as the child's exposure to an increasing number of forms of trauma increases (Copeland et al., 2007).

Furthermore, researchers studying the impact of traumatic experiences have found that childhood exposure to interpersonal trauma is associated with increased risk of both internalizing and externalizing psychological symptoms (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009), as well as affective and impulse dysregulation problems in adolescence and later adulthood (Ford, Gagnon, Connor, & Pearson, 2011; Trickett, Negriff, Juye, & Peckins, 2011). In fact, researchers have found that traumatized youth with symptoms of PTSD are not only more susceptible to particular psychiatric disorders (e.g., depression, anxiety) and medical conditions, but are also more likely to experience disruptions to healthy childhood development

(Cohen et al., 2010; Felitti et al., 1998; Trickett et al., 2011). For instance, childhood maltreatment and abuse have been associated with disruptions in peer relationships and friendships (e.g., lower perceptions of peer acceptance, less satisfaction with friendships, increased social withdrawal; Feiring, Rosenthal, & Taska, 2000; Trickett et al., 2011), increased delinquency in adolescence (Arata, Langhinrichsen-Rohling, Bowers, & O'Brien, 2007), increased substance use/abuse in adolescence (Arata et al., 2007; Trickett et al., 2011), as well as problematic romantic relationships, dating violence, risky sexual behavior, and increased risk of teen pregnancy (Cyr, McDuff, & Wright, 2006; Noll, Shenk, & Putnam, 2009; Trickett et al., 2011). In addition to this, data collected from the Adverse Childhood Experiences (ACE) Study – a large-scale, longitudinal study examining the relationship between cumulative exposure to traumatic stress during childhood and adult risk behavior, health status, and disease – has repeatedly shown that the effects of childhood trauma have profound impacts on an individual's health later in adulthood (Anda et al., 2006; Brown et al., 2009; Felitti et al., 1998). For instance, Brown et al. (2009) found that individuals with six or more adverse childhood experiences (e.g., being raised in a dysfunctional household environment, physical, sexual, or emotional abuse, neglect, parental discord) were at a significantly increased risk of experiencing premature death in adulthood. Moreover, the effects of childhood interpersonal trauma and posttraumatic stress further contribute to the likelihood of lifelong impairments in domains of interpersonal functioning, emotional regulation, and self-concept (Cloitre et al., 2009; D'Andrea et al., 2012; Margolin & Vickerman, 2007). Consequentially, impaired ability to self-soothe and self-regulate emotions is particularly apparent amongst youth exposed to trauma (Cook et al., 2005), and chronic and repeated exposure to traumatic stress has been associated with enduring patterns of impairment on the brain and endocrine system well into adulthood (Anda et al., 2006).

Furthermore, negative emotions resulting from traumatic experience in childhood, such as excessive guilt, shame, and anger (Negrao, Bonanno, Noll, Putnam, & Trickett, 2005), have been found to play a significant role in posttraumatic outcomes and adjustment (Fletcher, 2011).

Childhood trauma studies have found attribution of self-blame and feelings of guilt to be central reactions to traumatic stressors in childhood (Fletcher, 2011).

These attributions have been found to be strongly associated with negative outcomes, and predictive of more long-term adjustment difficulties (Barker-Collo, 2001). That being said, studies of childhood trauma indicate that in addition to developing PTSD, 40% of children with a history of experiencing any type of trauma, develop at least one mood, anxiety, or disruptive behavior disorder (Copeland et al., 2007). Findings indicate that childhood experiences of sexual and physical abuse are strongly associated with the development of serious psychiatric disorders, as well as impaired externalization and internalization (Trickett & McBride-Chang 1995). More specifically, victims of interpersonal violence are at increased risk of internalizing psychiatric problems (e.g. anxiety, depression) as well as externalizing psychiatric problems (e.g. aggressive behaviors, impulsivity, hyperactivity, substance abuse; Finkelhor et al., 2009). Additionally, Leverich and Post (2006) noted that the experience of trauma during childhood is associated with elevated frequencies of attempted suicide, substance and alcohol abuse, and medical disorders.

### **Trauma Focused-Cognitive Behavioral Therapy**

Trauma Focused Cognitive-Behavioral Therapy (TF-CBT) is an empirically-supported and best-practice treatment approach for addressing the trauma-related symptoms of children and adolescents, including those who have experienced complex and/or ongoing traumatization (Cohen, Mannarino, & Deblinger, 2006; Murray, Cohen, & Mannarino, 2013). A breadth of empirical data supports TF-CBT's efficacy in the treatment of trauma-related symptoms amongst



youth, and it has been repeatedly proven efficacious through the use of randomized controlled trials (RCTs; Cohen et al., 2006). TF-CBT is a flexible, phased-oriented treatment model for traumatized youth, and treatment typically includes involvement of a supportive caregiver or non-offending parent. TF-CBT integrates several established treatment approaches (i.e., cognitive therapy, behavioral therapy, and family therapy), and every session consists of activities and exercises that contribute to the youth's desensitization and gradual exposure to non-threatening trauma reminders. TF-CBT is structured to be a short-term treatment, lasting approximately 12-20 weeks. Sessions typically last from 50-90 minutes, with the therapist meeting with the child first individually, then the parent individually, until the beginning conjoint sessions after the processing of the trauma narrative. TF-CBT targets children between the ages of 3 and 18 years of age experiencing symptoms of posttraumatic stress and other trauma-related issues. The model specifically integrates cognitive-behavioral principles and exposure techniques to address symptoms of depression, anxiety, behavioral problems, and relevant caregiver difficulties. In addition to improving PTSD symptoms, it addresses distorted thoughts and feelings about the self and others, and trauma-related feelings such as guilt and shame (Cohen et al., 2006).

TF-CBT is comprised of 10 individual treatment components, summarized by the acronym *PRACTICE*, which include: Psychoeducation, Parenting Skills, Relaxation Skills, Affective Expression and Modulation Skills, Cognitive Coping and Processing, Trauma Narrative, In-vivo Exposure and Mastery of Trauma Reminders, Conjoint Child-Parent Sessions, and Enhancing Future Safety and Development. As mentioned, gradual exposure is one of the key principles guiding TF-CBT and is included in all components of the model. The graded exposure to the child's traumatic experience within a hierarchical, skills acquisition framework is

an essential aspect of this unique treatment model (Cohen et al., 2006). Thus, this phased-based approach is designed so that the child's mastery of one-component points to the child's readiness for the component that follows. The developmentally sensitive approach of TF-CBT ensures that children learn coping strategies early on, to help them adaptively manage their trauma related-distress. The exposure component of TF-CBT (e.g., trauma narrative) allows the child to create their own story or narrative of their experienced trauma. A variety of exposure exercises encourage the gradual exposure to in-vivo trauma reminders and cues as well, so as to teach the child appropriate ways to manage and control their emotional reactions. Following the completion of the trauma narrative, clients work with the therapist to identify, challenge, and replace cognitive distortions and beliefs. Parent involvement is central to TF-CBT, and has been identified to be an integral part of the model. Parental engagement in treatment is a central focus of TF-CBT, given that it serves to improve parenting skills and parental support of the child, and enhances parent-child communication, which have all been found to be directly related to treatment outcomes in traumatized youth (Cohen et al., 2006).

### **Efficacy of TF-CBT In Treating Traumatic Stress Among Children and Adolescents**

According to Copeland et al. (2007), approximately 65% of children will experience at least one traumatic event before adulthood; and, among those youth, at least 50% will experience multiple traumatic events (Fitzgerald & Cohen, 2012). Given these alarming rates of traumatic exposure, along with the previous discussion of trauma's short and long-term sequelae, there is strong evidence pointing to a need for efficacious child and family treatments. However, Copeland and his colleagues (2007) argue that if left untreated, approximately one-third of those youth exposed to significant traumatic events will also experience symptoms of PTSD, while others may experience additional affective (e.g. labile mood, sadness, fear, anxiety), behavioral

(e.g., avoidant behaviors, sexually inappropriate behavior, school problems, abuse towards others), and/or cognitive difficulties (e.g., self-blame, guilt, low self-concept, shame; Cohen & Mannarino, 2008). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), developed by Cohen et al. (2006), is considered to be among the most efficacious evidence-based treatments for treating youth (ages 3-18) with trauma-related symptomatology and has been found to be effective in treating a wide range of traumatic experiences, including those that are acute, multiple, and even chronic (e.g., child physical, sexual, emotional abuse, neglect, domestic violence, community violence, terrorism, traumatic grief, natural disasters, HIV/AIDS-related traumas, and complex trauma; Cohen & Mannarino, 2008; Fitzgerald & Cohen, 2012). Moreover, TF-CBT has frequently been recognized as the most empirically supported and efficacious treatment for child and adolescent trauma survivors (Fitzgerald & Cohen, 2012). In their systematic review of TF-CBT, Cary and McMillen (2012) identified several reputable organizations recognizing TF-CBT as a highly efficacious treatment. For instance, in a report sponsored by the U.S. Department of Justice, Saunders, Berliner, and Hanson (2003) found TF-CBT to be the most well-supported and efficacious intervention in a comparison of 24 interventions designed to treat child maltreatment. Similarly, the Kauffman Best Practices Project (2004) described TF-CBT as the “best practice” for treating childhood abuse and maltreatment, while the National Registry of Evidence-Based Programs and Practices (NREPP), a sector of the U.S. Department of Health and Human Services (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008), issued TF-CBT a 3.6-3.8 out of 4.0 points on its ability to treat PTSD, depression, and behavioral problems (Cary & McMillen, 2012).

The evidence supporting TF-CBT’s efficacy in treating youth and families affected by trauma is further strengthened by the extensive number of randomized controlled treatment trials

(RCTs) used to evaluate the treatment model (Cohen & Mannarino, 1996, 1998; Cohen, Mannarino, Perel, & Staron, 2007; Deblinger, Lippmann, & Steer, 1996; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Deblinger, Stauffer, & Steer, 2001). While earlier RCTs of TF-CBT demonstrated its efficacy in treating posttraumatic stress in child and adolescent survivors of sexual abuse (Cohen & Mannarino, 1996, 1998; Deblinger et al., 1996; Deblinger, Steer, & Lippmann, 1999; Fitzgerald & Cohen, 2012), subsequent RCTs have further demonstrated its efficacy in improving the PTSD symptoms of youth from more diverse populations and cultural backgrounds, as well as youth with different types of trauma, including exposure to complex trauma (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Iyengar, 2011; Dorsey et al., 2014; Jensen et al., 2013; O’Callaghan, McMullen, Shannon, Rafferty, & Black, 2013). For example, Cohen and her colleagues (2004) conducted a study that found TF-CBT to be highly efficacious when used with youth who have experienced more than one traumatic event. Similarly, Cohen et al. (2011) found that TF-CBT was highly effective in treating youth with domestic violence-related PTSD symptoms and whose families were seeking treatment through a community-based domestic violence center. The study’s authors also found that a modified version of TF-CBT, which emphasized issues of safety, was efficacious in reducing the children’s PTSD and anxiety symptoms, as well as preventing further adverse events, despite the children’s exposure to ongoing domestic violence (Cohen et al., 2011).

In RCTs comparing TF-CBT to other interventions designed to address child maltreatment and abuse, such as nondirective, supportive therapies, child-centered therapies (CCTs), and treatment as usual (TAU), as well as in comparison to waitlist control groups and community control conditions (Cohen et al., 2011; Deblinger et al., 1996; King et al., 2000), the efficacy of TF-CBT has been found to be superior (Fitzgerald & Cohen, 2012; Jensen et al.,

2013). Additionally, Deblinger, Mannarino, Cohen, and Steer (2006), found TF-CBT to be more efficacious than child-centered therapy (CCT) in treating more severe cases of childhood trauma, such as those youth experiencing multiple traumatic events and symptoms of both depression and PTSD (Deblinger et al., 2006). Furthermore, studies of TF-CBT with a 1-2 year follow up found that those treated with TF-CBT experience ongoing benefits relative to other treatment conditions, and that youth attained faster relief from depression and behavioral difficulties than the control groups (Cohen et al., 2004; Cohen, Mannarino, & Knudsen, 2005; Deblinger et al., 1996; Deblinger et al., 2006; Deblinger et al., 1999). Lastly, TF-CBT has been found to reduce feelings of trauma-related shame, and these benefits appear to have been maintained at a one-year follow-up (Deblinger et al., 2006).

As previously mentioned, it is not uncommon for youth being treated for trauma-related symptoms to have been exposed to multiple forms of trauma (e.g., maltreatment, neglect, witnessing domestic violence, sexual abuse, physical abuse), especially among adolescents, socially marginalized youth, or youth from high-risk communities (Copeland et al., 2007; Kliethermes & Wamser, 2012; Lanktree et al., 2012; Trickett et al., 2011). Exposure to multiple traumas can greatly impact a child's ability to develop secure attachments, form a positive self-concept, and self-regulate affectively, biologically, and behaviorally (Cook et al., 2005). While many RCTs tend to focus on a singular type of trauma, such as physical or sexual abuse, leading many clinicians to doubt the efficacy of evidence-based treatments (EBTs) in treating youth experiencing multiple and chronic forms of interpersonal trauma (Amaya-Jackson & DeRosa, 2007), TF-CBT has demonstrated efficacy in treating both acute and complex forms of trauma (Cohen, Mannarino, Kliethermes, & Murray, 2012). For example, O'Callaghan et al. (2013) conducted an RCT in the Democratic Republic of Congo (DRC), a war-torn country with high

rates of child sexual victimization, in order to assess TF-CBT's efficacy in treating multiply traumatized and sexually exploited young girls between the ages of 12 and 17. These youth had been exposed to multiple forms of interpersonal trauma, including sexual violence and frequent disrupted attachments; and, with a mean of 11.9 different types of trauma, as well as multiple trauma symptoms, including PTSD, depression, anxiety, and conduct problems, they clearly met criteria for complex trauma (O'Callaghan et al., 2013). Furthermore, utilizing a culturally modified version of TF-CBT, which included sexual violence prevention education disseminated by female administrators, well-known Congolese stories, songs, and references, Swahili translation, and efforts to reintegrate sexual trauma survivors – often socially ostracized due to cultural stigma – back into their families and communities, O'Callaghan et al. (2013) found that TF-CBT significantly reduced the youths' symptoms of PTSD, depression, anxiety, and conduct problems, while increasing prosocial behaviors. Furthermore, these gains were found to have been sustained at a 3-month follow-up (O'Callaghan et al., 2013). In sum, this study by O'Callaghan and colleagues demonstrates TF-CBT's efficacy in treating adolescent survivors of complex trauma in multicultural settings, especially when modifying the treatment to meet the youth's unique cultural and contextual variables or needs. Thus, further research is warranted to determine if culturally sensitive and relevant modifications or recommendations can be used to enhance the TF-CBT model, whereby increasing its attractiveness, effectiveness, and applicability to adolescent trauma survivors from other minority populations.

### **Towards Adapting or Modifying Evidence-Based Treatments**

Given the breadth of empirical data demonstrating TF-CBT's efficacy in treating PTSD symptoms and other trauma-related outcomes amongst youth (Cohen & Mannarino, 1993, 1996, 1997, 1998; Deblinger et al., 1999), further exploration is warranted to determine if cultural

modifications or adaptations of TF-CBT can be used to enhance its utility amongst specific cultural groups or minority populations. Over the past two decades, a growing body of research literature has urged practitioners and researchers to consider cultural and contextual variables, such as language, gender, socioeconomic status, and minority status, as relevant to the development of a competent, evidence-based psychological practice (EBPP; American Psychological Association [APA], 2003, 2006; Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Cardemil, 2010; Task Force on Promotion and Dissemination of Psychological Procedures, 1995; Whaley & Davis, 2007). Amaya-Jackson and DeRosa (2007) noted that there is often strong debate among clinicians over what constitutes evidence-based practice (EBP), as well as how and if such treatments are able to meet the needs of culturally diverse populations and children presenting to treatment with complex forms of trauma. However, they assert that “evidence-based practice typically incorporates systematic assessment, requires clear articulation of treatment goals, and implementation of core components of the treatment in combination with ongoing monitoring and outcome assessment” (Amaya-Jackson & DeRosa, 2007, p. 379). Thus, under this broad definition of competent clinical practice, clinicians are expected to integrate the best available research evidence with their own clinical judgment and expertise, while taking into consideration the client’s unique values, preferences, and circumstances (Amaya-Jackson & DeRosa, 2007). Moreover, according to the APA, empirically-supported or evidence-based treatments (EST/EBTs) should be differentiated from EBPs in that they require more robust empirical validation (i.e., empirical support from two or more experimental studies, with at least some of the research conducted by those who are not the creators of the treatment) and must be manualized (Task Force on the Promotion and Dissemination of Psychological Procedures, 1995). Thus, given the manualization of TF-CBT and the repeated RCTs demonstrating it

efficacy, TF-CBT has been considered an empirically supported treatment (Cohen et al., 2006). Furthermore, a number of published guidelines have emphasized the need for culture to inform the development and selection of ESTs, especially for use with youth from varying ethnocultural backgrounds (e.g., APA, 2003; Bernal, Bonilla, & Bellido, 1995; Cardemil, 2010; de Arellano, Ko, Danielson, & Sprague, 2008). For example, a 2003 APA joint task force consisting of Divisions 17 (Counseling Psychology) and 45 (The Society for the Psychological Study of Ethnic Minority Issues) proposed a comprehensive set of guidelines encouraging psychologists to consider the influence of culture in terms of their clients' experiences, the practitioner's own experience and how that may, in turn, affect the therapeutic relationship, as well as the application of multiculturalism in education, training, research, practice, and organizational change. More specifically, Guideline #5 of the report identified the need for psychologists to apply culturally appropriate skills in the practice of clinical interventions, whereby urging clinicians to expand traditional psychotherapeutic interventions to include multicultural awareness and culture-specific strategies. Additionally, the report encourages psychologists to recognize that culture-specific therapy (individual, family, and group) may require nontraditional interventions, such as enlisting the help of respected community leaders or taking into consideration the effects and appropriate use of translation services.

While some have argued that any manualized treatment or related EBT runs the risk of creating a one-size-fits-all approach to intervention (Addis, Cardemil, Duncan, & Miller, 2006; Westen, Novotny, & Thomspon-Brenner, 2004), others, such as Kendall and Beidas (2007), have taken a more pragmatic stance by calling for increased flexibility with EBTs within a framework of fidelity. In alignment with this argument, numerous authors have advocated for systematic adaptations to manuals or EBTs in which culture, language, and socioeconomic contexts are



more explicitly considered (Bernal et al., 2009; Hall, 2001; Sue, Bingham, Porche-Burke, & Vásquez, 1999; Trimble & Mohatt, 2002). Much debate, however, has arisen over how to define cultural modification, as well as how to delineate the process by which evidence-based treatments may be adapted (Griner & Smith, 2006); and, others, more specifically, have questioned *how* and *when* to incorporate such cultural considerations into empirically-supported treatments (Comas-Díaz, 2006; Elliot & Mihalic, 2004; Lau, 2006).

In response to this lack of clarity, Bernal et al. (2009) reviewed the available published frameworks for cultural adaptations of EBTs and provided helpful definitions, as well as a number of key arguments favoring the cultural adaptation of treatments. These authors defined cultural adaptation as “the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client’s cultural patterns, meanings, and values” (Bernal et al., 2009, p. 362). They further assert that a careful description of the methodological process used in developing an evidence-based cultural adaptation may provide a potential framework for future systematic treatment adaptations, whereby increasing their responsiveness to the particular needs of culturally diverse clients. Moreover, one of the central arguments offered by these authors and other proponents of cultural adaptation is that of ecological validity. According to this argument, increasing the congruence between the client’s cultural context and the properties of the particular treatment being used ultimately serves to enhance cultural sensitivity (Bernal et al., 1995). For instance, incorporating aspects of the client’s cultural identity and community (e.g., language and culture specific metaphors) into the treatment process is likely to increase client participation and engagement; however, ignoring the client’s cultural experiences and values is more likely to lead to disengagement. Thus, culturally sensitive adaptation may bridge a

significant gap between research and practice, given that the majority of well-researched EBTs for youth have been developed and tested in research settings with primarily homogenous samples of majority group families (Cardemil, 2010; Constantine, Miville, & Kindaichi, 2008; Lau, 2006). Lau (2006), among others (Morrison, Bradley & Westen, 2003), has argued that there is reasonable concern regarding the external validity of many EBTs and asserts that, as a consequence, a lack of ecological and social validity may affect the acceptability and viability of the intervention when implemented in a particular community setting. For instance, Lau (2006) noted that when treatment participants view component treatment strategies as “irrelevant, unhelpful, or unacceptable,” (p. 299) they may be less inclined to engage in the treatment and are likely to exhibit higher rates of attrition. In a report by the U.S. Surgeon General, a review of the literature on ethnic minority mental health found evidence to support significant disparities in care and resulted in the following conclusions: minorities have less access to and availability of mental health resources; minorities are less likely to receive necessary mental health services; minorities in treatment are more likely to receive a poorer quality of mental health care; and, minorities are significantly underrepresented in mental health research, especially with regards to evidence-based treatments (Miranda, Nakamura, & Bernal, 2003; U.S. Department of Health and Human Services [USDHHS], 2001).

Another argument supporting the adaptation of EBTs is the evidentiary argument. Bernal et al. (2009) argued that there is a preponderance of research literature supporting the need for cultural adaptations based upon the relationship between cultural variables (e.g., interdependence, spirituality, and discrimination) and particular ethnocultural groups’ levels of engagement and attitudes toward treatment (Cauce et al., 2002; Hall, 2001; Sue, 1998). For example, evidence from large archival studies of mental health centers have shown that ethnic

minority clients who are matched with therapists of their own ethnicity and who speak the same language tend to remain in therapy longer than those not matched on these same variables (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). While more contemporary meta-analyses of ethnic match and psychotherapy have found similar results, small effect sizes indicate that ethnic match alone is a weak predictor of either retention in therapy or an increase in the use of therapy sessions (Maramba & Hall, 2002). In response to these findings, Zane et al.'s (2005) research on the relationship between client-therapist cognitive matching and treatment outcomes elaborated on some of the mechanisms likely contributing to enhanced client engagement within ethnically matched dyads. Their findings suggested that ethnically-matched dyads appear to be more effective due to client-therapist similarities in terms of problem perception and attitudes about coping and treatment goals, each of which, potentially, can be enhanced through increased cultural sensitivity and training. Similarly, Bernal, Bonilla, Padillo-Cotto, and Perez-Prado (1998) demonstrated that improving cultural competence through the incorporation of culturally sensitive criteria (e.g., considering the language, metaphors, context, and goals for specific minority or cultural groups) has been shown to improve the development of the therapeutic alliance by enhancing client-therapist communication and trust, and has also contributed to the retention of diverse ethnocultural clients in treatment.

Lastly, and perhaps most critical to the argument supporting the use of EBTs and culturally adapted treatments has been the increasing number of research studies evaluating the efficacy of treatments with ethnic minorities and culturally adapted interventions. For instance, two recent meta-analyses of culturally adapted treatments for ethnic minorities have shown promising preliminary results (Griner & Smith, 2006; Huey & Polo, 2008). In a review of 76 culturally adapted interventions, Griner and Smith (2006) found a moderately strong benefit of

culturally adapted interventions ( $d = 0.45$ ), however, their analysis also revealed a wide range in types of cultural adaptations reported, including a frequent failure to describe the cultural adaptation process used. Additionally, Huey and Polo's (2008) meta-analysis of EBTs for ethnic minority youth revealed overall treatment effects of medium magnitude ( $d = 0.44$ ), suggesting that, in comparison to the control group, 67% of the minority youth treated reported improved symptoms post-treatment. While it is encouraging that Huey and Polo's review of the literature suggests that there are currently EBTs available that appear to be efficacious for use with ethnic minority youth, the authors, among others, have also pointed out significant limitations to their study, such as low statistical power, small sample size, and poor representation of less acculturated youth (Bernal et al., 2009). Furthermore, with regards to TF-CBT specifically, despite Huey and Polo's findings that TF-CBT was "probably efficacious" for use with ethnic minority youth, and given the aforementioned limitations of their study, as well as the arguments made for culturally modifying EBTs, a number of culturally adapted versions of TF-CBT have emerged and are beginning to demonstrate both fidelity to the model and ecological validity amongst diverse ethnocultural groups.

A prime example of a well-designed, culturally adapted model of TF-CBT is culturally modified TF-CBT (CM-TF-CBT). Developed by Cohen and her colleagues, CM-TF-CBT is a trauma-related intervention designed to specifically and flexibly address the unique needs and cultural values of Latino children and their families (de Arellano, Danielson, & Felton, 2012). The development of CM-TF-CBT was informed by the theoretical and research literature on treatment with Latino populations, the authors' own qualitative and quantitative research with trauma-exposed Latino populations, as well as their extensive clinical experience providing TF-CBT to Latino children and their families. The authors adapted the model to incorporate

common themes or cultural constructs relevant to various Latino families and communities, such as the importance of spirituality/religion, traditional gender roles (e.g., *machismo/marianismo*), involvement of the extended family in treatment, conservative beliefs about sex and the importance of virginity, and traditional childrearing practices. Further modifications to CM-TF-CBT were made based upon feedback from focus groups consisting of Latino caregivers and providers serving Latino families from differing geographic regions, nationalities, socioeconomic statuses, and immigration/citizenship statuses (de Arellano et al., 2012). Feedback regarding the acceptability, cultural relevance, and effectiveness of the treatment led to the inclusion of increased psychoeducation to parents and children about mental health problems and treatment, increased efforts to involve Latino fathers in the treatment, and an increased emphasis on therapists' cultural sensitivity and willingness to address other clinically relevant issues (e.g., general parenting problems, immigration issues, and acculturative stress). Additionally, the authors offered culture specific strategies for enhancing engagement among Latino families, for instance, considering the role that *personalismo* and *respeto* play in the development of a strong therapeutic relationship. Overall, CM-TF-CBT maintains fidelity to the original model while flexibly incorporating relevant cultural values for each particular Latino family throughout each of the treatment modules. Moreover, Cohen and colleagues assert that the adaptation process used in CM-TF-CBT may serve as a model for tailoring trauma-informed interventions for other cultural groups (de Arellano et al., 2012).

A second example of culturally adapting TF-CBT is offered by Walker, Reese, Hughes, and Troskie (2010), who address the relevance of religious and spiritual issues in TF-CBT for child and adolescent survivors of physical and sexual abuse. Utilizing three case studies as a guide for incorporating specific intervention adaptations, they offer suggestions for assessing and

treating religion and spirituality throughout each of the treatment modules. In each of the clinical examples, religion and spirituality play a central role in the youth's clinical presentation. Each case differs, however, in terms of the role that the parents' religiousness played in treatment, the potential for religion to be used as an adaptive coping tool, and the effect of the abuse on the client's personal religious and spiritual functioning. The aim of this adapted intervention was to assist clients in processing changes between their pre-existing religious and spiritual functioning and their beliefs or feelings about religion/spirituality after the abuse. In terms of assessment, the authors offered suggestions such as assessing the potential role of religion and spirituality in intensifying or reducing the client's trauma-related symptoms (Walker, Reid, O'Neill, & Brown, 2009). They maintained that moving from a broad to a more specific assessment of the client's spiritual beliefs would facilitate clinicians in adapting components of the modules such that they address client's specific religious and spiritual concerns. Furthermore, based upon these assessments, the authors provide examples of incorporating religious or spiritual values into each of the interventions prescribed by the particular TF-CBT module. For instance, throughout different modules, such as the cognitive coping and processing modules, the authors utilized religious passages from the Qu'ran, the Bible, and the Torah, depending on the client's particular religious identification, in order to increase client engagement and the relevance of the skills being taught. Additionally, Walker and his colleagues maintained that while it is not the role of the therapist to answer or offer reasons for why God might have allowed the client to suffer from the particular trauma, it is the role of the therapist to "bear witness to the client's spiritual struggles related to meaning, purpose of the trauma, and suffering" (Walker et al., 2010, p. 178). Lastly, the authors also encourage involving the youth's parents in a discussion of the youth's

religious or spiritual issues, such as anger at God for allowing a trauma to happen, arguing that it can help youth feel supported and validated by their parents as well.

A final example of a well-established cultural modification of TF-CBT is BigFoot and Schmidt's (2010) Honoring Children, Mending the Circle (HC-MC), which was designed to treat the unique needs of traumatized American Indian and Alaska Native (AI/AN) youth by incorporating and affirming the cultural views and values held by their community. According to BigFoot and Schmidt (2010), TF-CBT was selected as an appropriate treatment model for traumatized AI/AN youth because its core principles were found to be compatible with many of the traditional tribal healing and cultural practices of American Indians and Alaska Natives. BigFoot and Schmidt specifically identified the centrality of support provided by caregivers and family members, the importance of attending to and listening to children, the use of ceremonies and storytelling to share experiences, the interplay of emotions, beliefs, and behaviors, as well as the identification and expression of feelings, as both consistent with TF-CBT and central to the AI/AN culture. Moreover, BigFoot and Schmidt partnered with tribal programs in order to identify, design, test, and refine the program. Thus, in the process of adapting the TF-CBT model to enhance its effectiveness amongst AI/AN community members, they enlisted the help of community tribal leaders and stakeholders (e.g., tribal leadership, consumers, traditional and society helpers and healers), local programs (e.g., schools, tribal colleges, behavior health, law enforcement, etc.), and other providers, who assisted in incorporating the beliefs, practices, and understandings of distinctive tribal cultures into the overall HC-MC model. Common themes generated from contact with these tribal community partners, which, in turn, formed the foundation of the HC-MC model, included the significance of the extended family, practices regarding respect, beliefs regarding the sacred symbol of the Circle, and the relationship between

spirituality and healing. For example, one of the more distinctive features of this adaptation is the incorporation of a widely recognized AI/AN symbolic circle, the Medicine Wheel. The wheel represents particular core AI/AN worldviews, such as the belief that existence is dynamic and that all things are interconnected and have a spiritual nature (BigFoot & Schmidt, 2010).

Moreover, the HC-MC model defines well-being as “balance and harmony both within and among one’s spiritual, relational, emotional, mental, and physical dimensions” (BigFoot & Schmidt, 2010, p. 851). Using the model of the Medicine Wheel, HC-MC places spirituality at the center of the circle, representing the AI/AN belief that the four physical dimensions (e.g., relational, emotional, mental, and physical) are inextricably intertwined with the spiritual dimension, which is at the core of the individual. Thus, the Medicine Wheel represents a culturally adapted expansion of TF-CBT’s core concept of the “cognitive triangle.” Furthermore, BigFoot and Schmidt (2010) offer component worksheets to help clinicians determine the range of an AI/AN client’s cultural affiliation and its implications for treatment, as well as opportunities for clinicians to address the relational, emotional, cognitive, physical, and spiritual sections within each of the traditional PRACTICE components of TF-CBT.

### **A Rationale for Developing Culturally Sensitive Treatments Specific to LGB Youth**

**Prevalence of LGB youth.** It is difficult to accurately estimate the prevalence of lesbian, gay, and bisexual (LGB) adolescents, or sexual minority orientation youth (SMY), within the United States. A variety of factors, such as the stigma associated with sexual minority identification (Hunter & Hickerson, 2003), complex, evolving, and inconsistent sexual identity labels (Austin, Conron, Patel, & Freedner, 2007; Rosario et al., 1996; Saewyc, 2011), the ongoing process of sexual identity development (Institute of Medicine [IOM], 2011; Ott, Corliss, Wypij, Rosario, & Austin, 2010; Patton & Viner, 2007; Savin-Williams & Ream, 2007), and the



limited use of probability sampling in nationally representative studies (IOM, 2011; Shields et al., 2013), have contributed to this limited demographic information. More recent research utilizing school-based, population-based, and nationally representative samples of sexual minority youth, however, have started to explore and distinguish important demographic characteristics, such as sexual minority identification, same-sex sexual activity, and same-sex attraction, in turn, offering more informative, yet still tentative, prevalence statistics (Savin-Williams & Ream, 2007; Ueno, 2005). In a recent report by the CDC, Kann et al. (2011) analyzed data on sexual minority youth collected from a national survey, the Youth Risk Behavior Survey (YRBS), which was conducted among large population-based samples of public school students in grades 9–12, during 2001–2009, across seven states—Connecticut, Delaware, Maine, Massachusetts, Rhode Island, Vermont, and Wisconsin—and six large urban school districts—Boston, Chicago, Milwaukee, New York City, San Diego, and San Francisco. According to the report, data from the high school administration sites produced a range of LGB population estimates from 3.9% to 7.8%. Also using the YRBS, Shields and her colleagues (2013) sought to estimate the size of the LGBT population of middle school students (grades 6–8) within the San Francisco Unified School District (SFUSD), which in 2011 became the first district in the country to include survey items on both sexual orientation and gender identity on their middle school Youth Risk Behavior Survey. Based upon the population estimates of their study, 3.8% of students in the SFUSD middle schools identified as LGB (with 1.7% identifying as gay/lesbian and 2.1% as bisexual), and, consistent with other studies, across available demographic variables, the proportion of LGB youth appeared to increase with age. Taking this into consideration with data from other studies indicating that LGB youth are self-identifying at younger ages (Floyd & Stein, 2002), whereby increasing their risks for family rejection and

school harassment than those who wait to openly identify as LGB in young adulthood (D'Augelli et al., 1998), it appears that developing therapeutic interventions specifically targeting sexual minority concerns during early-to-late adolescence is of critical importance.

**Increased exposure to interpersonal trauma among LGB youth.** Despite variable population data, there is consistent evidence demonstrating higher rates of early-life adversity and exposure to trauma among sexual minority youth as compared to youth with heterosexual orientations or opposite-sex only attractions (McLaughlin, Hatzenbuehler, Xuan, & Conron 2012; Roberts, Austin, Corliss, Vander Morris, & Koenen, 2010; Rothman, Exner, & Baughman, 2011). Numerous studies have found that sexual minority orientation individuals report higher rates of frequency, severity, and persistence of childhood sexual abuse and assault (Austin et al., 2008; Balsam, Rothblum, & Beauchine, 2005; Corliss, Cochran, & Mays, 2002; Herek, 2009; Pilkington & D'Augelli, 1995; Saewyc et al., 2006). In a nationally representative sample, Roberts and her colleagues (2010) reported a number of significant findings on the prevalence of traumatic exposure among U.S. sexual minorities in comparison to non-sexual minorities, including the following: LGB individuals have a significantly elevated risk of having been exposed to a wider variety of traumatic events, are twice as likely as to have been exposed to violence, are more likely to have experienced childhood maltreatment and interpersonal violence, and are more likely to have experienced their most traumatic event at a younger age. The literature also offers evidence of higher rates of victimization experiences stemming from family and romantic relationships in childhood and adolescence, including disproportionate exposure to physical and sexual victimization by intimate partners (Balsam, Rothblum, & Beauchine, 2005; Corliss et al., 2002; Tjaden et al., 1999). Additionally, in comparison to their heterosexual counterparts, sexual minority adolescents are significantly more likely to be

targeted for violence in every setting (Coker, Austin, & Schuster, 2010), including a greater likelihood of experiencing both verbal and physical sexual harassment at school and in their communities (DuRant, Krowchuk, & Sinal, 1998; Faulkner & Cranston, 1998; Robin et al., 2002; Russell, Franz, & Driscoll, 2001; Williams et al., 2003). Data collected from a large scale, school-based population of Massachusetts youth, grades 9-12, who were randomly selected from 50 public high schools (Massachusetts Department of Education, 2004), found that students who identified as LGB or had same-sex contact were significantly more likely than their heterosexual peers to have been bullied (42% vs. 21%), threatened or injured with a weapon (22% vs. 5%), skipped school because they felt unsafe (15% vs. 4%), to have experienced dating violence (30% vs. 9%), or to have experienced forced sexual contact (41% vs. 8%). Furthermore, there is also evidence that LGB adolescents are at an elevated risk for experiencing homelessness (Corliss et al., 2011; Rice et al., 2013). In the first nationally representative estimate of homelessness among sexual minority youth, approximately 1 in 10 LGB adolescents were found to have experienced homelessness, more than twice the rate among heterosexuals in the same study (McLaughlin et al., 2012). Taken together, these increased rates of exposure to trauma among sexual minority youth place them at significantly greater risk for developing adverse physical and mental health outcomes, much of which are well documented in the literature.

In addition to this, given that youth are beginning to come out earlier (i.e., between 10-14yrs old), often while they are still living at home and dependent upon their parents or family, not only for social and emotional support, but financial and instrumental support as well, LGB adolescents face the unique stressor of having to negotiate how and when to come out to family, friends, peers, and others (LaSala 2010; Rosario, Schrimshaw, & Hunter, 2009; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). In general, when they do come

out to their families, adolescents often report lower levels of family connectedness and parental support than their heterosexual peers, especially in the period immediately following disclosure (Eisenberg and Resnick, 2006; Needham & Austin, 2010; Saewyc et al., 2009; Savin-Williams, 1998). Several researchers have identified rejection of a youth's sexual orientation by their parents as one of the greatest stressors facing LGB adolescents (Bregman, Malik, Page, Makynen, & Lindahl, 2013; D'Augelli & Hershberger, 1993). In a study of 81 LGB youths (ages 14-25), Willoughby, Doty, and Malik (2010) found that family rejection of sexual orientation had a significantly negative impact on LGB identity development. LGB adolescents who anticipate negative reactions from their parents are less likely to disclose their sexual orientation, and, as a result, may become emotionally distant from parents and other sources of family support (Savin-Williams 1998). Moreover, in a study of victimization among LGB youth, D'Augelli (2006) found that many reported verbal abuse from their mothers (13%) or feared verbal abuse from their parents (30%) due to their sexual orientation. Also within that study, 13% of the youth reported living in fear that a parent would physically abuse them. In another study, 50% of LGB adolescents experienced a negative reaction from their parents when they came out and 26% were ejected from their homes (Remafedi, 1987). Furthermore, Waldo, Hesson-McInnis, and D'Augelli (1998) found that in addition to disclosure as a trigger for family maltreatment, LGB youth who do not conform to social and cultural gender norms are at an even higher risk for parental rejection and are more likely to experience violence perpetrated by their families and communities. D'Augelli, Grossman, and Starks (2006) further noted that since gender-nonconforming LGB youth are more likely to fear or anticipate rejection from their parents, they often conceal or delay disclosure, again, making them increasingly vulnerable to sexual orientation violence and future mental health problems.

**Health disparities among LGB youth related to increased trauma exposure.** In terms of health disparities and the effects of increased exposure to trauma during childhood, the results of nearly all population-based studies, regardless of sampling methods, measures of sexual orientation, geographic location, or time, consistently indicate that sexual minority youth experience greater rates of emotional distress, depression, anxiety, self-harm, suicidal ideation, and suicide attempts than their heterosexual counterparts (Coker et al., 2010; King et al. 2008; Saewyc et al., 2007), with several studies estimating that at least one-third of LGB adolescents have either contemplated or attempted suicide (D'Augelli, Hershberger, & Pilkington, 2001; Fergusson, Horwood, & Beautrais, 1999; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999). In addition, population-based data indicate that adolescents who identify as LGB are 3-4 times more likely to meet diagnostic criteria for an internalizing disorder and 2-5 times more likely to meet criteria for an externalizing disorder than their heterosexual peers (Fergusson et al., 1999). Research has also found elevated rates of PTSD among sexual minorities in comparison to heterosexuals, with Roberts et al. (2010) finding that sexual minority young adults are at a significantly increased risk for lifetime probable PTSD due to higher exposure to childhood abuse. According to a meta-analysis of sexual orientation related health disparities, Marshal et al. (2008) found that sexual minority youth are also nearly three times more likely to report substance use than heterosexual adolescents, including higher prevalence rates of smoking, alcohol use, and other drug use, such as injection drug use. Furthermore, increased risk of homelessness places LGB youth at greater risk for being exposed to violence and victimization, as well as increases their risk of teen pregnancy or engaging in risky sexual behaviors, such as not using condoms, survival sex, or prostitution (Coker et al., 2010; Saewyc et al., 2008).

**Culturally-sensitive treatments for LGB youth.** Unfortunately, despite these alarming statistics, there is a dearth of literature pertaining to culturally sensitive treatments for sexual minority youth exposed to various forms of interpersonal trauma, and, more broadly, for all LGB people, suggesting a greater need for LGB-specific interventions in general (King, Semlyen, Killaspy, Nazareth, & Osborn, 2007). For the most part, culturally sensitive interventions for sexual minority youth have focused on the multicultural competence of the practitioner or the use of evidenced-based practices rather than tailoring treatments themselves to address specific sexual minority-related concerns. For example, Hays (2009) has provided a framework for integrating multicultural considerations, such as one's sexual orientation, into the practice of cognitive-behavioral therapy, highlighting the natural fit between multicultural therapy and CBT. Moving towards greater specificity, however, Craig, Austin, and Alessi (2013) have developed a more clearly defined adaptation of CBT for sexual minority youth that integrates minority stress theory and gay affirmative practices into an existing evidence-based CBT model. Within their ten-component model, specific sexual minority youth issues such as coming out, managing stigma and discrimination, and exploring the role of social support and community, are addressed. As noted by the authors and others, LGB-affirmative therapy is not an independent practice approach, but rather a mode of enhancing a practitioner's existing treatment model by normalizing and affirming the client's sexual identity while combating and "deprogramming" feelings of difference and shame, which are often perpetuated by stigma and marginalization (Alessi, 2014; Davies, 1996; King et al., 2007). As such, the model presented by Craig et al. (2013) only provides a framework for addressing issues of sexual minority stress within a broader CBT context, and the authors acknowledge the model's limitations with regards to addressing more serious types of clinical issues. Still, there is evidence to suggest that targeted or

modified mental health interventions for LGB individuals may increase treatment acceptability, retention, and effectiveness. Preliminary findings from an adaptation of attachment-based family therapy (ABFT) for use with suicidal LGB adolescents has shown significant reductions in study participants' suicidal ideation and depressive symptoms (Diamond et al., 2012); and, in a similar study, researchers demonstrated that methamphetamine-dependent gay and bisexual men given "gay-tailored" cognitive behavioral therapy (CBT) showed more rapid declines in depressive symptoms and methamphetamine use as compared to those given traditional CBT or other general interventions (Jaffe, Shoptaw, Stein, Reback, & Rotheram-Fuller, 2007). Moreover, in a concerted effort to bridge the gap between clinical research and practice, these findings suggest a valid need to develop interventions specifically addressing the unique concerns of sexual minority youth affected by interpersonal trauma.

## **Methodology**

### **Rationale for This Project**

Although TF-CBT has been found to be “probably efficacious” for use with ethnic minority youth (Huey & Polo, 2008), several published guidelines have emphasized the importance of improving culturally competent treatment (APA, 2003; 2006; Bernal, Bonilla, & Bedillo, 1995; de Arellano, Ko, Danielson, & Sprague, 2008; Cardemil, 2010), including TF-CBT’s authors, who support continuing adaptation of their model and have adapted it for use with Latino populations (de Arellano, Danielson, Felton, 2012). Utilizing Anna Lau’s (2006) conservative approach to EBT adaptation, an LGB-specific adaptation of TF-CBT is warranted on the basis that the symptoms of trauma being treated by TF-CBT in LGB youth are likely to be related to or influenced by their sexual minority status, and, thus, selective and directed modifications would likely enhance community engagement and the relevance of treatment content. For instance, in regards to sexual minority youth, there is consistent evidence demonstrating higher rates of childhood abuse, early-life adversity, and exposure to trauma, (McLaughlin et al., 2012; Roberts et al., 2010; Rothman, Exner, and Baughman, 2011), as well as evidence that LGB youth are significantly more likely to be targeted for violence across a multitude of settings (Coker, Austin, & Schuster, 2010), including a greater likelihood of experiencing both verbal and physical sexual harassment at school and in their communities (DuRant, Krowchuk, & Sinal, 1998; Faulkner & Cranston, 1998; Robin et al., 2002; Russell, Franz, & Driscoll, 2001; Williams, Connolly, Pepler, & Craig, 2003). Additionally, Roberts et al. (2010) found an elevated risk of posttraumatic stress in sexual minority youth due to increased childhood abuse and other more culture-specific contextual variables such as gender nonconformity, which has been associated with increased parental rejection, harassment, and



physical and verbal victimization (D'Augelli et al., 2006). Given this relationship between posttraumatic stress and factors related to childhood sexual minority status, culturally sensitive recommendations or modifications to TF-CBT that explicitly addresses complex LGB-related risk factors such as bullying, peer and family rejection, limited social support, minority stress, and gender nonconformity are warranted.

## **Overview**

The purpose of this study was to develop a supplemental resource manual – to be used in conjunction with Cohen et al.'s (2006) TF-CBT treatment manual – that would provide TF-CBT therapists with additional information on the unique strengths and stressors experienced by lesbian, gay, and bisexual (LGB) adolescent survivors of interpersonal trauma, as well as to provide LGB-affirming content and culturally sensitive recommendations that might enhance each of TF-CBT's core PRACTICE components. Rather than making any formal alterations or adaptations to the TF-CBT treatment manual, this supplemental resource maintains fidelity to the treatment model and is intended to be used in conjunction with the TF-CBT treatment manual in order to enhance the clinician's cultural sensitivity and competency around issues facing LGB youth and their families, to provide suggestions for ways to incorporate LGB-affirming content within each corresponding chapter of the 2006 treatment manual, and, ultimately, to increase the relevance of content for LGB clients while enhancing client engagement and preventing drop out. Culturally sensitive recommendations or modifications to the model were made by utilizing the theoretical and research literature on treatment with LGB populations, collaborative input of practitioners in the field of LGB adolescent trauma, as well as recommendations made by dissertation committee members.

The target audience for this supplemental resource includes self-identified, lesbian, gay, or bisexual youth, between the ages of 13 and 18, who have experienced or witnessed interpersonal trauma, as well as the youth's parents, caregivers, or identified adult advocate. Thus, use of this resource manual is most appropriate for treating LGB youth who have experienced or witnessed interpersonal violence – including neglect, community violence, physical, sexual, or emotional abuse –as well as for those experiencing significant Post-Traumatic Stress Disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. Additionally, youth who are experiencing depression, anxiety, and/or shame related to their traumatic exposure and/or sexual identity may also benefit from the treatment recommendations.

This resource will not be appropriate for transgender youth unless they also identify as LGB, given that the recommendations are focused on issues related to having a sexual minority orientation or sexual identity and not the equally important issue of gender identity. Also not appropriate for this treatment are youth experiencing significant disruptive behavior problems (e.g., substance abuse, defiance, aggression) which, though not uncommon in relation to traumatic exposure or PTSD, may first warrant individualized treatment (Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004). The following criterion will exclude participants from treatment: significantly disruptive and aggressive behavior, acute suicidality, frequent substance use that impairs either the child or parent's ability to participate in treatment, psychosis, clinical eating disorders, and serious self-harm behaviors. Additionally, youth who are currently experiencing or witnessing ongoing trauma might also be excluded from treatment (Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004). If any of the aforementioned problematic behaviors or situations occurs during the course of treatment, TF-CBT should be

suspended and the clinician should follow appropriate protocol to ensure the child's safety, and, if necessary, refer the child to another provider or higher level of care for more intensive treatment (Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004).

### **Development of the Resource Manual**

**Review of the literature.** A thorough review of the literature was conducted in order to provide a basis and rationale for the proposed LGB cultural modifications or recommendations. The review was divided into four sections. The first section focused on general information about adolescent experiences with interpersonal trauma in order to establish a general fund of knowledge about the rates and effects of such trauma. The second section explored the efficacy of TF-CBT in treating traumatic stress among adolescents. The third section addressed the circumstances under which it is acceptable to adapt or modify an evidenced-based treatment and referenced current, empirically supported, cultural adaptations of TF-CBT. Based upon the guidelines for adaptation addressed in the previous section, the final section explored the rationale for developing culturally sensitive treatment recommendations specific to LGB youth. Particular attention was paid to the estimated prevalence of LGB youth, specific health disparities, vulnerabilities, and risk factors related to interpersonal trauma among LGB youth, as well as the lack of culturally sensitive treatments designed to address the unique trauma-related variables affecting this population.

The primary literature review was conducted through a search of online databases such as PsycINFO, PsycARTICLES, and EBSCOHOST, which offer access to a library of peer-reviewed articles and e-books. In addition to this, literature was obtained through books and journals in print, internet resources (e.g., Google Scholar), and online publications and materials

provided by national organizations including the American Psychological Association (APA), the Centers for Disease Control and Prevention (CDC), the National Child Traumatic Stress Network (NCTSN), and the Substance Abuse and Mental Health Services Administration (SAMHSA), which is a branch of the U.S. Department of Health and Human Services (HHS). Specific search terms for this project included various terms related to TF-CBT, LGB child/adolescent trauma and treatment, and parenting LGB youth (e.g., lesbian, gay, bisexual, sexual minority, sexual orientation minority, youth/child/adolescent, trauma, interpersonal violence, posttraumatic stress, PTSD, minority/gay stress, risk factors, etiology, prevalence, gay affirmative treatment, resilience, cultural adaptation/modification, evidence-based, parents of LGB youth), as well as cultural adaptations of evidence based treatments (e.g., EBT, EST, CBT, cognitive-behavioral, cultural modification/adaptation, manuals, efficacy, outcome, theory, manualized treatments).

Cohen et al.'s (2006) TF-CBT treatment manual served as the basis for the development of this supplemental resource, and, as such, was referred to over the course of its development. Culturally informed recommendations to the 2006 TF-CBT treatment manual were built upon the existing literature regarding the integration of multicultural and LGB affirmative psychotherapeutic practices into evidence-based treatments (e.g., Craig et al., 2013; Crisp & McCave, 2007; Davies, 1996; Eamon, 2008; Hays, 2009).

**Format, structure, and content of the resource manual.** For the purpose of maintaining fidelity to the model, the format and structure of this supplemental resource manual is intended to parallel the original model developed by Cohen et al. (2006), and the content is meant to compliment the 10 core PRACTICE components, rather than to substitute or replace any of the original content. Moreover, paralleling the structure of the 2006 manual, within each

PRACTICE component chapter, LGB-specific recommendations included: a related psychoeducation piece, clinical considerations for both the child and parent, and a homework assignment or in-session activity. For instance, recommendations included activities such as researching a famous LGB person who has also survived trauma, or, more broadly, engaging in LGB community activities, identifying community sources of support, providing LGB-related resources specifically designed for parents of LGB youth, or utilizing LGB-related art, metaphors, and cultural icons as forms of expression.

### **Evaluation of the Resource Manual**

**Expert reviewers.** A panel of three expert reviewers were selected to review the supplemental resource manual and provide feedback and/or recommendations that would be carefully considered for incorporation into the final draft of the manual. Selection criteria for these reviewers included: at least three years of licensure as either a licensed clinical psychologist, a licensed marriage and family therapist, or a licensed clinical social worker, as well as at least three years post-license clinical experience in one of the following areas: treating interpersonal trauma, providing TF-CBT or CBT, or treating LGB adolescents/young adults (i.e. between the ages of 13 and 25).

**Recruitment strategies and procedures.** Potential expert reviewers were selected through convenience and snowball sampling methods (e.g., experts known by or referred to the researcher who met the inclusion criteria). After obtaining an IRB approval, those identified as potential participants were sent a recruitment email (Appendix B) that included an explanation of the research project, as well as information about the necessary requirements for participation as a reviewer (i.e., inclusion criteria), their required level of involvement, and compensation for participating as a reviewer. Additionally, potential participants were asked to complete a brief

Expert Questionnaire (Appendix C), also attached to recruitment email, in order to ensure that they met the inclusion criteria. Once the three potential participants were selected, each was sent a follow-up email asking for a copy of their CV in order to verify their relevant training and experience. After confirming their status as an expert reviewer with the research chair, each of the three participants were sent a follow-up email inviting them to participate in the study. After agreeing to participate as an expert reviewer, they were each emailed an Informed Consent Form (Appendix D) detailing the purpose of the study, privacy and confidentiality issues, potential benefits and risks, as well as the voluntary nature of participation, an Evaluation Form (Appendix E) for them to complete and return via email, as well as a copy of the resource manual (Appendix A). The evaluation form included sections for providing written feedback regarding the supplement as a whole, as well as each area of specific content. Experts were asked to return the evaluation form via email so that the feedback could be considered for incorporation into the final draft of the supplemental resource. After receiving the reviewer's completed evaluation form via email, they were sent a \$50 Amazon gift card via email. Additionally, each reviewer was offered the opportunity to have their contribution to the research project recognized in the supplemental resource, or they could elect to have their contribution remain confidential.

**Analysis of the evaluation.** Once the expert reviewers completed and returned their evaluation forms, this author reviewed their feedback and recommendations and discussed in Chapter III-Results.

## **Results**

This chapter includes an overview of the development of the supplemental resource manual, as well as a summary of the evaluation process. The resource itself can be found in Appendix A. Feedback and recommendations from three expert evaluators regarding the resource are reviewed and examined.

### **Brief Overview of the Development of the Resource Manual**

A comprehensive review of the literature was conducted in order to gain a better understanding of the unique challenges, needs, strengths, risks, and resilience factors experienced by LGB adolescent survivors of interpersonal trauma. This review included examination of the research supporting TF-CBT's efficacy in treating child and adolescent survivors of interpersonal trauma, as well as the research supporting cultural modification of TF-CBT and other evidence-based treatments. The purpose for developing this resource manual was to enhance the cultural sensitivity of TF-CBT therapists working with LGB adolescents and their families and to provide them with culturally sensitive resources, activities, and clinical recommendations that could be used to supplement or enhance each of TF-CBT's core PRACTICE components. Ultimately, the goal was to increase the relevance, attractiveness, and acceptability of the treatment by LGB adolescent clients and their families, whereby leading to decreased attrition and increased treatment engagement and effectiveness. Following development of the supplemental resource manual, three expert evaluators with backgrounds in CBT, TF-CBT, adolescence, interpersonal trauma, and/or LGB youth, were recruited to evaluate the resource using an Evaluation Form which was provided to them along with an electronic copy of the resource.

The *Supplemental Resource Manual for TF-CBT Therapists Working with Lesbian, Gay, and Bisexual Adolescents* is 145 pages in length, including references. It begins with a brief preface, explaining the purpose of the resource, who it was designed for, and how therapists might utilize the resource during treatment. The resource manual consists of nine chapters, each paralleling the ten chapters of the 2006 TF-CBT treatment manual, with chapters five and seven combined into one chapter (i.e., Chapter 5 & 7), which addresses both part I and II of the cognitive coping and processing components. Each chapter contains background information and content for the therapist, followed by clinical considerations for both the child and parent. Each chapter also has an in-session practice assignment or homework activity related to the content of the chapter or PRACTICE component. Therapists are encouraged to use the in-session practice assignments and homework activities flexibly and interchangeably throughout the treatment process, always tailoring the use of any content, recommendations, or activities to the particular developmental, cultural, and contextual needs of the child and their family. Lastly, a list of LGB-affirming resources and organizations were provided in appendices of the resource manual, providing therapists – and clients – access to a wide range of additional culturally sensitive and specific resources.

### **Summary of the Results**

Three expert evaluators were consented to provide written feedback on the supplemental resource manual developed as part of this dissertation project. Each completed their evaluation of the resource within a one-week period. Two of the expert evaluators are licensed clinical psychologists and one is a licensed marriage and family therapist (Table 1). All are currently licensed within the state of California. All three evaluators have experience treating interpersonal trauma in youth and adolescents, have worked with LGB adolescents and their families, and



identify Cognitive Behavioral Therapy (CBT) as one of their primary theoretical orientations. While none of the experts are certified in TF-CBT, each has had some level of training in TF-CBT and has provided TF-CBT to children and adolescents. Evaluator 1 has had seven years of licensed experience providing TF-CBT to adolescents, has completed the online TF-CBT training course, and has attended continuing education and day-long workshop trainings related to TF-CBT “over several years.” Evaluator 2 has had two years of experience providing TF-CBT (i.e., one year of pre-doctoral internship and one year of post-license experience), has completed the online training, has had one year of specialized training in providing TF-CBT in schools, and has had specialized training in providing CBT to youth and adolescents. Evaluator 3 has had four years licensed experience providing TF-CBT, has completed the online training as well as “multiple day-long workshops” and continued education in TF-CBT, has provided TF-CBT to LGB adolescents, and has had specialized training in providing CBT to LGB youth. Furthermore, all currently work with children and adolescents. Evaluator 1 works in a community mental health setting and supervises individuals with child and adolescent trauma caseloads. Evaluator 2 works in a child and family psychiatry department of an outpatient medical center. Evaluator 3 primarily works with an LGBT patient population in a community mental health setting and has a part-time private practice as well.

Table 1.

*Evaluators’ Characteristics*

Evaluator	Gender	Title	Years of Experience
1	Female	Licensed Psychologist	19
2	Male	Licensed Psychologist	8
3	Male	Licensed Marriage & Family Therapist	4

The resource evaluation form (Appendix E) was completed by all three experts and consisted of open-ended questions which asked for feedback regarding the resource as a whole, as well for additional or optional feedback regarding each of the nine individual chapters. Each of the expert evaluators provided detailed feedback, critiques, and suggestions for further improvement of the resource, and each provided some additional feedback regarding the individual chapters as well.

Feedback obtained from the evaluators is summarized below (Tables 2 through 17). Questions 1, 2, and 3, asked the evaluators to provided feedback on the strengths and weaknesses of the manual. In general, there appeared to be agreement among the evaluators on what they considered to be strengths and weakness of the manual. Strengths included a “comprehensive” review of the literature related to LGB youth and families, the use of “clear and accessible language,” an emphasis on LGB-youths’ unique needs, risks, and protective factors from an LGB-affirming perspective, inclusion of a sexual identity developmental model, an emphasis on the unique needs and role of parents in the lives LGB youth and its relevance to trauma-focused treatment, and the use of specific activities and clinical recommendations designed to engage both youth and their parents (Tables 2 and 4). Weaknesses included the length of the manual – with all three evaluators recommending a shortened version of the resource, a need for greater specificity on how to “integrate the LGB-related information and concepts into the parlance of TF-CBT practices,” and a need for further exploration of the cognitive distortions and overt/internalized homophobic beliefs and attitudes that some parents may have (Table 3).

Table 2.

*Feedback on Recommendations (Question 1)*

What do you consider to be the <i>strengths</i> of this manual?	
Evaluator	Comments
1	The manual reviews current and relevant literature about LGB youths' unique treatment needs in a comprehensive and thoughtful manner. The manual is written in a clear and accessible language that is useful to clinicians. The accompanying activities described at the end of each chapter are relevant, creative, and representative of gay affirmative concepts. Finally, the manual is consistent with its stated goal of offering supplemental information on the needs of LGB youth and their families who undergo trauma-focused treatment.
2	This companion manual does an excellent job of highlighting the unique risk factors and complex treatment considerations inherent in work with LGB youth populations. Specifically, the author's choice of providing a compendium of common neutral, LGB-affirming terminology to define sexual identity, identity development phases, and LGB-specific community terms to facilitate clinical dialogue is tremendous. Similarly, the author is well-versed in the necessary parenting/support system consideration and challenges for LGB youth. The provision of both clinical considerations for child and parent, as well as specific homework or in-session tools is helpful.
3	The homework portion of this manual appears to be a useful resource in assisting families to open a dialogue about potentially challenging yet necessary topics. Specifically, the homework relates to not only opening a difficult conversation, but to also foster deeper connections between parent and child. The invitation to invite parents to explore LGBT monuments and centers is a very useful approach to assist the child in conceptualizing him-or-herself as part of a larger community and queer history. A much needed intervention is found in chapters 2 and 9, wherein parents are taught how to decrease invalidating or harming homophobic remarks.

Table 3.

*Feedback on Recommendations (Question 2)*

What do you consider to be the <i>weaknesses</i> of this manual?	
Evaluator	Comments
1	<p>While the use of scientific information and relevant references from the literature are helpful and appropriate, the manual, at times, reads more like an academic literature review than a manual.</p> <p>The manual is rather lengthy which can somewhat compromise its practicality for busy clinicians applying manualized treatment (TFCBT) which in and of itself requires learning and practice for application with fidelity. In other words, a supplemental manual should probably include information that is more "compacted" and presented with summaries and bullet point conclusions, rather than a lengthy narrative.</p>

(continued)

Evaluator	Comments
2	The manual may benefit from greater specifics on how to integrate the LGB information and concepts into the parlance of TF-CBT practices. For example, where there is the development of the trauma narrative, a treating clinician would insert discussions of sexual identity development stages, or how to discuss LGB-affirming terminology in addressing automatic negative thoughts for use in reframing. Such “logistics of practice application” sections could be very helpful, especially to trainees or clinicians very new to working with this population. Also, the length of the manual may make it challenging for some clinicians to utilize.
3	As a clinician who strives to facilitate useful interactions between parents and queer youth, I believe there needs to be more emphasis on how parents can identify internalized and/or overt homophobic beliefs/attitudes to be able to process effectively with the parents about how those biases can be carefully looked at and changed given appropriate treatment.  Another way that this manual could better serve this population is through more emphasis on the parent’s involvement in the child’s school so as to assist the child in communicating educational and social fears, hopes and expectations.

Table 4.

*Feedback on Recommendations (Question 3)*

To what extent does the manual strengthen the relevance of TF-CBT for LGB adolescents?	
Evaluator	Comments
1	To a great extent. This manual enhances the understanding of therapists of the unique needs of LGB youth in TFCBT treatment. The information presented in this manual emphasizes the importance of therapists increasing treatment effectiveness by familiarizing themselves with the factors that contribute to the trauma experiences of LGB youth, as well as the protective factors that are associated with a sense of pride and belonging to the LGBTQ community. In addition, the manual emphasizes the importance of understanding the special needs and unique roles of parents and families of LBG youth as central to TFCBT treatment for this population.
2	This manual makes a strong case for the frequency of and opportunity for multiple traumatic events in the course of LGB-teens development, as well as the need for specific, symptom-focused and time-limited structures for addressing treatment goals in a population for whom access to appropriate care may be severely limited (for a number of reasons).
3	The emphasis on conjoint sessions earlier in therapy for parent and child appear to be an appropriate intervention. Role-playing as a way to prepare for sessions, is a very beneficial tool.

The evaluators, again, appeared to be in agreement in their responses to Question 4 (“To what extent does the manual appear to be culturally sensitive?”), as illustrated in Table 5. All three evaluators described the resource as being sensitive to issues of culture, noting the

inclusion of various cultural contexts (i.e., sexual orientation, race, ethnicity, gender, geographic location) and the importance of recognizing intersecting cultural identities in trauma-focused treatment. Evaluator 3 also noted the importance of allowing sexual minority youth to define themselves, whereby affirming “their sense of personal power around their sense of self.” In regards to Question 5 (“How useful do you find this manual?”), each of the evaluators described the resource as useful, though for different reasons (Table 6). Evaluator 1 described it as “extremely useful,” noting that it “addresses a gap in information regarding trauma treatment of LGB youth;” however, Evaluator 1 also noted that the usefulness of the resource could be increased if it offered “a more concise ‘Summary and Recommendations’ section at the end of each chapter.” Evaluator 2 described the manual as “very useful” and stated he would “recommend it for use in any urban Child & Psychiatric Clinics, LGB Community Centers, and possibly in school-based wellness centers.” Evaluator 3 described the manual as “useful” in that it helps to “strengthen the family unit” by addressing shared cultural values between LGB youth and their parents and by enhancing parent-child communication in order to foster a deeper sense of family cohesion and connection.

Table 5.

*Feedback on Recommendations (Question 4)*

To what extent does the manual appear to be culturally sensitive?	
Evaluator	Comments
1	To a great extent. The manual consistently refers to the intersectionality of sexual orientation and other diversity factors (e.g., ethnicity, race). Case examples also include relevant information regarding cultural background as a factor in treatment planning.
2	This manual does a commendable job of addressing cultural contexts ranging from race to gender to rural vs. urban populations. Specifically, the discussion of intersectionality during Ch. 6’s explanation of considerations during the development of the trauma narrative is incredibly relevant and helpful for the treating clinician.

(continued)

Evaluator	Comments
3	Addressing myths about trauma and the development of a sexual minority orientation or identity, as well as developmental considerations for treating traumatized LGB youth is an excellent way to promote cultural sensitivity. A very useful approach this manual uses to promote cultural sensitivity, when working with sexual minority youth, is allowing them to define themselves. Asking what terms they are comfortable with is a way to affirm their sense of personal power around their sense of self.

Table 6.

*Feedback on Recommendations (Question 5)*

How useful do you find this manual?	
Evaluator	Comments
1	Extremely useful. This manual addresses a gap in information regarding trauma treatment of LBG youth. Specifically, it offers current, research based, information that can support therapists' decisions to augment and/or supplement TFCBT treatment when working with LGB youth. In my opinion, what would increase the usefulness of this manual (i.e., make it more "user-friendly") is to offer a more concise "Summary & Recommendations" section at the end of each chapter, perhaps using a bullet point format, in order to facilitate therapists' ability to more easily "digest" the information.
2	This manual would be very useful, especially for clinicians treating urban, diverse populations or in environments that may be less supportive of LGB-youth. I would recommend it for use in any urban Child & Family Psychiatric Clinics, LGB Community Centers, and possibly in school-based wellness centers depending on the training-level of the staff.
3	I appreciate the approach as well as the information shared. I found the manual to be useful in being able to identify the family's newly discovered and shared cultural values as well as in strengthening the family unit. This resource provides families the ability to incorporate specific communication styles that maintain healthy working relationships so that the parents and families of LGB adolescents can foster a deeper sense of connection.

Question 6 ("Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters:"), was broken into nine questions (Questions 6a through 6i), and the evaluators specific feedback regarding each of the resource manual chapters can be found in Tables 7 through 15. In general, the feedback was positive and Evaluators 1 and 2 provided several specific recommendations for inclusion in future revisions on the manual. Some of the feedback included shortening the resource, broadening the discussion around sexual identity to include terms such as "pansexuality" as well as definitions or categories for youth who do not fully identify with a lesbian, gay, or bisexual identity, and incorporating concepts of

“acceptance, mindfulness, willingness, and forgiveness” from didactical behavior therapy in order to mitigate distress in the parent/family adjustment to trauma disclosure and/or sexual identity disclosure (Tables 7 and 8). Feedback regarding “Chapter 3: Relaxation Skills,” suggested renaming the chapter “Stressors & Protective Factors,” given that its focus on environmental stressors/triggers and increasing social support, or, alternatively, the inclusion of self-care practices such as “listening to music, meditating/yoga, creative activities, spending time in nature, reading/writing, etc.” (Table 9). In terms of the cognitive coping and processing components, Evaluator 2 suggested the inclusion of activities that highlight the difference between negative core beliefs and negative automatic thoughts, in particular, demonstrating how the youth’s negative core beliefs relate to developing a negative sense of self or sexual identity (Table 11). Evaluator 2 also emphasized the importance of using more “present-focused coping phrases as opposed to coping thoughts or phrases that focus too much on the future, which would be better suited to “adolescent perceptions of time and immediacy” (Table 11). While each of the evaluators described the Chapter 6 discussion of intersectionality, race/ethnicity, and religion/spirituality as a strength, Evaluator 1 identified a need to relate these concepts back to the development of the trauma narrative, and Evaluator 2 recommended an in-session activity where the youth’s stages of sexual identity development are laid over the trauma narrative timeline “in order to create connections and meaning between experiences, emotions, and thoughts in the trauma sequence” (Table 12). In terms of Chapter 8, which focused on the in-vivo treatment component, Evaluator 2 recommended helping youth identify the differences between “past traumatic stressors” and “current risk stressors,” and creating a menu of LGB-affirming rewards and incentives for accomplishing increasing levels of exposure (Table 13). Moreover, while Evaluator 1 noted that the content of “Chapter 9: Conjoint Child-Parent Sessions” seemed

somewhat redundant, and suggested integrating it into Chapter 2, Evaluator 2 suggested re-addressing content covered in Chapter 2 and including discussions about micro-aggressions or unconscious heterosexist biases that parents may not be aware of and how such behaviors may communicate “non-acceptance” to their child (Table 14). Lastly, Evaluators 1 and 2 both commended the inclusion of discussions around sexual health and assertive communication in Chapter 10 (Table 15). Evaluator 2 also recommended teaching LGB youth how to recognize the signs of a developing mood disorder, problematic substance use or compulsive risk-taking, and how to monitor sexual health risks. He also encouraged including information for therapists on how to describe or define “risky sexual behavior” or “compulsive sexual encounters” for LGB youth (i.e., what risky sexual behavior looks like and how to differentiate it from a healthy sexual encounter).

Table 7.

*Specific Feedback on Recommendations (Question 6a)*

Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters: (Chapter 1: Psychoeducation)	
Evaluator	Comments
1	<p>Perhaps include a brief discussion on the concept of pansexuality. A therapist might be interested in knowing whether the manual is applicable to youth who refuse to define themselves as “either/or.” Since this term has become increasingly more popular in social media and represents a population that has not been researched extensively, it might be a relevant concept to define and include or exclude from the manual.</p> <p>I think the discussion of the myth of the connection between trauma experiences and an LGB orientation is excellent and a valuable contribution to the manual. It is gay affirmative and it serves to reduce stigma. The resources presented at the end of the chapter are a valuable addition to this chapter.</p>
2	<p>Excellent discussion addressing sexual orientation/identity development and childhood sexual abuse, as well as data supporting the need for LGB-specific trauma tools.</p> <p>Consider including terminology descriptions for Pansexual/Asexual/Sapiosexual orientations as they are recently more common in younger teens, and may be a transitional identity crucial in long-term sexuality and gender identity, perhaps during the Immersion stage.</p>

(continued)



Evaluator	Comments
3	Discussion of stages of identity development was helpful, as was discussion of myths related to trauma.

Table 8.

*Specific Feedback on Recommendations (Question 6b)*

Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters: (Chapter 2: Parenting Skills)	
Evaluator	Comments
1	The chapter emphasizes the important role that parents play in supporting LGB youth through experiences of victimization. It does a great job of both calling for therapists to understand the specific challenges that parents of LGB youth face and elucidating their special role as the youth support system. This is a strength-based and more holistic approach.
2	<p>Consider addressing the order in which teens self-identify THEN choose to tell their parents (i.e. teens rarely report to parents that they identify as a sexual minority if they aren't "sure" first), thus it may be helpful to educate parents not to "second guess" their child's disclosure of sexual identity (not sure if there is research on this, it is only anecdotal from clinical practice).</p> <p>Consider discussion of specific clinical interventions/skills for therapist such as borrowing DBT models to promote Acceptance, Mindfulness, Willingness, Forgiveness and Emotion Regulation as tools to mitigate distress and interpersonal relationships during parental/family adjustment (although not CBT, DBT techniques may be appropriate for older teens/parents).</p> <p>Excellent use of specific behavioral suggestions for parents to demonstrate support/acceptance.</p>
3	Already addressed in general feedback.

Table 9.

*Specific Feedback on Recommendations (Question 6c)*

Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters: (Chapter 3: Relaxation Skills)	
Evaluator	Comments
1	This chapter places more emphasis on the sources of stress specific to LGB youth, and the importance of increasing their social support system, than on how to supplement the teaching and practicing of relaxation skills to the youth.
2	Consider brief elaboration on how, due to less-salient minority identifiers (aka "invisible minority"), LGB youth may be exposed to increased direct and indirect heterosexism and homophobia during the encounter and immersion stages of development.

(continued)

Evaluator	Comments
	Consider renaming Chapter 3: Stressors & Protective Factors, as the chapter appears to focus mostly on environmental stressors/triggers and homework seems to focus on fostering improved support system
	Alternatively, consider adding section to expand social support knowledge that includes self-care practices such as “listening to music, meditating/yoga, creative activities, spending time in nature, reading/writing, etc” to emphasize specific methods of relaxation and relieving stress.
3	(Blank)

Table 10.

*Specific Feedback on Recommendations (Question 6d)*

Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters: (Chapter 4: Affective Expression & Modulation Skills)	
Evaluator	Comments
1	This chapter presents information that is highly relevant to the treatment of trauma in LGB youth. Specifically, information presented on the particular emotional vulnerability of LGB youth and the importance of adjusting the pace of trauma work (i.e., working more gradually) is a very important and helpful recommendation.
2	Consider discussion of strategies to promote recognition of emotional awareness as a strength in LGB identity development, such as psychoeducation on Purpose of Emotions and tools for practicing mild-moderate emotional exposure.  Excellent discussion of how emotional dysregulation increases likelihood of interpersonal victimization.
3	(Blank)

Table 11.

*Specific Feedback on Recommendations (Question 6e)*

Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters: (Chapter 5 & 7: Cognitive Coping & Processing)	
Evaluator	Comments
1	The vignette is highly effective in demonstrating the importance of the therapist being familiar with specific cognitions that form as a result of LGB minority status and how they are helpful to address in processing trauma experiences.  The review of gay affirmative CBT principles can be briefer.
2	Consider discussion of Negative Core Beliefs as they relate to developing sense of self/sexual identity, vs identification of related passive automatic negative thoughts.

(continued)

Evaluator	Comments
	<p>Possible tools for recognizing ANTs vs Core Beliefs recruiting supportive parent and teen in writing out lists of recognized thoughts shared by teen and comparing results (cross-over between lists indicates ANTs, while Core Beliefs usually appear on teen list only)</p> <p>Consider discussion of ways that borrowing from DBT model of Acceptance may help counter cultural limitations of CBT as a western paradigm</p> <p>Consider discussion of methods of creating individualistic/tailored Positive Affirmations specific to LGB teens' sexual identity to counter Negative Core Beliefs.</p> <p>Excellent illustration of using "helpfulness/effectiveness" focus for cognitive restructuring, rather than developing balanced thoughts/affirmations that challenge ANTs VALIDITY.</p> <p>Consider emphasis on the importance of creating PRESENT-focused coping thoughts, rather than ones that focus on the future (i.e. "I am proud of my self-awareness" or "I have people who love and support me" rather than "It gets better,") fitting with adolescent perceptions of time and immediacy.</p>
3	(Blank)

Table 12.

*Specific Feedback on Recommendations (Question 6f)*

Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters: (Chapter 6: Trauma Narrative)	
Evaluator	Comments
1	<p>The information presented on resiliency and posttraumatic growth, intersectionality, ethnic and racial identity, and religious and spiritual identity could use greater and more specific focus on trauma narrative.</p> <p>The section of the chapter that includes clinical implications for developing a trauma narrative with LGB youth was informative and I suspect will be very useful for therapists.</p>
2	<p>Consider exercise of laying the Stages of Sexual Identity Development over the narrative timeline of trauma in order to create connections and meaning between experiences, emotions, and thoughts in the trauma sequence.</p> <p>Consider use of collage-making activity as a practice for converting fragmented or emotionally encoded imagery/aspects of self into meaningful, cohesive storyline and statements about self. Begin by allowing LGB youth 30+mins to cut-out assorted images and words that "speak to them," regardless of content or source, then help them glue/affix items to a canvas/poster - when they have finished, ask them to tell you about what they made.</p>

(continued)

Evaluator	Comments
	Excellent discussion of Intersectionality as both a complicating and a possible protective factor in creating the trauma narrative.
	Consider discussion of differentiation between “religious” as a structured, rule-based form of spirituality, as compared to “spirituality” being “any practice that contributes to an individual’s sense of meaning or purpose, and that helps an individual feel connected to others, the world around them, and themselves.” This is a distinction myself and many colleagues often use to describe spirituality’s role in self-care and resilience, given the emphasis on meaning-making and connection/support separate from specific religion.
3	Good discussion of spirituality and religion. An important piece and comes up often in my work with LGBT clients, especially late adolescence and young adults. I work with many adult gay men who once identified as Mormon or Christian. Clients frequently disclose childhood sexual abuse and the role religion played in worsening trauma symptoms and negative feelings about themselves. It could be very powerful to help children and their parents address and heal the divide between spiritual and sexual identities.

Table 13.

*Specific Feedback on Recommendations (Question 6g)*

Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters: (Chapter 8: In-vivo Exposure and Mastery of Trauma Reminders)	
Evaluator	Comments
1	This chapter does a great job of keeping the information concise and applicable. I think the emphasis on decreasing avoidance while increasing safety constitutes a really important message. This message is supported by a valuable resource (Appendix G) that describes combating avoidance through increasing safe involvement and healthy engagement in the LGBTQ community.
2	<p>Good discussion of necessity for therapist to ascertain if any avoidance strategies are continuing to serve protective role in actuality, and citation of LGB-specific risk factors that may persist. Similarly with selective vs. general avoidance strategies.</p> <p>To this end, consider brief worksheet activity to examine “Past traumatic stressors vs. Current Risk Stressors” to address each avoidance behavior and develop appropriate LGB-affirming exposure tactics and steps</p> <p>Similarly, consider creating “LGB-affirming Tool Kit” of LGB-specific coping thoughts, mantras, and affirmations for use during exposure exercises.</p> <p>Consider also establishing LGB-affirming rewards/incentives for accomplishing increasing levels of exposure.</p>
3	(Blank)

Table 14.

*Specific Feedback on Recommendations (Question 6h)*

Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters: (Chapter 9: Conjoint Child-Parent Sessions)	
Evaluator	Comments
1	This chapter includes information that has already been presented in previous sections (e.g., chapter on parenting skills)-Perhaps it could be integrated into chapter 2?
2	<p>Consider including discussion of parent-preparation strategies to include not only identification of specific LGB-affirming behaviors parents can engage in, but also a re-examination of previous parental negative core beliefs and automatic negative thoughts (from Ch 2) and inadvertent behaviors parents may not be aware communicate non-acceptance (failure to ask if the youth is dating/interested in anyone, lack of LGB acquaintances or other relatives in the parents' lives, never having been to a gay establishment or gay neighborhood, etc.).</p> <p>Consider use of preparative role-plays with parents to help them practice use of LGB-affirming terms in common conversations (i.e. how to use "girlfriend/boyfriend" or "sex partners" in a relaxed, fluid way during conversation).</p> <p>Wonderful citation of the Potter-Efron "Fives A's" as a framework for helping parents examine their behaviors toward their child.</p>
3	Already addressed in general feedback.

Table 15.

*Specific Feedback on Recommendations (Question 6i)*

Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters: (Chapter 10: Enhancing Future Safety and Development)	
Evaluator	Comments
1	This chapter presents practical and vital information on enhancing safety in LGB youth who experienced trauma. I found the discussion about promotion of sexual health (and related suggested resources) to be extremely relevant and useful.
2	<p>Consider discussion of LGB-specific risk factors for depression/anxiety, including prevalence of alcohol consumption in the LGB community, and perhaps risk "self check-ins" to monitor for developing of signs of mood disorder or self-harm behaviors (i.e. fatigue, irritability, change in appetite, difficulty sleeping, difficulty concentrating, thoughts of death or dying) or compulsive risk-taking/sexual health risks over the course of the last week or month. In essence, a "Knowing the Signs" tool for LGB youth.</p> <p>Consider discussion of how to use specific, operationalized frameworks for discussing "risky sexual behavior" or "compulsive sexual encounters" for LGB youth; for instance, "What exactly does such behavior look like?" And "What differentiates a healthy sexual encounter from a risky sexual encounter?"</p>

(continued)

Evaluator	Comments
	Good discussion of how to employ role-plays and YouTube clips for help in practicing self-assertive language and problem-solving, as well as considerations for use of strengths-based planning to both anticipate and navigate risks as well as in helping patients achieve long-term goals.
3	(Blank)

Table 16.

*Feedback on Recommendations (Question 7)*

What are your overall impressions of the resource manual?	
Evaluator	Comments
1	It is evident that the manual was developed with careful attention to relevant details related to both TFCBT and to its application to LGB youth. It contains a much needed and current review for any clinician working with or planning to work with LGB youth in any clinical capacity, not solely in work that is focused on trauma and the application of TFCBT. I also appreciate that the manual is written from a gay-affirmative perspective, which provides a unifying author's "voice" to it, consistent with the purpose of developing the manual.
2	Very informative, specific strengths in the development of interventions for both child-patient and parent.
3	I appreciate the focus on both the needs of the child and the parents. This is a piece often overlooked in the literature and in working with an LGBT population. Your manual is detailed and informative. It will be an asset to clinicians working with gay youth, especially for those new to working with this population.

Table 17.

*Feedback on Recommendations (Question 8)*

How could the manual be improved to make it more effective for use with LGB adolescents who have experienced interpersonal trauma?	
Evaluator	Comments
1	<p>It might be helpful to start each chapter with a brief summary.</p> <p>Given the amount of information presented in each chapter, the manual can be more "user friendly" by offering a short summary (perhaps in bullet point?) at the end of each chapter. The purpose of the summary would be to offer a concise "tie in" between the information presented on the unique challenges of LGB youth and their families, and the specific component of the TFCBT model. At times, this "take-home message" is somewhat obscured by the comprehensive and detailed nature of the information reviewed.</p> <p>Perhaps change the proportions of each chapter, whereby the supplemental information is shorter and more concise and the clinical considerations for TFCBT work are more detailed.</p>

(continued)

Evaluator	Comments
2	See Chapter-specific feedback.
3	See my comments under the weaknesses question.

In regards to the evaluator’s overall impressions of the resource manual (Question 7; Table 16), Evaluator 2 described it as “very informative,” with “specific strengths in the development of interventions for both child-patient and parent.” Evaluator 1 stated that she “appreciated that the manual is written from a gay-affirmative perspective” and that it provides relevant information “for any clinician working with or planning to work with LGB youth in any clinical capacity.” Evaluator 3 described the resource as “detailed and informative” and stated that he appreciated the focus on both the child and the parent, as well as their relationship with one another. Finally, on Question 8 (“How could the manual be improved to make it more effective for use with LGB adolescents who have experienced interpersonal trauma?”), Evaluators 1 and 2 directed attention back to their previous feedback, while Evaluator 1 reiterated shortening the manual, summarizing content using bullet points, and including a brief 2-3 sentence summary at the beginning of each chapter to remind the reader of what the specific chapter consists of in the original TF-CBT manual (Table 17).

## Discussion

The aim of this dissertation project was to develop a resource manual for TF-CBT therapists working with lesbian, gay, and bisexual (LGB) adolescent survivors of interpersonal trauma and to provide therapists with culturally sensitive recommendations for each of the 10 core PRACTICE components in Cohen et al.'s (2006) TF-CBT treatment manual. The content, clinical recommendations, activities, and resources contained within the supplemental resource were designed to be used in conjunction with the 2006 TF-CBT treatment manual rather than serve as a stand-alone treatment manual. The purpose of providing therapists with these culturally sensitive recommendations was to enhance the cultural sensitivity of the therapist, to encourage the flexible incorporation of LGB-affirming practices into TF-CBT treatment while maintaining fidelity to the model, and to increase the relevance, attractiveness, and acceptability of the treatment by LGB adolescent clients and their families, whereby decreasing attrition and enhancing treatment engagement and effectiveness.

The development of the supplemental resource was informed by an extensive review of the literature on the unique challenges, needs, strengths, risks, and resilience factors experienced by LGB adolescent survivors of interpersonal trauma, the unique needs, experiences, and role of parents of LGB youth within the treatment process, as well as the adaptation and development of existing therapeutic treatment models and recommendations for working with LGB youth. Moreover, the approach to modifying or enhancing content within the evidence-based treatment (EBT) model of TF-CBT was guided by recommendations made by Anna Lau (2006) and Bernal, Jiménez-Chafey, and Domenech Rodríguez (2009). For instance, Lau (2006) has advocated for a conservative approach to the cultural adaptation of EBTs in which target populations are carefully selected on the basis of their unique needs, vulnerabilities, risks, or



resilience factors (e.g., higher rates of interpersonal trauma among LGB adolescents, moderating effects of sexual minority stress, unique parent-child dynamics, and access to unique protective factors such as the LGB community). Lau also noted that culturally sensitive modifications to an EBT should be specific, directed, and based on data (e.g., incorporating novel treatment components such as homework activities that affirm an LGB identity or highlight the impact of sexual minority stress on the youth's identity development in order to enhance engagement and increase contextual relevance). Similarly, Bernal et al. (2009) stated that the adaptation of an EBT may be necessary in order to increase the ecological and social validity of the treatment for a particular cultural group or community (i.e., sexual minority youth and their families). Furthermore, TF-CBT's authors have advocated for continued research on the cultural modification process of TF-CBT in order to increase its effectiveness among different populations, and evidence-based cultural adaptations of TF-CBT have been identified in the literature (e.g., modified TF-CBT for Latino youth and American Indian/Alaska Native youth, and culturally sensitive recommendations for addressing spiritual/religious issues in TF-CBT with adolescents; BigFoot & Schmidt, 2010; de Arellano, Danielson, & Felton, 2012; Walker, Reese, Hughes, & Troskie, 2010).

In order to strengthen the culturally sensitive recommendations made in this supplemental resource manual, a panel of three experts, who met the eligibility criteria, were asked to evaluate the resource and provide their written feedback regarding its strengths and weaknesses, as well as their suggestions for improvement. Their feedback was collected and analyzed to assess the usefulness of the recommendations, and will be considered for inclusion in future development of the resource.

## **Strengths of the Resource**

Overall, the three experts agreed that the manual was useful and culturally sensitive to the needs of LBG youth and their families. Two of the evaluators indicated that they would recommend it to clinicians working with LGB youth, and one stated he would “recommend it for use in any urban Child & Psychiatric Clinics, LGB Community Centers, and possibly in school-based wellness centers.” Other strengths identified by the evaluators included the resource manual’s “comprehensive” review of the literature related to LGB youth and families, the use of “clear and accessible language,” and an emphasis on LGB-youths’ unique needs, risks, and protective factors from an LGB-affirming perspective. These comments are consistent with the literature suggesting that for too long LGB individuals have been “over-pathologized,” and their strengths overlooked (McDavitt et al., 2008; Ritter & Terndrup, 2002). Thus, while understanding the unique risks factors, vulnerabilities, and challenges faced by LGB youth is important for conceptualization and treatment purposes (McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012), researchers and clinicians continue to assert the need for LGB-affirming treatment approaches that empower LGB youth by emphasizing their unique strengths, adaptive coping strategies, resources and protective factors, and resiliency in the face of trauma and other types of stressors (Craig, Austin, Alessi, McNroy, & Keane, 2016; Crisp & McCave, 2007; Hill & Gunderson, 2015; Proujansky & Pachankis, 2014; Russell & Fish, 2016; Saewyc, 2011).

The evaluators also noted strengths such as the inclusion of a sexual identity developmental model, an emphasis on the unique needs and role of parents in the lives LGB youth and its relevance to trauma-focused treatment, and the use of specific activities and clinical recommendations designed to engage both youth and their parents. Again, consistent with the research literature, the evaluators have highlighted the importance of including the parents of

LGB youth into the treatment process (Bouris et al., 2010; LaSala, 2010; Needham & Austin, 2010). For instance, Doty, Willoughby, Lindahl, and Malik (2010), among others, have consistently found that both parental acceptance and sexuality specific support (e.g., supporting youth in connecting with an LGB community, talking openly about sexuality-related topics) are especially important protective factors for LGB adolescents and facilitate optimal identity development (Bregman, Malik, Page, Makynen, & Lindahl, 2013; Mustanski, Newcomb, & Garaofalo, 2011; Needham & Austin, 2010). The evaluators also found the addition of clinical case examples, LGB-affirming and inclusive language, the use of timely and relevant interventions (e.g., social media and Internet videos), and the inclusion of an “LGB Resources and Organization” appendix as helpful.

### **Weaknesses of the Resource**

The three evaluators provided a variety of recommendations to help strengthen the resource, some general and some very specific. General weaknesses of the resource included the length of the manual – with all three evaluators recommending a shortened version of the resource, a need for greater specificity on how to “integrate the LGB-related information and concepts into the parlance of TF-CBT practices,” and a need for further exploration of the cognitive distortions and overt/internalized homophobic beliefs and attitudes that some parents may have. To this last point, Ryan and her colleagues (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014) have highlighted the importance of addressing the homophobic attitudes of parents, and have noted that by reducing parents’ shaming, stigmatizing, and physically harmful behaviors related to the youth’s sexual orientation, one can significantly decrease an LGB youth’s risks for suicide, depression, substance abuse, and risky sexual behavior. Moreover, they advocate for an approach to working with such parents that meets them

where they are at, assumes that they want the best for their children, and are able to grow and learn new skills for improving communication with their LGB youth (SAMHSA, 2014). Thus, based on the feedback of the evaluators, and coinciding with the relevant research literature, more specific examples and activities for addressing the needs of parents may be warranted for inclusion in future versions of this resource. Furthermore, one evaluator specifically suggested shortening the manual, summarizing content using bullet points, and including a brief 2-3 sentence summary at the beginning of each chapter to remind the reader of what the specific chapter consists of in the original TF-CBT manual. Two of the authors also suggested broadening the discussion around sexual identity to include terms such as “pansexuality” as well as definitions or categories for youth who do not fully identify with a lesbian, gay, or bisexual identity. According to the literature, self-definition is an important aspect of optimal LGB identity development, and providing youth with more inclusive terms to understand themselves should be encouraged in any treatment with sexual minority youth, especially those who feel disempowered as a product of overt and institutionalized forms of trauma and heterosexism (Gentlewarrior, 2009; Institute of Medicine [IOM], 2011; Ritter & Terndrup, 2002; Szymanski & Balsam, 2011). Other suggestions included the need for helping LGB youth identify LGB-affirming self-care practices, and, perhaps, the inclusion of a separate component or module for discussing LGB-related stressors and protective factors. This last comment is consistent with the literature on prioritizing the importance of helping LGB individuals connect with relevant sources of LGB-affirming social support and understand how negative societal influences (e.g., heterosexism/homophobia) impact one’s identity development and ability to recover from trauma (Craig et al., 2013; Pachankis, 2014).

## **Limitations and Future Directions**

While this dissertation project sought to provide culturally sensitive and clinically relevant recommendations for TF-CBT therapists working with LGB survivors of interpersonal trauma, and their families, the research literature on this population and specific clinical interventions aimed at treating symptoms of LGB trauma survivors are relatively limited or not yet well defined (Pachanksi, 2014; Saewyc et al., 2006; Syzmanski & Balsam, 2011; Triffleman & Pole, 2010). In addition to this, despite the growing number of youth who identify as LGB and despite the increased risk of experiencing interpersonal trauma, as compared to their heterosexual peers, sexual minority youth still only represent a small portion of adolescents exposed to interpersonal trauma, and therefore may be a difficult population to reach with LGB-specific treatment interventions (Saewyc et al., 2006). Moreover, many adolescents may not identify with labels such as “lesbian,” “gay,” or “bisexual,” therefore their needs may be different from those who identify as LGB or may be overlooked by clinical recommendations geared solely towards adolescents who openly self-identity as LGB. Additionally, there is a significant amount of diversity within and between lesbian, gay, and bisexual individuals, and therefore any treatment recommendations that propose to address the unique needs, risks, and resilience factors of each of these groups collectively may run the risk of a “one-size-fits-all” treatment approach (Pachankis, 2014).

Aside from the specific weaknesses of the resource manual, as identified by the expert evaluators, there are additional limitations that may impact the practicality and applicability of the proposed recommendations. One limitation is that the proposed recommendations are not the product of a randomized controlled trial, and, instead, were made based upon a review of the available research literature and clinical recommendations from those working with LGB youth.

Another limitation is this researcher's lack of clinical experience and formal training in the provision of TF-CBT, which may prohibit a more nuanced discussion of how to adapt TF-CBT and its component parts. Lastly, this resource manual is not a substitute for clinicians who may need more extensive training and exposure to working with sexual minority populations before being able to apply many of these concepts or recommendations in practice.

Future steps to improve and strengthen this resource would include: 1) making modifications to the current resource manual based on feedback provided by the expert evaluators and from the dissertation committee; 2) Obtaining feedback and recommendations from expert evaluators who are certified in TF-CBT and who currently provide TF-CBT to LGB youth; 3) Obtaining greater knowledge of TF-CBT by attending a two-day training in the model and making appropriate revisions to the resource before publishing or disseminating the resource to the public; 4) Reviewing, referencing, and incorporating updated components of the 2017 version of the TF-CBT treatment manual; and 5) Making the manual more concise while including brief chapter summaries as well as expanding sections on sexual identity development and self-definition, self-care practices, and interventions targeting parents' internalization of heterosexism and homophobia.

### **Conclusion and Implications**

This resource manual was developed as a supplemental guide for TF-CBT therapists working with LGB survivors of interpersonal trauma and their families. It was designed to be used in conjunction with Cohen et al.'s (2006) TF-CBT treatment manual as a means of increasing the therapist's cultural sensitivity around issues of LGB adolescence and experiences with trauma, while also incorporating LGB-affirming practices into this evidence-based treatment as a way of preventing attrition, enhancing client engagement and satisfaction, and

enhancing the treatment's contextual relevance to the client. This resource was developed via a comprehensive review of the literature on LGB adolescence and interpersonal trauma, parenting issues related to LGB youth, and treatments targeting the unique mental and behavioral health needs of LGB adolescents. The resource manual was evaluated by three mental health professionals who currently work with adolescents and who have had experience providing TF-CBT, working with LGB youth, and/or providing TF-CBT to LGB youth. It is hoped that the proposed cultural recommendations will bring greater awareness to the unique needs, risk factors, and strengths of LGB youth affected by interpersonal trauma, while also encouraging the involvement of parents and family members into the youth's treatment process. Thus, the recommendations made in the resource manual would be most appropriate for TF-CBT therapists with some level of cultural competency around issues of LGB youth, and for youth who both self-identify as LGB and are interested in exploring issues related to their sexual identity or drawing strength from their LGB identity as a means of recovering and growing trauma.

Furthermore, given the higher rates of exposure to interpersonal trauma and its negative effects, it is unclear as to why LGB youth have not previously received a cultural modification to TF-CBT, or other treatment approaches for that matter. However, one might hypothesize that the shame and secrecy surrounding sexual abuse and trauma, coupled with issues of shame and secrecy related to having a sexual minority identity, may make it difficult for many youth to report issues of abuse earlier in life, either for fear of being "outed" or for fear of losing further power, privilege, or status. In addition to this, only in the past decade or so, has research demonstrated trends in LGB individuals coming out earlier – in adolescence as opposed to young adulthood (LaSala 2010; SAMHSA, 2014; Troiden, 1988; Wilber, Ryan, & Marksamer, 2006). This shift in the age of coming out has made LGB youth particularly reliant on the support of

their parents, and, in fact, may make them more vulnerable to interpersonal violence at home and at school (SAMHSA, 2014). Thus, LGB adolescent survivors of interpersonal trauma, a less visible minority group and already smaller portion of youth receiving trauma-focused treatment, may, unfortunately, have been overlooked in the past. Lastly, a surprising finding throughout this process of the literature review and development of the resource manual has been the limited number of case studies and relative lack of research on treating LGB youth exposed to interpersonal trauma. While several current studies, most often qualitative research studies, have examined the risk and resilience factors, needs, and coping strategies of LGB youth, few studies or articles have proposed any specific recommendations for treating LGB youth exposed to interpersonal violence. As such, this paucity in the research suggests a need for not only more LGB-affirming approaches towards treating sexual minority youth, but also specific intervention strategies aimed at addressing the unique needs and strengths of LGB youth. Moreover, in developing a resource for therapists working with LGB adolescent trauma survivors, the hope was to begin filling this gap in the research literature by proposing concrete, accessible, and practical tools to support therapists in helping LGB adolescents grow and thrive in the face of adversity.



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## APPENDIX A

### Supplemental Resource Manual

A SUPPLEMENTAL RESOURCE FOR TRAUMA-FOCUSED  
COGNITIVE BEHAVIORAL THERAPISTS WORKING WITH  
LESBIAN, GAY, AND BISEXUAL ADOLESCENTS

Developed by: Paul Perales, M.A

## **PREFACE**

The purpose of this supplemental resource manual is to provide TF-CBT therapists with additional information on the unique strengths and stressors experienced by lesbian, gay, and bisexual (LGB) adolescent survivors of interpersonal trauma, as well as to provide LGB-affirming content and recommendations that might enhance each of TF-CBT's core PRACTICE components. Rather than making any formal modifications or adaptations to the TF-CBT treatment manual, this supplemental resource is intended to be used in conjunction with the TF-CBT treatment manual in order to enhance the clinician's cultural sensitivity and competency around issues facing LGB youth and their families, to provide suggestions for ways to incorporate LGB-affirming content within each corresponding chapter of Cohen, Mannarino, and Deblinger's 2006 treatment manual, and, ultimately, to increase the relevance of content for LGB clients while enhancing client engagement and preventing drop out.

This supplemental resource manual consists of nine chapters, each paralleling the ten chapters of the 2006 TF-CBT treatment manual, with chapters five and seven combined into one chapter which addresses both parts I & II of the cognitive coping and processing component. Each chapter contains background information and content for the therapist, followed by clinical considerations for both the child and parent. Each chapter also has an in-session practice assignment or homework activity relevant to the content of the chapter.

Furthermore, the clinical recommendations and information provided throughout this resource manual are specific to working with adolescents who self-identify as lesbian, gay, or bisexual (LGB) and to parents who are aware of their child's sexual orientation. This resource manual, however, does not address the equally important needs of youth or families who are presenting to treatment with concerns related to the youth's gender identity. Therapeutic

considerations for treating transgender or gender-variant youths would require different language, context, and content focus, which are beyond the scope of this current resource manual. Additionally, the recommendations made throughout this manual may not be appropriate for youth who are questioning their sexual orientation, given that this may constitute an earlier phase of sexual identity development with different behaviors and concerns than youth who currently identify as a LGB.

## Chapter 1: Psychoeducation

### Purpose

The purpose of this chapter is to provide basic psychoeducation regarding LBG youth and interpersonal trauma. Topics include use of appropriate terminology, addressing myths about trauma and the development of a sexual minority orientation or identity, developmental considerations for treating traumatized LGB youth, LGB adolescent prevalence rates and trauma statistics, risk factors facing LGB youth, the role of the family support system, and the role of the therapist in creating an LGB affirming therapeutic environment and working alliance.

### Definitions

Utilizing language and definitions adapted from a variety of sources, the intention of discussing and defining key terms related to sexual minorities is important both for enhancing cultural competency and for facilitating a common understanding between the therapist and client. In defining terms related to sexual orientation, such as the terms lesbian, gay, and bisexual, it is important to point out that their meanings are influenced by personal, cultural, historical, and social factors (Gentlewarrior, 2009; Institute of Medicine [IOM], 2011; Pierce, 2001; Scheer, et al., 2003). Sabrina Gentlewarrior (2009) notes that, ideally, these terms should be defined by individuals themselves, in a way that is most congruent with their life circumstances, values, customs, and culture. Moreover, the term *sexual orientation* is broad in that it encompasses attraction, behavior, and identity; typically, it refers to the enduring patterns of sexual and romantic feelings or attractions one has towards males, females, or members of both sexes or genders (IOM, 2011). *Lesbian* and *gay* individuals are those who develop romantic, sexual, and/or emotional attractions to members of the same sex or gender and sometimes partner with members of the same sex or gender only. *Bisexuals* are individuals who

develop romantic, sexual, and/or intimate attractions to others regardless of the person's sex or gender, and may choose to partner with both males and females (Gentlewarrior, 2009). The term *sexual minority* is an umbrella term which typically includes anyone who identifies as lesbian, gay, or bisexual (Adelson, 2012). For the purposes of this resource manual, the term "sexual minority" and the acronym "LGB" will be used interchangeably. Moreover, the terms lesbian, gay, and bisexual also constitute a personal or social identity that one adopts based on their attractions to members of the same or both sexes, as well as their identification with membership in a sexual minority community (i.e., LGB community; IOM, 2011). Therefore, the term *sexual identity*, more specifically, refers to a sense of membership in a social group based on a shared sexual orientation and a link between one's sense-of-self and that group (IOM, 2011). Adding to this, some individuals may chose to use other terms, such as "queer," "same gender loving," or "same gender affection" to define their sexual orientation or identity in a way that is most congruent with their cultural and social understanding of themselves (Lassiter, 2014; Ritter & Terndrup, 2002). While the focus of this resource manual is to provide recommendations for sexual minority youth who identify as lesbian, gay, or bisexual, it is important to also understand the closely related, yet distinctly separate concepts of gender and gender identity. For instance, the terms sex and gender, though distinct concepts, are often confused with one another (Adelson, 2012; IOM, 2011). An individual's *sex* is generally understood as a biological construct and refers to one's sense of being male or female based on the genetic, hormonal, anatomical, and physiological characteristics of males or females. Sex is typically assigned at birth (i.e., "birth sex") based on the appearance of the individual's external genitalia (Adelson, 2012; IOM, 2011). *Gender*, however, refers to social constructions and expectations of what it means to be male or female, and *gender identity* refers to an individual's personal sense of self as

male, female, or other gender (IOM, 2011; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). For instance, *transgender* individuals are broadly defined as individuals who cross or transcend culturally defined categories of gender and thus feel that their gender is not congruent with their biological sex. Furthermore, given that gender identity and sexual identity are two separate constructs, transgender individuals may also identify as lesbian, gay, bisexual, or heterosexual depending on their gender and the sex/gender(s) of those to whom they are sexually and/or romantically attracted. For example, a transgender female who is sexually and romantically attracted to other females may choose to self-identify as a lesbian.

*Homophobia* is a term used broadly to define any attitudes or behaviors that demean, disempower, stigmatize, or marginalize lesbian, gay, and bisexual people because of their sexual orientation; it is based on the assumption that heterosexuality is both normative and desirable (Gentlewarrior, 2009; IOM, 2011). Others have defined homophobia as “the irrational fear and hatred of gay, lesbian, and bisexual people, their behaviors, choices, and lives” (Brown & Colbourne, 2005, p. 264). Similarly, *biphobia* can be defined as any prejudiced attitudes or behaviors that stigmatize or marginalize bisexual people; such prejudice is based in the assumption that only intimate and sexual relationships with individuals of the opposite sex are normative and desirable (Gentlewarrior, 2009). Furthermore, *Transphobia* is defined as any attitude or behavior that conveys prejudice or dislike towards transgender people or gender ambiguity; “it is predicated in the assumption that biological sex and gender are binary and synonymous” (Gentlewarrior, 2009, p.1). Like racism and sexism, homophobia, biphobia, and transphobia can be experienced at systemic, institutional, and individual levels; and, as with other forms of bias – they frequently become internalized sources of emotional distress for LGB youth (Brown, 2008).

In light of these definitions, it is important for therapists to avoid making assumptions about the labels youth use to identify themselves. Thus, it is necessary when working with sexual minority youth to allow them the opportunity to define themselves. Asking them what term is most comfortable for them and trying to mirror that type of language not only affirms their identity and restores power, but also validates and normalizes their experience. Doing so might also offer insight into their process of sexual identity formation and can be a starting point for further exploration. For instance, not all youth who engage in same-sex behaviors identify as LGB; they may identify as heterosexual, same-gender loving, queer, questioning, or unsure, or may not have the language to describe their feelings, thoughts, behaviors, and attractions. Providing sexual minority youth with the language and freedom to define themselves can be an empowering intervention and a step towards healing any traumas related to the youth's sexual minority status.

### **Myths About Trauma and the Development of a Sexual Minority Orientation or Identity**

Given the high rates of childhood sexual abuse experienced by LGB individuals, it is important to address the social and cultural myths that have been used to explain minority sexual orientations and identities as a pathological result of childhood sexual abuse (Gentlewarrior, 2009; King, 2000). This “deficit-oriented” explanation reflects the heterosexist society in which we live and makes the assumption that individuals begin to identify as LGB due to traumatic sexual experiences (Walker, Hernandez, & Davey, 2012). However, contemporary research argues against such explanations and makes clear that there is no direct causal link between experiencing childhood sexual abuse and later identifying as LGB or non-heterosexual (Balsam, 2003; Balsam et al., 2005; Dietz, 2001; Russell, Jones, Barclay, & Anderson, 2008; Saewyc, Skay, Pettingell et al., 2006). For instance, in a large, community-based, quantitative study,



Morris and Balsam (2003) found no evidence that childhood sexual abuse influenced the sexual identity of lesbians and bisexual women. Similarly, in another study, Tomeo and colleagues (2001) found that the majority of gay men and lesbians in their sample reported identifying as homosexual prior to experiencing childhood sexual abuse. However, while contemporary research has dispelled myths about a direct causal link between childhood sexual abuse and one's sexual orientation, researchers have also reported an approximately 25-50% higher prevalence rate of childhood sexual abuse among non-heterosexual individuals. Balsam et al. (2005) have hypothesized that some perpetrators are aware of an adolescent's sexual orientation and engage in sexual abuse as a form of anti-homosexual aggression against the adolescent, which would suggest an opposite direction of causality. Additionally, some LGB adults who experienced sexual abuse as adolescents, and had already identified themselves as LGB, reported that their perpetrators targeted them because of their sexual orientation. Therefore, this increased risk for sexual trauma among LGB youth demonstrates a need for interventions specifically addressing this population's unique vulnerabilities and strengths (Walker, Hernandez, & Davey, 2012; Arreola et al., 2009; Bradford, Ryan, and Rothblum, 1994).

In terms of the research seeking to explain what might cause, contribute to, or influence the development of one's sexual orientation, much of the focus has been on the potential biological mechanisms underlying sexual orientation development (i.e., neuroendocrine factors, genetic factors, and neuroanatomy; Adelson, 2012). In a critical review of the biological research literature, Mustanski, Chivers, and Bailey (2002) identified several studies providing support for prenatal neuro-hormonal influence in sexual orientation development, though only among men. Similarly, family and twin studies have provided evidence of a substantial genetic component to sexual orientation (Rahman & Wilson, 2003), though, to date, no specific genes have been

consistently identified (Mustanski et al., 2002). Additionally, while some have explored psychological and social factors that might influence one's sexual orientation (e.g., closeness in parent-child relationships, social learning), there has been a lack of empirical support for these theories (Adelson, 2012; Mustanski et al., 2002; Rahman & Wilson, 2003). To the contrary, there has been evidence to suggest that knowledge of other homosexual people is not necessary for the development of one's own homosexuality, and parents' sexual orientation appears to have no influence on their child's sexual orientation, as is the case with children of LGB parents (Adelson, 2012; Rahman & Wilson, 2003). Moreover, while research scientists have examined a variety of possible influences on sexual orientation (e.g., genetic, hormonal, developmental, social, cultural), no findings have emerged that would allow one to conclude that sexual orientation is determined by any one particular factor or set of factors; rather, the actual mechanisms are still unknown (Adelson, 2012; Mustanski et al., 2002; Rahman & Wilson, 2003; Saewyc, 2011). Nevertheless, most individuals experience or report little or no sense of choice regarding the development of their sexual orientation (Saewyc, 2011).

### **Stages of Sexual Identity Development**

While researchers and theorists have proposed several differing and overlapping models of sexual identity development, Heidi Stern-Ellis and Al Killen-Harvey (2007), have proposed a model of sexual identity development adapted from the works of Eli Coleman and Vivienne Cass, that is particularly useful when considering the unique challenges and risk factors faced by LGB adolescent survivors of trauma. What we know about the stages of identity development, however, is that there does not appear to be a singular, linear path. Therefore, it is important to respect and honor whatever stage the client is in. Intervention strategies should be adapted to meet the client wherever they are at within this process of understanding their sexual identity.

For instance, for clients in an early stage of sexual identity development, the language the therapist uses or the resources they provide will likely be very different than those used with clients who have a more fully integrated sense of sexual identity. Thus, assessing where a client is on the continuum of identity development is essential to forming an effective working alliance with them. The following five stages (i.e., pre-encounter, encounter, immersion, internalization, and synthesis and commitment) offer a guide for understanding how the process of sexual identity development among LGB youth may unfold; however, it should be noted that development along these stages may not occur in a linear fashion and may be affected by a host of different cultural factors, such as race, ethnicity, gender, geographic location, as well as access to resources and support.

**Pre-encounter.** This is the first stage, where the individual sees themselves as belonging to “the mainstream” (Stern-Ellis & Killen-Harvey, 2007). They often have no information or exposure to other identity groups. During this time, the individual typically sees him or herself within a heterosexual paradigm, meaning that they have not begun to identify as lesbian, gay, or bisexual. Thus, youth who are in the pre-encounter stage of sexual identity development would not be appropriate for an LGB-specific treatment model.

**Encounter.** During this stage, the individual has their initial exposure to a gay, lesbian, or bisexual concept. The encounters may include thoughts, feelings and/or behaviors with someone of the same sex or may be intellectual, academic, or social exposure to information. During this stage there are positive, neutral, and negative encounters. The types of encounters a youth experiences may impact the types of risk factors they experience and may positively or negatively influence their movement into further stages of development. An example of a positive encounter may be one in which the youth is watching a film or reading a book where an

LGB character is introduced and may become a hero or is portrayed in a positive or realistic way. There may also be a larger description or narrative of what it means for that character to be LGB and an acknowledgement and affirmation of their unique experiences, challenges, and strengths. An example of a neutral encounter may be one where the youth hears about a friend's aunt who will be coming to visit them, and that the aunt also happens to be a lesbian. In this context, the comment or disclosure is usually made in a neutral and non-emotional tone, as more matter-of-fact information. A more negative encounter may be one in which the youth is watching TV and hears a politician talking negatively about the LGBT community, perhaps blaming homosexuals for destroying traditional values within the country or not deserving the same rights as heterosexuals or legal protections as other minorities. Moreover, each of these different types of encounters become integrated into the youth's schemas about themselves, the world, and others, and, depending on the frequency and types of encounters they are experiencing, may significantly impact their development during this stage. Thus, the encounter stage is considered to be crucial to one's sexual identity development. When working with anyone struggling with questions about their sexual identity, it is useful to ask them questions about their earliest recollections and encounters around sexual identity and sexual orientation. Many individuals may not be aware of the impact that messages about sexual orientation, especially early in childhood, may have had or continue to have upon them. Often times, clients with higher rates of negative encounters have greater difficulty integrating their own sexual or gender identities as adults. Key considerations for therapists working with youth in this stage include being aware of higher rates of vulnerability and confusion, and the role that internalized homophobia may play in stymying further identity development.

**Immersion.** By the time he or she has reached the immersion stage, the individual has moved from being unaware of differences in sexual identity or orientation amongst others, to encountering the fact that there are a variety of ways in which people configure their lives – erotically, emotionally, psychologically, and intimately – and, perhaps, that there are concepts called gay, lesbian, and bisexual. In contrast to the encounter stage, which is largely informational, during the immersion stage, the individual begins to explore aspects related to their sexuality. This experiential process may take many forms, such as intellectual, social, physical, and/or sexual experiences. Stern-Ellis and Killen-Harvey (2007) refer to this as the “sponge stage” because youth are eager to explore the boundaries of their sexual identity and absorb new experiences. For example, an adolescent in the immersion stage may begin to search the internet and actively seek out websites with lesbian, gay, or bisexual content. Adolescents, especially those living in or near urban areas, may also begin to explore parts of town or visit organizations where they know that LGB individuals often go. Youth might also begin to explore interpersonal relationships or what it might be like to experience intimacy between members of the same gender. It is particularly important for therapists to consider and explore the significant risks that adolescents face during this stage of identity development, as well as how the adolescent’s culture, geographic location, and information they possess may positively or negatively influence their levels of risk. Often times, with very little guidance or support, adolescents will begin to seek out information and experiences that have the potential to be both positive and dangerous. Stern-Ellis and Killen-Harvey note that in their extensive clinical work, they have frequently encountered traumatized LGB youth who have been exploited or targeted by online predators due to the youth’s naiveté and desire for knowledge, as well as due to a lack of opportunities to ask questions about or be provided with adequate and nonjudgmental

information about sexual identity. Therefore, the immersion stage is considered to be a very challenging and risky time for adolescents, and therapists are likely to play a crucial role in providing or recommending safe and affirming opportunities for adolescents to explore their sexual identity. Additionally, as youth begin to explore various aspects of a newfound sexual identity, their efforts may cause confusion and alienation to those around them. Furthermore, it is also important to note that while the target population for this resource manual is self-identifying LGB adolescents, the immersion stage, as well as all of the other stages, may or may not occur during adolescence, and, instead, may occur at a much earlier or later time in one's life. Culture, access to information and economic resources, religion and spirituality, nationality, and geographic location all have a significant influence on when and how these stages of identity development occur.

**Internalization.** For some individuals, the immersion stage may mark the end of their exploration with a sexual minority identity. Such youth may come to the conclusion that the experiences they had do not relate to or are incongruent with how they see themselves. For other individuals, experiences during the immersion stage will coalesce around the emergence of a more stable LGB identity. Thus, internalization can be understood as the stage of solidifying and accepting one's sexual minority identity. Other theorists, such as psychologist Vivienne Cass (1979, 1983/1984), in her seminal model of homosexual identity development, emphasize a stepwise process from tolerance to acceptance of one's LGB identity. Cass (1979) asserts that as the individual begins to tolerate their LGB self-image, there is a partial relief from the stressful uncertainty about their identity, allowing them to acknowledge their social, emotional, and sexual needs. Cass notes that during this period what is more critical for identity formation than establishing contact with other LGB people, is the emotional quality of these encounters.

Therefore, during this period, in order for one to move from tolerance to acceptance, it is essential that he or she perceives their encounters within the LGB community as favorable or positive (Ritter & Terndrup, 2002). However, several variables may interfere with this process and contribute to negative perceptions of such encounters, for example, “poor social skills; shyness; low self-esteem; and fear of exposure” (Cass, 1979, p. 230). Thus, depending on the youth’s developmental stage and unique needs, it may be useful for the therapist to be aware of and address any social skills deficits that might interfere with the youth’s socialization process within the LGB community. Moreover, ongoing and additional contacts with other LGB individuals that are validating and normalizing will likely lead to greater self-acceptance during this internalization stage. Lastly, in addition to the clarity and acceptance individuals experience during the internalization stage, this may also be a time of profound grief and loss as well. For instance, individuals might experience the loss of family members who are unwilling to accept them for who they are, they might lose connection to a particular community or religious group or other kinds of activities and cultural aspects of their life due to their sexual minority identity. Therefore, this is a time when depression may occur or return, and clients may need help exploring alternatives to replace the loss of important social and emotional supports.

**Synthesis and commitment.** In this stage, the struggle around who one is, or how they fit into the world as a sexual minority, no longer becomes the primary motivation or struggle for the individual. Although this is an ongoing, life-long stage of development, the individual begins the process of addressing the other broader life tasks that all people face; for instance, they may be focusing on developing more meaningful relationships, establishing career goals, or forming a family. During this stage an individual accepts that although others might not accept their sexual minority identity, their sense of self will not be changed. Psychologist Eli Coleman (1981/1982),

in his five-stage model of identity development, referred to this as a stage of “integration,” where “individuals incorporate their public and private identities into one self-image” (p. 39). Similarly, Cass (1979) described this as a stage of “identity synthesis,” in which an individual integrates their sexual orientation into a broader self-identity, along with many other identity dimensions (Ritter & Terndrup, 2002). However, it should be noted that this stage of development is typically observed in early and later adulthood.

**Additional considerations.** While the majority of self-identifying LGB adolescents that a TF-CBT therapist may be working with will likely be in the immersion and internalization stages of development, many may still be dealing with issues related the encounter stage as well (Stern-Ellis & Killen-Harvey, 2007). However, Saewyc (2011) notes that a review of more contemporary research on adolescent sexual orientation and identity development suggests that youth appear to be identifying as LGB earlier and may no longer be feeling constrained by the more structured categories of sexual orientation labels. Additionally, due to a variety of social, cultural, and economic contexts, adolescents may not fit neatly into many of the proposed and aforementioned linear models of sexual identity development. Thus, it is important for the therapist working LGB youth to avoid making assumptions, to ask clients how they identify or define themselves, and to explore other cultural and contextual variables that may be impeding the process of positive sexual identity formation, including the impact of trauma. Lastly, when exploring the stages of identity development with LBG adolescent clients, it may also be helpful to discuss how the adolescent’s parents or caregivers are experiencing a similar developmental process, in which they too must come to understand what it means to LGB and how their child’s sexual identity can be incorporated into their image of the family and parent-child relationship.



## **Prevalence Rates, Trauma Statistics, and Associated Health Disparities Among LGB Youth**

Although it is difficult to accurately estimate the prevalence of lesbian, gay, bisexual, or or sexual minority orientation youth in the United States, there is an abundance of evidence from population-based and large-scale longitudinal studies indicating that a greater proportion of adolescents who endorse some form of nonheterosexual orientation report unsupportive environments, less nurturing parental relationships, and increased risk of developmental stressors and health disparities when compared to their heterosexual peers (Saewyc, 2011). There are a variety of factors that make such population estimates difficult, for instance, the stigma associated with sexual minority identification (Hunter & Hickerson, 2003), complex, evolving, and inconsistent sexual identity labels (Austin et al., 2007; Rosario et al., 1996; Saewyc, 2011), the ongoing process of sexual identity development (IOM, 2011; Ott, et al., 2011; Patton & Viner, 2007; Ritter & Terndrup, 2002; Savin-Williams & Ream, 2007), and the limited use of probability sampling in nationally representative studies (IOM, 2011; Shields et al., 2013). In a report by the CDC, Kann et al. (2011) analyzed data on sexual minority youth collected from a national survey, the Youth Risk Behavior Survey (YRBS), which was conducted among large population-based samples of public school students in grades 9–12, during 2001-2009, across seven states—Connecticut, Delaware, Maine, Massachusetts, Rhode Island, Vermont, and Wisconsin—and six large urban school districts—Boston, Chicago, Milwaukee, New York City, San Diego, and San Francisco. According to the report, data from the high school administration sites produced a range of LGB population estimates from 3.9% to 7.8%. Furthermore, a recent update to the YRBS in 2015, which, for the first time, included more specific questions about LGB adolescent sexual behavior and self-identification of sexual identity, estimated that there are approximately 1.3 million LGB identifying high school students in the United States, with

321,000 identifying as gay or lesbian, 964,000 as bisexual, and 514,000 as unsure of their sexual identity (Kann et al., 2016). Taking this into consideration with data from other studies indicating that LGB youth are self-identifying at younger ages (Floyd & Stein, 2002), whereby increasing their risks for family rejection and school harassment than those who wait to openly identify as LGB in young adulthood (D'Augelli, Hershberger, & Pilkington, 1998), it appears that developing therapeutic interventions specifically targeting sexual minority concerns during early-to-late adolescence is of critical importance.

Along with increasing population estimates of LGB identifying and questioning youth, there is consistent evidence demonstrating higher rates of early-life adversity and exposure to trauma among sexual minority youth as compared to youth with heterosexual orientations or opposite-sex only attractions. (McLaughlin et al., 2012; Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Rothman, Exner, and Baughman, 2011). Numerous studies have found that sexual minority orientation individuals report higher rates of frequency, severity, and persistence of childhood sexual abuse and assault (Austin et al., 2008; Balsam, Rothblum, & Beauchaine, 2005; Corliss, Cochran, & Mays, 2002; Herek, 2009; Pilkington & D'Augelli, 1995; Saewyc et al., 2006;). In a nationally representative sample, Roberts and her colleagues (2010) reported a number of significant findings on the prevalence of traumatic exposure among U.S. sexual minorities in comparison to non-sexual minorities, including the following: LGB individuals have a significantly elevated risk of having been exposed to a wider variety of traumatic events, are twice as likely as to have been exposed to violence, are more likely to have experienced childhood maltreatment and interpersonal violence, and are more likely to have experienced their most traumatic event at a younger age. The literature also offers evidence of higher rates of victimization experiences stemming from family and romantic relationships in childhood and

adolescence, including disproportionate exposure to physical and sexual victimization by intimate partners (Balsam et al., 2005; Corliss et al., 2002; Tjaden et al., 1999). Additionally, in comparison to their heterosexual counterparts, sexual minority adolescents are significantly more likely to be targeted for violence in every setting (Coker et al., 2010), including a greater likelihood of experiencing both verbal and physical sexual harassment at school and in their communities (DuRant, Krowchuk, & Sinal, 1998; Faulkner & Cranston, 1998; Robin et al., 2002; Russell, Franz, & Driscoll, 2001; Williams et al., 2003). Recent data collected from the 2015 Youth Risk Behavior Survey (YRBS) further indicated that when compared with their straight peers, students who identified as LGB reported a significantly higher prevalence of being bullied at school (34.2% vs. 18.8%), experiencing electronic bullying (28% vs. 14.2%), being forced to have sexual intercourse (17.8% vs. 5.4%), experiencing physical dating violence (17.5% vs. 8.3%), and experiencing sexual dating violence (22.7% vs. 9.1%). Students identifying as unsure about their sexual identity also reported higher rates of all these behaviors in comparison to their heterosexual identifying peers (Kann et al., 2016). Furthermore, there is also evidence that LGB adolescents are at an elevated risk for experiencing homelessness (Corliss et al., 2011; Rice et al., 2013). In the first nationally representative estimate of homelessness among sexual minority youth, approximately 1 in 10 LGB adolescents were found to have experienced homelessness, more than twice the rate among heterosexuals in the same study (McLaughlin et al., 2012). Moreover, taken together, these increased rates of exposure to trauma among sexual minority youth place them at significantly greater risk for developing adverse physical and mental health outcomes, much of which are well documented in the literature.

In terms of health disparities and the effects of increased exposure to trauma during childhood, the results of nearly all population-based studies, regardless of sampling methods, measures of sexual orientation, geographic location, or time, consistently indicate that sexual minority youth experience greater rates of emotional distress, depression, anxiety, self-harm, suicidal ideation, and suicide attempts than their heterosexual counterparts (Coker et al., 2010; King et al. 2008; Saewyc et al., 2006). In the most recent, large-scale, nationally based survey of high school adolescents conducted in 2015 (Kann et al., 2016), more than 40% of LGB students reported that they have seriously considered suicide, and 29% reported having attempted suicide during the past 12 months. Additionally, in this survey, 60% of LGB adolescents reported having been so sad or hopeless that they stopped doing some of their usual activities. Moreover, other population-based data estimate that LGB adolescents are 3-4 times more likely to meet the diagnostic criteria for an internalizing disorder and 2-5 times more likely to meet the criteria for an externalizing disorder than their heterosexual peers (Fergusson, Horwood, & Beautrais, 1999). Research has also found elevated rates of PTSD among sexual minorities in comparison to heterosexuals, with Roberts, Rosario, Corliss, Koenen, and Austin (2012) finding that sexual minority young adults are at a significantly increased risk for lifetime probable PTSD due to higher exposure to childhood abuse. According to a meta-analysis of sexual orientation related health disparities, Marshal et al. (2008) found that sexual minority youth are also nearly three times more likely to report substance use than heterosexual adolescents, including higher prevalence rates of smoking, alcohol use, and other drug use, such as injection drug use. In the 2015 YRBS it was estimated that LBG adolescents are up to five times more likely than other students to report using illegal drugs. Furthermore, LGB youth are at increased risk of homelessness, placing them at greater risk for being exposed to violence and victimization, as

well as increasing their risks of teen pregnancy or engaging in risky sexual behaviors, such as not using condoms, survival sex, or prostitution (Coker et al., 2010; Saewyc, Poon, Homma, & Skay, 2008).

### **Unique Challenges and Risk Factors Facing LGB Youth**

In line with the aforementioned higher rates of exposure to trauma and increased health disparities among LGB adolescents, when working with such youth, it is imperative that therapists consider the unique risk factors, challenges, and types of traumatic experiences facing LGB youth and how these experiences might impede normal sexual identity development or recovery from trauma.

**Parental support.** Unlike members of other ethnic and cultural minority groups, most LGB individuals do not share the same sexual orientation status as their immediate family members. Thus, many LGB youth develop their sexual identities “in a vacuum informed by myth, misinformation, and negativity” (Brown, 2008, p. 170). Often times, when LGB youth disclose their sexual orientation to family members and relatives they report experiencing a lack of support, and, as a result, are at increased risk of being rejected, subjected to maltreatment, or experiencing negative health-related outcomes (Eisenberg and Resnick, 2006; Needham & Austin, 2010; Saewyc et al., 2009). Ryan et al. (2009) found that in comparison to LGB young adults who reported no or low levels of parental rejection, LGB young adults who did report higher levels of parental rejection during adolescence were also more likely to report attempted suicide, high levels of depressive symptoms, illegal drug use, and unprotected sex.

**Coming out.** Coming out is a lifelong decision-making process in which LGB individuals must first acknowledge and/or accept their own LGB identity, and, when ready, may choose to disclose their sexual identity to others. Shainna Ali and Sejal Barden (2015) highlight

the cyclical nature of this process, which occurs multiple times across an individual's lifespan and carries unique challenges depending on the context, such as coming out to family members, friends, classmates, various communities, or coworkers. Moreover, the act of coming out carries both risks and benefits. Stressors may include fears of rejection, bullying, harassment, safety, oppression, and discrimination (Ali & Barden, 2015; Coker, Austin, & Schuster, 2010; Kosciw, Greytak, Palmer, & Boesen, 2014). Additionally, during the coming-out process, internal discord may cause youth to experience negative emotions such as feelings of loneliness and isolation, confusion, grief, shame, anger, fear, vulnerability, powerlessness, as well as depressive symptoms and suicidal ideation (Bernal & Coolhart, 2005; Human Rights Campaign [HRC], 2014). As a result of internal conflict, individuals may suffer low self-esteem, low self-confidence, and may turn to negative coping strategies, such as substance use, self-harm, and engaging in high-risk sexual behaviors (Ali & Barden, 2015). Additionally, there is also ample research evidence to support several benefits of coming out as well, such as reduced levels of distress, anxiety, and depression, increased social skills and closeness in relationships, positive and strengthened identity, greater feelings of authenticity, and increased interest and involvement in social advocacy (Vaughan & Waehler, 2010; Rosario et al., 2001; Floyd & Stein, 2002; Savin-Williams, 2001; Stevens, 2004; Oswald, 2000). When working with traumatized LGB youth, Stern-Ellis & Killen-Harvey (2007) caution therapists to be aware that some youth may deny or minimize sexual abuse from a same-sex perpetrator for fear that it might "out" them before they are ready to disclose, or fully understand, their sexual identity. Thus, the coming out process, already complex and stressful, may be especially complicated or challenging for LBG survivors of interpersonal trauma.

**Minority stress, discrimination, victimization, and homophobia.** In addition to the stress of coming out and the fear of rejection or lack of support from parents and family members, LGB individuals frequently experience several forms of minority-related stress, both from external sources as well as internal sources. Researchers have identified antigay violence and discrimination as core stressors affecting LGB individuals. Meyers (2003) noted that institutionalized forms of antigay prejudice, discrimination, and violence can be observed throughout history, from the Nazi extermination of homosexuals to the enforcement of anti-sodomy laws punishable by imprisonment, as well as current laws prohibiting sexual minorities from having the same legal protections and rights as heterosexuals or other minority groups. Research further suggests that LGB youth are particularly vulnerable and more likely than adults to be the victims of antigay prejudice events, in turn, producing more severe psychological sequelae and negative health-related outcomes (Meyers, 2003). Recent surveys of schools in several regions of the United States, for instance, have shown that LGB youth are exposed to more experiences of discrimination, peer rejection, bullying, and violence than their heterosexual peers (Kann et al., 2016; Kosciw et al., 2014). Also, in comparison to heterosexual youth, LGB adolescents are increasingly at risk for being threatened and assaulted, are more likely to fear for their safety at school, and are more likely to miss days of school due to this fear (Kann et al., 2016; Kosciw et al., 2014). In addition to these external threats, LGB youth are also susceptible to threats from within. Internalization of the heterosexist and homophobic messages that permeate society often leads to greater self-loathing; and, as these feelings of self-hatred, depression, alienation, and isolation grow, LGB youth are more likely to contemplate suicide and engage in high-risk or self-destructive behaviors (Ritter & Terndrup, 2002; Saewyc et al., 2006).

**Cultural factors.** There are a variety of cultural factors that may impact one's process of sexual identity development, as well as one's feelings of connectedness within the LGB community or among other identity groups. Intersecting identities related to race, ethnicity, gender, religion, disability, socioeconomic status, and sexual orientation can all be a source of conflict and confusion for LGB youth (Ritter & Terndrup, 2002). Ethnic minorities who identify as LGB may feel pressured to choose between their different cultural identities, perhaps fearing separation or rejection from their ethnic group or family, which, in turn, may provide important buffers or safe havens from other forms of oppression (Garnets & Kimmel, 1991; Greene, 1994). Though some studies have identified ethnoracial group identity as a strong protective factor, others studies have indicated that those identifying as both an ethnoracial and sexual minority may be more likely to experience internal conflict, increased social stressors, as well as cultural prohibitions against such identities (Munoz-Laboy, 2008; Triffleman & Pole, 2010). For example, in a study examining the role of family acceptance among LGBT adolescents, Ryan and her colleagues (2010) found that, on average, Latino, immigrant, religious, and low-socioeconomic status families appeared to be less accepting of their adolescent's LGBT identity. Additionally, Sanders, Thompson, Noel, and Campbell (2004) found that clients who reported discrimination on the basis of multiple stigmatized identities reported greater levels of anxiety and depression than those reporting discrimination for only one reason. In a study exploring the intersection of gender, race, and sexual orientation among a sample of lesbian and bisexual victimized women, Morris and Balsam (2003) found that survivors were significantly more likely to experience sexual and/or physical assault as adults, to report difficulties coming out or developing a positive sexual identity, and to report identifying as lesbian or bisexual and having their first same-sex encounter at an earlier age. Lastly, Meyer (2010), among others, have also



noted that many ethnoracial LGB individuals experience racism within the LGB community, which tends to privilege gay, White males (Díaz, Ayala, Bein, Henne, & Marin, 2001). Taken together, these research findings suggest that LGB individuals from multiple marginalized groups may be particularly vulnerable and at greater risk for parental rejection, problems with sexual identity formation, and future physical and sexual abuse (Walker, Hernandez, & Davey, 2012).

### **Clinical Considerations**

**Child & parent.** Using the “LGB Psychoeducation” handout in Appendix B of this manual, spend time with both the child and the parent, either together or independently, to assess and discuss their knowledge and level of comfort talking about LGB and sexuality-related topics and definitions. The LGB Psychoeducation handout – adapted from an online resource provided by Planned Parenthood – was designed to provide child-and-parent-friendly language that is informative, though somewhat more comprehensive than may be needed for the purposes of this treatment. The therapist should use their clinical judgment when discussing issues such as gender, gender identity, and transgender issues as these may not pertain to the youth or parent and may be confusing. However, some parents may express concerns about their child’s non-gender conforming behaviors or interests, and, as a result, may conflate their child’s sexual and gender identities. Therefore, this information may be useful in helping parents and adolescents begin to better understand the various and distinct, yet overlapping, identities that different youth might have. Furthermore, assessment and psychoeducation are important early components of trauma-focused treatment. By asking questions about the youth’s sexual orientation and identity in a thoughtful, nonjudgmental, and open manner, the therapist will be able to create a safe space in which the child’s LBG identity can be affirmed and explored, especially as it may relates to

child's traumatic experiences. Moreover, the stages of sexual identity development were outlined in order to assist therapists in developing strategies for helping their LGB clients form positive sexual identities. Helping LGB youth and their parents normalize and better understand the child's unique developmental trajectory, including the impact of trauma and other social, cultural, and contextual factors affecting their development, is an important first step in providing an LGB-affirming trauma-focused intervention. This knowledge can aid clients by reducing confusion and increasing perspective related to their own feelings, thoughts, and behaviors, as well as decreasing feelings of isolation by allowing them to feel more like others. Throughout the following sections of this manual, homework activities and resources have been designed and provided in order to foster healthy sexual identity exploration and development. Depending on the therapist's assessment and understanding of the child's stage of sexual identity development, level of parental support, and unique contextual factors, it is recommended that the exercises throughout this resource manual be used interchangeably and flexibly by the therapist.

### **Homework: Child & Parent**

**Bibliotherapy.** Using the Resource Guide in Appendix A of this manual, provide the adolescent and their parent with a list of LGB themed books, movies, online content, and resources. Have each choose a film or book that they will watch or read, individually or together, for the purpose of discussing their thoughts, feelings, and reactions in the next session. If possible, help the client in selecting content that is appropriate for their particular stage of identity development, and that may elicit themes relevant to the client's unique cultural background. Be prepared to ask and answer questions with both the child and the parent independently or together.

## **LGB Resources & Organizations**

(Appendix A)

### **Topic Headings:**

Bibliotherapy Resources

- Books
- Films
- Television
- Music

LGB Youth Advocacy Resources

General LGB Resources

Family and Parenting Resources

LGB Communities of Color Resources

- Latino & Hispanic Communities
- Asian Pacific Islander (API) communities
- African American Communities

LGB Anti-violence & Hate Crimes Resources

LGB Sports Resources

LGB Affirming Religious and Spiritual Organizations

LGB Legal Resources

Crisis Hotlines for LGB Youth

### **Bibliotherapy Resources**

#### **Books**

##### **For LGB Youth**

- It Gets Better: Coming Out, Overcoming Bullying, and Creating a Life Worth Living, *by Dan Savage and Terry Miller (editors) (2012)*
- Gay & Lesbian History for Kids: The Century-Long Struggle for LGBT Rights, with 21 Activities (For Kids series), *by Jerome Pohlen (2016)*
- What If Someone I Know Is Gay?: Answers to Questions About What It Means to Be Gay and Lesbian, *by Eric Marcus (2007)*
- Free Your Mind: The Book for Gay, Lesbian, and Bisexual Youth and Their Allies, *by Ellen Bass and Kate Kaufman (1996)*
- GLBTQ: The Survival Guide for Queer and Questioning Teens, *by Kelly Huegel (2003)*
- Coming Out to Play, *by Robbie Rogers and Eric Marcus (2014)*

##### **For Lesbian Youth**

- Girl from Mars, *by Tamara Bach (2008)*
- Fun Home: A Family Tragicomic. *by Alison Bechdel (2006)*
- Ruby, *by Rosa Guy (2005)*
- Gravity, *by Leanne Lieberman (2008)*
- Rage: A Love Story, *by Julie Anne Peters (2009)*

### **For Gay Youth**

- Bullied, *by Jeff Erno (2011)*
- Dumb Jock, *by Jeff Erno (2013)*
- How They Met & Other Stories, *by David Levithan, Knopf (2009)*
- Mousetraps, *by Pat Schmatz (2008)*
- Out of the Pocket, *by Bill Konigsberg, Dutton (2008)*

### **For Bisexual Youth**

- People David Inside Out, *by Lee Bantle (2009)*
- My Invented Life, *by Lauren Bjorkman (2009)*
- Bi America: Myths, Truths, And Struggles Of An Invisible Community, *by William Burleson (2005)*
- The Mysteries of Pittsburgh, *by Michael Chabon (2008)*
- The Bisexual's Guide to the Universe: Quips, Tips, And Lists for Those Who Go Both Ways, *by Nicole Kristal and Mike Szymanski (2006)*
- The New Kid, *by Eliot Schrefer (2007)*

### **For Parents of LGB Youth**

- This Is a Book for Parents of Gay Kids: A Question & Answer Guide to Everyday Life, *by Dannielle Owens-Reid and Kristin Russo (2014)*
- Is It a Choice?: Answers to 300 of the Most Frequently Asked Questions About Gay and Lesbian People, *by Eric Marcus (2005)*
- Always My Child: A Parent's Guide to Understanding Your Gay, Lesbian, Bisexual, Transgendered, or Questioning Son or Daughter, *by Kevin Jennings (2002)*
- Coming Out, Coming Home: Helping Families Adjust to a Lesbian or Gay Child, *by Michael C. LaSala, Ph.D. (2010)*
- Love, Ellen: A Mother/Daughter Journey, *by Betty DeGeneres (2000)*
- Beyond Acceptance: Parents of Lesbians and Gays Talk About Their Experiences, *by Carolyn Griffin, Marian Wirth, and Arthur Wirth (1997)*
- Now That You Know: A Parents' Guide to Understanding Their Gay and Lesbian Children, *by Betty Fairchild and Nancy Hayward (1998)*
- Something to Tell You, *by Gilbert Herdt and Bruce Koff (2000)*
- My Son Eric: A Mother Struggles to Accept Her Gay Son and Discovers Herself, *by Mary V. Borhek and Christine M. Smith (2001)*
- The Family Heart: A Memoir of When Our Son Came Out, *by Robb Forman Dew (1995)*
- Different Daughters: A Book by Mothers of Lesbians, *by Louise Rafkin (2001)*
- Prayers for Bobby: A Mother's Coming to Terms With the Suicide of Her Gay Son, *by Leroy Aarons (1996)*
- How Homophobia Hurts Children: Nurturing Diversity at Home, at School and in the Community, *by Jean M. Baker, Ph.D. (2002)*

### Films

- **Pariah**, (2011) R – A lesbian coming of age story about an African American teenager from Brooklyn who juggles conflicting identities and risks friendship, heartbreak, and family in a desperate search for sexual expression.
- **Moonlight**, (2016) R – Follow the childhood, adolescence and burgeoning adulthood of a young, African-American, gay man growing up in a rough neighborhood of Miami.
- **Matthew Shepard Was A Friend of Mine**, (2014) Not Rated – A film about the boy behind the headlines. An honest and intimate portrait of Matthew as he is remembered by those who knew him.
- **Prayers For Bobby**, (2009) Not Rated – The true story of Mary Griffith, gay rights crusader, whose teenage son committed suicide due to her religious intolerance. Based on the book of the same title by Leroy Aarons.
- **Milk**, (2008) R – The story of Harvey Milk, and his struggles as an American gay activist who fought for gay rights and became California's first openly gay elected official.
- **The Times of Harvey Milk**, (1984) Not Rated – A documentary of the successful career and assassination of San Francisco's first elected gay councilor.
- **Torch Song Trilogy**, (1988) R – A Gay New Yorker's search for love, respect and tradition in a world that seems not especially made for him.
- **The Broken Hearts Club**, (2000) R – A group of gay friends in West Hollywood lean on each other to work their way through gay life.
- **But I'm A Cheerleader**, (1999) R – A hilarious mockery of a gay "treatment" center.
- **Chutney Popcorn**, (1999) PG-13 – A young Indian artist deals with her culture, family and lesbianism.
- **The Edge of Seventeen**, (1998) R – The story of a young man coming out in Ohio in the early 80s.
- **The Family Stone**, (2005) PG-13 – Hilarity breaks out when a man takes his uptight girlfriend home for Christmas to meet his family, which includes an interracial gay couple.
- **The Incredibly True Adventure of Two Girls In Love**, (1995) R – The school dyke and the popular straight girl fall in love in this cute, romantic comedy.
- **Saved!**, (2004) PG-13 – Comedy about a girl who gets pregnant trying to save her boyfriend from homosexuality and finds herself ostracized from her Christian private school.
- **All About My Mother**, (1999) R – A mother mourning her son's death sets out to find his father, a transvestite prostitute, and meets a pregnant nun and a lesbian actress on the way.
- **Angels In America**, (2003) Not Rated – Playwright Tony Kushner adapts his political epic about the AIDS crisis during the mid-eighties around a group of separate but connected individuals.
- **Beautiful Thing**, (1996) R – A pair of teenage boys in a working-class neighborhood, both vaguely aware they might be gay, become aware of their homosexuality, but once they realize that they're attracted to each other, neither is sure just what to do.
- **Boys Don't Cry**, (1999) R – Based on the life of Brandon Teena.
- **Brokeback Mountain**, (2005) R – Love story of two cowboys who fall for each other one summer and form a lifelong bond that they struggle to maintain as they marry and go about their separate lives.
- **If These Walls Could Talk 2**, (2000) R – A three part story about different groups of lesbians living in the same house over the decades.

- **Imagine Me & You**, (2005) R – A bride finds herself attracted to the woman in charge of the floral arrangements at her wedding.
- **The Laramie Project**, (2002) Not Rated – Based off the play of the same name and compiled from interviews gathered from citizens of Laramie, WY, after the murder of Matthew Shepard.
- **Latter Days**, (2003) R – A gay party boy falls for a young Mormon missionary.
- **Philadelphia**, (1993) PG-13 – Tom Hanks won best actor for his performance opposite Denzel Washington as a gay man suing his law firm for AIDS discrimination.
- **Quinceanera**, (2006) R – A girl discovers she's pregnant and, after being kicked out of her house, moves in with her great-uncle and her gay cousin.
- **The Wedding Banquet**, (1993) R – A Taiwanese-American gay man convinces his parents he's getting married to a nice girl to get them off his back, but things get complicated when his parents decide to fly in to help plan the wedding and his partner starts to get irritated.
- **The Aggressives**, (2005) Not Rated – Generally acclaimed as a piece profiling "stories from the NYC lesbian subculture," the Aggressives is a piece about LGBTQ-identified people of color (predominately Afro-Americans) in trans, masculine, butch, and other gender non-conforming spaces.
- **For The Bible Tells Me So**, (2007) Not Rated – Focuses on five very different and diverse religious families and how they reacted to their children coming out.
- **Fish Out Of Water**, (2009) Not Rated – A documentary that faces down the controversies between homosexuality and religion, examining Bible verses quoted as condemnatory and discussing alternative meanings.
- **All God's Children**, (1996) Not Rated – A documentary that analyses the relation between Christianity and sexual orientation in the context of the African American community.
- **Trembling Before G-d**, (2001) Not Rated – A cinematic portrait of various gay Orthodox Jews who struggle to reconcile their faith and their sexual orientation.
- **A Jihad for Love**, (2007) Not Rated – A documentary on gay, lesbian, and transgender Muslims across the Muslim and Western worlds.

### Television

- **The Real O'Neil's**, (2016-2017) ABC – A family's bond is strengthened when the youngest son tells his parents that he's gay.
- **The Fosters**, (2013-present) ABC Family – A teenager is placed in a foster home with a lesbian couple and their blend of biological, adoptive and foster children.
- **Noah's Arc**, (2005-2006) Logo – This series follows the lives and relationships of four African American gay men in Los Angeles.
- **Looking**, (2014-2016) HBO – The experiences of three close friends living and loving in modern-day San Francisco.
- **Modern Family**, (2009-present) ABC – Three different, but related families face trials and tribulations in their own uniquely comedic ways.
- **Glee**, (2009-2015) Fox – A group of ambitious misfits try to escape the harsh realities of high school by joining a glee club, where they find strength, acceptance and, ultimately, their voice, while working to pursue dreams of their own.
- **RuPaul's Drag Race**, (2009-present) Logo – RuPaul searches for America's next drag superstar.

- **The L Word**, (2004-2009) Showtime – Follows the lives and loves of a small, close-knit group of lesbians living in Los Angeles as well as the friends and family members that either support or loathe them.
- **Will & Grace**, (1998-2006) NBC – Will and Grace live together in an apartment in New York. He's a gay lawyer, she's a straight interior designer.
- **Ugly Betty**, (2006-2010) ABC – A young, smart and wise woman named Betty Suarez goes on a journey to find her inner beauty.

### **Music**

- |                     |                       |
|---------------------|-----------------------|
| • Sam Smith         | • Freddie Mercury     |
| • Years & Years     | • Elton John          |
| • Lady Gaga         | • Tracy Chapman       |
| • George Michael    | • Scissor Sisters     |
| • Frank Ocean       | • RuPaul              |
| • Rufus Wainwright  | • Boy George          |
| • David Bowie       | • Meshell Ndegeocello |
| • Melissa Etheridge | • Tegan & Sara        |

## **LGB Youth Advocacy Resources**

### **It Gets Better Project**

info@itgetsbetter.org  
www.Itgetsbetter.org

### **Gay & Lesbian Alliance Against Defamation (GLAAD)**

info@glaad.org  
www.glaad.org

### **Advocates For Youth**

202-419-3420, ext. 30  
www.advocatesforyouth.org  
www.youthresource.com  
information@advocatesforyouth.org

### **American Civil Liberties Union LGBT and AIDS Projects**

212-549-2627  
www.aclu.org/getequal  
getequal@aclu.org

### **The Gay, Lesbian and Straight Education Network (GLSEN)**

212-727-0135  
www.glsen.org  
glsen@gslen.org  
**Gay-Straight Alliance Network**  
415-552-4229

[www.gsanetwork.org](http://www.gsanetwork.org)  
[info@gsanetwork.org](mailto:info@gsanetwork.org)

**Human Rights Campaign**

202-628-4160  
TTY 202-216-1572  
[www.hrc.org](http://www.hrc.org)

**OutProud: The National Coalition for Gay, Lesbian, Bisexual and Transgender Youth**

[www.outproud.org](http://www.outproud.org)  
[info@outproud.org](mailto:info@outproud.org)

**The Safe Schools Coalition**

24-Hour Crisis Line:  
1-877-723-3723  
206-957-1621  
[www.safeschoolscoalition.org](http://www.safeschoolscoalition.org)

**United States Department of Education**

[www.ed.gov](http://www.ed.gov)

**Youth Guardian Services**

877-270-5152  
[www.youth-guard.org](http://www.youth-guard.org)

**Bisexual Resource Center**

617-424-9595  
[www.biresource.org](http://www.biresource.org)  
[brc@biresource.org](mailto:brc@biresource.org)

**General LGB Resources**

**National Gay and Lesbian Task Force (NGLTF)**

202-393-5177  
TTY 202-393-2284  
[www.thetaskforce.org](http://www.thetaskforce.org)  
[info@thetaskforce.org](mailto:info@thetaskforce.org)

**CenterLink: The Community of LGBT Centers**

[www.lgbtcenters.org](http://www.lgbtcenters.org)



### **Family and Parenting Resources**

#### **Parents, Families and Friends of Lesbians and Gays (PFLAG)**

202-467-8180

[www.pflag.org](http://www.pflag.org)

[info@pflag.org](mailto:info@pflag.org)

#### **Family Equality Council**

[info@familyequality.org](mailto:info@familyequality.org)

[www.familyequality.org](http://www.familyequality.org)

### **LGB Communities of Color Resources**

#### **Latino & Hispanic Communities**

##### **Familia es Familia**

[familiaesfamilia.org](http://familiaesfamilia.org)

##### **League of United Latin American Citizens (LULAC)**

##### **LGBT Program**

[lulac.org/programs/lgbt](http://lulac.org/programs/lgbt)

##### **Queer Undocumented Immigrant Project (QUIP)**

[unitedwedream.org](http://unitedwedream.org)

##### **National Latino LGBT and Ally Convening**

[sites.google.com/site/creatingchangelatino](http://sites.google.com/site/creatingchangelatino)

#### **Asian Pacific Islander (API) communities**

##### **API Equality (Northern California)**

[norcal.apiequality.org](http://norcal.apiequality.org)

##### **API Equality (Southern California)**

[apiequalityla.org](http://apiequalityla.org)

##### **National Queer Asian Pacific Islander Alliance (NQAPIA)**

[www.nqapia.org](http://www.nqapia.org)

##### **Trikone (South Asian communities)**

[www.trikone.org](http://www.trikone.org)

#### **African American Communities**

##### **National Black Justice Coalition**

[www.nbjc.org](http://www.nbjc.org)

##### **Audre Lorde Project (multi-cultural)**

[www.alp.org](http://www.alp.org)

##### **Gay Men of African Descent (GMAD)**

[www.gmad.org](http://www.gmad.org)

##### **Zuna Institute**

[www.zunainstitute.org](http://www.zunainstitute.org)

### **LGB Anti-Violence & Hate Crimes Resources**

**National Coalition of Anti-Violence Programs (NCAVP)**  
www.ncavp.org

**Matthew Shepard Foundation**  
www.matthewshepard.org

**Community United Against Violence**  
www.cuav.org

### **LGB Sports Resources**

**LGBT Sports Foundation**  
www.facebook.com/lgbtsportsfoundation/

**You Can Play Project**  
www.youcanplayproject.org

**National Center for Lesbian Rights (NCLR) Sports Project**  
www.nclrights.org/explore-the-issues/sports/

**The Ben Cohen StandUp Foundation**  
www.standupfoundation.com

### **LGB Affirming Religious and Spiritual Organizations**

**Affirmation (Mormon)**  
661-367-2421  
www.affirmation.org

**The Fellowship**  
415-861-6130  
www.radicallyinclusive.com

**Al Fatiha (Islam)**  
www.al-fatiha.org

**Gay Lesbian and Affirming Disciples (GLAD) Alliance, Inc.**  
703-866-4628  
www.gladalliance.org

**Association of Welcoming and Affirming Baptists**  
240-515-8664  
www.wabaptists.org

**Gay and Lesbian Vaishnava Association (Hindu)**  
www.galva108.org

**Brethren Mennonite Council for LGBT Interests**  
612-343-2060  
www.bmclgbt.org

**Integrity USA (Episcopalians)**  
800-462-9498  
www.integrityusa.org

**The Covenant Network of Presbyterians**  
415-351-2196  
www.covnetpres.org

**Keshet (Jewish)**  
617-524-9227  
www.keshetonline.org

**Dignity/USA (Catholic)**  
800-877-8797  
www.dignityusa.org

**Lutherans Concerned**  
651-665-0861  
www.reconcilingworks.org

**Metropolitan Community Churches**  
310-360-8646  
[www.mcccchurch.org](http://www.mcccchurch.org)

**New Ways Ministries (Catholic)**  
301-277-5674  
[www.newwaysministry.org](http://www.newwaysministry.org)

**Queer Dharma (Buddhist)**  
212-675-6544  
[www.queerdharma.org](http://www.queerdharma.org)

**Reconciling Ministries Network (Methodist)**  
773-736-5526  
[www.rmnetwork.org](http://www.rmnetwork.org)

**Room for All (Reformed Church in America)**  
201-364-4538  
[www.roomforall.com](http://www.roomforall.com)

**Seventh-Day Adventist Kinship International**  
[www.sdakinship.org](http://www.sdakinship.org)

**Unitarian Universalist Association's Office of BGLT Concerns**  
[www.uua.org/obgltc](http://www.uua.org/obgltc)

**The United Church of Christ Coalition for LGBT Concerns**  
800-653-0799  
[www.ucccoalition.org](http://www.ucccoalition.org)

**Unity Fellowship Church Movement**  
[www.unityfellowshipchurch.org/](http://www.unityfellowshipchurch.org/)

### **LGB Legal Resources**

#### **Lambda Legal**

www.lambdalegal.org  
 www.lambdalegal.org/help  
 Legal Help Desk 866-542-8336

#### **American Civil Liberties Union LGBT and AIDS Projects**

212-549-2627  
 www.aclu.org/getequal  
 getequal@aclu.org

#### **National Center for Lesbian Rights (NCLR)**

Legal Help Line: 800-528-6257  
 415-392-6257  
 www.nclrights.org  
 info@nclrights.org

### **Crisis Hotlines for LGB Youth**

#### **The Gay and Lesbian National Hotline (GLNH)**

National Hotline: 888-843-4564  
 GLBT National Youth Talkline: 800-246-7743  
 www.glnh.org  
 questions@GLBTNationalHelpCenter.org

#### **National Runaway Switchboard**

800-RUNAWAY  
 Agency and Information Line:  
 800-344-2785  
 773-880-9860  
 www.1800runaway.org  
 info@nrscrisisline.org

#### **The Trevor Project**

Toll-free hotline: 866-4U-TREVOR  
 310-271-8845  
 www.thetrevorproject.org  
 support@thetrevorproject.org

#### **The Safe Schools Coalition**

24-Hour Crisis Line:  
 877-723-3723  
 206-957-1621  
 www.safeschoolscoalition.org

#### **National Hotline for Gay, Bisexual and Lesbian Youth**

800-347-TEEN

## **LGB Psychoeducation**

(Appendix B)

### **How to talk about LGB terms and definitions with adolescents and parents:**

(Adapted from Planned Parenthood Federation of America Inc., 2016:

<https://www.plannedparenthood.org/teens/lgbtq/all-about-lgbtq>):

### **What's sexual orientation?**

- **Sexual orientation** includes the terms gay, lesbian, bisexual, and heterosexual describes which gender(s) you're attracted to, sexually and/or romantically. Sometimes a person's sexual orientation changes over time, but people can't choose or decide to change who they're attracted to.
- **LGBTQ** stands for lesbian, gay, bisexual, transgender, or questioning.
- A woman who is attracted to other women often calls herself **gay**, a **lesbian**, or **homosexual**.
- A man who is attracted to other men often calls himself **gay** or **homosexual**.
- People who are attracted to both women and men often called themselves **bisexual**.
- People who are attracted to people of opposite genders often call themselves **heterosexual** or **straight**.
- We use the word "often" instead of "always" because some people don't think that any of these labels really fit who they are or describe how they see themselves. Some people use labels and terms that we haven't even talked about here (there are a lot of them). Still, some people prefer not to use any labels at all.
- It can take many years for some people to understand their sexual orientation, and for others, they might have known that they were gay, straight, or bisexual from a very young age. Therefore, some people call themselves **questioning** because they aren't sure about their sexual orientation or gender identity yet. This is especially common for teens.

### **What's the difference between sex and gender?**

- A lot of people think that sex and gender are pretty much the same, but there's actually a big difference.
- **Sex** is biological – it's about your body. It includes your genes, hormones, and physical parts (like genitals) that people use to determine if our bodies are female, male, or intersex (people whose bodies aren't clearly female or male).
- **Gender** is how society thinks we should look, think, and act as girls and boys, women, and men. Often times, gender is based on the sex someone was assigned at birth.
- **Gender identity** is how we feel about our sex and gender and how we express those feelings by the way we dress, act, speak, etc.

### **What do transgender and cisgender mean?**

- **Transgender** is the "T" in LGBTQ. Some people have a gender identity that doesn't match up with their biological sex – for example, they were born with "female" sex organs, such as a vulva, vagina, or uterus, but they feel and identify as being male. People in this community sometimes call themselves transgender or "trans." However, don't use

terms like transgendered, tranny, or transvestite because they're hurtful to the trans community.

- Most people who have female bodies feel like girls or women, and most people who have male bodies feel like boys or men. These people are often called **cisgender (or cis)**.
- **Trans** can also include people who don't identify with the strict male/female gender roles the world tells us we should fit into. Sometimes people who don't feel either male or female call themselves **genderqueer**.

### **What does queer mean?**

- Queer is often used to include lesbian, gay, bisexual, transgender, and intersex people — but queer is not the same as LGBTQ. “Queer” is sometimes used to express that sexuality and gender can be complicated and change over time for lots of people. If you're still confused about what queer means, that's okay. It can be hard to understand.
- Something to keep in mind though... the word “queer” has been, and sometimes still is, used to hurt or disrespect LGBTQ people. So, rather than just calling someone “queer,” it's better to ask them what labels or words they prefer.

### **What are homophobia & transphobia?**

- **Homophobia** is fear or hatred of people who are or are thought to be lesbian, gay, or bisexual (LGB).
- **Transphobia** is fear or hatred of people who are trans or who don't look the way some people think males and females should look.
- Homophobia and transphobia can lead to bullying against LGBTQ and straight people.
- If you or someone you know is being bullied, the best thing you can do is to ignore the bully or stand up to them (calmly and without violence), and then talk to an adult you trust.
- **What do homophobia and transphobia look like? Here are some examples:**
  - Trying to avoid contact with people who are LGBTQ.
  - Bullying someone you think is LGBTQ.
  - Getting grossed out by PDA (kissing, hugging, holding hands) between two men or two women, but not between a man and a woman.
  - Assuming that everyone you meet is straight/cisgender.
  - Being afraid to touch or be too close with someone of the same gender as you, especially if you know they're LGBTQ.
  - Assuming that if an LGBTQ person of the same gender is nice to you, they're flirting with you.
  - Calling a trans person by their born name or gender if they don't think of themselves that way (e.g., calling someone “him” if they identify as female)
- **Why does this matter?** Homophobia and transphobia hurt everyone. They can prevent LGBTQ people from feeling safe, living full lives, and being their true selves. Homophobia and transphobia lead to discrimination and violence against LGBTQ people and those suspected of being LGBTQ. They can result in feelings of depression, anxiety, and isolation; and may even lead to suicide. Homophobia and transphobia don't just hurt LGBTQ people, but they also hurt straight people by causing them to think that they can't form close friendships with people of the same gender, and by forcing men to act “macho” and women to act “feminine,” even if those roles don't feel right for them.

## Chapter 2: Parenting Skills

### Purpose

The purpose of this chapter is to explore the role of parental support within the context of LGB adolescent sexual identity development, to discuss ways in which parents' rejection or acceptance of their child's sexual orientation may contribute to or mitigate the effects of trauma experienced by LBG youth, and to provide therapists with strategies for enhancing parental support among LGB adolescents affected by trauma.

### Parental Support and LGB Adolescent Identity Development: Differing Perspectives

**Adolescent experience.** Over the past three decades, research has shown a trend towards young people coming out or identifying as LGB at an increasingly earlier age (LaSala 2010; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). An analysis of research conducted on lesbians and gay men in the 1970's, for instance, found that, on average, individuals reported having their first awareness of same-sex attractions between the ages of 14 and 16, and reported self-identifying as LGB between the ages of 19 and 23, usually after moving away from home (Troiden, 1988; Wilber, Ryan, & Marksamer, 2006). In comparison, more recent studies have found that, on average, young people report awareness of their first same-sex attractions around the age of 10 (Herdt and Boxer, 1993; D'Augelli, 2006; Rosario, Schrimshaw, & Hunter, 2009). Ryan and her colleagues at the Family Acceptance Project – an ongoing research initiative studying LGBT adolescents and their families – also found that the youth in their study tend to begin self-identifying as LGB around the age of 13 (SAMHSA, 2014). Some explanations for this shifting trend likely include greater awareness and visibility of LGB figures in society and the media, as well more widespread access to information about sexual orientation and sexual minority identities via the internet (Gomillion & Giuliano, 2011).

Nonetheless, this increasingly early age at which young people are disclosing means that adolescents are more likely to come out while still dependent on their families and communities for emotional and instrumental support (SAMHSA, 2015). However, despite coming out earlier, many youth continue to report that fear of negative parental reactions remains one of the primary reasons for concealing or delaying disclosure of their sexual orientation (Savin-Williams, 2003).

In general, when they do come out to their families, adolescents often report lower levels of family connectedness and parental support than their heterosexual peers, especially in the period immediately following disclosure (Eisenberg and Resnick, 2006; Needham & Austin, 2010; Saewyc et al., 2009; Savin-Williams, 1998). LGB adolescents who anticipate negative reactions from their parents are less likely to disclose their sexual orientation, and, as a result, may become emotionally distant from parents and other sources of family support (Savin-Williams 1998). In one study, more than two-thirds of LGB adolescents reported that it was “somewhat” or “extremely” troubling to come out their parents (Pilkington & D’Augelli, 1995). Another study found that one-fifth of its LGB participants reported having mothers who were intolerant or rejecting of their sexual orientation after disclosure (D’Augelli & Hershberger, 1993). Similarly, in a study of victimization among LGB youth, D’Augelli (2006) found that many reported verbal abuse from their mothers (13%) or feared verbal abuse from their parents (30%) due to their sexual orientation. Also within that study, 13% of the youth reported living in fear that a parent would physically abuse them. In another study, 50% of LGB adolescents experienced a negative reaction from their parents when they came out and 26% were ejected from their homes (Remafedi, 1987). Not surprisingly, then, LGB adolescents represent a disproportionately high number of homeless youth. Based on a comprehensive review of the research literature, the National Gay and Lesbian Task Force estimated that between 20% and



40% of all homeless youth in the United States identify as LGBT (Ray, 2006). Thompson, Safyer, and Pollio (2001) further noted that among their study's large sample of homeless youth, more than one-third of their LGB respondents reported experiencing a violent physical assault when they came out. Thus, although parents do not always respond negatively, disclosure of sexual orientation to parents has been identified as one of the most stressful developmental tasks for LGB adolescents (Ueno, 2005).

**Parent experience.** For many parents, finding out that their son or daughter is beginning to exhibit behaviors consistent with a same-sex attraction, or identifies as LGB, comes as a shock (Savin-Williams, 2001). This often creates disruption to the parent-child relationship and poses significant challenges to a parent's ability to provide support (Ryan, Huebner, Diaz, & Sanchez, 2009). Susan Saltzburg (2004), in her in-depth interviews with parents of LGB adolescents, found that in addition to shock, following a child's disclosure many parents report experiences of panic, deep sadness and loss, a sense of existential aloneness, and feelings of shame. Saltzburg noted that all of the parents in her study spoke of a deep disappointment that their children would not live out the lives that they had imagined for them, or for themselves as parents. Saltzburg (2004) also found that parents experienced significant emotional turmoil and cognitive dissonance as they struggled to assimilate negative beliefs about homosexuality with the loving thoughts they had for their children. As a result of this internal conflict, many parents in the study withdrew socially, becoming emotionally detached and disengaged from their parental responsibilities at a critical juncture in their child's life. Thus, Saltzburg observed that when a child comes out, parents often engage in critical self-thoughts, and beliefs about having failed as a parent may cause them to become further depressed. In addition to this, for all of the parents in Saltzburg's (2004) study, fears of estrangement due to their child's growing identification with

an LGB subculture, which many parents knew little about or felt excluded from, seemed to further intensify feelings of detachment and loss. According to Saltzburg, embedded within these fears of estrangement were the parents' beliefs that they would no longer be able to serve as role models for their children due to the differences that now seemed to separate them.

In a similar study, Barbara Bernstein (1990) also observed several recurrent themes among parents' reactions to their child's disclosure of an LGB identity. Bernstein found that one of the major obstacles preventing parents from accepting their child's LGB identity was fear of social stigma, either for being seen as an inadequate parent or for having a defective child. Along with this, a majority of the parents in her study also presumed that psychological factors were responsible for their child's sexual minority orientation. As a result, parents tended to blame themselves, their partners, or outside influences for the child's perceived difficulties. Others have noted that this theme may be particularly salient among parents of LGB youth who have been sexually abused by a same-sex perpetrator who is also LGB (National Child Traumatic Stress Network [NCTSN], 2014). For example, due to a lack of opportunities to meet other sexual minority youth, LGB adolescents, and gay male youth in particular, may be more likely to explore their sexuality in secrecy, which, in turn, may put them at greater risk for being exploited by adults (Rind, 2001). This type of abuse may result in both the child and the parent developing or building upon preexisting myths or stereotypes that sexual trauma either causes or is caused by one's homosexuality (Saewyc et al., 2006). Thus, based on this premise, some parents may seek to blame the child's sexual orientation on the sexual trauma, and, as a result, may seek assistance in attempting to change or alter their child's sexual orientation, a process deemed harmful and widely discredited by contemporary research (American Psychological Association [APA], 2009; SAMHSA, 2015). As mentioned before, despite the fact that LGB youth are at

higher risk for experiencing sexual trauma, several studies have disproven the myth that sexual abuse causes one to develop a non-heterosexual orientation (Saewyc, 2011; Saewyc et al, 2006). For instance, Saewyc (2011) noted that several large population-based surveys across North America found that less than half of the LGB-adolescent respondents reported experiences of sexually abuse; and, in addition to that, the majority of youth who reported experiences of sexual abuse identified as heterosexual. Ultimately, however, it is therapist's task to help parents and their children separate sexual abuse and its effects from sexual orientation (King, 2000).

Furthermore, the parents in Bernstein's study also reported significant feelings of disappointment around the lost fantasy of a heterosexual child. In general, parents were anguished by the belief that they might not have biological grandchildren, or that they would miss out on sharing important rituals, such as weddings, anniversaries, and births, typically associated with a traditional family life. Finally, other reactions included fears that their children would become victims of violence, discrimination, or illness, that their children would live lonely lives without children or marriage, and that their children might alienate themselves from the family. Taken together, Saltzberg (2004) and Bernstein's (1990) findings suggest that parents are likely to experience significant challenges as they attempt to adjust to their adolescent's sexual minority orientation, and these difficulties may be further amplified by the nature of their child's traumatic experiences. As such, parents may need help processing both internal and external conflicts, as well as help in developing appropriate strategies for responding to their children. While some authors have likened this process of family adjustment to Kubler Ross's (2005) stages of loss – denial, anger, bargaining, depression, and acceptance, others have theorized that parents may experience their own parallel “coming out” process, in which they too

must undergo a process of identity development as the parent of an LGB child (Phillips & Ancis, 2008).

In a study examining parental reactions to the disclosure of a child's sexual minority orientation, Phillips and Ancis (2008) focused their research on developing a model for how parents might adapt over time both to their child's LGB identity, as well as their own identity as the parent of an LGB child. What they found is that parental adjustment generally occurred across three broad phases (i.e., early, middle, and later adjustment), and that within each phase parents underwent a range of emotional, cognitive, behavioral, moral, and spiritual developmental processes. Consistent with the previous discussion of parental reactions, Phillips and Ancis found that in the early phase of adjustment, parents' responses were predominantly emotionally focused, ranging from shock and denial to anxiety, fear, anger, and confusion. They, too, found that an important early issue for many parents was the question of causality, and suggested that accurate information and guidance at this time was related to more adaptive coping strategies and healthy identity development. During the middle phase of adjustment, parents reported greater emotional distress as they began to deal with positive and negative reactions from other family members, as well as thoughts of how their children might be discriminated against in society. Phillips and Ancis noted that during this phase, parents who put more effort into learning about sexual orientation, spent time immersing themselves in the gay community and culture, and developed friendships with LGB people, reported an easier adjustment process, as well as stronger relationships with their children. However, at the same time, some parents appeared to distance themselves from important sources of support, such as family members, friends, or faith communities that were not accepting of their child's sexual orientation. This suggests that parents may need support in navigating difficult relationships and

setting healthy boundaries, reconciling conflicting values and belief systems, and managing issues around their own process of disclosure. In the later phase of adjustment, Phillips and Ancis observed dramatic differences from earlier phases in terms of the parents' level of commitment to new values and perceptions of themselves, their children, and the gay community. Having come to accept their child's sexual identity, as well as their own identity as parents of an LGB child, many parents expressed a new found ability to accept their children for who they are, rather than for who they wanted them to be, and identified love for their children as their highest value. Additionally, many parents reported becoming more assertive about addressing expressions of intolerance, developing greater compassion and sensitivity to people of other marginalized groups, and engaging in greater social advocacy efforts. In sum, the research demonstrates that while parental reactions and perceptions of an adolescents' LGB identity may be initially distressing, there is often room for significant growth and change to occur. However, understanding the relationship between supportive or harmful parental responses and the associated health risks and wellbeing of LGB youth is essential in assessing family needs, educating parents, and developing strategies for helping families decrease stressors and prevent further victimization among already traumatized LGB youth.

### **Parental Support and Relationship to Health Risks and Wellbeing**

As previously mentioned, parental responses towards LGB youth have been observed to vary widely (Phillips & Ancis, 2008; SAMHSA, 2014). Though the research on families of LGB adolescents is relatively limited, both parental rejection and parental support appear to be significantly related to the sexual identity development of LGB youth, and play an important moderating role in terms of youths' mental and physical health risks and wellbeing (Bouris et al., 2010).

### **Parental rejection: Impact on identity development and increased health risks.**

Several researchers have identified rejection of a youth's sexual orientation by their parents as one of the greatest stressors facing LGB adolescents (Bregman, Malik, Page, Makynen, & Lindahl, 2013; D'Augelli & Hershberger, 1993). In a study of 81 LGB youths (ages 14-25), Willoughby, Doty, and Malik (2010) found that family rejection of sexual orientation had a significantly negative impact on LGB identity development and corresponded to greater internalized homophobia, identity confusion, and needs for acceptance. Moreover, research conducted in both the United States and Canada has well documented the anxious, angry, and sometimes violent ways in which some parents respond to their child's disclosure of an LGB identity (Reis & Saewyc, 1999; Saewyc et al., 2006). Waldo and his colleagues (1998) found that in addition to disclosure as a trigger for family maltreatment, LGB youth who do not conform to social and cultural gender norms are at an even higher risk for parental rejection and are more likely to experience violence perpetrated by their families and communities. D'Augelli, Grossman, and Starks (2006) further noted that since gender-nonconforming LGB youth are more likely to fear or anticipate rejection from their parents, they often conceal or delay disclosure, again, making them increasingly vulnerable to sexual orientation violence and future mental health problems. Similar fears have been found among ethnic minority LGB youth who tend to conceal or delay disclosure, not only for fear of being rejected by their parents, but also for fear of being rejected by their ethnoracial community, an important source of self-identification and buffer from ethnicity related stressors (Garnets & Kimmel, 1991; Greene, 1994; Grov, Bimbi, Nanín, & Parsons, 2006; Meyer, 2010; Potoczniak, Crosbie-Burnett, & Saltzburg, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Wynn, Filmore, & Paladino, 2014).

In their extensive interviewing and data collection among LGB adolescents and their families, researchers at the Family Acceptance Project (FAP) identified over 100 specific ways in which parents and caregivers react to their child's LGB identity; of those behaviors, 51 were categorized as rejecting (Ryan, 2009; 2010). A list of rejecting family behaviors that the FAP found to be significantly associated with an increase in physical and mental health problems among LGB youth is summarized below (Ryan, 2009, p.8):

- Hitting, slapping, or physically hurting the youth because of his or her LGB identity.
- Verbal harassment or name-calling because of the youth's LGB identity.
- Excluding LGB youth from family events and family activities.
- Blocking the youth's access to LGB friends, events, and resources.
- Blaming the LGB youth for discrimination experienced because of his or her LGB identity.
- Pressuring the youth to be more (or less) masculine or feminine.
- Telling an LGB youth that God will punish him or her because of their sexual orientation.
- Telling an LGB youth that you are ashamed of him or her, or that how he or she looks or acts will shame the family.
- Making an LGB youth keep their LGB identity a secret in the family and not letting them talk about it.

Moreover, the FAP found that LGB youth whose parents engaged in the aforementioned rejecting behaviors reported significantly higher levels of negative health problems (Ryan, Huebner, Diaz, and Sanchez, 2009). For example, Ryan and her colleagues (2009) found that among LGB young adults, those who reported high levels of family rejection during

adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal substances, and 3.4 times more likely to report having engaged in unprotected sex. In addition to this, youth who are unable to gain acceptance from their parents are more likely to seek acceptance outside of the home, which may put them at increased risk for substance use, victimization, and high-risk sexual behaviors (Coker, Austin, & Shcuster, 2010; Padilla, Crisp, & Rew, 2010). Lastly, as previously mentioned, a disproportionate number of LGB youth runaway or are ejected from their homes due to parental rejection, in turn, putting them at even greater risk for sexual and physical violence (Coker et al., 2010; Ray, 2006; Saewyc, 2011). Thus, identifying specific behaviors perceived as rejecting or unsupportive and helping parents understand the physical, mental, and emotional toll such behaviors have on their children, is one way in which therapists can prevent further trauma or disruptions to healthy identity development among sexual minority youth.

**Parental acceptance: Affirming LGB identities and promoting wellbeing.** In strong contrast to the effects of parental rejection among LGB youth, parent-child relationships characterized by closeness, acceptance, and support have generally been associated with positive LGB identity development, as well as increases in physical health and mental wellbeing (Bergmann et al., 2013). In a study of 317 gay and lesbian youth, Savin-Williams (1989) found that those who perceived their parents' attitudes towards their sexual orientation to be relatively positive were more likely to have greater self-esteem, to feel comfortable with their sexual orientation, and to be less self-critical. Similarly, Floyd et al. (1999), in a study of 72 LGB youth ages 16-27, found that parental acceptance of a child's same-sex attractions was associated with the child's feeling more open and comfortable with their sexual orientation, whereby leading to



greater consolidation of the child's sexual identity. Additionally, in a study of 169 LGB youth ages 14-24, Bregman et al. (2013) found that parental acceptance and support, specifically related to the youth's sexual identity, were significantly associated with developing a more positive LBG identity. As such, the current research literature suggests that many youth may need help in coping with stressors directly related to their sexuality (Friedman and Morgan, 2009). Therefore, parents who are able to provide emotional support as youth encounter experiences with discrimination, rejection, or internal conflict, or who can provide advice about romantic relationships and coming out, or who can offer practical forms of assistance, such as transportation to LGB-related social events, are more likely to help their youth cope with sexuality-related stress and develop a more positive LGB identity (Bregman et al., 2013; Doty et al, 2010; Nesmith, Burton, & Cosgrove, 1999).

In addition to developing a more positive sense of oneself as an LGB person, data from the FAP indicated that high levels of family acceptance in adolescence predicted greater self-esteem, social support, and general health status, in addition to protecting against depression, substance abuse, and suicidal ideation (Ryan et al., 2010). The FAP found that LGB youth who felt accepted by their families were much more likely to believe they would have a good life and grow up to be happy and productive adults. In comparison to youth from rejecting families, the FAP also found that young people who are accepted by their families have much closer relationships with them, are more satisfied with their lives, and are more likely to want to become parents themselves (Ryan, 2009). Moreover, the FAP identified several, specific, supportive family behaviors that have been found to reduce an LGB child's risk for physical and mental health problems as well as promote wellbeing and positive identity development (see list adapted from Ryan [2009] below):

- Talking with the youth about his or her LGB identity.
- Supporting the youth's identity even though you may feel uncomfortable.
- Advocating for the youth when he or she is mistreated because of their LGB identity.
- Requiring that other family members respect the LGB youth.
- Connecting the youth with an LGB adult role model or mentor.
- Bringing the youth to LGBT organizations or events.
- Working to make your religious congregation supportive of LGBT members or finding a supportive faith community that welcomes your family and LGB child.
- Welcoming the youth's LGBT friends and partners to your home and to family events.
- Supporting the youth's gender expression.
- Believing that the youth can have a happy future as an LGB adult.

In addition to identifying ways in which families can provide both general and sexuality-specific support to their children, the most recent findings from the FAP have shown that parental reactions to a child's sexual minority identity appear to be more varied and more hopeful than had been previously assumed (SAMHSA, 2014; Ryan et al., 2010). For example, Ryan and her colleagues found that while family reactions may range from highly rejecting to highly accepting, an increasingly larger proportion of families are responding to their LGB youth with acceptance or ambivalence, as opposed to uniform rejection (SAMHSA, 2014). Along with this, several studies have found that families who initially rejected their adolescent's sexual orientation tend to become less rejecting over time (Cramer & Roach, 1988; D'Augelli, 2005; Potoczniak, Crosbie-Burnett, & Saltzburg, 2009), and there is research to suggest that many families become more accepting of their youth's sexual orientation within approximately two-to-three years of disclosure (SAMHSA, 2014). Researchers also found that parents and families, in

general, desire a better relationship with their LGB children and often want to support them, though many report not knowing how. In line with this finding, the FAP observed that parents and caregivers perceived as rejecting or who engaged in rejecting behaviors towards their LGB youth, (e.g., attempting to change the child's sexual orientation) were often motivated by "care and concern" or the hope of helping their LGB child "fit in" and be accepted by others (SAMHSA, 2014, p.5). Based on this premise, the FAP found that if parents are provided with support, accurate information, and a knowledgeable source for guidance, then several negative outcomes for LGB youth, such as suicide, homelessness, or placement in foster care, are likely to be prevented or reduced. Lastly, the FAP observed that many parents whose LGB youth were placed in out-of-home care, who ran away, or were ejected from their home continued wanting to have a relationship with their LGB child. Furthermore, given the unique needs of LGB youth and their parents, along with research suggesting that specific parental behaviors can either increase or reduce trauma and other stressors among LGB youth, there are clear ways in which therapists working with such families can provide meaningful support and guidance as they also engage in trauma-focused therapy.

### **Strategies for Working With Families and Increasing Parental Support**

Given that LGB youth consolidate their sexual orientation while still living with their family, the level of support LGB youth perceive and/or experience within the context of these close and intense parental and familial relationships has a significant impact on their psychological adjustment and physical wellbeing, as well as their ability to accept and disclose their sexual orientation to others (Savin-Williams, 2005). While the literature on LGB adolescents and their families indicates the importance of parental support throughout the coming-out process and beyond, only more recently have researchers begun to advocate for

interventions that address the unique experiences and needs of the parents of LGB youth, especially within the context of their child's developing sexual identity (Bouris et al., 2010; LaSala, 2010; Needham & Austin, 2010; Saltzburg, 2004; Troutman & Evans, 2014).

In order to help therapists provide education, guidance, and support to parents and families of LGB youth, Ryan and her colleagues (SAMHSA, 2014) developed nine guiding principles, or core assumptions, for therapists working with LGB youth and their families. Drawing upon a strengths-based perspective, this family intervention framework views families and caregivers as potential allies in reducing risk, promoting well-being, and creating a healthy future for their LGB youth (Ryan & Chen-Hayes, 2013). Thus, this approach views the family's cultural values, including deeply-held beliefs, as strengths. Research findings are aligned with underlying values to help families understand that it is specific behaviors and communication patterns that contribute to both their LGB child's risk and their well-being. Below, is an adapted list of the core assumptions Ryan and her colleagues (SAMHSA, 2014) suggested therapists maintain when working with the parents and families of LGB adolescents:

- Assume that families love their children and want them to have a good life, while also acknowledging that the hopes and dreams they have for their children's future are shaped by cultural and religious beliefs that may be at odds with their child's sexual orientation.
- Meet families where they are. This includes starting at the family's level of knowledge, expectations, and beliefs about the child's sexual orientation.
- Use a strengths-based framework to align research findings, education and prevention messages, and a family support approach with each individual family's unique set of cultural values and spiritual beliefs around the family.

- Support the need for families to be heard and understood by providing a nonjudgmental space where parents can tell their story and share their experiences and expressions of care and concern for their children's well-being, while understanding that these experiences and expressions are rooted in culture, values, and specific beliefs such as faith traditions.
- Recognize that parents who are seen as rejecting their LGB child are generally motivated by care and concern to help their child "fit in," have a "good life," and be accepted by others.
- Understand that family behaviors are not isolated incidents, but occur in a cultural context aimed at socializing youth to adapt and be successful in a hetero-normative (heterosexual) society. Thus, family behaviors are often aimed as protecting children from harm, including victimization due to an LGB identity.
- Use research findings in demonstrating to families the link between family reactions to a child's LGB identity and negative or positive outcomes in terms of the child's physical and mental health, process of identity development, and future well-being. Aside from building a strong alliance between families and providers, family awareness of the consequences of their behavioral reactions is the most important mechanism of change.
- Be aware that parents and families experience their lack of knowledge about LGB issues as inadequacy that feels disempowering and shameful. Many families perceive their children's LGB identity as a loss, particularly as a loss of control over their children's future. Providers should help families validate and address these feelings by affirming the importance of family support to build their child's self-esteem, to promote their child's well-being, and to buffer rejection and negative reactions from others.

- Recognize that when both rejecting and accepting behaviors exist, parents and caregivers experience ambivalence, and their struggle to validate their LGB child results in decreased support and increased risk. Educating parents on how their reactions affect their LGB children can improve communication and help parents and caregivers respond in ways that help their LGB child feel supported and loved rather than misunderstood or rejected.

### **Clinical Considerations**

**Parent.** In addition to the guiding principles advocated by Ryan and her colleagues at the Family Acceptance Project (SAMHSA, 2014), the FAP emphasizes that meeting families where they are at is an essential first step in treating not only the child, but the entire family system supporting the child. Therefore, assessing where parents are within their own process of identifying as parents of an LGB child is as equally important as assessing the child's stage of sexual identity development. As several other authors have pointed out (LaSala, 2010; Phillips & Ancis, 2008; Saltzburg, 2004; 2009), parents may be experiencing a wide range of thoughts, emotions, and spiritual dilemmas as they attempt to understand and respond to their child's sexual identity and how that relates to their role as parents. It is especially important, then, when working with parents of LGB youth who have experienced interpersonal trauma, to understand how the trauma may have affected the parents' beliefs, attitudes, or perceptions about their child's sexual identity, how it may be influencing their current behaviors, and what kinds of support they are capable or incapable of providing to their child. For example, if an adolescent was abused by a parent or family member due to a suspicion or disclosure of the youth's sexual orientation, then the therapist would need to work with the non-offending parent to first ensure the youth's safety and then, secondly, to assess the non-offending parent's attitudes towards the

offending parent/family member as well as their child. If the non-offending parent believes that the child is to blame for the abuse because of their sexual orientation or gender non-conforming behavior, then the therapist would need to work with that parent to gain an understanding of where he or she developed such beliefs, and if these beliefs are congruent or in conflict with their current values and goals as a parent (SAMHSA, 2014). As suggested by Ryan and her colleagues, therapists can utilize information, electronic materials, and handouts developed by the Family Acceptance Project (see Appendix A) to give to parents when discussing how their behaviors, words, and beliefs influence their LGB child's mental and physical wellbeing (SAMHSA, 2014). Additionally, in such a situation, the therapist may encourage conjoint sessions earlier in therapy to address any concerns that the child may be feeling unsafe or unsupported at home.

Furthermore, after allowing parents to share their experiences, thoughts, and feelings in a supportive and nonjudgmental environment, providing them with accurate information, as well as relatable and respectful language to talk about sexual orientation, may help to normalize their child's LGB identity and decrease feelings of shame and discomfort (SAMHSA, 2014). For some families, talking about sexual orientation issues in an open and non-disparaging, neutral, or even positive way may be challenging or new to them; however, helping them start to frame these issues differently could help to de-stigmatize their youth's sexual minority identity, create the space for change, and combat needs for maintaining secrecy (Saltzburg, 2009). Moreover, for LGB adolescents who have experienced trauma such as sexual abuse or sexual orientation violence, family and cultural messages about secrecy and keeping one's LGB identity hidden may prevent youth from talking about traumatic experiences or asking for help, perhaps due to fears of being outted to others or targeted for further abuse (NCTSN, 2014). Therefore, helping

parents understand how their reactions and behaviors may be perceived by or impacting their child, and offering more adaptive alternative behaviors, will empower parents and allow them to regain a sense of self-efficacy as parents. Lastly, assessing the parents' needs for support and helping them develop strategies for coming out to friends and family members as parents of an LGB child will increase not only their own support system, but the support system for the child as well. Parents may also need or benefit from their own individual therapy, especially if feeling significantly depressed or detached from their child, and may also benefit from connecting to other parents of LGB youth.

**Child.** LGB youth consolidate their sexual orientation while still living with their family, thus, the level of support LGB youth perceive or experience within the context of these close and intense parental and familial relationships has a significant impact on their psychological adjustment and physical wellbeing as well as their acceptance and disclosure of their sexual orientation to others (Savin-Williams, 2005). When LGB youth come out to their families with the hopes of being accepted, they are often met with disappointment by their parents' initial reactions, and, as a result, may distance themselves from their parents or take a defensive and attacking stance. While helping parents become more supportive and less rejecting, clinicians may also help their LGB clients by reminding them of their own adjustment trajectories in order to help them empathize with their parents' responses. By reframing their parents' reactions as part of a normal and hopefully progressive adaptation process, similar to their own, clinicians may be able to help LGB youth not to personalize or react emotionally to their parent's distress. Thus, if LGB youth can begin to perceive their parents' hurt and anger as part of a temporary grieving process, they may be less likely to engage in conflict and more open to receiving support from their parents as treatment progresses (LaSala, 2000). Moreover, when working with



LGB adolescents who have experienced trauma, youth and their families may need help, not only in processing the trauma, but also in learning how to disclose the youth's sexual orientation to family members. By helping LGB youth become more integrated into their families, therapists can help to decrease future victimization of youth, as well as enhance relationships between youth and their families (D'Augelli, Grossman, & Starks, 2005). Lastly, while helping to foster acceptance among parents, it may also be necessary for clinicians to continue helping LGB clients become more accepting of their own developing sexual identity. Talking about sexual identity issues, attending to ongoing trauma or abuse related to the client's sexual orientation, and exploring the impact of the trauma on the client's sexual identity will help to normalize and affirm their experiences and reactions. Helping LGB youth identify sources of strength and derive cultural values, such as pride, from within the LGB community will likely foster resiliency, facilitate adaptive self-exploration, and affirm the client's LGB identity.

**Homework: Parent**

**Increasing support.** There are several ways in which therapists can help parents increase sources of support. During session, use role-play and rehearsal to help parents practice telling others about being the parent of an LGB son or daughter. Help parents identify friends, family members, colleagues, and spiritual leaders who they trust and believe may be supportive, and encourage parents to overcome fears of telling others while normalizing their reactions. Therapists, however, should advise parents to talk with their child first before disclosing the child's sexual identity to others. Also, if their child has friends who identify as LGB, parents should be encouraged to get to know them and perhaps meet their parents as well. In addition to increasing the support network of parents, this type of sexuality-specific support will likely

increase bonding and communication between parents and their youth, while affirming the child's LGB identity and relationships.

Using the Resource Guide in Appendix B, therapists can also refer parents to support groups for parents of LGB children, such as those offered through Parents, Families, and Friends of Lesbians and Gays (PFLAG). PFLAG is an internationally recognized organization with over 400 chapters across the United States and more than 200,000 members and supporters. In addition to advocating for LGBTQ rights and providing educational resources about LGBTQ issues, PFLAG's primary focus is offering supportive services to parents, families, and allies of LGBTQ individuals. Parents and family members can search the website, [www.pflag.org](http://www.pflag.org), for chapters in their area where they can attend group meetings and interact with other parents of LGB youth. PFLAG also offers several resources for parents and families from a wide variety of religious denominations and spiritual backgrounds.

**Bibliotherapy.** Refer parents to the variety of resources provided in Appendix B, such as books and films that specifically address parenting issues. The book, *This Is A Book for Parents of Gay Kids*, by Owens-Reid and Russo, is an example of an especially easy-to-read and practical resource for parents of LGB youth that covers a broad range of topics and utilizes a question and answer format. Additionally, films such as *Prayers for Bobby* (2009) and *Families are Forever* (2013) address conflicts that can arise between one's religious beliefs and parenting an LGB youth. Other films, such as *The Family Stone* (2005), offer depictions of positive, supportive, and LGB affirming parent-child relationships. As parents utilize these resources, it may be helpful to process their experiences in session, as well as to provide additional resources that are specific to their unique circumstances, concerns, or culture.

## Homework: Child

**“Colors of Pride.”** Using Appendix C-1 of this manual, either in-session or as homework, provide the adolescent with a blank copy of the “Colors of Pride” activity sheet. The purpose of this activity is to provide a fun and creative way for adolescent clients to learn about the LGBT community and their history by researching one of its most well recognized symbols, the rainbow flag. Created by artist Gilbert Baker in 1978, the first rainbow flag appeared in San Francisco’s Gay Freedom Day Parade on June 25, 1978, and since then has become an international symbol of hope, diversity, and pride for the LGBT community. Baker’s original design was composed of eight stripes, with each colored stripe representing a different meaning or value: pink for sexuality, red for life, orange for healing, yellow for sunlight, green for nature, turquoise for art, blue for harmony, and violet for spirit. However, due to the high cost of certain fabric colors, among other reasons, today’s rainbow flag only consists of six colors: red, orange, yellow, green, blue, and violet (Pohlen, 2016).

As homework, ask the adolescent client to research the history of the rainbow flag and the meaning of each of its colors. Ask them to color in the blank stripes and write what each of the colors represents to them, encouraging them to be as creative as they would like. For example, clients may chose to use all eight stripes, illustrate each of the colors through drawings or collage, or even create their own version of a flag. Clients can find information about the rainbow flag by searching the internet, can watch videos of the original flag’s debut and interviews with its creator, or can learn about the history and context of the flag by reading books such as *Gay and Lesbian History For Kids* by Jerome Pohlen (see Appendix A for resources and Appendix C for a completed version of the activity with the corresponding colors and meanings). In the following session, discuss the activity, asking what the client learned about their history

and community, what each of the colors means to them, and if any of their meanings align with the client's own values. The goal of the activity is to affirm and explore the client's LGB identity and help them connect to strengths within their LGBT community that can be used as part of their healing and recovery from trauma. Additionally, therapists may encourage clients to share their artwork and what they learned about the rainbow flag with their parents and family members. This is an excellent opportunity for parents to affirm their child's LGB identity by praising and reinforcing their child's sexual identity exploration.

# **Colors of PRIDE!**

(Appendix C)

<b>RED:</b> Represents “life”
<b>ORANGE:</b> Represents “healing”
<b>YELLOW:</b> Represents “sunlight”
<b>GREEN:</b> Represents “nature”
<b>BLUE:</b> Represents “harmony”
<b>PURPLE:</b> Represents “spirit”

**Colors of PRIDE!**

(Appendix C-1)


## **Chapter 3: Relaxation**

### **Purpose**

The purpose of this chapter is to explore stressors unique to sexual minorities and how such stressors might impact the functioning and recovery process of LGB adolescent survivors of trauma. LGB youth, for example, face several, unique external and internal stressors, such as heterosexism, homophobia, internalized homophobia, experiences of discrimination and violence based on their sexual orientation, as well as the ongoing stress of coming out. These stressors, which, in themselves, may also be the cause of the youth's trauma symptoms, are likely to exacerbate trauma-related symptoms and may impede efforts to help youth relax or cope with posttraumatic stress. Suggestions for how to help LGB youth and their parents cope with or decrease sexual minority related stress are offered.

### **Minority Stress Theory**

While experiencing stress plays an important role in healthy adolescent identity development, as members of a sexual minority class, LGB youth are taxed with the additional burden of developing a sexual identity that a heteronormative environment labels as deviant. As a result, LGB youth frequently experience several unique stressors that have been found to negatively impact their physical and mental health. Understanding the process through which these additional stressors influence the mental health of sexual minorities is particularly relevant when addressing ways to help traumatized LGB youth develop relaxation and coping skills related to their experiences with interpersonal trauma. Thus, Illan Myer's (2003) minority stress model is a useful tool for understanding how stressful experiences related to a sexual minority identity can affect the mental health of LGB youth and impede recovery (Cox et al., 2010).

According to Meyer's (2003) minority stress theory, minority stress is conceptualized as the excess stress an individual experiences as a member of a stigmatized minority group. Sexual minorities, in particular, are exposed to excess stress related to a variety of stigma-related experiences that stem from their sexual minority status. For instance, LGB individuals experience prejudice and stressful life events in the form of verbal and physical assaults, everyday discrimination – including microaggressions and slights – expectations of rejection, decreased feelings of self-worth due to internalized homophobia, and stress related to having to conceal their LGB identity or negotiate how and when to come out (Meyer, 2003; Meyer et al., 2008). Meyers (2003) posited that these sexuality-specific stressors place LGB individuals at an increased risk for experiencing a variety of mental and physical health problems, including depression, anxiety, suicidal ideation, substance abuse, high risk sexual behaviors, and higher rates of sexually transmitted diseases. Additionally, researchers have found that when LGB individuals report experiencing both interpersonal trauma and sexuality-specific forms of discrimination (e.g., being bullied at school for identifying as LGB), they are at an even greater risk for engaging in self-injurious behavior, including suicidal ideation and attempts (House et al., 2011).

Underlying Meyer's concept of sexual minority stress is the assumption that minority stressors are unique (i.e., not experienced by non-stigmatized populations), chronic (i.e., occurring across one's lifespan), and socially based (i.e., deriving from social processes, institutions, and structures outside the individual's control) (Meyer, 2003). Therefore, while some forms of minority stress can be experienced by any socially stigmatized group (e.g., prejudice, everyday discrimination, and expectations of rejection), other stressors, such as internalized homophobia or the concealment of one's sexual minority status, are unique to the



experience of sexual minorities (Frost, Lehavot, & Meyer, 2015). Consequently, for LGB adolescents, school-based victimization due to their sexual orientation and the ongoing stress of coming out (i.e., the process of deciding to conceal or disclose one's sexual orientation) have been identified as particularly salient stressors (Baams et al., 2015).

### **Heterosexism, Homophobia, and Internalized Homophobia**

According to Gregory Herek (2009), two of the most prominent and pervasive forms of sexual minority stress include external and internal experiences of heterosexism and homophobia. Herek (2009) further argued that both are manifestations of sexual stigma, a cultural phenomenon in which society collectively constructs heterosexuality as the standard of normality and denies, denigrates, or stigmatizes any non-heterosexual behaviors, identities, relationships, or communities. Thus, while both represent forms of bias against sexual minorities, heterosexism represents an indirect form of bias that privileges heterosexual lives and relationships, while homophobia represents a more direct, anti-LGB sentiment or fear of homosexuality (Brown, 2008; Herek et al., 2009). Like racism and sexism, both heterosexism and homophobia can be experienced on systemic, institutional, and individual levels and frequently become internalized by both heterosexual and LGB people alike.

**Heterosexism.** More specifically, Herek (1986) defined heterosexism as “a world-view, a value-system that prizes heterosexuality, assumes it as the only appropriate manifestation of love and sexuality, and devalues homosexuality and all that is not heterosexual” (Herek, 1986, p. 925). According to this definition, heterosexism is founded on the presumption that all people are, or should be, heterosexual; and, when sexual minorities are addressed, they are viewed as unnatural or deviant. Therefore, heterosexism shapes the environment in which homophobia takes place. It creates a structural form of stigma and discrimination that pervades social

institutions, privileges heterosexuality, and marginalizes LGB individuals and communities (Herek et al., 2009). As a result, heterosexism becomes embedded in society's values, laws, organizations, and institutions, whereby determining who receives what treatment or services within a society (D'Anna et al., 2012). Examples of heterosexism within the United States include previous bans against LGB military personnel (i.e., "don't ask, don't tell"), a widespread lack of legal protections from anti-LGB discrimination in employment, housing, and services, anti-LGB legislation such as the passage of federal and state laws banning same-sex marriage, and the existence of sodomy laws in more than one-third of the United States. Moreover, examples of heterosexism in high schools might include rules banning students from attending school dances with a same-sex partner, students being disciplined for public displays of affection that non-LGB students are not punished for, school curriculums that fail to discuss the contributions of important LGB figures or that "erase" their sexuality, sexual education instruction or classes that ignore, or even pathologize, the sexual lives and health of LGB youth. Other examples include a general lack of LGB representation in history, education, and media, which further serve to limit the visibility and power of LGB people in society (Brown, 2008). In addition to this, several of the largest religious institutions in America have taken non-LGB-affirming positions, such as labeling same-sex behavior as sinful, barring LGB people from spiritual leadership roles, refusing to sanction same-sex union ceremonies, and condoning harmful practices such as conversion therapy (Barnes & Myer, 2012; SAMHSA, 2015). Furthermore, by identifying heterosexism as a form of covert structural discrimination, it distinguishes it from more overt acts of homophobia and acknowledges how prejudice and bias are woven into society's values, laws, and institutions of power (Herek et al., 2009).

The concept of heterosexism is particularly relevant when considering the context that

LGB youth live in and how such a culture might influence their ability to seek out support or engage in treatment for trauma. If the youth's trauma-related symptoms are the result of sexual orientation violence or discrimination, it may be especially difficult for them to trust institutionalized sources of support, such as the police, school staff, social workers, religious organizations, or medical and mental health professionals (SAMHSA, 2015). Thus, perceptions of limited support or expectations of harm and rejection from society's institutions (e.g., churches, schools, legal institutions) place an additional burden on adolescent LGB survivors of trauma, one which may impede their ability to seek out support, disclose their trauma, or explore how their trauma may be related to or affecting their sexual identity.

**Homophobia.** In terms of homophobia, Herek and his colleagues (2009) described it as the active expression of the internalized cultural values associated with heterosexism and sexual stigma. Thus, homophobia includes both internal negative attitudes about homosexuality, as well as external expressions of animosity, such as excluding, threatening, or physically harming individuals who are perceived to be, or identify as, LGB (Brown & Colbourne, 2005). Other examples of homophobia may include calling someone a "fag" or a "dyke," using the term "gay" in a negative way, making the assumption that all LGB people are sexually promiscuous, or choosing not to confront a homophobic remark for fear of being identified as LGB. Moreover, while some instances of homophobia are expressed through violence, others are enacted through more subtle forms of stigma, such as the aforementioned microaggressions (Nadal et al., 2011). Furthermore, research has consistently demonstrated that LGB youth are significantly more likely to be the targets of homophobic prejudice and violence than adults, and that the psychological effects of their victimization are likely to be more severe (Burton et al., 2013; Meyers, 2003; Saewyc, 2011; Saewyc et al., 2006). Adding to this, the pervasive nature of

heterosexism and homophobia has resulted in less protections for LGB youth, has contributed to a cultural belief that sexual minorities are somehow more deserving of abuse, and, when abuse has occurred, has made it more difficult for LGB youth to seek help or trust the support of others (Saewyc et al., 2006). For example, when LGB youth, whether out or not, hear parents, friends, family members, teachers, and other authority figures making homophobic remarks or conveying negative stereotypes about LGB people, they are more likely to experience feelings of isolation and shame, and less likely to see the important people in their lives as those whom they can trust. Instead, many LGB youth may come to fear the very sources of support that they need in times of distress or following experiences of interpersonal trauma. Youth who experience homophobia from school staff, or watch as teachers and administrators ignore or permit homophobic bullying and teasing on campus, are less likely to feel safe or protected at school, which has been associated with higher rates of truancy, lower grade point averages, and lowered aspirations for the future among some LGB youth (Kosciw et al., 2014). Several research studies have also found direct links between experiences of homophobia and increased rates of health risks among LGB youth, including depression, PTSD, suicidality, substance use, risky sexual behaviors, and teen pregnancy (e.g., Almeida et al., 2009; Birkett et al., 2009; Bontempo & D'Augelli, 2002; D'Augelli et al., 2006; Homma & Saewyc, 2007; Saewyc, 2011; Saewyc et al., 2008). For instance, LGB youth who are derided by or made to feel like they are a disappointment to their friends and family members because of their sexual orientation may feel alienated and alone or come to develop the belief that they are a burden on others, both of which are known factors contributing to suicidal behavior (Joiner et al., 2009). In addition to this, Szymanski and Balsam (2011) found that even non-life-threatening experiences of sexual orientation discrimination predicted PTSD symptoms among lesbians in their study, noting that while some discriminatory

events may not pose a direct threat to one's physical integrity, they may nonetheless provoke a sense of horror, helplessness, or fear among sexual minorities. As such, LGB youth are particularly vulnerable, not only to institutionalized and overt forms of discrimination, but also to a more insidious form of trauma, the internalization of sexual stigma.

**Internalized homophobia.** Several different terms have been used to describe the phenomenon by which sexual minorities internalize society's anti-LGB attitudes (i.e., internalized homonegativity, internalized heterosexism, and internalized sexual stigma), however, internalized homophobia is perhaps the most commonly recognized term in clinical practice (Meyer, 2003). As defined by Meyer and Dean (1998), internalized homophobia is "the gay person's direction of negative social attitudes toward the self, leading to the devaluation of the self and resultant internal conflicts and poor self-regard" (p. 161). Internalized homophobia, then, is a product of living in a heterosexist environment, one in which LGB youth are frequently bombarded with messages insisting that it is unacceptable, unnatural, or even dangerous to be gay. By accepting and integrating society's negative stereotypes and myths about homosexuality into the self-concept, LGB individuals develop negative beliefs about themselves, their sexual orientation, and other LGB people (Herek et al., 2009; Newcomb & Mustanski, 2010). As such, internalized homophobia may be experienced or expressed as feelings of worthlessness, shame, dislike, disgust, fear, or even anger directed at oneself due to one's sexual orientation (Herek et al., 2009). For example, LGB youth may internalize or express beliefs that they are unable to love or are unworthy of being loved because they are gay, that their sexual orientation brings shame to their family, or that they have somehow caused or are deserving of abuse and discrimination because of their LGB identity. Other manifestations of internalized homophobia may include excessive judgment, resentment, anger, or disgust towards other LGB people for

expressing pride in their identity or for not adhering to heteronormative expressions of gender and sexuality. For instance, some LGB youth might find it acceptable for a heterosexual couple to hold hands or show affection in public, while admonishing a gay couple for engaging in the same behavior. Consequently, LGB individuals who have internalized homophobic and heterosexist attitudes are often less comfortable disclosing their own sexual orientation to others, tend to distance themselves from other LGB individuals, and may experience greater discomfort with same-sex sexual activity (Newcomb & Mustanski, 2010). For LGB youth who have experienced interpersonal trauma, especially for those who have been sexually assaulted by a same-sex perpetrator, the internalization of anti-LGB myths, such as sexual assault causes homosexuality or that LGB individuals deserve to be assaulted because they are immoral, is likely to cause or compound feelings of guilt and shame, whereby increasing posttraumatic stress symptoms, impeding recovery, and disrupting the process of sexual identity development (Gagnier & Collin-Vézina, 2016; Gold, Marx, & Lexington, 2007). Moreover, Newcomb and Mustanski (2010) noted that internalized homophobia may lead LGB survivors of sexual orientation violence to identify with their aggressors, and Gold et al. (2007) found an association between PTSD and depression in gay male survivors of sexual assault who demonstrated high levels of internalized homophobia. Gold et al. (2007) found further evidence to support the theory that LGB sexual assault survivors with internalized homophobia may associate their traumatic experiences with their sexual orientation, in turn, causing them to avoid both same-sex thoughts, attractions, and arousal, as well as unwanted thoughts, feelings, and memories related to their sexual assault (Carbone, 2008; Hertzmann, 2011). They argued that such “rigid and unworkable” avoidance could lead to the development and maintenance of greater posttraumatic stress symptoms, including attempts to suppress same-sex attractions and difficulty forming and

sustaining same-sex relationships in the future. Furthermore, several research studies have found internalized homophobia to be significantly correlated with a variety of negative physical and mental health outcomes, such as depression, anxiety, PTSD, substance use, eating disorders, HIV risk behaviors, self-injury, and suicidal ideation (DiPlacidio, 1998; Meyer & Dean, 1998; Williamson, 2000). Additionally, LGB individuals with internalized homophobia tend to demonstrate greater self-conflict, self-blame, and lower levels of self-respect when compared to individuals who have not internalized homophobic and heterosexist attitudes (Newcomb & Mustanski, 2010). For instance, when LGB youth internalize and accept negative messages about themselves or their sexual orientation, they also become more susceptible to accepting blame for any abuse they might receive, whether in the form of social stigma or physical victimization. In turn, this may lead some client's to develop negative or faulty attributions about the causes of their trauma. Moreover, given these findings, it appears that internalized homophobia may lead to negative physical and mental health outcomes by lowering one's self-esteem, decreasing their perceived availability of social support, and contributing to greater internal conflict (Berg, Munthe-Kaas, & Ross, 2016). Lastly, as noted by Meyer and Dean (1998), though it originates within the heterosexist attitudes of society, internalized homophobia is perhaps the most insidious of the minority stressors in that it has the ability to become self-perpetuating, persisting within the LGB individual even when he or she is not being directly exposed to a particular external stressor.

### **Peer Victimization and Bullying**

Another significant source of stress for LGB youth involves school-based peer victimization and bullying related to their sexual orientation. Researchers have consistently found that, in comparison to their heterosexual peers, LGB adolescents are more likely to report

being harassed or physically assaulted while at school, and that much of the victimization they experience is related to their actual or perceived sexual orientation (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Kessel, Schneider, O'Donnell, Stueve, & Coulter, 2012; Russell et al., 2011). For some LGB clients, peer victimization and bullying may be the primary trauma for which they are seeking treatment; however, for other adolescent clients, it may be an added source of stress that can vary widely in its intensity and may even contribute to more complex forms and presentations of trauma. Moreover, LGB youth may experience peer victimization in a variety of forms, including direct or indirect aggressive behaviors that can be verbal, physical, sexual, or relational (Collier, van Beusekom, Bos, & Sandfort, 2013). The most common type, verbal victimization, includes name-calling, teasing, and verbal threats of physical harm (Collier et al., 2013). However, many also experience more aggressive forms of victimization, such as physical or sexual assault, being threatened with a weapon, having property damaged or stolen, or being chased or followed (Collier et al., 2013). In addition to these direct forms of victimization, LGB youth also suffer indirect or relational forms of peer related abuse, such as social exclusion by their peers, being made the target of hurtful rumors, and cyberbullying (Collier et al., 2013). Moreover, bullying among LGB adolescents not only occurs more frequently, but is also often qualitatively different from bullying among heterosexual peers (Beckerman & Auerbach, 2014). For instance, peer victimization of LGB youth often involves homophobic remarks, taunting, and bullying that might include graphic sexual content or the sexual assault of LGB students (Beckerman & Auerbach, 2014; D'Augelli, et al., 2006). In addition to this, researchers have found that greater gender atypicality among LGB youth, especially among males, has been associated with increased exposure to sexual orientation violence at school (D'Augelli, et al., 2006; D'Augelli, Pilkington, & Hershberger, 2002). Brady



(2008) contended that violence is often used against gender atypical boys in order to punish them for breaking social norms or rules, which, in turn, places them at a higher risk for being stigmatized, ostracized, and abused. Thus, experiencing interpersonal trauma in a culture that stigmatizes, devalues, and punishes homosexuality, LGB youth are less likely to seek out support, though are more likely to present for treatment with complex forms of trauma symptoms (King, 2011).

In a recent national survey of sexual minority youths' experiences at school, the Gay, Lesbian, and Straight Education Network (GLSEN) found that 55.5% of the students they surveyed reported feeling unsafe at school in the past year because of their sexual orientation (Kosciw, Greytak, Palmer, & Boesen, 2014). Most of the students surveyed (i.e., 64.5%) reported hearing homophobic and negative remarks about their sexual orientation from fellow students, teachers, or other school staff, and 90.8% reported feeling distressed because of this language (Kosciw et al., 2014). Additionally, of those surveyed, 74.1% reported being verbally harassed (e.g., called names or threatened), 36.2% reported being physically harassed (e.g., pushed or shoved), 16.5% reported being physically assaulted (e.g., punched, kicked, injured with a weapon), and 49% reported being cyberbullied (e.g., via text messages or postings on Facebook) in the past year because of their sexual orientation. When these students were asked if they had reported the harassment or assault to school staff, 56.7% stated that they did not, most commonly because they doubted that effective intervention would occur or believed that the situation would become worse if reported. In addition to this, 61.6% of the students who did report an incident stated that school staff did nothing in response (Kosciw et al., 2014). Results of the GLSEN study further found that, on average, sexual minority students of color and those who do not conform to stereotypical gender roles experienced higher rates of victimization

(Kosciw et al., 2014). Sexual minority youth in middle school and those living in rural areas were also found to report higher overall rates of sexual orientation victimization due to a lack of support from schools and teaching staff, as well as a lack of LGB affirming resources (e.g., LGB student groups or information about LGB identity development). Moreover, the results of the GLSEN survey are consistent with several other studies indicating that LGB youth are disproportionately bullied by their peers in middle and high school and that they often report experiencing a chronic state of harassment in school (Almeida et al., 2009; Beckerman & Auerbach, 2014; Friedman et al., 2011; Kosciw, Greytak, & Diaz, 2009; Kosciw, et al., 2014; Poteat & Espelage, 2005; Russell, Franz, & Driscoll, 2001; Savin-Williams, 1994; Wyss, 2004).

The impact of sexual orientation victimization on LGB adolescents' mental health and wellbeing is also well documented. LGB youth who experience higher levels of victimization are 2.6 times more likely to report feeling depressed and 5.6 times more likely to attempt suicide than LGB youth who experience lower levels of victimization (Russell et al., 2011). Similarly, LGB youth who experience higher levels of at-school victimization have also been found to engage in more externalizing behaviors, such as conduct problems and delinquency (Williams, Connolly, Pepler, & Craig, 2005), as well as health risk behaviors such as substance abuse, high-risk sexual behavior, and self-harm (Bontempo and D'Augelli, 2002). Sexual orientation victimization and discrimination have been linked to negative academic outcomes, including higher rates of truancy, lower grade point averages, lowered sense of school belonging, and lowered expectations of completing high school or pursuing post-secondary education (Aragon, Poteat, Espelage, & Koenig, 2014; Collier et al., 2013; Kosciw et al., 2014). In addition to missing school more frequently due to concerns about their safety, LGB youth who report being victimized or discriminated against at school also tend to avoid participating in school activities

such as sports teams, clubs, and school dances. They also tend to avoid spaces at school where they feel most vulnerable, such as bathrooms, locker rooms, physical education classes, athletic fields, and lunchrooms (Kosciw et al., 2014). The combined effect of homophobic teasing, peer victimization, heterosexist school policies, and passive acceptance of student's homophobic behavior by school administrators further perpetuates a cycle of violence against LGB students and decreases their access to and perception of support. These sexuality specific stressors negatively impact LGB adolescents' self-esteem and self-efficacy at a critical juncture in their identity development, whereby reinforcing feelings of worthlessness, anxiety, and depression that are likely to extend into adulthood and contribute to internalized homophobia (Aragon et al., 2014; Beckerman & Auerbach, 2014; Friedman et al., 2006; Poteat, Mereish, DiGiovanni, & Koenig, 2011).

Given the significant impact that school-based peer victimization and sexual orientation violence has on LGB adolescents, it is also important to highlight ways in which school and peer networks can and have been utilized as sources of support and coping among LGB youth. For instance, having friends with whom LGB youth can be out about their sexual orientation has been linked to improved mental health and wellbeing (Doty, Willoughby, Lindahl, & Malik, 2010; Elizur & Ziv, 2001). More specifically, having other LGB friends may be especially important in that they are more likely than heterosexual friends to provide support for sexuality-related stress, which has been associated with lower levels of emotional distress and sexuality distress (Doty et al., 2010; Shilo & Savaya, 2011; Snapp, Watson, Russell, Diaz, & Ryan, 2015). In addition to this, participating in or attending a school with a Gay-Straight Alliance (GSA) – a student-led, school-based club aimed at providing a safe space for LGBTQ students – has been associated with improved psychosocial and academic wellbeing among LGB students (Toomey

et al., 2011). According to the aforementioned GLSEN study, LGB students who attended a school with a GSA reported hearing anti-LGBT remarks less frequently than LGB students in schools without a GSA (i.e., 57.4% vs. 71.6%). LGB students were also less likely to feel unsafe because of their sexual orientation (i.e., 46.0% vs. 64.4% of students without a GSA) and reported experiencing less severe victimization related to their sexual orientation or gender expression (i.e., 19% vs. 36.2% of students without a GSA) (Kosciw et al., 2014). LGB students attending schools with a GSA also reported a greater number of supportive school staff, more accepting peers, feeling more connected to their school community, and reported fewer past suicide attempts (Goodenow, Szalacha, & Westheimer, 2006; Kosciw et al., 2014). In addition to providing accurate affirmative information and social support, another way in which GSAs are thought to decrease school victimization and promote the acceptance and safety of LGB youth, is by increasing awareness of anti-LGB bias in the school environment and promoting training for educators on LGB issues. Thus, GSAs may help LGB youth by offering greater social support and visibility on campus, as well as by increasing the likelihood that school staff will intervene when they hear anti-LGB remarks (Kosciw et al., 2014).

### **The Coming Out Process: Identity Concealment Versus Identity Disclosure**

**Identity concealment.** Adding to the complexity of stressors facing sexual minority youth, LGB-identifying adolescents are also burdened with the task of choosing whether to conceal or disclose their sexual orientation to others, otherwise known as the “coming out” process (Meyers, 2003). According to Meyers (2003), due to the stigma surrounding a minority identity, LGB youth often choose to conceal their sexual orientation in order to protect themselves from real or perceived harm (e.g., peer victimization) or out of shame and guilt (e.g., internalized homophobia) (Pachankis, 2007). However, the cost of concealing one’s sexual

orientation can have significant and deleterious consequences, such as the cognitive burden associated with constantly worrying about being identified as LGB or that others will “find out” (Smart & Wegner, 2000). In describing how LGB adolescents often use concealment as a form of coping with a stigmatized identity, Hetrick and Martin (1987) noted that

Individuals in such a position must constantly monitor their behavior in all circumstances: how one dresses, speaks, walks, and talks become constant sources of possible discovery. One must limit one’s friends, one’s interests, and one’s expression, for fear that one might be found guilty by association... The individual who must hide of necessity learns to interact on the basis of deceit, governed by fear of discovery... Each successive act of deception, each moment of monitoring which is unconscious and automatic for others, serves to reinforce the belief in one’s difference and inferiority. (pp. 35-36)

By engaging in constant self-monitoring and continual suppression of their thoughts and feelings, many LGB youth become increasingly hypervigilant, socially anxious, and depressed (Pachankis & Goldfried, 2006; Radkowsky & Siegel, 1997). In addition to this, concealment leads to increased isolation, which prevents LGB youth from identifying and affiliating with other LGB individuals (Meyers, 2003). As a result, LGB youth are less likely to access formal and informal support resources within the LGB community, depriving them of important opportunities to challenge or resolve negative attitudes and beliefs about their sexuality (i.e., internalized homophobia) (Meyers, 2003; Pachankis, 2007). Furthermore, despite the function of concealing their identity, many LGB individuals perceive identity concealment in social interactions as an act of deception, which further leads to lowered self-esteem, feelings of shame and worthlessness, and increased internalized homophobia (Pachankis & Goldfried, 2006).

**Identity disclosure.** In relationship to identity concealment, identity disclosure (i.e., coming out) is fraught with its own risks and challenges, however, researchers have identified several significant benefits associated with being more open about one's sexual orientation (Kosciw, Palmer, & Kull, 2015; Kosciw et al., 2014). As defined by Watson, Wheldon, and Russell (2015), coming out is part of a complex developmental process in which individuals with same-sex sexual identities begin to acknowledge, explore, and disclose their same-sex attractions and behaviors. Within the broader context of identity development, the coming out process also parallels many of the achievements of adolescence, such as establishing an identity, developing self-esteem and socialization skills, and accepting one's own sexuality as an essential part of one's identity (Radkowsky & Siegal, 1997). Therefore, the coming out process can be conceptualized as both an internal process of identity development, as well as an ongoing, interpersonal and decision-making process in which LGB individuals must continually negotiate how, when, and if to disclose their sexual identity to others (Ali & Barden, 2015). Ultimately, the success of the coming out process "involves the integration of one's LGB identity into one's overall sense of self" (Pachankis & Goldfried, 2004, p. 233).

While the process of coming out often occurs during adolescence, with recent studies finding initial disclosure occurring around age 14 or 15 (Cox, Dewaele, van Houtte, & Vincke, 2011; Ryan, Huebner, Diaz, & Sanchez, 2009), some individuals do not begin the process of coming out to themselves or others until later in adulthood. Even still, it may take several years before the individual comes to a place of greater self-acceptance (Floyd & Stein, 2002). Typically, LGB youth first disclose their sexual orientation to another LGB person, then to close friends – who may or may not be LGB, then to peers, adults, and finally to family members (Kosciw, Palmer, & Kull, 2015; Rosario et al., 2008). While some LGB youth make the choice

to come out to parents and peers on their own terms, other youth may have been outted by someone else or against their will. This is important to note, since research suggests that the potential benefits of being out may be diminished by the way in which one's LGB identity was disclosed. For example, in a study by Herek, Gilis, and Cogan (2009), it was found that LGB individuals who had been outted to their parents but had not discussed it directly with them, scored significantly lower on a measure of internalized homophobia when compared to those who had directly disclosed and discussed their sexual orientation with their parents. Thus, when working with youth who have been outted to their parents or others as a result of sexual orientation violence or trauma, it may be especially important to explore the youth's coming out process, acknowledging and validating their feelings about the experience and investigating how the disclosure may have impacted the youth's feelings and beliefs about their sexual identity. Moreover, LGB youth may find the development of a positive sexual identity especially challenging in the face of significant social stigma and marginalization (Bregman et al., 2013). The stress associated with coming out is often the result of actual or perceived negative reactions from friends, family, and peers. For instance, due to their sexual orientation or gender nonconforming behavior, many LGB youth face victimization, exclusion, and unfair treatment in school, and may be forced out of their homes, places of worship, or community organizations (e.g., Boy scouts) (Meyer, 2003). Consequently, coming out is often paired with a high level of stress, which is often associated with higher levels of depression and suicidal ideation (Baams, Russel, & Grossman, 2015). Therefore, disclosing one's sexual orientation to others is a key factor that may shape the social relationships and support systems of LGB youth. Coming out becomes an ongoing task in which LGB youth must constantly be aware of whom they are out to

and how they plan to manage disclosure across a variety contexts (e.g., school, home, online) (Watson et al., 2015).

In addition to these risks, however, research also has demonstrated many benefits to coming out. For example, being out to family and peers has been associated with increased social support and better relationships (Potoczniak, Aldea, & DeBlaere, 2007), as well as greater psychological wellbeing, including higher self-esteem, lower rates of depression and anxiety, and lower levels of internalized homophobia (Kosciw et al., 2010; Ueno, 2005; Wright & Perry, 2006). Being out has also been associated with decreases in psychological distress, risky sexual behavior, and substance abuse (Corrigan & Matthews, 2003; Morris, Waldo, & Rothblum, 2001). Among LGB youth, being out in school has been associated with increased academic performance, (Watson et al., 2015), greater satisfaction with the support they receive from their social networks (Grossman & Kerner, 1998), as well as increased self-esteem and decreased rates of depression and anxiety that have been found to continue into young adulthood (Russell et al., 2014). Additionally, Rosario, Hunter, Maguen, Gwadz, and Smith (2001) found that youth who disclose their sexual identity to more individuals tend to be more comfortable with their sexual identity and tend to have a more favorable view of other sexual minorities.

In addition to identifying the potential risks and benefits associated with being out, research has also shed light on how particular cultural and contextual variables might influence the coming out process. For example, Rosario, Schrimshaw, and Hunter (2004) found that African American and Latino youths tend to disclose to fewer individuals than White youths, which may partially explain why African American youths also report engaging in fewer gay-related social and recreational activities than White youths. In addition to this, LGB youth of color are significantly less likely to disclose their sexual orientation to their parents, with African



Americans, Asian Americans, and Pacific Islanders reporting significantly lower rates of disclosure than White youths (Grov, Bimbi, Nanin, & Parson, 2006). Furthermore, when youth of color do disclose to their parents – or are outed – many are thrown out of their home, mistreated, or made the focus of their family's dysfunction (Savin-Williams, 1994). Other factors that have been found to influence the process and timing of identity development and disclosure include geographic locations that might limit access to LGB-related resources and experiences, as well as family factors, such as parental attitudes, religion, and socioeconomic status (Gray, 2009; Kosciw, Palmer, & Kull, 2015; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). In addition to these cultural variables, contextual factors also have a significant influence on the coming out process. For instance, in a study of LGB youth between the ages of 12 and 18, Watson and his colleagues (2015) found that those who reported being out to everyone (i.e., family, peers, and school) and those who reported not being out to anyone, both reported the highest grades and lowest levels of harassment at school. They also found that LGB youth who were only out at home (i.e., not at school) reported the worst grades and experienced higher levels of harassment. Thus, these findings suggest that LGB youth who are constantly engaged in managing where and with whom they are out to may perform worse at school than students who are out to the majority of others in their social environment. Similarly, others have found that LGB youth who disclose to a larger number of people across a larger number of roles (e.g., parents, siblings, family, friends, classmates, teachers, online acquaintances) tend to report less internalized homophobia (Cox et al., 2011). Lastly, research also suggests that LGB youth who report affiliating more strongly with the LGB community also report learning more from their coming-out process and demonstrate greater stress-related growth (Bonet et al., 2011; Cox et al., 2011). Thus, given that cultural factors and the context in which one chooses to disclose their

sexual orientation (e.g., school or home), and to whom, have a significant impact on the coming out process, the short and long-term risks and benefits of coming out must be considered on an individual basis, as well as weighed against the costs of identity concealment.

### **Clinical Considerations**

**Child.** Given the deleterious effects of minority stress, therapists working with LGB adolescents, especially those who have experienced interpersonal trauma related to their sexual orientation, need to assess and gain a better understanding of the culture and context in which the youth lives. Therapists should inquire about the youth's experiences with environmental stressors such as heterosexism, homophobia, peer victimization, and coming out, as well as more insidious stressors such as internalized homophobia, expectations of rejection, or identity concealment. The effects of minority stress, in addition to interpersonal trauma, may cause some LGB youth to become more isolated and less trusting, to perceive their environment as more dangerous, to develop negative beliefs about themselves and their sexual orientation, and to become more susceptible to adverse mental and physical health outcomes (e.g., depression, anxiety, suicide, substance abuse, and risky sexual behavior) (Meyers, 2003; Walker, Hernandez, and Davey, 2012; Brady, 2008). Additionally, sexual minority youth are less likely to have access to the same protective factors and coping resources that other stigmatized individuals possess due to their stigma being invisible and not typically shared by their parents or other early visible role models (Pachankis, 2015). Thus, LGB youth may have difficulty recognizing how external forces such as heterosexism and homophobia contribute to negative beliefs about oneself or one's sexual orientation, and, instead, may incorrectly attribute their psychosocial distress or experiences of abuse to personal failings rather than stigmatizing social forces (Pachankis, 2015). By normalizing the adverse impact of multiple forms of minority stress and helping youth shift

the blame for this distress toward society, rather than themselves, therapists can help to mitigate the negative effects of minority stress (Pachankis, 2015).

In addition to education and normalization, the research literature also emphasizes the importance of enhancing social support as a means of reducing minority stress (Doty et al., 2010; Mustanski, Newcomb, & Garofalo, 2011; Ryan et al., 2010; Watson, Grossman, & Russell, 2016). Therapists should assess the client's perceptions of sexuality-specific support within their home, school, and community, and discuss any potential safety concerns, such as ongoing verbal, physical, or emotional abuse related to their sexual orientation. It is also important to ask the youth about instrumental sources of support. For example, if the youth needs a safe place to spend the night outside of their home, helping them identify a person whom they are confident would be a resource to them may be comforting, if not necessary. In addition to providing informational sources of support, such as online resources like the Trevor Project, therapists should also explore emotional sources of support outside of therapy, such as friends, peers, family members, or neighbors with whom the youth can talk to about their feelings or struggles. Furthermore, therapists should also be aware of any cultural and contextual factors that may place the youth at greater risk of being victimized, such as gender nonconforming behavior, especially among boys, living in a rural area with limited access to LGB resources, or attending a religiously affiliated school (D'Augelli et al., 2006; Kosciw et al., 2009). Some LGB youth may need help learning how to advocate for themselves, and, at times, such as when the child is being victimized at school, the therapist may need to work with the parent and the school in order to intervene on the child's behalf (Craig, Austin, & Alessi, 2013). Moreover, there are several ways in which therapists can work with youth and their families to enhance both the amount and the quality of social support. Youth may benefit from being involved in or attending a school with a

Gay-Straight Alliance (GSA), and are likely to experience greater psychological wellbeing and decreased internalized homophobia as a result of strengthening connections with other LGB people in their environment (Watson et al., 2016). Other sources of sexuality-specific support may include LGB mentors (e.g. either in the community or as part of a formal mentoring program), local LGBT centers, LGB youth support groups and after school programs, and involvement in LGB affirming spiritual or religious organizations (Doty et al., 2010; Watson et al., 2016). Lastly, there is research suggesting that LGB youth interventions focused on improving peer support may be most effective across the 16-24 age range, while interventions focused on improving family support may be most effective among younger LGB adolescents (Mustanski et al., 2011).

An additional barrier preventing many LGB youth from developing a positive sexual identity or seeking out sources of support within the LGB community includes the stress of determining how, when, and with whom it is safe to come out (Meyer, 2003). Thus, therapists may need to help LGB youth identify supportive people in their lives, as well as situations or contexts in which it is safe for them to come out. As such, therapists should recognize that coming out is a recurring process, influenced by a variety of factors (e.g., social, cultural, economic, and political contexts, geography, access to resources, peer and familial relationships), and consists of many social layers, risks, and benefits (Ali & Barden, 2015). Ali and Barden (2015) encourage therapists to always have the client's safety in mind, stressing that that while the power of choice is always understood to be within the client, the therapist should be realistic, open, honest, and genuine in aiding the client to address concerns prior to disclosure. They also suggest helping clients develop a safety plan while conducting a costs-benefits analysis related to disclosure. For example, if the youth is deciding to disclose their identity to members of their

church, the therapist should help the youth consider the risks and benefits of disclosure (e.g., increased spiritual support, non-acceptance, or rejection), while thoroughly processing the client's action plan and potential outcomes. Youth may also benefit from in-session role plays of coming out, in which they take turns as the one disclosing or being disclosed to (Ritter & Terndrup, 2002). There are also many LGB-affirming online resources, such as websites (i.e., [www.itgetsbetter.org](http://www.itgetsbetter.org)) or Youtube videos, that youth can utilize in preparation for disclosing to others. Furthermore, LGB youth in the process of accepting or exploring their sexual minority identity may still be dealing with a sense of grief and loss related to a heterosexual identity. Most individuals, including LGB youth, have been raised in a cultural that values heterosexuality and with heterosexuality comes many privileges and expectations of how one is supposed to behave in the world (Ritter & Terndrup, 2002). Therefore, LGB youth, especially those already experiencing a loss of power and control resulting from a trauma, may need additional support in identifying the strengths and benefits associated with adopting an LGB identity. Ultimately, by assisting LGB youth in enhancing coping, problem-solving skills, and social support, therapists can also help them develop a greater sense of self-efficacy to buffer against the added effects of minority stress (Craig et al., 2013).

**Parent.** As with their LGB children, many parents also experience stressors related to managing a stigmatized identity. Parents may struggle with issues of secrecy and deciding whether to conceal or disclose their identity as the parent of an LGB child. Parents, too, may need help mourning the loss of the child's heterosexual identity while also learning how to support and affirm the child's new LGB identity (Saltzburg, 2009). This task may become further complicated by feelings of guilt, shame, sadness, and anger related to their child's experiences of being victimized or abused. As a result, parents may isolate themselves and feel

alienated from other parents (Saltzburg, 2009). Thus, in addition to helping parents manage their own stress, therapists must also educate parents on the role of sexual minority stressors in the lives of their children. For instance, therapists can provide parents with information on the risks and benefits of being open about one's LGB identity, they can emphasize the importance of increasing the child's sexuality-specific social support in order to combat heterosexism and internalized homophobia, they can help parents understand the impact of sexual orientation violence and harassment, both at home and school, and they can support parents in creating safer, more affirming spaces for LGB youth in their home, school, and community. Therapists are also in a position to model for parents of what it means to affirm an adolescent's LGB identity by acknowledging strengths and resiliencies inherent within the LGB community and dispelling myths or misassumptions that contribute to minority stress. Therapists can also support parents in advocating for their youth's safety in school by educating them on GSA's or directing them to resources such as those provided by the Gay, Lesbian, and Straight Education Network (GLSEN).

In addition to this, therapists should also work with parents to strengthen their own social support networks. For instance, Saltzburg (2009) found that parents who have empathic outlets for discussing their feelings and opportunities to exchange their stories with other parents (e.g., PFLAG meetings, adult LGB friends, their own individual therapy) report feeling more accepting of their child's sexual identity and more hopeful about maintaining positive relationships with their children in the future. The parents in Saltzburg's study all spoke to the vital role that adult members of the LGB community played within their social support networks. Parents noted that face-to-face encounters with supportive LGB individuals helped to increase their awareness of the challenges and benefits of being LGB, decrease their feelings of fear and

uncertainty about their child’s future, and reconcile feelings of loneliness and isolation. Therefore, by helping both youth and their parents foster connections within the LGB community, therapists can help alleviate significant sources of minority stress that might otherwise contribute to trauma-related symptoms and impede recovery.

### **Homework: Child & Parent**

**“Circles of Support.”** Using Appendix D of this manual, provide the client with a sample version of the Circles of Support handout. It may be helpful to begin this exercise during session, and then encourage the client to continue working on the exercise from home. The purpose of this activity is to help clients identify and increase LGB affirming sources of social support within their environment. The activity is intended to be completed by both the child and the parent, individually, given the literature suggesting that both children and parents are likely to benefit from increased support, especially around managing a stigmatized identity.

Using the Circles of Support activity handout, at the bottom of the sheet, ask the client (e.g., adolescent or parent), to write the names of as many people, groups, or places where support or assistance is readily available. Sources of support have been grouped into four broad categories (i.e., family, friends, school/work, and community). Sources of support within the youth’s support network may include parents, aunts, grandparents, siblings, friends from school or the neighborhood, teachers, school counselors, GSA’s, sports teams and coaches, and other school staff. Adolescent clients might also identify people or organizations in their community, such as neighbors, therapists, social workers, faith-based groups, LGB organizations, and after school programs (e.g., athletic teams, fine arts, dance, and other performing arts groups). Parents may identify similar and overlapping sources of support with their children, and may also include work friends or colleagues as well as community resources such as members of their PFLAG group, spiritual counselors, and online communities for parents of LGB youth. Therapists should ask clients to think of any additional sources of support outside of these categories

(e.g., clients may want to include their pets or may identify their therapist or social worker as someone important to them, but existing outside of their “community”).

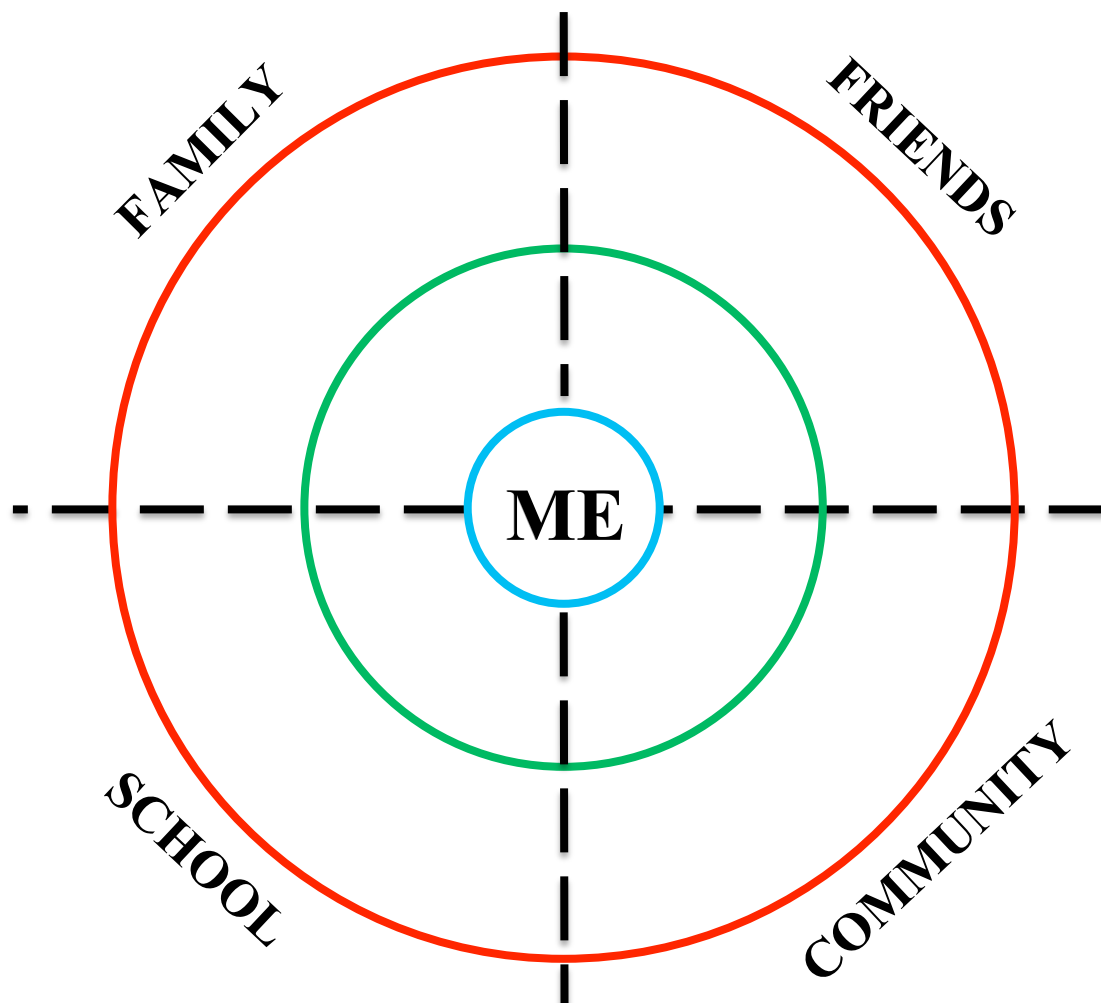
Once this list is complete, ask the client to fill in the circle at the top of the handout with each of the names, placing those whom the client perceives as the strongest sources of LGB affirming support in the circle closest to them. People whom the clients feels are supportive, though perhaps not strong sources of LGB affirming support, or perhaps that the client has not disclosed their identity to, could be placed in the second circle. Again, the activity is intended to prompt discussion about the importance of LGB affirming support and to help clients identify existing sources of support, while also identifying areas in their life where support may be lacking or weak. Therapists may also help clients consider additional sources of support that they would like to include on their list, but do not have yet. For instance, youth may desire more LGB friends, an LGB mentor, or opportunities to engage at a local LGBT center. Parents may not be aware of groups such as PFLAG or the benefits of having adult LGB friends and mentors who can help them learn about the LGB community. Thus, therapists can utilize this as an ongoing activity throughout the course of therapy, helping clients identify ways to bring existing sources of support closer to the client or consider adding new sources of support. Therapists might also use this activity to help clients compare levels of support before and after the trauma, perhaps helping to identify how trauma has impacted the client’s social functioning as well as their perceptions of themselves, others, and the world. Conducting a costs-benefits-analysis, role-playing, or rehearsing coming out to friends, family, classmates/co-workers, and others can also be used to augment this exercise. Therapists may also use this activity to help parents recognize areas in which the therapist and parent may need to intervene to prevent or stop violence and increase perceptions of support, such as advocating for the child at school. Lastly, therapists should encourage clients, especially adolescents, to be as creative as they would like. Some youth may want to draw or create a collage of their circles of support, using pictures of themselves, others, or community organizations. Youth can then add or move images or pictures of support throughout the course of treatment. Furthermore, this is an excellent opportunity for therapists and parents to praise the youth for their work and creativity, and it may be



helpful to facilitate conversations between the parent and child regarding any barriers to increasing sources of support or concerns the parent might have about who the adolescent would like to include in their circles of support.

# Circles of Support

(Appendix D)



Make a list of the supportive people in your life. You can also include people or organizations you would like more support from. See how many you can come up with!

FAMILY	FRIENDS	SCHOOL/WORK	COMMUNITY

## **Chapter 4: Affective Expression & Modulation**

### **Purpose**

The purpose of this chapter is to provide therapists with information on common emotional challenges and risk factors facing LGB youth and how such issues might impact the client's ability to effectively cope with difficult emotions. As discussed in chapter 3, LGB youth face an array of unique challenges in addition to many of the developmental stressors facing heterosexual adolescents. In particular, LGB youth who have experienced chronic and complex forms of interpersonal trauma, including sexual minority stress, are at increased risk for developing posttraumatic stress symptoms as well as other forms of psychological distress, such as depression and suicidal ideation, social anxiety, and excessive shame. Additionally, accumulating research has identified emotion regulation difficulties (e.g., poor emotional awareness, rumination, suppression, avoidance) as significant mediators between sexual minority stress and psychological distress, thus making emotion regulation an important focus of intervention when working with LGB youth. Coping strategies utilized by LGB youth to regulate their emotions, both adaptive and non-adaptive, will be addressed, as well as LGB affirming approaches for helping clients identify, express, and regulate their emotions more effectively.

Furthermore, the purpose of understanding and addressing these potential problem areas is to either prevent them from occurring or to help youth and their families develop strategies to overcome them. In particular, while emotional difficulties such as anxiety and shame can have debilitating effects on a youth's identity and sense of self, when these struggles are brought into the light, confronted, and explored, they can be transformed into increased self-confidence and self-assertiveness, empowered anger, and even expansive pride (Greenberg & Iwakabe, 2011). For example, McDermott, Roen, and Scourfield (2008) noted the importance of "pride"

discourses within the LGB community, and, in their research, found that many LGB youth draw strength from these discourses of pride in order to develop positive LGB identities that can counteract feelings of shame, depression, and anxiety, as well as self-destructive behaviors. Thus, by helping LGB youth identify and express difficult emotions, therapists can provide youth with ways to transform their struggle into strength, teaching them not only how to regulate their emotions, but also how to channel their emotions and experiences into something greater, such as social advocacy and change, increased compassion and empathy for others, or opportunities to support and pass along their skills and experiences to other LGB youth (Harper, Brodsky, & Bruce, 2012).

### **Emotion Regulation and Challenges Facing LGB Youth Affected by Interpersonal Trauma**

Emotion regulation consists of the processes responsible for identifying, evaluating, and modifying one's emotional reactions in order to respond to environmental demands and pursue one's goals (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Thompson & Meyer, 2007). It consists of both conscious and non-conscious, internal and external, strategies that are used to increase, maintain, or decrease one or more components of an emotional response (Gross, 2001). These components consist of the feelings, behaviors, and physiological responses that make up the emotion, affect, or mood state (Gross, 2001). According to James Gross' (2001) process model of emotion regulation, there are a limitless number of emotion-regulation strategies that can be employed across the timeline of an unfolding emotional response. Thus, Gross' process-oriented model, which highlights the ways in which an individual might behave before, during, and after an emotional response, is a useful framework for understanding how LGB adolescents might effectively, or non-effectively, cope with difficult emotions and the events or stressors that elicit them.

At the broadest level, Gross (2001) identified two distinctly different types of emotion-regulation strategies: antecedent-strategies and response-focused strategies. Antecedent-focused strategies are implemented before an emotion has been fully enacted and refer to things an individual might do in order to prevent a negative emotional response from occurring. Common antecedent-focused strategies include problem solving, distraction, and cognitive reappraisal (Gross, 2001). An example of an antecedent coping strategy would be one in which an LGB adolescent selects activities, such as spending time with LGB peers or visiting LGB friendly spaces, where he or she is more likely to experience positive emotions, such as feeling safe, accepted, and supported. On the other hand, response-focused strategies are initiated after an emotion has taken full form; thus, they focus on changing one's feelings, behaviors, or physiology after an emotional response is already under way. A great deal of research has centered on response-focused strategies that are considered to be maladaptive, such as attempting to suppress one's emotions or the use of substances or self-harm as a means of escaping or avoiding a difficult emotional experience (Aldao et al., 2010). For example, an LGB adolescent might use alcohol to escape or cope with feelings of sadness, anger, and shame elicited by an incident of bullying at school. Emotion regulation, therefore, encompasses a wide range of cognitive and behavioral strategies that may be considered adaptive (e.g., cognitive reappraisal, problem-solving, seeking out social support, acceptance, selective avoidance) or maladaptive (e.g., rumination, suppression, avoidance (i.e., total social withdrawal or emotional escape)) based on the environmental context, the individual's goals, and the strategy's long-term effects on psychological functioning (Aldao et al., 2010; McDavitt et al., 2008). In general, given that antecedent-focused strategies have the ability to influence an emotion before it takes full form,

they tend to be more effective for regulating emotions than response-focused strategies, especially over time (Aldao & Nolen-Hoeksema, 2013).

While developing effective strategies for coping with difficult emotions is considered an essential developmental task of adolescence (Zeman, Cassano, Perry-Parrish, & Stegall, 2006), chronic stress during childhood and adolescence often results in emotion regulation deficits (Cicchetti & Toth, 2005). Additionally, early life adversities and experiences with stigma cause youth to experience higher levels of emotional arousal and reactivity (Cicchetti & Toth, 2005). Over time, the effort required to manage these states of heightened arousal and negative affect are likely to exceed or deplete the coping resources of stigmatized and traumatized youth (Inzlicht, McKay, & Aronson, 2006). As such, increased exposure to early life adversities, including interpersonal trauma and chronic sexual minority stress (e.g., sexual orientation violence, family rejection, heterosexism, internalized homophobia, and identity concealment) may make it more difficult for LGB youth to successfully develop effective emotion regulation skills (Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008; Russell & Fish, 2016). In turn, LGB youth may experience greater difficulty identifying, understanding, and adaptively managing their emotions, whereby leaving them more vulnerable to adverse mental health outcomes (McLaughlin, Hatzenbuehler, & Hilt, 2009). For example, Proujansky and Pachankis (2014) argue that being raised in a heterosexist society teaches LGB youth that their natural feelings of attraction towards individuals of the same sex are “wrong” and shameful, whereby leading them to mistrust their emotional and physiological experiences. Additionally, gay and bisexual males might internalize homophobic attitudes and cultural messages suggesting that emotions are “feminine” or “too gay,” in turn, causing them to avoid or suppress their emotional experiences (Proujansky & Pachankis, 2014).

In terms of the unique stressors that threaten LGB adolescents' ability to effectively regulate emotions, there is ample evidence demonstrating that LGB youth are at increased risk for experiencing both interpersonal trauma and stress related to having a stigmatized identity (Friedman, Koeske, Silvestre, Korr, & Sites, 2006; Friedman et al., 2011; McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012). A recent meta-analysis of studies conducted in the U.S. and Canada between 1980 and 2009 found that, in comparison to heterosexual individuals, sexual minorities were 3.8 times more likely to have experienced childhood sexual abuse, 1.2 times more likely to have been assaulted by a parent or guardian, 1.7 times more likely to have been assaulted by a peer at school, and 2.4 times more likely to have missed school for fear of being victimized due to their sexual orientation (Friedman et al., 2011). Similarly, a study comparing experiences of victimization between LGB individuals and their heterosexual siblings, found that LGB participants reported significantly higher levels of psychological, physical, and sexual abuse throughout their childhood than did their heterosexual siblings (Balsam, Rothblum, & Beauchaine, 2005). As such, LGB adolescents presenting for trauma-focused treatment are more likely to have experienced complex forms of trauma, such as those that are multiple, chronic, and interpersonal in nature. According to Briere and Lanktree (2013), when an individual experiences such severe and multiple forms of trauma, the psychological results are often severe and multiple as well – a phenomenon sometimes referred to as complex PTSD. Briere and Lanktree (2013) further note that the impact of complex trauma may include a plethora of negative mental health outcomes, including anxiety, depression, dissociation, affective dysregulation, cognitive distortions, somatization, externalizing behaviors (e.g., self-injury and violence), sexual disturbance, substance abuse, eating disorders, and susceptibility to re-victimization.

In addition to this, there is a growing body of research suggesting that, among LGB adolescents, emotion regulation difficulties play a pivotal role in mediating the relationship between experiences of sexual minority stress and psychological distress (Hatzenbuehler et al., 2008; Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009). According to Mark Hatzenbuehler's (2009) mediation framework, a theoretical framework incorporating both minority stress theory and emotion regulation theory, sexual minority stress results in maladaptive coping and emotion regulation strategies, which, in turn, confer risk for psychopathology. More specifically, Hatzenbuehler (2009) proposed that sexual minority stress leads to three areas of risk in LGB individuals: (a) cognitive processes that exacerbate or maintain symptoms such as hopelessness and negative self-schemas; (b) social and interpersonal problems, such as isolation and risky behaviors; and (c) emotion dysregulation, including maladaptive strategies such as rumination. Furthermore, poor emotion regulation places LGB youth at greater risk for developing other maladaptive coping strategies (e.g., excessive self-blame, substance use as avoidance/escape from negative emotions) that further exacerbate the effects of minority stress and contribute to poorer mental health outcomes (Aldao et al., 2010; Hatzenbuehler, 2009). For example, gay and bisexual young men have been shown to experience a broad range of negative emotions regarding their stigmatized identity and experiences of discrimination, including shame, fear, sadness, guilt, and loneliness (Russell & Fish, 2016). Research studies both within the United States and abroad have consistently found that LGB youth, in comparison to their heterosexual peers, report higher prevalence rates of emotional distress, symptoms related to mood and anxiety disorders, self-harm, suicidal ideation, and suicidal behavior (Eskin, Kaynak-Demir, & Demir, 2005; Fergusson, Horwood, Ridder, & Beautrais, 2005; Fleming, Merry, Robinson, Denny, & Watson, 2007; Marshal et al., 2011; Russell & Fish, 2016). Consequently,



compromised mental health has been identified as a significant predictor of a variety of behavioral health disparities among LGB youth, including substance use, abuse, and dependence (Marshal et al., 2008). In addition to this, sexual minority adolescents have been found to demonstrate poorer emotional awareness and more rumination about their negative emotions than their heterosexual peers, placing them at an increased risk for developing internalizing disorders such as depression and anxiety (Hatzenbuehler et al., 2008). Therefore, developing adaptive coping skills informed by an LGB affirming lens may be especially beneficial for sexual minority youth (McDavitt et al., 2008). By gaining a better understanding of these unique mental health disparities, their associated risk factors, and the potential psychological mechanisms underlying them, therapists will also be better equipped to develop interventions aimed at helping LGB adolescents improve emotional awareness and regulate emotions more effectively.

### **Depression and Suicidality**

A particularly prominent mental health disparity facing LGB youth, especially those with a history of both interpersonal trauma and sexual orientation-based discrimination, is the increased risk of depression and suicidality (House, Van Horn, Coppeans, & Stepleman, 2011). In a recent meta-analysis, Marshal and colleagues (2011) found that LGB youth, in comparison to their heterosexual peers, are significantly more likely to experience depression and are approximately three times more likely to report suicidality. Research has also demonstrated significant within group differences related to depression and suicidality among LGB youth. For instance, studies have found increased rates of suicide attempts among sexual minority males in comparison to sexual minority females (Fergusson et al., 2005), as well as greater reports of suicidality among bisexual youth in comparison to both lesbian and gay youth (Marshal et al.,

2011; Saewyc et al., 2007; Ybarra, Mitchell, Kosciw, & Korchmaros, 2015). Despite a limited number of studies assessing racial and ethnic differences in LGB youth mental health, Consolacion, Russell, and Sue (2004) found that same-sex attracted, African-American youth also exhibited higher rates of suicidal ideation and depressive symptoms and lower levels of self-esteem than their African-American, heterosexual peers, while same-sex attracted, Latino youth also reported higher rates of depressive symptoms than their Latino, heterosexual peers.

Several factors, such as sexual minority stress and increased exposure to trauma, appear to be associated with these higher rates of depression and suicidality among LGB youth. LGB adolescents, for instance, report increased depression as a result of homophobic bullying and victimization (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009), and sexual orientation violence has been associated with increased risk for suicide (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Additionally, experiences of interpersonal trauma and discrimination related to one's sexual minority orientation have been associated with greater suicidal and non-suicidal self-injurious behaviors (House et al., 2011). In a meta-analytic review of studies examining the relationship between psychopathology and internalized homophobia, Newcomb and Mustanski (2010) found a strong relationship between internalized homophobia and depression, suggesting that the internalization of negative societal attitudes may engage cognitive processes that negatively affect one's self-view, resulting in lowered self-regard, demoralization, and depressive symptomatology (Meyer, 2003). Lastly, LGB individuals have been found to be at highest risk for suicidal ideation and attempts when "coming out" to their immediate family members (Igartua, Gill, & Montoro, 2003). Recent studies confirming the influence of family support and disapproval on the mental health of LGB youth have found that those who report

high levels of rejection are significantly more likely to report suicidal ideation, attempt suicide, and to score in the clinical range for depression (Ryan, Huebner, Diaz, & Sanchez, 2009).

According to Hatzenbuehler and colleagues (2008), one of the primary mechanisms mediating the relationship between sexual minority stress and depressive symptomatology in sexual minority adolescents is the development of maladaptive emotion regulation strategies. More specifically, Hatzenbuehler et al. (2009) have found that LGB young adults, as a result of experiences with minority stress, demonstrate poorer emotional awareness and are more likely to engage in rumination when compared to their heterosexual peers, and that these maladaptive coping strategies are predictive of later symptoms of depression and anxiety. In a similar, large-scale study of young adolescents, McLaughlin et al. (2009) found that emotion dysregulation, including dysregulated expressiveness and rumination, mediated the relationship between peer victimization and internalizing symptoms. Thus, a likely initial target of intervention for LGB survivors of interpersonal trauma is the identification and expression of emotions. As noted by Hatzenbuehler (2009), the ability to accurately recognize and identify emotions is a prerequisite for effectively managing an emotional reaction and must occur before one can utilize emotional information to guide behavior. Adding to this, Briere and Lanktree (2013) note that many adolescent survivors of complex trauma experience difficulty knowing or understanding what exactly they are feeling when triggered into an emotional state. For example, some youth may only be able to identify feeling “bad” or “upset,” or may not be able to discriminate different feelings from one other (e.g., differentiating anger from anxiety or sadness). As a result, such youth might interpret their internal experience as an overwhelming and undifferentiated state of chaotic, intense, and unpredictable emotions. This inability to identify the quality of an emotional state is likely to foster a sense of helplessness. It is also likely to prevent the

adolescent from making connections between their current emotional distress and the event or conditions that produced it (Briere & Lanktree, 2013). For instance, if an LGB adolescent has difficulty identifying feelings such as sadness or shame, it is highly unlikely that they will be able to attribute these feelings to abstract concepts such as internalized homophobia or, perhaps, to even more overt acts of violence such sexual orientation victimization. Thus, poor emotional awareness is likely to prevent LGB adolescents from being able effectively manage their emotional distress or intervene in the causes of their distress.

A second underlying mechanism related to depression in LGB adolescents is rumination. Rumination is defined as a maladaptive emotion regulation style in which one passively and repetitively focuses on one's symptoms of distress and the circumstances surrounding these symptoms (Nolen-Hoeksema, 2000). Thus, rumination is characterized as a *style* of thinking – a process of recurring thoughts and ideas – rather than just the *content* of one's thoughts (e.g., themes of self-blame) (Nolen-Hoeksema, 2000; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Hatzenbuehler and colleagues (2009) found stigma-related stress to be a particularly salient contributor to rumination because it engenders hypervigilance, a component of ruminative self-focus. Moreover, research has shown that when people ruminate in the context of a dysphoric mood, they recall more negative memories from their past, interpret their current circumstances more negatively, and are more pessimistic about the future (Nolen-Hoeksema, 2000). Additionally, depressive rumination results in diminished problem solving capabilities and decreased social support from others (Nolen-Hoeksema, 2000). There is also an extensive body of research demonstrating that rumination prolongs and exacerbates psychological distress, and is linked to the onset and maintenance of depressive symptoms in adolescents (Nolen-Hoeksema, 2000; Nolen-Hoeksema et al., 2008). Thus, one way in which LGB youth tend to

respond to sexual minority related stress and trauma is to engage in ruminative thought processes, focusing both on the sources of their distress as well as the resultant negative feelings, such as sadness, fear, shame, guilt, and anger. In turn, this rumination amplifies their distress, decreases their problem solving capabilities, and further isolates them by alienating or reducing sources of social support.

In terms of the specific thought content that depressed and suicidal LGB adolescents might ruminate about, Baams, Grossman, and Russell (2015) found that LGB youth who perceive themselves to be a burden to others are significantly more likely to experience depression and suicidal ideation than those who do not; and, within their study, “perceived burdensomeness” was found to fully mediate the relationship between sexual minority stress and symptoms of depression and suicide. According to their findings, stress related to sexual orientation victimization and the coming out process prompt some LGB youth to develop the belief that they are a burden to the important people in their lives, which, in turn, leads to feelings of depression and thoughts of suicide. Similar observations regarding this relationship have been found in research with other LGB individuals. For instance, Díaz and his colleagues (2001) found that many gay and bisexual Latino men report feelings of hurt and embarrassment for their families due to their sexual orientation and that these feelings are often associated with suicidal ideation. A further significant finding of the Baams et al. (2015) study was that the relationship between “thwarted belongingness,” (i.e., feelings of alienation from one’s friends, family, or community) and depression and suicidal ideation was fully explained by perceived burdensomeness (Baams et al., 2015). This latter finding may be especially important given that much of the discourse around mental health interventions for LGB youth have focused on improving youths’ sense of belonging through increased social support; however, the results of

this study suggest that, in addition to increasing social support, extra attention should also be given to ways of reducing the experience of feeling like a burden (Baams et al., 2015). In sum, poor emotional awareness and rumination appear to play a key role in mediating the relationship between sexual minority stressors, such as internalized homophobia, and symptoms of depression and suicidality. And, when LGB youth ruminate on the belief that their sexual orientation or experiences of trauma have brought shame to their family or cause them to be a burden to others, the effects can be especially deleterious and warrant immediate intervention.

### **Social Anxiety**

Anxiety, related to trauma and minority stress, is another significant mental health issue affecting many LGB youth. Several studies have shown that symptoms of anxiety are common among those who have experienced sexual orientation violence and/or discrimination (Cramer, McNeil, Holley, Shumway, & Boccellari, 2012; Nadal et al., 2010; Pilkington & D'Augelli, 1995). Burlew, Pulliam, and Grant (2014) note that anxiety among sexual minorities can present in several different forms depending on the type and severity of issues facing the individual. During the early stages of coming out, for instance, LGB youth may be more prone to develop generalized anxiety as a result of efforts to conceal their sexual orientation (Bybee, Sullivan, Zielonka, & Moes, 2009). Similarly, adolescents and young adults who are less open about their sexual identity and who feel less comfortable with their sexual orientation have been found to experience increased symptoms of social anxiety (Pachankis & Goldfried, 2006; Safren & Pantalone, 2006). In the later stages of the coming out process, as LGB youth become more visible and open about their sexual identity, they also become more vulnerable to victimization, including verbal and physical harassment, which, in turn, increases their likelihood of

experiencing post-traumatic stress symptoms (Alexander, 2012; Huebner, Rebchook, & Kegeles, 2004; Iwasaki & Ristock, 2007).

As such, LGB adolescents presenting to treatment for interpersonal trauma are at increased risk for developing problems related to anxiety, especially social anxiety. Defined as excessive fear and avoidance of situations that might involve evaluation by others, the avoidance behaviors associated with social anxiety can have a crippling effect on an LGB individual's inter- and intrapersonal development (Walsh & Hope, 2010). Among LGB adolescents, social anxiety has been found to serve as a barrier to receiving satisfactory social support, experiencing or engaging in competence-building activities, fostering a positive LGB identity, and developing adaptive coping and social skills (Potoczniak, Aldea, & DeBlaere, 2007; Safren & Pantalone, 2006). LGB adolescents with social anxiety are also at increased risk for experiencing depression and suicidal ideation (Safren & Pantalone, 2006), as well as developing other maladaptive coping strategies such as substance abuse or risky and compulsive sexual behaviors (Pachankis, 2007; Pachankis & Goldfried, 2006). Moreover, one of the key components of social anxiety, social interaction anxiety, is characterized by a fear of initiating or maintaining social conversations and interactions with others (Safren & Pantalone, 2006). Thus, due to fear and expectations of rejection related to their sexual orientation, LGB youth who have been traumatized or discriminated against because of their sexual identity may be more likely to develop symptoms of social interaction anxiety as well (Feinstein, Goldfried, & Davila, 2012; Meyer, 2003; Pachankis & Goldfried, 2006). Pachankis, Goldfried, and Ramrattan (2008) found that parental rejection of an individual's sexual orientation has an especially salient stigmatizing effect, leading not only to an increase in rejection sensitivity, but also greater internalized rejection of one's sexual orientation as well. Not surprisingly, research has shown that sexual

minorities frequently engage in identity concealment as a strategy for managing anxiety and fear associated with their stigmatized identity (D'Augelli, 1992; Safren & Pantalone, 2006). For instance, in a study of social anxiety among gay and heterosexual men between the ages of 18 and 24, Pachankis and Goldfried (2006) found that 75% of their gay male participants reported changing their behavior, even during nonthreatening social situations, due to fears that they might be identified as gay and therefore targeted for harassment and attack. Some of the strategies that participants engaged in included avoiding certain locations, avoiding being seen with other LGB people, attempting to appear more masculine, and monitoring the content of their speech. Thus, the researchers found that expectations of rejection not only lead to increased social anxiety in young gay men, but also often result in the implementation of specific behavioral strategies aimed at reducing fear and anxiety over perceived or potential threats (Pachankis & Goldfried, 2006).

These research findings have important implications for LGB youth given that adolescence is a time when most young people are learning how to socialize with peers. However, due to fears of rejection or harm, LGB adolescents may be learning to hide a core aspect of their identity from the important people in their lives, which is likely to diminish access to support following a traumatic event (Potoczniak et al., 2007). Thus, coping with minority stressors via detachment is a common maladaptive emotion regulation strategy utilized by many sexual minorities (Szymanski, Dunn, & Ikizler, 2014). Detachment involves a process of distancing oneself from others or not using others for emotional support. It also involves disengaging from problem solving because the individual subjectively feels that they lack the ability or means for dealing with the distressing situation (Szymanski et al., 2014). Therefore, an LGB adolescent may detach from others or the problem-solving process as a way of socially and



cognitively avoiding the stress of managing a stigmatized identity, or in an attempt to avoid further rejection (Szymanski et al., 2014). LGB youth may also hold the belief that others will not be able to fully understand their minority-based stressor and therefore choose not to seek out emotional support. For instance, unlike ethnic minority youth, most LGB youth do not have parents or other family members who can directly relate to or identify with their sexual minority identity, and, therefore, LGB adolescents are more likely to lack LGB role models and sexuality-specific sources of social support. Additionally, for concealable identities like sexual identity, there may be a lack of perceived opportunities to connect with similar others; as such, LGB adolescents may be less likely to utilize more adaptive strategies for coping with stress, such as seeking out social support (Hatzenbuehler et al., 2009).

Furthermore, there is a significant cognitive and emotional toll associated with maintaining a secret, such as concealing one's sexual identity (Pachankis, 2007; Smart & Wegner, 1999). When LGB youth attempt to conceal their sexual identity they are likely to engage in several maladaptive emotion regulation strategies, including suppression, rumination, and social avoidance (Pachankis, 2007). In an effort to prevent or manage emotional distress, many LGB youth attempt to suppress any thoughts, feelings, sensations, or urges related to their sexual orientation. However, this often results in greater preoccupation with one's stigmatized identity and is likely to lead to greater distress as a result of increased hypervigilance, rumination, and intrusive thoughts related to the suppressed content (Pachankis, 2007). For instance, LGB youth may experience increased anxiety due to rumination over potential experiences of discrimination, violence, or rejection (Meyer, 2003). In turn, these strategies are likely to reinforce fears of rejection and lead to greater social anxiety, isolation, diminished support, and other negative mental and behavioral health outcomes (Pachankis, 2007).

Additionally, when confronted with a stigma-related situation or when perceiving themselves as incapable of concealing their stigmatized identity, LGB youth may become increasingly distressed and vigilant in their search for cues that others might suspect their stigma (Pachankis, 2007). This may be especially difficult for LGB youth who fear not only being rejected for their sexual orientation, but also for the stigma associated with interpersonal trauma such as sexual abuse (Saewyc et al., 2006). Moreover, for some LGB youth, such as those who were outted as a result of their trauma, or before having made the personal choice to come out, anxiety related to fears of rejection, rumination, and hypervigilance may be especially prevalent (Brady, 2008).

### **Shame**

For many LGB youth, experiences of interpersonal trauma and sexual minority stress are likely to result in excessive feelings of shame (Allen & Oleson, 1999; Brown & Trevethan, 2010). While not a clinical diagnosis, shame has been linked to a variety of mental health problems, including depression, PTSD, substance abuse, and suicide (Dearing, Stuewig, & Tangney, 2005; Hastings, Northman, & Tangney, 2000; Orth, Berking, & Burkhardt, 2006; Saraiya & Lopez-Castro, 2016). Dearing and Tangney (2011) describe shame as a complex, prevalent, and painful feeling or emotion that arises when an individual perceives that he or she has committed an egregious offense or violated a social norm. According to Rizvi, Brown, Bohus, and Linehan (2011), shame is “an aversive emotional state accompanied by negative self-judgment, perceived risk of rejection or loss of social attraction, and the urge to hide or disappear” (p. 242). In relation to posttraumatic stress, Budden (2009) described shame as “the quintessential social emotion underlying social threat, comprising a family of negative feelings ranging from mild embarrassment to severe humiliation. It is the painful self-consciousness of, or anxiety about, negative judgment, unwanted exposure, inferiority, failure, and defeat” (p.

1033). Thus, while the adaptive function of shame is to regulate peer relationships and social hierarchies by helping individuals learn the boundaries of socially acceptable behavior, excessive shame can result in debilitating fears of rejection, social avoidance, aggression, extreme self-contempt, and even self-destructive behaviors (Herman, 2011). As such, shame is frequently experienced as an intense and overpowering state of emotion. It has also been described as a “self-conscious” emotion because it tends to occur in conjunction with negative evaluations or cognitive appraisals of the self (Herman, 2011). These appraisals often include thoughts or beliefs that one is bad, worthless, defective, or fundamentally flawed. For example, Potter-Efron (2011) proposed five types of thoughts or phrases that convey different ways in which shame can be experienced or expressed: “I am not good,” “I am not good enough,” “I do not belong,” “I am unlovable,” and “I should not be” (p. 224). In addition to these self-deprecating thoughts, shame evokes a sense of powerlessness, often accompanied by sensations of shrinking, feeling small or exposed, and urges to hide oneself (Dearing & Tangney, 2011). Therefore, the immediate action tendency that accompanies shame is to hide or escape from whatever triggered or elicited the painful emotion. Other action tendencies may include attempts to eradicate the discomfort by denying culpability, by blaming others, or by lashing out in anger (e.g., physical violence, verbal attacks, or self-harm) (Rizvi et al., 2011). Moreover, due to these associated action tendencies, shame has been found to impede social engagement, promote interpersonal disconnection, and interfere with interpersonal problem solving (Luoma & Platt, 2015). When experiencing shame, for instance, the focus of one’s cognitive and emotional energy is directed inward. Thus, the negative self-focus inherent in shame is likely to interfere with one’s ability to respond empathically towards others, or to treat oneself with compassion in the face of suffering (Gilbert, 2011).

While the words “shame” and “guilt” are often used interchangeably within our culture, it is clinically useful, both for the therapist and the client, to be able to distinguish one from the other. The primary difference is whether the focus is on the triggering behavior or attribute (guilt) or more broadly on the self (shame). For instance, if the negative evaluation or focus of attention is on a specific event or behavior (e.g., “I *did* something bad”) then guilt is the likely emotional outcome, whereas, when the focus is on the broader self (e.g., “I *am* bad”), then shame is the likely emotional outcome (Dearing & Tangney, 2011). Though somewhat subtle, this distinction is important and clinically relevant in that guilt is associated with action tendencies such as wanting to make things right by apologizing, making amends, or engaging in efforts to repair a relationship. In stark contrast, however, shame reduces empathy and elicits action tendencies and maladaptive coping strategies such as avoidance, aggression towards oneself or others, and urges to hide (Dearing & Tangney, 2011). The behavioral outcomes associated with guilt, then, are often more adaptive than those associated with shame, and are therefore more positively linked with movement towards empathic connection and the ability to take the perspective of others (Gilbert, 2011; Orth et al., 2006).

In relation to LGB adolescents, shame is a common manifestation of minority stressors such as heterosexism, stigma, discrimination, threats of rejection, and acts of violence (Meyer, 2003). Shame, especially as a result of childhood sexual abuse, has been found to be particularly salient during the early stages of sexual identity development, such as adolescence (Greene & Britton, 2012; Herek, 2004), and has been found to hinder normal sexual identity development (Kaufman & Raphael, 1996; Walker, Hernandez, & Davey, 2012; Wells & Hansen, 2003). While the direct empirical evidence linking stigma and shame is limited, especially among LGB youth, (Johnson & Yarhouse, 2013), a significant correlation between shame and internalized

homophobia has been well established (Allen & Olsen, 1999; Brown & Trevethan, 2010). For instance, Johnson and Yarhouse (2013) contend that sexual minorities typically experience shame as a result of chronic exposure to social stigma, which then becomes internalized, and, with repetition, develops into broader, negative global beliefs or statements about the self. They argue that while stigma says, “Something is different about me that makes me not as good as others,” the internalization of this message eventually develops into shame, which says, “I am different because I am inherently bad, and must hide this difference from others” (p. 88).

Moreover, this self-condemning script is both the product and the cause of shame, whereby fostering a self-perpetuating cycle of shameful thoughts and feelings (Herman, 2011). Therefore, when an LGB adolescent internalizes negative beliefs and attitudes about their sexuality, he or she will be more prone to experience shame (Johnson & Yarhouse, 2013). Furthermore, chronic shame is likely to impede healthy identity formation among LGB youth, contribute to increased internalized homophobia, and cause LGB adolescents to postpone or avoid coming out others. Additionally, a combination of high levels of shame, internalized homophobia, and insecure attachment styles are likely to negatively impact LGB adolescent’s ability to form intimate and healthy relationships in the future (Brown & Trevethan, 2010).

Adding to this, the literature on shame and its relationship to trauma has continually demonstrated that shame is a common emotional consequence of repeated interpersonal trauma, especially among survivors of sexual violence (Saraiya & Lopez-Castro, 2016). For instance, among sexually abused adolescents, shame and self-blame have not only been found to be predictive of PTSD, depression, and suicidal ideation (Alix, Cossette, Hébert, Cyr, & Frappier, 2017; Herman, 2011), but are also significantly associated with increased PTSD symptom severity and maintenance over time (Feiring, Taska, & Lewis, 2002). According to Finkelhor and

Browne (1985), who were among the first to explicate the role of shame and self-blame in the symptomatology of sexually abused youth, negative connotations surrounding sexual abuse, such as taboo, shame, guilt, and victim-blaming, are communicated to the victims by their environment, their aggressor, or society and are then integrated by the victims into a self-stigmatizing schema. As a result of this process, survivors of sexual trauma are more likely to blame themselves for the abuse, whereby leading to feelings of shame and guilt (Alix et al, 2017). Thus, the stigma and shame surrounding interpersonal trauma is likely to cause victims of violence to feel increasingly different from others, more isolated, to have lower self-esteem, and, possibly, to engage in self-destructive behaviors such as substance abuse and suicide (Alix et al, 2017). Given that LGB youth are at greater risk for experiencing minority stress and interpersonal violence related to their sexual orientation, including sexual abuse, the likelihood that shame will play a role in their presenting symptomatology is significantly higher as well (Saewyc et al., 2006). For LGB adolescents, sexual abuse, is likely to compound or add to the stigma-related shame of having a sexual minority identity via internalized homophobia and the maladaptive attributions that one makes about the causes of their abuse (House, Van Horn, Coppeans, & Stepleman, 2011; Saewyc et al., 2006; Rivera, 2002). For instance, the internalization of homophobic myths, such as sexual abuse causes homosexuality or having a same-sex attraction makes one more deserving of abuse, can perpetuate or reinforce feelings of shame in the sexually abused LGB adolescent. In addition to this, research has found that individuals with early exposure to severe forms of interpersonal trauma, such as childhood sexual abuse, are more likely to experience a generalized disposition towards feelings of shame and self-blame (i.e., shame-proneness) (Bockers, Roepke, Michael, Renneberg, & Knaevelsrud, 2016). Furthermore, Greenberg and Iwakabe (2011) note that “an early learning history of

rejection, ridicule, and criticism as well as abuse and neglect generally leads to the development of a core sense of self as flawed, worthless, unlovable, or bad” (p.81).

In terms of emotion regulation strategies, rumination, avoidance, and the individual’s attributional style have all been found to play an important role in the development and maintenance of excessive shame, as well as the negative psychological and behavioral outcomes associated with shame. Since shame is inherently self-focused and acts as an indicator for risk of being rejected, it has also been found to elicit increased hypervigilance and rumination. In turn, this rumination, fueled by shame-based thoughts and feelings, has been observed to lead to depression (Orth et al., 2006). Additionally, increased rumination on one’s perceived failures, otherness, fears of negative evaluation, or feelings of worthlessness, is also likely to perpetuate the internal experience of shame (Johnson & Yarhouse, 2013). Moreover, given that the instinctive action tendency associated with shame is to hide oneself, avoidance and social withdrawal have also been observed as common coping strategies for managing shame (Skinta, 2014; Gilbert, 2011). In LGB adolescents, avoidance or escape from shame may be achieved through substance use, high risk sexual behaviors, self-harm and suicide, or through social withdrawal, as demonstrated by hiding or concealing one’s stigmatizing qualities, such as one’s sexual orientation or history of interpersonal trauma (Goldbach, Fisher, & Dunlap, 2015; Hequembourg & Dearing, 2013; Pachankis, 2015; Rivera, 2002). As Pachankis (2007) notes, however, the act of concealment is, by its very nature, shame inducing, and is therefore likely to perpetuate the shame cycle as well as reduce sources of support. Lastly, maladaptive cognitive appraisals and attribution styles also appear to be strongly associated with shame and adjustment following interpersonal trauma (Feiring et al., 2002). As previously discussed, shame is essentially linked to how individuals perceive themselves, and how they believe others perceive

them. When victims of interpersonal trauma engage in a pessimistic and internalizing attributional style – meaning they make internal, stable, and global attributions for the causes of negative events, such as their abuse – they are also more likely to experience greater symptoms of shame, depression, anxiety, and PTSD (Feiring et al., 2002; Mannarino & Cohen, 1996). In sum, when LGB youth are victims of both interpersonal trauma and sexual minority stress, they are increasingly at risk for developing powerful and painful feelings of shame. The internalization of negative social messages about one's sexuality, combined with distorted attributions about the causes of one's abuse, often lead to more general and global negative beliefs about the self. These self-critical and self-deprecating beliefs give rise to shame-based rumination, and any attempts by the individual to avoid, escape, or suppress their experience of shame often result in its further reinforcement.

### **Clinical Considerations**

**Child.** Due to the additive effects of sexual minority stress and interpersonal trauma, LGB adolescents tend to experience greater difficulties in identifying, expressing, and regulating their emotions (Hatzenbuehler et al., 2008; Inzlicht et al., 2006; Russell & Fish, 2016). Increased exposure to minority stress and trauma in childhood is believed to deplete or overburden the coping resources of LGB youth, whereby leading to emotion regulation deficits and the development of maladaptive coping strategies (e.g., substance use, self-harm, risky sexual behaviors) (Cicchetti & Toth, 2005; Hatzenbuehler, 2009). In turn, these emotion regulation deficits place LGB youth at increased risk for developing symptoms of PTSD, depression, suicide, social anxiety, and excessive feelings of shame (Hatzenbuehler et al., 2008).

Rumination, in particular, has been found to underlie a variety of internalizing disorders (e.g., depression, anxiety, and PTSD) and is believed to be the product of minority stressors such



as internalized homophobia, discrimination, threats of rejection, and identity concealment (Hatzenbuehler et al., 2009). This passive and repetitive self-focus on one's symptoms of distress is a counterproductive style of thinking that causes dysphoric LGB youth to dwell on negative memories from their past, interpret their current circumstances more negatively, and develop more pessimistic beliefs about their future. In addition to this, rumination leads to diminished problem-solving capabilities and decreased social support, as well as further problematic coping strategies such as avoidance and social withdrawal (Nolen-Hoeksema, 2000). By its nature, rumination engenders hypervigilance, which is why it has also been found to contribute to symptoms of PTSD, social anxiety, and shame (Szymanski et al., 2014). While there are few treatments that specifically target rumination, Ed Watkins and his colleagues (2007) developed an adaptation of CBT that has shown promise in reducing symptoms of depression. In rumination-focused cognitive behavior therapy (RFCBT), Watkins et al. (2007) conceptualize maladaptive rumination as a form of avoidance and emphasize the importance of helping clients distinguish between helpful and unhelpful ways of thinking about their distress. They also utilize behavioral activation strategies to help clients reduce ruminative avoidance by replacing it with more helpful approach-oriented behaviors such as relaxation and assertiveness. RFCBT also makes use of experiential and imagery exercises, such as having clients envision times where they approached a challenging situation with confidence or responded to emotional pain with self-kindness and compassion (Watkins et al., 2007).

In line with this approach, Johnson and Yarhouse (2013) recommend that when working with LGB clients who ruminate on thoughts of shame, helping them develop awareness of this process and the content of their self-defeating thoughts can be a powerful initial intervention. In order to do this, they advise therapists to first look for the emotional, cognitive, and behavioral

signs of shame. For instance, therapists might notice the presence of shameful feelings, such as inferiority, worthlessness, or inadequacy, as well as shame-based cognitions, such as “God hates me because I’m a lesbian,” “I’m a disappointment to my family,” or “I deserve all the bad things that have happened to me because I’m gay.” Moreover, behaviors that suggest the presence of shame often include an averted eye gaze, lowered head, hunched shoulders, frequently avoiding or changing topics during session, and recurrent tearfulness (Dearing and Tangney, 2011). By helping LGB youth gradually identify, acknowledge, and express their shame-based thoughts and feelings in a safe, supportive, and validating environment, therapists can begin to facilitate a process of titrated exposure and habituation. Johnson and Yarhouse (2013) also state that in order to further regulate shame, LGB clients must learn how to withhold their natural reactions to hide, avoid, or lash out by developing strategies to moderate the intensity of the shame and to willfully refocus their attention outside of the self so they can respond more effectively. One particularly useful strategy for reversing the typical action tendencies associated with shame is the “opposite-to-emotion action” technique developed by Marsha Linehan (Johnson and Yarhouse, 2013). According to Linehan (1993), this emotion regulation skill requires the client to act opposite to the urge that he or she feels compelled to act upon when experiencing a feeling such as shame. For example, a gay teenager who experiences shame because he believes his voice is “too gay sounding” might typically respond to his feelings of shame by not talking in class or interacting with peers. A more adaptive set of affect regulation skills, however, would suggest that the youth stay in the situation and withhold his natural maladaptive reaction to hide or avoid social interaction. To do this, the youth might first try to reduce the intensity of his shame by utilizing a self-soothing technique, such as a breathing exercise or cognitive coping phrase (e.g., “My voice is important and something to be proud of”). The youth could also

engage in a distraction technique in order refocus his attention away from shaming thoughts about his voice and on to something else in the situation at hand, such as the color of someone's clothes. Finally, the youth could employ his opposite-to-emotion action skill by choosing to speak in class or interact with his classmates, perhaps even sharing with a safe person his negative self-thoughts or fears of being rejected because of his voice. According to Johnson and Yarhouse (2013), once the client has developed this ability to more effectively regulate his emotions, then the cognitions underlying the client's shame can be more closely examined and adjusted. Furthermore, when LGB clients present to trauma-focused treatment with these types of mental health issues, therapists should be aware that internalized homophobia could be a significant contributing factor (Gold, Marx, & Lexington, 2007). However, it is also important not to over attribute symptoms solely to manifestations of internalized homophobia (Newcomb & Mustanski, 2010; Puckett & Levitt, 2015; Szymanski, 2005). For instance, in the previous example, the youth's symptoms may be more attributable to ongoing victimization, rather than negative feelings about their sexual orientation or gender expression. Thus, a thorough clinical interview that addresses the interrelatedness of minority stressors will help therapists in determining if the client's symptoms are related to or exacerbated by internalized homophobia, or if there is a need to intervene on the child's behalf in order to address ongoing threats of violence among other safety issues (Puckett & Levitt, 2015). In addition to this, therapists should also be particularly attentive to any shamed-based thought content suggesting that the youth believes they are a burden to their family or loved ones (Baams et al., 2015). Coupled with feelings of isolation and thwarted belongingness, perceiving that one's sexuality or victimization experiences make them a burden to others has been associated with increased risk for suicide and significant depressive symptoms.

In addition to the strategies already discussed, utilizing the creative arts or other methods of creative expression, both in and outside of therapy, can help youth become more aware of their emotions and provide them with the language and means for expressing themselves. For example, in a study examining strategies utilized by young gay and bisexual men to cope with heterosexism, McDavitt and his colleagues (2008) found that many of their participants spoke of dealing with strong emotions through creative expression, such as drawing pictures or writing letters, stories, or poems that conveyed their different thoughts and feelings. In addition to providing a sense of cathartic relief, these forms of creative expression also enabled participants to gain insight into their feelings, which later facilitated cognitive change processes. Similarly, Pachankis and Goldfried (2010) found that young gay men who participated in a series of brief expressive writing exercises about their experiences with sexual minority stress demonstrated improved psychosocial functioning several months later, especially among those who reported lower social support or who wrote about more severe topics. The writing exercise was also associated with an increase in participants' openness about their sexual orientation (Pachankis & Goldfried 2010). Other ways for therapists to facilitate emotional exploration is through the use of music and film (McDavitt et al., 2008). For instance, Warfield (2013) recommended using culturally relevant songs and lyrics in session to help adolescents identify, name, and express feelings while discussing issues such as depression and anxiety. In working with LGB adolescents, therapists might explore feelings related to themes of homophobia, shame, identity, gender expression, or community by referencing the music and lyrics of out LGB artists such as Frank Ocean, Betty Who, Tegan and Sara, Sam Smith, the Indigo Girls, or Melissa Ethridge, as well non-LGB artists such as Lady Gaga, Macklemore, and Cyndi Lauper, who have all written popular, LGB-affirming songs. In addition to this, therapists might also engage youth in

discussions about their feelings and emotions related to LGB-themed films such as *Moonlight* (Romanski, Gardner, Kleiner, & Jenkins, 2016), *Milk* (Jinks, Cohen, & Van Sant, 2008), *The Family Stone* (London & Bezucha, 2005), *Chutney Popcorn* (Carnival & Ganatra, 1999), *Quinceañera* (Clements, Glatzer, & Westmoreland, 2006), or *The Laramie Project* (Baldwin & Kaufman, 2002). Each of these films, for instance, deals with a wide range of social, cultural, and political issues, including race, ethnicity, gender, religion, sexuality, and disability, and viewing or discussing them may help both to validate the youth's experiences and provide a context for exploring their emotions (See Appendix A for additional music, film, and media resources).

Finally, mindful-meditation and the practice of acceptance are also frequently cited in the literature as helpful emotion regulation tools for sexual minority youth and survivors of interpersonal trauma (Beckerman & Auerbach, 2014; Briere & Lanktree, 2013; Skinta, 2014; Tangney & Dearing, 2011). Walsh and Shapiro (2006) describe meditation as “a family of self-regulation practices that focus on training attention and awareness in order to bring mental processes under greater voluntary control” (p. 228). While it might not be a good fit for all adolescent clients, such as those who are chronically overwhelmed or psychologically unstable, mindful-meditation is a practice that can help LGB youth learn how to observe and become more aware of their thoughts and feelings, in the present moment, with less judgment and greater acceptance (Briere & Lanktree, 2013). In particular, LGB youth who are highly self-critical and shame prone may benefit from a more explicit focus on mindfulness-based practices such as self-compassion (Luoma & Platt, 2015). A wide variety of meditative techniques have been developed to cultivate greater kindness and compassion towards oneself, such as loving-kindness meditation, compassion meditation, and Christian contemplation (Galante, Galante, Bekkers, &

Gallacher, 2014). According to Paul Gilbert (2011), who developed compassion-focused therapy (CFT) for individuals struggling with high levels of shame and self-criticism, compassion, both for the self and others, can be a powerful antidote to shame. Gilbert (2011) notes, however, that shame-prone individuals, due to experiences of minority stress, neglect, and interpersonal trauma, often have little experience with compassion, which is why it is incumbent upon therapists to teach it to them. Thus, by using mindfulness-based techniques to increase self-compassion and self-acceptance, LGB youth will be better able to step back and simply observe their thoughts and feelings rather than engage in a shame-induced processes of evaluation and judgment. Ideally, they would also develop an ability to tolerate negative emotion states by learning to accept, rather than to avoid or escape them (Pepping et al., 2017). One particular method for enhancing self-compassion is to ask the youth to imagine giving advice or comfort to a real or imaginary friend who might also be experiencing a similar shame-induced problem. By taking “the self” out of the equation, it may be easier for the youth to first generate strategies for helping to reduce the suffering of their friend. However, as the youth begins to recognize compassion as an adaptive reaction to suffering, he or she may be more willing to experiment with self-compassion as a strategy managing their own emotional distress (Tangney & Dearing, 2011). Another method for cultivating self-compassion is to incorporate mediations that focus on helping the youth create an image of a “compassionate other” – someone who is wise, strong, kind, and nonjudgmental and who is relating to them in various ways (Gilbert, 2011). This compassionate other can be a real person, perhaps a friend, relative, or someone the youth admires, perhaps a religious figure, such as Christ, Buddha, or the Dalai Lama, a historical figure, such as Harvey Milk or Audre Lorde, or they can even be imaginary, like a superhero. Using this imagery, the therapist can help the youth imagine how that compassionate figure might respond

to the youth's suffering (e.g., feelings of shame or fear, internalized homophobia), then helping the youth imagine how she or he might respond to themselves in the same way as their compassionate figure did. Furthermore, Briere and Lanktree (2013) suggest that therapists who feel uncomfortable or that they lack the training to incorporate mindfulness-based and compassion-focused meditations into their work can also consider referring clients to group or individual meditation practices within the community.

Lastly, when working with LGB adolescents who have experienced complex trauma and who demonstrate significantly impaired emotion regulation abilities, Briere and Lanktree (2013) would caution that such youth are more likely to be easily overwhelmed or destabilized by negative emotional experiences, such as those associated with current negative events or those triggered by painful memories. Given that TF-CBT involves activating and processing traumatic memories, youth who are less able to internally regulate painful emotional states are more prone to becoming highly distressed or overwhelmed during treatment and may engage in increased avoidance strategies or even dissociation (Kliethermes & Wamser, 2012; Briere and Lanktree, 2013). Such responses, in turn, might impede the adolescent's ability to approach and process traumatic material or to benefit from the healing aspects of the therapeutic relationship. Therefore, more time and practice identifying, expressing, and regulating emotions, as well as continuing to enhance relaxation skills, may be warranted before moving on to the cognitive coping and processing of traumatic memories (Kliethermes & Wamser, 2012). In addition to this, Briere and Lanktree (2013) suggested that treating youth with significant emotion regulation difficulties should proceed carefully, utilizing a titrated exposure approach in which traumatic memories are activated and processed in smaller increments, so as not to exceed the client's

capacity to tolerate distress, while, at the same time, providing as much processing of traumatic emotional material as possible.

**Parent.** In addition to helping children identify and cope with difficult emotions, therapists may also need to help parents and caregivers process their own emotions around the youth's traumatic experiences, or difficult emotions related to the youth's LGB identity. Cohen, Mannarino, and Deblinger (2006) recommend using many of the same strategies taught to children in the TF-CBT manual (i.e., thought interruption, distraction, positive self-talk). For example, therapists can help parents develop positive statements to say to themselves when experiencing shame or emotional distress related to their child's LGB identity. Statements such as, "I can be proud of my child for who they are," "My child is stronger when I support him/her," "My child is stronger because they are part of an LGB community," or "I can learn to accept myself like my child has learned to accept herself," can help to reduce the intensity of distressing emotions. Similar to the previous recommendations for working with LGB adolescents, parents may also benefit from using LGB-themed media to acknowledge and express difficult emotions around a child's LGB identity. Films such as *The Laramie Project* (Baldwin & Kaufman, 2002) and *Prayer's For Bobby* (Sladek & Mulchay, 2009) both deal with themes of parents and communities struggling to accept and understand their LGB youth. The documentary, *Matthew Shepard Is A Friend of Mine* (Josue, 2014), is another film that explores the experiences of the parents and friends of a young gay man who is well known for having being murdered because he was gay. In the film, Matthew Shepard's mother, Judy Shepard, who is now an outspoken advocate for LGBT youth, also discusses a lesser-known fact that her son was sexually assaulted as a teenager. Matthew's mother, as well as his friends, talk openly and in-depth about the impact that Matthew's sexual assault had on him, how they struggled with not knowing how to



support him, and how they have since learned to cope with their own feelings of sadness, grief, and guilt.

Apart from learning how to manage their own distress, however, parents and caregivers also have the responsibility of teaching their children how to manage their own emotions and stressful situations as well. One way that parents can do this is through “emotion coaching” (Shipman et al., 2007). According to Stettler and Katz (2017), emotion coaching involves the parent’s ability to identify and attend to low-level emotions in their child (e.g., minor irritations or frustrations), to validate and label these emotional experiences, and to help their child explore possible solutions for resolving or coping with their emotions. Emotion coaching may be particularly relevant for traumatized LGB adolescents given the additive stress of having a sexual minority identity (Stettler and Katz, 2017). Research has shown that higher rates of parental validation and emotion coaching of children exposed to violence and stress has resulted in children’s improved emotional functioning and coping (Shipman et al., 2007). Thus, validation and emotion coaching appear to help children by affirming their experiences and teaching them how to label their emotional states and tolerate distress (Linehan, 1993). Lastly, throughout the parenting literature related to LGB youth, high levels of parental support and acceptance have consistently been associated with decreases in depression, suicidality, and substance use (Bouris et al., 2010). In particular, therapists can help parents learn how to better understand or become more accepting of their child’s individual forms of affective expression, which may take the form of the arts, expressing themselves through fashion or social media, or in gender non-conforming ways. In doing so, therapists may be able to decrease or prevent shaming and punishing experiences that would disrupt the parent-child relationship, and, instead, foster parent-child interactions that affirm and celebrate the youth’s unique and creative forms of

emotional expression. Ultimately, parent-child relationships characterized by acceptance, warmth, and connectedness are generally associated with less risky behavior, more adaptive emotion regulation, and improved mental health (Bouris et al., 2010).

### **Homework: Child**

**“Inside Me, Outside Me.”** In this activity, adapted from Pelton-Sweet and Sherry (2008), the client is encouraged to use art and creativity to explore different aspects of the self by drawing or depicting two self-portraits: the inside self and the outside self. The purpose of this activity is to help LGB youth elicit feelings and beliefs about the self that may have been too difficult for them to discuss verbally or expose in the past. For instance, emotions such as shame, anger, sadness, and fear may be represented, as well as negative beliefs about the youth’s sexual identity, traumatic experiences, or fears of future violence and rejection. Additionally, the therapist may also help the client uncover unique strengths, such as empathy, compassion, resiliency, self-pride, and self-acceptance. By helping youth learn how to identify and express their emotions, both positive and negative, in a safe, supportive, and nonjudgmental space, the therapist can help the client learn how to become curious about themselves and their emotions, as well as how to develop different strategies for dealing with challenging emotions.

There are a variety of ways in which the youth can choose to depict themselves, though, essentially, the child is asked to create two self-portraits. One is of the outside or public self (i.e., “Outside Me”), while the other portrait is of the private, internal self (i.e., “Inside Me”). The outside self is the part of ourselves that we show to others, or what we think others might see when they look at us, while the inside self includes our private thoughts, feelings, desires, urges, hopes, and dreams. There may be significant discrepancies between the child’s self-portraits, which can foster a variety of different discussions. It may be helpful to return to this exercise at

different points in the treatment. It can also serve as a helpful precursor or introduction to the cognitive processing components, or can be incorporated into the child's trauma narrative, perhaps with a before-and-after "Inside Me, Outside Me" self-portrait. Moreover, this activity can be done using a variety of materials (i.e. markers, collage, paint) and the client can create representations of their inside and outside selves using different forms, such as drawing two different portraits on a piece of paper, by decorating the inside and outside of a small cardboard box, or by decorating two different sides of a mask (e.g., using a paper plate or a paper Mache mask bought at an arts-and-crafts store). Using the theme of a mask has several therapeutic implications and can be a useful metaphor to incorporate throughout treatment, especially pertaining to issues of identity concealment, internalized homophobia, and shame. Some youth may be interested in exploring the meanings and symbols related to their mask further, and could be encouraged to create poems or songs about the masks that they wear or the feelings they hide.

Instructions for presenting the activity to the youth using the mask:

We all wear "masks" from time-to-time. Like the masks we wear at a costume party, the outside of the mask sometimes tells a very different story or portrays a very different image than what's behind the mask. We wear masks for all sorts of different reasons. Sometimes we try to act and look different than who we really are or how we would really like others to see us because we worry about what other people might think about us or that they might reject us for who we really are. Many LGB people have worn masks to hide the fact that they are gay, lesbian, or bisexual. For instance, actresses and actors like Ellen DeGeneres, Colton Haynes, Ellen Page and professional athletes like Robbie Rogers and Jason Collins have each shared their personal stories of what it was like to "mask" or hide their true thoughts, feelings, and selves because of

their sexual orientation. Each of them have also talked about the freedom, strength, and support they found when they eventually chose to shed those masks. Have you ever felt like you needed to wear a mask with other people... maybe at home, at school, on the sports team, or with friends? Try to imagine a time where you wore a mask, or pretended to be someone that you really weren't, maybe because you didn't feel safe or you weren't sure how other people might react towards you.

In this activity, I would like for you to pretend that this paper plate is a mask. Using these markers, magazine cut-outs, and supplies I'd like for you to create a mask that describes you individually. Now you'll notice that there are two sides to this mask...

The *outside* of the mask represents the side of us that people see – including how we want people to view us (e.g., our “reputation”) and how people might label us. When most people think of us, this is what we believe they see. This could include the way that we act or carry ourselves, it could include the things we say, or the emotions and feelings that we show or that people might see when they look at us.

The *inside* of the mask includes who we really are – the parts of our lives that others may or may not know about. This could include any thoughts, feelings, desires, hopes, dreams, or fears. It can include the things we're afraid to show others or aspects of ourselves that we love and feel proud of. Sometimes who we are on the outside is very different from the way think or feel about ourselves on the inside, and sometimes they're really similar. This is an opportunity to be honest about things that most people may not know about you – past experiences that have shaped you, your family history, hobbies, or interests, etc.

Feel free to be as creative as you want. There are no rules and you can choose to depict yourself however you want. You can draw, collage, write words or poems, or use colors to represent different thoughts and feelings. After you're done I'd like for you to tell me about your artwork and what it means, and maybe we'll learn something new about the artist as well!

Follow up questions:

- Can you tell me about the drawings or artwork you created?
- What do the two sides of your mask represent? Can you tell me story about each side?
- How did you feel when you were making them? Was one side easier than the other?
- How are the drawings different? How are they the same?
- What do the different colors mean to you?
- Did you learn anything new about yourself?
- If you were looking at this piece of art in a museum, what kinds of things would you think about the artist? What else would you want to know?

## **Chapter 5 & 7: Cognitive Coping and Processing I & II**

### **Purpose**

The purpose of this chapter is to provide information on how cognitive-behavioral therapy (CBT) techniques, utilizing an LGB-affirming lens, can be used to help clients begin to identify, challenge, and restructure inaccurate and unhelpful thoughts related to sexual minority stress and interpersonal trauma. Common stereotypes and cognitive distortions related to one's LGB identity and negative attributions related to experiences of interpersonal trauma – in particular, sexual abuse – will be addressed. A case illustration will be used to explore the cognitive restructuring process and how sexuality-specific issues might be explored with an LGB adolescent survivor of interpersonal trauma. Moreover, the content of this chapter corresponds to chapters 5 and 7 of the TF-CBT manual and is intended to compliment the use of traditional trauma-focused CBT techniques by highlighting some of the strengths and challenges facing LGB youth and their families.

### **CBT and Minority Stress-related Cognitive Distortions Among LGB Youth**

As previously discussed, due to sexual minority stress, LGB adolescents, in comparison to their heterosexual peers, are more likely to be exposed to a variety of traumatic experiences, in turn, placing them at disproportionate risk for developing a range of emotional and behavioral health problems (Marshall et al., 2011; Meyer, 2003; Russell & Fish, 2016). However, interventions aimed at reducing isolation, increasing social support, enhancing coping and problem-solving skills, and combatting maladaptive thoughts related to sexual minority stress and trauma can serve as buffers against these negative effects (Hatzenbuehler, 2009; LaSala, 2006; Mustanski, Newcomb, & Garofalo, 2011; Newcomb & Mustanski, 2010; Pachankis, 2015). According to Craig, Austin, and Alessi (2013), as a conceptualization and treatment

model, CBT is particularly well suited for addressing the unique concerns of sexual minority youth. It does so by helping LGB youth develop more adaptive ways of thinking about situations and problems, whereby prompting emotional and behavioral changes that are later reinforced through practice. Craig and her colleagues (2013) argued that sexual minority stressors, in particular, the internalization of homophobic stereotypes, attitudes, and beliefs, may lead LGB youth to develop dysfunctional thoughts and perceptions about themselves, the LGB community, and how others will treat them in the future. In turn, these distorted beliefs negatively impact the social and emotional functioning of LGB youth, whereby contributing to symptoms of low self-esteem, depression, and anxiety, as well as maladaptive behaviors, such as substance use, risky sexual behavior, and social isolation (Meyer, 2003; Newcomb & Mustanski, 2010; Safren, Hollander, Hart, & Heimberg, 2001).

Utilizing a cognitive-behavioral model, Martell, Safren, and Prince (2004) further noted that negative schemas or core beliefs about the self tend to form early in the development of sexual minority youth. They argued that before LGB adolescents begin to identify as LGB, or even develop an awareness of their sexuality, many have a sense of themselves as being different from their peers. This perceived difference may be due to gender nonconforming behaviors and interests, the emergence of emotional and physical attraction towards members of the same-sex, or, perhaps, due to experiences of overt discrimination, bullying, and victimization (Martel et al., 2004). For example, a young boy who is punished by his parents for playing with his sister's dolls, or who is called a "sissy" or "faggot" by his peers, or who is pressured by friends, family, and other authority figures to conform to specific gender stereotypes (e.g., rough-and-tumble play, dating girls) may come to believe that the behaviors, interests, thoughts, and feelings that come naturally to him are invalid and unacceptable. Thus, Martel and his colleagues (2004)

posited that these early socialization processes teach children that being different is “bad,” and that those who are identified as different, especially those identified as “queer” or non-heterosexual, are especially likely to be targeted for teasing and abuse. Therefore, early awareness of one’s difference, whether due to sexual orientation, gender nonconformity, experiences of interpersonal trauma, or some combination of factors, may in turn lead to the development of beliefs that one is inherently flawed or “bad,” and that “being gay is especially bad.” These maladaptive beliefs are further reinforced by the youth’s ongoing interactions with heterosexism and homophobia, which include a variety of harmful myths and stereotypes about LGB people. The following examples reflect some of the common myths and stereotypes to which LGB youth are likely to be exposed (Balsam, 2003; Garnets, Herek, & Levy, 1990; Gold, Marx, & Lexington, 2007; Kite, 1994; LaSala, 2016; Martel et al., 2004; Ritter & Terndrup, 2002; Safren et al., 2001; SAMHSA, 2012):

- “Homosexuality is a mental illness and can be changed.”
- “Homosexuality is a sin.”
- “Being gay is a choice or a lifestyle.”
- “LGB people are child molesters and sexual deviants.”
- “LGB people are unable to have meaningful relationships.”
- “Gay men are promiscuous and obsessed with sex.”
- “Gay men are weak and are not real men.”
- “Bisexuals are confused or in denial about their sexual orientation.”
- “Bisexuals are hypersexual and will have sex with anyone.”
- “Lesbians either hate or want to be men.”
- “All gay men are effeminate, and all lesbians are masculine.”



- “Openly gay people deserve to be discriminated against and they bring abuse upon themselves.”
- “Sexual abuse causes homosexuality.”
- “LGB people deserve to be sexually abused because they are immoral and deviant.”

Again, these examples represent only a few of the different types of negative messages that youth may learn in their homes, schools, communities, places of worship, and social media; and, although society is slowly changing its attitudes towards LGB people, these stereotypes often occur in the absence of alternative or more LGB affirming attitudes and messages (LaSala, 2006). Furthermore, these myths and stereotypes lay the foundation for many of the cognitive distortions that LGB youth develop about themselves, others, and the world around them. Some of the common cognitive distortions that LGB youth develop in relation to sexual minority stress (e.g., internalized homophobia, discrimination, identity concealment, rejection sensitivity, threats of violence) may contain a variety of catastrophic, pessimistic, self-shaming, polarized, and over-generalized themes (Baams et al., 2015; Díaz, Ayala, Bein, Henne, & Marin, 2001; LaSala, 2006; Martel et al., 2004; Safren et al., 2001; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015):

- “Everyone will reject me because I’m gay.”
- “It’s not safe to be ‘out’ to others.”
- “I will never be happy because I’m gay.”
- “Being LGB makes me inferior to heterosexual people.”
- “I’m a burden on my family.”
- “My sexual orientation has brought shame to my family.”
- “I have to chose between my sexual orientation and my ethnic/religious identity.”

- “I can’t be gay and a Christian.”
- “I must have done something wrong if I’m LGB.”

As such, LGB youth who develop maladaptive automatic thoughts related to their sexual identity (e.g., “My teammates will reject me if they find out I’m bisexual”) or negative core beliefs such as “I’m unlovable because I’m bisexual” or “I’m inferior because I’m different,” are likely to experience increased feelings of shame, fear, sadness, and anger, which, in turn, may lead to maladaptive behaviors such as avoidance (e.g., identity concealment, social withdrawal, passivity), conformity (e.g., “acting straight,” perfectionism), or acting out (e.g., self-injury, substance use, risky sexual behavior, responding to other LGB people with homophobic behaviors) (Alessi, 2014; Herek, Gillis, & Cogan, 2009; LaSala, 2006; Meyer, 2003; Pachankis & Goldfried, 2013; Ritter & Terndrup, 2002; Safren et al., 2001). In addition to this, while the coming-out process may help to reduce the credibility of beliefs that being LGB is wrong – as alternative beliefs gain increasing credibility – many openly LGB youth may continue to struggle with the residual and lingering effects of internalized homophobia (Martel et al., 2004). Again, the belief that being different is bad, which may have developed early in the life of an LGB adolescent, can lead some openly LGB youth to view themselves as frauds and imposters, harboring a “dark secret” regardless of their being “out” (Martel et al., 2004, p. 9). Additionally, identity concealment, whether necessary or not for the youth’s safety, is likely to further reinforce feelings of being different, bad, or even a pariah (Martel et al., 2004). Lastly, youth who experience interpersonal trauma (e.g., emotional, physical, or sexual abuse), whether directly related to the youth’s sexual orientation or not, may attribute the cause of their abuse to failings of the self due to internalized homophobia and core beliefs such as shame (Dillon, 2001; Dragowski, Halkitis, Grossman, & D’Augelli, 2011; Gold, Marx, & Lexington, 2007).

Other types of inaccurate and unhelpful thoughts that LGB youth might develop following experiences of interpersonal trauma may include negative attributions or self-stigmatizing beliefs, such that they are to blame for their abuse (Finkelhor & Browne, 1985; Mannarino & Cohen, 1996). According to cognitive theory, our feelings and behaviors are influenced by how we perceive events, and the way in which we explain the causes of an event determines our attributional style (Beck, 1995; Weiner, 1985). In particular, shame related to sexual abuse is greatly influenced by one's attributional style (Dorahy & Clearwater, 2012). For example, when a child attributes the causes of their abuse to internal (e.g., "I'm the cause"), stable (e.g., "I will always be at fault"), and global (e.g., "It was me who caused it, not just my behavior") factors, then increased feelings of shame are likely to be the result (Dorahy & Clearwater, 2012; Lewis, 1992). Thus, LGB individuals who believe or attribute their experiences of trauma, especially sexual assault, to their sexual orientation or same-sex attractions may develop greater feelings of shame, depression, anxiety, and posttraumatic stress, as well as avoidance behaviors that further reinforce mental health problems (Gold et al., 2007). For instance, Feiring et al. (2002) found that sexually abused youth who experience high amounts of shame following their abuse and attribute the causes of their abuse, or other negative events, to negative aspects of themselves, tend to exhibit greater posttraumatic stress symptoms and poorer adjustment over time. Furthermore, Gold et al. (2007) posited that myths such as "Sexual abuse causes homosexuality" and "LGB individuals are deserving of abuse" result in greater internalized homophobia among LGB individuals, which, in turn, causes them to react to their sexual assault histories with shame, self-blame, and guilt. In fact, in their study, which examined the relationship between internalized homophobia and psychological symptom severity among gay male sexual assault survivors, Gold and his colleagues (2007) found that

internalized homophobia was consistently a stronger predictor of depression and PTSD symptom severity than was the severity of the assault. Similarly, Dillon (2001) found a relationship between internalized homophobia and shame among gay men who experienced trauma, and Burns, Kamen, Lehman, and Beach (2012) found internalized homophobia to be significantly correlated with both global and internal attributions. Furthermore, the literature suggests that myths about sexual abuse, maladaptive attribution styles, internalized homophobia, self-blame, and shame should be targeted in interventions with sexually abused LGB adolescents (Alix, Cossette, Hébert, Cyr, & Frappier, 2017; Burns et al., 2012; Dillon, 2001; Gold et al., 2007).

### **LGB affirmative CBT for sexual minority youth**

As previously mentioned, Craig and her colleagues (2013) argued that CBT can be, and has been, successfully adapted for use among LGB adolescent clients (e.g., Hart & Heimberg, 2001; LaSala, 2006; Lucassen, Merry, Hatcher, & Frampton, 2015; Safren et al., 2001; Pachankis, 2015; Willoughby & Doty, 2010). They, among several other authors, have noted that as a “best practice” for treating adolescents with a wide range of mental health issues (e.g., depression, social anxiety, suicidality, PTSD), CBT also utilizes a collaborative, individualized, and client-driven approach that is culturally responsive and able to incorporate the unique strengths and challenges facing LGB youth and their families (Eamon, 2008; Hays, 2009; Martel et al., 2004). It is important to note, however, that there are also several potential limitations to multicultural and LGB-affirming applications of CBT. For example, Pamela Hays (2009) argued that CBT, like all other major practice theories, is inevitably influenced by the values of the culture in which it is developed. She points to the fact that CBT places an emphasis on assertiveness, personal independence, verbal ability, rationality, cognition, and behavior change, while other cultures may emphasize values such as subtle communication, listening over talking,

acceptance over behavioral change, and a more spiritually oriented worldview (Hays, 2009). Additionally, Hays noted that CBT maintains a present-focused orientation, which could cause a therapist to neglect or overlook historical aspects of the client's culture that are relevant to the client's current functioning and behavior. Lastly, and particularly relevant to working with LGB youth and their families, Hays noted that the individualistic orientation of CBT may lead more novice therapists to overemphasize the cognitive restructuring process while neglecting important environmental influences that are impacting the clients' mental health and wellbeing. Therefore, when working with LGB clients, especially those from various ethnoracial and spiritual backgrounds, TF-CBT therapists should be aware of these potential limitations and should be cautious not to neglect the cultural values and perspectives of the client or the need for important environmental interventions (e.g., ensuring that the LGB youth's school is safe for them to attend). Furthermore, Craig and her colleagues (2013) have outlined several ways in which incorporating gay affirmative practice techniques can enhance the effectiveness and cultural responsiveness of traditional CBT. Thus, by infusing LGB affirming values and content throughout the therapeutic process –as has been the primary goal of this resource manual – TF-CBT therapists may also find many of Craig et al.'s suggestions useful when working with LGB youth. The following is an adaptation of Craig et al.'s (2013, p. 261-263) ten-component model of gay affirmative CBT for sexual minority youth, which they have built upon existing research literature (e.g., Crisp & McCave, 2007; Hays, 2009; Eamon, 2008) in addition to their own clinical and research work:

1. *Affirm the identities of sexual minority youth during the assessment process.* Therapists are encouraged to begin assessing for the effects of heterosexism, discrimination, and internalized homophobia from the beginning of the treatment process. This will help

therapists begin to conceptualize the nature of the client's presenting problems, while affirming the client's sexual identity and demonstrating that issues pertaining to sexual identity are valued and important areas to be explored in therapy.

2. *Foster collaboration by clearly explaining the treatment process.* Therapists are encouraged to be transparent about the treatment process with sexual minority youth, which can be very empowering for them, especially given that LGB youth who have experienced trauma may be struggling with issues of trust and feelings of safety.
3. *Identify the sexual minority youth's personal strengths and support networks.* Craig and her colleagues suggest that therapists ask clients to make a list of any positive feelings about identifying as lesbian, gay, or bisexual. Youth may also be asked to describe or discuss their favorite LGB icons or to describe traits and attributes of other LGB people that they might know or look up to. By eliciting these positive attributes and strengths, TF-CBT therapists may be able to utilize them during the cognitive coping and processing components of treatment, in which the youth will be asked to develop more balanced, helpful, and accurate thoughts, perhaps pertaining to their sexual identity or negative attributions about their abuse. In addition to this, therapists should also inquire about the youth's support system, which may include the client's supportive family members, informal sources of support (e.g., friends, partners, teachers), formal peer supports (e.g., gay-straight alliance at school), community groups (e.g., sexual minority support group or involvement in LGB youth centers), as well as experiences participating in LGB affirming events or rituals (e.g., gay pride parades). The homework exercise discussed in chapter 3 of this resource manual (i.e., "Circles of Support") may

be a helpful tool for identifying and exploring the youth's sources of support or lack thereof.

4. *Distinguish between problems that are environmental and those that stem from dysfunctional thoughts.* This is a particularly important strategy when working with LGB youth who have experienced, or continue to experience, interpersonal trauma in the forms of sexual orientation violence, homophobic bullying and teasing, or parental rejection. For instance, if an LGB youth is being rejected by their parent or being bullied at school due to the youth's sexual orientation, these events and their impact on the youth may not be easily changed by modifying dysfunctional thoughts or changing behaviors. By acknowledging these concerns, however, therapists can help youth develop coping skills for situations that are out of their control (e.g., a parent who refuses to acknowledge the youth's LGB identity). Additionally, Craig and her colleagues noted that the cognitive restructuring process may be particularly useful in helping LGB youth identify, challenge, and modify dysfunctional thoughts that work against their long-term goals or contribute to feelings of hopelessness (e.g., "I'll never feel safe at school, so what's the point of going?"). Thus, by acknowledging that there are actual challenges and risks that LGB youth face, often on a daily basis, will validate the youth's experience and lead to realistic cognitive, behavioral, and environmental interventions and coping strategies that can help the youth thrive and feel supported.
5. *For environmentally-based problems, help clients make changes that decrease stress, increase personal strengths and supports, and to build their skills for interacting with the social environment.* Craig and her colleagues suggest helping the youth connect to LGB community resources (e.g., a school's GSA, local LGBT center, PFLAG, LGB

mentoring program) that can provide additional support for environmental stressors such as bullying, as well as other sexual minority-related stressors. Several suggestions for increasing sexuality-specific support have been offered throughout this resource manual (i.e., chapters 1, 3, 4, and 8).

6. *Validate the client's self-reported experiences of discrimination.* Craig et al. emphasize the importance of validating an LGB youth's sexual minority-related stress experiences and caution against attempts to search, too quickly, for alternative hypotheses for the youth's distress. They argue that this might be perceived as an attempt to minimize or doubt the youth's experience, and, as such, might rupture the therapeutic relationship. Particularly, when working with traumatized LGB youth who may be struggling with issues of trust, shame, internalized homophobia, and rejection sensitivity, validating and inquiring about their experiences with discrimination will be an important intervention in and of itself (Pachankis, 2015; Szymanski, Dunn, & Ikizler, 2014). In addition to this Pachankis (2015) suggests normalizing the adverse impacts of minority stress. He contends that gay and bisexual clients, especially those who are younger, may not be aware or able to recognize that a potential source of their distress is due to stigmatizing social forces, and, instead, may incorrectly attribute their distress to personal failings rather than minority stress. Therefore, by identifying and normalizing the various forms of distress caused by sexual minority stress (e.g., self-defeating thoughts related to internalized homophobia), the therapist can help the LGB clients shift the blame for this distress to a stigmatizing society rather than themselves, whereby reducing their emotional suffering.



7. *Emphasize collaboration over confrontation, with attention to client-therapist*

*differences.* This point builds upon the last recommendation, adding that working collaboratively with LGB youth is especially important given that many may lack supportive and LGB affirming adult figures in their lives. For example, art, music, writing and other expressive activities (e.g., “Inside Me, Outside Me” activity in chapter 4 of this resource manual) which allow the client to take the lead in generating difficult thoughts, feelings, memories, or experiences related to their trauma, while the therapist offers support, are likely to foster collaboration and minimize confrontation.

8. *With cognitive restructuring, question the helpfulness (rather than the validity) of the thought or belief.* According to several researchers and clinicians (Craig et al., 2013; Hays, 2009; Pachankis, 2015; Safren et al., 2001), when working with LGB clients, therapists should be cautious in questioning the validity or rationality of a belief or behavior – especially those pertaining to sexual minority stressors – because the therapist may appear unempathic or even naïve. Rather, it is suggested that a more culturally responsive approach would be to help the client consider the helpfulness or utility of the belief or thought. For example, if a lesbian teenager states, “I’m certain my basketball coach will drop me from the team if I come out at school,” rather than questioning the validity of this thought, the therapist could employ a more affirming approach to cognitive restructuring by helping her evaluate the utility of the belief. For instance, the therapist might ask, “Is it helpful for you to say that if you come out at school you’ll be kicked off the team, or to repeat this thought or image to yourself?” In addition to this, Craig et al. might suggest working with the client to create a list of what the client thinks will happen after they “come out” at school. Then, the therapist and

client can work together to determine what are the “helpful vs. unhelpful thoughts” and to assess the utility, or costs/benefits, of holding on to a particular thought. This type of an intervention can be very empowering for the client by allowing her to determine the utility of the thought for herself, within the context of her own life, while also avoiding an extensive discussion of whether the belief is irrational or not. In regards to restructuring minority stress cognitions, Pachankis (2015) also states that for many LGB clients, the development of cognitive biases, such as hypervigilance and fears of being rejected due to one’s sexual orientation, may have been adaptive at some point in the client’s life because it kept them safe from harm. However, if the client is no longer in significant threat of danger or the current context of their life is safer, then these minority stress-driven cognitive biases may no longer be adaptive or useful. Therefore, helping client’s identify and understand the original function of their current cognitive distortions may facilitate the cognitive restructuring process and lead to the generation of more adaptive thoughts.

9. *Use client-identified strengths and supports to help sexual minority youth develop a list of helpful thoughts.* As previously mentioned, helping LGB youth identify strengths and sources of support early in the therapeutic process can be useful when later helping clients generate new thoughts to replace less adaptive ones. For example, clients may be able to generate positive coping statements by drawing support from others or reflecting on successful experiences in their past, such as, “All the adversity I have experienced has only made me stronger,” “My differences are what make me unique and special,” or, “Knowing that there are a lot of other gay kids out there who have gone through this too reminds me that I’m never alone” (Craig et al., 2013; Lucassen et al., 2015) Thus,

writing and practicing these statements in session, at home, and with parents can provide LGB youth with concrete skills that they can use to weaken cognitive distortions and negative attributional styles while strengthening more adaptive and affirming beliefs.

10. *Ensure that homework assignments emphasize congruence with LGB culture as well as the client's stage of sexual identity development.* Given that between session homework and practice assignments are a key mechanism to enhancing and sustaining cognitive and behavioral change, it is recommended that therapists ensure that assignments are culturally relevant to their LGB clients as well as appropriate for their age, developmental level, and intellectual ability. For example, within this resource manual are a range of LGB affirming exercises and activities, some of which may be more appropriate for youth who are more comfortable with their sexual identity and being out to others. For instance, Craig et al. note that while a client who is still in the early stages of coming out might not be interested in joining their school's gay-straight alliance, watching an LGB-affirming movie, spending time with a straight ally, or watching LGB-affirming videos on Youtube may be a more plausible and appealing recommendation for them. Moreover, assignments that involve music, creative expression, socializing with friends, or being physically active are more likely to appeal to adolescents in general (Warfield, 2013).

In sum, in TF-CBT, therapists teach clients how to identify, label, evaluate, and modify their dysfunctional thoughts and beliefs related to trauma and stress in order to replace them with more adaptive, realistic, or helpful thoughts. By incorporating LGB-affirming practices, TF-CBT therapists can draw upon their LGB clients' unique strengths and community resources, while

being culturally attuned to the client's specific needs and challenges as well. Thus, LGB-affirming practice encourages therapists to be aware of and assess for any pertinent developmental and risk factors facing their LGB clients in order to strengthen treatment conceptualization and avoid invalidating or minimizing the effects of sexual minority stress. In the next section of this chapter, a clinical case illustration will be used to demonstrate how the cognitive restructuring process might be used to address trauma and sexual minority stress-related cognitions.

### **Processing and Restructuring Trauma and Minority Stress-related Cognitions**

According to LaSala (2006), therapists can help LGB clients by first teaching them how to identify inaccurate and unhelpful thoughts about themselves, especially those stemming from negative core beliefs related to internalized homophobia. Once the client's cognitive distortions have been identified, therapists, using the cognitive restructuring process, can then help the client challenge and transform their dysfunctional thoughts into more adaptive, balanced, and realistic thoughts. A variety of techniques can be utilized to achieve this goal. Socratic questioning is a particularly useful technique in which the therapist asks questions designed to foster the client's own independent, rational problem solving. In this process, the client learns how to evaluate the evidence that does and does not support their belief, as well as how to construct an alternative response to the dysfunctional belief. In working with adolescent survivors of interpersonal trauma, Briere and Lanktree (2013) also encourage therapists to use open-ended questions to facilitate exploration of any unhelpful beliefs or conclusions that the youth may have developed as a result of their traumatic experience. In doing so, the therapist may find cognitive distortions related to blame, deservingness, or responsibility. In these instances the therapist may feel compelled to rescue the client by assuring them that they are not to blame; however, Briere and

Lanktree (2013) caution therapists to avoid simply arguing or disagreeing with the client's distorted beliefs. Rather, they note that "the intent of such cognitive exploration is for the youth to update his or her trauma-based understanding—not to incorporate the therapist's statements or beliefs regarding the true state of reality or the client's 'thinking errors'" (Briere & Lanktree, 2013, p. 76). Thus, the client is most likely to benefit from the cognitive processing and restructuring process if he or she is provided with a safe and supportive environment in which the therapist uses gentle inquiry and guidance while allowing the youth to compare prior trauma-based versions of reality with newer understandings. In this context, clients will likely be able to revise their trauma narratives by updating faulty assumptions and beliefs that were made during a time of intense distress or had not been fully considered. Ultimately, the goal is to help clients experience a cognitive shift in which the strength of their dysfunctional thinking decreases and their ability to accept or take on a broader, more adaptive perspective increases (Martell et al., 2004).

### **Clinical Case Illustration: "Carlos"**

The following is a clinical case illustration to demonstrate how the cognitive restructuring process can be used to address both trauma and sexual minority stress-related cognitions with a gay youth following a sexual assault.

**Background.** Carlos is a 16-year-old, Mexican-American male who identified himself as gay at age 14, though he is only out to his mother, cousin, and a few close friends at school. His parents are divorced and Carlos primarily lives with his mother, who is supportive of his sexual identity. Carlos stays with his father, Julian, every other weekend. Julian was raised in Mexico and considers himself "extremely conservative" and believes in "traditional Catholic values." Although Carlos has never discussed his sexuality with his father, Julian once caught Carlos

looking at gay porn on his computer. Since then, Julian has repeatedly made homophobic comments towards Carlos, calling him a “sissy” or a “maricón” (Spanish slang for “faggot”), and has told Carlos that all gay people are “sick” and “deserve to have the crap beat out of them.” In addition to this, over the past year, Carlos has been bullied at school by a small group of boys.

Carlos’ mother brought him into treatment after Carlos disclosed that he was sexually assaulted by someone he met online. The man who assaulted Carlos had befriended him on an LGB social media website, pretending to be another gay teenager who lived in his area. Coming from a very conservative community, Carlos had no LGB friends and was excited at the opportunity to meet someone else just like him. Carlos was invited over to “watch a movie and hang out,” though, when he arrived to the man’s house, he realized that something was wrong. The perpetrator tried to convince Carlos to stay, however, when Carlos attempted to leave, he was overpowered by the man and sexually assaulted. Since then, Carlos has blamed himself for what happened. In his trauma narrative, Carlos expressed, “my father was right, gay people are sick, and that must mean there’s something wrong with me too. I don’t know what I was thinking. This is all my fault.”

In the following dialogue, the therapist uses cognitive processing and restructuring to help Carlos explore his inaccurate self-blame in order to challenge his thoughts and replace them with more realistic and adaptive thoughts. The therapist helps Carlos learn how to differentiate between blame and responsibility. Whereas blame requires intention, responsibility has to do with one’s actions in a particular situation that may have contributed to a certain outcome. Thus, while someone might feel regret for having taken or not taken an action, if there was no intention, then blame is not appropriate (Kaysen, Lostutter, & Goines, 2010). Even still, there is the possibility of the unforeseeable. In Carlos’ situation he was deceived and manipulated, and

the stress of having a sexual minority identity likely contributed to his desire for secrecy and willingness to meet a stranger from online:

**Therapist:** So in your trauma narrative you said that the sexual assault was your fault?

Can you help me understand how it was your fault?

**Carlos:** Yeah, because I'm the one that went over to the house and because I was talking to him online. Like my dad said, I was just asking for it.

**Therapist:** I think it would be helpful for us to discuss the difference between blame and responsibility. Responsibility is about your behavior causing a certain outcome. Blame means you intended for something to happen. And sometimes, bad things happen even when we don't intend for them to happen and there's nothing we could have done to stop them from happening. So I can understand this better... When you went to the house, did you want to be physically attacked or forced to have sex? Did you ask for any of that to happen?

**Carlos:** No way. Not at all. I was just excited to meet someone else who was gay and my age. It's like I don't have anyone to talk to about that kind of stuff.

**Therapist:** So it sounds like you didn't want *or* intend to have sex with this man who lied to you and pretended to be someone else. And you certainly did not ask to be attacked.

Instead, it seems like you were excited about meeting a new friend.

**Carlos:** Well yeah, but it's still my fault because I met him online through a gay website and I know it's not all the time, but sometimes things like this can happen.

**Therapist:** So even though lots of gay people meet other gay people online without any problems, or without ever being sexually assaulted, you knew that this time you were going to be attacked?

**Carlos:** Well no, I guess that does sound pretty ridiculous. I guess it just feels like it's my fault though. It's like being gay is a curse.

**Therapist:** And what about the man who attacked you? What do you think his intentions were? What's his level of blame?

**Carlos:** He definitely lied to me. I would never have gone over there if I knew that. And even after I told him no and tried pushing him off of me to get away, he just wouldn't stop. He was a lot bigger than me. I just wish it had never happened.

**Therapist:** I wish it hadn't happened either, Carlos. After everything you've just told me, it seems very clear that you didn't intend to be sexually assaulted and you didn't deserve to have this happen to you either. It's pretty clear that you were lied to, and even after doing everything you could to make it stop... saying no, fighting back... this man continued to hurt you. It sounds like your intentions were to make a new friend, not to be attacked. I'm not hearing any way that you could have been responsible what happened.

**Carlos:** I guess if it has to do with intentions, then it's really his fault, not mine.

**Therapist:** How does it feel to say that?

**Carlos:** A lot better, but I still feel pretty sad about everything.

**Therapist:** You also mentioned that being gay feels like a curse, and that your dad has said some pretty negative things about gay people. Do you think that those thoughts might have contributed to your feeling like what happened was all your fault?

**Carlos:** Probably. I'm always hearing about how terrible gay people are... at school, from my dad. I'm always going back and forth between feeling good about being gay and feeling like there's something wrong with me.



**Therapist:** That makes a lot of sense, and that's a pretty normal response. When you constantly hear negative things said about gay people, and you know that you're gay, you might even start to believe some of the myths and stereotypes that you hear, especially when they come from important people, like friends and parents.

**Carlos:** That's why I wanted a gay friend so bad. Like someone who just gets it... maybe someone who's going through some of the same things I am.

**Therapist:** That also makes a lot of sense, and I think that's a great idea. What if we can come up with some safe ways for you to meet other gay kids your age?

**Carlos:** Yeah, that'd be good, I think... but how?

**Therapist:** I know of some different resources in your area. Maybe we can work together with your mom to help you get connected to them? It sounds like your mom is really supportive of you and that she really wants to help you in anyway she can. If we all work together, I know we can come up with some new ideas for helping you feel stronger and safer.

**Carlos:** Yeah, I'd like that.

**Therapist:** You know, Carlos, when I hear all the obstacles you've had to deal with... the bullying at school, negative comments from you dad, and having been assaulted by a stranger... it reminds me of strong you must be to put up with everything. You're a really special kid, it takes a lot of courage to be out and proud of who you are... because being gay isn't always easy. How do you find that courage?

**Carlos:** I don't know. Sometimes, I just tell myself that this will all get better someday. And when people say mean things to me I try to ignore them or remind myself that they're just ignorant. But sometimes it's hard.

**Therapist:** Those are some great messages that you tell yourself, Carlos. How do you feel when you have thoughts like... “I will get through this and it gets better” or “There’s nothing wrong with me. The only thing that’s wrong is other people’s ignorance.”

**Carlos:** I feel good... usually more confident. I know I don’t think about all the bad stuff as much.

**Therapist:** Exactly. Remember when we talked about how our thoughts and the things we say to ourselves can change the way we feel?

**Carlos:** Yeah. I can see that when I tell myself positive things, like I’m strong and I can get through this, I usually feel better... or at least less bad.

**Therapist:** You got it. So when your mind starts handing you negative statements about being gay, maybe things you’ve heard from others, you can try replacing them with more helpful thoughts... like “Being proud of who I am makes me stronger and I can get through this.”

**Carlos:** I think I can do that.

While this case illustration represents only a small piece of the cognitive restructuring process, through the use of Socratic questioning, empathic concern, and psychoeducation the therapist is able to help Carlos start to reconsider and challenge his dysfunctional beliefs of self-blame. At the same time, Carlos alludes to the belief that his sexual orientation may have been a cause for the sexual assault. This belief will need to be explored further with Carlos, though in this early interaction, the therapist can help Carlos begin to identify how negative messages and attitudes about gay people, which are learned from society, can become internalized and affect that way that he thinks about himself and makes sense of the bad things that have happened to him. By reflecting Carlos’ strengths, such as the courage it must take for him to be openly gay

despite several challenges, the therapist can also elicit and reinforce more adaptive alternative thoughts that Carlos already possesses about his sexual identity. Some additional interventions might include working with Carlos' father to address the negative impact that his homophobic remarks are having on Carlos and their relationship, providing Carlos' mother with parenting and LGB youth resources that can help her nurture her son's sexual identity, and, perhaps, working with the family to intervene at Carlos' school in order to help him feel more supported, protected, and safe.

### **Clinical Considerations**

**Child.** In addition to the recommendations already provided regarding the cognitive restructuring process and using an LGB affirming lens to guide cognitive-behavioral interventions, therapists should also pay close attention to the effects of shame associated with heterosexism, internalized homophobia, and interpersonal trauma (Dorahy & Clearwater, 2012; Johnson & Yarhouse, 2013; SAMHSA, 2012). Neisen (1993) offers several recommendations for helping LGB clients heal from the shame of heterosexism and homophobia, which can be incorporated throughout the cognitive coping and processing components. Recommendations include helping youth "break the silence" by telling their stories of homophobia related abuse and victimization, including both overt acts of violence as well as micro-aggressions and heterosexist or homophobic stereotypes perpetuated in society and the media (Neisen, 1993; SAMHSA, 2012). For instance, during the cognitive processing components, therapists can explore the emotional costs of hiding and denying one's sexual identity, discuss attempts the youth has made to change in an effort to fit in, or examine the beliefs (e.g., self-blame, unlovable) that are associated with shaming messages about LGB sexuality. Another recommendation is that therapist's help LGB clients shift the fault for their minority stress-

related cognitions to a heterosexist and homophobic society, and away from themselves. This can help the client understand that feelings of anger and negative self-perceptions are the result of cultural and/or interpersonal victimization and not a personal defect. Lastly, through the cognitive restructuring process, therapists can help LGB adolescents reclaim personal power by teaching them how to identify internalized negative messages about their sexuality, change these negative messages to positive and affirming statements about themselves, integrate public and private identities, and build a support network of people who value and support them for who they are (Neisen, 1993; SAMHSA, 2012).

Furthermore, therapists can also help LGB youth develop cognitive coping phrases as a way to combat negative stereotypes and self-defeating or self-blaming thoughts, as was demonstrated in the case illustration above (Lucassen et al., 2015). When researchers ask LGB youth about their preferred strategies for coping with minority stress, many report the use of cognitive coping statements that affirm their LGB identities (McDavitt et al., 2008). Often, these statements include themes of acceptance (i.e., of self and others), connection (i.e., to the LGB community and supportive others), hope, self-efficacy, and activism (Goldbach & Gibbs, 2015; Harper, Brodsky, & Bruce, 2012; McDavitt et al., 2008). For example, youth might develop coping statements such as, “I’m proud of who I am,” “I’m not alone because I’m part of an LGB community,” “It gets better,” “I am strong because I’ve already overcome so much,” and “Being out and proud of who I am lets others know that it’s okay to accept themselves, too.” Therapists can also turn this into an activity by encouraging the youth to research LGB affirming quotes made by outspoken LGB advocates, such as Harvey Milk, RuPaul, Dustin Lance Black, Margaret Cho, Dan Savage, Harvey Fierstein, Allen Cummings, and Ellen DeGeneres to name a few. Youth can create or decorate their own board with LGB affirming quotes or add to one that

the therapist keeps in their office. For instance, the therapist could ask the youth to write an LGB affirming coping statement that will help another LGB youth that therapist works with in the future (Warfield, 2013).

**Parent.** In addition to examining the beliefs of adolescent clients, it is also necessary for therapists to assist parents and caregivers in identifying, challenging, and adapting their own inaccurate and unhelpful thoughts related to the child's sexual minority status and/or traumatic experiences (LaSala, 2006). For example, in the case illustration above, Carlos' father, Julian, held a number of negative beliefs about LGB people, including that they are immoral, sick, and deserve to be abused. It became clear during the cognitive processing and restructuring phase that Julian's beliefs, which resulted in homophobic comments directed towards his son, had a strong and negative impact on Carlos' beliefs about himself, what it means to be LGB, what the future holds for him, and contributed to Carlos' maladaptive attributions about the causes of his abuse (i.e., self-blame). Similar to working with youth, therapists can provide parents with psychoeducation on internalized homophobia, as discussed in previous chapters of this manual, as well as help them begin to explore where, how, and when they learned these messages about LGB people and the impact these messages have on their children (Ritter & Terndrup, 2002). For instance, based on Julian's background, the therapist might want to explore issues related to Julian's ethnic and religious beliefs or experiences in order to help him understand the basis for his homophobic beliefs and attitudes. The therapist could help Julian explore discrepancies between his different actions, beliefs, and values, for example, the belief that verbally abusing his son is his duty as a parent, while, on the other hand, holding the value that the family is a sacred source of loyalty and support (i.e., "familismo;" LaSala, 2006). Furthermore, parents are likely to have internalized many of the same myths, stereotypes, and negative attitudes about

LGB people that their children have. However, other dysfunctional beliefs that parents may hold include beliefs that they somehow caused their child to be LGB, that their child's sexual orientation is a phase, that their child will never marry or have children, that they will never lead a "normal" life, that being LGB makes one hypersexual, or that their child will never be able to cope with discrimination and homophobia (Willoughby & Doty, 2010). Again, through the cognitive restructuring process, family members can learn how to identify, challenge, and adapt their homophobic and heterosexist beliefs and assumptions (Fish & Harvey, 2012). Lastly, prior to beginning the trauma narrative, parents who continue to feel guilty or blame their child's abuse on their sexuality should first undergo cognitive processing to address these cognitive distortions. Also, if the parent is religious, as was the case with Julian, it may be helpful for the therapist to provide resources or advise the parent on how to seek out support from spiritual advisors within the LGB community (see Appendix A for LGB-affirming spiritual and religious resources).

### **Homework: Child & Parent.**

**"Where Did You Learn That?"** Adapted from an exercise developed by Boyd and Whitman (2003, p. 56), the general purpose of this activity is to help clients develop an awareness of how their external world affects their internal thoughts, feelings, and experiences. More specifically, using the Appendix E handout ("Where Did You Learn That?: Challenging Homophobic Stereotypes"), clients are asked to elicit and identify harmful and dysfunctional thoughts related to the internalization of negative attitudes, myths, and stereotypes about LGB people (i.e., internalized homophobia). The therapist's goal is to help clients become more aware of the heterosexist, homophobic, and discriminatory messages they have internalized from society, to understand that these messages are stereotypes rather than realistic descriptions, to

examine the impact that these messages have on themselves and other LGB people, and to explore when, where, and how they learned these messages. Once clients are able to recognize the negative beliefs that they hold about themselves and/or other LGB people and that these beliefs are learned, then they can begin the process of reevaluating and rewriting the messages or beliefs as a means of increasing self-esteem, improving relationships, and decreasing the effects of minority stressors such as internalized homophobia.

For example, a lesbian teen may report having heard the message that “being gay is a sin,” and internalized this as a belief. In turn, she might think of herself as bad, defective, or immoral, she might attribute a traumatic sexual assault as a punishment from God because of her sexual orientation, and she might avoid going to church despite the importance of spirituality in her life. She might report having observed other LGB people being treated negatively as a result of this stereotype, whereby increasing her feelings of shame and urges to conceal her sexual identity. As a result of this stereotype, the client might also develop the belief that she has to choose between her religion and her sexual orientation, and that other LGB people will reject her for her religious beliefs. By helping the client identify where, when, and how she came to learn this message (i.e., “being gay is a sin), as well as the impact that this message has had on her and others, the therapist can then work with the client to examine the validity or usefulness of her beliefs, as well as ways to debunk the message or stereotype that that the belief originated from. For instance, the therapist and client might explore the credibility of the source of the information, the context in which the client learned the message/stereotype (e.g., at home or church, her age at the time), and, perhaps, any evidence for and against this message or her dysfunctional beliefs. In addition to this, the therapist can encourage the client to look up LGB-affirming spiritual and religious resources (see Appendix A of this manual), to find examples of

other LGB youth who share her religious values, or to speak with an LGB-affirming religious leader in her community or through the internet. Ultimately, the therapist can support the client in rewriting the message and adopting a new, more affirming belief (e.g., “If God made me who I am then I can be proud of being a lesbian”).

Furthermore, this activity can be used with parents as well. While parents are also likely to have internalized homophobic messages, attitudes, and stereotypes, they may be less aware of such thoughts and how they impact themselves and their children. By engaging parents in a similar process of identifying, challenging, and modifying maladaptive beliefs related to internalized homophobic attitudes and stereotypes, therapists can help parents develop greater empathy for their children, while decreasing the parent’s emotional distress and improving their relationship with their child.



**Where Did You Learn That?**  
*Challenging Homophobic Stereotypes*  
(Appendix E)

Name 5 different stereotypes you have heard about lesbian, gay, or bisexual people.

How do these stereotypes affect gay people's lives?

How are gay people treated by others because of these stereotypes?

How do gay people treat each other because of these stereotypes?

Where, when, and how did you learn about these stereotypes?

## **Chapter 6: Trauma Narrative**

### **Purpose**

The purpose of this chapter is to help therapists identify and explore some of the unique characteristics and aspects of the LGB client's various cultural identities, which, in turn, can be used to bring a strengths-based and LGB-affirming approach to the re-writing of the trauma narrative. The goal is to foster resiliency, strength, and posttraumatic growth following experiences of interpersonal trauma by helping LGB adolescents connect to the protective and empowering aspects of their diverse cultural identities and communities. The concept of intersectionality will be addressed, including ways in which a client's ethnoracial, religious/spiritual, and sexual identities might intersect to form a unique constellation of potential risk factors, challenges, and strengths. Homework activities are designed to promote resiliency and hope, increase identity integration, as well as to increase parental support and foster connection to the LGB community.

### **Resiliency**

According to Hill and Gunderson (2015), resiliency can be defined as the "phenomenon of positive adaptation and development in the face of risk and adversity" (p. 233). While many LGB youth are exposed to a variety of unique stressors, including potentially traumatizing experiences (Craig & McInroy, 2013; Meyer, 2003), the vast majority of them demonstrate great resiliency in their ability to overcome or defy the negative consequences of such stressors (Kosciw, Palmer, & Kull, 2015; Mustanski, Newcomb, & Garofalo, 2011; Russell, 2005; Saewyc, 2011). Morris and Balsam (2003) noted that while lesbians and bisexual women appear to be at greater risk for victimization and negative mental health outcomes, "it is also likely that they experience strengths or resilience factors due to their sexual orientation that may protect

against or moderate the negative mental health consequences of victimization” (p. 70).

Moreover, due to issues of revictimization and chronic stress related to homophobia and heterosexism, understanding the personal qualities, environmental resources, and other factors that promote resiliency is of particular importance when working with traumatized LGB youth (Craig, Austin, Alessi, McInroy, & Keane, 2016; Hill and Gunderson, 2015). Thus, it may be beneficial and affirming to help LGB clients identify the qualities and characteristics of resiliency that are inherent within themselves, their communities, and their culture, and to help them incorporate these qualities into the processing and restructuring of their trauma narrative.

In reviewing the limited literature regarding factors and processes that promote resiliency among LGB survivors of sexual trauma, Walker, Hernandez, and Davey (2012) identified factors such as belonging to an LGB community that is more accepting and open to discourses about personal problems, increased self-esteem and self-confidence derived from being open about one’s LGB identity, learning how to cope with the challenges of the coming out process (e.g., managing stigma, hostile environments, rejection, lack of family support, and difficult emotions), increased support from LGB friends and allies of the LGB community, and greater acceptance towards seeking out mental health services. Other factors that have been found to correlate with resilience in LGB populations include effective emotion regulation skills, practice and support in using adaptive coping skills for managing stress, as well as social support from parents and peers (Hatzenbuehler, 2009). Mustanski et al. (2011) also observed that while social support does not fully buffer youth from the effects of sexual minority stress and victimization, parental support may be an especially important protective factor among younger LGB youth, while among older LGB youth (i.e., ages 16-24), increased peer support may be a more relevant protective factor. In addition to this, Russell (2005) posited that a supportive school environment (i.e., schools with a

GSA) and support from sexual minority peers, exposure to LGB-affirming sexual health education, holding positive attitudes about homosexuality, having positive self-esteem related to coming out, and LGB-affirming spiritual beliefs also appear to be associated with greater resilience among LGB youth. Lastly, Proujansky and Pachankis (2014) have maintained that when working with LGB clients, especially those experiencing internalized homophobia, therapists should highlight the various strengths associated with an LGB identity, such as the resilience that the LGB community, as a whole, has demonstrated throughout history. Proujansky and Pachankis (2014) state, “we aim to help clients not just accept their sexual minority identities, but to actively embrace them while recognizing the historical legacy of which they are a part of” (p. 9). Furthermore, the factors of resilience that Proujansky and Pachankis seek to promote include encouraging social activism and volunteerism, social and cultural creativity, a sense of shamelessness and pride, and community building. Speaking to the last point mentioned, the authors discuss the ability of LGB people to form non-biological families of support (i.e., “families-of-choice”) as a unique and important aspect of LGB culture that helps to maintain LGB heritage, history, and the transmission of values such as acceptance, love, pride, and self-respect (Proujansky and Pachankis, 2014; Pachankis, 2015). Thus, each of the aforementioned resiliency factors can be fostered when working with LGB survivors of interpersonal trauma and may be helpful to integrate into the process of re-writing the trauma narrative.

### **Posttraumatic Growth**

The theory of posttraumatic growth is another concept that provides a useful guide for helping LGB adolescent survivors – and their families – discover ways to grow from and make meaning of their experiences with minority stress and interpersonal trauma (Bonet, Wells, & Parsons, 2007; Cox, Dewaele, van Houtte, & Vincke, 2010; Phillips & Ancis, 2008; Vaughn,

Roesch, & Aldridge, 2009). While posttraumatic growth and resiliency are conceptually distinct, they compliment each other by enhancing a youth's ability to grow from and overcome current and future challenges and stressful life circumstances (Jayawickreme & Blackie, 2016).

According to Tedeschi and Calhoun (2004), posttraumatic growth, also known in the literature as stress-related growth (Cox et al., 2010), can be defined as "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (p.1).

Tedeschi and Calhoun emphasize that rather than a coping strategy, posttraumatic growth can be conceptualized as both an outcome and an ongoing process of personal development that moves beyond "surviving" a trauma or returning to prior levels of functioning. Instead, when an individual experiences posttraumatic growth, he or she is fundamentally and positively changed or transformed by their traumatic experience due to the way in which the individual has interpreted or processed the events (Tedeschi and Calhoun, 2004). Thus, one of the primary mechanisms through which posttraumatic growth occurs is through the processing and restructuring of trauma-related cognitions, which, in turn, may lead to the development of a new life narrative (Tedeschi and Calhoun, 2004). Using the metaphor of an earthquake, Tedeschi and Calhoun (2004) state that traumatic events create a "seismic" set of circumstances that "severely shake, threaten, or reduce to rubble many of the schematic structures that have guided understanding, decision making, and meaningfulness" (p.5). Therefore, in therapy, as an adolescent client begins the challenging task of "rebuilding" the cognitive structures affected by the trauma (i.e., cognitive processing and restructuring), the therapist supports the youth in developing more adaptive and resilient beliefs and schemas that will be better equipped to withstand any future "shocks" or stressors (Tedeschi and Calhoun, 2004, p. 5). Adding to this, Tedeschi and Calhoun highlight the importance of the narrative process in facilitating

posttraumatic growth, noting that many survivors of trauma come to conceptualize their lives as having a “before and after” the trauma. According to Hall (2011), narratives are important because they help to “organize social relationships and to frame plans for the future through interpreting the past in coherent wholes of stories;” in essence, helping people make sense of their lives (p.4). Similarly, Pals and McAdams (2004) note that posttraumatic growth is most likely to develop, and to last, when survivors openly process the impact of their traumatic experiences, and when they construct a positive ending for their story, one which provides coherence and resolution. Thus, in TF-CBT, the trauma narrative is not only used as a form of emotional processing and exposure, but through the cognitive restructuring process, also allows the youth and their family to form a new narrative or story that both explains the past and provides a more hopeful path for the future.

Furthermore, Tedeschi and Calhoun (2004) have identified several ways in which posttraumatic growth is often manifested. These include a general increase in one’s appreciation for life, more meaningful interpersonal relationships, a greater sense of personal strength, the creation of new priorities, values, and life meaning, and, for some, an enriched sense of spirituality. Particularly relevant for LGB youth and their parents, may be the development of more meaningful and deepened relationships with others, especially those who have shared similar traumatic experiences or stressors. Several researchers have expressed a wide range of benefits for sexual minority youth and their parents who are able to find support from others, especially through support groups such as gay-straight alliances, PFLAG, or therapeutic groups for managing sexual minority stress (LaSala, 2006; Pachankis, 2015; Phillips & Ancis, 2008; Willoughby & Doty, 2010). These types of groups can be important adjunctive therapies to individual treatment. They may contribute to the development of posttraumatic growth by

providing youth and their parents with an opportunity to create narratives about the changes that have occurred and by exposing them to new perspectives that can then be integrated into schematic changes (Tedeschi and Calhoun, 2004). For example, sharing one's "coming out" story with other LGB adolescents or discussing one's experiences of trauma with other survivors, may help an LGB adolescent feel less alone and more normal, and may foster a sense of emotional vulnerability, openness, and intimacy that prepares them for change (Cox et al., 2010).

Lastly, Tedeschi and Calhoun (2004) acknowledge that while there is a paradoxical element to posttraumatic growth, such that "out of loss there is gain," this does not mean that loss or trauma are viewed as desirable; rather, what is "good" or desirable is the growth that is produced when one faces these obstacles (Jayawickreme & Blackie, 2016; Tedeschi and Calhoun, 2004). For example, a gay teenager who was assaulted at school because of his sexual orientation may have grown from the experience by processing his feelings about the trauma and developing the narrative, "In spite of all the challenges I've experienced, I've learned that I'm a lot stronger than I ever knew." However, holding this new perspective or narrative does not assume that having been assaulted was "good," or that this youth will no longer feel pain or distress when exposed to instances of homophobia and sexual minority stress. Instead, this theme of positive self-transformation will allow the youth to decrease suffering while building resiliency for the future (Pals & McAdams, 2004).

### **Intersectionality**

According to Pals and McAdams (2004), concepts such as posttraumatic growth cannot be fully understood without considering how culture influences one's narrative. They contend that "life stories are constructed, told, and understood according to the narrative assumptions, parameters, frames, and taboos that prevail within a culture" (Pals & McAdams, 2004, p. 67).

For example, social and cultural myths about sexual trauma and what it means to be LGB, especially within the context of particular ethnic and religious communities, are likely to shape the stories that survivors of trauma develop about themselves and the meanings they ascribe to their experiences. Thus, cultural narratives will inevitably shape one's understanding and expectations of posttraumatic growth (Pals & McAdams, 2004). Moreover, the concept of intersectionality can provide a useful framework for exploring the cultural contexts in which certain risk and resilience factors influence the lives of LGB youth (Craig et al., 2016).

A broad definition of intersectionality is that it examines an individual's multiple cultural identities and the ways in which they overlap and intersect to form a unique, core identity (Institute of Medicine [IOM], 2011). Thus, the intersection of multiple identities creates a whole, or core identity, that is greater than the sum of its component parts (Follins, Walker, & Lewis, 2014; Wynn, Filmore, & Paladino, 2014). Intersectionality assumes that "individual and group identities are complex – influenced and shaped not just by race, class, ethnicity, sexuality/sexual orientation, gender, physical disabilities, and national origin but also by the confluence of all of those characteristics" (IOM, 2011, p. 22). For example, Cianciotto and Cahill (2003) described the confluence of risk factors experienced by LGB youth of color as a result of holding multiple, marginalized, minority identities. They noted that such youth may confront a "'tricultural' experience: they face homophobia from their respective racial or ethnic group, racism from within a predominantly white LGBT community, and a combination of the two from society at large" (Cianciotto & Cahill, 2003, p. 17). Thus, models of identity development that only address ethnicity or sexuality without consideration for how these and other identities overlap and intersect might fail to capture the nuance and reality of many LGB clients' lives (Bowleg, 2013; Wynn & West-Olatunji, 2009). Furthermore, while examining the myriad of intersecting cultural



identities experienced by LGB youth and their families is well beyond the scope of this resource manual, it is nonetheless helpful to consider a few ways in which ethnoracial, religious/spiritual, and sexual identities might intersect within the lives of LGB adolescents. What is important to consider, then, is how the client's intersecting identities confer certain risks and resilience factors that may be addressed during the trauma narrative component of treatment. Ultimately, the goal is to help LGB adolescents and their families draw strength and resilience from their various cultural identities in order to reduce minority stress-related risk factors, enhance coping skills, increase support, and achieve greater identity development and integration.

**Racial and ethnic identities.** According to Wynn et al. (2014), LGB youth of color may face a wide range of challenges as they attempt to navigate and integrate their ethnic, racial, spiritual, and sexual identities. Some of these challenges or risk factors include homophobia – both within and outside one's ethnoracial community, parental rejection, discrimination from religious institutions, and experiences of racism and marginalization within the LGB community (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Craig et al., 2016; Follins et al., 2014; Meyer, 2010; Potoczniak, Crosbie-Burnett, & Saltzberg, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Wynn et al., 2014). Due to these multiple risk factors, some LGB youth of color may delay or avoid disclosing their sexual orientation to family members (Grov, Bimbi, Nanín, & Parsons, 2006). However, those that do come out to their families often report feeling ostracized by their disclosure and may run the risk of losing the sense of solidarity frequently found in communities of color (Wynn et al., 2014). LGB youth of color may also experience the loss of necessary social supports that buffer them against minority stressors related to their ethnoracial identities (Garnets & Kimmel, 1991; Greene, 1994; Ryan et al., 2010). Similarly, while some LGB youth of color are accepted by their immediate family members, they may also

receive the conflicting and confusing message that it is not okay for them to be open about their sexual orientation with those in their extended family or community (Miller & Parker, 2009).

There may be many reasons for these conflicting messages, such as strong cultural ties to traditional religious beliefs and gender roles or, perhaps, a parent's fear that having multiple minority statuses will put their child at greater risk for harm (Miller & Parker, 2009). Either way, ethnic and sexual minority youth may feel pressured to choose between their different cultural identities, rather than learning how to integrate them (Yuk Sim Chun & Singh, 2010). Thus, intersecting cultural identities inevitably shape the way in which LGB youth of color experience the world, and may positively or negatively impact how one comes to understand their LGB identity in the wake of interpersonal trauma.

In addition to the many risk factors associated with intersecting identities of race, ethnicity, and sexual minority status, the resiliency hypothesis suggests that LGB youth of color, due to their experiences with racism prior to coming out, may be better equipped than their White counterparts to cope with stressors related to homophobia and heterosexism (Meyer, 2010). Therefore, experiences of marginalization and oppression related to race, or other minority statuses for that matter, may serve to inoculate LGB youth of color from some of the negative effects of discrimination (Craig et al., 2016; Follins et al., 2014; Meyer, 2010). As such, LGB youth may draw strength from coping strategies learned to deal with racism, prejudice, and oppression and apply them towards strategies for dealing with sexual minority stress and experiences of trauma. For instance, modeling the cultural value of community and family interdependence, many LGB people of color report creating their own communities of support as a strategy for managing sexual minority stress (Follins et al., 2014; Craig et al., 2016). Additionally, in qualitative studies examining the various coping strategies utilized by sexual

minority youth of color, many report the importance of religion and spirituality as sources of strength and hope (Craig et al., 2016; Follins et al., 2014). Despite frequently feeling excluded or rejected by their particular faith communities, resilient LGB youth have described negotiating complicated religious perspectives in order to persevere their spiritual connections and create safe spaces for themselves (Craig et al., 2016). Furthermore, some LGB people of color have drawn strength and wisdom from a rich history of social and political activism, whereby adopting strategies for fighting systems of oppression and discrimination such as heterosexism and homophobia (Della, Wilson, & Miller, 2002). In sum, these are only a few examples of how aspects of an LGB youth's ethnoracial and sexual identity can be integrated into their overall self-concept, which may ultimately lead to greater resiliency, a more cohesive and affirming narrative, and improved identity development.

**Religious and spiritual identities.** While religion has been found to serve as a protective factor for heterosexual youth, there have been mixed findings regarding the roles that religion and spirituality play in the lives of LGB youth (Dahl & Galliher, 2012; Kubicek et al., 2009; Rostosky, Danner, & Riggle, 2007; Sanabria & Suprina, 2014). Some LGB people experience deep conflict between their religious and spiritual identities, and many have reported losing important social relationships or feeling excluded and unwelcomed by their religious communities after coming out (Beagan & Hattie, 2015; Dahl & Galliher, 2012). LGB youth, in particular, have reported experiences of intolerance and hostility due to religious homophobia (e.g., messages condemning LGB people to hell), which, in turn, have been associated with increased internalized homophobia and poorer mental health (Ream & Savin-Williams, 2005). In addition to this, LGB youth seem to suffer further mental, emotional, and spiritual harm when they feel compelled to deny their religious identities or sever connections to their religious

beliefs and communities due to their sexual orientation (Ream & Savin-Williams, 2005). Moreover, LGB youth who identify as religious may also experience marginalization and intolerance from other sexual minorities due to antireligious sentiments within the LGB community (Beagan & Hattie, 2015; Rodriguez, 2009; Super & Jacobson, 2011). Lastly, LGB youth from highly religious families, especially ethnoracial families with strong cultural ties to religion, are more likely to be rejected by their parents or expected to conceal their sexual identity (Della, Wilson, & Miller, 2002; Kubicek et al., 2009; Lassiter, 2014).

Despite these various challenges and risk factors, however, many LGB youth continue to report that their religious and spiritual identities are important to them (Bozard & Sanders, 2011; Kubicek et al., 2009; Ream & Savin-Williams, 2005). And, for many LGB youth of color, religion often plays an integral role within their intersecting cultural and family identities (Craig et al., 2016; Lassiter, 2014). Research has shown that when LGB youth are able to integrate their sexual and religious/spiritual identities they tend to exhibit greater resiliency, increased self-acceptance and self-esteem, as well as improved social support and enhanced spiritual wellbeing; additionally, youth also report decreased internalized homophobia and are less likely to engage in substance use and risky sexual behavior (Craig et al., 2016; Dahl & Galliher, 2012; Duarte-Vélez, Bernal, & Bonilla, 2010; Kubicek et al., 2009; Ream & Savin-Williams, 2005; Rosario, Yali, Hunter, & Gwadz, 2006). A number of studies have found that LGB youth's resilience is often facilitated by their ability to reframe and reconstruct challenging or harmful relationships, environments, and messages (Craig et al., 2016; Kubicek et al., 2009). For instance, in a study examining the role of religion in the lives of young men who have sex with men, Kubicek and her colleagues (2009) found that many of their participants were able to maintain their faith-based beliefs by rejecting or reframing the anti-gay religious messages that they were frequently

exposed to within their communities and places of worship. Some of the young men in their study challenged assertions such as “homosexuality is an abomination to God” by developing more adaptive and affirming beliefs, such as, “God made me for a reason” and “God wouldn’t want us to be fake” (Kubicek et al., 2009, p. 617). Similarly, Craig et al. (2016) found that the lesbian and bisexual youth in their study were able to retain aspects of their religious and cultural backgrounds that were congruent with their sexual identities by challenging discrimination, seeking out supportive relationships, and creating their own relationship with religion. Craig et al. (2016) further noted that the presence of positive LGB role models (e.g., an out sexual minority adult from one’s ethnoracial or religious community) might be particularly important in reducing feelings of isolation and creating a needed sense of support among LGB youth. Another set of strategies that appears to facilitate the integration of faith-based and sexual identities includes redefining one’s religious beliefs or developing a self-definition of spirituality that affirms one’s LGB identity (Kubicek et al., 2009; Sanabria & Suprina, 2014). For instance, Kubicek et al. (2009) found that the young men in their study frequently differentiated religiosity from spirituality, “with religion often described as having ‘rules’ and ‘structure’ while spirituality was described as something internal and based on an individual relationship with a higher power” (p. 626). In this way, LGB youth seeking to integrate their faith and sexuality may benefit from focusing on a more personal or individual relationship with God or a higher power who is seen as loving, benevolent, and accepting rather than punitive and judgmental (Beagan & Hattie, 2015; Bozard & Sanders, 2011; Sanabria & Suprina, 2014). Furthermore, Sanabria and Suprina (2014) suggest helping those struggling to integrate their religious and sexual identities by exploring the distinct but overlapping concepts of religion and spirituality. Beagan and Hattie (2015) also recommend focusing on values rather than beliefs, which allows the client to select

elements from a range of spiritual paths, including teachings from parents, religious messages and doctrine, social, cultural, and family values, as well as personal experiences (Kubicek et al., 2009). Lastly, Dahl and Galliher (2012) encourage therapists to be prepared to help LGB adolescents and their families connect with LGB-affirming spiritual and religious resources, organizations, churches, and communities. While becoming an advocate for social change in their respective religious communities may empower some LGB youth and their families, others have found greater acceptance, normalization, and support after changing religious affiliations and connecting with LGB-affirming clergy who supported these transitions (Dahl & Galliher, 2012).

In sum, when LGB individuals are able to integrate multiple cultural identities into their self-concept, while at the same time holding multiple group identities or memberships, they are likely to experience greater overall well-being than those who identify with only one group to the exclusion of others (Consolacion, Russell, & Sue, 2004; Singh & Harper, 2012). For example, LGB youth who feel like they must choose between their ethnic or racial identity and their LGB identity, or those who identify only with their sexual minority status while ignoring the other aspects of their identities (e.g., spiritual, ethnic, family), may not be able to benefit from the strengths associated with each of these other identities or groups. However, for LGB youth who are able to integrate their sexual minority identity with their other group identities (e.g., gender, ethnicity/race, religion/spirituality), they may experience fewer stressors (e.g., internalized homophobia, rejection sensitivity) as well as a decreased risk for psychopathology (e.g., hopelessness, isolation; Hatzenbuehler, 2009). Therefore, integrating one's various cultural identities (e.g., ethnic and spiritual identities) is likely to increase social support, strategies for coping with minority stress, and other general psychological factors that may shield youth

against the effects of stress and the onset of mental and behavioral health problems (e.g., depression, suicide, substance use, risky sexual behaviors; Craig et al., 2016; Hatzenbuehler, 2009; Wynn et al., 2014). Lastly, LGB youth who are able to adopt a strong sexual minority identity, in addition to their other group identities, will be better prepared to deal with minority stress, to reject stereotypes and restructure heterosexist messages, to respond effectively to homophobia and victimization, and to evaluate themselves through a more positive and affirming lens (Herek & Garnets, 2007). By helping LGB youth explore and integrate their

### **Clinical Considerations**

**Child & Parent.** For LGB youth who have experienced multiple and chronic forms of trauma, including previous and ongoing minority-related stressors, it may be helpful to have them create a “life narrative” rather than a “trauma narrative” (Cohen, Mannarino, & Deblinger, 2006; Kliethermes & Wamser, 2012). Cohen, Mannarino, and Deblinger (2006) have recommended making a “timeline” of the child’s life or having them put together a picture album starting from when the youth was much younger, then asking the youth to write about different times in their life that were particularly influential. This timeline approach can also be useful in helping the child identify periods between their multiple traumas that were happy or fun, and can be used by the therapist as an opportunity to point out the child’s unique strengths and resiliencies in the face of so much adversity. Depending on the youth’s experiences prior to their trauma, it may also be helpful for the child to include in their trauma narrative any negative messages, myths, or stereotypes about their sexual orientation or the LGB community that might have influenced their initial maladaptive thoughts, beliefs, or attributions related to the trauma. For instance, a youth who constantly heard and internalized messages from those around him that being gay is a sin or that LGB people are “perverts,” may have related those experiences to a

traumatic event, such as a sexual assault. As such, the youth may want to include those experiences at the beginning of his trauma narrative, as a precursor to the traumatic event; then, towards the end of the narrative, may include new, more adaptive beliefs about his sexual identity or more resilient forms of coping with minority stressors. Given that sexual minority stressors such as internalized homophobia, stigma, rejection sensitivity, and identity concealment are likely to have played a significant role in the child's early development, they may be important contextual factors to be incorporated into the child's overall narrative.

In addition to this, as recommended by Pachankis (2015), therapists might also encourage LGB youth to research different elements and symbols of LGBT history in order to connect with and draw strength from the LGBT community, which has shown tremendous resilience in the face of adversity. For example, youth might enjoy learning about the history of Stonewall, Harvey Milk's running for political office, the making of the AIDS Quilt, or the creation of the rainbow flag as a symbol LGBT hope and pride. They might also identify with themes of posttraumatic growth embedded throughout LGBT history. Activist groups such as ACT Up and the Mattachine Society, works of art, such as the play, *The Laramie Project*, or the transformation of symbols of oppression into symbols of pride and remembrance (e.g., the pink triangle used by the Nazis to label sexual and gender minorities who were placed in concentration camps) are all positive examples of how the LGBT community has coped with and grown from stigma, stress, oppression, violence, and trauma.

According to Poteat et al. (2011), therapists can also work with LGB youth of color to identify strengths, resources, and coping strategies from their experiences with racial discrimination that may be useful or adaptive for coping with homophobic discrimination as well. Additionally, for sexual minority youth of color who are out to their parents, though do not



feel comfortable talking about sexuality-related issues (e.g., dating, friendships with LGB peers, LGB community involvement), it may be important for the therapist to discuss this with the youth's parents, providing psychoeducation on the importance of sexuality-specific parental support while respecting the family's values and encouraging them to consider the benefits of this type of dialogue (Poteat et al., 2011). Moreover, such youth may also need greater assurance that it is okay to talk about their sexual orientation, especially as it relates to experiences of interpersonal trauma or ongoing victimization, and families may need practice and suggestions in how to offer this type of support (see chapters 2 and 9 of this resource manual for additional information, and Appendix A for parent resources).

Lastly, during the trauma narrative component of treatment, it is important to let LGB adolescents know that while some aspects of the individual sessions may remain confidential, that parts of the trauma narrative might be shared with their parents (Cohen, Mannarino, & Deblinger, 2006). In particular, due to internalized homophobia and rejection sensitivity, some youth, although out to their parents, may still fear further rejection from them, or may feel ashamed by aspects of the trauma that are related to their sexual orientation (e.g., abuse from another LGB person, sexual orientation violence and harassment at school). It will be important for the therapist to assure the child that their parent is able to cope with these details of their trauma account, and as equally important for the therapist to help the parent learn how to cope with these details and offer support, especially sexuality-specific support (Cohen et al., 2006). Additionally, as previously discussed in chapter 3, therapists may need to pay close attention to youth who report feeling like a "burden" to their families. It is plausible, for instance, that such youth might be highly concerned about disappointing or causing emotional pain to their parents, or, perhaps bringing shame to their family. Again, it will be important for the therapist to convey

these concerns of the child to the parent, in order for the parent to remain an effective source of support and not to reinforce the child's fears or unhelpful thoughts. Lastly, under some circumstances, such as if the child does not want to share their trauma narrative with the parent – perhaps because the parent is strongly opposed and negative toward the child's sexual identity – it may be in the best interest of the child and the parent to not share the narrative. Moreover, as noted in the TF-CBT manual (Cohen et al., 2006), if the therapist believes that the parent would not be able to tolerate the details of the trauma narrative, or, for whatever reason (e.g., the child's sexual orientation) would not be able to appropriately support the child, then it would likely be in the family's best interest not to share the trauma narrative with the parent. However, the therapist and adolescent client may choose to share a portion of the narrative which they think the parent would be able to support, for example, the ending of the narrative, how the child has grown from his or her experience, or how therapy has been helpful. Thus, while therapists should strive to help parents learn how to support their children, both in terms of their traumatic experiences and the child's sexual orientation, it is necessary to meet families where they are at, and, ultimately, to ensure that the child is safe and out of danger from experiencing further victimization, at home or elsewhere.

### **Homework: Child & Parent**

**“Identity Map.”** Using Appendix F of this manual, provide the client with a sample version of the Identity Map handout. It may be more effective to begin this exercise during session. The purpose of the activity is to help LGB youth identify their various cultural identities, the unique strengths and stressors associated with each of them, and to explore how these different identities intersect and overlap to form a unique core identity. In doing so, the therapist can help the LGB youth identify internal, social, and cultural strengths and resources that can be

utilized to foster resiliency, grow from adversity, and create a more cohesive and LGB-affirming narrative. Therapists can also use this activity to prompt discussion around how one might begin integrating their various identities. For instance, some LGB adolescents may believe that they must choose between their LGB and religious identities. Thus, LGB adolescents may be curious about ways to reconcile their spiritual beliefs and ethnoracial values with their sexual identities, especially if they have experienced significant homophobia and sexual minority stress within their family, school, or communities. In addition to this, recognizing that they belong to several different cultural communities may help youth feel more supported and less alone. Furthermore, by emphasizing that one's core identity is a unique combination of their values, customs, cultural practices, and experiences, the therapist can empower the youth to define themselves using their own terms, language, values, and perceptions.

Using the Identity Map sample and blank handouts (Appendices F & F-1), ask the client to read the instructions and fill in each of the circles. The therapist and client can work together to answer each of four the additional probing questions, or they can be assigned as homework. Beginning the exercise in session will help to ensure that the child understands how to do the activity. As with the other activities, therapists should encourage youth to be as creative as they would like. For instance, clients can recreate this activity using a larger sheet of paper where, perhaps, they place a photograph or drawing of themselves in the middle and then use collage, color, or drawings to depict each of their unique identities. Creating a dialogue to help youth explore the challenges and strengths associated with each of these identities and how they combine to create a unique individual can help them learn new ways of coping, foster resiliency, and develop a more integrated and affirming sense of self. These cultural strengths and identities can then be incorporated into the youth's re-writing of the trauma narrative.

Lastly, if appropriate, therapists can adapt this activity to be used with the child's parent as well. For instance, the therapist can ask the parent to write in each of their different identities and answer the same questions that their child did. The therapist and parent can then compare what the parent and child each wrote, noticing any differences, similarities, or overlapping identities. This can be helpful for parents who focus on the issue of their child's sexual orientation or trauma to the exclusion of other aspects of their child's life or identity. Using this activity, therapists can help parents recognize that their child's LGB identity is only one facet of their life, and that many other aspects and characteristics make up their child's unique identity. This can also be an opportunity to help parents explore the strengths associated with being LGB and to discuss ways that they can support their child's sexual identity so that they can become more resilient and self-accepting. Additionally, for parents who might feel alienated from their child or that they cannot help them because they are not LGB themselves, this exercise can help to normalize those differences while highlighting cultural similarities and ways in which the parent can provide important sources of support.

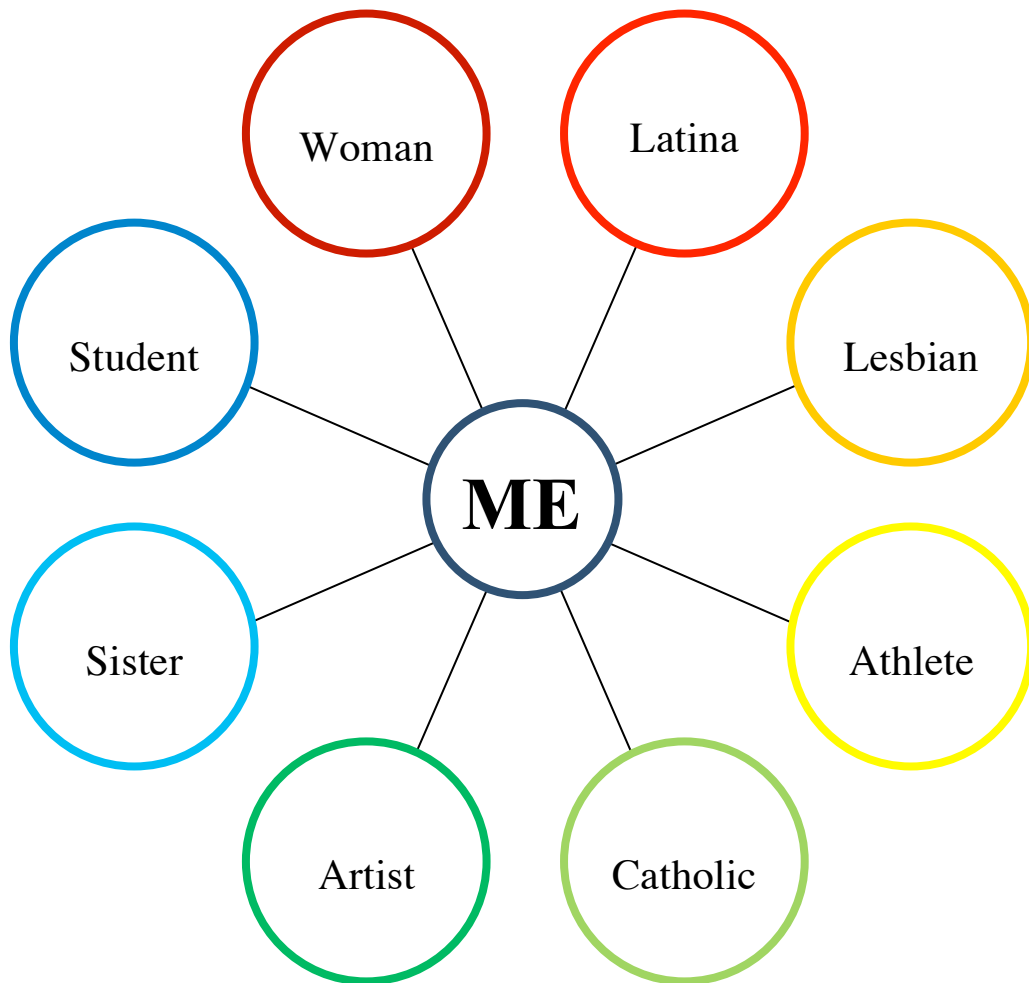
### **Homework: Child**

**“Models of Pride: From Surviving to Thriving.”** In this homework exercise, the child is asked to research an LGB survivor of interpersonal trauma; for instance, someone who has overcome or grown from their traumatic experiences and who is now thriving. A prominent LGB figure and outspoken survivor of interpersonal trauma, Ellen DeGeneres is an excellent example of someone who has overcome great adversity – as a survivor of childhood sexual abuse, as the first person to come out on a national television show, and as an artist who struggled to be true to herself while pursuing a career in entertainment. Through this activity, the youth can draw strength and develop connections to the LGB community and the resiliency that so many LGB

people demonstrate in the face of heterosexism, homophobia, bullying, and interpersonal violence. Therapists might also encourage youth to look up the website, [itgetsbetter.org](http://itgetsbetter.org), where they can find videos of outspoken LGB artists, actors, public figures, every-day-people, young and old, who are sharing their stories of overcoming the challenges of sexual minority stress. Videos include testimonials from actresses and actors such as Wanda Sykes, Raven-Symoné, Jane Lynch, and Neil Patrick Harris, musicians such as Adam Lambert, Tegan and Sara, and Jake Shears, as well as professional athletes such as Jason Collins. Many of the videos explore themes such as coming out, facing rejection or finding support from friends and family, challenging stereotypes, integrating multiple cultural identities, and finding support and drawing strength from the LGB community (See Appendix A for additional resources). If interested, youth might also enjoy making their own “it gets better” video or creating a piece of artwork – written, visual, or audio – of their “it gets better” story that they can incorporate into the re-writing of the trauma narrative.

# Identity Map

(Appendix F)



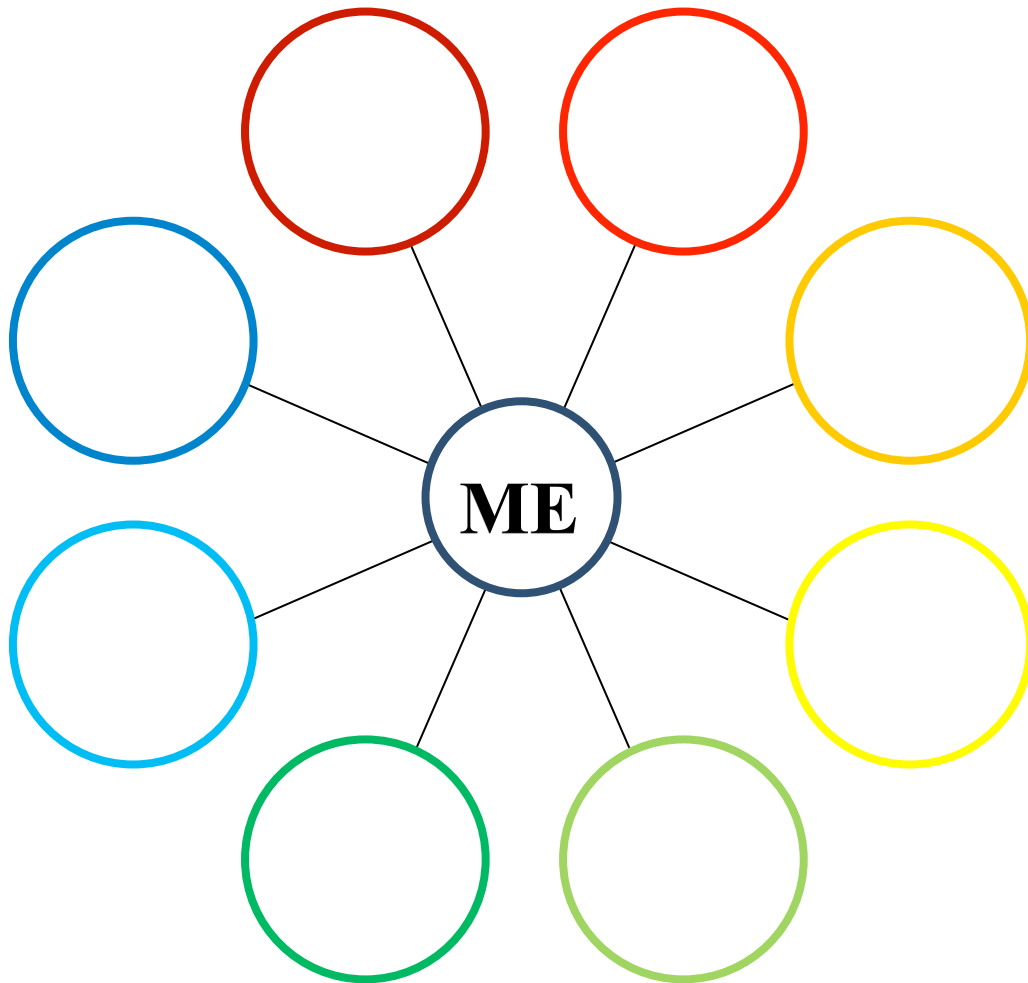
In each of the circles above, write a word or phrase that says something about *who you are* or *what makes you unique*. Some people might use words like “teenager,” “soccer player,” “bisexual,” “artist,” “Christian,” “Asian American,” “writer,” “grandson,” “gamer,” etc....

Next, outside each of the circles, write something that you like about that part of your identity. Try answering these questions for each of the circles:

- What do you like about being gay ? What’s good about it?
- What things have you learned from being an African American ?
- What are the challenges and strengths of being a Christian ? How has it made you stronger?
- Who do you know that is also a bisexual ? Is this someone you can talk to?

# **Identity Map**

(Appendix F-1)



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- What are the challenges and strengths of being a Christian ? How has it made you stronger?
- Who do you know that is also a bisexual ? Is this someone you can talk to?

## **Chapter 8: In-Vivo Mastery of Trauma Reminders**

### **Purpose**

The purpose of this chapter is to highlight issues of avoidance among LGB adolescent survivors of interpersonal trauma, as well as to provide LGB-affirming strategies for overcoming problematic avoidance behaviors. A list of LGB-affirming activities that can be incorporated in the youth's in-vivo hierarchy is provided as a homework assignment.

### **Problematic Avoidance Behaviors and LGB Youth**

According to Cohen, Mannarino, and Deblinger (2006), some traumatized youth develop generalized fears as a result of “ongoing avoidance of perceived trauma cues that are inherently innocuous” (p. 147). Therefore, trauma cues that are innocuous reminders of past experiences – meaning that they do not function to keep the child safe in the present – or those that have become overgeneralized, are likely to interfere with the child's quality of life and ability to fully recover from trauma (Cohen et al., 2006). For example, a gay teenager who was sexually abused by an older gay male might develop an overgeneralized fear of all LGB people. As a result, he avoids interacting or associating himself with any members or aspects of the LGB community. While avoidance and hypervigilance are common reactions to a traumatic situation, over time, if left unresolved, they can significantly impair one's ability to function effectively in the world (Foa, Chrestman, & Gilboa-Schechtman, 2009). Thus, in the example above, by avoiding all interactions with the LGB community, the youth may be cutting himself off from potential resources and social supports that are important for healthy sexual identity development. Additionally, he may be more likely to develop negative beliefs and unrealistic fears about his own sexuality. Furthermore, the youth may try to suppress any thoughts, feelings, or physical sensations (i.e., experiential avoidance) related to his sexual orientation, having associated



homosexuality with his trauma, and, as a result, may resort to concealing his sexual identity from others. Although this scenario is hypothetical, there is evidence to suggest that a common problem for LGB individuals following sexual orientation-related stress or trauma is the emotional, cognitive, and behavioral avoidance of both internal and external trauma reminders (Brady, 2008; Gold, Dickstein, Marx, & Lexington, 2009; Gold, Marx, & Lexington, 2007; Hall, 1998; Pachankis, 2015; Puckett & Levitt, 2015).

Among LGB youth, avoidance can manifest in variety of forms (i.e., emotional, cognitive, and behavioral) and may be related to experiences with minority stress or other forms of trauma such as sexual abuse, peer victimization, parental physical abuse, or parental rejection (Balsam, Rothblum, & Beauchaine, 2005; Pachankis, 2015; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). For instance, some youth may try to avoid or escape difficult emotions through the use of substances or risky sexual behavior (Pachankis, 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Others may engage in cognitive forms of avoidance, such as rumination or worry, which have been found to mediate the relationship between minority stress (e.g., internalized homophobia, discrimination) and symptoms of depression and anxiety (Hatzenbuehler, Nolen-Hoeksema, Dovidio, 2009; Szymanski, Dunn, & Ikizler, 2014). According to Pachankis (2015), among sexual minorities, behavioral forms of avoidance may manifest not only as increased isolation and avoidance of trauma reminders, but in more subtle forms, such as unassertive interpersonal behavior or perfectionistic tendencies. Among gay and bisexual youth, unassertiveness has been closely related to parental rejection and/or rejection sensitivity and has also been associated with increased risk for HIV infection (Hart & Heimberg, 2005; Pachankis, Gold, & Ramrattan, 2008). For example, LGB youth who withdraw from social interactions as a form of coping with minority stress (i.e., detachment) or

who demonstrate behavioral unassertiveness (i.e., not asserting one's needs, wants, desires, or boundaries) for fear of being rejected by others may experience increased internalized homophobia and shame, poorer communication skills and interpersonal functioning, lowered self-efficacy, passive brooding and self-blame for experiences of victimization, body image issues and eating disorders, as well as higher rates of substance use and intimate partner violence (Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011; Kimmel & Mahalik, 2005; Pachankis, 2015; Pachankis, Hatzenbuehler, & Starks, 2014; Skinta, 2014; Szymanski et al., 2014).

Furthermore, Pachankis (2014) has identified several forms of avoidance behaviors commonly associated with sexual minority stress: avoiding romantic relationships with members of the same-sex, perfectionism, avoiding heterosexuals, social withdrawal, hypervigilance, unassertiveness, and substance use. In order to address these issues in therapy, Pachankis (2014) suggests that therapists help client's identify their common avoidance patterns and triggers, examine their relationship to minority stress, and develop strategies for approaching these distressing stimuli in order to habituate to aversive states of arousal. In treating LGB youth who have experienced interpersonal trauma related to their sexual orientation, teaching them how to gradually expose themselves to innocuous triggers associated with sexual minority stress, whereby decreasing the hypervigilance and hyperarousal responses that have resulted in avoidance behaviors, may be particularly relevant and empowering for LGB youth. While no randomized controlled trials have been used to explore the efficacy of exposure techniques for treating avoidance related to sexual minority stress, there are several case studies which have demonstrated the utility for the use of exposure techniques with LGB individuals (e.g., Glasgold, 2009; Kaysen, Lostutter, & Goines, 2005; LaSala, 2006; Safren, Hollander, Hart, & Heimberg, 2001; Safren & Rogers, 2001).

## **LGB-affirming Strategies to Counteract Problematic Avoidance Behaviors**

As discussed in the TF-CBT manual, an important step in helping youth overcome problematic avoidance behaviors is to first ensure that the avoidant or hypervigilant behaviors being targeted for change are not serving some sort of function to keep the youth safe (Cohen, et al., 2006). In situations where the youth is experiencing ongoing threats to safety, attempts to desensitize him or her to cues that signal danger may put the youth at increased risk for harm. For example, if an LGB adolescent is being physically and verbally assaulted at school on a daily basis because of their sexual orientation, it is expected that he or she would want to avoid going to school, or, at the very least to remain hypervigilant. In this type of a scenario, it would be important for the youth to be aware of the antecedents to violence so that the youth could respond effectively by removing him or herself from danger or by contacting the proper authorities. However, this strategy is ultimately untenable and will inevitably interfere with the youth's education, as well as their mental and emotional development. In this situation, therapists may need to coordinate with parents and school staff to intervene on the child's behalf and advocate for their safety at school (LaSala, 2006). Once the school environment has been made safe, then the therapist can work with the youth to help him or her habituate to innocuous trauma reminders, for instance, areas around school where the abuse may have occurred. Furthermore, the therapist would likely need to help the youth learn how to differentiate between safe and unsafe situations, people, and places.

Another issue to consider when addressing avoidance related to sexual minority stress is the use of "selective" versus "general" avoidance coping strategies. McDavitt and his colleagues (2008) argued that the research literature often fails to distinguish between the use of selective avoidance strategies (e.g., avoiding homophobic individuals) and broader forms of avoidance,

such as total social withdrawal or emotional escape. In studies examining the coping strategies utilized by LGB youth to deal with sexual minority stress, while indiscriminate social withdrawal was typically found to be problematic, some studies found that forms of selective avoidance, such as avoiding interactions with homophobic family members, were potentially adaptive strategies for youth (Craig, Austin, Alessi, McInroy, and Keane, 2016; McDavitt et al., 2008). Adding to this, while coming out has been associated with several mental health benefits for LGB youth, it has also been associated with increased risks for violence and sexual minority stress, especially for those attending schools in rural communities (Kosciw, Palmer, & Kull, 2015). However, as Goldbach and Gibbs (2015) point out, LGB youth who rely on avoidant coping strategies to manage PTSD symptoms related to sexual minority stress and trauma are also more likely to maintain or exacerbate their symptoms over time. Therefore, before implementing any exposure based strategies for decreasing avoidance, it will be important for the therapist and client to determine the function of the client's avoidance and how it is impacting the client's life. For example, in the case of coming out, some youth, despite the risks of being out at school, may report that concealing their identity is causing them significant distress. In such a situation, the therapist and client might work together to create a list of people that the client has been avoiding coming out to. The therapist and client might then order the list of individuals that the youth would like to come out to from "most-to-least likely" to be accepting. Using a titrated exposure approach, the client might first role-play coming out in session and then initiate coming out to one of the "more likely to be accepting" individuals on their list (e.g., an LGB friend of the family, an older heterosexual cousin who has LGB friends, a school counselor). In this particular intervention, the therapist can help the client address avoidance

behaviors which, whether they are a result of interpersonal trauma or sexual minority stress, are ultimately interfering with the youth's quality of life (Pachankis, 2014).

In regards to developing an in-vivo hierarchy, Foa and her colleagues (2009) identified three different types of exposures that might be the focus of treatment when working with adolescent survivors of trauma: situations that the adolescent perceives as more dangerous than they are in reality, situations that are reminders of the traumatic event, and situations or activities that increase pleasure or demonstrate competence. Building upon their recommendation for utilizing exposures – or behavioral activation strategies – that increase pleasure and demonstrate competence, it may be especially helpful when working with traumatized LGB youth to include activities that foster supportive and affirming connections to the LGB community (Pachankis, 2014; Szymanski et al., 2014). Therefore, including activities that allow the youth to develop sources of support and connection with other LGB people will likely decrease feelings of isolation, depression, and social anxiety (Pachankis, 2014; Safren et al., 2001). For instance, LaSala (2006) suggested that LGB youth experiencing social anxiety related to sexual minority stress or trauma would likely benefit from participating in an LGB support group where they can habituate to fears of speaking openly about their sexuality. In addition to this, including in-vivo activities that encourage the youth to become more assertive and open about their needs, wants, and boundaries can also serve to enhance self-efficacy and improve competencies related to social communication and interpersonal effectiveness (Pachankis, 2014). While these types of activities may not be appropriate for all LGB clients, some youth may benefit from activities that encourage social activism and fighting back against forms of social injustice, such as discrimination, bullying, heterosexism, and homophobia (Higa et al., 2014). For instance, LGB youth might benefit from joining their school's gay-straight alliance, participating in LGB youth

activates at their local LGBT center, or volunteering at an LGB-related charity. In addition to this, Craig and her colleagues (2016) found that for ethnoracial and sexual minority girls simply being out to their family members, or educating them about LGB issues, improved their ability to cope with minority stress and improved their overall sense of well being. Rather than engaging in avoidance or escape strategies, by actively working to change their families' negative perceptions about sexual minorities, these youth developed assertiveness skills and improved self-advocacy (Craig et al., 2016). In sum, in addition to helping LGB youth overcome avoidance behaviors related to trauma cues, therapists might also consider incorporating activities to the youth's in-vivo hierarchy that would foster connection to the LGB community and enhance the youth's assertiveness and interpersonal skills.

### **Clinical Considerations**

**Child.** As discussed throughout this chapter, bringing an LGB-affirming approach to the creation of the youth's in-vivo hierarchy may serve to improve the youth's self-esteem and decrease the likelihood that they will engage in high-risk behaviors as forms of avoidance or escape (Harper, Brodsky, & Bruce, 2012). In particular, interventions aimed at fostering youths' connections with the LGB community, increasing their assertiveness and self-advocacy skills, and helping them become more accepting and open about their sexual identities are likely to enhance wellbeing while decreasing forms of avoidance and anxiety (Corrigan & Matthews, 2003; Higa et al., 2014; Pachankis, 2014; Ryan, 2003; Szymanski et al., 2014). Adding to this, Kocet (2014) has stressed the importance of helping sexual minority adolescents develop friendships with other LGB youth. He suggests that such friendships can serve as buffers against sexual minority stress and trauma, provide positive role models for coping with stress, and enhance identity formation. However, given that LGB youth may have difficulty meeting other

LGB teens, perhaps due to social anxiety, internalized homophobia, traumatic experiences related to their sexual orientation, or even geographic location and limited resources, therapists may need to be creative in helping youth develop safe outlets for forming LGB friendships. Thus, activities aimed at fostering LGB friendships and connections may be important to add to the youth's in-vivo hierarchy.

One of the primary ways that LGB youth today seek out information about sexuality, what it means to be LGB, or how to connect with other LGB people, is through the Internet (Craig & McInroy, 2014). Much of the research literature on how sexual minority youth use the Internet, however, has focused on the potential risks or dangers associated with being online (Pingel, Bauermeister, Johns, Eisenberg, & Leslie-Santana, 2013). For instance, several researchers have observed an increased risk for HIV and STI transmission among young gay and bisexual males who use the Internet to seek out partners for dating or sex (Garofalo, Herrick, Mustanski, & Donenberg, 2007; Horvath, Rosser & Remafedi, 2008; Pingel et al., 2013). Other forms of new media, such as video sharing, social networking sites (e.g., Facebook), and social media applications (or “apps,” e.g., Snapchat, Instagram, Tinder), also pose several risks and benefits for LGB youth looking to connect with others or who wish to explore their sexual identity (Craig & McInroy, 2014). Therapists working with LGB youth should inquire about the youth's use of social networking sites and social media applications, and should have conversations with parents about ways to keep youth safe. In particular, dating or “hook up” apps, such as Grindr, Tinder, Bumble, and Down Dating – to name just a few – are easily accessible phone applications that youth can use to meet other people for anonymous sexual encounters or relationships. While these apps might offer youth opportunities to meet other LGB people that they might not otherwise have access to, they are also likely to put youth at risk by

making them more vulnerable to sexual predators, and their activity is also more likely to be kept in secrecy. In addition to this, many LGB youth also report experiences of cyber-bullying and sexual harassment online (Guan & Subrahmanyam, 2009; Palmer et al., 2013). As such, therapists should ask youth if they feel safe online, what types of social media sites or content they look at online, and what their experiences have been like. Given the developmental tasks and challenges of being an LGB adolescent, coupled with the natural curiosity of youth and the ubiquity of technology in their lives, it is necessary for therapists and parents to have conversations with LGB youth about the risks and benefits of these new forms of media and to help them identify safe ways to learn about their identity and connect with an online community. For instance, Craig and McInroy (2014) found that many LGB youth utilize new forms of Internet-based media to safely access LGB resources, to explore, rehearse, and develop their LGB identities online, to observe others with similar interests and experiences, and to practice coming out in a relatively safe and anonymous setting. Craig and McInroy (2014) also found that these online experiences frequently translated into greater identity development offline, providing youth with the information, resources, hope, and courage to develop their own authentic LGB identities at home and in their communities.

Furthermore, providing safe and LGB-affirming online resources may be particularly relevant for therapists serving youth and families in rural areas, restrictive religious communities, or areas of mostly immigrants. Such youth are likely to feel more isolated or alienated because of their sexual orientation, may face increased threats of sexual orientation violence and discrimination, and may not have access to in-person LGB resources or a local LGB community (Kosciw, Greytak, & Diaz, 2009; Palmer, Kosciw, & Bartkiewicz, 2012). In addition to this, some youth, especially from rural or low-income areas, may not have access to the Internet



outside of their schools, where it may not be safe, or even possible due to firewalls and online restrictions, to look up LGB-related content (Palmer et al., 2012). Given these challenges, therapists may consider utilizing Internet-based activities in session with such youth, and can look to Appendix A of this resource manual for a variety of online resources and suggestions, including content that is LGB youth-related, as well as content specific to different ethnic and religious/spiritual communities. In addition to this, private Facebook pages such as GLSEN's National Student Council Facebook group or private GSA Facebook pages are often safe and supportive spaces for LGB youth to access information, post comments and questions, or talk to other LGB youth. The Trevor Project's "trevorspace.org" is another example of a safe social media forum developed by a reputable, national LGB organization specifically for LGB youth to connect with one another and foster community engagement. Many LGB youth have also reported that watching Youtube videos of LGB role models or other youth exploring issues such as coming out, dealing with homophobia, or fostering proud identities, has helped them to process their own feelings and struggles, decrease feelings of isolation, and learn new strategies for managing stress (Craig, McInroy, McCready, & Alaggia, 2015). LGB youth are also more likely to find a greater diversity of representations of LGB people online than those provided in offline media (e.g., television, print media), and, therefore, may feel more empowered by seeing images and hearing experiences from youth and families who look and sound like them (Craig et al., 2015). For example, a San Francisco Bay organization by the name of Somos Familia ([www.somosfiliabay.org](http://www.somosfiliabay.org)) has created a series of Youtube videos titled "*Tres Gotas de Agua*," which document the stories of three Latina immigrant mothers who talk about their child's coming out process and how they were able to accept their children with unconditional love. This short documentary film series, in Spanish with English subtitles, is just one example of how new

online media can be utilized to help diverse LGB youth and families find a place and a voice within the broader LGB community. Furthermore, by engaging in online media activities in session, especially for youth who lack access to in-person LGB resources or community, therapists can affirm the youth's natural curiosity while providing relevant, safe, and affirming resources that foster identity development and provide opportunities for exposure to the LGB community that might not otherwise exist for some youth.

Lastly, when working with LGB youth who have experienced more complex forms of trauma, and who demonstrate limited emotion regulation capabilities, Briere and Lanktree (2013) would encourage therapists to proceed cautiously when assigning in-vivo exposure activities. They suggest that the ability of such youth to tolerate exposure may be quite compromised. They also note that outside stressors (e.g., ongoing school and community violence), including the level of support youth have available to them in terms of friends, family, and others, may further limit the youth's ability to tolerate exposure to trauma reminders and triggers outside of session. Thus, a titrated exposure approach that takes into account the client's strengths, vulnerabilities, resources, and external realities is essential. Kliethermes and Wamser (2012) have also noted that when working with youth who have experienced complex trauma, it may be necessary to begin in-vivo work earlier in treatment in order to facilitate the development of stability and engagement. However, it may not be until after the completion of the trauma processing that the therapist and youth have a better sense of what specific trauma triggers and cues to address through in-vivo exposure. Either way, being mindful of the youth's levels of distress tolerance, as well as their goals for treatment, is important when attempting to construct an in-vivo exposure plan that will not only be effective, but will be utilized by the youth (Foa et al., 2009).

**Parent.** When developing an in-vivo exposure plan, in addition to gaining buy-in from the youth, it is also essential to have the full support and involvement of the youth's parents (Cohen et al., 2006). Thus, when encouraging LGB youth to engage in activities such as LGB social advocacy or developing friendships and connections to other members of the LGB community, it is necessary to help the youth's parents understand the rationale and function of these activities as well. Parents may also need to provide instrumental sources of support to their youth, such as providing transportation to an LGB community center or allowing the youth's LGB friends to come over to their home. Parents must also be engaged in order to provide reinforcement and praise when their children accomplish tasks on the in-vivo hierarchy (Cohen et al., 2006). Furthermore, parents who are struggling to accept their child's LGB identity or who have had very limited contact with the LGB community, may also benefit from their own in-vivo exposure activities. For example, Willoughby and Doty (2010) utilized a series of exposure exercises with the parents of a gay teen who were struggling to adjust after their son's recent coming out. The parents were encouraged to join their local PFLAG meeting and were encouraged to have direct contact with someone in their lives who identified as gay (e.g., a coworker, friend, relative). In session, they were also exposed to discussing increasingly salient topics related to their son's sexuality in order to help them habituate to the anxiety provoked by such discussions. For instance, the therapist would press the couple on topics that they appeared to be avoiding, such as what it would be like to be introduced to their son's boyfriend, or how their extended family members might react to learning that their son is gay. Moreover, Willoughby and Doty (2010) found these strategies to be highly effective in decreasing emotional avoidance and anxiety around sexuality-specific topics within just a few brief sessions. Thus, therapists might utilize in-vivo exposure techniques both in and outside of

therapy to help parents decrease anxiety and avoidance, as well as increase their own competence and self-efficacy, around supporting their child's LGB identity.

### **Homework: Child & Parent**

**“How to Get Involved in Your LGB Community.”** The purpose of this exercise is to provide LGB youth with LGB-affirming activities that the youth might find appealing and want to include in their in-vivo hierarchy in order to increase pleasure or foster competence (Foa et al., 2009). The Appendix G handout, “How to get involved in your LGB community,” was designed to provide LGB and adolescent friendly activities and resources to help youth become aware of ways in which they can develop their own sexual identities and connections with the LGB community. While the handout was created for the youth to read, it would be most effective to have the youth go through the list of activities with the therapist during session. The therapist should also discuss the list of activities with the youth's parents, highlighting the importance of supporting the youth in developing connections to the LGB community and fostering self-advocacy and assertive communication skills (Pachankis, 2014). As mentioned on the handout, these are merely recommendations, and it will be important for the therapist to consider the youth's level of sexual identity development, the youth's goals and values, as well the level of support required from the youth's parents when identifying realistic goals and activities to include on the youth's in-vivo hierarchy or over the course of treatment.

## **How to Get Involved In Your LGB Community**

(Appendix G)

Below is a list of different ways that you can get involved in your LGB community. Remember, these are just suggestions, so be creative, ask for help from people familiar with resources in your area, and know that there are lots of ways for you to get involved – from joining a GSA or marching in a Pride event, to just spending some fun time with other LGB friends and allies:

**Visit your local LGBTQ Community Center** and learn about different resources for LGB youth in your community. Some LGBTQ centers have groups for teens, activities for families, and many organize trips and social events for LGB youth, such as “Gay Prom.” Visit [www.lgbtcenters.org](http://www.lgbtcenters.org) to find an LGBTQ Community Center near you.

**Volunteer or participate in community service activities** that make the LGBTQ community stronger, more visible, and proud. You can usually learn about different charities and service opportunities through your local LGBTQ center or by searching online. For example, in Los Angeles, organizations such as Gay-4-Good and Project Angel Food offer opportunities for LGB youth to represent the LGBTQ community by volunteering to prepare meals for those in need or helping other local schools and communities with a variety of service projects.

**Find an LGBTQ friendly church, synagogue, or faith-based organization** in your community. If your faith or spiritual beliefs are important to you, there are lots of different religious organizations who will embrace your LGB identity and benefit from your involvement. This might even be something you and your parents or family members can do together (See Appendix A for additional resources).

**Find an LGB mentor.** Knowing and having other LGB people to look up to can be a great source of support and can help you overcome fears about what it means to be LGB and what it is like to be an LGB adult. Many cities and LGBTQ centers across the country have LGB mentoring programs for LGB youth. If you are interested in finding out about mentoring opportunities, contacting your closest LGBTQ center is a great start. You might also already know an LGB adult in your life. If so, reaching out to them may be another way to develop an informal mentorship and increase your support.

**Join your school’s Gay Straight Alliance (GSA)** where you can meet other LGB youth, including teachers and other staff members who are willing to offer support.

**Invite local activists** or representatives from LGBTQ organizations to speak at your school. This can increase LGB visibility at your school and is a great way to fight homophobia and make schools safer and more respectful of everyone.

**Host a movie night** with some of your favorite films about LGB issues or featuring LGB characters. You can do this at school or with other LGB friends and allies. You can make this gathering as big or as little as you would like. Spending time with LGB friends and allies is a great way to feel more comfortable talking about LGB issues that are important to you... and it reminds you that you are not alone!

**Write an article or column** for your school newspaper on LGB issues at your school. Or create a blog, website, or zine and publish your own writing and artwork about being LGB. This is a great way to practice expressing yourself and is an opportunity for you to help others as well. Your voice and your ideas are an important part of the LGBTQ community and deserve to be heard.

**Organize a book club** and plan to meet once a month after school to discuss a book by a lesbian, gay, or bisexual author. This can be a great way to get to know other LGB teens from your school or community. You could also make this a movie or music club where you get together to listen to music or watch movies that relate to your experiences of being LGB.

**Observe and commemorate important people and events in LGBTQ history.** Either at school, home, or among your group of friends, you can choose to celebrate special moments and dates in LGBTQ history. For instance, with the permission of your school or teachers, you might place calendars or displays on campus to help raise awareness about important LGBTQ holidays, events, or historical figures, such as the Stonewall riots or Harvey Milk's life and legacy as an LGBTQ advocate.

Here is a list of different LGB-themed holidays and events celebrated throughout the U.S. and around the world. See if you can come up with some fun and creative ways to celebrate any of these events at home, in your school, or with friends and other LGB community members. You can also go to [www.gsanetworks.org](http://www.gsanetworks.org) for more information about annual LGBTQ holidays and events:

- **February 12: National Freedom to Marry Day:** This holiday falls on the same day as Abraham Lincoln's birthday and comes just before Valentine's Day. The Freedom to Marry Day incorporates themes of equality and love, and brings awareness to the fight for marriage equality. Visit [www.freedomtomarry.org](http://www.freedomtomarry.org) for more information.
- **April: GLSEN's National Day of Silence:** This is a student-led day of action where those who support making anti-LGBTQ bias unacceptable in schools take a daylong vow of silence in recognition and protest of discrimination, homophobia, and harassment against LGBTQ students and their allies. Many GSA's throughout the country organize events to celebrate the Day of Silence. You can visit [www.dayofsilence.org](http://www.dayofsilence.org) for more information.
- **June/July: LGBTQ Pride Month:** Most LGBTQ Pride events take place in June and July in honor of the Stonewall Riots of June 28th, 1969; however, many Pride events occur all year round and vary from city-to-city. Pride events often include parades, marches, rallies, festivals, and other activities that celebrate LGBTQ people and culture or commemorate important LGBTQ historical events.
- **September: Bisexual Awareness Week:** This is a weeklong celebration recognizing and increasing visibility of the bisexual community. Celebrations typically begin the Sunday before **Celebrate Bisexual Day** (on September 23<sup>rd</sup>). The month of September was

chosen to honor the birthday of Freddy Mercury, the lead singer of the rock band Queen, who was an openly bisexual musician and fierce advocate for the LGBTQ community. Visit [www.glaad.org/bisexual](http://www.glaad.org/bisexual) for more information.

- **October 11: National Coming Out Day:** This is a national holiday commemorating the first march on Washington D.C. by LGBTQ people in 1987. It is dedicated to promoting honesty and openness about what it means to be lesbian, gay, bisexual, transgender, or queer. To celebrate the day you could share your coming out stories with other LGB friends and allies, create a “Coming Out Day” bake sale or fundraiser to promote LGB visibility and donate the profits to an LGB charity, or you could even watch LGB-themed movies about coming out with friends.
- **October 20: Spirit Day:** This is a day where LGB and straight youth all around the United States wear purple (a color that symbolizes “spirit” on the rainbow flag) to show support for LGBTQ youth and to take a stand against bullying. The idea for the event came from Brittany McMillan, a teenager who wanted to honor the memory of all the young people who lost their lives to suicide and to speak out against bullying by spreading a message of solidarity and acceptance to LGBTQ youth. To celebrate the day, you and your friends can coordinate wearing purple to school or can create banners and posters around the school to increase LGB visibility and respect on campus. Visit [www.glaad.org/spiritday](http://www.glaad.org/spiritday) for more information.
- **October: LGBT History Month:** In the tradition of Black History Month and Women’s History Month, LGBT History Month is designed to promote the teaching of LGBT history in schools, as well as in LGBT communities and mainstream society. It was first celebrated in October of 1994 and was declared a national History month by President Barack Obama in 2009. To celebrate the month you read a book or watch a documentary about important LGB historical events and figures, you could give a presentation to your class or GSA on LGB history, or you can even visit museums in your community that have celebrate LGB artists and historical figures. If you enjoy being creative, research an important LGB artist, such as Keith Haring, and see if you can create your own artwork to demonstrate LGB themes of pride, social justice, and acceptance.

Adapted from: [www.lambdalegal.org/know-your-rights/article/youth-safe-inclusive-schools](http://www.lambdalegal.org/know-your-rights/article/youth-safe-inclusive-schools)

## **Chapter 9: Conjoint Child-Parent Sessions**

### **Purpose**

The purpose of this chapter is to provide ways in which therapists can help to deepen the relationship between LGB youth and their parents by creating a safe, supportive, and affirming environment both in and outside of therapy. Suggestions are provided for helping therapists prepare the parent and child for the conjoint session reading of the trauma narrative, as well as for engaging in more open communication about the trauma and issues related to the youth's sexual identity. A homework activity designed to help parents implement sexuality-specific support while increasing the frequency of positive family interactions is also included.

### **Sexuality Specific Support**

As discussed throughout this resource manual, both social and family support are of critical importance to the identity development and wellbeing of sexual minority youth. In particular, parental rejection or acceptance of a youth's sexual identity have been found to significantly impact youths' levels of self-esteem, their mental health, as well as their likelihood of engaging in high risk and self-injurious behaviors (Bouris et al., 2010; Bregman, Malik, Page, Makynen, & Lindahl, 2013; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; Watson, Grossman, & Russell, 2016). For example, in a systematic review of the literature on parental influences on the health and well-being of LGB youth, Bouris and her colleagues (2010) found a consistent pattern in which parent-child relationships characterized by support, caring, acceptance, and connectedness were generally associated with less risky behavior and improved health outcomes. As such, the parents of LGB youth are uniquely positioned to help in decreasing risk while increasing well-being for their LGB children. Moreover, in addition to increased parental acceptance and general



parental support (e.g., praise, encouragement, and warmth), Doty, Willoughby, Lindahl, and Malik (2010) found that sexuality-specific support is an especially important protective factor for LGB youth. They noted, however, that many LGB youth report receiving very little sexuality-specific support from their parents and family members. For instance, LGB youth who are experiencing ongoing sexual minority stressors, or who have experienced victimization, abuse, and/or trauma related to their sexual orientation, require support that directly addresses and provides solutions to these issues (Bregman et al., 2013). Therefore, parents who avoid discussing pertinent issues related to their child's sexuality or prevent them from learning about their LGB identity, or, even worse, who reject, abuse, or withdraw instrumental support from the child due to their sexual orientation may greatly increase the child's risk for suicide, depression, substance use, and risky sexual behavior (Rosario, Schrimshaw, & Hunter, 2012; Ryan, Huebner, Diaz, & Sanchez, 2009; Watson et al., 2016). However, parents who are able to provide emotional support as youth encounter experiences with sexual orientation victimization, discrimination, rejection, and internal conflict, or who can provide advice about romantic relationships, sexual health, and coming out, or who can offer practical forms of assistance, such as transportation to LGB-related social events, are likely to increase the strength of the parent-child relationship, whereby helping traumatized LGB youth feel less depressed and better able to cope with sexual minority stress and threats to self-esteem (Bregman et al., 2013; Doty et al., 2010; Watson et al., 2016). Adding to this, Ryan (2009) found that LGB youth who feel accepted by their families are more likely to believe that they will have a good life and grow up to be happy and productive adults, and, in general, have much closer relationships with their parents and family members, are more satisfied with their lives, and are more likely to want to become

parents themselves. Furthermore, Ryan (2009) outlined a variety of ways in which parents of LGB youth can provide sexuality-specific support:

- Talking with the youth about his or her LGB identity.
- Supporting the youth's identity despite feeling some discomfort or lack of knowledge.
- Advocating for the youth when he or she is mistreated because of their LGB identity.
- Setting the expectation that other family members will respect the LGB youth's identity.
- Connecting the youth with an LGB adult role model or mentor.
- Bringing the youth to LGBT organizations or events.
- Working to make one's religious congregation supportive of LGB members or finding a supportive faith community that welcomes LGB youth and their families.
- Welcoming the youth's LGBT friends and partners into the family's home and to family events.
- Supporting the youth's gender expression.
- Believing that the youth can have a happy future as an LGB adult.

Moreover, sexuality-specific support can begin with parents simply learning how to communicate with their child about the youth's LGB identity. This is particularly relevant as the youth and parent prepare for conjoint session readings of the trauma narrative, especially if the focus of treatment is related to sexual orientation violence or abuse. As addressed by Bouris et al. (2010), parent-child communication is most effective when there is an open and mutual exchange of information, and when youth perceive that their parents are trustworthy and supportive. Therefore, teaching parents, first, in individual sessions, how to prevent invalidating or harming their child by decreasing homophobic remarks, abuse, or rejection, and then, in both individual and conjoint sessions, teaching them ways to affirm their child's sexual identity will

likely improve family cohesion and the child's recovery from trauma (Diamond et al., 2012; Woodward & Willoughby, 2014).

### **Teaching Parents How to Increase Positive Interactions and Affirm Their LGB Child**

In addition to the previous recommendations for sexuality-specific forms of support, Willoughby and Doty (2010) also indicated that when working parents of LGB youth, increasing positive family interactions is necessary for improving communication and family cohesion. Similarly, Woodward and Willoughby (2014) noted that “sexual minority youths with cohesive, adaptable, and authoritative families have more positive interactions with parents around sexual minority issues than sexual minority youths whose families are rigid, disconnected, and authoritarian” (p. 398). Thus, helping parents learn how to communicate with their children about sexual minority related issues in a way that is affirming, flexible, and respectful is an important component of providing sexuality-specific support. Furthermore, Ronald Potter-Efron (2011) has proposed a set of specific strategies that families can use to increase positive family interactions while decreasing feelings of shame. These strategies can be particularly useful when attempting to enhance communication skills within shame-prone families or between parents and youth who report feelings of shame related to the child's sexual orientation and/or traumatic experiences. According to Potter-Efron (2011) families should strive to communicate with one another in a way that conveys, what he calls, the “Five As” of positive interactions: attention, approval, acceptance, admiration, and affirmation. Potter-Efron proposed teaching parents and family members to reflect upon these five simple phrases in order to reduce feelings of shame and enhance the quality of family interactions (2011, p. 234):

- Attention: I have time for you.
- Approval: I like what you do.

- Acceptance: It's OK for you to be you.
- Admiration: I can learn from you.
- Affirmation: I celebrate your existence.

By conveying these sentiments to an LGB youth, not only in words, but also in actions, parents are more likely to gain the trust of their child, to reduce their child's suffering from trauma, stress, and shame, and to create greater family cohesion. Moreover, Potter-Efron (2011) suggests that teaching families how to put these concepts into action may require guidance from the therapist in the form of role-plays and repeated communication practice. For instance, in individual sessions with the parent, therapists might role-play a scenario where the child is having a problem at school due to homophobic bullying, or, perhaps, where the child asks the parent if he or she is ashamed of the child because of their sexual orientation. In either of these scenarios, parents can practice demonstrating that they are willing to discuss their child's sexuality-related concerns, that they support their child's needs, and that they accept the child for who they are, which includes their sexual orientation. Additionally, parents might praise their child by expressing admiration for their bravery in the face of adversity and they might affirm the child's sexual identity by taking action to stand up for their child and resolve situations such as bullying at school. Furthermore, in between sessions and during conjoint sessions with the child, therapists can encourage parents to reflect upon these simple phrases as a way to guide their behavior with the hope of fostering a more positive and affirming communication style and pattern of family interactions.

### **Clinical Considerations**

**Parent.** As recommended in the TF-CBT manual, it may be helpful, or even necessary at times, to include conjoint sessions earlier in therapy (Cohen et al., 2006). If the therapist believes

that the parent and child would benefit from help or encouragement in talking about sexuality related issues, especially if they relate to the child's traumatic experiences, then the therapist may encourage conjoint sessions specific to these issues earlier in treatment. For instance, beginning as early as the psychoeducation component of treatment, it may be helpful to encourage parents to begin communicating with their youth more openly about the youth's sexuality and finding ways to affirm and support their youth's LGB identity (Woodward & Willoughby, 2014).

Clearly, this will vary depending on the child's stage of sexual identity development, the child's relationship with their parent, the nature of the child's trauma, as well as the parent's willingness to accept and explore the child's sexual identity. For instance, a parent whose child experienced sexual abuse perpetrated by a same-sex individual or family member may have more difficulty discussing their child's sexual orientation in an affirming way. Thus, the conjoint sessions can be an opportunity for therapists to facilitate a direct conversation between parents and their children about any concerns that the family might still have related to the child's sexuality (e.g., spiritual concerns, disclosing to family members, HIV prevention) and/or its relationship to the child's traumatic experiences (e.g., addressing the myth that sexual abuse causes homosexuality, concerns related to safety at school, problem-solving how to find safe and supportive LGB role models). Using the suggestions provided in this chapter and throughout this resource manual, therapists can model how to discuss difficult or once taboo subjects by using language and behaviors that affirm the child's LGB identity, as well as the vital role that parents play in the lives of their LGB children. Therefore, the parent's ability to accept and affirm their child's sexual identity may become an important therapeutic task, and is likely to require both individual and conjoint sessions to explore such issues. At this point in therapy, however, it is likely that the therapist would have already helped the parent process and challenge any

unhelpful or inaccurate thoughts and develop more adaptive thoughts and behaviors related to supporting their youth's sexual identity. This might occur, for instance, during the parenting skills component of treatment or, typically, during components that include the cognitive coping and processing of the child's trauma narrative.

Another important aspect of the conjoint sessions is preparing parents for the reading of the child's trauma narrative. Preferably, therapists can begin sharing parts of the child's trauma narrative during individual sessions as the child begins to develop the trauma narrative in their own individual sessions (Cohen et al., 2006). Again, the therapist would remind the adolescent client that parts of the narrative would be shared with their parents in individual sessions. Helping parents process the trauma narrative may be particularly important for parents of youth who have experienced sexual abuse or sexual orientation violence, as the parents may need to work through their own fears and concerns related to the child's sexual orientation with the therapist well before they are prepared to support, praise, and affirm the child during conjoint session readings. Also, as previously discussed in chapter 6 of this resource manual, there may be times, such as when a parent is unable to appropriately support the child or is too negative and rejecting of the child's sexual orientation, that it may not be helpful to share the child's narrative with the parent. In such circumstances, the therapist may encourage the child to share the ending of the trauma narrative with the parent, perhaps demonstrating how therapy has helped them grow from their experience. Additionally, in conjoint sessions where sharing the child's narrative is not the goal, then the therapist could use these sessions to work on improving communication, increasing sexuality-specific support, safety planning, or, perhaps, increasing positive family interactions.

Lastly, therapists should also work to prepare parents for any questions that the child might have for them during the conjoint sessions. For instance, the child may want to talk about the parent's past homophobic remarks or attitudes towards the child's sexuality following the trauma. Some youth may be concerned that their sexual orientation has brought shame to the family or has caused too great a burden on their parents. As discussed in the TF-CBT manual, therapists should help parents prepare for these types of questions ahead of time by using role-plays and helping parents consider their responses (Cohen et al., 2006). Furthermore, Briere and Lanktree (2013), among others, note the importance encouraging self-care for parents (Philips & Ancis, 2008; Saltzburg, 2009; Willoughby & Doty, 2010). Parents should be reminded that in order to care for their child and to be an effective source of emotional support, they must first take care of themselves. Therefore, therapists may recommend that parents seek their own individual therapy and remember to stay connected with their own sources of support. Again, parents are also likely to benefit from meeting other parents of LGB youth, such as through PFLAG support groups or, perhaps, by meeting the parents of the child's LGB friends.

**Child.** In helping the LBG adolescent prepare for conjoint sessions, therapists should continue to explore any unresolved concerns that the youth might have about their parent's ability to tolerate hearing their narrative or any unresolved feelings of shame or fears of being rejected related to their sexual orientation. Therapists could use this information to help prepare the parents for any questions that might arise in the conjoint sessions and to also provide suggestions for ways in which the parent might need to demonstrate additional support. In addition to allowing the youth practice at reading their narrative aloud several times in individual sessions, therapists might also encourage the youth to practice reading any questions they have prepared to ask their parents in the conjoint session. Many LGB youth may lack assertiveness

skills due to fears or experiences of having been rejected in the past due of their sexual orientation. Thus, role-playing different scenarios and potential responses from their parents might help to increase their confidence and allow for more open communication.

### **Homework: Child & Parent**

**“Harvey Milk & Cookies.”** The purpose of this homework activity is to increase the frequency of positive family experiences between LGB youth and their parents, while also encouraging the family to engage in a sexuality-specific form of support (Woodward & Willoughby, 2014). For instance, as referenced by the title of this activity, therapists might encourage the youth and their parents to schedule a fun family activity together, such as baking cookies, as they prepare to watch an LGB-themed film together, such as the movie *Milk*. Again, the goal is to create an opportunity for parents to demonstrate acceptance and support for their child’s LGB identity while creating a safe and supportive environment. Thus, parents and their children should be encouraged to be creative with this homework activity. There are a variety of LGB-themed films and TV shows that parents might find fun or interesting to watch with their child, some that are light-hearted (e.g., TV shows like *Glee* or *Meet the O’Neils*) and others that address issues of sexual minority stress or depict images of parents who affirm and support their LGB children (e.g., *Moonlight*, *If These Walls Could Talk 2*, *The Family Stone*; see Appendix A for a list of recommended films and TV shows). In addition to this, parents might be encouraged to take their son or daughter to explore a local LGBT center, attend an LGBT pride event together, volunteer at an LGB charity, or participate in an AIDS walk event. If their son or daughter has other LGB friends, then inviting them, and even their parents, over to the family’s home for dinner would be another example of a positive family interaction that also affirms the child’s identity. Furthermore, therapists should encourage the family members to talk about their



experiences and to learn from one another. This is a perfect opportunity for parents to practice the Five As of positive family interactions and to feel hopeful that their family, along with their children, can grow stronger from the challenges they have experienced together.

## **Chapter 10: Enhancing Future Safety and Development**

### **Purpose**

The purpose of this chapter is to address some of the challenges that LGB youth may encounter related to future safety and development, as well as strategies therapists can use to help youth and their families prevent future trauma while enhancing safety and coping skills. An LGB-affirming activity is provided that encourages LGB adolescents and their parents to openly discuss and address safety concerns related to the youth's physical and sexual health.

### **Challenges Facing LGB Youth Related to Safety and Future Development**

In addition to living in a heterosexist world where LGB youth are likely to experience ongoing sexual minority stressors, such as continually having to negotiate when, how, and to whom they come out, or dealing with discriminatory laws and negative stereotypes perpetuated by society, LGB adolescent survivors of interpersonal trauma must also contend with the heightened risk of revictimization and the challenges of developing a sexual minority identity with often little guidance from others (Balsam, Lehavot, & Beadnell, 2011; Morris & Balsam, 2003). Additionally, there is an extensive body of literature documenting a variety of increased mental, behavioral, and physical health risks and problems frequently experienced by LGB survivors of interpersonal trauma (Bos, de Haas, & Kuyper, 2016; Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Collier, van Beusekom, Bos, & Sandfort, 2013; Goldbach, Fisher, & Dunlap, 2015; Heidt, Marx, & Gold, 2005; Ryan, 2009; McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012; Saewyc, 2011; Saewyc et al., 2006; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). For instance, not only are LGB individuals at increased risk for experiencing childhood sexual abuse and violence within their homes, schools, romantic relationships, and communities, but, as a result of these traumatic experiences, are also more

likely to experience depression, suicidal ideation, externalizing behaviors (e.g., aggression, conduct problems, and delinquency), homelessness, increased substance use (e.g., alcohol, tobacco, marijuana, and other illicit substances), and higher rates of risky sexual behavior (e.g., sex without use of condoms or protective measures, anonymous sex with multiple sexual partners, sex under the influence of substances; Goldbach et al., 2015; Kosciw, Greytak, Palmer, & Boesen, 2014; McLaughlin et al., 2012; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Williams, Connolly, Pepler, & Craig, 2005). Furthermore, some studies have also found that bisexual youth, in particular, may be at greater risk for experiencing intimate partner violence or becoming involved in unhealthy and abusive relationships (McLaughlin et al., 2012). Another potential risk factor for future victimization is gender nonconformity, especially among gay and bisexual male youths (Bos et al., 2016). For instance, gender nonconformity has been associated with higher rates of parental rejection and sexual orientation victimization at home and at school (Bontempo & D'Augelli, 2002; D'Augelli, Grossman, & Starks, 2006; Friedman et al., 2011). Moreover, while several of these issues are likely to be addressed throughout the course of treatment, therapists may need to provide special attention in the safety planning phase of treatment in order address ongoing sexual minority related stressors, such as bullying at school or home, or to prevent the youth from engaging in high risk substance use and unsafe sexual behaviors.

### **Strategies for Helping LGB Youth Enhance Safety and Future Development**

According to Cohen et al. (2006), when working with youth who have experienced interpersonal violence, it is necessary for therapists to incorporate skill-building exercises that promote future safety by decreasing the youth's risks for future victimization and increasing their feelings of self-efficacy related to managing stress. One of the first steps they recommend is

enhancing the youth's ability to communicate with others when they are experiencing distress, for instance, helping youth develop the confidence and skills needed to respond effectively to abusive or potentially traumatic situations (Cohen et al., 2006). In line with this, Pachankis (2015) noted that, due to sexual minority stress, gay and bisexual youth may lack a strong sense of agency, develop poor social communication skills, and engage in submissive social behaviors. Pachankis argued that these factors place gay and bisexual young men at increased risk for multiple sexual health problems (e.g., sexual compulsivity, HIV infection). For instance, unassertive interpersonal behavior has been associated with increased risk for STIs and HIV infection among men who avoid asking their sexual partners to wear condoms or avoid asking about their partner's sexual health status (Hart & Heimberg, 2005; Pachankis, Gold, & Ramrattan, 2008). Thus, helping LGB youth, especially gay and bisexual males, learn how to communicate assertively about their sexual needs and sexual safety will help to reduce their risk of engaging in high risk sexual behaviors in the future (Pachankis, 2015). In addition to this, therapists may also need to provide education about sexual health, or, at the very least, be able to direct LGB youth to appropriate and LGB-affirming sources of information (see Appendix A for recommendations; Pachankis, 2015). Planned Parenthood, for example, is one such organization that provides LGB-affirming and sexuality specific recommendations regarding healthy sexual behaviors. Moreover, youth are also likely to learn best when engaged in role-plays or interactive activities (Cohen et al., 2006); therefore, the therapist may help the youth consider different scenarios where the youth might be put into a vulnerable situation, such as being pressured to have sex by an anonymous partner or being pressured to try alcohol or drugs in an unsafe setting. Moreover, helping youth develop strategies and skills to identify dangerous situations, to assert themselves and their needs, and to get help when needed will further serve to increase their self-

efficacy and decrease their anxiety or unassertiveness when responding to potentially harmful situations.

In addition to addressing the youth's sexual health behaviors, as noted throughout this resource manual, therapists may also need to address safety issues around the youth's school environment. Given that youth are likely to experience high rates of victimization and sexual minority stress at school, especially youth in rural areas or those attending religious schools, therapists should work with the youth, their family, and potentially the youth's school, to ensure that the child is safe and protected while on campus (Kosciw et al., 2014). Moreover, the therapist might work with the youth to identify situations at school where the youth feels less safe or is afraid to be assertive (e.g., in the locker room, at lunch tables, participating in class). Role playing different scenarios, such as being taunted by a bully, being invited to join people for lunch, or deciding whether or not to participate on a sports team or in a theatre group, might help to uncover different thoughts the youth has about harmful versus nonthreatening situations. Using cognitive coping and restructuring skills learned in previous sessions, the youth could practice differentiating between realistic, inaccurate, or even unhelpful thoughts related to each of these situations. For instance, a youth might challenge her fearful thought that if she lets her guard down around other students then she might be physically assaulted again. Helping the youth explore the evidence for and against this thought, whether it is habit or fact, or whether or not a problematic thinking pattern is involved (e.g., overgeneralization), might allow the youth to generate her own, more balanced, alternative thought (e.g., "Just because I was attacked by someone doesn't mean that it will happen again, and I'd rather take the risk than not have any friends at all"). Furthermore, working with the youth to develop empowered and assertive responses in each of these scenarios, again, could help the youth begin to feel more confident

about their ability to handle challenging or uncertain situations. Additionally, therapists should help youth identify specific people and places (e.g., school counselors and staff, parents, friends, GSA) that can provide safety or support when the youth experiences abuse at school or when the youth's safety is being threatened (Cohen et al., 2006). In sum, by having open, honest, and direct conversations with LGB adolescents about the unique stressors and challenges that they face at home, in school, and in negotiating social, romantic, and sexual relationships, therapists can help youth enhance their safety skills while affirming the youth's sexual identity, strengths, and natural resources. Thus, while noting that the youth is never to blame for their inability to predict or prevent violence, the goal of this component is to foster greater self-efficacy and to reinforce the youth's belief that they are capable, strong, and deserving of respect and safety.

### **Clinical Considerations**

**Child.** As discussed in the TF-CBT manual (Cohen et al., 2006), and among those who have written about working with adolescents with complex trauma, it may be necessary to include safety skills earlier in treatment, and more explicitly throughout the course of treatment, especially if there are concerns about substance use, self-injury, or risky sexual behaviors (Briere & Lanktree, 2013; Kliethermes & Wamser, 2012). In addition to discussing issues related to sex, therapists might also need to address issues and behaviors such as substance abuse, poor interpersonal boundaries, and impulsive decision making given that might increase the youth's risk of revictimization (Kliethermes & Wamser, 2012). For instance, therapists might need to work with youth and their parents to develop strategies for avoiding and detecting online predators. As discussed in chapter 8 of this resource manual, therapists may need to help youth identify safe spaces online where they can meet other youth safely. Additionally, teaching youth the dangers of sharing personal information (i.e., name, school, address, phone number, etc.) and

pictures of oneself (e.g., “sexting” or texting/sharing explicit photographs of oneself) online or through phone apps can help to prepare the youth for potentially dangerous internet-based threats to safety. Therapists may wish to role-play different scenarios so that the youth has practice responding effectively when pressured to send inappropriate pictures or information about themselves. Therapists can also help the youth identify trusted individuals whom they can talk to if the youth feels uncertain about what to do or if the youth is being intimidated or threatened by an online predator or bully. Furthermore, therapists can also use this component of treatment to help youth clarify and develop strategies for achieving future goals following treatment, such as finishing school, going to college, or finding employment. In addition to this, therapists might also utilize a self-affirming exercise to help the client reflect upon how far they have come, what they have learned, and how that can be applied to preventing future victimization (Burton, Wang, & Pachankis, 2017). For instance, the therapist might spend some time in session encouraging the youth to highlight their strengths, both as a survivor of trauma and as a member of the LGB community. The therapist could also utilize Youtube videos depicting a bullying experience directed at an LGB peer and ask the client how he or she might handle that type of situation. The youth could also be encouraged to write a letter to the person in the video, perhaps sharing their own experiences with bullying or sexual minority stress, and what types of strategies (e.g., cognitive coping or behavioral) that they used to overcome them (Burton et al., 2017).

**Parent.** When working on enhancing safety and future development with the parents of LGB youth, the therapist should reiterate the importance of parental support and acceptance in reducing the youth’s risks for developing a variety of physical, mental, and behavioral health problems (Ryan, 2009). At the very least, therapists can help parents understand that even by simply reducing rejecting behaviors they can significantly improve the wellbeing of their youth

(e.g., decreasing suicidal ideation and substance abuse; Ryan, 2009). In terms of helping to protect youth against sexual health risks and concerns, LaSala (2007) suggested that more important than offering the youth advice, is the parent's willingness to connect with the child and to establish a mutual level of respect and concern for one other. For instance, in a study he conducted on the role of parental influences on gay youth's decisions to avoid unsafe sex practices, LaSala (2007) found that youth who felt obligated to their parents to keep themselves safe and healthy were more likely to balance their needs for sex and autonomy with their parents' feelings as well as their desire for greater family cohesion and connectedness. Thus, LaSala (2013) has advocated for parents not only discussing issues of sexual health and HIV risk prevention with their LGB youth, but being mindful of how they discuss these issues – hopefully bringing an affirming, open, and emotionally supportive attitude.

### **Homework: Child and Parent.**

**“Let's Talk About Sex and Health.”** Emphasizing the importance of sexuality-specific support and affirming communication behaviors discussed in previous chapters, the purpose of this activity is to encourage dialogue between LGB youth and their parents around issues of sexual health and safety. Perhaps due to cultural values, stigma, heterosexism, or internalized homophobia, many youth and their families may struggle to address topics related to sex or LGB sexuality. However, research has shown that LGB youth are at significantly greater risk for contracting HIV or other sexually transmitted infections, as well as for experiencing earlier initiation of sexual intercourse and experiencing higher rates of sexual coercion or forced sexual intercourse than their heterosexual peers (Ryan, 2003). As such, therapists should begin having the conversation about sexual health in session, modeling how to address issues related to sex and sexual health in an affirming and direct way that validates the youth's sexual development



and normalizes their feelings and attractions. With both the parent and child in session, the therapist might show the family different websites (e.g., [plannedparenthood.org](http://plannedparenthood.org), [gsanetwork.org](http://gsanetwork.org), [thetrevorproject.org](http://thetrevorproject.org)) that provide LGB-affirming information about sexual health and sexuality, or the therapist might ask the youth if they feel like they have someone that they could talk to about sex or any other sexual health related issues. Even if willing to provide support, some parents may not feel that they have the knowledge or ability to answer their youth's questions. Thus, the therapist might encourage the family to seek out an LGB-affirming physician, health care provider, or health organization that the youth could go to for sexual health information and support. For instance, Planned Parenthood is a good resource and many LGBT centers around the country offer health-screening services or can provide information regarding local resources. Another helpful resource for finding an LGB-affirming healthcare provider is the Gay and Lesbian Medical Association's Healthcare website ([glma.org](http://glma.org)). Furthermore, by beginning this conversation with youth and their families, it highlights the importance of the issue, affirms the youth's LGB identity and sexuality, and provides practical resources that can enhance the youth's future safety and development.

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## APPENDIX B

## Email to Recruit Expert Reviewer

To Whom it May Concern:

I am currently a fourth-year-doctoral student attending Pepperdine University's doctoral program in Clinical Psychology. As part of my dissertation project I am developing a culturally sensitive, TF-CBT supplemental resource manual for use with lesbian, gay, and bisexual (LGB) adolescents. The overarching goal of this dissertation project is to strengthen the resources available to clinicians working with LGB adolescent survivors of interpersonal trauma. This will be done by providing culturally sensitive information and recommendations to each of the core components of the TF-CBT treatment model, whereby enhancing minority community engagement and improving the contextual relevance of treatment content. For the purpose of this research project, I am seeking out potential reviewers who have at least 3 years of licensure, as either a licensed clinical psychologist, a licensed marriage and family therapist, or a licensed clinical social worker. Based upon your expertise in the area of CBT, TF-CBT, interpersonal trauma, or LGB youth/young adults between the ages of 13 and 25, I would like to invite you to participate as an expert reviewer of this culturally sensitive, supplemental resource manual. Your role as a reviewer would include the following:

1. Read and review the supplemental resource manual, which is designed to be used in conjunction with the standard (2006) TF-CBT treatment manual.
2. Provide revisions, suggestions, or comments based upon your expertise in this area, which will be carefully considered for incorporation into the final draft of the manual.

If you are interested in participating as an expert reviewer, please take a moment to complete and return the brief questionnaire attached to this email. Furthermore, if selected to review the manual, you will be compensated with a \$50 Amazon gift card (via mail or email) after reviewing the manual and providing your written feedback. If you would like further information or have any questions, please feel free to contact me. Thank you for your time and consideration.

Sincerely,

Paul Perales, M.A.

## APPENDIX C

## Qualification Form for Expert Reviewer

1. Please indicate the number of years you have been licensed and in what field(s) (i.e., licensed clinical psychologist, licensed marriage and family therapist, licensed clinical social worker, or other).
2. How many years of licensed clinical experience have you had in treating individuals with interpersonal trauma?
3. How many years of licensed clinical experience have you had in treating lesbian, gay, or bisexual (LGB) youth/young adults (i.e., between the ages of 13 and 25) and in what type(s) of setting(s)?
4. How many years of licensed clinical experience have you had in providing CBT?
  - Have you had any post-license clinical experience providing CBT to LGB youth/young adults?
5. How many years of licensed clinical experience have you had in providing TF-CBT?
  - Have you had any post-license clinical experience providing TF-CBT to LGB youth?
6. Have you had any specialized training in TF-CBT or CBT? If so, what type? Was it related to working with LGB individuals?



## APPENDIX D

## Informed Consent Form

**PEPPERDINE UNIVERSITY**  
**Graduate School of Education and Psychology**

**INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES**

Protocol Title: Developing a supplemental resource for Trauma-Focused Cognitive Behavioral Therapists working with lesbian, gay, and bisexual adolescents.

You are invited to participate in a research study conducted by Paul Perales, M. A. (Principal Investigator) and Thema Bryant-Davis, Ph.D. (Faculty Advisor) at Pepperdine University, because you are a licensed clinician with expertise in either interpersonal trauma, CBT, TF-CBT, and/or lesbian, gay, and bisexual adolescence or young adulthood. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for your records.

**PURPOSE OF THE STUDY**

The purpose of the study is to strengthen the resources available to clinicians working with lesbian, gay, and bisexual adolescent survivors of trauma. This will be done by making selective and directed adaptations to each of the components of the Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) treatment model and developing a supplemental resource that provides recommendations for TF-CBT therapists working with LGB adolescents. Therefore, the goal is to develop a culturally sensitive resource manual that can be used in conjunction with the TF-CBT treatment model.

**STUDY PROCEDURES**

If you volunteer to participate in this study, you will be asked to review and provide qualitative feedback on the supplemental resource being developed through this research project. You will be emailed a copy of the supplemental resource manual and asked to complete an attached evaluation form. The evaluation form will include sections for providing written feedback regarding the supplement as a whole, as well as within each area of specific content. You are free to conduct your review at any time or place convenient for you. It is estimated that the duration of your participation will range between 1-2 hours. You will be asked to return the evaluation form via email so that the feedback can be considered for incorporation into the final draft of the supplemental resource. You will be offered the opportunity to have your contribution to the research project recognized in the supplemental resource, or you may choose to have your

contribution remain confidential. The process mentioned within this paragraph is the sole procedural means of participation for this study.

### **POTENTIAL RISKS AND DISCOMFORTS**

The participation of expert reviewers presents only minimal, foreseeable risks, such as boredom or fatigue from completing the evaluation form.

### **POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY**

The primary goal of the TF-CBT recommendations for lesbian, gay, and bisexual adolescents is to enhance the effectiveness of the treatment and increase retention of LGB participants and their families by building upon the evidence based foundation of the seminal TF-CBT model. In doing so, the recommendations may serve to increase the cultural sensitivity of clinical providers and may reduce the subsequent shame that often accompanies trauma and establish greater resonance with LGB participants and their families. By providing an increased understanding of the variables (past and contemporary) that contribute to an LGB individual's unique experiences of trauma, providers will be better equipped to validate, normalize, empathize with, and address the unique needs of their LGB clients and their caregivers.

### **PAYMENT/COMPENSATION FOR PARTICIPATION**

You will receive a \$50 Amazon gift card for your time. The gift card will be given to you when you return the completed resource manual evaluation form via email. You may choose to have the gift card emailed to you or sent by mail.

### **CONFIDENTIALITY**

The records collected for this study will be kept confidential as far as permitted by law. However, if required to do so by law, it may be necessary to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if disclosed any instances of child abuse and elder abuse. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

Regarding confidentiality, email correspondence that contains dialogue between all participants, as well as requested forms for completion, will be stored electronically via the secured, password protected Pepperdine email server for three years total (viz., 2020), at which point the information will be deleted from the server.

### **SUSPECTED NEGLECT OR ABUSE OF CHILDREN**

Under California law, the researcher(s) who may also be a mandated reporter will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect

of a child, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If any researcher has or is given such information, he or she is required to report this abuse to the proper authorities.

### **PARTICIPATION AND WITHDRAWAL**

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

### **ALTERNATIVES TO FULL PARTICIPATION**

The alternative to participation in the study is not participating or only completing the items for which you feel comfortable.

### **INVESTIGATOR'S CONTACT INFORMATION**

You understand that the investigator is willing to answer any inquiries you may have concerning the research herein described. You understand that you may contact Paul Perales, M. A. (Principal Investigator), at paul.perales@pepperdine.edu or by phone at (XXX) XXX-XXXX, or that you may contact Thema Bryant-Davis, Ph.D. (Dissertation Chairperson), at XXXXXXX@pepperdine.edu or by phone at (XXX) XXX-XXXX, if you have any other questions or concerns about this research.

### **RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION**

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, (XXX) XXX-XXXX or XXXXXXX @pepperdine.edu.

### **SIGNATURE OF RESEARCH PARTICIPANT**

You have read the information provided above. You have been given a chance to ask questions. Your questions have been answered to your satisfaction and you agree to participate in this study. You have been given a copy of this consent form.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

**SIGNATURE OF INVESTIGATOR**

You have explained the research to the subjects and answered all of his/her questions. In your judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. S/he has the legal capacity to give informed consent to participate in this research study and all of the various components. The subject has also been informed participation is voluntarily and that s/he may discontinue s/he participation in the study at any time, for any reason.

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Name of Person Obtaining Consent

---

Signature of Person Obtaining Consent

---

Date

## APPENDIX E

## Evaluation Form

To: Expert Reviewer  
From: Paul Perales  
Subject: Evaluation Form

Dear: \_\_\_\_\_,

Thank you so much for making the time and effort to review my dissertation, *Developing a supplemental resource for Trauma-Focused Cognitive Behavioral Therapists working with lesbian, gay, and bisexual adolescents*. Please record any feedback and recommendations you might have for this project within this document. As mentioned previously, your contributions (viz., feedback, comments, recommendations) to this project will not be cited explicitly, however your name will be mentioned – unless otherwise specified – within the “Acknowledgements” portion of my final manuscript.

Additionally, once you have emailed me back your completed Evaluation Form, I will promptly mail or email you the \$50 Amazon gift card. In your email, please include your preferred method for delivery of the \$50 gift card (i.e., preferred email address or preferred mailing address.)

Again, thank you for your participation!

Kind regards,

Paul Perales, M.A.  
Pepperdine University

### **Feedback and Recommendations**

**What do you consider to be the *strengths* of this manual?**

**What do you consider to be the *weaknesses* of this manual?**

**To what extent does the manual strengthen the relevance of TF-CBT for LGB adolescents?**

**To what extent does the manual appear to be culturally sensitive?**

**How useful do you find this manual?**



**Please feel free to provide any additional feedback or recommendations regarding the individual components/chapters:**

- **Chapter 1: Psychoeducation:**
- **Chapter 2: Parenting Skills:**
- **Chapter 3: Relaxation Skills:**
- **Chapter 4: Affective Expression & Modulation Skills:**
- **Chapter 5 & 7: Cognitive Coping & Processing:**
- **Chapter 6: Trauma Narrative:**
- **Chapter 8: In-vivo Exposure and Mastery of Trauma Reminders:**
- **Chapter 9: Conjoint Child-Parent Sessions:**
- **Chapter 10: Enhancing Future Safety and Development:**

**What are your overall impressions of the resource manual?**

**How could the manual be improved to make it more effective for use with LGB adolescents who have experienced interpersonal trauma?**

## APPENDIX F

## IRB Approval Letter



Pepperdine University  
24255 Pacific Coast Highway  
Malibu, CA 90263  
TEL: 310-506-4000

## NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: February 28, 2017

Protocol Investigator Name: Paul Perales

Protocol #: 16-12-454

Project Title: Developing a supplemental resource for Trauma-Focused Cognitive Behavioral Therapists working with lesbian, gay, and bisexual adolescents.

School: Graduate School of Education and Psychology

Dear Paul Perales:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at [community.pepperdine.edu/irb](http://community.pepperdine.edu/irb).

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist