PART 2

SEXUAL AND GENDER MINORITIES

ALSO IN THIS SPECIAL REPORT

Special Report Chairperson
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FROM THE MAY ISSUE

The Trauma-Focused CBT and Family Acceptance Project: An Integrated Framework for Children and Youth

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Sexual and gender minority (SGM) youth experience the same types of traumas as their non-SGM peers, including child maltreatment, domestic and community violence, accidents, traumatic death, and separation. SGM youth are also at elevated risk for stressors common among minorities. Furthermore, these youth experience distinct ongoing stress related to discriminatory societal, medical, educational, housing, employment and/or legal attitudes, norms and/or practices, among others. In addition, SGM youth are at increased risk for traumas that are specifically related to their sexual orientation, gender identity ,and/or expression. They may be bullied, sexually or physically assaulted, or rejected by their parents. Thus, these youth are at significantly greater risk for cumulative trauma exposure, and for developing the negative mental health and medical problems related to stigma, minority stress, and trauma.

Trauma-Focused Cognitive Behavioral Therapy

Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based treatment for trauma-impacted youth, aged 3 to 17 years, and their nonoffending parents or primary caregivers.[1,2] With 23 randomized controlled trials assessing efficacy, TF-CBT has the strongest evidence for improving youth posttraumatic stress disorder (PTSD) diagnosis or symptoms, as well as trauma-related depressive, anxiety, behavioral, or cognitive difficulties.[1]

The TF-CBT model consists of 9 components summarized by the acronym PRACTICE; they compose 3 treatment phases (**Table 1**). Typically, TF-CBT treatment includes 12 to 15 sessions, with each phase lasting 4 to 5 sessions. For youth who develop complex PTSD reactions to multiple or interpersonal traumas, the enhancing safety component is typically provided first, and the stabilization/safety phase may be longer relative to the other 2 phases, taking up to half of the treatment sessions. Parent participation is an important part of TF-CBT, with youth and parent(s) seen individually for half of each treatment session; several conjoint youth-parent sessions are also included. Abusive or rejecting parents have not usually been included in TF-CBT treatment. These sessions typically use gradual exposure, ie, increasingly calibrated direct discussion about the youth's trauma reminders or personal trauma experiences and use of skills to cope with these. Evidence-based psychotherapies such as TF-CBT are the first-line treatment for youth with PTSD symptoms or other trauma-related difficulties.[3]

During a year-long learning community sponsored by the National Child Traumatic Stress Net-

Table 1. TF-CBT Components and Treatment Phases

Treatment components	Treatment phases
1. Psychoeducation	**1.** Stabilization and skills
2. Parenting skills	**2.** Trauma narration and processing
3. Relaxation skills	**3.** Consolidation
4. Affect modulation skills	
5. Cognitive coping skills	
6. Trauma narration and processing	
7. In vivo mastery	
8. Conjoint parent-youth sessions	
9. Enhancing safety	

Table 2. Components of the Family Acceptance Project's Family Support Model

ASSESSMENT Integrate FAP assessment questions and measures into intake process, individually for parent and child/ youth.	1. Assessment occurs individually with the parent and child. 2. Assess family strengths, identify cultural and religious values and beliefs. 3. Assess knowledge and attitudes about sexual orientation and gender identity. 4. Identify family behaviors toward LGBTQ/gender diverse child (rejecting + accepting behaviors) and underlying issues that affect capacity for family support.
PSYCHOEDUCATION Psychoeducation should be ongoing to reframe parent's perceptions of child/youth's identity and to support positive behavioral change and affirmative parenting.	1. Provide accurate information about sexual orientation, gender identity and child development. 2. Educate parents on the impact of family accepting/ rejecting behaviors on their child's risk and well-being, aligned with the family's cultural foundation. 3. Educate child/youth to identify rejecting and accepting behaviors and impact on their risk behaviors and relationships. 4. Family rejecting behaviors contribute to suicidality, self-harming behaviors, depression, drug use, and risky sexual behaviors. 5. Family accepting behaviors protect against suicide, depression, and substance abuse, and promote overall health, self-esteem, and positive development.
COUNSELING AND SKILL BUILDING Counseling is provided individually and for the parent and child together.	1. Address underlying issues that impact family support. 2. Provide counseling and family therapy that builds self-observation skills, increases empathy and communication, develops advocacy skills, and increases affirmative parenting and connectedness between parent and child. 3. Continue to assess growth and change.
PROVIDE ACCESS TO CULTURALLY RELEVANT PEER SUPPORT Decrease isolation, increase peer support and reframe perceptions of child's LGBTQ identity and life course	1. Connect caregivers with other caregivers who are learning to support their SGM children, particularly parents who share language, cultures, and faith traditions to decrease the parent's isolation and build a positive new reference group.

work (NCTSN), TF-CBT was implemented with trauma-impacted SGM youth in order to modify the model for this population, collect data, and develop an implementation manual to describe these modifications. Family Acceptance Project (FAP) data so convincingly documented the impact of specific family rejecting and accepting behaviors on risk and well-being for SGM youth and provided an evidence-informed family intervention framework that TF-CBT developers made the decision to include rejecting parents of SGM youth in TF-CBT treatment. FAP developer, Caitlin Ryan, PhD, ACSW, helped incorporate core FAP principles and strategies into the modified TF-CBT SGM implementation manual.[4] This manual describes an integrated TF-CBT-FAP framework for SGM youth recovery from trauma, and it is now available at no cost to clinicians.

For 1year, -long program, 32 clinicians from 12 NCTSN sites used TF-CBT for trauma-impacted SGM youth in order to modify the model for this population, collect data, and develop an implementation manual to describe these modifications.[5,6] The 24 youth—aged 8 to 12 years, with diverse gender identities and sexual orientations—experienced significant improvement on the University of California, Los Angeles PTSD Reaction Index for DSM-5 from pre- to post-treatment (mean scores of 44.0 [severe] to 17.89 [normal]; $t = 5.59$; $P < .0001$). In a subsequent quality improvement study, 19 youth aged 10 to17 years who self-identified as SGM and received TF-CBT with these modifications experienced improvement in the Child PTSD Symptom Scale for DSM-5 from pre-to post-treatment (mean scores of 50.05 [severe] to 26.21 [mild]; $t = 7.65$; $P < .001$).[6]

Exploring the Family Acceptance Project

The FAP is a research, education, intervention, and policy initiative that was developed in 2002 by Ryan and colleague Rafael Diaz, PhD. The goal was to help families support their SGM children to reduce health risks and promote well-being in the context of their families, cultures, and faith communities. FAP conducted the first comprehensive research on SGM youth and families and developed the first evidence-informed family support model for use in family guidance and treatment approaches for prevention, wellness, and care for SGM children and adolescents.[7]

FAP's family support model is grounded in participatory mixed methods research with diverse SGM youth and families. FAP's research identified more than 100 specific behaviors that parents and caregivers use to express rejection and acceptance of their SGM children and measured these behaviors to show how they contribute to health risks and increase well-being. FAP worked with racially, religiously, and linguistically diverse families and SGM youth to develop intervention strategies and multilingual research-based resources that can help families decrease rejection and increase support and acceptance for their SGM children.

FAP's family support model can be implemented to reduce risk for suicidality, depression, illegal drug use, ejection and removal from the home; to decrease family rejection; and to promote well-being. FAP strategies and resources can be used in any setting and by families. Moreover, core FAP intervention components can be integrated into other models of treatment, prevention, and care—as was done to integrate FAP and TF-CBT to support recovery and promote well-being for SGM children and youth, whether or not trauma is related to the child or youth's SGM identity.[8]

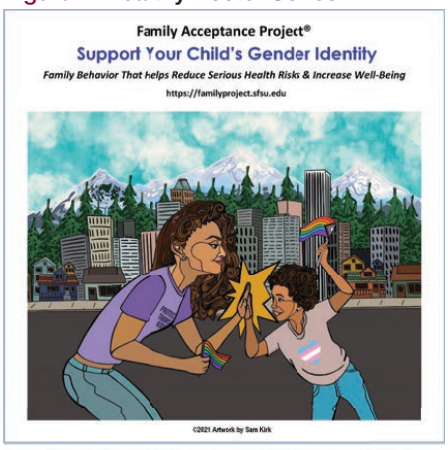
FAP's family support model uses a strengths-based and harm reduction framework to help parents, families, and caregivers understand sexual orientation and gender identity as components of child development. It teaches them how specific reactions to their SGM child affects the child's well-being and impacts their child's risk for suicide, depression, illegal drug use, and HIV (**Table 2**).

FAP has developed a series of research-based education materials to help parents understand the importance of family support, to guide behavioral change, and to educate extended family members as well as cultural and religious leaders. These resources include: family intervention videos that portray how diverse families move from struggle to support of their SGM children; family education booklets that are best practice resources for suicide prevention for SGM youth[9]; assessment scales to measure growth and change; and a multilingual Healthy Futures poster series that tells the story of family acceptance and rejection, suitable for use in homes, congregations, and any other public, institutional and clinical settings (**Figure 1**).[10]

Family Rejecting Behaviors That Are Traumatic

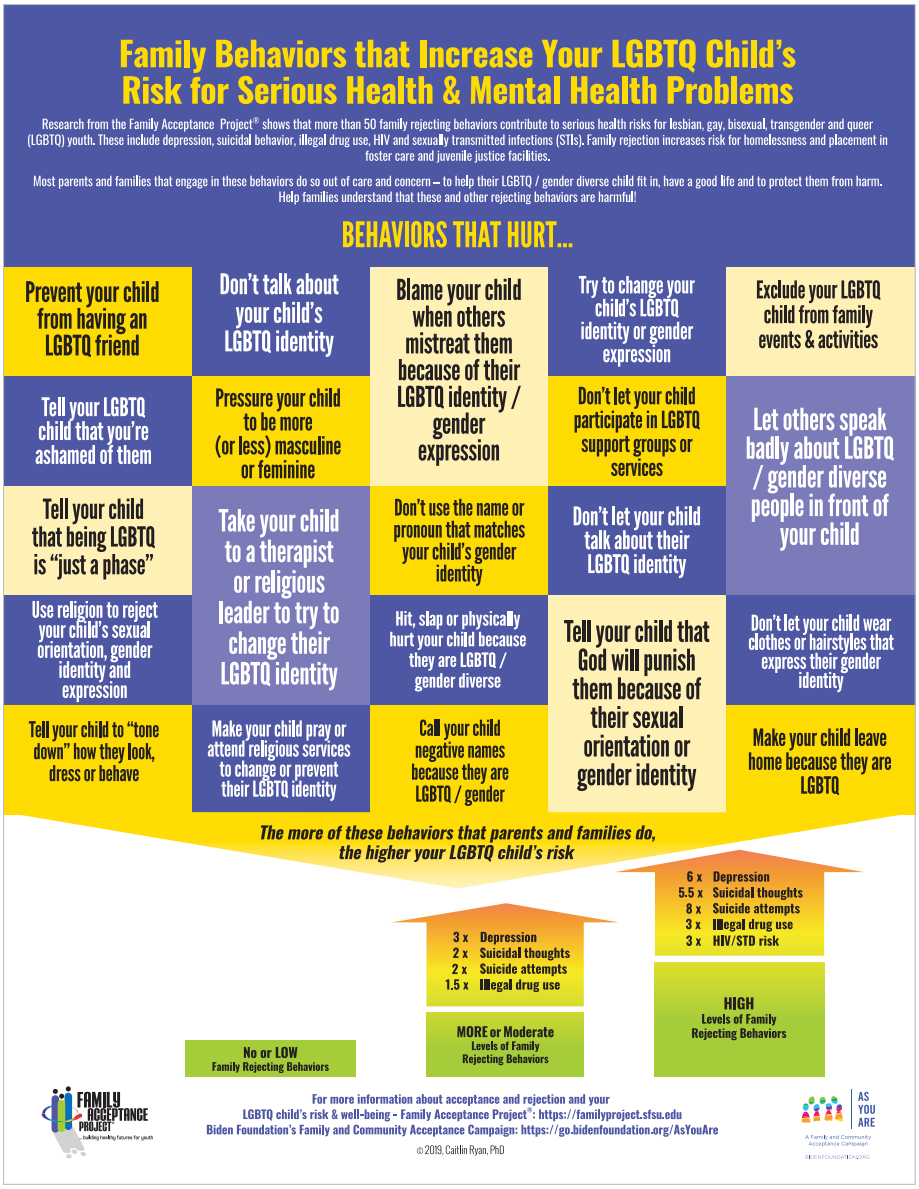
A critical element of FAP's approach is helping parents and clinicians understand that family behaviors that reject a child's core identity are traumatic and, combined with other trauma experiences, can contribute to complex mental health issues. Like Adverse Childhood Experiences (ACEs), the family rejecting (and accepting behaviors) identified and measured in FAP's research are predictive of risk for suicidal behavior, depression, illegal drug use, risky sexual behavior and decreased well-being in adulthood. But unlike ACEs,

Figure 1. Healthy Poster Series[10]



One of more than 50 family accepting behaviors measured in the Family Acceptance Project's research that help protect against health risks and promote well-being for LGBTQ young people

Figure 2. Statements and Actions That Undermine LGBTQ Children's Mental Wellbeing



these specific family rejecting behaviors are screened by few practitioners in SGM children and adolescents for these specific family rejecting behaviors. FAP's family support model aligns these research findings with the parent's underlying cultural and religious values to support positive behavioral change.[11,12]

Parents are typically surprised to learn that these "well-meaning" behaviors to help their child fit in, have a good life, and be accepted by others are actually contributing to high levels of depression, suicidality, substance use, and other adverse outcomes. Yet, all of the specific family rejecting behaviors studied by FAP focus on trying to change, prevent, deny, and minimize a child's SGM identity. Caregivers who believe that being gay or transgender is wrong routinely engage in rejecting behavior at early ages that undermine their child's self-worth, increase isolation and hopelessness, erode the parent-child bond, and significantly increase the likelihood of suicidal and self-harming behaviors.

In aligning the FAP and TF-CBT models, the significant benefits of integrating them became obvious. Applying core FAP strategies and resources in TF-CBT enables clinicians to help parents understand the harmful impact of specific rejecting behaviors, such as preventing the youth from having an SGM friend or making them pray or attend religious services to try to change their SGM identity (**Figure 2**). FAP's behavioral approach motivates parents to change harmful rejecting behaviors and to engage in affirming behaviors that increase connectedness and reduce risk—even when they continue to believe that being gay or transgender is wrong.

While the focus of treatment in TF-CBT remains on the child or youth, FAP is expanding the focus on the critical role of family support. Efforts to change a child's sexual orientation and gender identity expression are reinforced by social, cultural, and religious norms and are transmitted intergenerationally as a cultural default position. Helping the parent understand, take responsibility for, and ask the child's forgiveness for behaviors that have denigrated the child's SGM identity becomes part of the transformative narrative of TF-CBT for both the child and the parent.

Integrated Framework for Trauma Recovery

TF-CBT and FAP's integrated framework provides a pathway to healing and recovery that strengthens families and engages parents and caregivers as allies, not adversaries, for their SGM children.

TF-CBT and FAP help the parent and child to create meaning out of traumatic and harmful experiences and empower parents to nurture their SGM child. The COVID-19 pandemic has heightened vulnerability for SGM children and youth in numerous ways by confining them with rejecting and abusive family members, separating them from supportive peers and adults outside the home, and resulting in the sudden death of family members and cultural leaders. This combined treatment approach can play a crucial part of our national recovery.

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SPECIAL REPORT

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