

Independent Study Final

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Therapeutic Work with Queer Youth and their Families

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Introduction

Adolescents is a difficult time for any child, as the body reaches puberty, peers become more important, and relationships with parents change (Rosario, Schrimshaw & Hunter, Joyce, 2008). For LGBTQ (lesbian, gay, bisexual, transgendered, queer and/or questioning) youth, this turbulent phase is compounded by the development of sexual orientation (Kreiss & Patterson, 1997; Fontaine & Hammond, 1996). Coming out, or sharing their identity with others as gay, lesbian, bisexual, transgendered, queer and/or questioning, is a big step for youth (Kriess & Patterson, 1997). Usually, the biggest fear as youth come out is whether or not their family will accept their sexual orientation which becomes a bigger issue as more youth are coming out at a younger age and are still living at home (Kriess & Patterson, 1997; Tanner & Lyness, 2003; Rosario, Schrimshaw & Hunter, 2008; Coenen, 1998). The family is a large part of the youth's experience; they go through their own process of accepting their child as LGBTQ, and play a large role in the youth's well-being (Ryan, Heubner, Diaz & Sanchez, 2009). This paper will describe the different processes families experience as well as knowledge and skills for practitioners.

Prevalence and risk factors

Statistically, LGBTQ individuals make up 10% of the population, which was about 25 million on 2006 (Golding, 2006). Although gay figures are more visible in present society than in the past, homophobia is pervasive through gay youth life (Tanner and Lyness, 2003). Gay youth are in a statistically small peer group, compared to their heterosexual peer group (Kriess & Patterson, 1997). Therefore, marginalization by friends and family due to homophobia is a very real experience for gay youth; in one study, more than half the youth participants reported rejection by their family and friends (Coenen, 1998). Simply identifying as gay—even

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presenting as gay—can lead to bullying, emotion and physical harassment from peers and family members (Coenen, 1998). High rates of family rejection are actually linked to health risks, such as abuse by peers and family members, depression, suicidality, as well as homelessness and the need to engage in survival sex (Ryan, Huebner, Diaz & Sanchez, 2009). In fact, the rates of major physical abuse of LGB men and women as youth were at least double that of their heterosexual peers (Corlis, Cochran & Mays, 2001). Mental health risks include depression and suicidality; gay youth are 8 times more likely to attempt and follow through with suicide than their straight peers (Saltzburg, 2007; Kriess & Patterson, 1997). Furthermore, family rejection can lead to homelessness for youth, which places them at risk for substance abuse, survival sex and restricted access to health care (Mallon, 1997).

Family Reaction

Unfortunately, homophobia often has a presence in the family (D’Augelli, Anthony; Grossman, Arnold H. & Starks, Michael T, 2008). As children are coming out younger parents have a higher likely of the child coming out in the home, or even discovering a child is gay due to his or her belongings (Tanner & Lyness, 2003). Parent approval is important to most youth as they come out—many feel more comfortable telling a friend and extended family before they tell their parents since they are afraid of rejection or feel comfortable telling a sibling or a certain parent before other members of the family (Mallon, 1997; Duarte-Vélez, Bernal & Bonilla, 2010; D’Augelli, Grossman & Starks, 2008)

Fortunately enough, parental rejection is the exception rather than the rule. While many families react strongly and harshly and it is nearly impossible to have healthy relationships while family members are adjusting, parents who react negatively rarely ever completely sever ties to their children (Savin-Williams & Dubé, 1998; Tanner & Lyness, 2003). Not all parents react

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negatively; however, for some of those who do the process of accepting a gay child resembles grief and loss as parents mourn a heterosexual existence for their child.

Culture also plays a big part of family reactions to their child. Potoczniak, Crosbie-Burnett & Saltzburg studied the role that culture played in the coming out processes of White, African American and Hispanic families (2009). While all three cultures experienced parental hostility, the African American families were a phenomenon in that they were more likely to initially eject children from the home, but more likely to accept their children back (Potoczniak, Crosbie-Burnett & Saltzburg, 2009). Hispanic youth coming out were not only afraid of parental rejection like their African American and White counterparts, but for them the stakes were higher; they risked ejection for their Hispanic community (Potoczniak, Crosbie-Burnett & Saltzburg, 2009). Furthermore, all three cultures named religion as a conflict between their orientation and their parents, but the African American and Hispanic communities identified untraditional religious views in their families (Potoczniak, Crosbie-Burnett & Saltzburg, 2009). For example, a gay youth was said to “bring evil into the home” (Potoczniak, Crosbie-Burnett & Saltzburg, 2009; pg 198). However, extended family provided a support especially for the African American and Hispanic families (Potoczniak, Crosbie-Burnett & Saltzburg, 2009).

Some families also experience their own “coming out,” when they accept that they are the family members of a gay child (Jenkins, 2009). Even though it is the child who is LGBTQ-identified, the family members—especially parents—feel somehow labeled (Saltzburg, 2009). Therefore, as Saltzburg points out that parents feel to some degree the same isolation and stigma that their gay children face (2009). There is very little support for parents and other family members who seek help understanding what their child is experiencing (Fruhauf, Orel & Jenkins, 2009). Furthermore, although some parents react positively to their child’s identity, some

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parents go through a process similar to grief and loss regarding the heterosexual existence of their child (Savin-Williams & Dubé, 1998). For parents experiencing this loss, the process goes through several stages. First is the initial shock of the disclosure, followed by denial and isolation where the parents try to ignore their child's identity (Savin-Williams & Dubé, 1998). He or she may deny what it means for a child to be gay by saying "It's just a stage" (Savin-Williams & Dubé, 1998). Parents may feel anger when they are not able to explain away their child's sexual orientation (Savin-Williams & Dubé, 1998). Following is bargaining, when parents attempt to control who and to whom children out themselves, and afterwards parents enter depression, where they feel guilt and accountability for their child's sexual orientation and grief over the discrimination the child will face (Savin-Williams & Dubé, 1998). Lastly, parents accept that their child is gay, and the necessity for a heterosexual child wanes (Savin-Williams & Dubé, 1998).

Information for practitioners

In order to work effectively with families, practitioners need the basic model for working with multiculturalism the attitudes, knowledge and skills necessary to work with any minority population (Van Den Ber & Crisp, 2004). In the first place, practitioners will not be as effective with clients who they have a negative attitude towards (Van Den Ber & Crisp, 2004; Mallon, 1997). It is therefore important for practitioners to dismantle their own negative perceptions and stereotypes of minority (Van Den Ber & Crisp, 2004). Secondly, knowledge and familiarity of the population is important so that therapists are able to make informed decisions around their clients (Van Den Ber & Crisp, 2004). Knowledge includes elements as simple as language choice to risk factors for a population (Van Den Ber & Crisp, 2004). Lastly, being skilled in

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working with a population means that a practitioner is able to transfer his or her knowledge into a culturally-informed practice (Van Den Ber & Crisp, 2004).

Attitudes

In order to work with queer individuals, it is vital that practitioners are able to be supportive and validating of their orientation and experience (Kriess & Patterson, 1997). The relationship between the client and therapist is the foundation for progress, and a therapist's attitude towards the LGBTQ community can make or break that relationship (Duarté-Vélez, Bernal, & Bonilla, 2010). Because of the stigma of being LGBTQ, queer youth and their families are hesitant to seek service which makes providing a LGBTQ friendly-environment necessary (Fontaine & Hammond, 1996; Van Den Ber & Crisp, 2004). Respect and acceptance for the client's sexual orientation is therefore vital especially for youth, since many youth are not experiencing respect and acceptance from adult figures in their life (Tharinger & Wells, 2000). This could also be modeling behaviors for the parents, who may be struggling (Sanders and Kroll, 2000; Coenen, 1998).

Knowledge

Knowledge includes everything from language to resources (Tharinger, & Wells, 2000). First of all, in order to provide an informed practice, practitioners should be familiar with terms and concepts surrounding the LGBTQ community in order to be able to differentiate between stereotypes and actual experiences of individuals in the LGBTQ community (Sanders & Kroll, 2000). Practitioners can then also identify risks and resiliency factors related to identifying as LGBTQ, as well as LGBTQ-friendly resources that can be more helpful to LGBTQ clients (Van Den Berg & Crisp, 2004; Kriess & Patterson, 1997). Relatedly, practitioners should avoid making assumptions about a client's sexual orientation (Sanders & Kroll, 2000). The current

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heterosexual climate that assumes that an individual is heterosexual until proven otherwise can be dangerous for practitioners; for example, Sanders and & Kroll describe the case of a female client whose well-intentioned therapist asked if the client had a boyfriend (2000). The client identified as lesbian, and was so offended by the therapist's assumption that she did not return until she had attempted suicide (Sanders & Kroll, 2000). Lastly, the physical environment is also important; when the offices of treatment providers have LGBTQ materials visible or signs that designate the space as "safe" for LGBTQ individuals, LGBTQ clients feel that they are able to be honest about their experience, and will therefore receive relevant, respectful and safe care (Kriess & Patterson, 1997).

Skills

Lastly, certain skills are available to family practitioners to use with families with queer youth. Certainly, many models and theories could be fitted to queer youth and their families, but research shows a few that have been specifically helpful to queer youth and their families such as Narrative Therapy, Cognitive Behavioral Therapy (CBT) and Problem-Solving Communications Therapy (PSCT) (Saltzburg, 2007; Pachankis, 2009; Duarte-Vélez, Bernal & Bonilla, 2010; Coenen, 1998).

Narrative Therapy Narrative therapy takes a constructivist approach to a client's experience, which is called a client's story in the model (Saltzburg, 2007; Fontaine & Hammond, 1996). Meaning, client's story is her or her own truth, and the therapist is not there to correct it (Saltzburg, 2007; Fontaine & Hammond, 1996). Therefore, the therapist's role is to accept the client's story as his or her own experience, but not assume this story is the whole story (Saltzburg, 2007). For example, if a heterosexual family comes to therapy feeling that homosexuality is wrong, the therapist takes a constructivist approach and does not "correct"

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them right away (Saltzburg, 2007). The therapist explore with the family where their views originate from and process how homophobia has become a part of their language. By doing this, the therapist “externalizes” the conversation by separating the individuals from their conversation and their beliefs (Saltzburg, 2007). Eventually, the family finds that homophobia was a part of the parent’s upbringing, and does not need to be part of the family—the homophobia is externalized from the family (Saltzburg, 2007). Another part of narrative therapy is re-framing; when a therapist reframes a story, he or she is working with the family to view a certain element in a different light (Saltzburg, 2007). For example, some families go through a process of grief and loss when a child comes out and they mourn the loss of anticipated grandchild and a heterosexual lifestyle (Savin-Williams & Dubé, 1998). A therapist could reframe this experience through exploring whether these were reasonable expectations for the child regardless of sexual orientation, or the fact that sexual orientation does not prohibit an individual from experiencing “traditional” life experiences such as enjoying a long term relationship or having grandchild. Narrative therapy is helpful for families with queer youth as it values the story and the truth of each member, and externalizes the “problem” away from the individual (Saltzburg, 2007).

Cognitive Behavior Therapy While research is scarce on Cognitive Behavioral Therapy (CBT) work with families, CBT does offer some techniques to youth who are coming out. For example, CBT assertiveness training helps an individual determine his or her rights and the rights of others to uncover what are realistic expectations of what an individual is and isn’t (Pachankis, 2009). Furthermore, CBT is able to help an individual accept those parts of him or herself that he or she was denying before he or she determined he or she had the right to those parts (Duarté-Vélez, Bernal & Bonilla, 2010). Pachankis analyzes a case study in which a

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young gay male felt he needed to be more masculine than his true self was, and assertiveness training helped him find his true self (2009). In this example, the youth discovered that he had the right to be himself, and others did not have the right to project an image on to him (Panchankis, 2009). By asserting what he would like to be, the client was able to see the unnecessary guilt and shame he was placing upon himself and the psychological toll it was placing on him (Panchankis, 2009). In this way, CBT is able to help an individual find and accept his true self and what is realistic to expect of himself, and how unrealistic expectations have negative psychological outcome (Panchankis, 2009; Duarté-Vélez, Bernal & Bonilla, 2010).

Problem Solving Communications Therapy Problem Solving Communications Therapy (PSCT) is used, in general, to improve family communication skills, create dependable problem solving tools and redirect flawed thought processes (Coenen, 1998). Meaning that PSCT deals with the individual's thought base that creates and sends messages, how that individual sends messages and how family members receive it, and create alternate avenues to solve problems (Coenen, 1998). When applied to a family with a homophobic lens towards a LGBTQ youth coming out, PSCT therapeutic goals (which are similar to narrative are to help the family redefine their values and beliefs in relationship to LGBTQ individuals (Coenen, 1998). The first step in PSCT, like other theories, is to build rapport with the family system, and it is useful to divide the system to give all of the members (especially parents) room to voice their distress (Coenen, 1998). Then the therapist turns towards skill building, which includes the basic five-step problem solving: identifying the problem, creating solutions, choosing and then implementation of the solution, and lastly, renegotiating the solution if necessary (Coenen, 1998). Skills also include communication training, where the therapist blocks and names

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communication that is inappropriate (Coenen, 1998). The therapist then models the communication, has the family enact it, and helps the family process their reaction (Coenen, 1998). Lastly is thought reconstruction, where the therapist points out inappropriate thoughts and models appropriate ones (Coenen, 1998). The therapist then creates situations for the families to enact positive exchanges (Coenen, 1998). PSCT then is another way to reform homophobic family thoughts and values; while PSCT has been shown to be more effective than other forms of therapy, Coenen advises that it should be used as a foundation rather than a strict model (1998).

Conclusion

To do the best work with queer youth and their families, practitioners need to examine their attitude towards the LGBTQ community, be knowledgeable of the experience of queer youth and their families and lastly, have the skills to successfully intervene with queer youth and their families (Tharinger, & Wells, 2000). Additionally, it is wise to recognize that each family's experience is different, and all react differently to a child coming out, therefore skills need to be adjusted according the family's experience (Tanner & Lyness, 2003). For example, not all parents will need to experience the grief and loss process as some will be accepting of their child's identity (Saltzburg, 2009). Therefore, just as with youth, it is unwise to make assumptions about a family's experience (Sanders and Kroll, 2007). Lastly, homophobia in families will continue unless individuals continue fight for societal acceptance for LGBTQ communities. Hopefully in the future there will be no need for family therapy with queer youth.

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