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, i.e., 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 Network...
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. 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 1-year-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.

The 24 youth—aged 8 to 12 years, with diverse gender identities and sexual orientations—experienced significant improvement in 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]; \( t = 7.65; P < .001 \)).

**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.

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.

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; 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).

**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, these effects were measured for trauma-impacted 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.

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

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSESSMENT</td>
<td>Integrate FAP assessment questions and measures into intake process, individually for parent and child/youth.</td>
</tr>
<tr>
<td>PSYCHOEDUCATION</td>
<td>Psychoeducation should be ongoing to reframe parent’s perceptions of child/youth’s identity and to support positive behavioral change and affirmative parenting.</td>
</tr>
<tr>
<td>COUNSELING AND SKILL BUILDING</td>
<td>Counseling is provided individually and for the parent and child together.</td>
</tr>
<tr>
<td>PROVIDE ACCESS TO CULTURALLY RELEVANT PEER SUPPORT</td>
<td>Decrease isolation, increase peer support and reframe perceptions of child’s LGBTQ identity and life course.</td>
</tr>
</tbody>
</table>

**Figure 1. Healthy Poster Series**

A 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.
Family Behaviors that Increase Your LGBTQ Child’s Risk for Serious Health & Mental Health Problems

These specific family rejecting behaviors are screened for 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. 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. 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. FAP’s family support model: practice guidance.

