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Recognizing, Treating, and Preventing Trauma in LGBTQ Youth

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Traumatic experiences in childhood and adolescence have been shown to have adverse impacts on later mental health and physical health outcomes across the lifespan (Felitti et al., 1998). Research suggests that lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) youth are at greater risk than their same-age counterparts of experiencing a wide variety of traumas. In fact, some traumas may be specific to LGBTQ youth who are at risk for discrimination, harassment, and abuse because of their sexual orientation and/or gender identity. This article will provide an overview of trauma in general as well as types of experiences of traumas that may be particular to LGBTQ youth in hopes that the professional community can be more aware of and appropriately assess for such experiences as part of a larger prevention and intervention effort to help these vulnerable youth.

A Brief Review of Trauma and Its Impact on Youth

According to the National Child Traumatic Stress Network (2005), a traumatic event is one in which "we experience an immediate threat to ourselves or to others, often followed by serious injury or harm. We feel terror, helplessness, or horror because of the extreme seriousness of what is happening and the failure of any way to protect against or reverse the harmful outcome" (p.4.). Examples of potentially traumatic events include acute incidents such as a car accident, a natural disaster, a death in the family, or an act of terrorism. Traumas may also be more chronic, lasting over multiple incidents or longer periods of time, including experiences such as exposure to ongoing domestic violence, child abuse and neglect, or community violence. Some research has indicated that approximately 68% of children may be exposed to at least one potentially traumatic event by the age of 16 (Copeland, Keeler, Angold, & Costello, 2007). This includes physical violence (3.1%), physical abuse by a relative (7.2%), and sexual trauma (11%), among a variety of other possibly traumatic events. About 30% of youth have experienced just one traumatic event whereas 37% have experienced two or more potentially traumatic events. Other research has found similar rates of physical assault (17.4%) and sexual assault (8.1%) among teens ages 12 to 17 (Kilpatrick, Saunders, & Smith, 2003).

Years of research have demonstrated that trauma can have wide-ranging impacts with regard to children's physical and mental health. The National Child Traumatic Stress Network (n.d.; 2005) reports that in the aftermath of traumatic events, many children experience fear and worry about their own safety or that of family and friends as well as anxiety related to the possibility of experiencing another traumatic event in the future. Many children also exhibit increased activity level, irritability, anger, and

aggression. Youth may have problems with sustaining their concentration and attention, have changes in sleep or appetite, or become more withdrawn. A large number of children describe somatic complaints such as aches and pains without an identifiable medical cause. Many caregivers note that their children begin to experience declines in grades or have increased problems with peers in school or in the neighborhood. And some children and teens may begin to engage in high-risk behaviors such as substance abuse or unhealthy sexual behaviors (National Child Traumatic Stress Network, n.d.; 2005). Although there are many known impacts of trauma on youth, estimates of Posttraumatic Stress Disorder (PTSD) among youth who have experienced traumatic events are highly variable, ranging from virtually none (0.4%; Copeland et al., 2007) to about 1 in 12 (8.1%; Kilpatrick et al., 2003).

In addition to the types of emotional symptoms and behavioral problems that often bring children and teens to the attention of mental health professionals and school personnel, there are significant negative impacts of trauma and chronic stress on brain development and functioning (De Bellis et al., 1999; National Scientific Council on the Developing Child, 2005/2014). Exposure to traumatic events has been linked to negative impacts on neurological structures and functioning including areas of the brain related to emotional regulation, learning and memory, and executive functioning. Additionally, the amygdala, which integrates sensory information with memories, has been found to be negatively impacted by trauma which is hypothesized to be related to symptoms of PTSD, such as intrusive traumatic memories and fears associated with trauma reminders (Cohen, Perel, DeBellis, Friedman, & Putnam, 2002).

Research has also consistently demonstrated that complex trauma has negative impacts on the attachments of children to caregivers (National Child Traumatic Stress Network, n.d.; Putnam, 2006). For example, inconsistent care or neglect has been linked to increased anxiety in youth when separated from their caregiver and/or the inability to be soothed when they resume contact. Further, the loss of or harm to a caregiver can lead to anxiety about safety in future relationships, causing children to worry about forming trusting relationships with other adults to whom harm may come. Experiences of abuse may make children wary of future relationships for fear that others will harm them again. This is especially prominent in the context of abuse and neglect by a close relative or primary caregiver. When people that a child should be able to rely upon to protect and care for them instead harm them, children may have difficulty trusting others in the future who also claim that they are there to protect or care for children (National Child Traumatic Stress Network, n.d.).

Traumatic Experiences Common to LGBTQ Youth

The first part of this discussion reviewed general findings for children who have experiences of trauma. However, the literature suggests that LGBTQ youth are at greater risk than their same-age counterparts of experiencing a wide variety of traumas. These disproportionate experiences are in turn related to higher rates of PTSD symptoms as well as other negative mental and behavioral health outcomes. Further, some particular types of traumas may be specific to LGBTQ youth, who are at risk for discrimination, harassment, and abuse *because of* their sexual orientation and/or gender identity.

Childhood Victimization

Multiple studies have found that emotional, physical, and sexual abuse, as well as rates of PTSD possibly related to these experiences, are more prevalent in LGBTQ youth than in heterosexual and cisgender[1] youth samples (Bontempo & D'Augelli, 2002; Friedman et al., 2011; Roberts, Rosario, Corliss, Koenen, & Austin, 2012b). There are also numerous studies that demonstrate that LGBTQ adults report having experienced much higher rates of victimization (up to 2 times higher for sexual and physical abuse and about 1.5 times higher for emotional abuse) during their childhood than have their heterosexual/ cisgender counterparts (Austin et al., 2008; Corliss, Cochran, & Mays, 2002; Roberts, Austin, Corliss, Vandermorris, & Koenen 2010; Schneeberger, Dietl, Muenzenmaier, Huber, & Lang, 2014; Zou & Andersen, 2015). LGBTQ adults also have higher rates of PTSD (from 1.6 to 3.9 times greater risk), often related to childhood experiences, as well as depression, suicidality, and substance abuse as compared to heterosexual and cisgender counterparts (Roberts et al., 2012b; Schneeberger et al., 2014).

Some findings indicate that gender nonconformity[2] in children accounts for at least a portion of the disparities in abuse. For example, Roberts and colleagues (2012a; 2012b) asserted that gender nonconformity prior to age 11 partly accounted for greater rates of child abuse prior to age 11 as well as later rates of PTSD. This research suggests that children and teens who do not look or act like society may expect them to, based on the sex they were assigned at birth, tend to

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[1] Cisgender is the term to describe when an individual's experience of their gender matches the sex they were assigned at birth.

[2] Gender nonconformity refers to when a person's gender expression in clothing, mannerisms, interests, etc., does not conform to what is expected based on their sex assigned at birth.

experience more verbal, sexual, and physical abuse than their peers. Importantly, gender nonconformity has also been found to be associated with significantly more symptoms of PTSD and depression as compared to other LGBTQ youth (Roberts, Rosario, Corliss, Koenen, & Austin, 2012a; Roberts et al., 2012b). This elevated risk of PTSD was only partially explained by exposure to childhood abuse for youth with gender nonconformity, suggesting that these youth may have a complex set of factors that put them at risk both for experiences of abuse and for developing a diagnosis such as PTSD.

Research also indicates that some youth actually experience victimization *because* of their sexual orientation or others' perceptions of their orientation (D'Augelli, Grossman, & Starks, 2006; Dragowski, Halkitis, Grossman, & D'Augelli, 2011; Kosciw, Greytak, Giga, Villenas, Danischewski, 2016). As opposed to the previous findings reported that are simply overall rates of childhood traumatic experiences without specificity of possible cause, these data suggest that these youth are actually targeted by peers or adults because of their sexual orientation or gender identity. For example, Dragowski et al., (2011) found that a significant majority (about three-quarters) of LGBTQ youth have experienced verbal victimization related to others' perceptions of their sexual orientation. Of those who reported verbal victimization based on their sexual orientation, approximately 30% were threatened with physical violence and 29% threatened with disclosure of their sexual orientation (Dragowski et al., 2011). Many LGB youth also report experiences of actual physical victimization because of their orientation, but rates vary widely across studies (ranging from 11-30%). According to Kosciw and colleagues (2016), 27% of LGBTQ students reported that they were physically harassed (pushed or shoved) in the past year because of their sexual orientation, and about 13% were physically assaulted (punched, kicked, or injured with a weapon) due to their orientation. About 9% of LGBTQ youth have reportedly experienced sexual victimization, including rape and sexual molestation, based on their orientation.

Victimization at School

For many years the Gay, Lesbian, Straight Education Network (GLSEN) has collected and reported on large national surveys of LGBTQ high school students from across America (Kosciw et al., 2016). GLSEN's findings indicate that a large majority (recently, 98.1%) of LGBTQ students have frequently heard "gay" used in a negative way, other homophobic remarks (e.g., "dyke" or "faggot," 95.8%), and negative remarks about gender expression (not acting "masculine enough" or "feminine enough,"

95.7%) from their peers during the school day. Additionally, about 40% had frequently heard negative remarks specifically about transgender people, like "tranny" or "he/she." In two large national surveys of adults who identify as transgender, more than three-quarters reported some form of harassment or mistreatment while in grades K-12 (Grant et al., 2011; James et al., 2016). Most report having been verbally harassed (e.g., called names or threatened, 54%), and many were also physically harassed or assaulted (24%) and/or sexually assaulted (about 11-13%) for being identified by others as transgender.

Although it is a relatively common occurrence for LGBTQ youth to be victimized by peers at school, unfortunately over half of students surveyed by GLSEN also reported hearing homophobic remarks and negative remarks about gender expression from their teachers or other school staff (Kosciw et al., 2016). More than half of the LGBT students who said that they were harassed or assaulted in school did not report the incident to school officials as they did not believe that effective intervention would occur or feared that things would get worse. As if to confirm this fear, more than 60% of the students who did report an incident said that school staff did nothing in response or told the students to simply ignore it.

There are important implications for LGBTQ youths' experiences of victimization at school given that these experiences are linked to a wide array of negative outcomes. For example, youth who identified with lesbian, gay, bisexual, or questioning sexual orientation and who had experiences of being threatened or injured with a weapon at school or had property deliberately damaged or stolen were found to be at much greater risk than their heterosexual peers for substance use, suicidality, and sexual-risk behaviors (Bontempo & D'Augelli, 2002). Further, youth with higher levels of victimization at school were found to have lower grade point averages, have more disciplinary incidents, miss more days of school, avoid school events, and decide not to pursue post-secondary education than do their peers who experienced less harassment (Kosciw et al., 2016). Many transgender individuals who experienced harassment during grades K-12 reported that their mistreatment was so severe that it led them to leave school altogether (15-17%; Grant et al., 2011; James et al., 2016).

Protective Factors for LGBTQ Youth

Research has demonstrated that there are many personal characteristics that contribute to resilience in the face of adversity (e.g., Agaibi & Wilson, 2005; Bonanno & Mancini, 2008; Brown, Henggeler, Brondino, & Pickrel, 1999). Some of these traits include intelligence, autonomy, special talents or skills, and a strong sense of self-esteem. Furthermore, people who

possess good interpersonal, problem-solving, communication, and adaptive coping skills appear able to cope more effectively with traumatic life events.

In addition to factors that appear to promote resiliency for most youth, it appears that for LGBTQ youth, family acceptance of their sexual orientation and/or gender identity may have a protective effect against many threats to well-being, including health risks such as high-risk sexual behaviors (e.g. unprotected sex), drug use, and suicide (James et al., 2016; Padilla, Crisp, & Rew, 2010; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Additionally, school safety as well as caring by adults in the youth's community or church have been shown to be significant protective factors against suicide ideation and behaviors for sexual minority youth (Eisenberg & Resnick, 2006). Further, the access to and ability to locate accepting and knowledgeable treatment providers appears to be important although most of the research has focused on health risk factors as opposed to protective factors (see Colpitts & Gahagan, 2016 for review).

Treatment for LGBTQ Youth Who Have Experienced Trauma

Given the key role that an LGBTQ-affirming provider may play as a protective factor for youth exposed to trauma, it is important to recognize the difficulty of finding such a provider. LGBTQ youth may face discrimination when they request services and disclose their identity or orientation. The youth or their caregivers may be given inaccurate information about resources or legal matters, especially for those who are transgender and may be seeking support for or information about medical interventions. These youth may be automatically referred to an LGBTQ-focused service provider because someone feels uncomfortable with or incompetent at providing services for this population. However, clients may also experience difficulties when they go to an LGBTQ-focused agency with problems related to trauma. Some LGBTQ agencies may feel narrowly limited to sexual orientation and gender identity issues and may be unwilling or unable to address issues they perceive to fall outside of those limits. Although LGBTQ-focused providers may want to provide services, they may give incorrect information or guidance due to misdiagnosis because of a lack of familiarity with how trauma impacts youth and their families.

There are also specific difficulties for transgender and gender-diverse youth who seek services. Minter and Daley (2003) found that one in five transgender people reported experiencing discrimination at a social service agency by an agency's staff and/or clients. Basic examples included the failure to use a client's correct name and/or the appropriate pronouns, denial of services, harassment and disrespect, invasive and

inappropriate inquiries, and denial of access to appropriate restrooms. Further, many traumatized youth end up in hospitals, residential treatment facilities, and juvenile justice settings, often because of their difficulties with emotional and behavioral regulation due to their traumas (Complex Trauma Treatment Network of the National Child Traumatic Stress Network, 2016a and 2016b; Evans-Chase, 2014; Rice & Tan, 2017). Transgender youth in sex-segregated residential facilities are often housed in an inappropriate facility and subjected to grooming policies based on their sex assigned at birth rather than their gender (Minter & Daley, 2003; Woronoff, Estrada, & Sommer, 2006). Finally, there are often failures to protect transgender clients from other residents or staff who may attempt to abuse, harass, or harm them due to their gender identity and expression (Fostering Transitions, 2012; Woronoff et al., 2006).

Given the importance for LGBTQ youth to find knowledgeable and accepting providers for their physical and mental health care, many professional associations have developed guidelines for such care. For the purposes of this review, we will highlight those developed by the American Psychological Association for practice with lesbian, gay, and bisexual clients as well as transgender and gender-nonconforming clients (American Psychological Association, 2012; American Psychological Association, 2015). These guidelines provide a broad, aspirational framework for treatment by and professional conduct of psychologists in their work with clients who identify as LGBTQ. Examples of these include striving to understand the effects of stigma on LGBTQ people; recognizing that a lesbian, gay, or bisexual orientation is normal and not representative of a mental illness; recognizing personal attitudes about working with LGBTQ clients; and evaluating professional knowledge of working with LGBTQ clients. The guidelines also highlight the important distinctions between sexual orientation and gender identity.

Both sets of guidelines reflect attention to the family environments specific to LGBTQ individuals. For example, attending to the needs of sexual minority parents and the construction of a "family" with non-biologically related people are important issues. Further, the guides recognize the important developmental needs of "gender-questioning" and transgender youth and recognize that one's orientation and/or gender identity may impact relationships within clients' families of origin. Both sets of guidelines indicate that psychologists should seek to increase their knowledge and understanding about LGBTQ individuals through professional education, continuing education and training, supervision, and consultation.

For LGBTQ youth who have experienced trauma, it is likely that professionals need additional training and education in the Substance Abuse and Mental Health Services Administration's principles of trauma-informed care (Substance Abuse and Mental Health Services Administration, 2012) and the National Child Traumatic Stress Network's (NCTSN) concepts for understanding traumatic stress responses in children (NCTSN, Core Curriculum on Childhood Trauma Task Force, 2012). The NCTSN has a wealth of information on its website (www.nctsn.org) for audiences including professionals, educators, and caregivers about many types of trauma, trauma's impacts on youth, and treatments that have been shown to be effective for treating trauma in children and adolescents. Further, the NCTSN has in recent years dedicated efforts and resources to providing education and information about the disproportional experiences of trauma by LGBTQ youth.

The NCTSN recommends that providers closely examine their own beliefs and experiences in working with LGBTQ youth and strive to create an inclusive environment through intentional visual cues, policies, and paperwork to demonstrate that LGBTQ youth are welcome at their practice setting (NCTSN, Child Sexual Abuse Collaborative Group, 2014). It is also noted that providers should consider the complex interplay of traumatic experiences with sexual orientation and/or gender identity development. Providers should consider the stage at which the youth was in the process of identity formation at the time of the traumatic incident. Providers should also be mindful that youth may experience additional stigma and persecution due to their trauma as well as their sexual orientation or gender expression. If a youth has experienced sexual abuse, there are often further myths and stereotypes that create complexity in treatment as children and their caregivers may have questions or concerns about how experiences of abuse may be related to orientation and identity. The NCTSN recommends that providers should be prepared to provide appropriate psychoeducation and facts to families to help them recognize that sexual abuse is not causally related to sexual orientation and that LGBTQ people are not more likely to sexually abuse others. Providers should be familiar with any other local resources that can offer support for LGBTQ youth and their families, such as affirming medical providers, attorneys, educators, faith-based organizations, and so on.

Case Illustration

In an effort to illustrate the complex interplay between traumatic experiences and sexual orientation/gender identity, a case illustration will be provided. This youth has shared this information in an attempt to help

educate providers in the community who may work with other LGBTQ youth so that others may be spared from similar experiences. All information has been de-identified and is used with her express permission.

"Tay" is a 17-year-old African American transgender female who had a history of early trauma, including sexual abuse by a family member at the age of 4 as well as the witnessing of the murder of her aunt by another family member that same year. She experienced multiple other instances of sexual abuse throughout her childhood by various men. She did not receive any treatment for these early experiences of abuse, and no reports were made to child protective services at the time.

When Tay was 9-years-old, she was found by her school to be eligible for Special Education services with labels of Emotional Disturbance and later Learning Disabilities. It was determined that she needed modifications or accommodations across all academic subjects. When asked about her label of having an Emotional Disturbance, Tay said, "I couldn't figure out how to do the work, so I'd just stop doing it. Then they'd force me to do it, so I'd go off." She also began to experience harassment and bullying around this same age, which continued throughout elementary school and was largely based on peers' perceptions about her sexual orientation (i.e., they assumed she was gay based on her more stereotypically feminine mannerisms). Tay's educational records document over 20 disciplinary incidents related to disruptive and aggressive behaviors between the ages of 10 and 14. According to Tay, nearly all of these were related to her peers' assumptions about her sexual orientation based on her gender non-conforming presentation. Despite these behavioral difficulties, Tay was promoted with satisfactory educational progress each year until she reached high school, when she failed all but two classes and had increased experiences with bullying. School records indicate that Tay experienced 25 different educational placements between ages 9 and 16, including Alternative Education Placements (AEPs) through the public school system as well as the charter schooling that was part of her later incarceration in juvenile detention facilities and inpatient stays at a state hospital.

At the age of 9, Tay was removed from her mother's care by Children's Protective Services due to allegations of improper supervision because of her repeated school disciplinary problems. In her first foster home placement, Tay was sexually assaulted by a man who was a friend to the foster parent and visiting the home. Tay did not report the assault at the time and subsequently began to have increasingly negative behaviors (e.g. aggression, defiance) at her foster placement and was eventually hospitalized in the children's unit of a state hospital. Tay recalls that she

was diagnosed during childhood with Schizoaffective Disorder, Bipolar Disorder, Attention-Deficit/Hyperactivity Disorder, and Oppositional Defiant Disorder. Her records do not reflect any diagnosis that is related to her multiple experiences of abuse.

When Tay was 12-years-old, she was arrested for assault against a classmate (who had been verbally harassing her) and resisting arrest; she received 9 months of probation. Six months after that, she was arrested for another assault against a different student after she was physically harassed at school. Her terms of probation were continued. However, several months later, Tay was again arrested for another assault resulting from a fight with a peer, but then she also had an additional charge of assault against a police officer (for becoming belligerent while being detained). Her probation was extended to 12 months. The following year, Tay had an altercation with her mother and was placed into the custody of the Chief Juvenile Probation Officer of her county to complete two years of probation. About 2 months later, she assaulted an officer at the Juvenile Correctional Treatment Center and was subsequently sentenced to complete her probation at the state's Juvenile Justice Department (JJD) facility.

Tay was incarcerated in the male unit at the JJD facility. While there, Tay faced multiple forms of harassment, abuse, and neglect, including sexual abuse by staff and physical assaults by peers. Tay reported that the JJD staff ignored and even encouraged her peers' abuse of her. Furthermore, Tay experienced frequent verbal abuse and harassment related to her gender identity and expression from both peers and staff. Tay recounted that one of the most hurtful incidents was when her caseworker stated, "I'm so proud of you for looking more masculine instead of looking like a girl."

While incarcerated, Tay struggled academically. She failed all but one of her classes and is described in JJD documents as being oppositional and unmotivated in the classroom. From Tay's perspective, she received none of the modifications and accommodations that were outlined on her Individualized Education Plan. She said that if she asked for help, she would be shown something once and then told to do the rest of the work on her own. Moreover, Tay feared being assaulted by her peers within the classroom due to her history of assaults while in public school as well as her experiences within the JJD facility. She stated that she "had to look over [her] shoulder and be on edge at all times" for fear of additional victimization. Thus, even if she was interested and able to complete the work, she experienced such anxiety and fear for her safety that she was

compelled to constantly monitor her environment; this resulted in additional classroom problems.

Over the course of her childhood and adolescence, Tay received very minimal mental health services. Her biological family did not have many resources and did not know about her abuse for many years. When she was incarcerated, Tay did receive some services including alcohol and drug treatment and treatment for her "aggression." Summaries of her treatment progress indicated that she did not participate much in her group therapy and had "not been successful in significantly reducing [her] risk factors or increasing [her] protective factors." Tay was described as having antisocial behaviors, and one of her treatment plans suggested that she needed to "develop self-control over [her] sexually aggressive impulses" in addition to reducing her aggression and improving frustration tolerance and conflict resolution. Tay's treatment records refer to her with only male pronouns and do not address the victimization she experienced related to her gender identity and expression or even her early childhood abuse.

Discussion

Tay's case exemplifies many of the challenges that LGBTQ youth who have been traumatized experience every day. For example, they often have early childhood experiences of abuse or neglect that put them at risk for a variety of emotional and behavioral problems; this may lead to problems at school or home or in relationships with peers. Tay's case is consistent with findings from the 2015 U.S. Transgender Survey (James et al., 2016), which found that most transgender people experienced significant forms of abuse and harassment during primary educational years. In addition to experiencing traumas at school, many were also disciplined for fighting back against bullies (36%) or believed that they were disciplined more harshly because school personnel thought that they were transgender (20%).

When LGBTQ youth drop out of school due to harassment or are placed into alternative education placements, they then begin to have contact with additional systems in which they may be further victimized. As occurred in Tay's case, when LGBTQ youth encounter law enforcement, they are often housed according to their gender identity and/or are placed into situations in which they may be further abused by peers or adults. LGBTQ youth often develop symptoms of PTSD or depression and may become suicidal or engage in high-risk behaviors such as substance abuse and unprotected sex. Medical and mental health professionals who come into contact with LGBTQ youth and who have little knowledge of working with such youth and/or trauma may inadvertently further marginalize these youth by using incorrect pronouns and names, not asking questions about

non-heterosexual orientations, and not inquiring about or addressing traumatic experiences. This type of bias is evident throughout Tay's JJD records in which she is referred to using incorrect pronouns and in which she is described as the aggressor when she was clearly being victimized by staff and peers due to their perceptions of her gender or orientation.

As the disproportional experiences of trauma among LGBTQ youth become better known, professionals should seek to prepare themselves for helping to assist these youth. All professionals should consult their professional association's guidelines for the treatment of LGBTQ individuals to at least have a basic understanding of the particular topics and concerns that may be more relevant to these youth than their heterosexual and cisgender peers. Further, professionals without a background knowledge of the impact of trauma on youth should seek out this information through the NCTSN and the Substance Abuse Mental Health Services Administration to understand the myriad ways that exposures to traumatic experiences may impact a variety of areas of daily functioning.

The NCTSN has outlined some guidelines for providing counseling to LGBTQ-identified youth (NCTSN, Child Sexual Abuse Collaborative Group, 2014). The NCTSN suggests that providers across settings should seek to create a welcoming environment for LGBTQ youth by attending to their office environment and practice details. This may include attention to items such as personal pictures, posters, or decorations that may reflect a provider's own relationships or beliefs that could be perceived as unaccepting or exclusionary (e.g., pictures of only heterosexual relationships, religious symbols/figures, etc.). Further, the NCTSN advises that providers should consider adding symbols to represent inclusion and welcoming, such as Safe Zone signs, rainbow flags, and Human Rights Campaign materials. Providers should review their promotional materials and brochures for inclusive language and may wish to explicitly note if they work with LGBTQ youth. Intake forms and paperwork should include options for transgender and gender-diverse youth to identify nonbinary gender expression and for youth to identify as being romantically attracted to or having sexual interactions with more than one gender. Providers should ask clients about the names and pronouns they use. The NCTSN also asserts that mental health providers should explicitly state that they do not provide "reorientation therapy" or "conversion therapy." When working with transgender or gender-diverse clients, providers should think about their bathrooms or other "gendered" areas and consider appropriate accommodations for LGBTQ people. Finally, the NCTSN notes that all providers should take care to avoid assumptions about gender, sexual orientation, and trauma. Young people will need to share their own

experiences in their own way once they feel safe. Providers will need to recognize that it is likely that other adults have discriminated against or directly harmed LGBTQ youth and that they may thus be wary of trusting new people. As with all trauma-focused treatments, establishing a sense of safety will be paramount and is the prerequisite for any additional work to be done.

Adults who come in contact with LGBTQ youth should seek to promote resilience through engaging other systems of support, especially the family if possible. Family acceptance has been demonstrated to play a key role in resilience for LGBTQ youth and therefore may also protect against some of the negative sequalae that are commonly reported in LGBTQ youth who have experienced trauma (e.g., substance abuse, suicidal ideation, and high-risk sexual behaviors; (James et al., 2016; Padilla et al., 2010; Ryan et al., 2009; Ryan et al., 2010). Although there can be considerable negative impacts for youth when they come out and whose families are not supportive, recent studies have found that families may be more likely to remain together and provide support for LGBTQ youth than stereotypes suggest (James et al., 2016; Padilla et al., 2010). In addition to family acceptance, there appear to be other protective factors in the lives of LGBTQ youth, including connections to other caring adults and a sense of school safety that may be related to less suicide ideation and behaviors (Eisenberg & Resnick, 2006). Thus, in the aftermath of traumatic experiences, it may prove useful to engage other community partners and caring adults who may be found within the extended families, neighborhoods, churches, and schools of LGBTQ youth in supportive and affirming ways. By including enhancement of protective factors as an element of treatment, providers may help lessen the chances of youth developing more negative sequalae. Furthermore, a focus on protective factors may increase the likelihood that LGBTQ youth will experience post-traumatic growth, that is, the positive change that people can experience as a result of traumatic events (Calhoun & Tedeschi, 1999). Thus, although this group of young people may be disproportionally impacted by traumatic events, there is hope that affirming and supportive treatment can yield more positive outcomes for them in the future. A shining example of the kind of post-traumatic growth that can occur when youth are given appropriate support and encouragement is Tay: she is now living in the community with her family, attends school, has a job, and shares her story in an effort to help others.

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