

Trust and Acceptance Can Encourage LGBTQ Youth to Disclose Abuse

Feelings of shame and embarrassment are common among youth who have been sexually violated or physically abused. In lesbian, gay, bisexual, transgender and questioning youth, those feelings may be magnified, to a degree that can impede their willingness to disclose the abuse. Al Killen-Harvey, LCSW, and Heidi Stern-Ellis, LCSW, who are both clinical supervisors at the Chadwick Center for Children and Families housed at Rady Children's Hospital and Health Center in San Diego, CA, have extensive experience training first responders and clinicians on issues of gender identification and development, including the common stereotypes around sexual identity. In their view, the dynamics of abuse disclosure require a nuanced response when the clinician is working with LGBTQ youth.

Suicide is the third leading cause of death among 15-to-24 year olds, and LGBTQ youth in general are up to four times more likely to attempt suicide than their heterosexual peers. The degree of risk may be associated with where the individual is in the process of coming out, and the reactions of family and friends. Messages of rejection from family and peers can lead to isolation and potential exploitation. An unwanted or unwelcome physical or sexual encounter can compound the multitude of developmental issues already faced by LGBTQ youth who are still coming to terms with their sexual identity or gender identity.

Communicating Acceptance

LGBTQ youth intuitively screen their environment for cues that they are valued and respected, so clinicians who work with these youth must be sensitive to the messages that they and their agencies impart. "We

know that the kids we work with are very reluctant to disclose and will only do it with someone with whom they feel safe and comfortable," said Killen-Harvey. Clinicians who demonstrate an attitude of acceptance about diversity will help start that conversation from a place of safety.

Killen-Harvey said that language used at the organizational level can also help convey acceptance. This includes language about sexual orientation or gender identity in an agency's nondiscrimination policy and published mission statements. More inclusive language on gender identity and family relationships can also be used in official forms. Because

LGBTQ youth may feel excluded by traditional language used to connote gender identity and family relationships, organizations should consider revising intake and registration forms to be more inclusive—for example, replacing the terms "Mother/Father" with "Parent / Guardian."

The simple display of a symbol such as the rainbow flag also communicates inclusion. At one facility, clinicians wear name badges that include the words "Safe Space."

Stern-Ellis said that during initial interviews, clinicians can phrase their questions to LGBTQ youth in ways that encourage conversation. For example, instead of "Do you have a girlfriend/boyfriend?", the therapist can ask, "Is there someone special in your life?"

Becoming the Safe Harbor

LGBTQ youth are most likely to disclose abuses to an adult they trust, such as a child welfare worker, a caring police officer or school officer, or a mental health clinician. However, Stern-Ellis and Killen-Harvey



cautioned that having a lone ally in an organization can inadvertently put an LGBTQ youth in a riskier position. If the organizational culture has not embraced diversity, that ally could, due to an unplanned transfer or other outside situation, be forced to refer the youth to a co-worker who is not as accepting or understanding.

The two trainers noted that it's imperative that organizational outreach to LGBTQ youth come from the top down, which is why they always insist that management personnel be included in training sessions requested by frontline providers.

Becoming advocates for abused youth does not require clinicians to abandon their own personal belief systems. Research conducted by Caitlin Ryan and colleagues at the Family Acceptance Project at San Francisco State University has established that accepting or non-rejecting reactions can foster health and emotional well-being. "One doesn't have to be accepting of diverse sexual orientation in order to mitigate harm," Killen-Harvey said. "One just has to stop being rejecting, and that's what we ask organizations and agencies to do."

For clinicians who feel that working with this population is beyond their clinical comfort zone, Killen-Harvey said "there is no shame" in admitting that referral of a youth to another clinician may be the most ethical course. Stern-Ellis added that the clinician must first be knowledgeable about the available referral programs and agencies, asking them specific questions such as, "What percentage of LGBTQ youth are represented in your client base?" and "Have staff undergone training in cultural competency and diversity, and specifically sexual orientation and gender diversity?".

Finally, clinicians working with abused LGBTQ youth and their families should not be afraid to address "the elephant in the room." Killen-Harvey said he is still astounded when parents voice the concern: "Will being abused by a person of the same sex make my child gay?" That's just one of the myths about sexual abuse that can be addressed with appropriate psychoeducation. "LGBTQ youth who have been traumatized need to know that we understand them, that we respect them, and that we value them," he said.