Summer 2009

Asset-based approaches for lesbian, gay, bisexual, transgender, questioning, intersex, and two-spirit (LGBTQI2-S) youth and families in systems of care

Peter E. Gamache

Katherine J. Lazear

Research and Training Center for Children's Mental Health

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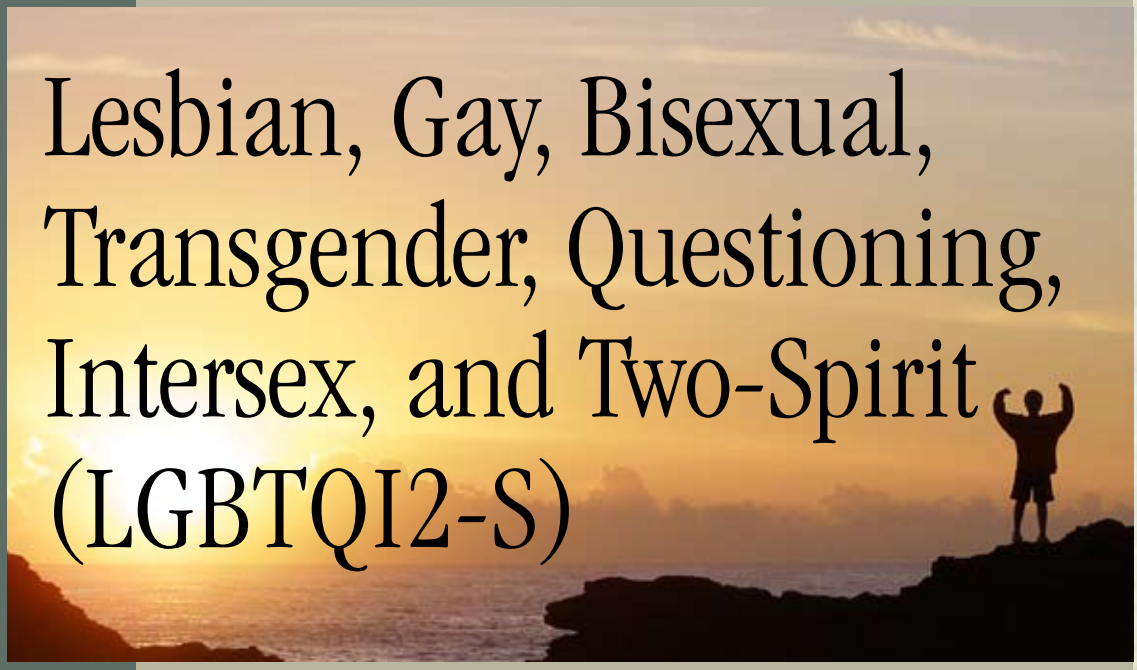

Youth and Families in Systems of Care

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Peter Gamache, MBA, MLA, MPH
& Katherine J. Lazear, MA

The Research & Training Center for Children's Mental Health
Louis de la Parte Florida Mental Health Institute
College of Behavioral & Community Sciences
University of South Florida

USF
UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

This monograph offers a public health approach for communities to meet the needs of families comprising a parent, child, or youth who is lesbian, gay, bisexual, transgender, questioning, intersex, two-spirit (LGBTQI2-S) or transitioning.

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College of Behavioral & Community Sciences, University of South Florida

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For more information

Please contact Kathy Lazear at 202-337-2412
or Peter Gamache at 202-232-6749.

Research & Training Center for Children's Mental Health
Department of Child & Family Studies
College of Behavioral & Community Sciences
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612

USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

Asset-Based Approaches for
Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirit
Youth and Families in Systems of Care

The following definitions illustrate the commonalities and differences between the LGBTQI2-S population:

Lesbian – a woman who is physically, emotionally, and mentally attracted to other women.

Gay – a man or woman who is physically, emotionally, and mentally attracted to the same gender. This term is used either to only identify men or all sexual minority individuals.

Bisexual – a man or woman who is physically, emotionally, and mentally attracted to both genders.

Transgender – a person whose self-identity as male or female differs from their anatomical sex determination at birth.

Questioning – a person, often an adolescent, who questions his or her sexual orientation or gender identity and does not necessarily identify as definitively gay, for example.

Intersex – a person born with an indeterminate sexual anatomy or developmental hormone pattern that is neither male or female. The conditions that cause these variations are sometimes grouped under the terms "intersex" or "DSD" (Differences of Sex Development).

Two-Spirit – a contemporary term used to describe North American Aboriginal People who possess the sacred gifts of the female-male spirit, which exist in harmony with those of female and male. Two-spirit people were respected, contributing members of traditional Aboriginal societies. Today, Aboriginal people who are two-sprit may also identify as LGBT. The term is not universally accepted among Native communities and nations; some also use terms from their own nations.

Transitioning – often defined as the process of ceasing to live in one gender role and starting to live in another, undertaken by transgender and transsexual people. Many people also use the term to refer to the entire transgender/transsexual process (from living 24/7 in the beginning gender role to after sexual reassignment surgery).

(Adapted from Lambda Legal, 2006; Bearse, 2007)

Peter Gamache, MBA, MLA, MPH
& **Katherine J. Lazear**, MA

Research & Training Center
for Children's Mental Health
Department of Child & Family Studies
College of Behavioral & Community Sciences
University of South Florida

Background

Families comprising a parent, child, or youth who is lesbian, gay, bisexual, transgender, questioning, intersex, two-spirit (LGBTQI2-S) or transitioning navigate varying levels of acceptance and support when accessing and utilizing needed services within the mental health system. This population shares the experience of interpersonal discovery set against social signals of exclusion in the form of negative beliefs and attitudes, stigma, stereotypes, and targeted violence such as bullying, harassment, and abuse; intrapersonal uncertainty when acknowledging, disclosing or asserting their sexual orientation and/or gender identity within new or unfamiliar settings; and multidimensional challenges related to the coming out process (D'Augelli, 2002; Doueck & Maccio, 2002; Fisher, Easterly, & Lazear, 2008; Oswald, 2002; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001).

Non-standardized definitions and measures of sexual orientation that alternately classify participants based on self-report and/or same-sex sexual behavior obfuscate estimates of individuals who are LGBTQI2-S, including children and youth (McDaniel, Purcell, & Sell, 1997; Stacey & Biblarz, 2001). Estimates for this population range from one to greater than ten percent of the overall U.S. population (Remafedi, Resnick, Blum, & Harris, 1992). The American Community Survey (ACS) provides an estimate of 8.8 million gay, lesbian, and bisexual persons in the U.S. (Gates, 2006).

Same-sex households, established as a category of interest by the 2000 U.S. Census, are found in all Congressional districts in the U.S. and total 594,391 unmarried-partner residents (i.e., "a close and personal relationship that goes beyond sharing household expenses") (Congressional Budget Office, 2004; Simmons & O'Connell, 2003). While same-sex marriage, civil unions, and spousal rights form a patchwork of state recognition to same-sex spouses, the U.S. Census 2010 will continually survey same-sex partner spouses as "unmarried partners" as in the 2000 census (Lee, 2008).

"Young people become aware of sexual attraction at about age 10 on average, and teenagers are coming out as LGBTQI2-S at younger ages."

According to the American Academy of Pediatrics (Perrin, 2002), as many as six million children are being raised by parents who are LGBT (Stacey & Biblarz, 2001; Stein, Perrin, & Potter, 2004). Patterson and Freil (2000) estimate an upper limit of more than double this figure (14 million) for children with one or two gay or lesbian parents in the U.S.

Studies are showing young people become aware of sexual attraction at about age 10 on average, and teenagers are coming out as LGBTQI2-S at younger ages (Damon, Lerner, & Eisenberg, 2006; Elias, 2007; Kreiss & Patterson, 1997; Setoodeh, 2008). Racial/ethnic youth in Black and Latino communities, however, have been found to disclose their homosexuality to fewer others than their White peers (Rosario, Schrimshaw, & Hunter, 2004), indicating greater degrees of underestimation cited in the research literature. Using comparative estimates of the percentage of LGBTQI2-S individuals in the total population, an estimated number of children who are LGBTQI2-S is 1,065,858 to 5,329,292.

Risk and resilience factors associated with a LGBTQI2-S identity are salient to mental health providers seeking to uphold system of care principles, improve quality of care, and increase effective outreach, engagement, treatment, and support for this population. Effective services and supports to youth and families who are LGBTQI2-S requires that both processes and structures in systems of care be addressed, including frontline practice shifts that focus on the skills, knowledge, and attitudes of service providers, evidence-based practices and promising approaches, treatment efficacy monitoring, and ongoing evaluations for continuous quality improvement (Pires, 2002; Savin-Williams, 2001).

Purpose of this Monograph

This monograph presents a description of the research literature related to youth and families who are LGBTQI2-S to inform future research and practices. Much of the current research literature on this population is unfortunately deficit-oriented, problem-based, and focused on risk factors. While there is incremental growth of LGBTQI2-S research that is asset-based, there remains a paucity of research in this area.

The monograph also discusses a conceptual model of cultural competence to develop programs to serve the LGBTQI2-S population. This model describes a framework for examining the compatibility and adaptability between the characteristics of a community's population and the way an organization's combined policies, structures, and processes work together to impede or facilitate access, availability, and utilization of needed services and supports (Hernandez, Nesman, & Isaacs, 2008).

Lastly, recommendations are suggested for next steps in a research agenda to develop an inclusive and asset-based system of care to meet the needs of youth and families who are LGBTQI2-S and to support the development and enhancement of promising approaches to serve this population.

Deficits and Problem-Based Approaches

Much of the research on LGBTQI2-S individuals to date has been deficit and problem based. Caution has been expressed that an overarching focus on problems associated with being LGBTQI2-S in the research literature and mental health field may pathologize sexual orientation and gender identity as causing negative outcomes (Bakker & Cavender, 2003; Harper & Schneider, 2003; Meyer, 2003; NAMI, 2007).

For example, transgenderism remains a gender identity disorder (i.e., a "cause of distress or disability" for those that experience intense, persistent gender dysphoria) within the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994). In comparison, the American Psychological Association lifted its characterization of homosexuality as a mental disorder in 1975 (Conger, 1975). While a disorder/disability label increases access to services (e.g., counseling) for transgender individuals, attributing negative personal outcomes to the disorder/

"55% of the young men (aged 15-22) did not let other people know they were sexually attracted to men, and were therefore less likely to seek HIV testing."

disability does not explain or resolve negative social conditions. In addition, harm reduction approaches that largely center on risks associated with being LGBTQI2-S (i.e., the person-at-risk model) can ignore how individuals who are not LGBTQI2-S can mistakenly be perceived as such and experience the same types of hate crimes and hate incidents (Herek, 2003; USDOJ, 2004).

The following sections examine the predominant focal points in the research literature concerning LGBTQI2-S inquiry: HIV/AIDS, homelessness, alcohol & substance abuse, and suicide (Hughes & Eliason, 2002). The identification, diagnosis, and expectation of such at-risk and high-risk pathways for the LGBTQI2-S population are well-established. Unfortunately, much less is documented on the factors that promote achievement and resilience in maintaining health and well-being. Emerging research on resilience theory discussed after these sections holds promise for an inverted approach to transform deficits to assets.

HIV/AIDS

HIV infection disproportionally affects the population of men who have sex with men (MSM). According to the Centers for Disease Control and Prevention (CDC) (2008a), MSM comprise more than two thirds (68%) of all men living with HIV in 2005. Fifteen percent of individuals with a new HIV diagnosis in 2006 were between the ages of 13 and 24 (CDC, 2008b). Biological properties (e.g., cellular and genetic functions) among the LGBTQI2-S population do not explain or predict disproportionate risk for HIV infection, since disease transmission, resistance, and immunity are functions of individual health, susceptibility, and social determinants. For example, factors related to variant barrier protection, injection drug use, incorrect assumptions about one's own risk and the serostatus of partners, and non-consensual (i.e., forced) sexual dynamics (e.g., rape in correctional facilities) act in concert to challenge HIV risk reduction efforts (Mayo Clinic, 2009; Ratelle et al., 2005). The CDC (2008c) estimates that 30% of individuals who tested HIV positive during 2000 did not know their serostatus because they did not return to receive their HIV testing results. While the anxiety era of traditional HIV testing is over in some regions of the country and rapid (20 minute) testing has taken its place, serious disconnects remain, continue, and are given rise.

Among the 246,461 women reported as HIV infected through December 2004, the CDC (2008d, p. 1) maintains that "to date, there are no confirmed cases of female-to-female sexual transmission of HIV in the United States database." Nearly three percent (7,381 / 246,461) of the women with HIV were reported to have had sex with women, of which most had other risk factors, such as injection drug use. However, Goldstein (1997, p. 86) criticizes the "myth of lesbian immunity from the AIDS epidemic," fostered by an avoidance of help-seeking and outreach to identify and target this population of women.

Clements-Nolle, Marx, Guzman, and Katz (2001) studied 392 male-to-female and 123 female-to-male transgender persons to assess HIV prevalence, risk behaviors, health care use, and mental health status. The authors discovered higher risk factors among the male-to-female participants, of which 35% had positive HIV test results. These factors included lower level of education (e.g., having less than a high school degree), multiple lifetime sexual partners, and using injection drugs independent of hormone therapy. The authors illustrate that many female-to-male individuals perform sex work following severe employment discrimination, and there is also a high rate of incarceration. Among female-to-male participants, two percent had positive HIV test results.

Young people are at persistent risk for HIV infection, with a higher risk for youth of minority races and ethnicities (Ford & Norris, 1993; Miller, Boyer, & Cotton, 2004). According to the CDC, an estimated 7,761 young people were living with AIDS in 2004, a 42% increase since 2000 when 5,457 young people were living with AIDS. As noted earlier, young men who have

"LGB adolescents (ages 16-19) are more likely than heterosexual adolescents to have been kicked out or to have run away because of conflict over their sexual orientation."

sex with men (MSM) were at high risk for HIV infection. The CDC also found that 55% of the young men (aged 15-22) did not let other people know they were sexually attracted to men, and were therefore less likely to seek HIV testing (CDC, 2008e). Another potential risk factor among young men is the personal fable (i.e., a developmental stage in which youth believe they are invincible to problems that occur to others) (Jack, 1989).

Homelessness

Very few homeless shelters are specifically established for LGBTQI2-S youth, and local services requests based on national research findings can fall flat in the absence of local area data (Roder, 2008). The total number of homeless LGBT youth within the homeless population is estimated between 11% to 35% (Kruks, 1991; Tenner, Trevithick, Wagner, & Burch, 1998; Wormer & McKinney, 2003), although within these estimates are several limitations some researchers say leads to underrepresentation and conservative estimates from undercounted samples. Difficulties posed for data collection include visibility (i.e., locating the "hidden homeless" in places researchers cannot reach), willingness (i.e., disconfirming homeless status or opting out of participation in studies), and timing (i.e., missed windows of short-term, periodic homeless episodes that contribute to uncounted turnover and mobility) (Link, Susser, Stueve, Phelan, Moore & Struening, 1994). The reasons underlying these difficulties can include social desirability effects, stigma, and situational independence (Phelan & Link, 1999; Phelan, Link, Moore, & Stueve, 1997; Rafferty, 1995).

Homeless service access is also dependent on inclusive policies (e.g., identification, legal status, age, and health/mental health status requirements for qualification) and dependent on meeting definitions of homeless. The federal definition of "homeless," "homeless individual" or "homeless person" (Title 42, Chapter 119, Subchapter I, §11302) is:

(a) (1) an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is — (1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (2) an institution that provides a temporary residence for individuals intended to be institutionalized; or (3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Homeless individuals excluded from this definition include "any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a State law" and those that fall outside income eligibility requirements of specific programs (HUD, 2007). Additional excluded individuals include those that "double up" or share housing, reside in motels, live in permanent housing designated for the homeless, reside temporarily in hospitals, institutions, treatment facilities, or correctional facilities, or are at-risk of a homeless event (FDCF, 2007, p. 1).

According to a study by Rew, Whittaker, Taylor-Seehafter, & Smith (2005), leaving home as a result of parental conflict about sexual orientation was more likely for gay and lesbian youth than bisexual youth. When compared with heterosexual and bisexual youth, more gay and lesbian youth left home as a result of sexual abuse. Health disparities by sexual orientation among youth who are homeless are supported by data indicating a higher incidence of HIV diagnosis and treatment coupled with lower immunization rates for hepatitis B among LGB youth when compared with their heterosexual peers.

Multivariate analyses investigating factors that contribute to high-risk street behaviors among LGB youth by Whitbeck, Chen, Hoyt, Tyler, & Johnson (2004) similarly indicate LGB adolescents (ages 16-19) are more likely than heterosexual adolescents to have been kicked out or to have run away because of conflict over their sexual orientation. In addition, gay males were

"One third of suicide first attempts (of LGB youth) occurred within the same year of self-identification as gay or bisexual."

more likely than heterosexual peers to have engaged in survival sex [defined by Greene, Ennett, and Ringwalt (1999, p. 1406) as "selling sex to meet subsistence needs such as shelter, food, drugs, or money."] A matched sample of LGBT homeless adolescents (ages 13-21) found this group was more likely to report victimization, engage in substance abuse, leave home more frequently, have more sexual partners, and have higher rates of psychopathology when compared with heterosexual adolescents (Cochran, Stewart, Ginzler, & Cauce, 2002). One study found that 65% of 400 homeless youth in their sample reported having been in a child welfare placement at some point in their life (Berberet, 2006). Whitbeck et al. (2004, p. 340) suggest a clustering of risk factors and a "cumulative continuity" for homeless and runaway LGB adolescents that makes disengaging from homelessness increasingly difficult.

Alcohol & Substance Abuse

A number of studies find that lesbian and gay individuals experience higher rates of substance abuse than heterosexuals (Gruskin, Hart, Gordon, & Ackerson, 2001; Hughes & Eliason, 2002; Skinner, 1994). Researchers point out several underlying factors, including younger lesbian and bisexual women's participation in the lesbian "bar culture," coping with the stress of homophobia and heterosexism by smoking, drinking heavily, or both, and negative stress responses that include depression and anxiety.

A meta-analysis by Marshall et al. (2008) of 18 studies from 1994 to 2006 revealed that gay youth reported higher rates of cigarette, alcohol and marijuana use, as well as other illicit drugs, including cocaine, methamphetamines and injection drugs (Marshall et al., 2008). Transgender people are also at higher risk of substance abuse than the general population (Reback & Lombardi, 2001). The research points to a lack of sensitivity and respect on the part of health care providers and a lack of help-seeking among transgender persons due to reports of discriminatory treatment by other transgender individuals (Lombardi, 2001; Lombardi & van Servellen, 2000; Nemoto, Operario, Keatley, Nguyen, & Sugano, 2005).

Suicide

McDaniel, Purcell, and D'Augelli (2001) discuss the methodological and substantive limitations of conducting LGB suicide research. These include definitional differences of LGB, as well as suicide attempt (which may or may not correlate with self-harm). Another prominent limitation is that "most researchers have examined risk factors but have ignored factors that promote resilience" (McDaniel, Purcell, & D'Augelli, 2001, p. 86). Reviewed are five studies that utilized heterosexual comparison groups, where all found higher rates of suicide attempts among LGB people. Identified risk factors include stress, lack of social support, and ineffective coping (Safren & Heimberg, 1999), in addition to psychiatric and substance abuse disorders, discrimination and homophobia, and a HIV/AIDS diagnosis (McDaniel, Purcell, & D'Augelli, 2001; Moscicki, 1997).

Studies have found that LGBT youth were more likely than their heterosexual peers to report suicidal ideation, intent, and attempts (Goodenow, 2004; Remafedi, French, Story, Resnick, & Blum, 1998). In an earlier study, Remafedi, Farrow, and Deisher (1991) found that sexual orientation for gay and bisexual youth was tangential to self harm. Of particular note is the finding that one third of first attempts occurred within the same year of self-identification as gay or bisexual.

With minority youth more likely to express feelings of alienation, cultural and societal conflicts, academic anxieties, and feelings of victimization, it is clear that careful attention must be paid to the needs of minority youth and their families within the context of their culture. For sexual minority students, research has shown sexual orientation to be correlated with identified risk factors for suicide and is less a factor after controlling for these risks (Lazear, Doan, & Roggenbaum, 2003).

"Family support and acceptance explains adolescent comfort and resilience in later life."

Assets-Based Approaches

Resiliency Development

Resilience theory, emergent from the health sciences and developmental psychology in particular, supports an assets-based approach by: (1) identifying qualities of individuals and support systems that explain or predict success, (2) describing the process of coping with negative stressors, and (3) creating experiences that move individuals toward reintegration (Masten & Powell, 2003; Richardson, 2002; Zimmerman & Arunkumar, 1994). An evolving fourth wave of inquiry particularly applicable for cultural competence program evaluation is how organizational infrastructure and direct service domains interact to promote compatibility (Macro International CLC Study Team, 2008).

The concept of resilience has been defined as a "risk factor that has been averted or unrealized" (Keyes, 2004, p. 224), a "phenomenon that some individuals have a relatively good outcome despite suffering risk experiences" (Rutter, 2007, p. 205), and a "class of phenomena characterized by patterns of positive adaptation in the context of significant adversity or risk" (Masten & Reed, 2002, p. 75). Resilience research has found that

1. early and continuous attachment positively shapes relationship development in later years among all young children, adolescents, and adults (Rutter & Rutter, 1993),
2. self-efficacy is impingent upon an internal locus of control (Anderson, 1998), and
3. protective factors in one setting can compensate for risks in multiple settings (Bernard, 2004).

Studies of resilience applicable for LGBTQI2-S youth have demonstrated: (1) positive social relationships moderate the relationship between stress and distress (Rosario, Schrimshaw, & Hunter, 2005), (2) affirming faith experiences contribute to less internalized homonegativity, more spirituality, and psychological health (Lease, Horne, & Nofffsinger-Frazier, 2005), and (3) family support and acceptance explains adolescent comfort and resilience in later life (Glicken, 2006).

Consistent with these findings, a longitudinal study comparing Black, Latino, and White LGB youth found that cultural factors do not impede sexual identity formation; however, identity integration involving internal and external acceptance and comfort being known as LGB, in addition to positive engagement in LGB social activities, is delayed by negative cultural factors (Rosario, Schrimshaw, & Hunter, 2004). These cultural factors affect internalized anxiety and avoidance as they relate to LGBTQI2-S individual's experiences with attachment figures. For example, secure attachment during the coming out process functions to enhance coping with antigay prejudice, self-acceptance, and self-esteem (Griffin & Bartholomew, 1994; Mohr & Fassinger, 2003).

The development of resiliency interventions for the LGBTQI2-S population is at a nascent stage as the knowledge base for developmental psychology parallels the coming out process for this population with life stage development. Family dynamics among a network of support (e.g., friends as family, building community) are particularly indicative of promoting resilience (Oswald, 2002; Russell & Richards, 2003). For example, a study of baby boomers (born between 1946 and 1964) conducted by the MetLife Mature Market Institute in 2006 found approximately 40% of LGBT respondents cited being LGBT helped them to develop positive character traits, resilience, and support networks (MetLife Mature Market Institute, Lesbian and Gay Aging Issues Network of the American Society on Aging, & Zogby International, 2006).

With studies showing that young people become aware of sexual attraction, on average, at about age 10, the impact of the family environment cannot be underestimated (Damon, Lerner, & Eisenberg, 2006). Compelling new research on LGB young adults and their families from the San Francisco-based Family Acceptance Project establishes a clear link between family rejecting reactions to sexual orientation and gender expression during adolescence to negative health and mental health outcomes in LGB young adults (Ryan, Huebner, Diaz, & Sanchez, 2009).

"LGBT programs that emphasize dialogue demonstrate effective ways to begin to dissolve fear and produce actions without fear of controversy or confrontation."

The social support literature throughout the last thirty years has identified natural helping networks as support systems (Gottlieb, 1983; Pancoast, 1980). For example, surveys and studies repeatedly show that individuals first go to friends, relatives, neighbors, and lay helpers such as bartenders and beauticians for information and help (Cohen & Wills, 1985; Germain & Patterson, 1988; Gottlieb, 1988). This is especially true of racially and culturally diverse populations (Lazear, Pires, Issacs, Chaulk, & Huang, 2008). A review of randomized trials of community-based family support programs for children with chronic health conditions indicates that social support from other families can reduce anxiety in parents (Ireys, Sills, Kolodner, & Walsh, 1996).

PFLAG (Parents, Families and Friends of Lesbians and Gays) is an example of the power of family and social support, and a successful grassroots organization. PFLAG grew from an organization of parents supporting each other and their GLBT children to an organization of more than 500 chapters nationwide with 200,000 members, supporters, and affiliates representing the largest chapter network in the struggle for GLBT rights. The national organization was launched after receiving 7,000 letters requesting information following a mention of PFLAG in "Dear Abby" (PFLAG, 2008). In addition, a growing number of youth-run organizations also provide peer-to-peer support, information and education.

Numerous challenges best met by a peer-to-peer approach include addressing the tensions regarding age appropriateness for children's education programs regarding same sex relationships, religiosity and intergenerational divisions, and antagonistic environments beset with misinformation about sexuality. These issues necessitate dialogue rather than avoidance and silence. LGBT programs that emphasize dialogue demonstrate effective ways to begin to dissolve fear and produce actions without fear of controversy or confrontation to protect all youth (YES Institute, 2008).

A limitation of utilizing resilience theory to explain, observe, or predict LGBTQI2-S resistance to adversity, however, is its dependency on complex and interdependent relationships among physical, mental, emotional, and social states.

Since resilience is upheld by the dual constructs of nature and nurture, proponents that are polarized may not accept such a dual view. For example, the belief that existing as LGBTQI2-S is a choice rather than a state of personal being that includes physical, mental, and emotional attraction takes a side between nature and nurture rather than a combined perspective. Asking whether identity is fixed or variable provides a point of reflection on identity choice and determination.

Community-Focused Cultural Competency

The concept of community-focused cultural competence provides a framework for an assets-based approach for the LGBTQI2-S population. Cross, Bazron, Dennis and Issacs (1989) propose a definition of cultural competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations. They maintain it is essential that cultural competence efforts of any organization or system must include working in partnership with the community. While the authors' work focuses on delivering culturally relevant services to children and youth of color, the philosophical framework is equally relevant to meeting the needs of youth and families who are LGBTQI2-S. For example, the Family Organization of Burlington County, New Jersey, introduced the idea of a book club because of some uneasiness about issues associated with the LGBT population. They began with a book about the American Indian experience, as a way to engage the staff and community. The success of their first meeting empowered them to take on a book about the LGBT experience (Dunne & Goode, 2004).

A second premise of community-focused cultural competence is found in Pires (2002), which

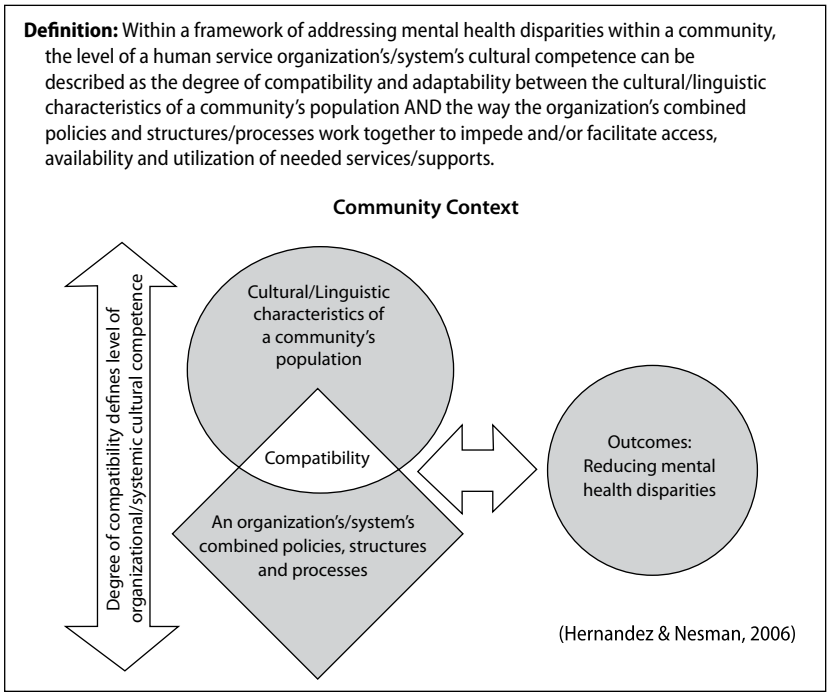
recognizes the importance of developing a population of focus, that is, being clear about the children, youth, and families for whom a system of care exists and serves. Pires (2002, p. 172) states, "system builders must be thoughtful about the characteristics, strengths, and needs of subpopulations within the population [of focus] so that relevant strategies will be pursued and responsive structures built."

Following these premises, a conceptual model developed by Hernandez and Nesman (2006) illustrates the importance of understanding community context in the development of compatibility between mental health organizations and the populations they serve. Since contextual factors can facilitate or limit help-seeking and pathways through which LGBTQI2-S individuals enter into care and develop resilience, assets-based approaches for this population must incorporate specific competencies or social /environmental conditions (Hernandez, Nesman, Mowery, & Gamache, 2006; Hughes & Eliason, 2002; Masten & Reed, 2002).

Figure 1 indicates the compatibility between an organization's/system's structures and processes and the community's characteristics. Outreach to and engagement of the LGBTQI2-S population, for example, would include an awareness of both their struggles and achievements to be effective. Specific practices, such as those that employ messaging (e.g., risk awareness messages, health maintenance messages) would also incorporate an understanding of labeling and self-identification within a regional context.

The expected outcome of organizational cultural competence is reduced mental health disparities for children and their families. The model illustrates that this outcome is the product of joint organizational and community efforts. Diverse community representation thus mirrors organizational capacity.

Figure 1.
Conceptual model for adaptability of mental health services to culturally/linguistically diverse populations.



Organization-Focused Cultural Competency

Figure 2 illustrates a derivative or break-out model of cultural competence that details an organization's/system's combined policies, structures, and processes (Hernandez, Nesman, Mowery, & Gamache, 2006). The infrastructure domain on the left supports staff conducting outreach and engagement, while the direct services domain to the right functions to enable community access, availability, and utilization of mental health services.

Access encompasses the mechanisms that facilitate entering, navigating, and exiting appropriate services and supports as needed. Availability includes having services and supports in sufficient range and capacity to meet population needs. Utilization is the rate of the use of services or their usability by a population.

Compatibility is enhanced through

acceptance, ally development, and the institutionalization of affirmative policies for LGBTQI2-S individuals. These components function to increase access, availability, and utilization. For example, LGBTQI2-S diversity training curricula, used within programs such as SafeZone, center on recognition and awareness of their particular needs, challenges, and experiences of difference. Participants are presented with the choice to become an ally and display a sticker on their office door or other location indicating a safe zone for dialogue with LGBTQI2-S individuals. Since the sticker functions to increase access, recognition and awareness, capacity and availability, LGBTQI2-S individuals are more likely to engage with and utilize services.

Taken together, these domains contribute to cultural competence when they provide LGBTQI2-S youth shared decision-making along heightened levels of a ladder of participation (see Figure 3).

Rethinking Interventions

Prevention, treatment, and care interventions for LGBTQI2-S individuals ideally incorporates awareness of the social determinants of health as well as individual behaviors to reduce disease, illness, injury, and disability across communities (Marmot, 2005; World Health Organization, 2003). Social inequality among the LGBTQI2-S population weakens health systems' ability to engage communities in a common dialogue if race, gender,

Figure 2.
Organizational/system implementation domains for improving cultural competence.

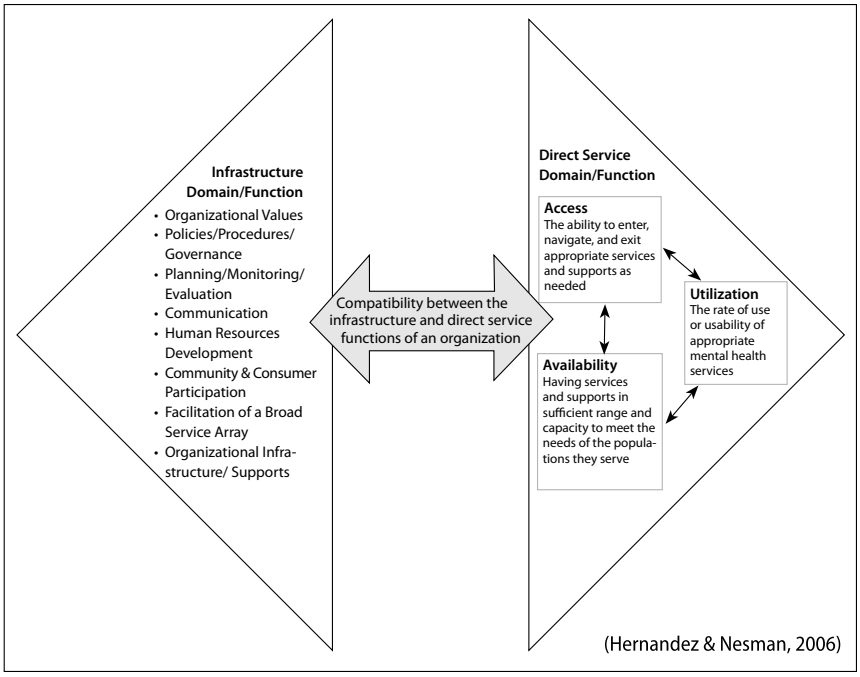
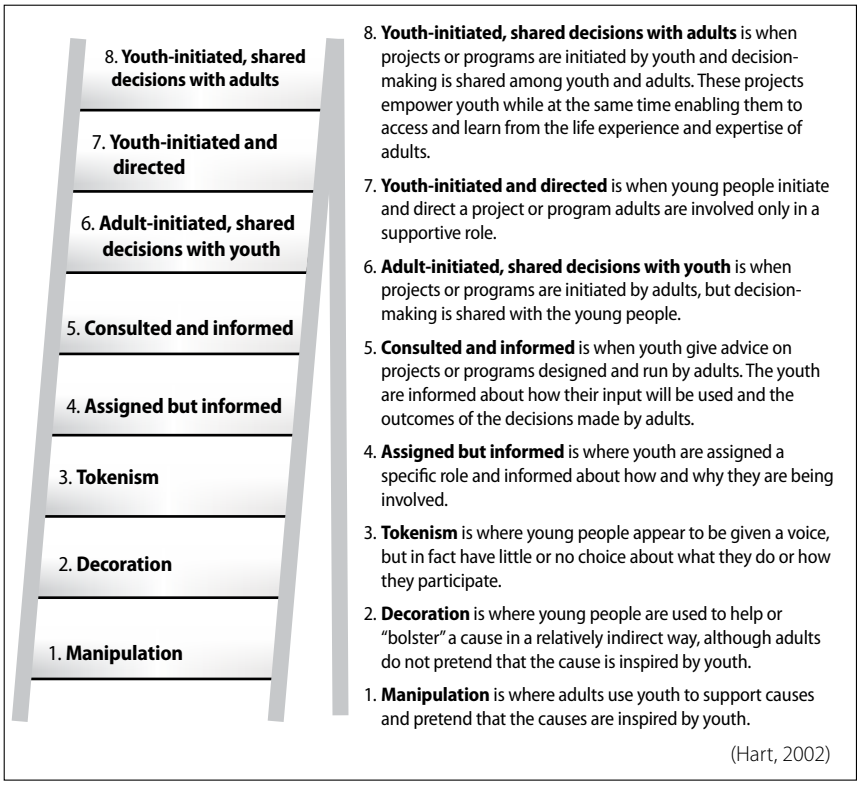


Figure 3.
Ladder of participation model.



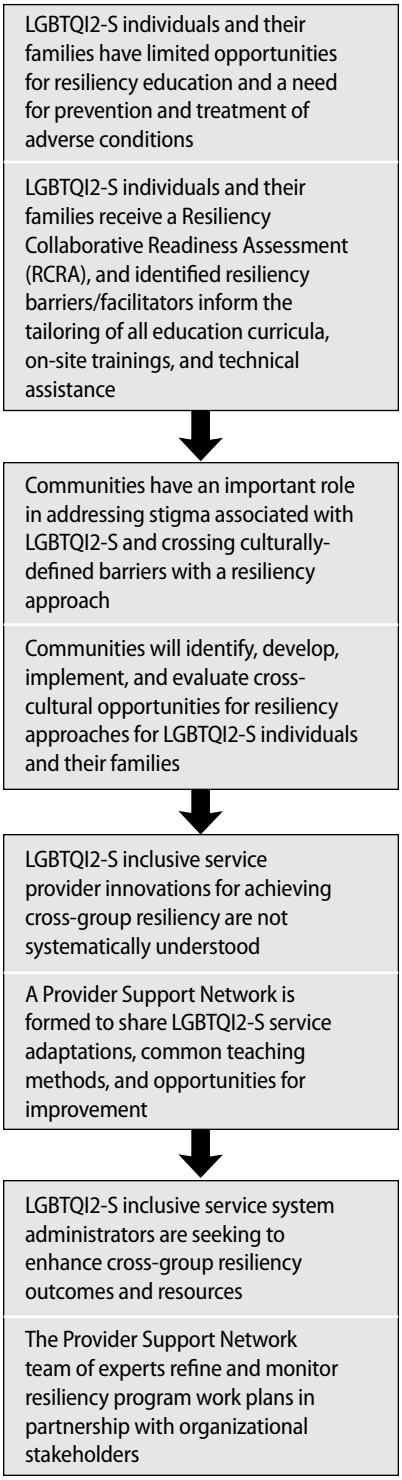
sexual orientation, ethnicity, and culture are perceived as mutually exclusive and non-interactive across groups (Halperin et al., 2004).

With respect to HIV in particular, this unbalanced social equation is marked by poverty and disparities that conflate structural barriers and functions to perpetuate minority status for all those with a viral load of > 400 copies/ml and < 200 CD4 CD4+ T-lymphocytes/uL (CDC, 1992). Reflecting on missed opportunities to cross social boundaries and carry light for others is too late when realized at an AIDS candlelight vigil.

Interventions that utilize resiliency provide a framework for not only risk reduction, but also community development of behavior change expectations. The Theory of Change that drives this framework is illustrated in Figure 4.

The theory of change progresses along focal points that originate with the needs and opportunities of LGBTQI2-S individuals and their families, communities, LGBTQI2-S inclusive service providers, and LGBTQI2-S inclusive service system administrators. A need for prevention and treatment of adverse conditions for LGBTQI2-S individuals will be met by determining the degree of resiliency barriers and facilitators and then tailoring program activities (on-site trainings, technical assistance, and curricula) to identified needs.

Figure 4. LGBTQI2-S theory of change.



At the community level, reducing and eliminating stigma and culturally-defined barriers associated with individuals who identify as being LGBTQI2-S and their families will be addressed through an informed process of identifying, developing, implementing, and evaluating community and resiliency-based approaches.

The opportunity for systematic understanding of LGBTQI2-S inclusive service provider innovations for achieving cross-group resiliency will be met with a Provider Support Network (LGBTQI2-S individuals, service personnel, family members) that will share service adaptation lessons learned, common teaching methods, and opportunities for improvement. Finally, LGBTQI2-S inclusive services organizations seeking to enhance cross-group resiliency outcomes and resources will gain from this Provider Support Network of experts (inclusive of LGBTQI2-S individuals and family members) who will formulate work plans in partnership with organizational stakeholders.

Assets-Based Research and Recommendations

Miceli (2002) wrote, "Despite the increase in visibility, gay, lesbian and bisexual youth are still one of the most under-researched groups of children and adolescents" (p. 199). Due to this invisibility, there is limited systematic information about disparities in treatment outcomes for this population. This monograph proposes a framework for LGBTQI2-S research that focuses on assets for a number of

reasons: (1) the assets-based research on this population is minimal, necessitating an adaptation of assets-based research from other populations, and (2) the focus of LGBT research for so long has been on the problem/harm approach that it creates a sense of inevitability that existing as LGBTQI2-S will lead to being in harms way.

All of the assets-based approaches presented in this monograph can be structured within a population-based approach, that is, a public health approach concerned with the health of all people, including their relationship to the physical, psychological, cultural, and social environments in which people live, work and go to school. A growing body of literature is moving in this direction. For example, research by Riggle, Whitman, Olson, Rostosky, and Strong (2008) found that the positive aspects of gay or lesbian identity were belonging to a community; creating families of choice; forging strong connections with others; serving as positive role models; developing empathy and compassion; living authentically and honestly; gaining personal insight and sense of self; involvement in social justice and activism; freedom from gender-specific roles; and exploring sexual relationships.

It is especially encouraging to see the larger systems involved with policy and the provision of services addressing the issues and needs of the estimated 2.7 million youth who are LGBTQI2-S. For example, the Center for Mental Health Services (CMHS) Child, Adolescent and Family Branch of the Substance Abuse and Mental Health Services Administration (SAMHSA) recently established a LGBTQI2-S National Workgroup to:

- provide guidance and input on policies, programs, and materials such as cultural competency practice briefs in partnership with the National Center for Cultural and Linguistic Competence to address the needs of children and youth who are LGBTQ2-S and their families in the Community Mental Health Initiative (Poirier, Francis, Fisher, Williams-Washington, Goode, & Jackson, 2008);
- develop the 2006 National Child Traumatic Stress Network brief focused on trauma among youth who are LGBTQ;
- work with the Child Welfare League of America on best practice guidelines for serving LGBT youth in out-of-home care (Wilber, Ryan, & Marksamer, 2006); and
- partner with Lambda Legal on a "toolkit" to support LGBTQ youth in care (CWLA/Lambda Legal, 2007).

Using an assets-based approach to examine the complex biological, psychological and sociological dynamics of sexual orientation and gender identity can inform policy makers, front line service providers, parents, other caregivers, youth, and the community who are concerned with the LGBTQI2-S population (Espinoza, 2008; Lazear & Gamache, 2008; NIH, 2007; SAMHSA, 2008, 2001; Stroul, 2006). An asset-based approach is also consistent with the values and principles of a child and family team approach to service provision, such as Wraparound (Walker & Bruns, 2007).

Research methodologies must be planned and funded that examine assets-based approaches, such as the impact of positive development programs; stigma reduction strategies; positive role models and adult connections; and supportive family settings. We especially need to better understand how peer-to-peer support organizations reduce stigma, social withdrawal and isolation.

By taking a strengths-based approach and focusing on how to infuse inclusionary and asset-based approaches that are responsive to this population into existing systems of care and professional training, research can identify the critical variables in promising practices that can be adapted to programs and communities.

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Acknowledgements

Reviewers

Linda Callejas, MA, Ph.D. candidate
Project Director & Faculty
Department of Child & Family Studies
College of Behavioral & Community Sciences
University of South Florida

Mario Hernandez, Ph.D.
Chair, Department of Child & Family Studies
College of Behavioral & Community Sciences
University of South Florida

Rohan Jeremiah, MPH, Ph.D. candidate
Department of Public Health and Preventive Medicine
School of Medicine
St. George's University
Grenada, West Indies

Lynn McBrien, Ph.D.
College of Education
University of South Florida

Marlene Penn, MSW
National Family Technical Assistance Consultant,
Medford, New Jersey

Sheila A. Pires, MPA
Partner, Human Service Collaborative
Washington, D.C.

Tony Tan, Ph.D.
College of Education
University of South Florida

Antonio Wilson
Youth MOVE National
Houston, Texas

For more information

Please contact Kathy Lazear at 202-337-2412
or Peter Gamache at 202-232-6749.

Research & Training Center for Children's Mental Health
Department of Child & Family Studies
College of Behavioral & Community Sciences
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612