A New Family Systems Therapeutic Approach for Parents and Families of Sexual Minority Youth

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ABSTRACT: Recent legislation introduced in the United States, and abroad, to restrict "conversion" or "change" therapies for clients under the age of eighteen has brought upon increasing challenges for religious and/or rejecting families of children who identify as lesbian, gay, bisexual, transgender, questioning (LGBTQ), or experience unwanted same-sex attractions or gender identity conflicts. Currently, fourteen states, the District of Columbia, and forty-four cities have passed laws to prohibit such therapies, with more legislation being introduced every year. While reports of abuse and/or forced therapy with licensed clinicians are hard to verify, outcome studies on the effects of "conversion" or "change" therapy for minors have not been published in the scientific peer-reviewed literature, and even less is known about successful therapeutic interventions for religious and/or rejecting families of such youth. With the increasing scrutiny brought about by such laws, licensed mental health practitioners should consider adopting innovative models of family systems therapy in order to safely and effectively work with sexual minority youth, and their families. This article presents one such family systems therapeutic model, while also addressing several important ethical considerations for working with religious and/or rejecting families of sexual minority youth.

Key Words: **Conversion therapy; change therapy; sexual minority youth; family systems therapy; minors; religious families; rejecting families.**

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Introduction

Recently, legislation has been introduced to restrict "change" or "conversion" therapies for minors that experience sexual and/or gender identity conflicts in a number of states and jurisdictions across the United States. Presently, laws restricting licensed therapeutic efforts to reduce or eliminate homosexual or transgender attractions, behaviors, and/or identities for minors have been passed in fourteen states, including California, New Jersey, Illinois, Oregon, Vermont, Nevada, New Mexico, Connecticut, Rhode Island, Washington, Hawaii, Delaware, Maryland, and New Hampshire. Additionally, forty-four cities, as well as Washington, D.C., have passed local ordinances prohibiting such efforts. Such legislation argues that "conversion" therapies for minors are ineffective, harmful, and abusive, citing anecdotal reports that some parents and/or families may coerce their sexual minority children into therapeutic efforts to change their sexual attractions, behavior, and/or identity to conform with religious and/or societal expectations or norms.

While such reports of abuse are not easily verified, and in some cases, have been shown to be fraudulent (National Task Force for Therapy Equality, 2017), there is some evidence in the literature demonstrating that high levels of family rejection among sexual minority youth may lead to harmful outcomes. In a non-clinical sample of 224 white and Latino self-identified lesbian, gay, bisexual (LGB) youth, Ryan, Huebner, Diaz, & Sanchez (2009) found that higher levels of family rejection was significantly associated with poorer health outcomes in that young adults were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse, compared to their peers who came from families that reported no or low levels of rejection. While these outcomes showed negative effects for sexual minority young adults who experienced higher levels of family rejection, there was no data in this study for sexual minority youth, and their families, that have undergone professional, licensed psychotherapy, either through individual therapy or family-based interventions.

Contributing to the lack of therapeutic outcomes for sexual minority youth, and their families, is the likelihood that a majority of rejecting families come from faith backgrounds that may favor spiritual counseling or religious interventions that align with their beliefs, rather than utilize licensed professional counseling that may incorporate more secular approaches or mainstream psychological techniques. For example, Loue (2010) examined minors who engage in faith-based mental health treatment using data from the National Comorbidity Survey—a cross-sectional survey of a nationally representative sample of 8,098 respondents between the ages of 18-54—and found that a higher proportion of those who seek mental health treatment do so from clergy who have not been trained in counseling than from either a psychiatrist or a general medical physician. One possible reason for this occurrence is that clergy are visible, relatively available, and do not charge for their services, while trained clinicians are not free or as easily accessible. While this sample did not differentiate between sexual and

non-sexual minority youth, it likely included young people that identified as LGB and/or were questioning their sexual and/or gender identity.

Examining the peer-reviewed scientific literature, there are no clinical reports on the outcomes of individual therapy or family counseling administered by licensed professionals that reduces negative outcomes for sexual minority youth that come from religious and/or rejecting families. Such interventions have largely gone unreported in the literature, and when considering current efforts to ban certain therapeutic interventions in states and cities across the United States, these therapeutic modalities merit consideration.

Outcomes of Minors in Psychotherapy

Before addressing the therapeutic needs of sexual minority youth, the effectiveness of psychotherapy among minors in general should be examined. According to the National Research Council and Institute of Medicine, about 13-20 percent of children experience a mental or emotional disorder in the United States. Yearly estimates to treat these disorders total around $247 billion (CDC, 2013). However, the effectiveness of psychotherapy among adolescents is relatively unknown; and without a strong theoretical foundation built on evidence-based treatments, psychotherapy among minors may actually prove more harmful than helpful.

According to reports summarized by Lambert (2013), while millions of youth are served each year in community–based mental healthcare settings, the small body of outcome studies in these settings has produced a mean effect size near zero (e.g., Weisz, 2004). For example, in a study comparing children being treated in community mental health (N 936) or through managed care (N 3075), estimates of deterioration were 24% and 14%, respectively (Warren, Nelson, Mondragon, Baldwin, & Burlingame, 2010) (p. 44).

Bychkova, Hillman, Midgley, & Schneider (2011) measured five different therapeutic modalities with minors using the Adolescent Psychotherapy Q-set (APQ). While the outcomes of this therapeutic modality have been widely documented in adults (Carr, 2010; Kendall, 2006; Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002), this study includes analysis of the process of therapy, and attempts to link specific therapeutic processes to outcomes specifically in adolescents. Overall, the APQ appears to be a promising measure for investigating the therapeutic process with adolescents and its efficacy.

Shirk, Karver, & Brown (2011) compiled a meta-analysis to provide an assessment of alliance-outcome relations in child and adolescent therapy and found that how the client and therapist form a relationship defines the difference between bond (relationship of client and practitioner) and work (the actual therapy), the emotional relationship, and the collaborative relationship. Through the Working Alliance Inventory and the Therapeutic Alliance Scale for Children, findings indicated a stronger association between alliance and outcomes for children than for adolescents. In other words, a strong therapeutic alliance was a better predictor for positive treatment outcomes for children, compared to their adolescent counterparts. Results suggest that the therapeutic alliance

is a robust predictor of outcomes with pre-adolescent children. There was a trend for alliance–outcome associations to be stronger in behavioral than non-behavioral therapies, though results suggest that the alliance is important for outcome in both types of therapy.

In a meta-analysis for clinicians exploring the effectiveness of psychotherapy in children and adolescents, Weisz, Weiss, Alicke, & Klotz (1987) found that the average treated minor was better adjusted after treatment than 79 percent of those not treated across various measured outcomes. Psychotherapy proved more effective for children than for adolescents, particularly when the therapists were paraprofessionals (e.g., parents, teachers), while professionals (PhD, MA, LCSW etc.) were especially effective in treating over-controlled problems (e.g., phobias, shyness), but were not more effective than other therapists in treating under controlled problems (e.g., aggression, impulsivity). Behavioral treatments proved more effective than non-behavioral treatments regardless of client age, therapist experience, or treated problem. Findings revealed significant, durable effects of treatment that differed somewhat with client age and treatment method.

Treatment and Ethical Considerations for Sexual Minority Youth Undergoing Therapy

While psychotherapy in minors can be effective, working with sexual minority youth adds another variable in the therapeutic setting that brings with it a host of complex issues. While anecdotal and/or qualitative reports suggest that some sexual minority youth may be coerced or forced into "change" therapies (Doyle, 2013), thus confirming harm, Young (2006) explored whether such therapies can actually be considered child abuse under current law and found that there is no reliable evidence that it is harmful for minors. While the consensus among mental healthcare professionals opposes such treatments, these opinions do not excuse overreaching beyond what the evidence has established. Nonetheless, the treatment of sexual minority youth presents mental health clinicians with a number of challenging ethical considerations.

According to Dopp (2013), the American Psychological Association (APA) Ethics Code is a valuable resource for addressing these issues, but psychologists require additional guidance in order to provide ethical treatment. For example, familiarity with the development of and variation within human sexuality and gender, detailed understanding of ethical issues, competence in gay-affirmative psychotherapy, and clinical skills for managing suicide risk are vital for the treatment of sexual minority youth. For example, the American Psychological Association has compiled an ethics code for psychological practice with lesbian, gay, and bisexual clients (APA, 2012). Additionally, clinicians working in "change" therapies should also familiarize themselves with any relevant practice guidelines for clients with unwanted same-sex attractions (SSA) and/or behaviors, such as those set forth by the National Association for Research and Therapy of Homosexuality (NARTH, 2010).

Clinicians must also be aware of how heterosexism may have a detrimental affect on their work with LGBTQ clients, as subtle forms of bias (e.g., making stereotypical assumptions of LGBTQ clients, such as the idea that all heterosexuals have superior

mental health than LGBTQ clients, which may impede the therapeutic relationship) (Sheldon and Delgado-Romero, 2011). Indeed, social stigma and perceived discrimination felt by LGBTQ clients has important mental health consequences, and therapy should take into account how discriminatory experiences may affect stress levels (Cochran and Mays, 2001).

One critical assumption that clinicians need to be aware of is the idea that LGBTQ youth can or should change sexual orientation, and the possibility that religious and/or rejecting families may pressure their minor children into "change" or "conversion" therapies against their will. According to Stoessel (2013), some foster care LGBTQ youth indicate that they have been subjected to "conversion" or religious therapy by foster parents. Particularly in the foster care system, the message is often thought of as preventing youth from becoming homosexual because of the assumption that all young people are, or can be, heterosexual. According to authors, this "hetero-centric" idea may jeopardize a youth's well being by coercively attempting to change his or her sexual orientation, or even suggesting that change is possible, which may create an extremely hostile social environment. Similarly, Cohan (2002) examined whether parents of a child under a certain age have the capabilities to force their child into therapy as an attempt to change their child's (homo) sexual orientation, and advised that parents need to be educated on what therapy entails and consider that therapeutic interventions often involve much more than changing an attraction or feeling (e.g., therapists often work with clients to address causes or certain issues surrounding sexual attractions or identification and do not simply employ behavioral techniques to alter feelings or attractions). He also questions, if forced into therapy, whether children can be considered unique individuals themselves, rather then an end result seeking their parent's approval. Thus, it is important for ethical reasons that clinicians ensure that youth undergoing therapy do so from their own volition, rather than as a means to please parents or simply conform to societal expectations.

It is also important that clinicians working in change therapies with sexual minority youth are adequately trained in effective therapeutic modalities. Pickup (2012) discusses common mistakes that therapists make with sexual minority adolescents in the course of change therapy that could be detrimental to successful outcomes. For example, educating clients about potential variables and causes of homosexuality and providing space for the client to address core wounds through grief and anger are vital. Providing "generic" therapy with no theoretical foundation may pose problems, while a failure to distinguish between behavioral and affective changes (i.e., a change in behavior is not necessarily indicative of sexual orientation change) can be problematic. The therapist might also lack adequate knowledge of impediments to client progress, or be unable to address and process client resistance, both of which may affect therapeutic outcomes.

Change Therapies and Sexual Fluidity in Adolescence

For some same-sex attracted (SSA) clients, identifying as LGBTQ does not resonate for various reasons. This may lead families and/or adolescents to seek out therapy

as a means of resolving underlying issues that may be contributing to unwanted SSA, especially considering the fact that research has not concluded that homosexual attractions are determined by birth, and therefore, may be subject to change. For example, according to the American Psychological Association (2008):

> There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles; most people experience little or no sense of choice about their sexual orientation (p. 2).

Research has also found that childhood sexual abuse (CSA) can have a psychological impact on the development of a lesbian, gay, bisexual, transgender, or questioning (LGBTQ) sexual or affectional identity. While there is no clear, direct causal link between experiencing CSA and later developing a non-heterosexual sexual identity, researchers have reported that there is a 25–50% higher prevalence rate of CSA among non-heterosexual individuals (Walker, Hernandez, & Dave, 2012). For example, Tomeo, Templer, Anderson, & Kotler (2001) found that in research with 942 non-clinical adult participants, gay men and lesbian women reported a significantly higher rate of childhood molestation than did heterosexual men and women. Forty-six percent of the homosexual men in contrast to seven percent of the heterosexual men reported homosexual molestation, while twenty-two percent of lesbian women and one percent of heterosexual women reported homosexual molestation. Additionally, in the ***2014 American Psychological Association Handbook on Sexuality***, Mustanski, Kuper, & Greene (2014) confirm there is scientific evidence in the peer-reviewed research for "associative or potentially causal links" between childhood sexual abuse and ever having same-sex partners, especially for some men (pp. 609-610).

Despite this data, the scientific literature has not established a clear causal pathway for the development of homosexual attractions via non-biological means (APA, 2009), nor has it demonstrated a clear genetic explanation for the emergence of a homosexual orientation (Whitehead & Whitehead, 2013; APA, 2009). For example, Whitehead (2013) used a standard statistical analysis to gauge the milestone status/genetic influence on the timing of first SSA by comparison with timing of puberty, and concluded that SSA is not a developmental milestone, nor does its timing have high genetic influence. These results are consistent with previous research that has found that sexual orientation identity milestones among non-heterosexual youth (homosexual/bisexual) tends to be in late adolescence and early adulthood (Floyd & Bakeman, 2006; Savin-Williams & Diamond, 2000). Thus, age of first attraction turns out to be a poor choice to illustrate alleged innateness. Although it is common to hear that first SSA coincides with earliest memories, very few individuals have SSA as their earliest memories, which is hence a false stereotype that individuals are born homosexual. Thus, according to Whitehead (2013):

> First SSA has such a wide relative standard deviation compared to other clearly genetically influenced milestones that it seems clear the appearance of first SSA is only weakly influenced by genetics. This means that the common belief that people with SSA are "born that way" is not supported by the literature on first attraction (p. 54).

Thus, if homosexual attractions are not innate or hard-wired, it is conceivable that SSA may be subject to fluidity or change across the lifespan, including adolescence. In fact, a significant percentage of individuals experiencing SSA in adolescence will find that these attractions resolve by the time they reach age 30 (Kinnish, Strassberg, & Turner, 2005; Laumann, Gagnon, Michael, & Michaels, 1994). Yet, controversy in delivering change therapies to clients who seek it out voluntarily persists, both among the general public and mental health practitioners. For example, Neukrug & Milliken (2011) surveyed a random sample of the American Counseling Association and found that only 38 percent of counselors believed it was ethical to refer a client who is unhappy with his or her homosexuality for therapy to reduce or eliminate homosexual attractions. Thus, a number of ethical considerations remain in making appropriate referrals for clients to obtain change therapies, as well as a considerable lack of data that demonstrates efficacy for minor clients who seek to change sexual orientation. For example, to date, there are no outcome-based studies published in scientific peer-reviewed journals on the efficacy and safety of change therapies for clients under the age of 18. However, sociological and epidemiological data on the fluidity of same-sex attractions and sexual identity in adolescence does exist.

Ott, Corliss, & Austin (2011) examined 13,840 youth ages 12–25 in self-reported sexual identity over four waves of data, finding that for those who described themselves as "unsure" of their orientation identity at any point, 66 percent identified as completely heterosexual at other reports and never went on to describe themselves as a sexual minority. While both males and females were equally as likely to report an "unsure" sexual orientation status, females were more likely to remain in this questioning stage for longer periods of time than males.

Whitehead (2009) examined the fluidity of homosexual orientation in a longitudinal study of subjects aged 16-22, with results indicating that SSA is not always consistent throughout adolescence. Using data from a large sample in the National Longitudinal Study of Adolescent Health (Add Health) survey (Savin-Williams & Ream, 2007), findings revealed that some adolescents with a homosexual/bisexual orientation, both in attraction and behavior, experienced change from year to year. From ages 16 to 17, the majority of individuals with SSA and bisexual attraction experienced shifts to opposite sex attraction (OSA). Results indicated that 16 year-olds with an SSA or bisexual orientation were 25 times more likely to experience change towards heterosexual at the age of 17 than those with a heterosexual orientation changing to a bisexual or homosexual orientation. At age 22, 75 percent of males went from SSA to opposite-sex attraction, and of those women whom initially identified exclusively as SSA, very few reported exclusive SSA at the time of the second interview.

Savin-Williams & Ream (2006) also conducted an analysis of three waves (six years) of the Add Health data and explored the prevalence and stability of sexual orientation. They found that participants indicating non-heterosexuality in wave one were often not the same individuals who indicated non-heterosexuality one and five years later. Despite a move towards heterosexual identity, non-heterosexual prevalence rates did not decline, indicating that even as individuals were abandoning the ranks of non-heterosexuality to join the heterosexual majority, a small proportion (but larger number) of opposite-sex attracted and behaving individuals and those with no attraction or sexual behavior were replacing them. Nonetheless, the authors concluded that the instability of SSA and behavior (plus sexual identity in previous investigations) presents a dilemma for sex researchers who portray non-heterosexuality as a stable trait in individuals.

In a longitudinal study of 156 lesbian, gay, and bisexual adolescents ages 14–21 years (at baseline), Rosario, Hunter, Maguen, Gwadz, & Smith (2006) estimated the odds of maintaining the same identity at follow-up over a 12-month period and found that among those who were gay/lesbian at baseline, females were 3.6 times more likely than males to maintain their gay/lesbian identity, while among those who were bisexual at baseline, females were 5.0 times more likely than males to maintain their bisexual identity.

Similarly, in a birth cohort of approximately 1,000 New Zealand late adolescents between the ages of 21-26, Dickson, Paul, & Herbison (2003) found that females appeared to report greater increases in same-sex attractions over the 5-year follow-up period than did males. At age 21, 9 percent of females in the cohort reported any same-sex attractions, which increased to 16 percent at age 26, whereas comparable estimates for males at age 21 and age 26 were 4 and 6 percent; however, there were methodological limitations in this study, as no statistical tests comparing mobility patterns in females versus males were presented.

Mitigating Risk and Maximizing Therapeutic Benefit for Families of Sexual Minority Youth

Due to the relatively hostile political climate in certain states and cities in the United States, coupled with the increasing controversial positions that so-called "mainstream medical and mental health" associations have taken regarding change or conversion therapies for sexual minority youth, licensed clinicians that work with rejecting families and/or those that hold religious or traditional biblical positions for sexual behavior, and their sexual minority children, may need to adapt their therapeutic modalities in order to comply with state licensing regulations and/or local city ordinances that prohibit certain types of therapies for minors.

When a child that comes from a religious and/or rejecting family identifies him or herself as LGB, or is struggling with their sexual or gender identity, parents may react in several different unproductive ways, including: 1) Cutting off the child; 2) Pressuring the child to attend unwanted counseling and/or spiritual interventions; 3) Applying forms of pressure (emotional, financial, or otherwise) to make the child comply with

family and/or religious expectations; and/or 4) Using other methods of subtle or overt coercion. While these actions appear to be a reasonable solution for parents to help their children, they ultimately produce the opposite effects of what family systems therapy tries to achieve, and in some cases, can cause harmful emotional and psychological outcomes for their children.

While rejecting and/or religious families may seek out therapies in the effort to change (in some cases, against the child's will) the sexual orientation or gender identity of their children, competent clinicians that promote a number of key factors in family systems therapy will help mitigate risks with such families, avoiding potential coercion and/or harm, while maximizing therapeutic benefit. As a result, utilizing effective, culturally competent, and developmentally appropriate family systems therapeutic interventions with families of sexual minority youth may be a successful modality in reducing potential future harmful outcomes of LGB and/or sexual minority youth that come from religious and/or rejecting families.

A New Family Systems Therapeutic Approach for Families of Sexual Minority Youth

Family systems therapeutic interventions examine the historical pattern of emotional functioning and how the family's anxiety levels may be inherited from previous generations and transferred to future children that fail to successfully differentiate from the unhealthy relational patterns of their families of origin. According to Bowen's (1978) multigenerational transmission process theory, individuals coming from similar dysfunctional families of origin, characterized by chronic anxiety projected onto them from their parents, are likely to marry each other and produce similar offspring who have difficulty processing emotions. Unless the adult-child marries a partner who is emotionally healthy and/or is able to differentiate themselves from the dysfunctional patterns of behavior in their family of origin, one or multiple children in successive generations, as a result, will manifest psychological or emotional disorders.

Factors that promote therapeutic success in this new family systems approach include: 1) Understanding hereditary and intergenerational family patterns; 2) Analyzing psychological factors associated with birth order and childhood roles, including sibling positions and dynamics; 3) Utilizing family history Genograms; 4) Incorporating effective processing of traumatic family experiences; 5) Teaching healthy communication patterns and boundaries among parents, children, and siblings; 6) Resolving past and present conflicts; and 7) Establishing appropriate models of emotional intimacy that promote healthy attachment and bonding.

One of the hallmarks that distinguishes family systems therapeutic approaches from other forms of counseling, and why this model works especially well for religious and/or rejecting families of sexual minority children, is that its goals do not focus on changing one person in the family, but rather: 1) Treating anxiety and finding relief from its symptoms; and 2) Increasing each family member's level of differentiation so they may adapt to changes in and outside of the family, different patterns of relating

with each other, and experience healthier emotional interactions among one another (Kerr & Bowen, 1988).

Over the course of two, successive eight-hour days of family systems therapy, clinician(s) work with the entire nuclear family (both parents and all children, if possible) to understand historical relational patterns, trans-generational and hereditary wounding, and present-day conflicts that have resulted in dysfunctional emotional and psychological patterns within the family unit. In some circumstances, it is helpful to include extended family, such as grandparents, aunts, uncles, and other in-laws, depending on the level of historical interaction these individuals have had with the nuclear family on a day-to-day basis. For example, while families in the United States typically have a high level of differentiation from their extended kinfolk, relatives in other cultures may play a more significant role in the raising and daily contact among parents and children, and thus, may play a major part in the family system that contributed to dysfunctional family patterns and wounding within the family. In this case, it is advisable to include extended relatives in the family systems therapeutic intervention.

While the specific therapeutic protocol the author uses to conduct this family systems therapy intervention is outside the scope of this article, designing therapeutic interventions on the above-mentioned factors reduces anxiety while healthy boundaries and emotional interactions within the family system increase; emotional connectedness within the family improves; attachment between parents and children increase; and dysfunctional intergenerational patterns can be clearly understood, addressed, and prevented for future generations.

Conclusion

Family systems therapeutic interventions do not seek to change the family's deeply held religious or theological beliefs regarding sexuality, nor do they incorporate change or conversion therapies for sexual minority youth. After undergoing effective family systems therapeutic interventions, disagreements between sexual minority children and their religious and/or rejecting parents and families may persist. However, anxiety among family members is reduced and differentiation is increased, thus producing greater emotional connectedness and healthier interactions. Despite any potential conflicts that may persist, family systems therapeutic interventions that promote effective lines of communications while reinforcing boundaries, promoting healthy attachment and bonding, and providing ongoing mental health support may reduce the incidence of unhealthy behavioral and emotional disorders among sexual minority youth as they reach adulthood.

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