

© Copyright 2017

Ryan Karnoski

Experiences of Healthcare Providers of Lesbian, Gay, Bisexual, and Transgender Foster Youth

Ryan Karnoski

A thesis

submitted in partial fulfillment of the
requirements for the degree of

Master of Social Work

University of Washington

2017

Committee:

Kevin Haggerty

Charlotte Sanders

Program Authorized to Offer Degree:

School of Social Work

University of Washington

Abstract

Experiences of Healthcare Providers of Lesbian, Gay, Bisexual, and Transgender Foster Youth

Ryan Karnoski

Chair of the Supervisory Committee:

Dr. Kevin Haggerty

School of Social Work

As a disproportionately overrepresented group in public child welfare, Lesbian, Gay, Bisexual, and Transgender (LGBTQ) foster youth have unique health disparities and needs related to their marginalized identities. This thesis discusses current research related to healthcare providers and their experiences serving LGBTQ foster youth in Washington State. The purpose of this study is to better understand the experiences of healthcare providers working with LGBTQ foster youth to improve their health outcomes. This research is performed through eight semi-structured key informant interviews, which provide a qualitative assessment of the experiences of healthcare providers of the LGBTQ foster youth population of Washington State, as well as these providers' insight into the intersectional issues of LGBTQ foster youth, including race, transgender and gender nonconforming identities, and homelessness.

Keywords:

LGBTQ, queer, gay, youth, social work, social welfare, foster care

Other key words: child welfare, care providers, medical, mental health, dental, therapy, challenges, caregivers, homelessness

TABLE OF CONTENTS

| | |
|-------------------------------------------|-----|
| Acknowledgements | i |
| Dedication | ii |
| Foreword on Positionality | iii |
| Chapter 1. Introduction | 1 |
| 1.1 Research problem..... | 1 |
| 1.2 Need for research | 5 |
| 1.3 Definitions..... | 5 |
| Chapter 2. Background | 6 |
| 2.1 Overview | 6 |
| 2.2 Search Methods..... | 8 |
| 2.2.1 Concept Analysis | 9 |
| 2.3 Literature..... | 9 |
| 2.3.1 Research Findings | 9 |
| 2.3.2 Literature Reviews | 12 |
| 2.4 Prepositions and Assumptions | 12 |
| Chapter 3. Methods | 14 |
| 3.1 Introduction..... | 14 |
| 3.2 Design | 14 |
| 3.3 Sample..... | 19 |
| 3.4 Analysis..... | 19 |

| | | |
|------------------|------------------------------------------------------|-----|
| 3.4.1 | Qualitative Data Analysis | 19 |
| 3.4.2 | Coding of Responses..... | 20 |
| Chapter 4. | Findings | 21 |
| 4.1 | Brief overview | 21 |
| 4.1.1 | Cohort profile..... | 21 |
| 4.1.2 | Interviews..... | 21 |
| 4.2 | Interview Themes..... | 29 |
| 4.2.1 | Strengths | 29 |
| 4.2.2 | Challenges..... | 31 |
| 4.3 | Discussion of Assumptions | 34 |
| Chapter 5. | Conclusions | 37 |
| 5.1 | Summary | 37 |
| 5.2 | Implications..... | 42 |
| 5.3 | Limitations | 43 |
| 5.4 | Suggestions for future research..... | 46 |
| 5.5 | Recommendations for future practice and policy | 47 |
| Works Cited | | 49 |
| Appendix A..... | | 56 |
| Appendix B | | 58 |
| Appendix C | | 106 |
| Appendix D..... | | 109 |

| | |
|------------------|-----|
| Appendix E | 111 |
| Appendix F..... | 114 |

ACKNOWLEDGEMENTS

I would like to thank Ester Matskewich, who has supported me academically and personally beyond a reasonable measure. Without her, this paper would not exist, the cats would go unfed, and the apartment would be a complete mess. I would also like to thank my research committee: Dr. Kevin Haggerty and Charlotte Sanders, for their support, constructive criticism, patience, and humoring of my “tin foil hat” ideas while I learn what a master’s thesis is and is not. Rachel Mahre, thank you for donating your time toward this project, you are a wizard of a librarian. I’d also like to acknowledge Paige and Emily Haley, Sam Knox, Evan Jayne, and Grace Olson for their undying support (thus far), and to my parents and extended family, for instilling in me the values of dignity, pride, and social justice. Michael, Summer, and Hunter, thank you for reminding me to act my age.

I owe this thesis to the efforts of Dr. Luana Ross, Dr. Nicole Robert, Dr. Nancy Kenney, Dr. Peter Pecora, Dr. Hyunzee Jung, Dr. Jane Macy, Linda Ruffer, and Jenn Maglalang for their exemplary scholarship, mentorship, guidance, and dedication. I am sorry for texting during your classes, it was probably very important or an emergency.

DEDICATION

*This paper is dedicated to Jean Anderson,
who forever lives on in the lives of those she touched with her fiery spirit,
leaving a legacy of advocacy for marginalized youth and those who care for them.*

FOREWORD ON POSITIONALITY

As a researcher, this author aims to explore “what roles we have been socialized to play, how we are affected by issues of oppression in our lives, and how we participate in maintaining them”. This process “must begin by making an inventory of our own social identities with relationship to each issue of oppression” (Harro, 2001) and explore how these identities intersect and influence positionality (Murphy, 2009), power, and privilege. This research is performed through the intentionality of an anti-racist white (Jackson, 1993), with the assumption that “most White Americans are unaware of the advantages they enjoy in this society and of how their attitudes and actions unintentionally discriminate against persons of color” (Sue, et al. 2007). By acknowledging his whiteness as a researcher, this author aims to create a counter narrative to their white skin being “neutral” or “normal” (MacIntosh, 1990) and confront this by examining it in the context of positionality.

Because ‘the personal is political’¹, we cannot isolate our identities, positionalities, and “politics” from how researchers or providers arrive to their participants or patients; those in target or marginalized groups are acutely aware of this. This research reflects the author’s personal values and ethics as a social worker of social justice, feminism, equity, advancement of opportunities, resources, services, and health outcomes for underserved communities. As well as personal bias as a member of the LGBTQ community, an activist, and an advocate in said community. This author has an undergraduate Bachelor of Arts degrees in both Gender, Women, Sexuality Studies, and Social Welfare. This compounding of academic backgrounds led to questions about how allied health providers serve LGBTQ foster youth with respect to current research, theory, and empirical data on best practices for this community as well as questioning

¹ Feminist slogan, not attributed to any single author.

the functionality of imagined communities and imagined professional networks as an emerging social worker.

As scholarly work rooted in social work values and ethics, this research is done from a strengths based perspective². This work aims to move beyond the personal biases and expectations of the researcher, which are rooted in personal and professional experiences with the topics and themes in the interviews. In acknowledging these biases, there is an active effort to uproot possible confirmation bias in data collection methods, or the conclusions which may be drawn from said data. These interviews are an alternative to anthropological immersion³ in what can be an extremely sensitive and personal time for many youth in their interactions with caregivers and medical providers. This author studies medical providers' lived experiences⁴ to “hone the sword” in a sense, which is to best understand how medical providers can have their community needs met to best serve a traditionally underserved population. As a collection of qualitative data, these interviews represent a snapshot in time of the experiences of the participants and those they serve, the current socio-political climate, and this author's skills, abilities, and experience with the research process.

² Social work principle that emphasizes the inherent worth of all people and their strengths.

³ Typical method of qualitative data collection with a negative reputation in anti-oppressive scholarship due to objectification and exotification of ethnic and racial minorities e.g. National Geographic exposés on indigenous women.

⁴ The term lived experience is used to describe the first-hand accounts and impressions of living as a member of a minority or oppressed group, in this

Chapter 1. INTRODUCTION

1.1 RESEARCH PROBLEM

“But any future vision which can encompass all of us, by definition, must be complex and expanding, not easy to achieve. The answer to cold is heat, the answer to hunger is food. But there is no simple monolithic solution to racism, to sexism, to homophobia. There is only the conscious focusing within each of my days to move against them, wherever I come up against these particular manifestations of the same disease. By seeing who the we is, we learn to use our energies with greater precision against our enemies rather than against ourselves”.

-Audre Lorde, 1982, “Learning from the 60s” Speech at Harvard University

As a disproportionately overrepresented group in child welfare, Lesbian, Gay, Bisexual, and Transgender (LGBTQ⁵) youth have unique health disparities and needs related to their marginalized identities. This article will discuss current research on healthcare providers for LGBTQ foster youth in Washington State, including a literature review and a series of key informant interviews of healthcare providers from within Washington State who serve this population. The purpose of this study is to better understand the experiences of healthcare providers working with LGBTQ foster youth to improve their health outcomes.

Why LGBTQ foster youth?

LGBTQ foster youth experience a uniquely marginalized identity because of their sexual orientation and gender identity, and its relationship to their experience in foster care. They are

⁵ The community title “LGBTQ” commonly includes people with the identity “Queer”, as well as other extended versions of the acronym including questioning, allied, Two Spirit, pansexual, and other identities. For this study, the acronym “LGBTQ” is used as a metonym for a larger community of Lesbian, Gay, Bisexual, and Transgender people.

more likely to face caregiver rejection than their straight or cisgender peers and more likely to be bullied and harassed in school, which is coupled with experiencing frequent school changes.

LGBTQ foster youth face unique challenges related to a lack of continuity of care. This issue is widely explored in the area of caregiver permanency, but very little research has been done on the impacts of healthcare provider permanency, and little to none has been done from the perspective of the healthcare providers themselves, which leads to the next question:

Why healthcare providers?

Several surveys and studies have been conducted on the experiences of LGBTQ youth and the education social workers receive on LGBTQ youth, but not on the healthcare providers who serve them. Healthcare providers have unique relationships with LGBTQ foster youth. As a particularly vulnerable population, foster youth are protected by confidentiality laws (HIPPA) and best practice guidelines which govern the minimal standards of care they should receive. There is opportunity for healthcare providers to make a large positive impact on a foster youth's health outcome.

What do we already know?

Caregiver Relationships

LGBTQ foster youth face unique challenges related to trust, communication, honesty, and openness with their caregivers, as well as disruptions in the continuity of their caregiver relationships. There are very few culturally relevant resources for building relationships between caregivers and LGBTQ youth. A few of these include the Connections Evidence Based Practice, LGBTQ Affirmative family therapy, Families Like Ours Adoption Support, and Gender Diversity support group meetings. Other initiatives aimed at improving caregiver relationships with LGBTQ foster youth include the Family Acceptance Project led by Dr. Katelyn Ryan, and

The House, in Madison, Wisconsin. Successful caregiver relationships are key to LGBTQ foster youths' equitable access to high quality medical care.

Health Outcomes

There are several unique healthcare related issues which can be specifically attributed to the relationships between child welfare systems and healthcare providers. These include (but are not limited to): continuity of care, reimbursements of claims for payment, and providers' communication with caregivers and social workers.

Research indicates that LGBT youth are at higher risk for many different health disparities when compared to their heterosexual peers (City of Seattle, 2006). Health issues effecting LGBTQ foster youth include substance abuse (self-medication, addiction, smoking), and Child Sexual Exploitation and human trafficking. Increased rates of mental illness, such as anxiety and depression, and homelessness. Other health issues which particularly impact LGBTQ include use of PeP⁶ and PreP⁷ for HIV prevention, as "half all new HIV infections are among youth 15-24 years" (Kirby, 2002). Furthermore, there are issues of partner appropriate birth control, recreational drug use GHB, Meth, MDMA, Poppers (NO₂), and other drug use "chemsex"⁸, harm reduction, privacy around medical issues and identity (being "outed"⁹), bar culture as a primary location for LGBTQ social events, differing social norms around age gaps in relationships, consent, domestic violence, cultures of secrecy and closetedness¹⁰, and other safety issues related to being outed (Spade, 2015).

⁶ Post Exposure Prophylaxis, used to prevent HIV after possible exposure.

⁷ Pre Exposure Prophylaxis, used to prevent HIV prior to possible exposure.

⁸ Term used to describe sex had while under the influence of drugs.

⁹ Having private information about gender or sexual orientation shared without consent, as opposed to "coming out" voluntarily.

¹⁰ The state of being "in the closet", also known as "not being 'out'".

For transgender youth, community specific health issues include access to Hormone Replacement Therapy (HRT), gender affirmative therapy, access to legal counsel for name changes and other legal documents, access to reputable doctors regarding HRT, and access to sexual reassignment surgeries (SRS)¹¹ Health issues may also present themselves in the areas of social adjustment and social transition related to sexual orientation or gender identity, or arise from other unrelated mental health issues¹². The National Transgender Task Force's survey of the United States' transgender population found that "41% of respondents reported attempting suicide compared to 1.6% of the general population" (Grant, et al., 2011), which can be largely attributed to the extreme levels of social marginalization that transgender people face daily. This marginalization accompanies unique safety threats, especially for trans women and girls¹³ and issues of "passing, "outing" and safety, or being "stealth".

What do we want to know?

- How do healthcare providers navigate complex care systems and protocols to serve LGBTQ foster youth?
- How do issues of cultural competency or humility arise?
- How are these issues different for LGBTQ youth and their caregivers?
- What are the unique challenges faced by these providers?

¹¹ Not all transgender people feel the need to have gender affirming surgery or take hormones or have "the surgery". "There is no one "sex change" surgery that all transgender people have, and many trans people do not have gender affirming surgeries or feel a need to" (Kreitler, 2012).

¹² The DSM V does not list gender dysphoria as a mental disorder, differing from DSM IV's use of "gender identity disorder.

¹³ Higher rates of assault and murder than the general population.

1.2 NEED FOR RESEARCH

There has been a small but strong body of research into the experiences of LGBTQ foster youth and their experiences, but little to none on the experiences of their healthcare providers, who face very different barriers when working with large bureaucracies (e.g. Children's Administration, Juvenile Justice Systems, Medicaid) and are aiming to meet the needs of a vulnerable and unique population of youth.

The intention of this research is to better understand the experiences of six to ten of these such providers in the Greater Seattle Area through discussing the findings of these interviews and exploring how they relate to current research in the areas of child welfare, LGBTQ youth, and health outcomes. In learning about these health professionals, we gain valuable insight into the needs of two communities, healthcare providers and LGBTQ foster youth.

At a January 2017 community meeting, Seattle area healthcare providers for the LGBTQ community reported that their prior authorizations and claims paperwork was being denied by the Washington Healthcare Authority. The providers stated that they had trouble communicating with each other, primarily done through an email listserv, including making and receiving referrals. This research seeks to determine whether there is interest in creating a more cohesive network of health providers for LGBTQ foster youth within the community, and if so, what it would look like.

1.3 DEFINITIONS

See Glossary p. 106 (Appendix C).

Chapter 2. BACKGROUND

2.1 OVERVIEW

“There is no such thing as a single-issue struggle because we do not live single-issue lives” (Lorde, 1982).

This paper confronts the notion of a salient, or primary social identity, with the concept of intersectionality, which describes a perspective of intersecting identities based on race, class, and gender (Crenshaw, 1991). Intersectionality as a concept has been explored to consider many other social and personal identities (e.g. age, disability, nationality, etc.) and life experiences in the Hays ADDRESSING model (Hays, 2008). The concept of a salient identity is purported by the ideology behind liberal humanism¹⁴, which would suggest that all persons are equally free to compete for opportunities. This perspective fails to account for the dynamics of privilege and oppression in the intersections of social identities. Briggs defines oppression as “attitudes, behaviors, and pervasive and systematic social arrangements by which members of one group are exploited and subordinated while members of another group are granted privileges” (Bohmer & Briggs, 1991). These different experiences of privilege, oppression, socialization, institutional support and reinforcement of identities influence an individual’s positionality as either a target¹⁵ or agent¹⁶ group member (Nieto, 2010).

The concept of one poignant or salient identity, such as to be LGBTQ, a healthcare provider, or a foster youth, or even to have one conglomerated identity such as “LGBTQ foster youth” or “healthcare provider of LGBTQ foster youth” is challenged in this paper, which seeks

¹⁴ A system of thought that focuses on humans and their values, capacities, and worth

¹⁵ Oppressed, disempowered

¹⁶ Privileged, power holding

to convey the complexities of intersectional agent and target identities of LGBTQ foster youth and their healthcare providers.

Key issues explored in this study are the experiences of healthcare providers of the LGBTQ foster youth population of Washington State, as well as these providers' insight into the intersectional issues of LGBTQ foster youth, including race, transgender and gender nonconforming identities, and homelessness. This study builds on previous research by examining the relationships between LGBTQ foster youth and their healthcare providers, including how those relationships may be unique to the Greater Seattle Area.

More than ten years ago, at a Seattle Queer Youth Forum, it was declared to be “time to reinvest and pro-actively address disparities in the LGBTQ youth community” (City of Seattle Commission for Sexual Minorities, 2006). This forum was held to “hear directly from youth, families and service providers regarding their experiences in Seattle, identify ways to address the needs of this population”. This mission was to be held “in conjunction with the 10-year plan to end homelessness” and stated that the City of Seattle should support sexual minority status [as a] key social indicator of health”. Now, “The Trans Moment”¹⁷ is putting a heightened focus onto a very small population proportional to the general population. This surge in research interest and attention from academics has inspired this author to consider his own experiences with LGBTQ identity and child welfare systems from an alternative perspective, through one of an emerging professional in an allied healthcare field.

¹⁷ The “trans moment” is a mainstream description of the recent attention given to transgender people in the media and civil rights improvements for transgender people in the United States.

2.2 SEARCH METHODS¹⁸

The goal of the searches performed was to find diverse results by using different terminology, as well as to specifically search for PDF results with the intention to find documents and articles as opposed to blog posts, company sites, or social media. Because this research began with a basis in King County, the intention behind search was to try to find some results in the area, which included searching for Seattle and youth in the anchor to filter out results that are not in Seattle, and that are focused on adults. The searches featured the key words: LGBTQ, queer, gay, youth, social work, social welfare, foster care, child welfare, care providers, medical, mental health, dental, therapy, challenges, and homelessness. These searches were performed primarily using the search engines and databases: Google, ProQuest, and EBSCO.

The same searches were performed in other research databases as well, searching first in the index for subjects relating to “gay” and “youth,” and then reviewing the results for other subject headings. However, it was discovered that databases outside of the field of social work yielded few (if any) relevant results. Other databases used included AccessMedicine, America, History, & Life, History of Science, Technology, & Medicine, Human Rights Documents, Sociological Abstracts, and Web of Science. The largest challenge of this literature review was finding materials that focused on the perspectives and challenges of care providers rather than those receiving care. Many of the sources focused on the needs of queer foster youth themselves. Another challenge was terminology; In the fields of social work and gender studies, language is

¹⁸ This literature review was performed in collaboration with Master of Library Science Candidate Rachel Mahre.

constantly evolving, and this reflects strongly in the research, especially when using monographic resources.

2.2.1 *Concept Analysis*

See Appendix D (p. 109).

2.3 LITERATURE

2.3.1 *Research Findings*

| <u>Title</u> | <u>Author(s)</u> | <u>Publication</u> <u>Date:</u> | <u>Publication</u> <u>Type</u> | <u>Key Findings</u> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| “A Glimpse Within: An Exploratory Study of Child Welfare Agencies’ Practices with LGBTQ Youth” | Mitchell Rosenwald | 2009 | Literature Review | This literature review presents findings from a national survey of agency members of the Child Welfare League of America (CWLA) with respect to organizational culture and service delivery for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. They found that “agencies fall short of fully subscribing to recommendations made by the CWLA” and that “they could improve their support for providing an inclusive environment, creating supportive policies, and selecting childcare providers regardless of sexual orientation/gender identity”. They suggest that “although some progress has been made, much work remains for child welfare agencies to fully address the needs of LGBTQ youth”. |
| “Basic Premises, Guiding Principles, and Competent Practices for a Positive Youth Development Approach to Working with Gay, Lesbian, and Bisexual Youths | Gerald P. Mallon | 1997 | Article | Mallon argues that “gay, lesbian, and bisexual youths in out-of-home care can best be helped providing them with the same types of supports and services that all adolescents need” and include a five-aspect model of areas for these supports and services. |

| | | | | |
|-------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| in Out-of-Home Care” | | | | |
| “Obstacles to Effective Child Welfare Service with Gay and Lesbian Youths” | Richard T. Sullivan | 1994 | Article | Sullivan “argues for a reconceptualization of service delivery by child welfare agencies dealing with gay & lesbian youth that begins with a recognition of the unique developmental challenges facing sexual minority youths and proceeds to an examination of the systemic obstacles to providing competent services in their behalf”. |
| “Revolving Doors: LGBTQ Youth at the Interface of the Child Welfare and Juvenile Justice Systems” | Sarah Mountz | 2016 | Article | Mountz argues that “tremendous obstacles exist in providing effective, high-quality services to lesbian, gay, bisexual, transgender, and queer (LGBTQ) adolescents in the child welfare and juvenile justice systems”. The article “argues for the need to embrace an intersectional lens in child welfare and juvenile justice research, policy, and practice”. |
| “Sexual Orientation and Gender Expression in Social Work Education: Results from a National Survey” | Lambda Legal in partnership with the Council on Social Work Education (CSWE) | 2015 | Article | This article examines the experiences of service providers of LGBTQ youth in out of home care, “reported on the findings of listening forums held in 2003-2004.” The research gleaned information from “stakeholders, including LGBT youth and social work child welfare practitioners, [who] were asked about casework and experiences with the child welfare system”. Lambda Legal found “that youth and practitioners alike felt that social workers were not adequately prepared to work effectively with LGBT youth in out-of-home care (Woronoff, Estrada, & Sommer, 2006)”. |
| “Rural Social Workers’ Perceptions of Training Needs for Working with LGBTQ-Identified Youth in the Foster Care System” | Jean Toner | 2013 | Article | As an alternative to the urban focused narratives of most articles which study LGBTQ foster youth and their care providers, this article “reports on findings from an exploratory qualitative study with rural child welfare professionals concerning their perceptions of services and training needs for working effectively with LGBTQ-identified youth in rural out-of-home care”. The study involved participants from one region of a Midwestern state, and found that the |

| | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | | | “emergent themes corroborated extant research findings”. |
| <i>beFIERCE: A Toolkit for Providers Working with LGBTQ Foster Youth</i> | Stephanie Perron | 2015 | Book | This book invites the reader “to actively engage in supporting lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) foster youth”. Perron tells providers that they “have the power to make an impact in the lives of LGBTQ foster youth” and that “we have the incredible opportunity to beFIERCE!”, which is “to bravely do what many others have not: to show LGBTQ foster youth unconditional positive regard; to see them for more than the lies that may be written about them, than the behaviors they may be showing us; to see the bigger picture; and to see their lives through an intersectional and trauma-informed lens”. |
| “CWLA Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care” | Wilber, Ryan, and Marksamer | 2006 | Article | This article focuses on the areas of “LGBT youth in out-of-home care, creating an inclusive organizational culture, a family-centered approach to serving LGBT youth, promoting positive adolescent development, collecting and managing confidential information, ensuring appropriate homes for LGBT youth, LGBT youth in institutional settings, and providing appropriate health, mental health, and education services to LGBT youth”. |
| “Moving the Margins: Curriculum for Child Welfare Services with Lesbian, Gay, Bisexual, Transgender, and Questioning Youth in Out-of-Home Care” | National Association of Social Workers | 2009 | Article/Training Manual | This article “intended to provide training on building the capacity, awareness and skills of social workers and other child welfare practitioners to better serve and respond to the needs of this population of youth”. |
| “Opening Doors for LGBTQ Youth in Foster Care: A Guide for Lawyers and Judges” | Laver and Khoury (American Bar Association) | 2011 | Article/Guide | From a legal perspective, this article states that “lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth in foster care are disadvantaged for many reasons and judges and lawyers can help them”. They argue “that a number of child welfare agencies and national organizations that work with agencies were improving the situation for LGBTQ youth in foster care, but little was being done to |

| | | | | |
|--|--|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | | | help judges and attorneys do their jobs better”. They state that they created the book and the accompanying trainings to help judges and lawyers to this effect. |
|--|--|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------|

2.3.2 *Literature Reviews*

A search for literature reviews related to LGBTQ foster youth and their healthcare providers produced the following results. “Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth in Out-of-Home Care: Selected Bibliography and Resource Guide” prepared by Rob Woronoff, MS; “LGBTQ in Child Welfare: A Systematic Review of Literature” prepared by the Anne E. Casey Foundation; “Recent Works on Practice with LGBTQ Youth” prepared by the Child Welfare Information Gateway; and “Working with Transgender Youth in Foster Care and Runaway and Homeless Youth Programs” prepared by the Child Welfare Information Gateway. These literature reviews contained varying quantities of articles with varying levels of analysis or meta-analysis, with some being as nondescript as a simple list of links to articles and their titles.

2.4 PREPOSITIONS AND ASSUMPTIONS

In this study, it is assumed that when healthcare providers work with LGBTQ foster youth, they face unique professional challenges related to providing continuity of care, culturally relevant treatment related to LGBTQ identities, and interacting with large bureaucratic social service organizations because of the complex needs and identities of this population. Furthermore, it is anticipated that despite these challenges, many providers feel personally drawn to this work due to a commitment to social justice and advocacy related to LGBTQ issues. In addition, provider’s experiences will reflect that LGBTQ foster youth face challenges unique to

their experiences of rejection by caregivers, unique medical needs related to transgender healthcare, such as the impact of guardianship on informed consent for Hormone Replacement Therapy (HRT), experiences with social rejection and bullying in schools, and involvement in the sex trades and/or commercial sexual exploitation.

Chapter 3. METHODS

3.1 INTRODUCTION

As a qualitative study, this research was performed through eight key informant interviews from service providers who accept or have previously accepted referrals from DSHS Children's Administration for current foster youth and extended foster youth, aged 0-21. The children served by these providers were all older than three years old who could verbalize a gender or sexual identity. No participants withdrew from this study. All information collected is anecdotal and empirically based on the perspectives of the participants involved.

3.2 DESIGN

This study was performed through a series of semi-structured interviews. The study received IRB Category 2 exemption with respect to participant anonymity. Inclusion criteria for subjects were: over eighteen years of age and has professional experience working with LGBTQ youth in a healthcare or related field. Subjects were excluded if they did not meet that criteria. Potential participants were identified through the King County LGBTQ Resource Guide, the Ingersoll Gender Center care provider listserv, and through snowballing of these collection methods.

Participant Recruitment Procedure:

Participants were recruited through a non-probability convenience sample. After recruitment via email, subjects were scheduled for interviews and informed that the interviews would take place over less than one hour and occur in person, over the phone, or via email if the participant is unable to meet either in person or over the phone. Participants were given

information about the study and a chance to decide if they will to participate. Participants were given an information statement via email and sent a list of interview questions from a questionnaire (see attached questionnaire) at least one week prior to the interview. During all but one of the interviews, participants were asked questions and the interviewer recorded their responses by transcribing the interview through note-taking.

One participant was unavailable to meet in person due to scheduling conflicts and their questionnaire was completed and returned via email. Another participant was unable to meet in person due to distance and their interview was performed over the phone. Lastly, participants were thanked for their participation and given the option of having their data withdrawn if needed. Participants were provided with transcripts of their interview with redacted personal information and given the opportunity to edit, add, or withdraw statements given during their interview.

Participants were given an information statement (See Appendix A: Information Statement) which stated the following:

... "there are always risks that accompany the research process. However, we do not anticipate any other risks than these risks that accompany the research process. Participants will respond to interview questions from a questionnaire read by the student investigator in a manner consistent with traditional interview procedure. No identifying information about subjects (Name, age, place of employment) will be contained with interview responses. Names of participants will not be published in the study and will be kept only by the student investigator on an encrypted and password protected computer. None of the data will be individually-identifiable data that you obtain without the subject's consent from a Washington State public institution of higher learning or the Washington State Department of Early Learning,

Department of Social and Health Services, Department of Health, or Department of Corrections”.

Redactions:

Redactions were used liberally in this research due to potential releases of confidential information about clients served by these healthcare providers, as well as possible personal identifying information about participant identities, those of their colleagues, and locations where they have worked. To provide useful information about the types of clinics where providers currently or have historically worked and to identify types of professional relationships they have with colleagues; responses have been redacted and coded with standardized terms including:

- Community Clinic
- Children’s Hospital
- Homeless Youth Shelter
- LGBTQ Youth Crisis Hotline
- Counseling Center
- LGBTQ Student Group
- Therapeutic/BRS Group Home
- Adoption Agencies
- Local Foster Care Support Nonprofit

Certain redactions were made without relabeling, such as names of colleagues or potentially identifying personal information about clients or providers’ families.

These redactions were intentionally made during the interview with the notification of the participant immediately after potentially identifying information was shared.

Comments made during the interviews which were requested to be “off the record” or “off the cuff” by either the interviewer or interviewee were not included in the transcribed interviews, nor were they noted by any markings or coding in the interview. On-record follow-up questions or comments made by the interviewer are noted with an asterisk in the interview transcripts. Throughout certain interviews, simple follow-up and clarifying questions were asked by the interviewer such as “what do you mean by that” or “can you tell me more about that” to gain greater insight into an interviewee’s response. These follow up questions are not included in the transcripts of the interviews to improve flow and readability.

The two names of nonprofit organizations are not redacted from this paper. The name of the “Big Brothers Big Sisters” organization was not redacted from this paper because the organization is of such a large scale that it is unlikely that a participant would be identified through sharing information about having participated in the organization. It is also not redacted because the name of the “Big Brothers Big Sisters” organization serves as proprietary eponym¹⁹ for similar type adult-youth mentorship programs. The name of the “Ingersoll Gender Center” was not redacted from this paper because the email listserv from which participants were recruited maintains the confidentiality of members of the listserv.

The names of the public institutions and services used in non-identifying contexts including the University of Washington, Washington State Department of Social and Health Services, Children’s Administration, Coordinated Care, and Medicaid are not redacted from this paper. The title of “Ryan White funded HIV program” is left as written by the participant as it does not specifically identify the name or type of program or the identity of the participant.

Interview Procedure:

¹⁹ Registered name which has become synonymous for the service or product it delivers, a cultural icon.

1. First, participants read the information statement (Figure 1 in the Index) and consented to participate in the study.
2. Participants shared their responses to each question through an emergent interview. At times, participants would begin to give responses that related to other questions, and thusly those questions would be skipped to improve the flow of the interview.
3. To record data, the interviewer used a method of en vivo documentation²⁰. Rather than recording interviews from audio and transcribing them to text or using a software with a speech-to-text function, the interviewer recorded interviews by manually typing participant responses during the interviews.
4. As the interviewer began performing interviews, by the second interview it was noticeable that both healthcare providers appeared to have pertinent experiences with certain clients or cases. As the interviews continued, participants were asked the question:
“Previous participants have stated that they have encountered specific clients or cases that have been challenging or troubling to them as a provider. Are there any particular cases that stand out to you or have been particularly challenging?”

This specific question was asked to participants 3-6 and 8, as participant 7 submitted a questionnaire which had not had this question added to it via email. To discourage attrition after initial agreement to participate, one participant was sent a \$5 ‘Thank You’ gift card for coffee to reaffirm active engagement through reciprocity²¹.

²⁰ Interviews were typed by the interviewer during the interview in real-time.

²¹ Mutual benefit through the principle of reciprocity can shows improved rates of participation in study participants.

3.3 SAMPLE

This study at its completion included eight participants who serve LGBTQ foster youth from Washington State, all of whom practice in the Seattle metropolitan area, except for one participant, who practices in Portland, Oregon, but who also serves Washingtonian LGBTQ foster youth.

Of the eight participants, two stated during the interview that they identify as gay men, one stated that they identify as transgender and use they/them and he/him pronouns, one stated that they identify as a straight cisgender woman, and two participants stated that they identify as bisexual women. As a group, at the time of interviews, the providers all had between five and fifteen years of experience working with LGBTQ foster youth. Of the eight total participants, four responded to emails containing their transcripts, one did not request any edits or redactions, one participant requested a redaction, one participant requested an edit to a quote, and one requested edits to their interview and one redaction.

3.4 ANALYSIS

3.4.1 *Qualitative Data Analysis*

Responses were coded for themes across a broad array of topics. A theme was determined by a topic or message which occurred in one or more interviews. For purposes of discussion and analysis, these themes were identified within and between interviews. If a participant were to make an emphatic point regarding a topic during their interview, this would be regarded as a ‘theme’. Participants’ verbal emphasis in their identification of a potential theme was interpreted as a more in depth discussion of a topic, or a more animated physical or vocal expression than other parts of the interview. This emphasis indicated a particular richness

of a specific topic in an interview which is key to determining findings in a qualitative analysis. Themes were determined based on their presence within individual interviews, as well as those which indicated trends shared among the collection of interviews.

3.4.2 *Coding of Responses*

Participant responses were coded for topics related to themes which emerged during their interviews. Apriori themes were those themes which corroborated the initial assumptions of this research, which were that practitioners encountered issues regarding:

- Continuity of care
- Personal connections to the LGBTQ community
- Intersectionality

Emerging themes were determined to be themes which occurred outside of the scope of these initial assumptions. These themes included:

- Visibility
- Credentials/authority
- Medicaid
- Legal issues
- At least one outstanding/plaintive patient or case

Chapter 4. FINDINGS

4.1 BRIEF OVERVIEW

4.1.1 *Cohort profile*

All eight participants responded to questions from the questionnaire, and six of these participants performed in person interviews, five of these were performed in the provider's offices, one was performed at a coffee shop in the community. One participant was unavailable to meet in person due to scheduling conflicts and their questionnaire was completed and returned via email. Another participant was unable to meet in person due to distance and their interview was performed over the phone. The shortest interview was interview 5 at approximately 45 minutes, and the longest interview was interview 4 at approximately one hour and a half. All other interviews lasted approximately one hour. The interviews were designed to meet the scheduling needs of the healthcare providers in the least burdensome way possible, as doctors and healthcare providers are notoriously busy. A few participants had schedulers who arranged the date and time of the interview on their behalf.

4.1.2 *Interviews*

Interview 1:

"Say a kid is suicidal and needs to be hospitalized; there's never enough beds, and the social workers are all busy and the whole process is so hard that it's often not helpful... and the last thing people need when they reach out to get helped is to be shown that they can't be helped because it just reaffirms all of the messages of homophobia transphobia and racism.

Are they out? Are they not out? What's their parent's reaction if they are? The message we're supposed to be able to send is that you were not safe before but you are safe now, you learned that you had to blow up or be constantly guarded and that's something we can help teach but when there's truth to that some people are never safe, what do we do? Real talk? You're right that you will be bullied and you're right to be worried about what your parents might say and that bathrooms will be hard for you... and how do you still show up and recognize that there are therapeutic moments to be had there? ...But it's infuriating, absolutely. Because they should... they should have better than they do".

This participant, a Licensed Independent Clinical Social Worker and Sexual Minority Mental Health Specialist, currently works with LGBTQ former foster youth as a child and family therapist at a transitional living program.

Interview 2:

"I think in general these kids are really well supported and they have a lot of advocates that are working for them. It's my impression that they have an adversarial relationship with getting their needs met and they come into medical care expecting more of the same...and I'm not sure how they find me but they do... and it's amazing for me to see apprehension melt into excitement. I'm a bulldog willing to get what they need and I'm willing to fight the fight, and they are sometimes sheepish about asking to get what they want, even if the social worker contacts me in advance...But once they know that I'm behind them and that there's things that are medically reasonable and they hear me say things in front of the social worker, they are really happy.

I call it 'gendercare'. I think that it's happy medicine. It's a transformation; helping a caterpillar become a butterfly... and in general kids are incredibly motivated. If you ask

a kid to do shots every week of their lives, if it's insulin they'll flake, but if its testosterone or estrogen they'll do it."

This participant, a physician in family medicine, is a medical doctor at an urban community clinic that serves transgender children and youth.

Interview 3:

"Here's something I see that concerns me: in the adoption community as a whole, a lot of people get into fostering and adoption from a conservative Christian perspective... and get into child saving... and have troubling reasons behind fostering, adopting, etc. So, you have a kid who comes into care with a family when they're like 6 years old. A conservative Christian family, and I actually feel like preparation and readiness for foster families is not done very well... so the kid comes out and it's kind of a disaster, and there's not a lot of advocacy on the part of Children's Administration saying 'you need to parent this child and be affirming of this child and their gender and sexuality'.

I feel like people need to be screened for that. There's also the white savior people and there's also a lack of preparation on the part of white people in the area of transracial adoption. I have seen horrible disruptions and I have seen families that decide to take on a kid and those disruptions have been around race. I [believe] that race can be even more of an issue [than sexual orientation or gender identity]. I've been approached by white people who have been interested in foster to adopt and I've had concerns about those people due to their "colorblindness". Most of the concerns I've had have been about race... and that often foster or adopt parents don't understand the impact of trauma and they take children's traumatic acting out personally."

This participant, a Licensed Mental Health Counselor and Certified Adoption and Foster Care Therapist, has worked with families who are in the process of adopting a foster youth, as well as helping families prepare for adoption.

Interview 4:

“There is no network. There are individual providers who are champions, who will work super hard, and who will drive kids places, but as soon as they leave... it collapses, and there is nobody there to do that free labor. There is no network of systems. That was my experience with burnout. I would put more kids on my caseload if I knew they were trans because I know they only had Medicaid... and I would stay up later and take that on as my emotional labor because I am not only helping these kids, but I am fighting the system. My supervisor would say, ‘it is your passion, not your job’ and that’s why I had to step back from community mental health. Now I’m an individual therapist at a local Counseling Center for kids that are queer and trans identified. [...] and we are all these queer and trans people working individually and experiencing burnout...and we don’t show up in community... and that burnout is from secondary trauma. I mean, I have thought of killing myself, you know? We don’t talk about this because of the shame... “

This participant, an adolescent, individual, and family therapist, has worked as a licensed marriage and family therapist, mental health counselor, and residential counselor at a Therapeutic/BRS Group Home.

Interview 5:

“I wanted to go into pediatrics because [youth] can have better outcomes as adults. As a gay cisgender male, I knew I wanted to help with some of the disparities that some of my peers were having... They didn’t feel comfortable coming out. I went to college during

the AIDS crisis and I wanted to give back to the patients that I saw. I wasn't geared towards foster youth, but I did my residency in adolescent medicine and I saw all kinds of youth; adoptions, foster youth... Here, I'm a subspecialist. We don't do primary care. We see chief complaints and we see the occasional foster youth that comes through, so ultimately learning some of the disparities that young people have, even adults, LGBTQ, whatever; I wanted to make sure that I could serve all of them. When I serve them, it's not a special thing that I do. I identify them and counsel them. The key thing with that population is to ask them, and when you ask them, generally they are upfront. When people go through medical school and training, they are taught how to ask about sexual history, but not gender identity. I've found that trans youth and gender nonconforming youth have higher health disparities...and I wanted to focus on them. So, when I came here, my boss asked me all the things I want to see patients for, and I said, 'obesity, eating disorders, LGBT patients'... So, that was when I started getting patients. Because they were showing up and needed special care".

This participant, a professor, researcher, and medical doctor of adolescent medicine, is the clinical director of the gender clinic at an urban children's hospital.

Questions 6 and 7 were skipped due to time constraints as participant gave responses that indirectly addressed those topics.

Interview 6:

"I think it's hugely enjoyable to take a group of kids who have often have negative experiences with healthcare providers in the past and take the opportunity to do some trust building and connect them with the resources they need, it's my favorite part of the job".

“One thing I’m sure of is that there is a lack of high quality homes for youth that identify as LGBTQ. We did a study with foster and kinship caregivers and stakeholders, and one participant who was a social worker... she talked about how she had to put kids who identify as LGBTQ in homes where it was ‘okay’ for the kid to be home, and it’s not ‘okay’. Tolerance is not an affirming environment; it’s not okay for her to have to place kids in homes like that. I do think there’s a huge need for truly affirming foster homes”.

This participant, a professor, researcher, and medical doctor of adolescent medicine, has worked almost exclusively with foster youth on reproductive health, including sexually transmitted disease and pregnancy prevention, and currently works in clinical research with the gender clinic at an urban children’s hospital.

Interview 7:

“Lack of resources available to this population means that as a social worker, you’re always trying to do more with less, which means more time and creativity, often when caseloads are already high. Because of the burnout that impacts workers for this population, clients are constantly having to start over with someone new, which can contribute to understandable cynicism and reluctance to engage with you as a new social worker. Additionally, the issues that impact LGBTQ foster youth are often ones that frankly make a lot of adults uncomfortable (adolescent sexuality, safer sex, drug use, mental health, etc.), so it can be tough to navigate conversations with other providers about why talking about these topics and normalizing bodily autonomy and informed decision-making are so important”.

This participant, a social worker and the program manager of pediatric transgender care at an urban children’s hospital, has offered specialized services to LGBTQ clients in several settings,

including HIV case management for patients who have recently aged out of foster care, chronic illness case management for LGBTQ foster youth and their families, and life skills and healthcare access coaching for LGBTQ foster youth.

This participant was not asked the question: “Previous participants have stated that they have encountered specific clients or cases that have been challenging or troubling to them as a provider. Are there any particular cases that stand out to you or have been particularly challenging?” because they submitted a written questionnaire via email.

Interview 8:

“...Another client who was in and out of foster care who started testosterone... he was lost, we couldn’t find him again... and the Juvenile Authority called us because he came up there and he ended up moving to a separate state. We had to work with the jail and they had to find him a provider in the other state to get him on testosterone again. We were working with the Youth Authority to determine whether he should start testosterone there or not and we all decided that he should start again in the other state so it could remain consistent once he moved. I think he was 16. That was a really rough case. Just the brightest kid, but really damaged by trauma, and some of the trauma was gender based. That was about 4 months ago... he finally moved. Our whole clinic is still thinking about it.

I think for people who aren’t in this field it illustrates how hard these stories are... and if they weren’t in state custody they would be getting decent medical care and people would be able to keep track of them... and there’s these things that happen that are so shocking...”

This participant, a psychiatric mental health nurse practitioner, has worked in community mental health, school based mental health, and currently works in private practice and at two multidisciplinary clinics, one of which is for transgender and non-binary youth.

This participant primarily practices in Portland, Oregon and was referred to this study by a colleague who is a member of the Ingersoll Gender Center email listserv. This participant was included as she fits the criteria of a healthcare provider who serves Washingtonian LGBTQ foster youth²².

²² Multnomah County is a large urban area which borders Southern Washington, which is a more suburban/rural area that does not offer as many services for LGBTQ foster youth as its neighboring city, Portland, Oregon. Providers in this area contract with Washington State Department of Social and Health Service's Children's Administration, Region 3, comprised of the Southwestern corner of Washington State.

4.2 INTERVIEW THEMES

4.2.1 *Strengths*

Visibility

Multiple providers (Appendix B: Interviews 1 & 2) discussed making themselves as a provider, their office, or their clinic visibly LGBTQ affirming as a way to serve their clients in ways that are more culturally specific and welcoming. In the LGBTQ community, there are growing movements²³ by patients to mitigate patient provider tensions, and many providers aiming to visibly identify themselves to patients using rainbow stickers or signals to indicate their practice as LGBTQ affirming, such as those mentioned in interview 2 (Appendix B: Interview 2).

Credentials/authority

One provider had obtained community specific credentials as a sexual Minority Mental Health Specialist (Appendix B: Interview 1). This higher level of specificity in an already specialized field shows a strong dedication to excellent standards of care as a provider for this community. One provider suggested that LGBTQ specific healthcare for foster youth showed strong evidence of medical compliance (Appendix B: Interview 2) due to its categorization as “happy medicine”, which may also be described in this context as “gendercare”.

Intersectionality

Providers’ awareness of issues regarding intersectionality and LGBTQ foster youth identity; Participants frequently referenced concepts or experiences which alluded to their

²³ LGBTQ patient advocacy groups, forums, and the presenting of medical providers with “Q Cards” which are pamphlets used as prompts for patients to discuss gender and sexuality with their patients.

experiences of intersectionality, and those of their clients. These concepts addressed issues of race, religion, gender, and sexual orientation.

Professional network

All providers stated that they felt there should be a community of medical providers serving LGBTQ foster youth, and many had cohesive and mutually shared ideas about what this network may look like “in an ideal world”.

Legal issues

Providers encountered opportunity to set legal precedents which may preserve LGBTQ foster youths’ rights to equitable medical care, particularly transgender foster youth and their access to hormone replacement therapy (Appendix B: Interview 2). Multiple providers desired legal changes to promote the continuity of medical care for LGBTQ foster youth (Appendix B: Interview 1, 5 & 6).

Personal connections to the LGBTQ community

Several providers cited their identity as members of the LGBTQ community as a driving force behind their desire to work with LGBTQ foster youth, which can be a motivating factor to enter the field, as well as to continue working in the field. All providers appeared to be extremely enthusiastic about their provision of healthcare for LGBTQ foster youth. These providers could give clearly identified needs of both communities, their own professional communities, and the needs of the LGBTQ foster youth that they serve.

At least one outstanding/plaintive patient or case

All providers but one explicitly mentioned having at least one case that was particularly challenging or memorable for them. From a strengths based perspective, this can be interpreted

as evidence of providers building strong relationships to their clients, and showing immense dedication to the outcomes of their health and wellbeing.

4.2.2 *Challenges*

Visibility

One participant suggested that the safety risks associated with visibility as a healthcare provider of LGBTQ foster youth could compare to the safety risks of being an “abortion provider” in areas outside of Seattle (Appendix B: Interview 2).

Credentials/authority

Multiple providers stated that they felt their authority as experts were challenged based on public opinion that sexual orientation and gender identity are social issues (Appendix B: Interview 3), not medically based issues. One provider suggested that their medical expertise is questioned (Appendix B: Interview 2) based on this concept and that it would not be the same for their opinion on an issue such as “vaccines”.

Intersectionality

Multiple participants noted that for many of their clients, their salient identity²⁴ was often more heavily rooted in their race or ethnicity (Appendix B: Interview 1, Appendix B: Interview 3), as this was immediately visible to peers, whereas sexual orientation or gender identity could be kept private until a moment of “coming out”²⁵. One participant stated that religious beliefs²⁶ (Appendix B: Interview 3) of foster care providers can be a major contraindication to LGBTQ affirming foster homes.

²⁴ Primary social identity

²⁵ Colloquial reference to disclosing one’s gender identity or sexual orientation, publically or privately.

²⁶ Specifically Christian

Medicaid

Multiple providers stated that they are unable to afford to accept Medicaid patients due to low reimbursement rates, despite that they have experience serving LGBTQ foster youth and would be ideal providers for this population.

Professional network

Several providers discussed the limitations of a professional network that is largely internet based with limited to no ability to make referrals, view other providers' professional information, receive continuing education classes, or to socialize.

Continuity of care

Several providers experienced challenges when their clients moved out of state for reasons related to their involvement in the child welfare system (Appendix B: Interview 2). These providers also struggled with the ethics of prescribing hormones when there may not be continuous gender affirming healthcare, such as beginning to take hormones but having to stop because of a lack of provider after the child moves (Appendix B: Interview 8).

Personal connections to the LGBTQ community

Multiple providers who identified themselves as members of the LGBTQ community spoke of their experiences of secondary trauma²⁷ related to their clients' experiences with their parents, with some of these instances of secondary trauma occurring during therapy sessions with providers (Appendix B: Interviews 3 and 4). These providers expressed their frustration with the challenges of working with parents and caregivers who reject their children based on their sexual orientation or gender identity.

²⁷ Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD). This is referred to as secondary traumatic stress (STS) which is sometimes also called "compassion fatigue", "vicarious trauma", or "indirect trauma".

Legal issues

One participant spoke at length about the need for doctors to testify as witnesses in court to set legal precedents based on their medical expertise regarding LGBTQ foster youth.

At least one outstanding/plaintive patient or case

All providers (except one who was not asked) explicitly mentioned having at least one case that was particularly challenging or memorable for them. Several of these providers said that they thought of this patient or these patients frequently, and many wondered what had happened to them. Several participants appeared or sounded forlorn or melancholy when reflecting on these patients.

Other challenges:

It is estimated that the population of LGBTQ persons is small, and that the transgender community is smaller yet. Studies suggest that the transgender population is somewhere near .6-.7 percent of the general population, which is double a previous estimate of .3 percent (Flores, Herman, Gates, & Brown, 2016). This relatively small population creates a proportionally smaller number of clients, and subsequently a smaller number of providers that specialize in serving these clients' medical needs. This means that many of these healthcare providers work together, or have direct collegial relationships with each other. Due to this dynamic, participants' professional interpersonal relationships posed a challenge in this study, as two providers seemed to fundamentally disagree on the topic of whether LGBTQ healthcare should be offered by 'all providers' (Appendix B: Interview 5) or whether it warrants specialized care and that the provision of this care by all providers is more of a "long term goal" (Appendix B: Interview 6). One participant stated that a colleague (who was not a participant in this study) "had a lot of 101 questions" (Appendix B: Interview 6).

Western medicine and public child welfare systems are both compliance based models (Appendix E). The attitude of “trust but verify”²⁸ shows a culture of distrust on the part of the investigator or social worker, acting as an agent of the public child welfare system. This builds a complicated and delicate relationship with LGBTQ youth, who are predisposed to be seen as noncompliant or transgressive due to their target identities outside of gender or sexual normativity. Due to their experiences with marginalization, LGBTQ foster youth must adapt socially to have their needs met, and these methods of survival are outside of compliance with laws or social norms. When these social adaptations become maladaptive, LGBTQ foster youth enter the prison industrial complex through school to prison pipelines, where LGBTQ foster youth are vastly overrepresented.

Adversarial relationships have existed between healthcare providers and the LGBTQ community, historically and currently, largely because of patients not having their needs met by their providers (Appendix B: Interview 2) subjected to humiliation, violations of privacy to parents or caregiver, or attempted “conversion therapy”.²⁹ There is also a legacy of distrust of medical providers and researchers by communities of color whose human rights have been repeatedly violated³⁰ by providers that have sworn oaths to “do no harm”³¹.

4.3 DISCUSSION OF ASSUMPTIONS

This researcher assumed that when healthcare providers work with LGBTQ foster youth, they face unique professional challenges related to providing continuity of care, culturally relevant

²⁸ Quote generally ascribed to Ronald Regan, which is commonly used in social work.

²⁹ Considered malpractice and illegal in many states, conversion therapy is a “therapeutic” attempt to change a persons’ sexual orientation, particularly devastating to youth and young people.

³⁰ E.g. Tuskegee syphilis study, HeLa DNA

³¹ Although not part of the Hippocratic Oath, an optional rite of passage for many medical providers, the phrase “first, do no harm” is included in many modern medical student oath swearing ceremonies.

treatment related to LGBTQ identities, and interacting with a large bureaucratic social service organizations because of the complex needs and identities of this population. It was also assumed that despite these challenges, many providers feel personally drawn to this work due to a commitment to social justice and advocacy related to LGBTQ issues.

Evidence from this study supported the assumptions that health care providers work with LGBTQ foster youth in the areas of homelessness, transgender and gender nonconforming identities, rejection by caregivers, and unique medical needs related to transgender healthcare, such as the impact of guardianship on informed consent for Hormone Replacement Therapy (HRT).

In this study, evidence from the healthcare provider interviews did not support the assumptions that LGBTQ foster youth in Washington State experience involvement in the sex trades and/or commercial sexual exploitation. However, one participant (Appendix B: Interview 2) discussed the challenge of discussing harm reduction methods in Sexually Transmitted Infection prevention such as PREP because this made parents or caregivers uncomfortable with the idea of their child's "promiscuity". Another participant (Appendix B: Interview 7) states that "the issues that impact LGBTQ foster youth are often ones that frankly make a lot of adults uncomfortable (adolescent sexuality, safer sex, drug use", and it is unclear whether the two participants' comments about "promiscuity" or adolescent sexuality, safer sex" may also refer to the sex trades and/or commercial sexual exploitation.

Regarding experiences with social rejection and bullying in schools, although there was mention of school related anxiety by one participant (Appendix B: Interview 8), as well as poor school performance related to risky behaviors including drug and alcohol abuse discussed by

another (Appendix B: Interview 3), none of the participants specifically discuss bullying or social rejection in a school setting.

The fact that these assumptions are supported in conversations with the study participants does not mean that these are not pertinent issues effecting the lives of LGBTQ foster youth in Washington State, but that based on the narrowness of the interview questions, participants' responses did not explicitly feature the aforementioned issues.

Chapter 5. CONCLUSIONS

5.1 SUMMARY

This research sought out to create a better understanding of the experiences of healthcare providers working with LGBTQ foster youth to improve their health outcomes. As a disproportionately overrepresented group in public child welfare, Lesbian, Gay, Bisexual, and Transgender (LGBTQ) foster youth have unique health disparities and needs related to their marginalized identities. In this study, it was assumed that healthcare providers that work with LGBTQ foster youth in Washington State face unique professional challenges related to providing continuity of care, culturally relevant treatment related to LGBTQ identities, and interacting with large bureaucratic social service organizations because of the complex challenges faced by this population. Furthermore, it was presumed that despite these challenges, many providers feel personally drawn to this work due to a commitment to social justice and advocacy related to LGBTQ issues. In addition, that the provider's experiences would reflect that LGBTQ foster youth face challenges unique to their experiences of rejection by caregivers, unique medical needs related to transgender healthcare, such as the impact of guardianship on informed consent for Hormone Replacement Therapy (HRT), experiences with social rejection and bullying in schools, and involvement in the sex trades and/or commercial sexual exploitation.

The research was performed through eight semi structured key informant interviews, and provides a qualitative assessment of the experiences of healthcare providers of the LGBTQ foster youth population of Washington State, as well as these providers' insight into the intersectional issues of LGBTQ foster youth, including race, transgender and gender nonconforming identities,

and homelessness. It was discovered that healthcare providers of LGBTQ foster youth have many unique strengths and challenges as providers, and many have a wealth of experience in navigating complex care systems and protocols to serve LGBTQ foster youth. They faced a variety of these issues across the key areas of:

- Visibility
- Credentials/authority
- Intersectionality
- Medicaid
- Continuity of care
- Legal issues
- Personal connections to the LGBTQ community
- At least one outstanding/plaintive patient or case

The apriori themes were those themes which corroborated the initial assumptions of this research, which were that practitioners encountered issues regarding:

- Continuity of care
- Personal connections to the LGBTQ community
- Intersectionality

It was assumed that practitioners would encounter issues in these areas based on the author's own experiences of facing challenges related to establishing continuity of care for clients in the child welfare system, identity as a member of the LGBTQ community, and encountering intersectionality from both professional and academic perspectives in the context of serving LGBTQ foster youth.

The emerging themes were determined to be themes which occurred outside of the scope of these initial assumptions. These themes included:

- Visibility
- Credentials/authority
- Medicaid
- Legal issues
- At least one outstanding/plaintive patient or case

These themes presented themselves outside of the scope of the assumptions of this study. Issues of visibility, credentials/authority, and Medicaid are all extremely unique to the positionality of a clinician in a healthcare field, which is outside of the scope of the professional experience of the author of this paper and was not considered beyond the general challenge of ‘working with large bureaucracies’ or social service organizations. It was surprising to find that clinicians could face the challenge of being asked to provide legal testimony which may set a judicial precedent regarding LGBTQ healthcare for foster youth. This finding emphasizes the extraordinary burden to act as an advocate for the community of LGBTQ foster youth in more spheres than ones’ sole profession. It was also remarkable (though less surprising) that nearly all participants felt that they had at least one outstanding/plaintive patient or case. This reflects the researcher’s own experience of struggling to find closure with several past clients who had lost contact with the service agency, never to be heard from again.

Participants also expressed several strengths in their practice with LGBTQ foster youth, including dedication to the LGBTQ community due to their own identities, passion for their work, and the feeling that they can make significant positive impacts in the lives of their patients and clients. Many of their challenges stemmed from difficulties with providing continuous care for their patients due to out of state changes in foster care placements, challenging interactions

with parents who do not accept their children's sexual orientation or gender identities, and feelings that their work was being undervalued or undermined.

These issues are unique to the relationships between LGBTQ foster youth and their healthcare providers because LGBTQ foster youth are uniquely vulnerable to changes of caregivers and placements, and struggle to obtain continuous healthcare. This challenge is exacerbated by the sensitive nature of healthcare that is related to ones' gender identity or sexual orientation. For providers, these challenges present themselves through experiences of burn out or exhaustion resulting from secondary trauma and systems fatigue³².

These research methods intended to take the onus of responsibility of storytelling away from a hyper marginalized community (LGBTQ foster youth), to learn about marginalization of professionals who serve this community, and through this inquiry, the experiences of their marginalized patients. Several of the interviews felt emotionally charged³³, with pauses that suggested moments of introspection and a return to professional bearing (Appendix B: Interviews 1, 3, 4, and 5). These interviews were unique due to the semiotics of the spaces where they were performed. As five out of the eight total interviews were conducted in providers' personal clinics, offices, and workspaces.

For several of these five providers, this would be the environment in which they treat patients. Participants shared personal information in an environment where they normally would instead be asking for personal information related to their patients' health and wellbeing. Participants were asked personal questions about experiences of "burnout" and other sensitive topics related to emotional wellbeing and vulnerability as a provider. This changed the dynamic

³² Colloquialism regarding the feelings of frustration and malaise one experiences from struggling to interact with or receive services from a large bureaucratic organization, or multiple organizations at one time.

³³ Author's subjective interpretation of the presence of strong feelings of emotion in either party.

of the typical relationship between a visitor to their office normally being the subject of an interview, to the provider themselves being interviewed in their own office. This change in the participants' role as a study participant in their workplace challenges the fourth wall³⁴ (Gurney, 2003) created by one's positionality and performativity as a professional, which should be portrayed to a client to create a sense of credibility and trust.

Challenges regarding the interpretation of these responses surround the ethical responsibility to present all available information from the interviews in appropriate context, and to acknowledge the potential for politically biased interpretation of anomalous information. By anomalous, it is implied that participants plausibly felt inclined to share unique case related information that outliers typical narratives of the experiences of LGBTQ foster youth seeking healthcare. The issues of informed consent present themselves here, because children have limited and varying capacities to provide informed consent, and need adults or other medical professionals to advocate for their needs and desires regarding their medical care. In the controversial area of pediatric and adolescent healthcare, it is imperative that these carefully sought decisions and these medical professionals' focus on these areas do not reflect "manipulating" kids to meet an agenda.

For example, two providers discussed the issues of reproductive health and informed consent in their experiences providing HRT to transgender youth. There are impacts on reproductive function across the lifespan after taking either blockers or hormones, which are dependent on onset, dosage, continuation of HRT, and the choice to undergo surgery which may impair or inhibit one's reproductive abilities. One participant discussed a client that "de-transitioned to live as gender non-conforming" (Appendix B: Interview 2), and another

³⁴ Term used in drama/stage acting to describe the separation between performer and actor, despite the physical presence of a physical wall.

participant discussed a client who began HRT as an adolescent, and reflected upon their decision as an adult who may desire to bear children (Appendix B: Interview 5). The participants both reported that neither client regretted transitioning or taking hormones, but one chose to stop using hormones to create a child.

5.2 IMPLICATIONS

The potential impacts of this study include positive impacts on healthcare providers of LGBTQ foster youth as a community, as well as better communication, better networking amongst professionals, and accountability systems for higher standards of care. Optimization of provider relationships and experiences should lead to better health outcomes for LGBTQ foster youth, including proactive, instead of reactive medical care, which is preventative in nature, instead of restorative. Through studying the motivating reasons why people choose to serve LGBTQ foster youth and the experiences of “burn out”, issues of provider recruitment and retention can be appropriately addressed in the workplace.

The themes of these interviews also suggest that provider continuity and communication greatly impact the quality of care and health outcomes that LGBTQ foster youth receive, especially regarding HRT, psychotropic medication management, and other time frame sensitive medical needs which require closely followed regimens and renewable prescriptions. This research suggests that healthcare providers of LGBTQ foster youth with a network of communication or support may be more likely to consider themselves experts, or that others would consider them experts due to their affiliation with a formalized body or association of providers.

Responses from this study suggest that it may be helpful for healthcare providers of LGBTQ foster youth to work with a coordinated care case manager or LGBTQ liaison from

Children's Administration. It would be imperative for government agencies seeking transgender related healthcare to be familiar with the World Professional Association for Transgender Health (WPATH) Standards of Care³⁵ (SOC's). It is possible that Children's Administration should consider adding caveats in specific safety threats³⁶ regarding children of diverse sexual orientation or gender identity and health as particularly vulnerable to psychological or emotional abuse or neglect related to these aspects of their identity, as evidenced by strikingly higher rates of suicide, anxiety, and depression in this population. This could appear as part of a wider approach to prevention and intervention initiatives related to LGBTQ foster youth. It may be helpful to incorporate a logic model for assessing the healthcare needs of LGBTQ foster youth, while making active efforts to seek healthcare provider input on specific issues regarding LGBTQ foster youths' healthcare plans or goals.

5.3 LIMITATIONS

Generalizability:

The primary limitation of this research is in its generalizability. Due to the nature of qualitative research as highly specific to the participants involved, the experiences and views shared by these such participants are not necessarily generalizable to populations outside of those featured in this study. This population would include health providers of LGBTQ foster youth, all but one of whom practice in the Greater Seattle Area. This does not, however, discredit the validity or significance of this empirical knowledge.

³⁵ Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People are non-binding protocols outlining the usual treatment for individuals who wish to undergo hormonal or surgical transition to the other sex.

³⁶ Criteria used by Children's Administration (17 Safety Threats) which indicate Child Abuse/Neglect (CA/N).

Scope of the study:

A theoretical assumption of this study is that healthcare providers of LGBTQ youth and LGBTQ foster youth are looked at as two separate communities. A limitation of this assumption is that it is unknown whether any of these providers themselves may have been LGBTQ foster youth, as this is not specifically asked of participants during the interviews, when the reality is that individuals are often simultaneously members of both dominant and subordinate groups (Tatum, 2000).

Positionality:

The limitations created by positionality in this research include the interviewer's transference of maleness, whiteness, possible impression of cisgender identity, and/or portrayal of sociological or anthropological research methods, any or all of which could have led to participant diffidence, microaggression (Sue, 2010), or apathy.

Key personal interests, bias, expectations:

While considering possible findings or outcomes, the author had to consider his own personal interests, which align with the advancement of social and civil rights for the LGBTQ community. The author had expectations about the types of responses participants may give about burnout or desiring a community or professional network because of his own experiences with burnout and desire for a stronger or more formal network of providers who serve LGBTQ foster youth.

Redactions:

Redactions must be used because of the sensitivity of information shared, including personal biases or opinions regarding issues of race, religion, gender, and other identities and topics, which could be legally or professionally discrediting. Without liberal use of redactions

and immense efforts to protect identity, participants likely would not have shared opinions, experiences, or biases that they felt may be detrimental to their reputations should their confidentiality be compromised. Despite these considerations regarding redactions and confidentiality, a limitation of a face to face, non-anonymously given interview is that participants can be expected to limit their responses based on their degree of comfort with sharing personal information with the interviewer.

Prompting:

Participants were prompted throughout the interview to share more information or to continue to the next question. These prompts, including follow up questions, were redacted from the paper in real time as it was not timely for the interviewer to type the follow-up question they were asking while simultaneously listening to and recording the participant's response. Because of this prompting for elaboration or clarification, certain participants went into more detail about certain question than others, which also created inorganic variation in the standardization of the interviews.

Standardization of interviews:

The ability to which the interviews could be standardized was limited due to the location of each interview varying from participant to participant, as well as the duration of each interview being ultimately dependent on the amount of time a participant had available.

Relationship to interviewer:

Due to the small size of the LGBTQ community and the smaller size of the community of healthcare providers for LGBTQ youth in Washington State, the interviewer's positionality as a member of both communities meant that the interviewer had social ties to certain participants in this study, personally and professionally. These relationships may have impacted the varying

degrees of formality of the interviews, and possibly the willingness of a participant to share or not to share more personal or candid information.

As convenience sampling was used to recruit participants, as well as the snowballing of participants through connections they held to other potential participants, this created a limitation in the distribution of participants within the community.

Time constraints:

Participant time constraints limited the length of time each individual participant could commit to an interview, which for one participant was less than the suggested length of one hour. The researcher's time constraints were limited by the duration of time allotted by an accelerated degree program which allowed for only six total months to propose and complete this study, which limited the depth of analysis and volume participant data which could be collected.

5.4 SUGGESTIONS FOR FUTURE RESEARCH

Through studying the motivating reasons why people choose to serve LGBTQ foster youth and the experiences of burn out, issues of provider recruitment and retention can be appropriately addressed in the workplace. It is important to explore interventions which may mitigate the effects of secondary trauma for LGBTQ healthcare providers of LGBTQ foster youth who may be especially susceptible to secondary trauma of their clients, or the parents of their clients. It is possible that practicing trauma stewardship³⁷ (Lipsky & Burke, 2009) could be explored as an intervention to be offered through continuing education opportunities for these

³⁷ "Trauma stewardship" is the term Lipsky uses to describe the overall practice of caring for oneself to remain effective at and avoid negative effects of caring for others.

providers. Patients' performativity of gender may be studied as an alternative to transference³⁸ or countertransference³⁹ in a medical setting or clinical relationship. Patient resistance (illustrated in Appendix E: Resistance Model) may be an alternative understanding of transference. Additionally, patients or caregivers may exhibit challenging behaviors because of systems fatigue.

Several participants identified themselves as members of the LGBTQ community. A suggestion for future research is to explore the concept of stereotype threat⁴⁰ related to both personal identity as a member of the community and a provider for this same marginalized community. Another area of exploration is whether professional identity is challenged by working with a marginalized community whose sexual orientation or gender is seen as a social identity, and is not always recognized as a population with unique medical needs. On a larger scale, latitudinal and longitudinal studies of the health outcomes of LGBTQ foster youth and their healthcare providers would provide valuable insight into the physical effects of the high levels of stress or other health disparities which may be present in either or both populations.

5.5 RECOMMENDATIONS FOR FUTURE PRACTICE AND POLICY

Interview participants expressed their opinions that policies and/or laws should be created, amended, or adapted to enforce continuity of care for LGBTQ foster youth. These would include medical plans to be followed when children move out of state and begin receiving care from new providers. Interview participants also expressed that foster parents should be screened

³⁸ Freudian psychoanalytic term; transference: the redirection of feelings and desires and especially of those unconsciously retained from childhood toward a new object, typically seen toward a therapist in a therapeutic relationship.

³⁹ Freudian psychoanalytic term; countertransference: the emotional reaction of the analyst to the subject's contribution.

⁴⁰ Stereotype threat is a situational predicament in which people are or feel themselves to be at risk of conforming to stereotypes about their social group.

for their cultural responsiveness to the needs of LGBTQ foster youth, as well as youth of color. Many providers also suggested that they would want an accessible database of providers who work with or specialize in healthcare for LGBTQ youth, including those who take Medicaid or Apple Health/Coordinated Care, their practice locations, and information about the insurance they accept. Washington State's Coordinated Care (a managed healthcare plan for foster youth) has the potential to be a great vehicle for excellent healthcare, including access to mental health and other related providers. Additionally, foster youth have strong legal protections which hold caregivers accountable for following up with medical care and appointments, which provide a policy based accountability system for follow-up medical appointments.

It is the position of this researcher that there is a need for a glossary of standardized terms related to healthcare for LGBTQ foster youth, as it would be helpful for providers, patients, and their caregivers to have shared language surrounding healthcare and diverse SOGIE⁴¹. As the sociolinguistics of the LGBTQ community are constantly and rapidly changing, it would be important for this document to be easily accessed and updated. Lastly, it is imperative to approach issues related to LGBTQ youth in foster care with an intersectionality lens, and it is equally important not to make assumptions about salient identities that a LGBTQ foster youth may have.

⁴¹ Sexual Orientation, Gender Identity/Expression

WORKS CITED

- Aleccia, J. (2016, February 25). Transgender kids' mental health boosted by family support, UW study finds. Retrieved from <http://www.seattletimes.com/seattle-news/health/family-support-boosts-transgender-kids-mental-health-uw-study-finds/>.
- Annie E. Casey Foundation. (2016). A Systematic Review of the Literature. Retrieved from <http://www.aecf.org/m//resourcedoc/aecf-LGBTQinChildWelfare-2016.pdf>.
- Bohmer, S. & Briggs, J. (1991). "Teaching Privileged Students about Gender, Race, and Class Oppression." *Teaching Sociology* 19:154-63.
- Bonnycastle, C. (2011). Social Justice along a Continuum: A Relational Illustrative Model. *Social Service Review*, 85(2), 267-295.
- Butler, J., & Judith Butler. (2006). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge.
- Child Welfare Information Gateway. (N.d.). "Recent Works on Practice with LGBTQ Youth". Retrieved from http://www.nrcpfc.org/webcasts/archives/23/Working%20with%20LGBTQ%20Youth_CWIG%20Bibliography.pdf.
- City of Seattle Commission for Sexual Minorities. (May 22, 2006). Report and Policy Recommendations from the Seattle Queer Youth Forum.
- Collins, P. (2015). Science, critical race theory and colour-blindness. *British Journal of Sociology*, 66(1), 46-52.
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241-1299.

- Durwood, K. O. (2016). What Alarmist Articles About Transgender Children Get Wrong. Retrieved August 10, 2016, from http://www.slate.com/blogs/outward/2016/01/14/what_alarmist_articles_about_transgender_children_get_wrong.html?wpsrc=sh_all_mob_em_ru
- Flores, A.; Herman, J.; Gates, G; & Brown, T. (2016). How Many Adults Identify as Transgender in the United States? . The Williams Institute. UCLA: The Williams Institute. Retrieved from: <http://escholarship.org/uc/item/2kg9x2rk>
- Grant, J. M., Mottet, L.A., Tanis, J. Harrison, J., Herman, J. L., & Keisling, M. (2011). Injustice at every turn: A report of the national transgender discrimination survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.
- Grass Roots Fundraising. (2012). Retrieved from <http://www.grassrootsfundraising.org/wp-content/uploads/2012/10/THE-FOUR-IS-OF-OPPRESSION-1.pdf>.
- Gurney, A. (2003). The fourth wall (Rev. ed.). New York: Dramatists Play Service.
- Hanisch, C. (1969). The Personal Is Political. Retrieved June 4, 2015, from <http://www.carolhanisch.org/CHwritings/PIP.html>
- Harro, B. (2001). The cycle of socialization. In M. Adams, W. Blumenfeld, R. Castañeda, H. Hackman, M. Peters, & X. Zúñiga, (Eds.), Readings for diversity and social justice(pp. 15-21). New York: Routledge.
- Hays, P. A. (2008). Addressing cultural complexities in practice: Assessment, diagnosis, and therapy (2nd ed.). Washington, DC, US: American Psychological Association.
- Horsely, S. (2016, May 13). White House Sends Schools Guidance On Transgender Access To Bathrooms. Retrieved August 10, 2016, from <http://www.npr.org/sections/thetwo->

way/2016/05/13/477896804/obama-administration-to-offer-schools-guidance-on-transgender-bathrooms

Jackson, B. & Hardiman, R. (1993). Social identity development model. In J. Andrzejewski (Ed.) *Oppression and social justice: Critical frameworks* (4th ed.), (pp. 1-4). Needham Heights, MA: Ginn Press.

Kirby, D. (2002). "HIV Transmission and Prevention in Adolescents", HIV InSite Knowledge Chapter.

Kreitler, K. (2012). Top 10 Myths About Transgender People. Retrieved June 3, 2015, from <<http://everydayfeminism.com/2012/08/myths-about-transgender-people/>>.

Lambda Legal in partnership with the Council on Social Work Education (CSWE). (2015). "Sexual Orientation and Gender Expression in Social Work Education: Results from a National Survey". Retrieved from https://www.researchgate.net/profile/Lori_Messinger/publication/242611014_Results_From_a_National_Survey_Sexual_Orientation_and_Gender_Expression_in_Social_Work_Education/links/0deec53a083e815966000000.pdf

Laver & Khoury. (2011). *Opening Doors for LGBTQ Youth in Foster Care: A Guide for Lawyers and Judges*. American Bar Association. Retrieved from http://www.americanbar.org/content/dam/aba/publications/center_on_children_and_the_law/lgbtq_book.authcheckdam.pdf

Lipsky, L. v. D., & Burk, C. (2009). *Trauma stewardship [electronic book]: An everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler Publishers.

Lorde, A., & University of Oregon. Center for the Study of Women in Society. (1984). *Sister outsider* (CSWS Speaker series ; Fall 1984).

- MacIntosh, P. (1990). White privilege: Unpacking the invisible knapsack. *Independent School*, 49(2), 31-36.
- Mallon, G. (1997). "Basic Premises, Guiding Principles, and Competent Practices for a Positive Youth Development Approach to Working with Gay, Lesbian, and Bisexual Youths in Out-of-Home Care". Retrieved from <http://search.proquest.com.offcampus.lib.washington.edu/socialservices/docview/61544141/123D31942C6040A6PQ/3?accountid=14784>
- Martin, M., Down, L., & Erney, R. (2016). *Out of the Shadows: Supporting LGBTQ youth in child welfare through cross-system collaboration*. Washington, DC: Center for the Study of Social Policy.
- McKnight, J.L. & Kretzmann, J.P. (2005). Mapping Community Capacity. In M. Minkler, ed.
- Merton, R. (2010). The Self-Fulfilling Prophecy. *The Antioch Review*, 68(1), 173-190.
- Minter, S., & Krehely, J. (2011). Working with Transgender Youth in Foster Care and Runaway and Homeless Youth Programs. Child Welfare Information Gateway. Retrieved from http://www.nrcpfc.org/webcasts/archives/22/CWIG%20Bibliography%20Working_with_Transgender_Youth_in_Foster_Care_and_Runaway_and_Homeless_Youth_Programs.pdf
- Mitchell, R., Panzarello, A., Grynkiewicz, A., & Galupo, M. (2015). Sexual Minority and Heterosexual Former Foster Youth: A Comparison of Abuse Experiences and Trauma-Related Beliefs. *Journal of Gay & Lesbian Social Services*, 27(1), 1-16.
- Mountz, S. (2016). "Revolving Doors: LGBTQ Youth at the Interface of the Child Welfare and Juvenile Justice Systems". Retrieved from http://www.villagecounselingcenter.net/Revolving_Doors_-

_LGBTQ_Youth_at_the_Interface_of_the_Child_Welfare_and_Juvenile_Justice_System
s.pdf

Mullaly, B. (2002). Internalized Oppression and Dominance. In Challenging Oppression: A Critical Social Work Approach. Canada: Oxford University Press.

Murphy, et al. (2009), Conceptual framework for understanding and using intersectionality to conduct research. From Incorporating Intersectionality.

National Association of Social Workers (NASW). (2009). Moving the Margins: Curriculum for Child Welfare Services with Lesbian, Gay, Bisexual, Transgender, and Questioning Youth in Out-of-Home Care. Retrieved from [https://www.socialworkers.org/images/practice/hiv/NASW%20LGBT%20Youth%20moving-the- margins.pdf](https://www.socialworkers.org/images/practice/hiv/NASW%20LGBT%20Youth%20moving-the-margins.pdf)

Nieto, L., Boyer, M. F., Goodwin, L., Johnson, G. R., & Smith, L. C. (2010). Beyond inclusion, beyond empowerment: A developmental strategy to liberate everyone. Olympia, WA: Cuetzpalin.

Oakley, N. (2016). Protocol for Safe and Affirming Care: Improving the Lives of LGBTQ+ Youth in Washington State's Child Welfare and Juvenile Justice Systems. Center for Children and Youth Justice. 1st Edition, 1-54.

Olson, K.R. (2016). Prepubescent transgender children: What we do and do not know. Journal of the American Academy of Child and Adolescent Psychiatry, 55(3), 155-156.e3.

Olson, K.R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. Pediatrics, 137(3),1-8.

Perron, S. (2015). beFIERCE: A Toolkit for Providers Working with LGBTQ Foster Youth. Retrieved from <http://www.sunnyhillsservices.org/beFierce-8.pdf>

- Resmovits, J. (2014). Yes, Schools Do Discriminate Against Students Of Color -- Reports.
Retrieved June 5, 2015, from http://www.huffingtonpost.com/2014/03/13/school-discipline-race_n_4952322.html
- Rosenwald, M. (2009). "A Glimpse Within: An Exploratory Study of Child Welfare Agencies' Practices With LGBTQ Youth". Retrieved from
http://search.proquest.com.offcampus.lib.washington.edu/socialservices/docview/61392812/1_23D31942C6040A6PQ/2?accountid=14784
- Seattle LGBT Commission. "LGBTQ Youth Resources" Retrieved from
<https://www.seattle.gov/Documents/Departments/SeattleLGBTCommission/documents/LGBTQYouthResourceList.pdf>
- Seip, N. "Seattle Mayor's LGBTQ Action Plan to Impact Youth Experiencing Homelessness". Retrieved from <https://truecolorsfund.org/2015/08/03/seattle-mayors-action-plan-to-impact-lgbt-homeless-youth/>.
- Spade, D. (2015). Normal life: Administrative violence, critical trans politics, and the limits of law.
- Spencer, M.S. (2008) A social worker's reflections on power, privilege and oppression. *Social Work*, 53 (2), 99-
- Stephens, N.; Markus, H., Fryberg, S. (2012). Social class disparities in health and education: Reducing inequality by applying a sociocultural self model of behavior. *Psychological Review*, Vol 119(4). 723-744. <http://dx.doi.org/10.1037/a0029028>.
- Sue, D. (2010). Microaggressions in everyday life : Race, gender, and sexual orientation. Hoboken, N.J.: Wiley.

- Sue, D.W., Capodilupo, C.M., Torino, G.C., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. American Psychological Association. 62, 271-286.
- Sullivan, R. (1994). "Obstacles to Effective Child Welfare Service with Gay and Lesbian Youths". Retrieved from http://search.proquest.com.offcampus.lib.washington.edu/socialservices/docview/61630254/1_6E90A8FCB0E4254PQ/11?accountid=14784
- Tatum, B.D. (2000). The complexity of identity: "Who am I?." In M. Adams, et. al. (Eds.), Readings for diversity and social justice(pp. 9-14). New York: Routledge.
- Toner, J. (2013). "Rural Social Workers' Perceptions of Training Needs for Working with LGBTQ-Identified Youth in the Foster Care System". Retrieved from www.journal.minotstateu.edu/crsw/article/download/466/182.
- Washington State Legislature. (2007). What is Child Abuse or Neglect?. Retrieved from <http://apps.leg.wa.gov/WAC/default.aspx?cite=388-15-009>.
- Wilber, Ryan, and Marksamer. (2006). CWLA Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care. Retrieved from <https://familyproject.sfsu.edu/sites/default/files/bestpracticeslgbtyouth.pdf>.
- Workers, N. A. (2008). NASW Code of Ethics (Guide to the Everyday Professional Conduct of Social Workers). Washington, DC: NASW.
- Woronoff, R. (N.d.). "Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth in Out-of-Home Care: Selected Bibliography and Resource Guide" Retrieved from <http://www.courts.ca.gov/documents/LGBTQYouthinOut-of-HomeCareBibl.pdf>.

APPENDIX A

Appendix A: Information Statement

UNIVERSITY OF WASHINGTON INFORMATION STATEMENT

LGBTQ Foster Youth Service Provider Interview

NOTE: YOU MUST BE AT LEAST 18 YEARS OLD TO PARTICIPATE IN THIS STUDY.

Researcher: Ryan Karnoski, Children Youth and Families, UW School of Social Work, 425-563-8857

Supervisor: Dr. Kevin Haggerty, Director, University of Washington Social Development Research Group

Researchers' Statement

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask questions about the purpose of the research, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions, you can decide if you want to be in the study or not. This process is called "informed consent."

PURPOSE OF THE STUDY

The purpose of this study is to learn about care provider's experiences offering medical care and other wraparound services (therapy, mental health care, dental services, etc.) to LGBTQ foster youth in Washington State.

STUDY PROCEDURES

If you choose to participate, you will be asked to carefully answer a series of questions about your experiences providing services to LGBTQ foster youth. The study will take place in one session. You do not have to answer every question. Participation in this study will take no longer than one hour.

RISKS, STRESS, OR DISCOMFORT

The risks associated with this study are no greater than those encountered in daily life. Some people feel that providing information for research is an invasion of privacy. If you feel uncomfortable and do not wish to continue the interview, you may discontinue your participation and decline to submit your responses at any time.

BENEFITS OF THE STUDY

Individuals who participate in this study will gain direct experience with Children Youth and Families Social Work research and learn more about the nature of our research question. We cannot and do not guarantee or promise additional benefits beyond the educational ones noted here. We hope the findings from this study will later benefit society.

OTHER INFORMATION

Being in this study is voluntary. You may refuse to participate, and you are free to withdraw from this study at any time. Information about you is anonymous. The information you give is not linked to your name. Only the interviewer will know if you have completed the interview or not.

SUBJECT'S STATEMENT

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, I can ask one of the researchers listed above. If I have questions about my rights as a research subject, I can call the Human Subjects Division at (206) 543-0098. I can keep this information statement.

Appendix A: Questionnaire

Ryan Karnoski

12/16/16

LGBTQ Foster Youth Wraparound Provider Interview Questionnaire

Intro:

Review Information Statement.

Ask if participant has any questions and repeat that if participant is not interested they may decline to continue or have their responses shared at any time during or after the interview. The responses will be anonymous. Only identifying information that participant wishes to share will be published in the final report.

Before the paper is submitted for completion, subjects will have the opportunity to review the paper and offer comments, concerns, clarification, or request redactions.

By proceeding with this interview, you confirm your consent to participate in this interview to be included in this research project titled: Healthcare Provider Experiences Working with LGBTQ Foster Youth.

1. What have been your experiences providing healthcare or related services to LGBTQ foster youth?

2. If you still work in this field, how long have you worked in this field?

If you no longer work in this field, how long did you work and why did you leave?

3. Why did you choose to work in healthcare and serve LGBTQ foster youth?

4. What did you enjoy about working with LGBTQ foster youth?

5. What were the challenges of working in this field with this population?

6. What were your experiences that motivated you to continue in this field working with this population?

(Explain “burn out”)

7. Did you have any specific experiences which led to “burn out”?

8. Do you think it is important to have a community of healthcare providers that work with LGBTQ foster youth?

9. In an ideal world, in the greater Seattle area or Washington state, what would this community look like to you? What would it offer?

10. Are there any questions or comments that you have for me about your experience, this research, or my goals or intentions with this project?

APPENDIX B

Appendix B: Interview 1

1. What have been your experiences providing healthcare or related services to LGBTQ foster youth?

One or two ever foster youth, youth and young adults 18-24 who currently or have been homeless, and the connections I have are to other folks who have done that. 3 days out of the week I was at a Homeless Youth Shelter, 2 days at [a different] Homeless Youth Shelter, employment programs as a therapist there 1 day a week. A lot of folks were currently or recently homeless, 1 day a week at [Name redacted] LGBTQ Homeless Youth Shelter LGBTQ program. There is definitely a learning curve, I was not a foster youth, I have never been homeless, I have had my process of learning. Maybe it's more of an age thing than a foster or homeless thing but when there's a young person who is relatively on their own- it is easier in a sense... but they were easier to work with than kids or families. One of my credentials is Sexual Minority Mental Health Specialist. "Thursday is my gay day". Queer clients tend to find me on my other days too. Statistically 30-40% of my clients tend to be LGBTQ and a huge number are former foster youth, probably 2/3 at Homeless Youth Shelter were LGBTQ, so it was disproportionate and they found me. And here at main campus at least half were queer too. My job is not "queer youth". There's some that I might never have known [were queer] but they saw a rainbow in my office somewhere, or that they saw my credential and came out. So it feels good, it's important to me to as somebody with a fair amount of privilege to be a resource to my community.

2. If you still work in this field, how long have you worked in this field?

When I was an undergrad, I went to [State University] and worked with the LGBTQ Student Group, I've done things here and there, so for about 15 years. Volunteered for the LGBTQ Youth Crisis Hotline in LA and worked at [LGBTQ Fundraising Event].

If you no longer work in this field, how long did you work and why did you leave?

3. Why did you choose to work in healthcare and serve LGBTQ foster youth?

Some of it was opportunity, I had an internship here and stayed as an on call- it was a weird confluence of events where they had an opportunity as a therapist in the "gay house", had experience working with LGBTQ youth in Las Angeles, so I was a uniquely good fit, opportunity and serendipity, I wanted to work with my community and it feels important to me some of it was a little bit strategic, I wanted macro and micro experience in graduate school, I will probably not be a micro person my whole career but it made more sense in terms of what I'd maybe like to do to get the micro experience right out of graduate school and then maybe work in program development or program management and you need to have a clear picture of what it's like on the ground, and to make systemic changes for queer youth to have more accepting families or to be supportive changes you need to know what it's like on the ground.

It's not such a different idea than doing research, the things that motivate me are the personal experiences and the relationships.

4. What did you enjoy about working with LGBTQ foster (AND FORMER FOSTER) youth?

What I love most, there's a couple things, one I just love working with young people in general; they're fun and interesting and keep me on my toes about pop culture, things that I learned later in life as a queer person they are learning earlier, like gender fluidity things I learned in college classes they're living it, they just know, gender can just change, sexuality can be fluid. I love talking about social justice with queer youth, it's not very often, I'm always surprised by this, it's

not very often that people get the message that it's not you that's fucked up it's the system that's fucked up, and when we get folks together and talk about systems that need to change and the relief that gives the individual and the pressure that takes off of them it's really gratifying.

5. What were the challenges of working in this field with this population?

Internalized homophobia and transphobia, seeing the same things play out with the same people, as a queer person. Actually seeing the effects of multiple systems of oppression which from the micro standpoint you can't do anything about, especially racism as a white person, which on one sense is good for me to keep me motivated to do the work, for bigger picture stuff for social justice, but on the other hand is just an awakening process is painful and uncomfortable. I think that's the biggest, but slamming up against the same systems and then fail and that they actively do harm again and again.

Say a kid is suicidal and needs to be hospitalized; there's never enough beds, and the social workers are all busy and the whole process is so hard that it's often not helpful... and the last thing people need when they reach out to get helped is to be shown that they can't be helped because it just reaffirms all of the messages of homophobia transphobia and racism.

Are they out? Are they not out? What's their parent's reaction if they are? The message we're supposed to be able to send is that you were not safe before but you are safe now, you learned that you had to blow up or be constantly guarded and that's something we can help teach but when there's truth to that some people are never safe, what do we do? Real talk? You're right that you will be bullied and you're right to be worried about what your parents might say and that bathrooms will be hard for you and how do you still show up and recognize that there are therapeutic moments to be had there but it's infuriating, absolutely. Because they should, they should have better than they do.

There are similarities and there are differences, queer kids are more likely to be homeless or suicidal, and this isn't even counting overlap, but black kids are more likely to be incarcerated, so the way those messages are internalized are different. Which says nothing to queer kids of color who have trouble belonging anywhere even among their oppressed peers. Yeah, I think there are similarities but there are real differences too. I think there's something about how queer people have to come out to themselves or others, there's an internal realization and an outward expression that needs to happen, for example kids of color get discriminated against because of how they look, but then that's true to an extent in other ways, "very clinical terminology". In one sense, that allows for the opportunity to hide and protect yourself in different ways but also leads to different internalizations of shame. Leads to different outcomes and different negative health outcomes in different populations of LGBTQ youth as opposed to youth of color, rates of suicide are higher among Native American youth than white youth, but for LGBTQ youth and trans youth and trans youth of color... and there's something we can extrapolate from those outcomes.

6. What were your experiences that motivated you to continue in this field working with this population?

Working with queer youth gives me a lot of hope, as a queer person myself it's helpful for me to give back to my community and especially to our young people that we can make tomorrow better. And there's my own shit and transference that is wrapped up in it so there's some truth there. I was a little surprised actually at how few genuinely, and what is competency, at how few queer competent service providers, there's a lot of people queer or otherwise, "I like gay people I'm down, I like trans people I'll support them" but don't know what that means, don't know how to write a hormone letter or ask for pronouns and there are actual things to know, and I find

myself in a strange position after a few years in the field, at least here, as somebody who knows some of those things, I feel weird about having the title sexual minority health specialist because I'm a white cis gay guy but I know that I know things that other people don't know so part of me is motivated to keep being that resource, especially with the privileges I have to do whatever I can to fill that gap and I see that as part of social justice because there's not that many that are, I thought that would be different but it's not.

They might watch *Transparent* but they don't know shit. Now that I have these licenses and credentials, I want to help bring other folks up. I'm a supervisor now and that's part of what I hope to do as a supervisor is help train other folks.

(Explain "burn out")

7. Did you have any specific experiences which led to "burn out"?

Mhm, yes, I have definitely been burnt out. A combination of things in an overburdened under resourced system, too many clients, too much crisis, a lot of experiences with secondary trauma and not enough resources to deal with that systemically and as a provider, \$18, I could pay my rent but I couldn't pay for nice vacations or days at the spa like they recommend for self care.

Some of it is that I definitely feel like that as a queer provider I do reach farther and not to say work harder but I do a little bit more work for my queer clients, I'm more likely to do extra case MGMT and offer extra support, extra sessions, go off site, for my clients that have fewer resources. When a good chunk of your clients are queer or oppressed, you stretch further.

8. Do you think it is important to have a community of healthcare providers that work with LGBTQ foster youth?

Yes absolutely. I'm not the expert but [one does not exist] that I'm aware of.

9. In an ideal world, in the greater Seattle area or Washington state, what would this community look like to you? What would it offer?

I think the fact of it existing would be nice, it could be a professional association there are formal and informal things for people working for adults but very few for people working for youth.

There are happy hours for gay male therapists for adults but there are not social events for providers for foster youth and nothing even like a resource center.

10. Are there any questions or comments that you have for me about your experience, this research, or my goals or intentions with this project?

Appendix B: Interview 2

1. What have been your experiences providing healthcare or related services to LGBTQ foster youth?

What's involved in prescribing medicines, what's involved in overall medical care. I spend an hour with kids under 16 when they are seeing me for the first time, that's unheard of, it's usually a 40-minute visit, most often I've found that kids that are coming in in foster care will come in with foster parents, sometimes they have legal control, sometimes they don't. Sussing out who has decision making is the first step, sometimes some kids are ready for whatever intervention but they don't have the right because bio family does. Sometimes everyone is on board, sometimes the decision has to be dragged through the courts.

Three kids had to go to court and it was found that the treatments we were proposing was found to be lifesaving and medically necessary and it emboldened me and made me more optimistic. One kid was at a Therapeutic/BRS Care Facility.

One psychiatrist had to consult from Vancouver [Washington]. The one case that happened the most recently in Vancouver, a judge was not averse to puberty blockers but wanted to have an evidentiary hearing. A kid was on the doorstep of puberty and in freak-out mode, social worker, doctor, and guardian ad litem, and judge said 'I don't really get it, let's have an evidentiary hearing, a lawyer with WA DOH [Department of Health] AAG's [Associate attorney general] she contacted me and said we want to bring you down and have a 6 hour testimony, but my clinic has an hourly rate you're not supposed to go below. They want you to quote the retail price. They wanted me to drive down, \$100/hour, but we wound up doing it as a teleconference. They asked me to verify documents to verify I was who I was, 6 hours was actually an hour and 20 minutes. The AAG [Associate Attorney General] sent me an email saying that this is a precedent setting

evidentiary hearing. I hope that that's the case that it's formalized so that when gender variant kids coming through the system they don't have to go through all the rigmarole that its medically appropriate at tanner 2 and the blocker is reversible and if you change the blocker the kid keeps growing but that's worst case scenario, kids come in saying they're gender variant because they want parents to not freak out because the soft shoe their affirmed gender to adults because they're afraid they're not in an affirming environment. The blocker goes in and they never look back.

The only time I've had patients who decide they want a blocker and then take it out, usually it's kids who are a little bit older who just want to pause the process and I think that's completely valid and it's a total non-event because it's just helping them actualize who they are. It's a decision I've come to over the years that I don't fret and that's what I'm hoping the court figures out so it's easier in the future, the fertility thing is something I see might be a sticking point, if the kid expressed that they wanted a family. One thing I could envision the court asking for is a thoughtful discussion of reproductive ability in the future. This is the one big impact this might have, do you have anything to show that this kid has thought about it, and understands the plusses and minuses. It's probably going to be a moot point at some point.

Adults' decision making is important because adults have a longitudinal two decades or three decades of experience to protect a kid who is saying I want this at all costs. Adult advocates also have to weigh each concern against each other and not blocking is not a non-action, it is an enormous and life ending action for kids, and if fertility hangs in the balance, so you are holding life vs, fertility, so whoever is holding those options means that [they need to be] doing the right thing for the kid. At conferences, some adults do express regrets and some people can afford that challenge and others just couldn't swing it, and none of them say that they regret taking a

blocker, and that decision comes with consequences but it's no different than other consequences.

2. If you still work in this field, how long have you worked in this field?

My first LGBTQ foster kid that came through was about 5 years ago, there were three other people in the room with the kid and none were biologically related. One social worker was stepping off the case, the Guardian Ad Litem was there with the upcoming court case in mind to learn about what I was proposing, I didn't know any terminology at the time so I was like 'who are you, what's your job?'. I had two or three foster kids who were not LGBTQ, which was similar but really different, just because the issues are not the same, you're not blazing new ground. If I have a foster kid and I want to give vaccines or a plan of care I know that's not an issue, whoever comes with the kid doesn't have to get legal certification from some other entity to move forward. I have kids who are on PREP, none are in the foster system and making parents agree to that is really tough because then they realize that their kids are really sexually promiscuous... so when we talk about blockers and hormones people are like 'what'? And it seems like a bigger intervention, and I don't think that it really is. I think that societally we're unable to uncouple hormones and the changes they make in somebody's body and other concerns that we apply to antibiotics, and vaccines but for some reason when you talk about hormones it's just a bigger deal.

If you no longer work in this field, how long did you work and why did you leave?

3. Why did you choose to work in healthcare and serve LGBTQ foster youth?

I volunteered for a year in Africa and it was during the time I was outside of the US that helping people with health was kind of transformative and my transformational experiences teaching English and math came down to that I had a first aid kit that was something that nobody else had,

what are all the ways I can intervene so that people can be healthier and not be limited to Band-Aids and antibiotic ointment, and that's kind of what made me want to go into medicine.

4. What did you enjoy about working with LGBTQ foster youth?

I think in general these kids are really well supported and they have a lot of advocates that are working for them. It's my impression that they have an adversarial relationship with getting their needs met and they come into medical expecting more of the same...and I'm not sure how they find me but they do... and it's amazing for me to see apprehension melt into excitement. I'm a bulldog willing to get what they need and I'm willing to fight the fight, and they are sometimes sheepish about asking to get what they want, even if the social worker contacts me in advance...But once they know that I'm behind them and that there's things that are medically reasonable and they hear me say things in front of the social worker, they are really happy.

I call it "gendercare". I think that it's happy medicine. It's a transformation; helping a caterpillar become a butterfly... and in general kids are incredibly motivated. If you ask a kid to do shots every week of their lives, if it's insulin they'll flake, but if it's testosterone or estrogen they'll do it.

5. What were the challenges of working in this field with this population?

Legal challenges: I also had a kid get shipped to Pennsylvania and I was trying to manage her height and she was petrified because she was 5'7" projected to be 6'5" and they had some care program that better met her needs and she was delightful and smart but apparently "manipulative" but I didn't hear squat for 14 months. When I saw her next she was 6 feet tall and still growing, and it was just sad because I feel like fractured care is based on where the resources exist so if they don't have the resources I feel like they send them where they exist so I sent them lab orders and care frequency that I thought would make it a success from a distance.

My only other frustration is when a kid's in foster care and when they people in the room don't have decision making ability and for kids, they don't have the patience.

6. What were your experiences that motivated you to continue in this field working with this population?

The continuity of care is so wonderful and seeing kids come in and one woman who came in and was angry, so pissed off, playing on a boys soccer team in a uniform and becoming the woman she was and now she's wonderful and engaging, there's no psychotropic medication I could prescribe for anyone that would have a similar transformative power. One parent was accepting one wasn't, there's a lot that goes on behind the scenes in a home environment but when I see that transformation 3-6 months out I love that we get to update photo identifiers, they're excited to get the photo taken. I just don't think that's an experience I would have anywhere else in medicine.

(Explain "burn out")

7. Did you have any specific experiences which led to "burn out"?

I haven't had enough of those types of experiences, I felt frustrated and at times I've felt disenfranchised because suddenly a medical expert can render their opinion and suddenly that can be invalidated by somebody with no medical background and it's that somebody else may have to approve recommended care pathways, on an emotional level it can be disheartening and frustrating.

8. Do you think it is important to have a community of healthcare providers that work with LGBTQ foster youth?

Of course.

9. In an ideal world, in the greater Seattle area or Washington state, what would this community look like to you? What would it offer?

I think it would be the listserv as it is now but it would also be a publicly available database where providers of care can list their areas of expertise and interests so that somebody on the outside could have access to that resource without having to be a part of a secret society, and then providers exchange a lot of information and hopefully a person is called back and something happens but it's not a transparent process. Psychology today has a website for psychologists to put their areas of practice, region, etc. It sure would be super spiffy if trans medicine today or gender care medicine today had something like that. And I think Washington state and Seattle is pretty familiar. In other places, I think what I'm doing is similar to an abortion provider because it goes against religious doctrine because I think there would be people who [would be] fearful to do it.

10. Are there any questions or comments that you have for me about your experience, this research, or my goals or intentions with this project?

If you google 'transgender medicine Seattle' I'm not secretive on the clinic website and I have a transgender medicine and it's opened to kids under 16 so it's not skywriting but at the same time it's not obscuring something I do a lot of the only other visibility is from word of mouth and giving presentations at gender odyssey or other conferences, answering questions on the listserv that seem relevant to medical opinion. We've talked about- a social worker putting a rainbow sticker out and getting safe space certified and increasing the inclusivity in paperwork and forms which isn't really going out into the community but more in our workspace.

Appendix B: Interview 3

1. What have been your experiences providing healthcare or related services to LGBTQ foster youth?

To be honest I haven't really provided a lot of services to LGBTQ foster youth because most of the work I've done is with families who are in the process of adopting a foster youth and a lot of experiences with LGBTQ foster youth but it's not the realm I work in, but I do work with a lot of LGBTQ parents and I work with families to help them prepare for adoption. A lot of my experience has been with families. The way that I work is I don't participate in home studies and I don't and when I'm working with prospective families or parents I don't get too involved with DCFS because I want this to be a really safe place for people to talk about what's going on- I think it's when people are going through the process of becoming adoptive parents there's a lot of people who are in an evaluative mode and it's a vulnerable process and exhaustive and exhausting and I don't want to be part of that process.

I feel like it's inherent for people to lie out of fear that they won't become parents and there's not a lot of space for them to work on things that they need to work on before they have a traumatized child in their home and if they are working with a therapist who is not part of that process they are more likely to get that support. I feel that this is related to DCFS's compliance standards and people who are also involved with adoption agencies such as [Name redacted] or [Name redacted]. [The] Youth [I work with] have been with these families for awhile but had at some point been foster youth and [I] meet with the family group as a whole, [it] depends on the age of the child. If it's a teenager, less with the family and those youth have been LGBTQ, but sometimes those youth come out once they've been in their placement for awhile.

Here's something I see that concerns me: in the adoption community as a whole, a lot of people get into fostering and adoption from a conservative Christian perspective... and get into child saving... and have troubling reasons behind fostering, adopting, etc. So, you have a kid who comes into care with a family when they're like 6 years old. A conservative Christian family, and I actually feel like preparation and readiness for foster families is not done very well... so the kid comes out and it's kind of a disaster, and there's not a lot of advocacy on the part of Children's Administration saying 'you need to parent this child and be affirming of this child and their gender and sexuality'.

I feel like people need to be screened for that. There's also the white savior people and there's also a lack of preparation on the part of white people in the area of transracial adoption. I have seen horrible disruptions and I have seen families that decide to take on a kid and those disruptions have been around race. I [believe] that race can be even more of an issue [than sexual orientation or gender identity]. I've been approached by white people who have been interested in foster to adopt and I've had concerns about those people. Most of the concerns I've had have been about race... and that often foster or adopt parents don't understand the impact of trauma and take children's traumatic acting out personally. They have been white affluent Seattleites from North Seattle and I strongly recommended that [one] family did not adopt a youth of color [and] that they did not have a placement of a black boy and then they went ahead and had a black teenager and it was a horrible [placement] disruption because of blatant racism such as behavior perceived as aggressive, him getting in trouble more than other youth. I didn't know his gender identity or sexual orientation.

2. If you still work in this field, how long have you worked in this field?

I am a certified adoption/foster care therapist, since 2010. And that came about through my own foster to adopt experience, so for 7 solid years I have worked with these families and kids.

If you no longer work in this field, how long did you work and why did you leave?

I have cut way back on dealing with foster to adopt families because of my frustration with the parents, racism, lack of ability to understand the impacts of trauma, conservative values, inability to parent the child they have, there have been situations where a child has come out, the parents have not been able to support that child. Anxiety and depression, risky behaviors, drug and alcohol, alcohol is a big one with teens in particular. Weed and alcohol are the ones that seem to be most destructive. Xanax is super scary as a drug used by teens and I have seen that, poor school performance, sabotaging (a really great student and their alienation from their family caused them to just stop performing in school) and you're trying to tell the parents 'get it together, you have to support your kid'.

Across the board I see foster parents and adoptive parents misunderstanding trauma so for lgbtq kids especially trans kids experiencing a lot of gender dysphoria (coming out narrative at 2 is not typical) there's a huge trauma impact on people for not knowing what that gender dysphoria is and being in a family knowing there is no way to get support is almost too much for those kids to bear.... And some experiences where parents have done an incredible job of supporting the child and those are the parents I work with now.

In general, I love kids and I love teenagers and I love working with teenagers and I'm getting away from working with young kids because I don't like sitting on the floor but the one problem is always the adults. When I'm working with LGBTQ youth that aren't being supported by their families there's not a whole lot I can do if they are with me for one hour a week and they are in an unsupportive and un-affirming environment for the rest of the time it is really hard on the kid.

*"Previous participants have stated that they have encountered specific clients or cases that have been challenging or troubling to them as a provider. Are there any particular cases that stand out to you or have been particularly challenging?"

I was in a consultation for a foster care LGBTQ youth, it was about a placement for a kid, a 4-year-old, and there was some stuff up with the kid's gender but they needed to place the kid so 'we're going to place him with this family' and I just remember being in the consult objecting and I don't know what happened to the kid but I'm pretty sure [the placement] happened. I had a teenager who had had really severe trauma history who had been in several foster placements probably some FASD came to live with her adoptive family when she was 6 and they came to see me when was 13-14 was bisexual and they slut shamed her, and the family (this happens to a lot of bi/pan people) was told she was going through a phase, threatened with being kicked out because of sexual behaviors and she really needed them to say we love you we are your parents and they just couldn't do it, they pulled her out of therapy with me because I was pushing them to support her and that's a really hard thing too is that parents can just pull their kid out.

I have a client currently who was adopted, legally free by the time he was two, and he has a fantastic mom and he shortly after his adoption came out as trans, has been totally affirmed 100% I think he's 8 or 9 now but there are all sorts of issues with birth family communication and reunion which is legally not required but highly advisable and there are grandparents and aunts and uncles but mom doesn't really know how to support/navigate doing that when the child is now a different gender. When a gender transition happens in an affirming family there is complications around communications with the birth family and there are even more complications with an open adoption which isn't the agreement here.

3. Why did you choose to work in healthcare and serve LGBTQ foster youth?

Because I'm a B [bisexual], I'm a queer and my comfort level is with other queer people... and growing up as a B in the 80's was pretty fucking challenging, so it's where my comfort level is... and because I am a foster to adopt parent it's where my comfort level is, so I am really passionate about children's issues and welfare and LGBT issues.

In a practicum at CPS there was a kid I was working with and the Social Worker was making recommendations about reunification with his mother that seemed like a horrible idea and me and a Local Foster Care Nonprofit [Name redacted] person fought back with CPS and I almost got fired from my internship. Before that, I did policy work about CPS reform so I went into my clinical work having an understanding. I worked with one other woman doing consulting work before I became a therapist and her little sister ended up being a foster placement so I got very involved with the struggle with Children's Administration with that and she took on some work on foster care reform. The horrible social worker turned out to be our social worker. They're not looking at how important gender affirming healthcare is, it's lifesaving.⁴²

4. What did you enjoy about working with LGBTQ foster youth?

5. What were the challenges of working in this field with this population?

Placement being a priority over affirming caregivers it's always the adults that are the problem, not the kids.

6. What were your experiences that motivated you to continue in this field working with this population?

(Explain "burn out")

7. Did you have any specific experiences which led to "burn out"?

⁴² Author note: Echoes voice of MD on expertise being discredited because it's related to LGBTQ rights being political

I think that my shift away from working with adoptive families has been based on burnout, I screen families much more now because I have the choice to do that and if I can't get a family on board to support their child there's not a lot I can do to support that kid and I have a very queer and trans affirming agenda and if the family doesn't like that they pull their kid out of therapy so I am much more careful about screening families to avoid doing unintentional harm if the therapist kid relationship is disrupted because the parents pulled the kid out of therapy. There is a point in my work where I was really trying to get the family on board and if I realize I can't it's about helping that child learn how to survive their childhood which unfortunately ends up with the child undermining the family a little bit.

8. Do you think it is important to have a community of healthcare providers that work with LGBTQ foster youth?

Hell yes. If there were more of a community I'd probably do more [work with LGBTQ foster youth].

9. In an ideal world, in the greater Seattle area or Washington state, what would this community look like to you? What would it offer?

It would look like in person meetings once a month, ability to interact online, a little bit like the Ingersoll group which is not as valuable as an actual consultation group but as far as advocating for clients and sharing resources it's really great. And also a place to fight back from.

10. Are there any questions or comments that you have for me about your experience, this research, or my goals or intentions with this project?

Appendix B: Interview 4

1. What have been your experiences providing healthcare or related services to LGBTQ foster youth?

I don't see a ton of foster youth because I'm in private practice now and I'm not taking Medicaid because it reimburses so little and that speaks to a lack of competent healthcare for foster youth who are queer and trans.

The most predominant time I worked with queer/trans foster youth was at a Therapeutic/BRS Care Facility and it makes me think of how terrible the services were for kids but they didn't have queer and trans competent therapists and we tried our best to take care of those kids and it was at the very beginning of my career and we were talking about it like having groups and taking kids to pride but there were people making homophobic and transphobic jokes around their back or assuming that stuff was based on gender and sexuality when it was really just a symptom and everybody was focused on one kid and if there was one kid there needed to be a pride group and it was never structural and ryther was run by lgbtq people but we never even had a conversation about trans people in the foster care system and the behavior of the youth at ryther and how the families didn't know how to support them either and they were bounced around from foster homes.

After I worked at a Therapeutic/BRS Care Facility, and while I worked at a Therapeutic/BRS Care Facility I got a Master's in psychology and I worked in chemical dependency and it was a boys' cottage. We never had an out trans woman there. It wasn't a safe place to come out and I was very closeted while I worked there and a lot of times it didn't feel safe and I would a little bit but there was a lot of homophobia there and a lot of times I got targeted because of homophobia or how I looked. A queer or trans kid trying to get sober who doesn't have queer

and trans support wouldn't have had the same in depth chance to get support in getting sober because there was no queer trans youth group. At the Counseling Center I only worked with queer trans youth, and ran the queer youth group there and the kids lived in different group homes.

*"Previous participants have stated that they have encountered specific clients or cases that have been challenging or troubling to them as a provider. Are there any particular cases that stand out to you or have been particularly challenging?"

I have two of them, I can see their faces and I know exactly who they are. I wonder where they are because I don't get to support them anymore because I don't take Medicaid. They're at home with their parents so much more... and if you invalidate them over and over again they will want to kill themselves.

We can agree on these things: that you love your kid and that you need to learn how your kid needs to be loved. Parents should worry about their kid, it's their job... and what any good parent would do is listen and empower and love their kid. When I'm working with doctors everybody is so worried about the kid's mental health that they don't want to prescribe hormones but maybe the hormones would help the mental health...because then they will feel validated and loved.

2. If you still work in this field, how long have you worked in this field?

I started working with kids who are incarcerated in a juvie prison in 2007 so about 10 or 11 years and started at Therapeutic/BRS Care facility during my undergrad in 2009.

If you no longer work in this field, how long did you work and why did you leave?

3. Why did you choose to work in healthcare and serve LGBTQ foster youth?

4. What did you enjoy about working with LGBTQ foster youth?

Working with kids that... they're cool! They're fun, funny, sassy, it's fun to be able to support a younger version of myself, it's healing to be able to support kids. It's good to focus on their strengths and their resiliency, I can't tell you how many times a kid has come out in my office and I tell them that I'm happy and their tears stream down their face, happy. They can ask me my own questions; I challenge my language to be more anti oppressive. It helps me be my best self. It's also just fun, and it's fun to be a therapist that kids keep wanting to come back. And its client centered. Kid led, the kids drag their parents to therapy and the kids are like 'come on parents' and the misconception is that the kids have a lot to work on and the misconception is that the issue is with the kids but it's really the parents or if they are in the foster care system and their parents aren't involved and the system can keep saying no for these kids to get the things they want but sometimes it says yes? And sometimes I'm just working on keeping these kids alive until they're 18 and can make their own decisions.

It is the hardest job and frankly as a trans person it's hard to want to sit with cis peoples' discomfort and I literally sit in a room and stay grounded and calm as they throw this transphobia and it hurts me also. My burnout has been so high lately I haven't been doing parent sessions, and these kids have to sit with that all day every day, and I have the privilege to say no thank you and these kids don't have that privilege.

5.What were the challenges of working in this field with this population?

6. What were your experiences that motivated you to continue in this field working with this population?

Running, going to the gym, working out sex, community, being connected and in love and love with what I'm creating as family and going out to the woods and being surrounded by queer

culture, seeing pretty movies that center on queerness or race, being in community. Reading being quiet, being quiet, being quiet.

(Explain “burn out”)

7. Did you have any specific experiences which led to “burn out”?

There is no network. There are individual providers who are champions, who will work super hard, and who will drive kids places, but as soon as they leave... it collapses, and there is nobody there to do that free labor. There is no network of systems. That was my experience with burnout. I would put more kids on my caseload if I knew they were trans because I know they only had Medicaid... and I would stay up later and take that on as my emotional labor because I am not only helping these kids, but I am fighting the system. My supervisor would say, ‘it is your passion, not your job’ and that’s why I had to step back from community mental health. Now I’m an individual therapist at a local Counseling Center for kids that are queer and trans identified. [...] and we are all these queer and trans people working individually and experiencing burnout...and we don’t show up in community... and that burnout is from secondary trauma. I mean, I have thought of killing myself, you know? We don’t talk about this because of the shame...

8. Do you think it is important to have a community of healthcare providers that work with LGBTQ foster youth?

Yes. I think it’s really important for trans clinicians to have community and support by other trans people because my supervisors didn’t know how to support queer/trans people and I need people who know what to do because I had to keep recreating the wheel every time and we need systems in place

9. In an ideal world, in the greater Seattle area or Washington state, what would this community look like to you? What would it offer?

People would be getting paid for this work and it would not be every other month but build into your system at work because the same questions keep getting asked; So, we don't have to ask the same questions. Everything is so 101 especially with trans clinicians and the counter transference and secondary trauma so that we can flourish and all training is so cis normative for cis clinicians. In the beginning of training I do I apologize to every queer/trans person in the room because its 101 and its where we're at and it needs to be in graduate school.

One thing that I've thought about is a conference for QT identified clinicians so that we can go deeper like 3 days of what this could look like. I think that having some kind of agency that supports queer and trans youth, not like a group private practice but like a drop-in center where they know we're centering around social justice, race, queer stuff.

I think CEU's for trans identified clinicians, it's not out there and it's not where the money is and as queer/trans therapists we're probably going to do a 101 training because it's where the money is and the money is coming out of our pockets and I was told that my old agency wouldn't give me money to go to a training to support queer and trans people because it wasn't my job so we do all this work because we just need to survive

10. Are there any questions or comments that you have for me about your experience, this research, or my goals or intentions with this project?

Appendix B: Interview 5

1. What have been your experiences providing healthcare or related services to LGBTQ foster youth?

So I've had not much exposure, the majority of my patients aren't in foster care. But I have had some... but I'd say that I've had lesbian, gay, bisexual, and questioning youth more in my clinic, and either they identified themselves, or by me asking them their sexual preference, romantic involvements, et cetera. In adolescent medicine, here we pride ourselves in confidentiality and we say that to the youth and foster parent. Sometimes they're okay with it and it's the second, third foster parent, and sometimes they're not okay talking about their orientation. With anybody who is sexually active what's important is the behaviors, because it may be different than their identity... so I do a lot of STD screening, risk reduction, and how to navigate that in their current situation. Sometimes if a patient is in foster care when I do screening, I ask for a phone number and how to get in touch with them... and maybe they don't have a phone number, so they use their foster parents' phone. So, then I have to ask 'who's your caseworker? I will contact them to contact you, I will not say anything to them'...so being mindful of that.

I had one trans, gender nonconforming youth who was in foster care and their parents and caseworker were totally supportive and they were already in mental health, and they already had their readiness evaluation, how their environment was like, school, environment, caseworker, and I ended up starting hormones on them but that was the only one I remember in the 7 years of trans health who I actually treated. I've had some come through for evaluations and then they go somewhere else. It's hard to know if they changed their mind or got lost in the system... and I don't have a way to follow through.

2. If you still work in this field, how long have you worked in this field?

About 7 years.

If you no longer work in this field, how long did you work and why did you leave?

3. Why did you choose to work in healthcare and serve LGBTQ foster youth?

I've always wanted to be a doctor ever since I was nine... and my mom had diabetes all of my life, and I went to doctors office visits with her and I loved her interactions with her healthcare provider. It really speaks to how resilient young people are and how an adult mentor can be very helpful for them in their future... So my parents paid for Catholic school for two years and I had a teacher who noticed I was good in math and science who asked me 'have you thought about being a doctor?' and that kept me going, so I was like 'maybe'... And we didn't have the internet then... So then I went to high school, and my counselor called me up and said I had the grades to go to college and I was the only one in my family... and I didn't have any role models and this whole idea of going to college... I was always interested in community health too, so I got my master's in public health.

I wanted to go into pediatrics because [youth] can have better outcomes as adults. As a gay cisgender male, I knew I wanted to help with some of the disparities that some of my peers were having... They didn't feel comfortable coming out. I went to college during the AIDS crisis and I wanted to give back to the patients that I saw. I wasn't geared towards foster youth, but I did my residency in adolescent medicine and I saw all kinds of youth; adoptions, foster youth... Here, I'm a subspecialist. We don't do primary care. We see chief complaints and we see the occasional foster youth that comes through, so ultimately learning some of the disparities that young people have, even adults, LGBTQ, whatever; I wanted to make sure that I could serve all of them. When I serve them, it's not a special thing that I do. I identify them and counsel them.

The key thing with that population is to ask them, and when you ask them, generally they are upfront.

When people go through medical school and training, they are taught how to ask about sexual history, but not gender identity. I've found that trans youth and gender nonconforming youth have higher health disparities...and I wanted to focus on them. So, when I came here, my boss asked me all the things I want to see patients for, and I said, 'obesity, eating disorders, LGBT patients'... So, that was when I started getting patients. Because they were showing up and needed special care.

4. What did you enjoy about working with LGBTQ foster youth?

I love the fact that we are able to identify them and really even affirm who they are and give them the advice that they need to be healthy, productive adults. I love that. And particularly the trans youth, when you affirm who they are you see the light in their eyes. It really helps with job satisfaction. And also, giving back; I was a gay youth and nobody asked me about my sexual activity and sexual orientation.

5. What were the challenges of working in this field with this population?

I would say, I think particularly the foster youth, you have to deal with the system which can be good or it can be bad and if that youth has a good system it can be good, but if that system has any flaws, from the case manager to the foster parent, it can make it difficult to treat them.

In general, with affirming people for who they are, especially 'LGBQ' patients, they can get the healthcare they need. With trans individuals, it includes hormone treatment, and that's a little bit different. [Doctors] are trained to screen for STDs and condoms and safe sex, but with trans youth, its hormones. In addition, there are insurance exclusions with treating gender non-conforming youth. Also, just an overall lack of coordinated care systems that will help.

6. What were your experiences that motivated you to continue in this field working with this population?

(Explain “burn out”)

7. Did you have any specific experiences which led to “burn out”?

8. Do you think it is important to have a community of healthcare providers that work with LGBTQ foster youth?

I think it is very, very important, and as I mentioned, particularly with foster youth, working with that system takes experience and finesse, and a group would be great. My caveat is that I think all providers should be able to care for all individuals and if they can't care for them, they should know who to refer them to. I'm hoping that my gender clinic will be obsolete in 10 to 20 years, and it's integrated in 10-20 years.

9. In an ideal world, in the greater Seattle area or Washington state, what would this community look like to you? What would it offer?

There was a group when I first joined there was a group of medical providers who met for happy hour monthly or quarterly. It would be nice to have a database of providers who maybe are vetted to their experience and not exclusionary with caring for these young people, and that database, so you can go to that database and say here is a list of providers and say here's who you can call and maybe even interface with what's covered by insurance. Again, I think the ideal situation would be to not necessarily have this network but particularly in primary care to be able to care for these young people.

10. Are there any questions or comments that you have for me about your experience, this research, or my goals or intentions with this project?

*"Previous participants have stated that they have encountered specific clients or cases that have been challenging or troubling to them as a provider. Are there any particular cases that stand out to you or have been particularly challenging?"

I do have that one patient who was in foster care who was in foster care who was a trans feminine patient who I started at birth who started at 14 who started with a few iterations of foster parents and was reunited with her mother because this mom was trying to be supportive but was very negative about the whole process and the mother was remarried and the foster father was more supportive than the mother and finally it got to the point where it didn't work and finally as the youth was becoming of age of consent she transferred to another foster parent who was a young woman who was homeless and still in the system and stayed with this person for quite some time and during this process came to me and said I think I'm more non binary and I think I want to explore the more masculine side of me and I've only had two and that person was one of the ones who went off medication and I saw them recently and their gender expression was more male and was not questioning what they did and did not regret it but was really mulling over the fertility things that could occur so that is a patient I often think about. I did I do the right thing, what does their future hold and people often say what if they change their mind and they did change their mind but they didn't regret what they did.

This patient's father was how they got into foster care, and their father died. That baggage carried into their mental health, eating disorder, PTSD, depression and anxiety. Ultimately I feel okay about it but I don't feel great about it.

Did you have any closure?

I did meet with that patient; they did change back to their birth name and was more gender queer and we talked about estrogen and the risk of fertility but the risk is high and you were on it for

about 4 years or so and there is a high risk but there is a possibility that you can still have children so I gave resources to a fertility specialist and if they have a partner and if they aren't able to conceive and they can work on the issues.

If they're not ready to have children so the issue was intercourse and I had to reiterate that you should still use a condom for STI's and it's still a possibility and I think they were satisfied.

I think young people are feeling more comfortable... but when I first started a lot of patients were telling me what I think they thought I wanted to hear... and they felt more nonbinary. I think they were telling me that they wanted to be more one way than the other because 'that's how you get hormones' but non-binary patients can get hormones too, so we work with them to get what they really need for the outcomes they are looking for. I also have patients who are nonbinary and like how they're feeling... but want more of the hormone but still a little nonbinary feminine or nonbinary masculine because they're okay with other aspects of their body.

Appendix B: Interview 6

1. What have been your experiences providing healthcare or related services to LGBTQ foster youth?

I maybe have a unique position compared to some of your interviewees. I'm an adolescent medicine doc and I do a good portion of research as well and it has been almost exclusively with foster youth on reproductive health... so STD and pregnancy prevention to help youth make their own decisions about reproductive and health lives. More recently, with the gender clinic. I'm not doing direct care, but processes to help direct the clinic and meet the needs of the kids we serve. Also, how does somebody's mental health change when they get involved in multidisciplinary care. I work at a group home and most of the kids are child welfare involved, many of whom identify as LGBTQ.

Another thing that is relevant to my perspective, my colleagues who do work with the gender clinic talk about making sure that they have folks whose job is to call transition aged youth and do transition screening to make sure they were incorporating LGBTQ friendly language and understood the unique background and health issues that arise. And they are really interested in this topic. There is one pediatrician who works in [Location redacted] and I don't think [they are] particularly experienced in working with LGBTQ youth. Had a lot of 101 questions, but is interested in improving care for kids who are gender/sexual minorities (GSM) and has worked with foster kids for a long time.

I also just think the landscape is changing... I will say in the last three years. These days I am frequently referring kids to the gender clinic. I work in adolescent medicine and I got involved with the gender clinic because of my research skills because it is a highly vulnerable population with a need, so I'm colleagues with [Names redacted]. Working with foster youth came with

personal experience as a Big Brothers Big Sisters mentor, I think having colleagues who were knowledgeable about it.

I'm very confident about [Name redacted] and [Name redacted] and having them as resources has moved my bar as far as comfort and right now I don't provide cross sex hormones or puberty blockers but I think there will be a time where I will be part of the clinical care and what's moved my comfort bar were concerns, could I do it right, could I unintentionally cause harm, am I doing something that could have these long term impacts on a kid and how do I know if they're ready and having skilled people around me is, I think, what made the difference

I would not have had the exposure at all, I would have probably made the same assessment that your other participants did but from the opposite perspective

Clinicians needs to feel like they're not in a vacuum and support and a safe space where they can acknowledge, what for me personally was, I had a lot of questions at the society for adolescent medicine and I had a lot of questions about GNC youth and whether small amounts of cross sex hormones are a good move. I was worried that maybe ultimately those kids will end up being on one or the other end of the spectrum, so when do you decide to use hormones? They had a workshop on their process on how they assess that, and there were a lot of other folks who provide trans care and care for GNC youth and understanding how they think through that. I would have been completely uncomfortable with GNC youth before that, and it definitely moved my bar, comfort-wise, to have access to that community of experts. I don't have personal experience being a gender or sexual minority, so maybe I'm not the right person to do this work? ...So having knowledgeable team members makes a huge difference.

Prior to three years ago between 2008 and 2014 or 15 [our clinic] had zero kids who identified as trans or gender non-conforming and [now] at times half the kids or more have identified

somewhere on the spectrum... so I think there is a societal shift where kids are more likely to overtly identify as somewhere on the spectrum... and there is more of a safe space. Not with recent political changes... I don't think sexual orientation has changed a lot as far as the number of kids that I see but the number of kids who identify as trans has changed massively in that setting at least.

I think general pediatricians should be referring to specialty clinics so that kids can get evidence based care, and at our clinic we are very careful that preferred name and pronouns are used from the front desk. There's a lot of work that goes into the infrastructure that makes the clinic friendly from start to finish, and eventually there maybe be enough, especially for kids where there should be somebody who has constant contact with the kids. I think PCP's can provide the safe space for kids to talk about this, and then help engage them with appropriate care providers who do have the knowledge and experience to provide evidence based care.

*Interviewer states that a previous participant suggested that "all PCP's should be able to provide care to LGBTQ foster youth".

I think that's a great long term goal- I think we'll get there and will be incorporated into standard practice and my worry with kids is that if care is not provided in an evidence based way and the mental health outcomes can be very scary if they aren't engaged in appropriate care and the starting place is to make sure there are places where kids can get evidence based and gender affirming care and eventually it would be great. It doesn't necessarily have to be at a primary care clinic, like Odessa Brown, they want to provide transgender healthcare in their own clinic and they want to work with our clinic to make sure those guidelines are in place. And I do think right now if you don't have the background and training necessary to provide evidence based gender affirming care [...] I just don't think we're there yet.

2. If you still work in this field, how long have you worked in this field?

Since 2008, so about 10 years.

If you no longer work in this field, how long did you work and why did you leave?

3. Why did you choose to work in healthcare and serve LGBTQ foster youth?

I'm trying to think of how long or short of a story... I had an experience wanting to work with foster youth as being a mentor to a foster youth while in medical school. And my interest working clinically and research wise with LGBTQ and foster youth is that there's a huge need, and I can use my research skills and the gender clinic just opened last fall and it's a great place to start observation measures and provide high quality care. Whether or not there's disproportionality, one thing I'm sure of is that there is a lack of high quality homes for youth that identify as LGBTQ. We did a study with foster and kinship caregivers and stakeholders, and one participant who was a social worker... she talked about how she had to put kids who identify as LGBTQ in homes where it was 'okay' for the kid to be home, and it's not 'okay'. Tolerance is not an affirming environment, it's not okay for her to have to place kids in homes like that. I do think there's a huge need for truly affirming foster homes.

4. What did you enjoy about working with LGBTQ foster youth?

I think it's hugely enjoyable to take a group of kids who have often have negative experiences with healthcare providers in the past and take the opportunity to do some trust building and connect them with the resources they need, it's my favorite part of the job.

5. What were the challenges of working in this field with this population?

Sussing out, trying to figure out what the landscape is with care providers, caseworkers, foster parents, biological parents, in the group home setting the team there as well and trying to figure out what's right for the kid and in a group home setting the team is tasked to figure out working

with the kids' community, family, and team. There's often some players who are not on board with gender affirming care in particular. A lot of issues come up around if a kid wants a binder and I often get asked if this is okay medically, and I'm like "it's not a medical issue it's something that a kid should have access to if they want it". Figuring out how to do what is right for the kid and move the family along slowly has been the biggest challenge.

*"Previous participants have stated that they have encountered specific clients or cases that have been challenging or troubling to them as a provider. Are there any particular cases that stand out to you or have been particularly challenging?"

Yeah I can think of specific examples where this kid was, I don't know if he was involved in the foster system, it may have been an adoptive parent but the kid wanted a binder and the mom was not super on board with it and I ended up having a conversation with her about it and I took a very straightforward evidence based approach and said this is what happens if kids are not getting "eh" care.

I wasn't sure if it had made a difference and she contacted me again for another reason and the kid had socially transitioned and she was on board and it was much more of a positive outcome story. There was another kid who we watched him go from, he identified as she when first admitted and it became very clear that he identified as trans male very early on in the stay and he really blossomed and went from having a lot of anxiety and physical symptoms but the family was not accepted at all and wanted nothing to do with him and there was a CPS referral as a result of that and ultimately I think the kid went back to the family.

Stories like that are heartbreaking and I don't know how that kid is doing and I hope he has supportive adults around him and it's really hard to connect a kid like that to the gender clinic because his family won't take him. I think it was complicated too because the kid had a huge

bond with his dad and his dad was supportive but his mom was not and I don't think he wanted to be placed out of home because of his dad and I think he would have been placed elsewhere if he said he didn't want to live there anymore and that wasn't his... that wasn't how he felt... Data suggests that chronic psychological abuse is more harmful than physical abuse.

6. What were your experiences that motivated you to continue in this field working with this population?

Working with a great team, it's been so fun working with the gender clinic team, I think having other people around who have a passion and good coping skills... And moments where I feel like I made a difference for a youth.

(Explain "burn out")

7. Did you have any specific experiences which led to "burn out"?

Mhm, when I first worked at the group home, probably maybe a year in I found myself getting super grumpy with the nurses all the time and I realized that I was taking their stories home with me and it was secondary trauma where I was taking these kids' stories home with me and I'm frustrated at this really inefficient and sometimes unhelpful system. I like my role at the group home because my role is to support physical health and develop plans around behavior issues with physical health consequences so if I'm not involved much or not making much of a difference so I'm not worried that I'm harming a kid or making a kid's life worse but for example if I'm helping a kid get on birth control or a specific health issue like work on skills around anxiety... So I have a special role where I get to make positive change and am not at the end of the day responsible for where a kid goes or mental health care

8. Do you think it is important to have a community of healthcare providers that work with LGBTQ foster youth?

Yes, I think the hard part with foster youth is that they're not all located in one place, community, or location, there's the Community Clinic for younger foster youth and they've tried several clinics that are dedicated to foster youth but that doesn't work because they move so I do believe that every physician needs to understand the needs of youth who are foster system involved and LGBTQ and I think it needs to be something we are all responsible for and I don't mean with puberty blockers or cross sex hormones but I think you need an understanding of how those issues are involved, being in child welfare and identifying as LGBTQ.

9. In an ideal world, in the greater Seattle area or Washington state, what would this community look like to you? What would it offer?

I think there needs to be sort of a basic level of understanding a clinic environment that is gender affirming that is very clearly open and affirming to youth of all genders and sexual orientations and a basic understanding of youth of all orientations who are child welfare involved, abuse is only one of the things that these youth go through, there are a lot of other adversities that they face.

They have unique risks in adolescence and I think ideally there'd be a system, is that you have folks who have a basic understanding and people you can refer to if it's beyond their comfort level and understanding and it's called collaborative care and I think that kind of model is a great model for trans care and I don't know about for foster youth, it's harder, I'm not sold on the idea of specialty clinics for foster youth because at the end of the day the social worker is going to take them to whatever clinic they can get them into.

It's how they can have more continuity, can they stick with the same provider even if the kid changes placements, I think there are unique systems solutions for kids in foster care but I don't think that a dedicated clinic is the right move.

There is the Community Clinic which does comprehensive assessments for kids who are just coming in to care. Coordinated Care; I think they're trying to do screening and kind of get a sense of the needs of the kids in care, I don't know what they're going to do with that information or what their ultimate objective is but they seem well intentioned and I don't have an in-depth sense of that organization. I thought about whether I was a good fit for the interview because a lot of my research comes from not my clinical work.

10. Are there any questions or comments that you have for me about your experience, this research, or my goals or intentions with this project?

It would be nice to think about upshots from the perspective of the child welfare system and the perspective of providers. From a policy perspective, what can we do to improve things?

Be a little bit more general, not about CARING for LGBTQ youth in the foster system- working with or working in organizations that serve and you would have to adapt your questions to ask what their organization does and thinks they need. Ask providers: What are the needs and challenges the community faces? Maybe the provider side, insurance side, what are the practical upshots? Continuity of care for kids' complex health needs? I think it would be nice for all youth, but even if [Children's Administration] had a policy [that] if they were on one physical health medication that continuity was prioritized.

"The child welfare system views providers as interchangeable and they are not it's a relationship and you need to develop trust and relationships with your clients and it is not possible to provide as high a quality of care without the continuity piece". It has been interesting working with child welfare providers. I think the issue is continuity, I don't think it's a bad thing for them to be seen by nurse practitioners; folks in allied professions can do a good job, but especially for kids with histories of abuse, they can't just spill their guts to an unfamiliar provider, it takes time".

Appendix B: Interview 7

1. What have been your experiences providing healthcare or related services to LGBTQ foster youth?

I have worked in a variety of health care settings, including a chronic illness community nonprofit, a Ryan White funded HIV program, a Medicaid chronic illness home visiting program, a school-based social work program, and now in an urban children's hospital in a pediatric transgender care program. I have offered specialized services to LGBTQ clients in all of these settings. This includes HIV case management for patients who have recently aged out of foster care, chronic illness case management for LGBTQ foster youth and their families, life skills and healthcare access coaching for LGBTQ foster youth, and as the program manager of a program for pediatric transgender care.

2. If you still work in this field, how long have you worked in this field?

I have been in social work for approximately 10 years and have worked with LGBTQ clients for all of that time, specifically with LGBTQ foster youth as part of my caseload for about 5 years.

If you no longer work in this field, how long did you work and why did you leave?

3. Why did you choose to work in healthcare and serve LGBTQ foster youth?

I think healthcare is such an important basic human need that is so underserved, and helping folks navigate such a daunting system is incredibly rewarding. I love working with youth for a lot of reasons, one of which is that they've got "squishy brains" (i.e. their prefrontal cortex is still developing) and there is so much potential to make a positive impact at a crucial developmental time. As an LGBTQ person, working within my own community means a lot to me, and because LGBTQ foster youth experience such intense health disparities, it is a particularly important area of work.

4. What did you enjoy about working with LGBTQ foster youth?

I like honesty and tough conversations, so I tend to enjoy the kind of clients that will tell you that social workers suck and they hate you during your first meeting. I think LGBTQ foster youth can really benefit from messaging about critical thinking and body autonomy and independent decision making, because there are so many systems at play for them and so much that they aren't hearing from parent figures that other kids might; I think these concepts are crucial to feelings of empowerment especially as they prepare for adulthood with sudden and drastic decreases in support. I enjoy being able to acknowledge the realities of what is difficult will still highlighting hope and helping find where you can make decisions and impact your environment.

5. What were the challenges of working in this field with this population?

Lack of resources available to this population means that as a social worker, you're always trying to do more with less, which means more time and creativity, often when caseloads are already high. Because of the burnout that impacts workers for this population, clients are constantly having to start over with someone new, which can contribute to understandable cynicism and reluctance to engage with you as a new social worker. Additionally, the issues that impact LGBTQ foster youth are often ones that frankly make a lot of adults uncomfortable (adolescent sexuality, safer sex, drug use, mental health, etc.), so it can be tough to navigate conversations with other providers about why talking about these topics and normalizing bodily autonomy and informed decision-making are so important.

6. What were your experiences that motivated you to continue in this field working with this population?

Seeing what a difference it makes for a client to overcome a fear of an annual physical, to learn about how they can be less likely to get preventable illness like diabetes or heart disease, to try

mental health medication, to know their HIV status has been positively joyful for me. I have had teenagers brag to friends and ask me for high fives once they accomplish one of these steps.

Seeing even small positive changes helps me stay motivated for this work, especially when we can standardize it into a system and watch it become a ripple effect for whole groups.

(Explain “burn out”)

7. Did you have any specific experiences which led to “burn out”?

I’ve worked really hard to avoid burnout. I’ve been privileged to be part of a multi-income household where I’ve been able to be somewhat choosy about what jobs I take, which means I can be really honest about only working a 40-hour work week and not checking work email outside of work hours. I’ve learned that to me, it’s really important to be out as an LGBTQ person at work so I don’t have the pressure of hiding/being outed, and so that others can have the opportunity to mind their LGBTQ microaggressions, which people seem to avoid more often when they know “those people” are in the room.

8. Do you think it is important to have a community of healthcare providers that work with LGBTQ foster youth?

Yes, absolutely. I think LGBTQ foster youth need to be able to develop positive relationships with healthcare providers as part of learning to be healthy adults, and this is so much easier when they don’t have to educate their providers about what their unique needs are as an LGBTQ person and a foster youth (and when microaggressions can be avoided by training providers!).

Preventive care like mental health screening, long-acting reversible contraception, the HPV vaccine and STI testing can make a world of difference in their current and future health outcomes, and having knowledgeable providers is a huge step forward.

9. In an ideal world, in the greater Seattle area or Washington state, what would this community look like to you? What would it offer?

I think that for new providers, having LGBTQ tracks in residency (like [Name redacted] Medical Center's family residency program does) or seminars in medical school (like [Name redacted] does at the University of Washington) can be huge. I also think that for existing providers, mentorship programs and consult groups can be great. I know I find the Ingersoll Consult Group helpful and often direct people to it. Additionally, offering LGBTQ patients and their caregivers/case managers resources to get referrals to culturally aware providers so they aren't learning who's good by trial and error is a huge step forward.

10. Are there any questions or comments that you have for me about your experience, this research, or my goals or intentions with this project?

As a total aside, I've noticed that often even as social workers, we can fall into the trap of thinking of LGBTQ identity for youth only in terms of a risk group, rather than as a strength. Whenever possible, I try to bring in LGBTQ history, like how trans women were the key players at Stonewall, how ACT UP changed queer health care, how trans identities have been a celebrated part of many indigenous cultures for centuries, etc. I think it's important to help LGBTQ youth, particularly foster youth, see people who they share traits with who are happy, healthy, and strong.

Appendix B: Interview 8

1. What have been your experiences providing healthcare or related services to LGBTQ foster youth?

I am a psychiatric mental health nurse practitioner, I have worked in community mental health, school based mental health, and currently a private practice and two multi-disciplinary clinics, one is for transgender and non-binary youth. They do forensic interviews, Trauma Focused Cognitive Behavioral Therapy... I am part of the treatment team and I provide psychotropic medication management and psychiatric interviews and in all of my locations I have worked with LGBTQ youth and some are in foster care and some have DHS involvement. Some are not out of home but DHS is still involved. [Redacted personal information regarding adopting a child from the foster care system] So, I have been around this issue I think in every possible way you can be in it.

2. If you still work in this field, how long have you worked in this field?

Probably about a decade.

If you no longer work in this field, how long did you work and why did you leave?

3. Why did you choose to work in healthcare and serve LGBTQ foster youth?

That is a big question, I was originally in sociology and did a lot of work on social inequality in various ways and after I finished that I decided I wanted to do something more hands on so I decided to go into nursing where I knew I could provide direct care and do research so that is my next step to do both so that's why I chose ... because they like their clinicians to also do research and I'd like to combine it so working with the gender diverse kids, that's going to be in my area of research as well. I was at a community based mental health center for young people and some

of our clients are LGBTQ and in foster care, a lot of our clients were in foster care and happened to be LGBTQ.

4. What did you enjoy about working with LGBTQ foster youth?

One I'm bisexual and I've been out for 20 some years so I feel a real affinity for these kids and my original education in my nurse practitioner program was all around trauma to my two big areas of interest were working around kids in the foster system and kids who are LGBTQ...And it's an area that not a lot of people are looking at and there is a large population of kids who are homeless, 40% why are they not served by the foster care system? We have a system to provide them with homes, why are they not being served by that? They percentage that are homeless far outweigh the percentage in the general population.

I haven't worked with homeless adolescents in a while but I do more with foster kids than homeless kids and that's my question- why are they two separate populations? Some teens 16 and up are in homes that they don't like and I've heard that some kids are encouraged by their caseworkers to [stay homeless] if they can't find them a good match so they can find better services.

*"Previous participants have stated that they have encountered specific clients or cases that have been challenging or troubling to them as a provider. Are there any particular cases that stand out to you or have been particularly challenging?"

Yes...And this was a kid, a young transgender female, and she was at the transgender clinic that I work at and she was in DSHS custody and was in residential treatment and the reason she was in DSH treatment was that her parents found out she was transgender and they started her on hormone blockers and we lost track of her and there was no follow up and she was about 13 and she was on Lupron and needed to be taking that or she would develop secondary sex

characteristics and those blockers can be very affirming for those kids and it was a really sad case because her mental health condition seemed to be based on how she was treated due to her mental health care. Now we have more of a protocol about how they are treated if they are in residential care or if they have a DSH worker so that they don't get lost when it comes to follow up like that.

What I realized having worked in a community based mental health center is that we have to work very hard to keep track of kids when they move from home to home. We had to work on getting a HELP passport for foster kids that was literally a little booklet on chronic health conditions so no matter what home they were in the parents would have that information. Kids would bring me a bag of medications and the foster parents wouldn't know why they were on the medication or if it was the correct dose which just created an incredibly dangerous situation...just basic health needs that weren't being followed. But now every DSH office has an RN so that they can deal with health issues and be an adviser to the other workers because they have so many health issues than kids who are on foster care, in Oregon there's no fluoride so teeth issues are terrible but there is no repository for information because everybody has a different health record.

"But since I work with transgender youth and I prescribe psychiatric medication I am really worried about it not being continued if a kid is moved. It also means we are wary to start cross sex hormones because it's not good for the kid if they have to go off of them- so we are not able to provide the best level of care that we want to". Some of those meds like SSRI's can cause pretty significant withdrawal effects if they're not kept up. One of my big concerns for lgbtq foster youth is that if kids are placed in a home when they're younger and then they come out and the parents are not open to who they are, it can be another ruptured attachment and the

attachment system is already so harmed by the original parental loss that it can be another attachment trauma. I know in most states they are not screening foster parents for whether they are homophobic or transphobic and what I have heard is that they're doing that for adolescents but if they're not out and come out later that can be a really serious disruption. If transgender youth choose to go forward with transition they need foster parents who can get them consistent medical care so they can be getting sufficient medical care for their transgender healthcare.

Another client who was in and out of foster care who started testosterone, and he was lost... we couldn't find him again... and the juvenile authority called us because he came up there and he ended up moving to a separate state. We had to work with the jail and they had to find him a provider in the other state to get him on testosterone again. We were working with the Youth Authority to determine whether he should start testosterone there or not and we all decided that he should start again in the other state so it could remain consistent once he moved. I think he was 16. That was a really rough case. Just the brightest kid, but really damaged by trauma, and some of the trauma was gender based. That was about 4 months ago... he finally moved. Our whole clinic is still thinking about it.

I think for people who aren't in this field it illustrates how hard these stories are... and if they weren't in state custody they would be getting decent medical care and people would be able to keep track of them... and there's these things that happen that are so shocking...

5. What were the challenges of working in this field with this population?

There are a lot of challenges. One is that a lot of foster parents are recruited by churches, and many by evangelical churches so they may not be open to kids who are non-heterosexual sexualities or gender, behavior, or identity that is not within a strict binary framework, so having a parent that can validate or accept these young people is vital so one is just recruiting people and

we are seeing problems in some states about allowing LGBT people to adopt these kids so everything from finding families to caseworkers who understand the needs and also finding therapists for kids who can validate that at the same time while treating their trauma. And there's just provision of healthcare that is consistent and making sure that everyone on the team knows why they're getting whatever medical or healthcare they're getting.

6. What were your experiences that motivated you to continue in this field working with this population?

(Explain "burn out")

7. Did you have any specific experiences which led to "burn out"?

Yeah. Haha so that's part of why I'm going back and getting a PhD and not doing clinical work full time and it's often really tragic. And for awhile after my daughter was first placed with us I decided not to work with foster kids for awhile because I was dealing with it in my personal life as well and needed a break.

I feel really strongly that if people are homophobic or transphobic kids should not be placed with them because you do not know what that kid is going to be because in two years that kid might have a different gender identity than what you would expect. I would love to see an incorporation about some kind of standard measure about whether or not a prospective parent is homophobic or transphobic.

8. Do you think it is important to have a community of healthcare providers that work with LGBTQ foster youth?

Well of course.

9. In an ideal world, in the greater Seattle area or Washington state, what would this community look like to you? What would it offer?

With the transgender clinic, we see kids from southern Washington as well.

I think that you'd have everyone trained, all DHS workers trained in the needs of GLBTQ adolescents and gender creative youth or children so that no matter who kids are assigned to they have somebody who's sensitive and then people with ore information so that they can be consultants to others

Healthcare provers who are knowledgeable and nurturing to these kids who take state insurance so that kids can go to these providers. As much consistency of care as possible, knowing what medication they're on, knowing why and then if they move that that follows them. And, people that are training foster parents need to be screening attitudes towards LGBTQ people and providing more information about what those parents should do if a foster kid comes out. I think that having a provider database that could be shared with DHS and between providers since a kid will see like, me as mental health provider first, and I will know what health provider to refer them to.

I do think it would be great to have some kind of conference or meeting group so we could refer to them too.

I know San Francisco has that, like Ingersoll (Gender Center), but Portland does not... the one in SF is specifically for kids and for kids and adolescents and a 13 y/o is not ready for informed consent, they need something in between "hey do you want this" and "lets start this". People that start working with adults open up their practices to adolescents and kids and they come in with the informed consent model but don't have the developmental framework. I've worked with some kids who can't transition from the house to school, how are they supposed to transition hormonally? And parents will say I think they should start immediately, let's be real and try to give them some skills like resilience so they can get out the door, and then get on hormones.

10. Are there any questions or comments that you have for me about your experience, this research, or my goals or intentions with this project?

APPENDIX C

Common LGBTQ+ Terms:

Unless otherwise noted, all definitions are adapted from:

The Center for Children & Youth Justice. (2015). Listening to Their Voices: Enhancing Successful Outcomes for LGBTQ Youth in Washington State's Child Welfare and Juvenile Justice Systems. Seattle, WA: Ganzorn, S., Curtis, M., & Kues, D. Retrieved from http://ccyj.org/wp-content/uploads/2015/04/LTTV_Full.pdf

Adapted from American Psychological Association. (2011). Definition of Terms: Sex, Gender, Gender Identity, Sexual Orientation. Retrieved from <https://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf>

Asexual: Describes an individual who does not experience sexual attraction, but may experience emotional or romantic attraction.

Biological sex: Describes an individual's biological status and is typically categorized as male, female, or intersex. There are a number of indicators of biological sex, including sex chromosomes, gonads, internal reproductive organs, and external genitalia. Biological sex assigned at birth is the sex marker placed on an individual's birth certificate at birth.

Bisexual: Describes an individual who is emotionally, romantically, and sexually attracted to both men and women.

Cisgender: Describes an individual whose gender identity and gender expression matches the gender typically associated with their biological sex. For example, a cisgender man is a male who identifies as a man and is perceived as a man.

Gay: Describes a man who is primarily emotionally, romantically, and sexually attracted to other

men. This term has also been used as an umbrella term to describe the LGBTQ+ community.

Gender Expression: Describes an individual's outward communication of gender through behavior or appearance. An individual's gender expression may or may not correspond with their biological sex assigned at birth.

Gender Identity: Describes an individual's inner sense of being a man, woman, or another gender.

Gender identity may or may not correspond with an individual's biological sex assigned at birth.

Gender Non-Conforming: Describes an individual whose gender expression does not correspond with their biological sex assigned at birth.

Heterosexual: Describes an individual who is only or primarily emotionally, romantically, and sexually attracted to the opposite sex. The term "straight" is often used to describe heterosexual individuals.

Intersex: Describes individuals whose combination of sex chromosomes, gonads, internal reproductive organs, and external genitalia are not "typical"—according to the medical community—of "female" or "male."

Lesbian: Describes a woman who is primarily emotionally, romantically, and sexually attracted to other women.

LGBTQ: A general term used to describe individuals who identify as lesbian, gay, bisexual, transgender, and/or queer/questioning. In some cases, I, for intersex, A, for asexual, 2, for twospirit, and/or +, to reflect a broader sense of inclusivity, is added.

Pansexual: Describes an individual who is emotionally, romantically, and sexually attracted to individuals of all gender identities and expressions including those who do not fit into the standard

gender binary (man and woman).

Pronouns or Preferred Pronouns: A term used to describe gender pronouns that an individual wants others to use when referring to that individual, such as: he, him, his; she, her, hers; or they, them, theirs. Others use less common pronouns.⁶ Pronouns may or may not match the individual's birth assigned gender and may be gender neutral or words not commonly used as pronouns.

Queer: An umbrella term describing individuals who identify as gay, lesbian, bisexual, transgender, gender neutral, questioning, and many other identities. While this term has been used in a derogatory way in the past, many individuals and groups are reclaiming it as an all-encompassing way to describe those who do not identify as heterosexual and/or cisgender.

Questioning: Describes an individual (often an adolescent) who has questions about his or her sexual orientation and/or gender identity. Some questioning individuals will identify as LGBTQ; some might not.

Two-Spirit: A term sometimes used to describe indigenous North American individuals who have a gender identity and/or gender expression that does not traditionally align with their sex assigned at birth or have a culturally distinct gender, apart from man or woman.

Sexual Orientation: Describes an individual's emotional, romantic, and sexual attraction to the same or opposite gender. An individual's sexual orientation is different from an individual's gender identity.

Transgender: An umbrella term that describes individuals whose gender identity differs from the biological sex assigned to them at birth. A transgender woman is a person who is assigned the sex of male at birth but identifies as female. A transgender man is a person who is assigned the sex of female at birth but identifies as male.

APPENDIX D

Concept Analysis:

Major concepts: LGBTQ / queer / gay, etc. youth social work / social welfare foster care

Other key words: child welfare, care providers, medical, mental health, dental, therapy, challenges, homelessness

Searches performed:

Google:

“social work care providers lgbtq youth filetype:pdf” “lgbtq | gay | queer | trans” child welfare challenges “care providers” filetype:pdf” “social workers | caretakers” “lgbt children” filetype:pdf”

With these searches, the goal was to find diverse results by using different terminology. The search for PDF results was with the intention to find documents and articles as opposed to blog posts, company sites, or social media.

“obstacles to effective child welfare service with gay and lesbian youths” Sullivan”

After finding this article by Sullivan via Social Work Abstracts (EBSCO), the title was searched via Google to find similar articles, or articles that listed it in their bibliographies.

“lgbt foster social work inanchor:seattle inanchor:youth”

Because this research began with a basis in King County, the intention behind this search was to try to find some results in the area, which included searching for Seattle and youth in the anchor to filter out results that are not in Seattle, and that are focused on adults.

Social Work Abstracts (EBSCO):

Index search for subject: “gay”

added “gays, gay rights, gender differences, gender identity, gays counselling (sic) services” with “OR”

Index search for subject: “youth”, added “youth, youth agencies, youth programs, and youth services” with “OR”

Both searches were then performed separately, then at the same time connecting with “AND”.

Social Services Abstracts (ProQuest):

Thesaurus search for subject: “gay”, added homosexuality

Thesaurus search for subject: “youth”, added youth

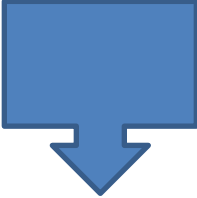

Searched the two subjects together with “AND”

APPENDIX E

Author's Models of Experiences of Healthcare Providers of LGBTQ Foster Youth:

Model of The Four I's of Oppression in a "Social Model" of Healthcare Providers of LGBTQ

Foster Youth

| | | | |
|-------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Macro Level | Societal | <p>Ideas</p>  <p>Projection of societally shaped ideas about LGBTQ foster youth onto institutional policy</p> | <ul style="list-style-type: none"> - Vary largely by region and political affiliation - Medical or biological determinist lens toward development of gender or sexual orientation - LGBTQ identity as solely social group affiliation - E.g. Transgender people as deceitful or manipulative - E.g. LGBTQ people at large as having Adverse Childhood Experiences which influenced sexual orientation or gender identity - |
| Mezzo level | Federal State Community Local | <p>Institutions</p>  <p>Institutional pressure to take a pre-determined, path of least resistance toward healthcare service navigation</p> | <ul style="list-style-type: none"> - Policies and procedures regarding LGBTQ healthcare, such as ICATH and WPATH - Policies and procedures regarding foster care and dependency case timelines - Coordinated Care as a facet of Medicaid - Department of Health - Department of Early Learning - Academic, clinical, political, church, third party agencies, non-profits - Children's Administration - Behavioral Rehabilitative Services - Foster homes as agents of social service institutions |


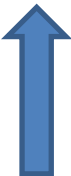
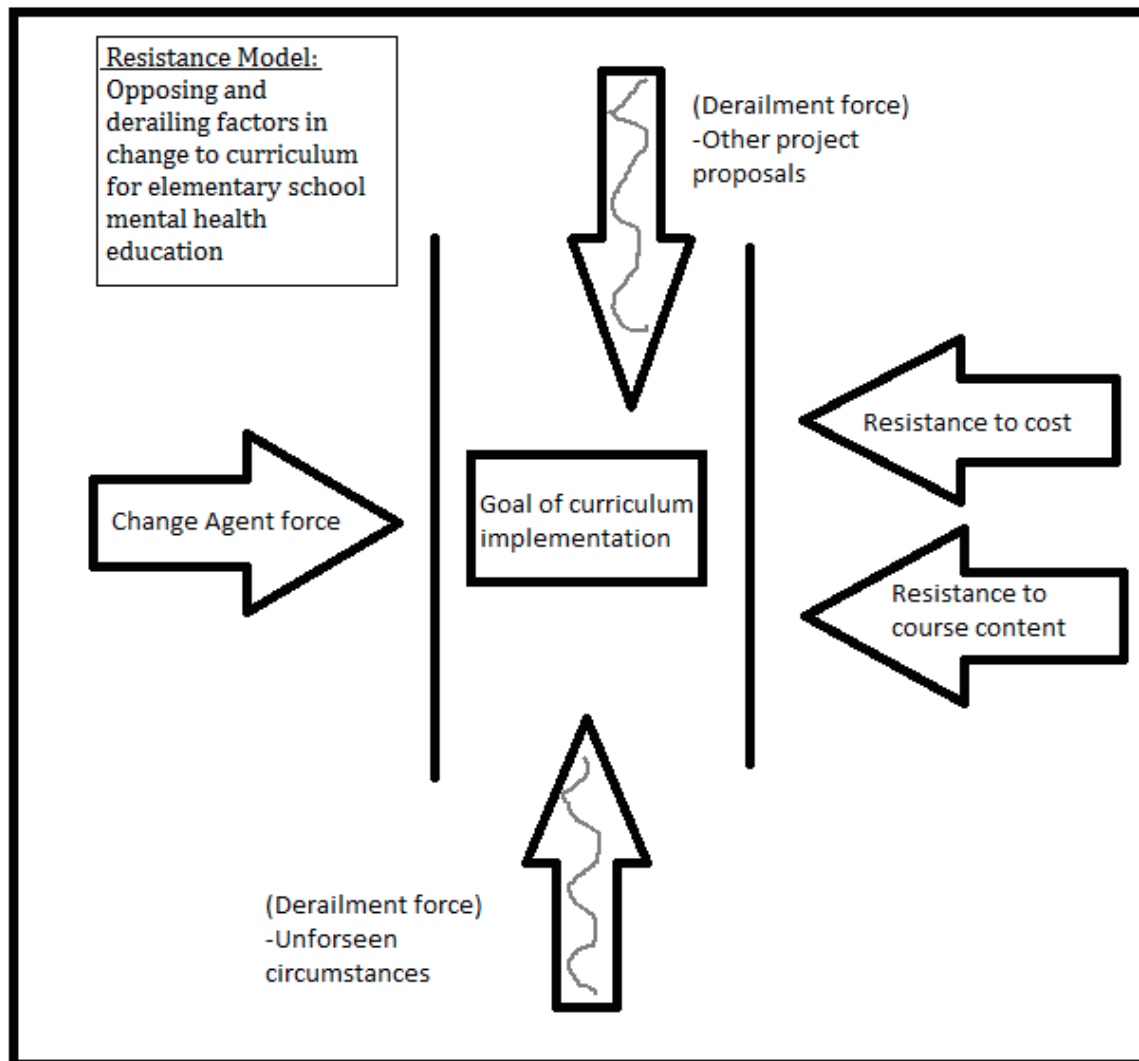
| | | | |
|-------------|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Micro level | Social |  <p>Convergence zone between societal ideas, institutional policy, interpersonal exchanges, and individual</p> | <ul style="list-style-type: none"> - Doctors, therapists, healthcare providers, patients (youth) - Medical provider to medical provider - Medical provider to caregiver - Caregivers, youth - Social workers, clients (youth), clients (birthparent), caregiver, medical provider - Continuity, attachment bonds, disruptions in caregiver and healthcare provider relationships |
| Micro level | Personal |  <p>Pushback against institutions through interpersonal relationships while trying to access healthcare services</p> | <ul style="list-style-type: none"> - Acute health concerns - Identity development - Preventative care |

Diagram of 4 I's of oppression as they relate to Micro, Mezzo, and Macro factors and stakeholders related to LGBTQ foster youth and their healthcare providers

This model considers institutions and organizations as participants and stakeholders which interact with individuals, as well as individuals who act as agents of those organizations and institutions by proxy. The groundwork theory behind this model are the concept of “co-created experiences”, the “Four I’s of oppression”, (ideas, institution, interpersonal, and individual/internal), Macro, Mezzo and Micro levels (social work perspective on scales of practice), eco-mapping, organizational culture cycles (Marcus and Connor 2013) (due to the relational feedback loops between sectors of the model), and the sociocultural self-model of

behavior by Stephanie Fryberg (relationships between individual conditions, structural characteristics, and socioeconomic factors).

Author's Resistance Model:



This Resistance Model illustrates the type of forces which healthcare providers of LGBTQ foster youth may encounter in their practices while advocating for their patients' needs.

APPENDIX F

Author Note: The following list is a collection of the author's personal notes of ideas and concepts which were not otherwise analyzed or elaborated upon in this paper. They are presented here to reflect future areas of research or exploration which are currently undeveloped and therefore not included in the Conclusions section of this thesis. They are presented here with the intention of inspiring further research and to serve as a reference to the thought processes involved in the writing of this paper.

- *Location, LGBTQ youth in Washington state and the idea of place and impermanency*
- *Physical location, Seattle as an urban, liberal, racially homogenous compared to other cities*
- *This author's own location is as an urban Seattleite, with a social location as a white man and a member of the LGBTQ community in an allied health profession.*
- *experiences with caregiver rejection, system involvement, transient homelessness, transition, and many of the issues I have seen faced by LGBTQ homeless youth in this state.*
- *Due to my change in positionality, from youth to professional, I have wondered what draws other health professionals to work with these youth, and whether this may mirror of the same identities, strengths, and challenges that I have experienced.*
- *Intergenerational trauma, indigenous feminisms, residential schools, and public child welfare as a source of violence against marginalized communities*
- *Stereotype threat vs. self-fulfilling prophecy*
- *Counter-storytelling allows us to explore identities that co-occur and challenge our ideas of place, role, imagined community, in lives of the healthcare professionals serving LGBTQ foster youth, these youth, and their families.*
- *Critical Race Theory, Patricia Hill Collins, Bonneycastle Social Justice Continuum*
- *Dominant social narratives regarding LGBTQ youth and foster youth are largely superficial and oversimplified, "inspirational", or overtly harmful and biased against LGBTQ foster youth.*
- *Mobility between oppressed, oppressive, how these identities create burnout, movement in providers' careers (working with DSHS vs not)*
- *The Self-Fulfilling Prophecy of an oppressed person (Merton, 2010).*
- *"The fact of white privilege means that whites have greater access to the societal institutions in need of transformation" (Tatum, 2000).*
- *Social work, as a profession, helps to assess and re-approach these internalized ideas in ways that work to undo oppressive systems and mechanisms (Workers, 2008).*
- *Performativity of gender, academic topics as ivory tower or inaccessible, recreated gender, citational (Butler, 2006)*
- *In an interview for The Seattle Times, Dr. Kristina Olson describes this gender performativity as conformity to "the criterion" of "consistent, insistent, persistent [...]" there are a very small subset of gender-nonconforming kids who believe themselves the opposite of the gender assumed at birth" (Aleccia, 2016).*
- *Authenticity and authority medical model "persistent, consistent and insistent" as evidence of*
- *Pediatric Transgender Identity*
- *LGBTQ healthcare is aimed at adults, because "coming out" is seen as a coming of age or adult experience, not an early childhood or young adolescent one.*
- *Developmental psychology and informed consent*
 - o *Young children may be able to verbally express gender identity or sexual orientation, but they are dependent on caregivers to affirm this or to facilitate healthcare related to this. Adolescents have a limited ability, but often need consent.*
- *Linguistic commentary*
- *Subversion through language, a cultural phenomenon*

- *Queering*⁴³ of language
- *Anti-oppressive (Appendix B: Interview 4)*
- *Dynamic in practice, regional, contingent on other social identities such as race and class*
- *How that's related to pediatrics: Need for age appropriate- may not want to say "queer" when you mean "genderqueer" to mean "nonbinary"*
- *Common language for children to relate to each other inside and outside the LGBTQ community that is portable between placements with different levels of education around the LGBTQ community*
- *Common language for providers to use in planning healthcare and community norms and standards*
- *Glossary general, non-standard glossaries*
- *Threat to professional identity*
- *Medical expertise*
- *Secondary trauma*
- *Provider networking-*
- *imagined community*
- *Clinical via email listserv – imagined community*
- *Conflicts between theory, policy and practice:*
- *There are clear differences in how adult healthcare is approached, versus adolescent or pediatric healthcare.*
- *Aspects of health and safety and their guardians, Children's Admin and medical providers*
- *LGBTQ foster youth or foster youth of color may face caregiver rejection as a threat to emotional safety in their placements, which is also a threat to the permanency or stability of a placement, as well as*
- *Health is typically looked at as a combination of physiological and psychological, while safety is viewed as physical and emotional.*
- *tolerance vs. "good placement"*
- *Christian adoption efforts and religious conservatism, not mutually exclusive to or analogous to political conservatism vs. liberalism*
- *Whether religious adoption agencies equitably serve LGBTQ foster youth or protect them from discrimination and disrupted placements*
- *Client resilience*
- *Child welfare theory- Strengths based perspective of re-examining LGBTQ foster youth marginalization as a unique creation of what is sometimes beneficial neglect- Susan Barkan Partners For Our Children.*
- *More of the challenge is in rural areas, the geographic disparities are really important*
- *"where do we lose providers?", "where do we lose kids?" Per se: where do the potholes in the road become so big that we lose either group member entirely? In a lack of coordination, continuity?*
- *Diffusion- participants may have changed their responses or supplemented their responses with information they otherwise would not have due to the use of priming questions related to previous interviews*
- *Selection: Non-random sampling causing inaccurate representation of population (Selection threat)*
- *Experimenter bias- a researcher may inadvertently affect the outcome of a study by allowing their assumption about the hypothesis to affect the way they unconsciously treat participants in either group (eliminated through double blind studies) (Experimenter threat)*
- *Participants could have said that they did not have 'one particular case which stood out to them', but none responded this way, thusly it is possible that temporal precedence of being primed with the question influenced the participants' willingness to share the related anecdote.*
Participants may have been more conservative in their responses due to factors of social desirability, such as most participants being limited in their descriptiveness of the emotional impact the challenges of their work have on them or their ability to practice.
- *Further research: Adverse Childhood Experiences (ACES) scores are typically higher for foster youth and LGBTQ youth, correlated with faster puberty onset by a whole year, and how this relates to accelerated need to consider hormone blockers for transgender boys and girls in foster care ideal age for hormone blockers and tanner stage -causal not correlational? Consider hormone blockers at an earlier chronological age for foster youth who may have higher ACES scores.*

⁴³ "Queering" means to reevaluate or reinterpret a work with an eye to sexual orientation and/or to gender, by applying queer theory.