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Sexual and Gender Minority Youth in Foster Care: An Evidence-Based Theoretical Conceptual Model of Disproportionality and Psychological Comorbidities

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Abstract

Sexual and gender minority youth (SGMY) are overrepresented in the foster care system and experience greater foster-care-related stressors than their non-SGM peers. These factors may further elevate their risk of anxiety/depressive, post-traumatic stress disorder, self-harm, and suicidality. The system currently produces unequal and disproportionate adverse mental health outcomes for SGMY and needs points of intervention to disrupt this status quo. This article provides an empirically grounded conceptual–theoretical model of disproportionate representation and burden of psychological comorbidities experienced by SGMY in the foster care system. We apply findings from an integrated literature review of empirical research on factors related to overrepresentation and mental health burden among SGMY to minority stress theory to explicate how and why the foster care system exacerbates mental health comorbidities for SGMY. Searches were conducted in June 2020 in PubMed using MeSH terms and title/abstract terms for foster care, sexual or gender minorities, and psychological comorbidities. Inclusion criteria are studies conducted in the United States, published in English, focused on mental illness, and published between June 2010 and 2020. Developmental/intellectual and eating disorders were excluded. The initial search returned 490 results. After applying inclusion criteria, 229 results remained and are utilized to build our conceptual–theoretical model. We assert that the phenomenon of disproportionate psychological comorbidities for SGMY in foster care is best represented as a complex and dynamic system with multiple feedback loops. Extant empirical and theoretical literature identifies three critical areas for intervention: family acceptance, community belonging and queer chosen/constructed family, and affirming and nondiscriminatory child welfare policy.

Keywords

GLBT, mental health and violence, child abuse, cultural contexts, adolescent victims, sexual assault

The last decade has seen a series of gains and some setbacks for the LGBTQ+ population, yet LGBTQ+ youth in our nation's foster care system encounter a system ill-equipped to provide the care and support they need. As defined most inclusively by the National Institutes of Health, sexual and gender minority youth (SGMY) include those who identify as lesbian, gay, bisexual, queer, transgender, or gender nonconforming. SGMY represent 9.5% (Conron et al., 2014) of the U.S. adolescent population yet comprise 15%–30% (Dettlaff et al., 2018; Schneeberger et al., 2014; B. D. M. Wilson et al., 2014) of youth in foster care, with youth of color overrepresented (Center for Study for Social Policy [CSSP], 2016; Hightow-Weidman et al., 2011). Critically, transgender and gender nonconforming/nonbinary youth are absent from many of these current studies due to the exclusion of systematized data collection of gender identity and expression information in research with child welfare involved youth.

Despite SGMY representing a disproportionate percentage of children in foster care, little attention has been paid to the SGM-specific stressors facing them, including biological family rejection, SGM-based abuse, exclusionary and biased child welfare policy and practice, and systemic racism, heterosexism, homophobia, and transphobia, which contribute to significantly elevated rates of mental and behavioral health problems

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compared to their peers (Lick et al., 2013; Meyer, 2003; Meyer & Frost, 2013; Testa et al., 2015). SGMY are also more likely to experience homelessness and to become involved in commercial sex trade or "survival" sex, which in turn contribute to adverse health and mental health outcomes for this marginalized population (Franchino-Olsen, 2019; Lannert, 2015). Evidence suggests that child welfare–involved youth experience greater levels of stress and potentially traumatic experiences compared to noninvolved youth, which in turn increases risk of psychological comorbidities. SGMY in the general U.S. population experience heightened levels of victimization and other stressors, placing them at higher risk of mental health comorbidities. SGMY in foster care are at the intersection of these two vulnerable groups.

In this article, we provide a needed conceptual model, linking minority stress (MS) theory with research on child welfare/foster care involvement stressors, to explain the overrepresentation of SGMY in care and disparate negative mental health outcomes they face compared to non-SGMY. We use a System Dynamics (SD) approach to visualize our theoretical conceptual model, thus showing how the interlocking systems of racism, heterosexism/cisgenderism, and queer/transphobia allow the disproportionality of SGMY in foster care to arise vis-à-vis individual (family) and institutional (child welfare) behavioral interactions over time, which manifests in adverse mental health for SGMY moving through this complex system. We then identify empirical and theorized protective factors, including family acceptance, chosen family, and affirmative child welfare policy, drawn from research literature. We conclude with directives for child welfare systems and practitioners for addressing the holistic needs of SGMY in child welfare to improve psychological outcomes.

Background

MS Theory

The MS framework was developed specifically for SGM individuals and has been used to explicate disproportionate adverse mental and physical health outcomes among this population (Lick et al., 2013; Meyer, 2003; Meyer & Frost, 2013; Testa et al., 2015). Originally developed by Meyer (2003), the theory articulates how MS-related stressors interact between multiple levels from distal stress processes (e.g., discriminatory laws and policy) to proximal stress processes (e.g., rejection, internalized homophobia) to increase the burden of mental health problems among sexual minorities (Meyer, 2003; Staples et al., 2018). A few studies have broadened the theory to include the unique experiences of transgender individuals such as transphobia, anti-transgender health care and workforce policy, and targeting for hate crimes based on gender identity and expression (Hendricks & Testa, 2012; Tebbe & Moradi, 2016).

Broadly, the MS framework utilizes a twofold approach by first identifying sources of SGM-specific stressors in the interpersonal, institutional, and larger structural realms and then establishing linkages between these sources of MS, individual appraisal and stress-coping responses, and negative mental/physical health outcomes (Lick et al., 2013). MS theory has traditionally articulated these relationships as linear and cause–effect or, less frequently, with a nested, or hierarchical approach. While hierarchical analytic application of MS can provide important understanding of person by context interactions and longitudinal trends, we assert that the phenomenon of disproportionate representation and psychological comorbidities for SGMY in foster care is better represented as a complex and dynamic system with multiple feedback loops.

Conceptual Model

Applying SD methods to articulate empirical constructs and theoretical linkages about the experiences and resources available to SGMY youth in foster care offers a novel approach to understand and intervene within a system. Moreover, SD makes visible the role of multiple and concurrent feedback loops inside of systems and how they play out over time—dynamics that are routinely missed with linear and hierarchical causal modeling. We are thus able to draw more valid inferences about cause–effect relationships when there are *multiple* factors interacting over time. For example, key factors, such as SGM-based abuse, neglect and rejection from biological family, placement in restrictive foster care (i.e., group home), increased placement instability, and harmful and biased child welfare policy and practices, along with other sources of stress have been identified as key contributors to disproportionality and related mental health comorbidities for foster care–involved SGM youth. However, to date, research has not accounted for how multiple feedback mechanisms may operate to produce unequal outcomes. For example, an SGM youth may be labeled as "high risk" for runaway or other undesirable behaviors by foster care system workers. This labeling can become part of a self-reinforcing cycle wherein the youth is then harder to find placement for, experiences greater placement instability (moves between placements) and, based on rejection experiences inside these settings, runs away. Thus, the cycle of negative labeling is fulfilled. Our conceptual model elucidates such "feedback loops" within the system, as well as times and places to interrupt cycles, and provides a complex system model of how the system works and offers a blueprint for system intervention.

In this section, we present two complex system models, each with critical constructs derived from empirical evidence. Figure 1 presents a causal loop diagram model construct from the most proximal (interpersonal and intrapersonal) to the most distanced (i.e., structural), articulating the feedback loops or relationship interactions found among constructs that explain SGMY disproportionately in foster care and comorbid mental health conditions. We then discuss theoretically and empirically derived points of intervention and protective factors that could interrupt the negative feedback loops and shift the relational interactions to produce better mental health outcomes for SGMY in foster care (see Figure 2). Table 1 presents each

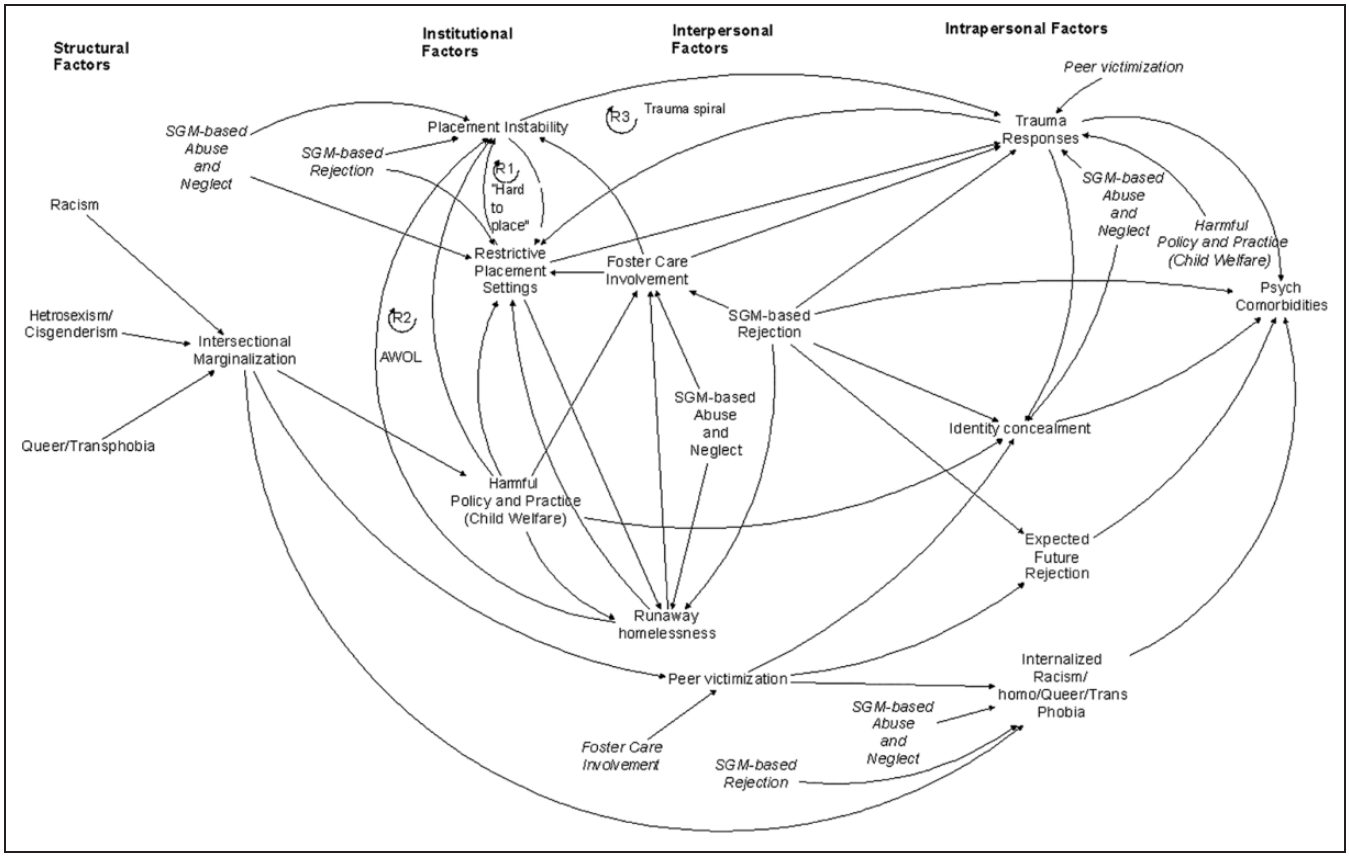

Figure 1. Causal loop diagram of sexual and gender minority youth disproportionality and psychological comorbidities.

pathway, feedback loop, and substantiating empirical and theoretical evidence.

Critical Constructs

Interpersonal stressors include the interpersonal stressors of (a) abuse and neglect based on sexual orientation and/or gender identity and expression, (b) rejection based on SGM, and (c) SGM-based peer victimization.

SGM-based abuse and neglect. SGM individuals experience higher rates of potentially traumatic events (i.e., sexual, physical, emotional abuse or neglect, family disownment, or interpersonal violence) compared to non-SGM individuals across the life course (*see systematic reviews*, Sterzing et al., 2017). Rates of childhood physical, sexual, and emotional abuse are significantly higher among sexual minority youth compared to their heterosexual peers and are associated with higher rates of depression, post-traumatic stress disorder (PTSD) symptoms, avoidant behavior, internalized homophobia; suicidality, and substance use (*see systematic review*, McGeough & Sterzing, 2018). Similarly, transgender and gender-nonconforming youth report significantly heightened levels of family victimization, which is in turn associated with poorer mental health, suicidal behavior, and nonsuicidal self-harm (Grossman et al., 2011; Strauss et al., 2020; Taliaferro et al., 2019). Moreover, there is a cycle of abuse and neglect that may begin with a parent or birth relative but evolves and is facilitated and amplified by the system through foster care placement, residential home staff, or caseworker.

Beyond the direct association of child abuse and neglect (CAN) with psychological comorbidities, there are several other pathways that may contribute to poor mental health outcomes. SGM-based CAN may instigate a youth to run away from home, leading to foster care system involvement. A history of running away flags youth as higher risk within the child welfare system. This assessment may result in placement in restrictive care settings (e.g., group home), which can lead to trauma responses and, in turn, psychological comorbidities. SGM-based CAN can result in foster care involvement and placement instability, leading to trauma responses and comorbid mental health outcomes. SGMY may be further traumatized based on SGM status within foster care, leading to trauma responses and psychological comorbidities. Finally, SGM-related CAN increases negative intrapersonal stress-coping responses including trauma response, identity concealment, and queer/transphobia, leading to increased psychological comorbidities.

SGM-based rejection. Negative responses to a youth's coming out process, such as shaming, invoking religious or moral judgments, or denying the youth's identity, are all aspects of family

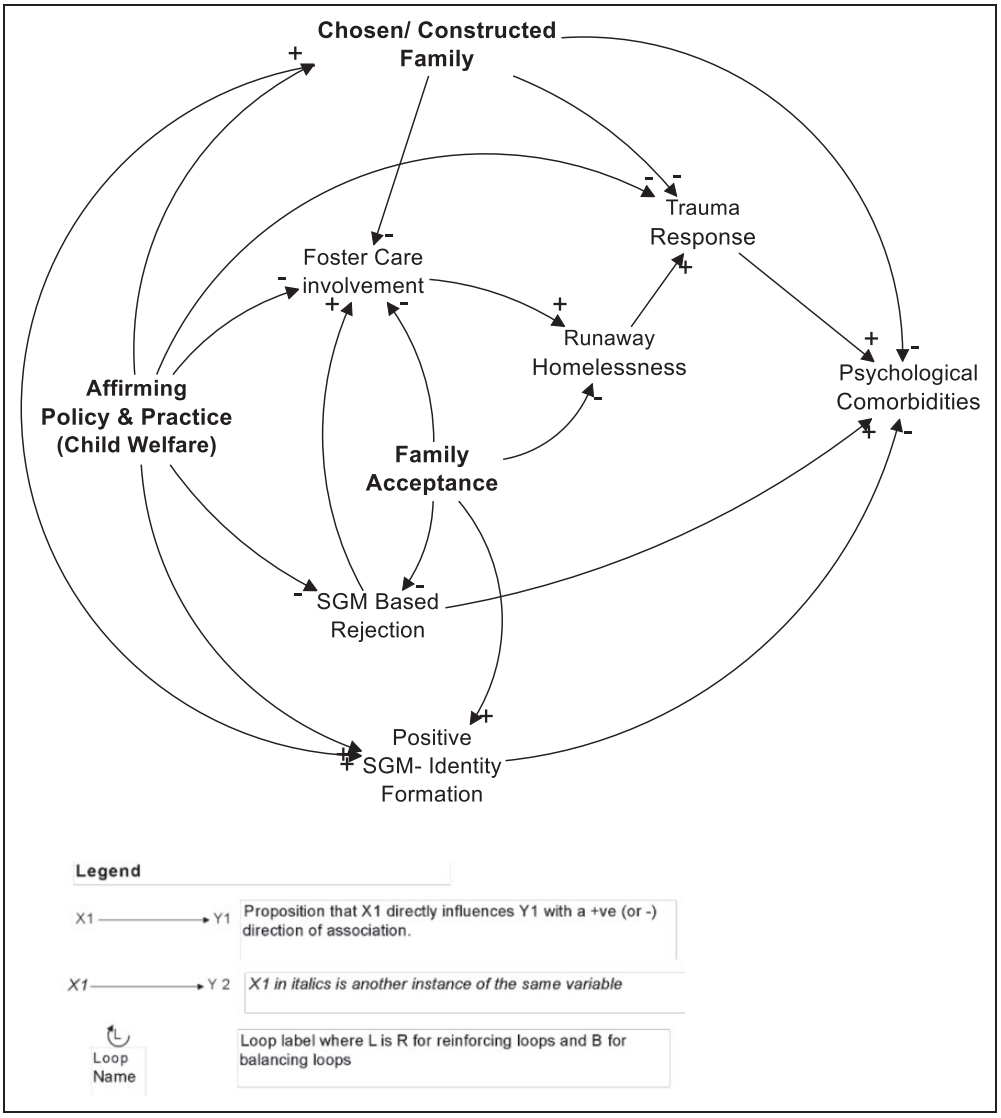

Figure 2. Protective constructs to reduce sexual and gender minority youth disproportionality and psychological comorbidities.

rejection. Family rejection is associated with significant increases in suicide attempts and depression among sexual minority youth (Ryan et al., 2009). Unfortunately, rejection from biological family is also common for transgender individuals. A study of transgender women of color found being forced out of the home as an adolescent to be subsequently linked with homelessness, poverty, and negative mental health outcomes (Koken et al., 2009). Family rejection based on gender identity was associated with increased odds of suicide attempts among a national sample of transgender and gender-nonconforming individuals (Klein & Golub, 2016). For foster youth, rejection may occur multiple times, first in the biological family of origin and then again within foster homes (Ryan et al., 2009). Foster parents may pressure SGMY to "change" or suppress themselves or terminate the living arrangement (Clements & Rosenwald, 2007; Mallon et al., 2002; Wilber et al., 2006). The pathways in our model from SGM-based rejection to psychological comorbidities follow the same patterns as those discussed for SGM-based CAN.

SGM-based peer victimization. Peer victimization, including bullying, hate crimes, and violent victimization, is a significant contributor to psychological comorbidities among SGMY (Burton et al., 2013; Duncan & Hatzenbuehler, 2014; Hightow-Weidman et al., 2011; Paceley et al., 2017; Toomey et al., 2010). These hostile experiences contribute to significantly greater odds of a range of negative mental and behavioral health problems (Espelage et al., 2018; Fedewa & Ahn, 2011). Higher and escalating rates of peer victimization among SGM young adults from ages 18 to 22 are associated with greater depression and PTSD (Mustanksi et al., 2016). Peer victimization is significantly associated with suicidal ideation, attempt, and nonsuicidal self-harm (Hatchel et al., 2019; Liu & Mustanski, 2012; Witcomb et al., 2019) and can cause identity

Table 1. Empirical and Theoretical Pathways and Feedback Loops.

Pathways to Disproportionality and Poor Psychological	Citations for Supporting Evidence (First Author, Date)
SGM-based rejection (REJ)→ foster care (FC) involvement → trauma response (TR)→ psychological comorbidities (PC)	Parker (2018) and Pearson (2017)
REJ → runaway → FCFC → TRTR → PC	Parker (2018) and Pearson (2017)
REJ → identity concealment (IC) and/or expected future rejection (ERJ) and/or internalized queer/transphobia (IQT)→ PC	Ryan (2009, 2010)
REJ → TR → PC	Duncan (2014), Finkelhor (2013), Grossman (2016), Mallon (2006), and Sterzing (2017)
REJ → PC	D'Augelli (1998)
SGM-based abuse/neglect (AN) → FC → TR → PC	Hightow-Weidman (2011), McGeough (2018), and Roberts (2012)
AN → runaway → FC → TR → PC	Hightow-Weidman (2011), McGeough (2018), and Roberts (2012)
AN → IC and/or IQT → PC	McGeough (2018)
AN → TR → PC	Duncan (2014), Finkelhor (2013), Grossman (2016), Mallon (2006), and Sterzing (2017)
Structural racism/heterosexism/cisgenderism/queer–transphobia (SRHCQ) → intersectional marginalization (IM) → harmful policy and practice → (a–e)	Hill (2004), Muñoz-Laboy (2009), Rich (2005), Conron (2014), Herek (2000), Lannert (2015), Priest (2019), Saewyc (2011), Livingston (2020), Meyer (2003), Meyer (2013), Poirier (2018), Przeworski (2020), Schneeberger (2014), Tebbe (2016), Testa (2015, 2017, 2012), Thompson (2016), van der Kolk (1994), and Cook (2014)
a. → FC → TR → PC	Courtney and Dworsky (2006), Courtney (2015), Heneghan (2013), Hussey and Guo (2005), Plöderl (2014), Shpiegel (2017), Stambaugh (2013), Strauss (2020), Thornberry (2010), Vidal (2019)
b. → FC → IC → PC	Ryan (2009, 2010), Anderson and Libby (2011), Choi (2018), Dettlaff (2018), Fish (2019), Green (2020), McCormick (2017), and Staples (2018)
c. → Runaway/homeless (RH) → FC → TR → PC	Courtney (2006), Courtney (2015), Heneghan (2013), Hussey (2005), Plöderl (2014), Shpiegel (2017), Stambaugh (2013), Strauss (2020), Thornberry (2010), and Vidal (2019)
d. → Restrictive placement (RP) setting → REJ and/or abuse/neglect within child welfare system (ANCW) → TR → PC	Musicaro (2019) and Ryan (2009, 2010)
e. → Placement instability (PI) → REJ and/or ANCW → TR → PC	Ryan (2009, 2010), Vidal (2019), and E. C. Wilson (2016)
SRHCQ → IM → (f and g)	(same as SRHCQ → IM)
f. → Peer victimization → IC and/or IQT and/or ERJ and/or TR → PC	Hatchel (2019), Witcomb (2019), D'Augelli (2001), Flores (2020), Mustanski (2016), Paceley (2017), Reisner (2014), Toomey (2010), Espelage (2018), Fedewa (2011), and Franchino-Olsen (2019)
g. → IC and/or IQT and/or ERJ and/or TR → PC	Baams (2018), Bauman (2006), Child Maltreatment 2018–U.S. DHHS (2020), Gattis (2017), Lick (2013), Liu (2012), Phan (2020), Taliaferro (2019), and Taliaferro (2017)
Theorized feedback loops	Empirical and theoretical support for feedback loops
R1: "Hard to place": PI → RP→ PI	Burton (2013)
R2: "AWOL": PI → RP → RH →PI	M. E. Collins (2011)
R3: "Trauma spiral": PI → TR → RP → PI	Briere (2003), Bronsard (2016), Reisner (2014), and Rogel (2020)
Protective factors and pathways	Citations for supporting evidence (first author, date)
Affirming child welfare policy and practice	
a. → Include chosen family → improved mental health (MH)	Levitt (2017)
b. → Decreased FC → MH	Ashley (2019), Center for Study for Social Policy (2016), M. E. Collins (2010), Fong (2015), Kimberly (2018), and Matarese (2017)
c. → Reduced TRs → MH	Durso and Gates(2012), Estrada (2006), Hendricks (2012), Levine (2013), Mallon (2002), Moreno (2017), Rafferty (2018), Russell (2018), Ryan (2014, 2020), Wilber (2013), Wilber (2006), and Woronoff (2006)
d. → Decreased REJ → MH	Grossman (2011)
e. → Positive SGM-identity → MH	Camp (2020) and Holloway (2014)
Chosen family	
a. → MH	Levin (2020) and Rutman (2016)
b. → Positive SGM-identity formation	Arnold (2018) and Brainer (2019)
Family acceptance → decreased FC/RH → improved MH	Cashmore (2006) and Rosenthal (2016)
Family acceptance → reduced REJ → MH	Clements (2007), Katz-Wise (2018), and Reyes (2015)
Family acceptance → decreased TRs → MH	Diamond (2013) and Dierckx (2016)
Family acceptance → positive SGM-identity formation → MH	Coolhart (2017), Klein (2016), and Koken (2009)

Note. SGM = sexual and gender minority.

concealment, internalized queer/transphobia, and expected future rejection, each of which is associated with psychological comorbidities. Intersectional marginalization, the product of structural racism, heterosexism/cisgenderism, and queer/transphobia has a direct impact on SGM-based victimization, which leads to increased comorbid mental health outcomes.

Intrapersonal stressors include trauma responses and stress appraisal processes inclusive of identity concealment, expected future rejection, and internalization.

Trauma responses. Individuals exhibit varying responses to stressful and traumatic experiences. Regardless of the behavioral response of the individual, physiological changes occur (van der Kolk, 1994). These changes affect the individual whether the threat is real or perceived, experienced, or witnessed (Rogel et al., 2020). SGMY in foster care have increased exposure to trauma and violence compared to their non-SGM counterparts. Additionally, they are directly and indirectly exposed to SGM-motivated violence and aggression by peers and the larger society (Flores et al., 2020; Lannert, 2015), leading SGM individuals to experience heightened fear, anxiety, and powerlessness resulting from uncertain safety (Franchino-Olsen, 2019; Lannert, 2015). The interaction between society and individual, with social messaging that SGM members are vulnerable, victimized, and unprotected, affects the identity of the individual as well as their coping strategies (Lannert, 2015). Behavioral responses or "traumagenic dynamics" may include a range of internalizing and externalizing behaviors; and poly-victimization in childhood can elicit ongoing trauma responses that are severe and highly detrimental (Greeson et al., 2011; Musicaro et al., 2019). In our model, trauma responses are an outcome of interpersonal- and institutional-level stressors and victimization experiences.

Stress-appraisal processes. As SGM individuals subjectively appraise SGM minority stressors at the interpersonal or institutional levels, their internal schemas may be altered. Over time, they may be socialized to anticipate negative evaluation from non-SGM people, which in turn may contribute to the expectation of future rejection. For example, SGMY who experience rejection from their biological parents may be vigilant in their future relationships in order to avoid similar rejection. Hypervigilance of external threats to safety based on the aspects of one's social identity (e.g., race or gender) has been found to be associated with increased internalizing and externalizing behaviors in marginalized groups (Phan et al., 2020; Rich & Grey, 2005). For SGM individuals, hypervigilance may manifest as identify concealment or actively altering self-expression in order to protect themselves from discrimination or shame (D'Augelli & Grossman, 2001; Meyer, 2003). Identity concealment, expectations of future rejection, and internalized homo- and transphobia are associated with a myriad of adverse mental health outcomes in SGM individuals (e.g., Camp et al., 2020; Meyer, 2003; Testa et al., 2015). In our model, these processes are the outcome of SGM-specific experiences of CAN, rejection, and institutional violence.

Institutional stressors are processes, policies, and practices that place SGMY at greater risk of adverse mental health outcomes: (a) placement instability, (b) restrictive care settings, and (c) harmful child welfare policies regarding placements, case planning, and services.

Placement instability. Placement instability (moving multiple times within one episode of out-of-home placement) is a common experience for adolescents in care, with between one third and one quarter of youth moving five or more times during one episode of care (Connell et al., 2006; Courtney et al., 2015; Shpiegel et al., 2017; Vidal et al., 2019). Such instability is associated with trauma and loss, increased externalizing behaviors, subsequent delinquency arrests, and early childbirth (Vidal et al., 2019). Reasons for placement disruption are varied and reflect a complex interplay of personal and systemic factors. For SGMY, disruptions may occur in part because of their sexual orientation, gender identity, and/or expression (B. D. M. Wilson & Kastanis, 2015). Placement instability may lead to trauma responses as well as running away and/or restrictive care settings, each of which is associated with increased psychological comorbidities.

Feedback loops (R1–R3). (R1) The "*hard to place*" feedback loop shows a self-reinforcing cycle in which SGMY are labeled "high risk," "challenging," or "unable to place" by the system and become caught in a cycle of instability and restrictive care settings. (R2) "*AWOL*" (Absent Without Leave, a term applied to youth who run away from a placement) shows how running away from a placement or restrictive care setting leads to experiencing homelessness and results in a stigmatizing label carried by both the youth (internalized) and system workers. This label results in increased placement instability and/or restrictive care settings. (R3) "*Trauma spiral*" youth exhibit behavioral responses such as fighting and self-harm to the experience of trauma within restrictive care settings, which then increases their level of restriction. In addition, depending on how trauma is expressed, it may lead to further confinement and/or instability in living arrangements for the youth.

Restrictive care settings. Disruptions in placement setting may also occur because SGMY are significantly more likely to run away and experience homelessness compared to their non-SGMY counterparts, in part because of family rejection (Gattis & Larson, 2017; Pearson et al., 2017). Running away from a placement triggers a punitive system response whereby youth are less likely to then be placed in a foster home and are more likely to carry labels of "hard to place" and poorer ratings on assessments of risk. They are then more likely to be placed into restrictive, nonfamily care settings (e.g., group home or residential). SGMY are significantly and disproportionately represented in such settings, for example, in L.A. County, 25% of SGMY were in group homes compared to 10% of non-SGMY (B. D. M. Wilson et al., 2014; B. D. M. Wilson & Kastanis,

2015; Woronoff et al., 2006). SGMY in foster care are also more likely to be hospitalized for emotional or mental health reasons compared to non-SGMY youth (Choi & Wilson, 2018; Dettlaff et al., 2018).

Harmful policy: SGM data collection, ethics, and privacy. Discriminatory policies within the child welfare system may be conceptualized as those that affect data collection, ethics, and privacy. Efforts to implement safe SGM data collection in State Automated Child Welfare Administrative Data in the United States have been slow, subject to political road blocking, and are currently nonexistent. Wilber (2013) established guidelines for safe identification in child welfare, yet the vast majority of child welfare jurisdictions do not have safe identification policies or procedures in place to obtain information about a youth's sexual orientation or gender identity and expression (Wilber, 2013). Without safe identification procedures, holistic and affirming care for SGMY is unattainable, and core information that may be related to child welfare involvement or contribute to negative or hostile environments in the system are unacknowledged. Effective conversation about SGM status may not occur or may occur in a harmful or unethical manner unless a youth opts to identify themselves as SGM or a caseworker makes assumptions about a youth based on appearance or behavior. In our model, failure to safely identify SGMY may lead to placement instability, restrictive placement, and/or youth runaway. In addition, this policy failure may result in identity concealment, as youth do not feel safe disclosing their SGM statuses for fear of rejection from foster parents, caseworkers, or other contacts in the child welfare system.

Harmful placement, case planning, and services practices. Unidentified SGM status relates to unidentified needs. Policies that sex-segregate youth (e.g., in "girls" or "boys" wards) in congregate settings or that prohibit foster parents from rooming children of the "opposite" sex in a shared bedroom penalize and render invisible transgender and gender-nonconforming youth. Relatedly, failure to provide clothing or products (e.g., hair care) that are aligned with youths' gender identity or to use youth's chosen name and/or pronoun is associated with increased suicidal behaviors among transgender youth (Grossman et al., 2016; Russell et al., 2018). Access to accepting and affirming mental and medical health is another area of policy concern. At the most harmful end of the spectrum in mental health are the so-called reparative or conversion therapies, which seek to "change" or "convert" sexual or gender minorities to heterosexual and cisgender norms. Such practices are unethical and harmful, resulting in an increased risk of anxiety, depression, and suicidal behaviors (Green et al., 2020; Przeworski et al., 2020). Lack of culturally appropriate mental and physical health services is also common. Policies and practices that fail to adequately assess and address SGM-based rejection and abuse and neglect may lead directly to out-of-home placement if a youth does not receive culturally appropriate SGM-affirming family intervention. Ineffective or nonexistent affirming training for foster parents and workers and ignorance or bigotry about sexual orientation and gender diversity can directly impact youths' ability to be safely housed and to maintain safe, affirmative care, thus increasing placement instability and restrictiveness.

Structural racism, heterosexism, cisgenderism, queer, and transphobia. Intersectional marginalization arises from a "matrix of domination" (P. H. Collins, 1990), a multidimensional and dynamic spatial organization of oppressions that intersect. White supremacy breeds structural racism, which in turn produces implicit and explicit bias in all systems, including the child welfare system. The legacy of racist and Eurocentric policy and practice in child welfare is well-documented and evidenced in disproportionate rates of removal of Black, Indigenous, and children of color from their homes and communities; longer times in foster care; and worse reunification/permanency outcomes compared to White children (Boyd, 2014; Magruder & Shaw, 2008). Political intersectionality (Bowleg, 2012; Crenshaw, 1990) illustrates how multimarginalized groups (e.g., Black women) face interlocking discriminatory practices arising from the interplay of sexism and racism. Heterosexism and cisgenderism articulate how expressions of gender and sexuality that are beyond a heterosexual or binary system are devalued, silenced, and pathologized. These interlocking systems of oppression result in individual bigotry and hatred of nonheterosexual or cisgender peoples *as well as* societal-level patterns of institutionalized oppression (Herek, 2000). Thus, SGMY in foster care are instant "outsiders." Heterosexism and transphobia interact on the systemic level by policing how SGMY act, dress, behave, love, and create belonging. Lack of acceptance from foster families amplifies SGMY's rates of internalized racism, homophobia/transphobia, and expected future rejection and often forces identity concealment, all of which lead to increased negative trauma responses and psychological comorbidities (Herek, 2000).

Intervention Points Based on Protective Factors

The system currently produces unequal and disproportionate adverse mental health outcomes for SGMY and needs points of intervention to disrupt this status quo. Empirical and theoretical literature identifies three critical areas for intervention: family acceptance, community belonging and queer chosen/constructed family, and affirming and nondiscriminatory child welfare policy. Each factor can disrupt the causal flows of constructs related to disproportionality, namely, placement instability, rejection, and psychological comorbidities (see Figure 2). In the next section, we describe each of these areas of intervention.

Family of origin affirmation and acceptance. A strong connection to a caregiver can serve as a protective factor for SGMY and reduce psychological comorbidities. There is evidence that family-centered intervention approaches may be most effective in decreasing adverse mental health outcomes in children who remain at home following suspected maltreatment (Fong et al.,

2015). For youth placed in out-of-home care, reports of suicidal ideation were lower for those youth who had a strong connection to their caregiver (Lalayants & Prince, 2014).

Family support has been associated with significant decreased odds of nonsuicidal self-harm and suicidality in a state-based sample of SGMY (Reisner et al., 2014). For bisexual and questioning youth, parent connectedness robustly reduces self-harm behaviors (Taliferro & Muehlenkamp, 2017) and has been associated with reduced depressive and anxiety symptoms, self-harm behaviors, PTSD, and suicidal ideation among transgender and GNC (gender nonconforming) youth (Katz-Wise et al., 2018; E. C. Wilson et al., 2016). Using data from a nationally representative sample of adolescents, Williams and Chapman (2012) found that lower levels of youth–parent connectedness were associated with significantly higher levels of unmet health or mental health needs among sexual minority youth.

Culturally specific research with Latinx (Muñoz-Laboy et al., 2009) and Filipino (Reyes et al., 2015) SGMY also demonstrates that parental acceptance is associated with improved mental health and reduced suicidality among differing ethnic and cultural groups. Ryan and colleagues (2010) specifically developed and tested a family acceptance measure for SMY and found that greater levels of family acceptance were associated with reduced suicidal behaviors, depressive symptoms, and substance use among White and Latinx SMY. In our model, family acceptance decreases caregiver SGM-rejecting behaviors, which in turn decreases adverse mental health outcomes. Family acceptance also disrupts foster care involvement and the linkage to running away, as youth may be diverted from entering the child welfare system. Finally, family acceptance promotes positive SGM identity formation and reduces trauma responses, both of which decrease psychological comorbidities.

Chosen and constructed SGM family. Chosen family refers to how sexual and gender minorities form communities of mutual care and support outside of biological or legal (bio-legal) ties (Levin et al., 2020). Chosen families can complement or compensate for a lack of bio-legal family support. For example, gay family networks and house/ballroom networks of gay, bisexual, and transgender people of color have been found to provide alternate systems of support that embrace the intersectional identifies of family members and enhance their ability to face severe minority stressors, including rejection, homelessness, and lack of bio-legal family support (Levitt et al., 2017). SGMY in and out-of-home placement may be a part of chosen family networks, including members of the drag or performance community, other transgender or sexual minority individuals who may be referred to as "sisters" or "brothers," or older mentors within the community who may be considered "mom" or "auntie." The familial naming and mutually aiding relationships are overlooked at best or, at worst, labeled as "inappropriate" or "unhealthy" within child welfare practices. Shifting the lens on what family is for SGMY to include and welcome youths' gay or chosen family is a point of intervention. In our model, changing child welfare policy around placement and permanency planning to include chosen families directly reduces psychological comorbidities. Inclusion also identifies other living arrangements and sources of support and thus decreases placement instability. Inclusion into queer chosen families can also reduce trauma and improve mental health. Finally, belonging to a chosen/queer family may contribute to positive SGM identity and reduction of internalization, concealment, or expectation for future rejection.

Affirming and nondiscriminatory child welfare policy and procedures for out-of-home placement, case planning, and services. Best practices for meeting the service and resource needs of child welfare–involved SGMY are rapidly developing in the field (Mallon & DeCrescenzo, 2006; Matarese et al., 2017). Among these are the inclusion of policies to promote gender-affirming practices such as clothing that matches youths' gender identity, out-of-home placements in gender-affirming settings, access to gender and sexual orientation–affirming therapies and community-based services, and shifts in protocols and policies for family reunification to limit barriers and include youths' chosen family.

Affirming out-of-home placements. Limited jurisdictions have enacted policies to support placement in gender-affirming homes. In practice, transgender youth are often placed in care settings (e.g., group homes) that are sex-segregated and not aligned with their gender identity. An exception is California State Bill 73119, which codifies what placement practice should look like for transgender youth. This bill specifies that foster youth have the right to be placed in accordance with their gender identity, not their sex listed in administrative court or child welfare records (CSSP, 2016). The vast majority of child welfare policies prohibit placement of children of the "opposite sex" within the same foster home or prohibit shared bedrooms for children of the "opposite sex." Such policies may preclude transgender youth from safe, affirming foster home placements due to lack of recognition of gender identity. In addition, policies to ensure foster parents are connecting youth with culturally appropriate resources, including participation in programming for SGMY in the community, are needed. Currently, Washington State and New Mexico require that foster parents connect children with resources that meet their needs regarding their sexual orientation and gender identity and case workers assist families as needed in making such connections (CSSP, 2016).

Gender affirming practices. Currently, 15 states and the District of Columbia have policies in place to ensure that children and youth in child welfare have the right to choose their own clothes while in foster care. Only California and Ohio require youth to be provided with clothing that is affirming of and in accordance with their gender identity (CSSP, 2016). Awareness of and enforcement of these rights continue to be lacking in many jurisdictions. In our model, affirming policies and practices disrupt the potential of increased psychological comorbidities by decreasing placement instability through the

inclusion of chosen family as part of a youth's support system and by reducing friction around youth sexual orientation or gender identity and expression in out-of-home placements. Affirming policies and practices that implement tailored services for bio-legal families and improve family functioning and family acceptance can reduce rejection by caregivers, thereby rerouting youth away from system involvement and back to family connection. In addition, rejection from caregivers within the system (e.g., foster parents or residential and group home staff) is reduced through affirming policies and practices with SGMY in out-of-home placement. Finally, affirming policies can reduce negative coping and stress responses, thus reducing internalization, stigma, and fear of future rejection.

Discussion and Implications

For SGMY, family connection is predicated on SGM-accepting attitudes and affirming behaviors (D'Augelli et al., 1998; Diamond et al., 2013). Affirming caregiving includes understanding and validating a wide range of sexual orientations and/or gender identity as normal and healthy and recognizing the impact of societal discrimination and bias vis-à-vis structural heterosexism/cisgenderism and queer/transphobia on the lives of youth. Despite the saliency of family acceptance for SGMY thriving, the field is behind on developing evidence for family-based interventions to reduce stigma, rejection, and discrimination against SGMY. A recent scoping review found that the majority of work to improve family environments for SGMY suffers from lack of outcomes data or rigorous evaluation (Parker et al., 2018).

Within the context of child removal and out-of-home placement, reduction in SGMY disproportionality relies on implementation of family-based interventions at strategic time points. When a family is in crisis about their youth's sexual orientation or gender identity or expression, tailored interventions to stabilize and shift parenting behaviors to acceptance are needed to prevent child welfare involvement. Two examples of such programs include the Family Acceptance Project (Ryan, 2014) and Family Builders Youth Acceptance Project, which rely on strengths-based, psychoeducational approaches to move families from rejecting behaviors toward acceptance. In addition to limited focus on bio-legal parents, this kind of work could also occur with broader kinship networks for CPS(Child Protective Services)-involved families. For example, Rosenthal and Hegar (2016) found that children in kinship adoptions as compared to nonkinship adoptions report fewer internalizing behaviors and higher levels of connectedness to their caregivers. Including kinship family members in family acceptance work may also promote affirming relationships for SGMY and reduce entry into child welfare. For those youth who have already been removed from their homes and placed into foster care, family acceptance work may still be a viable option for growing connected, affirmative relationships, and potential legal permanency. In addition, involving chosen family into the broader network of support is critical.

Within child welfare, family engagement and reconnection has historically rested on heteronormative and Eurocentric conceptualizations of the bio-legal family system. Constructed or chosen family networks are especially relevant within communities of color, where created families of non-bio-legal relationships exist in house, ballroom, and pageant families. "Gay family" or "queer family" are mutually supportive relationships that are not part of a performance culture, such as in house or ballroom. Youth-centered permanency work with SGMY, many of whom are also youth of color, necessitates a paradigm shift in how researchers and practitioners think about "family" and "family reconnection work," to include youth-identified chosen/queer family members as part of their constellation of affirming support.

Finally, as discussed in our conceptual model, institutional factors, such as safe identification in the child welfare system, are needed to reduce stigmatization, rejection, and undue mental health burden for SGMY youth. However, there are several key considerations in the development and implementation of affirming policy and practice interventions that necessitate thoughtful consideration (Ashley, 2019; Thompson, 2016). First, privacy and access to youths' SGM data must be protected. Disclosure of SGM information may be uncomfortable for the youth, and how this information has been used in previous interactions with systems (e.g., being "outed" or having personal information shared with unknown parties) can have significant and adverse effects on youth safety and mental health. Therefore, clear guidelines and training for child welfare workers about where, when, and how to ask youth these questions are needed to ensure trust and youth ownership of their data are maintained. Second, legal requirements may dictate that the youth's sex assigned at birth and legal name must be maintained in child welfare administrative records, particularly for identity verification purposes in court proceedings related to the case. Moreover, court proceedings may include biological family members who are not aware of the youth's sexual orientation or gender identity. Therefore, child welfare policies must prioritize youth safety and choice in how this information is shared and discussed in the court. Youth who are out about their SGM status may opt to have their chosen name and pronouns used in court hearings—a decision that should be honored. In other cases, a youth may prefer to conceal this information for safety reasons. Finally, the use of governmental and administrative data for purposes unintended by the original use can and does occur, with possibly devastating implications. Thus, while increased identification of marginalized and stigmatized populations can lead to increased affirmative services and improved health outcomes, it may also be used to further marginalize. For practice purposes, one possibility is to limit the number of parties within the child welfare system who are able to view these data through blinding. Another practice is to have clear guidelines about when a new worker or member of the youths' support team is brought into the conversation about the young persons' sexual orientation and/or gender identity. For research purposes, aggregated data

can provide individual privacy protection and should be adhered to for research with this population.

Finally, access to and medical coverage for gender-affirming medical services for transgender youth in out-of-home placement is another area of concern. Hormone "blockers" and hormone replacement therapies can be critical medical interventions for transgender youth, addressing gender dysphoria and suicidal behaviors (Priest, 2019). For youth in out-of-home placement, access to gender-affirming medical services is sparse. Without a supportive bio-legal family member helping to navigate and provide consent for these services, many child welfare agencies are left without directives in how to provide access to or financial coverage for care. A notable exception is The Pennsylvania Department of Health Services, which allows that services covering gender transition may be compensable under the Medical Assistance Program when medically necessary (CSSP, 2016). Despite such policies, procedures to connect transgender youth with necessary medical services is an area of need. The majority of child welfare systems do not have basic knowledge of or policies/procedures regarding gender-affirming treatment. Additionally, other gender-affirming interventions such as chest binders and packers for transmasculine youth are not included in policy and are not systematically recognized as medical or mental health needs.

Our causal loop models conceptualize psychological comorbidities as a result of intra- and interpersonal factors in the context of institutional and structural factors that place SGMY at heightened risk of poor mental health. As conceptual models, this contribution renders visible the complex and dynamic phenomenon of disproportionate representation of SGMY in foster care and the subsequent reinforcing pathways leading to the burden of mental health comorbidities for this population. It is important to note that future models that seek to test these pathways would need to utilize the feedback loops or interactions of psychological comorbidities with the other components of the model (e.g., trauma responses or placement in a restrictive care setting) to fully understand the complexity at play. In addition, other critical constructs, such as youth involvement in commercial sex trade or "survival" sex and how these experiences contribute to runaway/homeless and systems involvement, are not represented in the current model. Yet such experiences are disproportionately experienced by SGMY and are relevant in pathways to psychological comorbidities (Franchino-Olsen, 2019; Lannert, 2015). Other as-yet-to-be-determined feedback loops may also exist within our conceptual theoretical model, and future research should bear this in mind.

We have purposefully highlighted family-, community-, and system-level interventions, as the preponderance of evidence suggests that these interventions will have the most lasting impact. Individual-level interventions, such as individualized affirmative therapy, while important to promote healthy coping skills for SGMY, will not significantly alter the structural and institutional factors that put SGMY at risk in the first place. It is our conviction that only radical system disruptions into factors that structure and maintain systemic racism, heterosexism/cisgenderism, and queer/transphobia will support SGMY thriving in the future.

Implications for Practice, Policy, and Research

- Affirming caregivers support sexual and gender minority youth (SGMY) through normalization of sexuality and gender, recognition of systemic oppression, and connection with family of origin *as well as* chosen family
- *Timely* family-based interventions are critical to decreasing SGMY disproportionate representation in child welfare
- Effects of institutional stressors can be diminished through safe identification of SGM status which attend to privacy and legal requirements while *ending* misgendering and misuse of youth data
- Current culturally appropriate therapies and medical services that *affirm* youths' gender and sexuality are critically important
- Culturally appropriate and affirmative training for foster parents and child welfare workers

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