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'I actually know that things will get better': The many pathways to resilience of LGBTQIA+ youth in out-of-home care

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Abstract

Research on the lives of lesbian, gay, bisexual, transgender, queer, intersex, asexual and other forms of sexual identities and orientations (LGBTQIA+) youth in care has mainly examined their experiences from a risk-based approach, while few studies have explored their resilience experiences. Using in-depth interviews, the present study aims to illuminate the resilience experiences of 13 LGBTQIA+ young people in out-of-home care in the Netherlands. Four themes emerged from their narratives: relationships that support and empower; construction of a positive identity around their sexual orientation and gender identity and expression (SOGIE); community involvement and self-relying strategies. Our findings support the view of resilience as a complex process that shows at an individual, interpersonal and social level.

KEYWORDS

child protection, identity, LGBTQIA+, out-of-home care, resilience, youth

BACKGROUND

LGBTQIA+ youth in care

The lives of LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual and other forms of sexual identities and orientations—for a detailed explanation of these terms see LGBTQIA Resource Center Glossary, 2021) youth in out-of-home care have received little attention from the academic and practice fields of child protection until recent years (Kaasbøll & Paulsen, 2019; McCormick et al., 2017). The available knowledge shows that LGBTQIA+ youth in out-of-home care are often confronted with a system that does not meet their basic needs. Besides the multiple challenges they might experience due to being placed in out-of-home care, they might also need to deal with a child protection system (CPS) that fails to protect them against discrimination and violence based on their SOGIE. Research has documented prejudice, discrimination, harassment, bullying and barriers to participation in the decisions that affect their lives, which LGBTQIA+ youth often encounter in the care system (Cossar et al., 2017; Gallegos et al., 2011; González-Álvarez et al., in press; Mallon, 2019; McCormick, 2018; Paul, 2018; Wilber et al., 2006; Woronoff et al., 2006).

LGBTQIA+ youth are overrepresented in the CPS. Studies in the USA have shown that, compared to heterosexual or cisgender peers, LGBTQIA+ youth are nearly 2.5 times more likely to experience foster care (Fish et al., 2019). Other studies have come to similar numbers (Baams et al., 2019; Dettlaff et al., 2018; Irvine & Canfield, 2016; Wilson & Kastanis, 2015). Yet, they constitute a largely invisible population (McCormick et al., 2017). Furthermore, LGBTQIA+ youth, when compared to their heterosexual and cisgender peers, show less permanency in out-of-home care: higher number of placements, higher risk to age out of foster care without having adequate preparation for transitioning to adulthood and an overreliance on congregate care or group home settings (Jacobs & Freundlich, 2006; Mallon et al., 2002; Mallon & Woronoff, 2006; McCormick, 2018).

The inability of some families to accept the young person's SOGIE is one of the reasons for many of them to enter out-of-home care services (Mallon, 2001, 2019; Mountz & Capous-Desyllas, 2020; Woronoff et al., 2006). Despite this, a recent study exploring the families of origin of LGBTQ youth in care has also found that although some youth access the system due to reasons directly related to their SOGIE, many of them also access care because of family and community problems, poverty, racism and intergenerational substance abuse and mental illness in the family, etc. (Mountz & Capous-Desyllas, 2020).

In the Netherlands, where the CPS leans towards a family service orientation and considers out-of-home care measures a last resource, the situation for LGBTQIA+ youth in care is also complicated. Despite the Netherlands holding the 13th position in Europe in terms of the best human rights and policies for LGBTQIA+ individuals (ILGA Europe, 2020), research points to the negative experiences that LGBTQIA+ youth still go through. LGBTQIA+ youth are marginalised in society compared to hetero–cisgender peers (Bos & Sandfort, 2015), and within the care system, they lack professional's awareness and sensitivity to their SOGIE (De Groot et al., 2018; Emmen et al., 2014; Taouanza & Felten, 2018).

Resilience of LGBTQIA+ youth in care

Youth living in out-of-home care are subject to enormous adversities and are more prone to physical and mental health negative outcomes (Suárez-Soto et al., 2019). Although research has emphasised their problems and risks, strength-based approaches that study their resilience have also more often

emerged in the last years. Recent studies have documented the several ways in which youth in care are resilient. A study in foster care youth reported their high levels of resilience and highlighted the role of individual resources and parental acceptance (Davidson-Arad & Navaro-Bitton, 2015). In a systematic review by Lou et al., (2018), internal and external resilience factors in youth in residential care are summarised (e.g. availability of caring relationships, sense of future and self-reliability). The authors also concluded that resilience persists as a 'fundamentally internal attribute' and that this 'remains a popular, if not reductive, conceptualization'.

Resilience of LGBTQIA+ youth in care has barely been studied. Although a research overview on LGBTQIA+ youth refers to them as 'a population with much more resilience than risk' (McCormick et al., 2017), this idea does not seem to be substantiated in much research. However, a handful of studies have uncovered the role of several resilience factors: the value of education in LGBTQ former foster youth (Capous-Desyllas & Mountz, 2019), the importance of social support among LGBTQ youth in transitional living shelters (Forge., 2012), the important role of foster carers' acceptance (McCormick et al., 2016) and carers' provision of nurturing relationships with youth (Schofield et al., 2019). It seems that LGBTQIA+ youth relationships with care practitioners and especially with foster carers are of utmost importance for their resilience development.

Despite these previous resilience studies, research on LGBTQIA+ individuals, including youth in care, has often followed a 'risk-based approach', focusing on their negative outcomes, such as mental or physical health problems and the experience of social disadvantages and stressors (Gahagan & Colpitts, 2017; Kwon, 2013; Meyer, 2015; Russell, 2005). Although this approach has certainly brought important knowledge regarding the unfair and preventable differences in LGBTQIA+ people's health (health inequalities) and their causes, it also presents several disadvantages. Firstly, the LGBTQIA+ community could experience further stigmatisation resulting from overly risk-based research (Millum et al., 2019). Secondly, its strong biomedical approach has mainly searched for individual-level health determinants, where risk factors are conferred to personal characteristics, without paying much attention to the role of structural or systemic factors such as social marginalisation experienced, for example, as violence and discrimination, or the access to social resources that promote health (Gahagan & Colpitts, 2017; Russell, 2005). Lastly, this approach ignores that, despite the exposure to challenges, the majority of LGBTQIA+ individuals do not develop significantly higher mental or physical health difficulties compared to heterosexual or cisgender peers (e.g., Herrick et al., 2013).

To overcome these limitations, researchers must not only study the risk factors but also the determinants of health and well-being, while considering the contextual and cultural determinants. A more comprehensive resilience-based approach could provide a useful framework to understand how individuals and communities prevent, face and resolve stressors to avoid health problems and maintain successful functioning and well-being (Gahagan & Colpitts, 2017).

The use of the social ecology resilience model with LGBTQIA+ youth

Caution is warranted when using a resilience approach to understand the health of the LGBTQ community due to the absence of a globally accepted definition, the emphasis on individual traits that potentially reinforce stigma and the ethnocentric White–western perspective of the concept (Colpitts & Gahagan, 2016). Because of these reasons, broad understandings of resilience that consider individual, social, structural and cultural factors, might especially be relevant to study the resilience of LGBTQIA+ individuals.

We have decided to use Ungar's social ecology model of resilience (2011), as it accounts for the complexity of resilience processes, from individual to social ones, while recognising the importance

of culture and context in shaping the ways resilience shows. The social ecology model of resilience (Ungar, 2011) proposes to: shift the attention from the individual-based perspective to the individual–environment interaction, acknowledge that resilience shows in complex ways depending on context and time, understand that resilience can take atypical and unexpected paths and endpoints depending on contextual factors and recognise resilience as context-culturally defined processes.

The objective of this study is to explore the resilience of LGBTQIA+ youth in out-of-home care. The overall research question is: *What are the ways in which LGBTQIA+ youth in out-of-home care experience resilience?* The ecological resilience approach will provide us with information on the ways LGBTQIA+ youth in out-of-home care prevent, confront and overcome their adversities, through the interaction with their environments to achieve a successful adaptation within their context and culture. This knowledge has the potential to inform individual and systemic-based interventions to make the life of LGBTQIA+ youth in out-of-home care better.

METHOD

This study used data collected in the framework of a larger research study in the Netherlands—the Audre project—to investigate the needs and experiences of LGBTQIA+ youth in out-of-home care and the perspectives of their carers and practitioners.

Procedure and interview

We used several techniques to recruit LGBTQIA+ young people (e.g. snowball sampling, recruitment via social media and personal contacts). All of the participants gave informed consent and one of them also had to ask for parental informed consent due to their age (15 years old). A semi-structured guide was developed including several topics, such as experiences before care, coming out process, experiences of discrimination and future perspectives. All interviews were face to face (except one via telephone). Before the interview, the purpose of the study was explained to the young person, as well as the voluntary and confidential character of their participation, and that they could stop the interview at any moment without giving any reason. Most interviews were conducted at the young person's preferred location. In one case, this was not possible, as the person was in secure residential care. The interviews were audio-recorded with the consent of the participants.

Participants

In total, 13 young people participated in the study (ages 15 to 28 years old, mean age 18). Regarding their gender identity, our study included: four transwomen, one transman, one person who sometimes identified as a woman and one non-binary person; the remaining six people did not mention their gender identity. Regarding their sexual orientation, our study included: four gay people, one lesbian (she sometimes also referred to herself as gay), one bisexual, one pansexual, one questioning, one who liked women and one who liked both men and women; and three people did not disclose their sexual orientation. Young people were also diverse with regard to their cultural background, health, education and other characteristics: four of them had a bicultural background, one had a chronic illness and another had autism. Their experiences with care were also heterogeneous; most of them experienced both foster care and residential care, while only a few of them experienced only foster care. Other

forms of care were as follows: secure residential care placements, independent living programs, assisted living arrangements, inpatient hospital wards and living and treatment groups.

Analytical approach

Interviews were transcribed verbatim using the audio transcription program 'F4 transkript' and uploaded to Atlas ti, version 8.4. Data were analysed using a reflexive thematic analysis (reflexive TA) (Braun & Clarke, 2006, 2019; Braun et al., 2018). The reflexive approach of TA has a more organic and iterative process that does not search for a consensus or reliability in the coding process, compared to other forms of TA. Reflexive TA puts in the foreground the active role of the researcher in the interpretation of the data; thus, when differences are found between researchers during the analysis process, a reflexive dialogue is used to solve the differences and agree on the best codes and themes (Braun & Clarke, 2019).

We read the interviews and discussed notes and impressions to gain a rich first insight into the data. Afterward, we constructed the codes with an approach that fluctuated between deduction (from theory to data) and induction (from data to theory); we attempted to generate codes by using theory as a compass while at the same time, remaining flexible to generate codes which were close to the direct experiences of the youth. The main theoretical framework guiding our analyses was the social ecology resilience model. In the next step, we used the constructed codes to generate the first set of preliminary themes and represented them in a thematic map. As the last step, we revised, redefined and described the themes. We met multiple times to discuss the analysis focused on the different ways LGBTQIA+ youth prevented, confronted and resolved their adversities making use of several individual and social resources to achieve and sustain their well-being.

Ethics

The ethics committee of the University of Groningen approved the study in November 2017. Ethical issues were deemed of utmost importance in the designing and conducting of the study, and addressed in a reflexive approach prior, during and after the interviews. Young people interviewed were compensated for their time and energy through an incentive. In addition, the team prepared a resource guide about LGBTQIA+ organisations for the participants. After each interview, they could decide if and how they wanted to be included in the project, and how they wanted to be updated about the research process and results. The team reflected on how the research process went after each interview. The research team reached out to the young people to see how they were doing after the interview. In addition, participants were informed that they could contact the research team after the interview if they wished. Furthermore, one member of the research team was a trained care professional who offered consultation when needed.

FINDINGS

Loving and caring relationships: Supporting and empowering

LGBTQIA+ young people interviewed experienced a wide range of adversities in their life, such as difficult relations within their family, violence at school, mental health problems and unsafe and

unsupportive care services. However, through caring and loving relationships that offered support and empowered them, young people could withstand these stressors. These caring relationships took place sometimes in their family, sometimes with their friendships and sometimes with their practitioners and foster parents.

Young people's narratives about their family relationships were rather brief. They mentioned different difficulties at home before their placement, sometimes reasons for their care placement: an abusive father, parents with addictions or mental health problems and family conflicts. Despite young people did not elaborate much on the ways their family relationships supported them, it seemed that maintaining a family bond was important for some of them. A young person mentioned the unconditional love from his brother: *'And family has never been this important to me. And not just the idea of family, it's just the idea of that unconditional love. Just, I see my brother for example. I don't know why I love him, yes they do have blood, bond, but that … I see him, it's just inexplicable. That inexplicable love.'*

Other young people mentioned the need of limiting the contact with their parents or lowering the expectations of what they could obtain from them to prevent getting hurt: *'just good relationship'*: (referring to the mother) '*The contact is fine. Not that I can go to her with everything, she is also very evangelical. But the contact is now just good. And that is the most important.'*

Some young people were able to form meaningful friendships that offered them resources to face adversity. They described how their friends cared for them in many different ways: by listening and understanding their problems, by providing them with instrumental support like a temporary place to live or by just being their life companions with whom they enjoyed their hobbies.

Some young people experienced a lack of support from practitioners and foster carers and expressed how much they wished to receive more help from them. Others considered that their relationships with practitioners and foster carers were an essential source of support. This support came in different shapes: fostering in young people a sense of optimism, being available to answer all their practical questions or comforting them emotionally. Moreover, young people appreciated practitioners and carers who provided them with honesty, humour, trust and even physical comfort (e.g. a hug). They felt that this made a sharp contrast with the *'business-like bureaucratic'* relations that they sometimes encountered in care. Beyond the provision of practical help, young people needed care that was given in a more *'human way': 'Here you just have a lot of people who just, care providers, who just treat you in a human way, who are happy to go with you to the hospital, if necessary, still hold your hand if they should, they would still do, and yes [silence] just normal people. Yeah… who just still have a heart [laughs].'*

Practitioners' care could also take the form of empowering the young person, for instance, by letting young people be able to take part in the important decisions that concerned their life. Although young people valued carers' involvement in their lives, they also claimed space and time to be themselves. As a young person illustrates it, good care is a balance between protection and empowerment: *'And protective at the same time. Not so much that you don't… take too few steps, and not too many, but just good.'*

Building a positive identity around SOGIE: Understanding, accepting and affirming

An important way for young people to overcome some of the adversity in their life was by building a positive identity around their SOGIE. Two processes seemed to be key: understanding/ accepting and

affirming their SOGIE. The construction of a positive identity around SOGIE was a co-construction, as young people's social acceptance and affirmation were crucial.

For most young people, understanding their SOGIE was a hard process. Although some of them are mentioned to have always known their SOGIE, others came to realise it later in life. This realisation was experienced by most of them as a life stressor: '*I really worked on it a lot in my head last year… What am I going to do with this?*'. The difficulty of dealing with their SOGIE was especially hard as they sometimes had to face other life difficulties at the same time: *'And it was a really bad year for me… It really couldn't come at a worse time.'*

Their stories show how our society lacks cultural or media LGBTQIA+ role models who could offer a guide for LGBTQIA+ youth to understand their SOGIE. A young person struggling to understand their own gender identity put the feeling in these words: '*And seeking like, who am I? Because I am not a woman myself, I would like to be, but also I don't want to. Are there more people like me?'* Young people found on online resources important information to understand their SOGIE. For a bisexual young person, the search for self-understanding was especially hard, as he encountered mainly gay and lesbian representations in the media. Eventually, he found online resources: *'I had looked and searched a lot on the internet and at one point I came across a YouTuber and that man, his entire channel is about ehh, bisexual… he explains that very nicely. And that really helped me a lot. So basically a YouTuber who has helped me a lot.'*

Many young people interviewed experienced unacceptance of their SOGIE and discrimination based on it from their families, peers, foster carers, practitioners and society. The coming out process and the reactions to it were some of the most crucial moments that determined the acceptance and affirmation, or the lack thereof. Stress and fear prevailed, even in the period before coming out. To counteract these difficult processes, some young people found ways to first test the acceptance of their SOGIE in their nearby relationships by using jokes, games or other subtle ways before coming out: *'… I yelled for a very long time' I'm gay 'and if someone asked, are you gay, no, no, I'm not gay, I'm not gay, it's a joke.'*

Negative reactions to their coming out were deeply hurtful and could potentially cause young people to completely reject their SOGIE. A young transgender person on coming out to their foster parents: '*But they ignored me head-on and laughed at me. So then my body, or my brain then thought, yes, but you know, just look at it… I just put it back in quietly.'* Conversely, reactions of acceptance were highly appreciated by young people and helped them to accept their SOGIE: *'My friends were just like, we really don't care. Everyone is like "whatever", no one really makes it a big problem. The only one who made a big deal of it was myself.'*

Coming out had the potential of not only bringing up acceptance from their relationships but also offered other benefits, such as the relief from not having to hide their SOGIE anymore, experiencing less homophobia in their classroom, encouraging others to come out and putting them in contact with other LGBTQIA+ youth: *'And yes… and the more I came out the better it was and all.'*

Some practitioners and foster carers had an important position as young people's SOGIE affirming figures through educating themselves on SOGIE issues, giving young people space and time to understand themselves, protecting them from bullying, connecting them with LGBTQIA+ organisations and calling them with their real/preferred pronouns: *'She was like 'okay, we have to change your name in the system now, to woman and to [own name]. I just don't see a man in you, so we just have to…' and that really just really helped me.'* Getting in contact with LGBTQIA+ organisations, often put in contact through practitioners, also offered some young people a safe space to understand their SOGIE, be themselves without receiving judgment and form supportive relationships: *'But in the beginning, I was like, yes I just want to make friends who understand me, so I went there… and just felt at home, and I still go there now.'*

For most trans young people, medical transitioning was a big and important step towards the construction of a positive gender identity. Young people wished that carers could offer more help in this process. Supporting them with access to medical transitioning in a timely manner could prevent them from suffering mental health issues: *'B: No, no. No, I haven't been thinking about suicide since I've been at the [name of transitioning clinic]… No, I don't have to jump in front of the train. I have, I have faith, but um, if the waiting times get longer and I really have to wait, it will be a bit more serious.'*

Eventually, some young people encountered in their social environment the resources to develop a positive identity around their SOGIE. Pride in their SOGIE was a frequent way in which this positive identity showed during the interviews: *'I am also very proud of who I am and how I became.'*

Community involvement: understanding and engaging

For some young people interviewed, their resilience developed through their community involvement. This quest for an involvement with society expressed in two main ways: understanding of social injustice and development of their social values, and an active engagement in promoting social change through activism and taking care of others.

Young people's difficult experiences in life, and the witnessing of the struggles of significant others, made them especially sensitive and thoughtful about certain social problems and injustices. One young person who emigrated to the Netherlands searching for a safer place for himself and his family shared his understanding of the social problems around refugees in the country. He mentioned how the media are partially responsible for the bad image of the refugees: *'the media does take care of the bad sides, for what happened wrong',* and how crucial it is for the Dutch society to work on changing this negative image. This same person reflected on the fact that he did not belong to a *'white culture'* that relates to certain privileges: *'they really have a wonderful life, a big house, business, they go on vacation every year and they want to keep it that way. And just like that in that 'white culture' circle, and okay then I don't fit in.'*

Social injustices and inequalities for the LGBTQIA+ community were also mentioned by some young people. The contrast between how far society has progressed when it comes to LGBTQIA+ issues and the need at the same time for further steps was evident in some of the young people's discourses. For example, some young people mentioned the urgent need for SOGIE education at schools: *'And then I know yes but guys, why haven't you looked at this before (referring to SOGIE education at school)… It's fucking 2019. Go learn that.'*

Some young people reflected on the hetero-cis-normative ideology in our society. A young trans person who had endured transphobia expressed that the Netherlands was not a safe country for trans people. Another young person expressed that discrimination based on SOGIE was associated with specific geographical locations*: 'In that sense, it is just a dry peasant culture. But yes, go to [another place] and [another place] and it is very different there. But that is also a bit more urban and developed differently.'*

For a number of young people interviewed, their life stories and their early understanding of social injustice gave them the motivation to seek a social transformation through their active involvement in society. They took diverse ways to make a difference: working in the youth care system, participating in youth councils or LGBTQIA+ activist groups, or even by their participation in this research study itself. Changing the care system and addressing the inequalities faced by the LGBTQIA+ community were the two most frequent narratives of social change.

Many young people expressed their desire to be involved in some way or another with the care system. Their experiences with youth services gave them knowledge and motivation to work towards

a change. Some young people wanted to become foster parents, and others were studying or wanted to study to become social workers. They shared some examples of their success making a difference in the system; a young person who worked as an *'expert by experience'* in a youth organisation managed to implement some of his ideas in the organisation. Moreover, by giving back to society, they felt they received something as well: *'And to help other clients, and also to support care providers… that also gives me a lot.'*

Some young people managed to raise their voice about LGBTQIA+ issues and effect a change, individually or through their involvement with LGBTQIA+ organisations. A young non-binary person took the effort of educating people about the diversity of SOGIE and the non-binary experience. Other young people were involved in LGBTQIA+ organisations and joined demonstrations and training activities. Despite being aware of the social inequalities that several groups face, some young people remained positive and hopeful for a change: '*I actually know that things will get better then, that we will take really good steps, ehh for a better future. All together.'*

If you don't care for me, I will stand for myself: resist, escape and fight

Young people mentioned experiences of lacking competent adults who could protect them and help them to deal with stressors such as discrimination and violence based on their SOGIE, family conflicts and unwelcoming care systems. This lack of help was met by some young people with a self-relaying attitude. Young people relied on themselves to confront adversities using at least three main strategies: escaping or avoiding, resisting and fighting.

When confronted with fights with family members or unsafe care systems, some young people opted for escaping or avoiding. Escaping could take the form of a runaway when they flee from the negative environments seeking relief in a safer or less stressful place. Escaping from home was even interpreted by one young person as a form of self-care: *'just making sure that my stress becomes less.'* Sometimes they secluded themselves in their rooms and personal spaces, or spent most of their time at school, outside with friends or at work, in order to avoid problems. According to them, being by themselves provided them a double benefit, a way of keeping them away from problems with others, and at the same time a space that brought them joy. Escape was not only physical but it also meant an emotional or psychological avoidance of potential stressors, such as painful emotions. Some young people told us to have few emotions or to hide them away; for example, by putting up a wall so '*nothing comes out*.

For some young people, an alternative to escaping from their stressors was to resist them. They referred to several ways of resisting, a prominent one was by '*being strong*'. Personal strength signified for them to be able to experience hardships without being affected (or being less affected): *'You can, you can mentally give me a really hard blow…. I stay upright. You won't get me down anymore'*. It seems that this strength was acquired after experiencing stressors and difficulties: '*All in all, (I've) been through a lot. And yes, that makes you strong. And yes, you don't get it, how do you say that, you don't just get hit hard anymore'*. Downplaying or decreasing the importance of the violence experienced was another way for some of them to resist their stressors: '*I had a fight with a guy and he called me a 'lesbian whore' or something, but that, you should not take that too seriously*'.

Another option for some of them was to fight against their stressors. Some young people admitted having used physical and verbal aggression as a way to defend themselves from their aggressors. They considered this an effective strategy in certain contexts, as a trans young person who would not allow transphobic comments in her town: *'They really would not dare, because I would really go at them.'* However, she would choose not to fight back at the care home because she could get into trouble with

the practitioners. Their capacity to engage in discussions or difficult negotiations could also be seen as a fighting back strategy for some of them. When these negotiations were successful for the young person, they could regain a sense of control and power over their life: '*And when I went to war (discussing with the care system), 9 times out of 10 I got what I wanted.'*

DISCUSSION

Our findings highlight the importance of relationships to foster resilience with families, friendships, foster carers, practitioners and school staff. These relationships are a source of social support and empowerment for all young people, but for LGBTQIA+ youth they are also key to the construction of a positive identity around their SOGIE. In this vein, studies have shown that the acceptance and integration of the identity around SOGIE is a great predictor of resilience in LGBTQIA+ youth (Herrick et al., 2014; Mountz et al., 2018). Although *pride in their identity* has sometimes been understood as an important individual resilience factor in other studies, our findings show how relevant the other's acceptance and support are to come to positive terms with their SOGIE.

The social/community nature of resilience becomes evident through the narratives of young people making sense of their social reality and getting involved in their communities. This social connectedness, expressed through group affiliation and collective action or activism, has been linked to the experience of resilience (DiFulvio, 2011). In a recent study with LGBTQ migrant Latinas, resilience was also expressed through community building and activism; creating better living conditions for others was a way of healing the wounds that oppressive systems created (Borges, 2019).

When we compare our results to youth living in care, we naturally encounter overlaps. In our participants, we could also see the importance of individual resources and the support from relationships that resilience studies with youth in care have found (Davidson-Arad & Navaro-Bitton, 2015; Lou et al., 2018). But in contrast with those studies, we also found that identity formation processes around SOGIE and the understanding and engaging with society were additional relevant resilience processes. Questions remain: are these identity and social resilience processes unique or more relevant in LGBTQIA+ youth populations? Or are there other similar resilience processes that could be explored in youth in care in general?

Our results highlight the central role of care professionals in fostering the resilience of LGBTQIA+ youth and complement the work of other researchers (McCormick et al., 2016; Schofield et al., 2019). Practitioners and foster carers were an important source of support (emotional and instrumental) for youth. From youth narratives, we realise the power of relationships based on love. Youth yearn for true connections beyond cold and bureaucratic ones, relationships full of emotion and empathy; care given in a 'human way'. It is of great importance that these relationships embrace a balance between protection in the sense of getting actively involved in their lives and empowerment, as stepping aside to let them take steps for themselves. Furthermore, it is also important that these relationships promote a positive SOGIE identity and connect youth to the larger community in positive ways.

Ungar's social ecology model of resilience was used in this study as a guide to understanding the ways resilience presented in LGBTQIA+young people. Our findings support the view of resilience as a complex process that shows at an individual, interpersonal and social level. The many pathways to resilience observed in young people's narratives ranged from psychological resources (self-reliance), interpersonal (building a positive identity around SOGIE, and loving and caring relationships) to a more socio-cultural resilience (social understanding and community involvement).

This study presents several limitations. The use of personal interviews and the type of questions selected might have resulted in overly individual accounts of resilience. Other research methods, such

as focus groups, participatory observations or family or community evaluations, could offer a complementary picture of the social ecology nature of resilience. In addition, studies incorporating professionals' perspectives would be a valuable and rich source of insight. The Audre study has actually interviewed practitioners and foster carers but we did not incorporate them in the current analysis. This will certainly be a future option for our research team. Moreover, using a cross-sectional design limits our understanding of resilience as a process. Future research in this field should include longitudinal studies with individuals, relationships or communities. Concerning our participants, although our study does not seek to generalise results, our results might have failed to incorporate all the different voices in the LGBTQIA+ community as, to our knowledge, we did not hear intersex, queer or aromantic/asexual perspectives in our interviews. Lastly, although our study aimed to be as participative as possible, we did not incorporate participants' feedback on the results of our study.

This study also exhibits a number of strengths. The use of a qualitative approach with in-depth interviews gives us a rich understanding of strategies dependent on contextual and social factors that might be missed using quantitative instruments (e.g. escaping as resilience). The research team also followed a strict ethical and participatory stance in this study, which is especially relevant when working with marginalised communities (Graham et al., 2013; International Collaboration for Participatory Health Research—ICPHR, 2013). Lastly, although we had little information over other aspects of their identity, such as their racial or ethnic identity, we acknowledged that their challenges came from different oppressive systems and we strived to incorporate these different social categories in an intersectional way (Crenshaw, 1989; Konstantoni & Emejulu, 2017).

This study can offer some practical recommendations that child protection systems and all practitioners and carers involved in them could put in action in order to promote the resilience of the LGBTQIA+ young people in care. Child protection services and their professionals and carers should promote caring relations that support and empower LGBTQIA+ young people. These relationships should seek a balance between actively providing them resources while also allowing them the capacity to influence their life. Practitioners and foster carers should also foster these caring relations between LGBTQIA+ young people with their peers, friends, family and school staff.

Child protection services and their professionals and carers should offer LGBTQIA+ young people resources to construct a positive identity around their SOGIE. For this purpose, child protection services should implement clear policies that address bullying and any discriminatory practices within the organisation. Child protection services should also offer training on SOGIE to all staff to help them increase their supportive capacity.

Child protection services and their professionals and carers should help LGBTQIA+ young people to make sense of the difficult situations they have gone through, and to connect and engage with their community in positive ways for them and their society. Practitioners and foster carers should discuss with young people about relevant societal issues, such as social justice and inequalities; this can be done in everyday conversations, but also through workshops or lectures. Practitioners and foster carers have a key role in fostering the young person's community involvement; for instance, through connecting them with LGBTQIA+ advocacy groups.

LGBTQIA+ youth in care are subject to different forms of violence rooted in our hetero–cis–normative society. Despite the enormous challenges they are confronted with in care and the broad contexts they live in, LGBTQIA+young people find many personal, interpersonal and social resources that allow them to overcome their difficulties and achieve happiness, pleasure, success and other positive outcomes. It is indispensable to realise that their foster carers, their practitioners and the different systems they navigate during their pathway in care comprise a vital part of their resilience.

ETHICS APPROVAL STATEMENT

The ethics committee of the Department of Educational and Pedagogical Sciences at the University of Groningen approved the study in November 2017.

CONFLICT OF INTEREST

The authors certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

DATA AVAILABILITY STATEMENT

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data is not available. However, analyses (codes and thematic map) are available upon request.

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