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Risking It Anyway: An Adolescent Case Study of Trauma, Sexual and Gender Identities, and Relationality

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ABSTRACT

This article presents the case of a Chinese–American adolescent with a significant trauma history who was questioning her sexual and gender identities. The implications of the client's intersecting identities for case conceptualization and treatment are considered within the framework of affirmative practices for sexual and gender minority (SGM) clients. The impacts of stress and trauma on this client's experiences—and SGM clients more broadly—are also considered, particularly with respect to how this client understood and negotiated her experiences of relational trauma. This case is intended to illustrate some best practices with SGM clients within an intersectional framework which underscores the importance of multiple salient cultural identities.

When was the last time you felt a risk in the pit of your stomach? Can you remember making a choice to be vulnerable, to trust someone with your truth even if you were not sure how they would respond? We all long to be seen, though we often mask ourselves with layers of performance. These distractions and sleights of hand can loosen our knowing, obscuring us from our intimacies, even from ourselves.

This dance is more familiar to some of us than others. For some, the world feels naturally affirming: achievements are internalized as aptitudes; characters in film and television reflect one's history and culture; the act of simply being is not inherently political. For others, the landscape is more complicated: characterized by shifting experiences of identity depending on the context, by the labor and skill of maneuvering between worlds, by the threat of rejection or violence carried by marked identities.

For anyone, making the decision to risk being seen in therapy can be intimidating. For those of us whose experiences hold these complexities, this proposition may seem outright dangerous. As mental health professionals, it is our ethical responsibility to support our clients in taking these risks and to ensure that we are prepared to respond to their experiences with empathy, competence, and humility.

Trauma and mental health among sexual and gender minorities

The journey to understand and be seen as one's authentic self—and the risks this can entail—is familiar to many sexual and gender minorities (SGM). Although an incredible range of identities are included under the sexual (e.g., queer, asexual, demiromantic, skoliosexual, and dyke) and gender (e.g., gender fluid, agender, transgender, tomboy femme, and stud) umbrellas, the process of coming to understand and express one's identity is germane to them all. Unfortunately, for many SGM people, the

risk of expressing oneself authentically is often met with violence ranging from microaggressions to bullying and rejection to hate crimes and human rights' abuses (Dworkin & Yi, 2003; Mustanski, Andrews, & Puckett, 2016; Nadal, 2013). More severe forms of victimization, such as hate crime murders, are more common among SGM with multiple marginalized identities, such as transgender women of color (Stotzer, 2009). Beyond these individual experiences, SGM people are also negatively impacted by structural stigma, including discriminatory policies and institutional heterosexism (Fredriksen-Goldsen et al., 2014; Hatzenbuehler, 2014; Hughto, Reisner, & Pachankis, 2015).

In addition to experiencing violence on the basis of their sexual or gender identities, SGM people are more likely than their heterosexual and cisgender peers to experience other forms of trauma and abuse across the lifespan. Compared to heterosexual people, sexual minorities were more likely to experience psychological, physical, and sexual abuse, and violence in both childhood and adulthood (Balsam, Rothblum, & Beauchaine, 2005; Friedman et al., 2011). Less is known about the experiences of gender minorities, given the lack of standardized reporting procedures, less research with this population, and concern among transgender trauma survivors about experiencing cultural incompetence or revictimization should they choose to share their experiences or identities (Singh & McKleroy, 2011). Research that has been conducted has found that compared to cisgender people, gender minorities were more likely to experience emotional and sexual abuse in childhood and physical and sexual violence in adulthood (Richmond, Burnes, & Carroll, 2012; Stotzer, 2009).

Sexual and gender minorities are also more likely to experience homelessness, which increases their likelihood of experiencing victimization. Although they only represent about 10% of young people overall, SGM young people represent 40% of the homeless youth population in the United States (Durso & Gates,

2012). Youth named family rejection as the most common factor contributing to their homelessness; other reasons included aging out or running away from foster care, often due to experiences of harassment or violence (Durso & Gates, 2012; Keuroghlian, Shtasel, & Bassuk, 2014). Homelessness exposes SGM youth to a developmental cascade of risk (Masten & Cicchetti, 2010), including increased risk of being physically or sexually victimized on the streets, engaging in survival sex, and mistreatment by law enforcement (Healy, 2012; Keuroghlian et al., 2014). This pattern of polyvictimization underscores the importance of being able to draw from traumatogenic frameworks to understand the mental health difficulties experienced by SGM people (Brown & Pantalone, 2011; Minshew, 2015; Mizock & Lewis, 2008).

Perhaps not surprisingly, these multilevel experiences of stigma, victimization, and interpersonal trauma are in turn linked with disparities in mental health and well-being. Sexual and gender minority adolescents and young adults show increased risk for suicidality, self-harm, depression, anxiety, and substance abuse (Fredriksen-Goldsen et al., 2014; Haas et al., 2011; Hughto et al., 2015; McConnell, Birkett, & Mustanski, 2016; Saewyc, 2011). Research has documented the central role that both individual experiences of stigma, victimization, and interpersonal trauma (House, Van Horn, Coppeans, & Stepleman, 2011; McConnell, Birkett, & Mustanski, 2015; Mustanski et al., 2016; Saewyc, 2011) and structural experiences of oppression (Fredriksen-Goldsen et al., 2014; Hatzenbuehler, 2014; Hughto et al., 2015) play in driving these health disparities. These risks appear greatest in adolescence; victimization tends to decline (Birkett, Newcomb, & Mustanski, 2015), and some families become more supportive (McConnell et al., 2016) as adolescents become young adults.

Experiences of sexual and gender minorities in therapy

Given these experiences, a large number of SGM people seek therapy. However, the relationship between SGM communities and psychology remains tenuous. Historical mistrust stemming from the pathologization of sexual and gender diversity, lack of regard for people's self-designated identities, inadequate training of mental health professionals, and negative experiences with care providers all contribute to underutilization of mental health services among SGM populations (Ansara & Hegarty, 2012; Herek, 2010; Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; Singh & Shelton, 2011). Resolutions were adopted by the American Psychological Association (APA) that formally depathologized sexual and gender diversity in 1975 and 2012, respectively. However, the quality of care delivered to SGM people continues to vary greatly, and unethical therapeutic efforts to change sexual orientation or gender diversity persist (APA, 2012, 2015). In an important effort to close the gap between policy and practice, APA guidelines for psychological practice with sexual (2012) and gender (2015) minorities were recently developed. However, it remains unclear to what extent these guidelines are being implemented in clinical practice, training, and research.

There are also differences in how well the concerns of particular subgroups within the SGM umbrella are addressed. A

large proportion of SGM research and training focuses on the experiences of lesbians and gay men, which invisibilizes the experiences of gender minorities and people who identify as bisexual, pansexual, or other sexual minorities (Clarke & Peel, 2005; Singh & Shelton, 2011). Gender minorities, in particular, may be especially impacted by negative experiences in therapy, as gender diversity was only recently depathologized by the APA, and societal attitudes about gender diversity continue to shift rapidly. Less than a third of psychologists and graduate students reported receiving training on issues faced by gender minorities (APA, 2015), a lack which contributes to ineffective and even harmful mental health care. Practitioners are working to develop and disseminate affirmative models of care, which acknowledge that variations in gender identity are not disorders and that mental health difficulties typically stem from stigmatizing responses from others (e.g., Hidalgo et al., 2013).

It is also crucial to move beyond solely considering how sexual and gender identities shape the experiences of SGM people. Increasingly, psychologists are drawing on the contributions of Black feminists who articulated how people's multiple, intersecting identities shape their experiences and relationships to power (Bowleg, 2012). Intersectional, developmentally sensitive approaches are needed to address the experiences of SGM people of color and others with multiple salient cultural identities, particularly as they negotiate identity development processes in adolescence and early adulthood (APA, 2015; Ecklund, 2012; Fredriksen-Goldsen et al., 2014; Singh & Shelton, 2011).

This discussion of stigma, victimization, and trauma may communicate a bleak outlook for the mental health and well-being of SGM people. However, we often forget that marginalized groups often show an incredible capacity for resilience: despite facing numerous structural barriers, SGM people use a variety of coping skills and strategies to persist and even thrive in the face of adversity (Hill & Gunderson, 2015; Saewyc, 2011). Thus, our task as clinicians becomes more complicated: to balance knowledge of adversity and its potential impacts, on the one hand, with an appreciation of the capacity for resilience, on the other.

Clients are often at their most vulnerable when they come to therapy. It is our responsibility as mental health professionals to ensure that when diverse SGM people take this incredibly risky step, they are met by clinicians who are informed about best practices, sensitive to the complex cultural influences that may shape clients' experiences, and flexible enough to adapt their approach to the needs of the person in front of them. This journey is perhaps best understood within the context of cultural humility (Hook, Davis, Owen, Worthington, & Utsey, 2013): not as a simple arrival, but as a process of continually striving to do better by our clients.

Jae: A case study in trauma, identity, and relationality

This case history describes my experience working with Jae¹, a 19-year-old Chinese-American college student who was assigned female at birth and had known she was "probably gay" for about a year. Although the experiences of SGM clients in

¹ Client's name and identifying information have been changed to protect confidentiality.

therapy vary widely, I offer my experience working with Jae to highlight some best practices with SGM clients and to explore my own process of learning as a clinician who strives for ongoing growth in the context of cultural humility. As a cisgender White female who identifies as queer, some of my identities overlapped with Jae's, while others diverged in culturally significant ways.

Initial meeting

The person standing before me in the waiting room was wide eyed, a pair of too-big glasses resting halfway down her nose. Her frame was enveloped by a large black hoodie, her legs twigs in black skinny jeans that disappeared into a pair of clunky black boots. A backpack threatened to fall off her shoulder as she reached out one stiff arm to shake my hand. "I'm Jae," she said, and flashed a smile so fast that I barely had time to appreciate how much it illuminated her face. As we walked up the stairs to my office, I wondered what I would learn about this person. For the moment, all I had was our meeting in the waiting room and the bare bones of our intake form, which told me she was coming to therapy to "deal with stress." Sounded about right for a college student.

Jae's eyes darted around my office and she stood awkwardly to the side while I closed the door. I gestured for her to take a chair, which she perched on the edge of, placing her backpack in front of her and holding on to the top strap with both hands. It was not just her slight frame that struck me as bird-like: this was someone who stayed in motion, and I wondered what might come up if she slowed down. After reviewing the usual disclosures, I opened with a general, "Tell me about what brings you in today." Jae took a deep breath and began.

Jae was here to address family stressors and tearful, anxious mood, though she expressed confusion about what exactly therapy was and skepticism about the possibility it could help her. She disclosed a family history of conflict and abuse at intake, including physical and emotional abuse from her aunt and uncle, who had raised her, and sexual abuse from a male cousin. As Jae described these experiences, she appeared very calm and level. Although inside I felt pain and outrage at the violence she had experienced, I worked to match her tone and affect as we talked. Jae told me that her friends often "overreacted" when she shared her past, as they imagined it must have been more traumatic for her than she perceived it to be.

Jae's mother had died when she was young, and she had been raised from an early age with her aunt, uncle, and an older male cousin in the United States, while her father and older sister lived in China. Her uncle, father, and cousin were withdrawn and emotionally distant, while her sister and aunt depended a great deal on her for emotional support. Jae's sister, who was primarily responsible for taking care of her father, exhibited strong affective and relational dysregulation, suicidal ideation, and substance use; her aunt frequently drank heavily, became sad, and texted Jae. Jae became tearful as she described her deep concern for her sister, whom she felt would be doing better, perhaps even living independently, if she was a "better support." Although over time Jae had learned she needed distance in order to take care of herself first, she still felt a strong sense of responsibility for her aunt and sister's well-being. Very early on, these patterns of precocious caregiving struck me as likely related to

Jae's experience of complex developmental trauma (van der Kolk et al., 2009). From a feminist perspective, these ways of relating can be understood as learned strategies for coping with environmental stress (Brown, 2004).

As she described her family relationships, I imagined Jae spinning at the center of a wheel, her communication with each family member extending out in disconnected spokes, her experience the singular part that joined the whole together. These relationships were defined by abusive power differentials: Jae's uncle, father, and cousin had the most freedom and distance but also caused the most harm within the family, leaving Jae to "pick up the pieces" with her aunt and sister. Though Jae's relationships with her aunt and sister felt enmeshed to me, I was also aware of a need to avoid pathologizing these close interdependent relationships. I felt myself responding negatively to the strong gendered dynamics of family members' relationships to power, which can characterize Chinese families (Lee & Mock, 2006). The feminist in me was angry for Jae, and I struggled with what it would mean to help her process these experiences across our cultural divide.

Jae felt affirmed and supported in her sexual identity at school, and the idea of coming out to her family seemed "unimaginable," such that it felt too distant to be a current source of stress and was not something she was worried about. Jae's self-description as "probably gay" signaled to me that she was likely still engaged in a process of identity development and exploration, but she also made it clear that she had more significant sources of stress at present and her sexuality was not necessarily an issue she wanted to focus on therapy. This understanding that issues of sexuality or gender may not be a concern clients want to focus on in therapy is an important aspect of affirmative therapy with SGM people (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Israel et al., 2008), particularly when working with clients with multiple salient cultural identities (Ecklund, 2012). At the same time, communicating an affirmative response to a client's identity disclosure is important to create a sense of safety in therapy and support open dialogue about sexuality (APA, 2012; Garnets et al., 1991; Israel et al., 2008;). It is also important to recognize that the impact identity disclosure can have on a client's relationship with their family of origin, particularly when clients are likely to experience "conflicts of allegiance" between their racial or ethnic cultural group and their identification as a sexual or gender minority (APA, 2012; Gock, 2001; Morales, 1989). From a developmental perspective, this relationship can also work the other way around: a client's identity development and expression can be shaped by their family of origin's cultural norms and expectations (Ecklund, 2012). Given these potential complexities, therapy may be an especially important space for identity exploration and affirmation for SGM people of color (Richmond et al., 2012; Singh & McKelroy, 2011).

In this first session with Jae, I felt pulled in different directions by these competing impulses to establish myself as an affirming therapist and signal an openness to discussion about sexuality without inappropriately focusing on Jae's sexual identity. This tension was exacerbated by my cultural bias as a White person with an imperfect but relatively affirming family; it was difficult for me to understand how Jae was able to talk so casually about her certainty that she would be emotionally and financially cut off from her family if or when she came out to them, especially given the central role family relationships played in

her self-concept. Unsure of exactly how to strike this balance, I did my best to communicate a positive response to her disclosure and acknowledge the cultural tensions this involved without exaggerating them. In moments like these, I am grateful for the nonverbal signals I use to signal to clients: the “gender unicorn” (Trans Student Educational Resources, 2017) and safe space sign posted on my office wall, the stack of Q Cards next to other resources on the table (Q Card Project, 2017), and a selection of framed prints that communicate the value I place on diversity and social justice.

As we wrapped up our intake session, Jae and I had a discussion about what kind of treatment approach would best meet her needs. Given her history of complex trauma and the session limits in our clinic, I encouraged Jae to consider a referral to a community provider, whom she could see on a more ongoing basis. She was adamantly opposed to this suggestion, insisting that she just wanted a few sessions to “learn some new tools.” It was clear to me that Jae was either engaging in therapy in our clinic or not coming at all. I agreed to work with Jae, all the while understanding that our work might simply be to lay a foundation that opened her up to the idea of engaging in ongoing therapy.

After Jae left my office that first meeting, I felt the energy in the room shift. In the quiet few minutes before I went downstairs to meet my next client, I stared out the window, still taking in her experiences with the morning light. A bird was perched on the fire escape outside, turning its head side to side, watching me watching it. I did not move, but a loud clang sounded from the street and it flew off. I wondered if Jae would come back.

Conceptualization and theoretical approach

I practice as an integrative relational therapist: I strive to be responsive to diverse client needs, begin by establishing a foundation of empathic understanding and trust, and am attentive to here-and-now dynamics in the room. Thus, one of my early tasks with Jae was to work to bracket my biases and strive to use Rogers’s (1975) accurate empathy to understand Jae’s experience *from her perspective*. This approach is consistent with evidence on best practices for SGM clients, which underscores the importance of unconditional positive regard and creating a safe environment early on and links the quality of the therapeutic relationship with positive therapy outcomes (APA, 2012; Chazin & Klugman, 2014; Israel et al., 2008; Mandel, 2014; Richmond et al., 2012). As a feminist therapist and a community psychologist, I work to attend to issues of power and identity inside and outside of the therapy room, recognize the impacts of ecological systems on clients’ well-being, and highlight clients’ strengths. Finally, as a trauma-informed clinician, I recognize that experiences of trauma can present in diverse and complex ways and appreciate the importance of incorporating a traumatogenic frame into my therapeutic work (Cloitre et al., 2009; Minshew, 2015; van der Kolk et al., 2009).

From our initial meeting and throughout our work together, Jae struck me as someone who seemed wise beyond her years and more resilient than she had any reason to be. I imagined others must relate to her in a similar way, perhaps expecting of her a maturity and strength that may at times be exhausting and limiting. Although it was clear that Jae exhibited a profound capacity to care for others, I wondered about her experience of reciprocity

in relationships. I began to see part of my work being in relationship with Jae as both highlighting what was clearly an incredible capacity for resilience and gently creating room for her to examine and express the parts of her that might feel hurt, vulnerable, or weak.

Early phase of treatment: Sessions 2–4

It was not long before Jae shared with me some of these hurting places, although this unfolded in a way that likely neither of us would have chosen. The weekend after our first meeting, Jae (who typically abstained from alcohol) became very drunk and made vague suicidal remarks. Alarmed, her friends involved a Residential Assistant who consulted with our on-call clinician. Although the situation was resolved fairly quickly, the experience left Jae feeling uncharacteristically vulnerable and out of control. Jae communicated to me her frustration that her friends were again “overreacting” to her experience, underscoring that this way of feeling was “not a big deal” to her. Jae was left feeling like her friends were only concerned because they saw her behavior as a liability, and questioned whether being in therapy made her too vulnerable and she should stop coming.

I was aware of what an important turning point this was: Jae was deciding whether she wanted to trust me with her vulnerability, and she was making this decision on the heels of an experience where her attempt to communicate with others led to her loss of power as an institutional process was set in motion. Still, it was likely important that she experience the care and concern she aroused in others, particularly as she was more accustomed to giving than receiving this care. Jae was supposed to be the one who held together other people’s brokenness, not the one who was allowed to be broken herself. At the same time, I felt her testing the boundaries of our fledgling therapeutic relationship. Was she looking to see if I, like her friends, would “overreact”? Of course, rumbling beneath our conversation was my own concern about how active Jae’s suicidal ideation was and my understanding of the importance of assessing this without reducing Jae’s experience and personhood to a level of risk.

Given Jae’s recent experience of powerlessness and the palpable institutional hierarchy between us, I did my best to take a “down position.” I explained my dilemma to Jae, acknowledging how my concern for her well-being and my ethical responsibility made a conversation about risk important and inevitable, but also acknowledging her frustration at her lack of control and naming how confusing the boundaries around suicidality can feel to clients. I clearly outlined how I approach suicide risk assessment, including the point at which I involve a supervisor, what the process of consultation looks like, and when and why hospitalization might become an option. Jae asked several questions along the way, visibly brightening as we talked. This may have been hope talking, but I could almost feel her calculations about whether and how she wanted to trust me shifting. Our conversation drifted to other things as Jae continued the process of filling me in on her family history and background. As we talked, Jae connected her trauma history to her view of herself, wondering aloud if it was possible that “all of this happened to her” and she “may not be messed up.” In what felt like an important turn in a session that began with a conversation about symptom severity and powerlessness, our meeting ended with

a conversation about resilience in which I shared my genuine appreciation of her strength and self-determination. Jae took this in with wide eyes and a shy smile, as though the thought of her own strength had never occurred to her. She also agreed to come back.

Our next meeting was again characterized by a vulnerable lurch forward between sessions. However, this time it was me instead of Jae who felt like things were happening too quickly and out of my control. Jae had decided to confront her cousin about their abuse history and shared that the phone call that followed was “more honest and open” than she expected given her cousin’s characteristic position of power and distance within the family. Jae learned things about her cousin’s experience that increased her empathy for him, and she experienced their open communication as a relief. Although it worried me that Jae initiated such a significant conversation so quickly and without first talking it over, I also thought it may be a promising sign of our working alliance that she felt able to revisit and explore an experience she had kept contained and silent for years. I wondered if Jae would be able to find a middle ground, one where she could practice vulnerability without diving straight into the deep end, and if this might be part of our work together. I shared with Jae my image of her role in the family as the hub of a wheel, and she expressed a strong sense of identification with this metaphor.

Given the importance of family dynamics in shaping Jae’s sources of stress, patterns of coping, and ways of being in relationship with others, I felt a strong urge to understand her experience from the perspective of family systems theory (Bowen, 1966). From this perspective, well-differentiated family relationships lead to self-differentiation, which is, in turn, associated with psychological well-being. Although the concept of self-differentiation is in some ways culturally specific, there is also evidence that it is associated with psychological well-being for both Asian- and European-American students (Chung & Gale, 2006; Kerr & Bowen, 1988). Jae’s family system exhibited some patterns, typical of Chinese family culture, including a strong patriarchal hierarchy, unidirectional communication from family members in positions of greater power, and a very close attachment from Jae’s aunt toward her cousin and herself (in Jae’s words, “smothering”; Lee & Mock, 2006). I did not want to pathologize culturally normative family relationships. At the same time, Jae’s family evidenced a significant trauma history, and it was becoming apparent that their current relationship patterns were a considerable source of distress for Jae. Jae also exhibited some of the classic manifestations of poor self-differentiation, including emotional reactivity, emotional cutoff, and fusion with others (Kerr & Bowen, 1988), which can stem from experiences of complex developmental trauma (van der Kolk et al., 2009).

Ultimately, I decided to incorporate family systems theory into a discussion with Jae about boundaries and relationships within her family system. Using the concept of triangulation (Bowen, 1966), Jae and I identified the extent to which family members displaced their conflicts onto Jae and relied on her to contain their experiences and emotions. I gently questioned Jae’s sense of responsibility for her family’s well-being, wondering aloud about when this pattern started and what costs it might involve. Jae connected her sense of relief after talking with her cousin to the disruption of a long-standing

triangulation between her cousin and her aunt, and expressed interest in continuing to experiment with boundaries in her family relationships.

Middle phase of treatment: Sessions 5–8

Over the next few sessions, Jae continued to explore these boundaries in both her family and peer relationships. Her initial sense of relief after confronting her cousin was replaced by a feeling of disappointment when his uncharacteristic honesty appeared to be a passing moment and their typical distant, hierarchical pattern of relationship re-established itself. This prompted Jae to reflect on the gendered power dynamics of her cousin’s position in the family and her frustration with herself for longing for a closer relationship with him. On the other hand, she experienced a sense of confidence in creating new boundaries with her sister, within which she was able to balance defending her own needs and providing her sister with stable support. This confidence was soon tested one night when her sister’s symptoms became more acute, and Jae once more “picked up the pieces” by keeping her sister on the phone through an episode of polysubstance use and suicidality until her sister’s friends could connect her to care.

Jae also began to open up about her experiences of intimacy and boundaries in her peer relationships. She acknowledged that she was often a strong source of support for her friends, which at times felt empowering and at times felt overwhelming. She acknowledged how easy it was for her to place others’ needs ahead of her own, which could become so consuming that it disrupted her daily routine and class attendance, leading to overwhelming academic stress, depressed mood, and suicidal ideation. Jae noticed a similar pattern in her moods, explaining that she often “felt fine” until her sadness or anxiety became overwhelming, at which point she either “shut down” or “fell apart.” Although Jae recognized the extreme lengths to which she often went to support others, she also acknowledged her difficulty accepting any form of help or support. Jae identified that she was able to take others’ perspectives “instinctively” since she was a young child, a coping skill that she found indispensable in an unpredictable and hostile family environment. Through discussion, we were able to name this empathic understanding as a strength of Jae’s and also explore how the lack of reciprocity in her relationships impacted her well-being.

One week when these symptoms were particularly severe, Jae came to therapy looking uncharacteristically disorganized and listless. Her typical confidence and containment were missing, so much so that I was quietly surprised she was willing to let me see her this way. Jae shared that she had been “distracted” caring for a struggling friend, and her symptoms were to the point that she was experiencing passive suicidal ideation and active self-harm ideation. Jae and I worked together to identify coping skills she could use and create a plan for how she could reach out for help if these skills were not working. After some hesitation, Jae agreed that I could reach out in a couple of days to see how she was doing. Although Jae was clearly going through a difficult time, I viewed her decision to come to therapy and her willingness to receive this outreach as promising signs. Jae was placing trust in our therapeutic relationship, and this was evident in her willingness to share with me some of her “messed up parts.”

At our next meeting, Jae's mood was much improved. The same day that she responded to my outreach, Jae's friend, concerned that she was not eating or leaving her room, repeatedly requested that Jae come with her on a walk. Jae's initial response was to reject this offer, but when her friend turned up at her dorm room, her sense of obligation outweighed her discomfort and she agreed to leave her room. Jae found that it felt "surprisingly good" to accept support from others, identifying that in fact this acceptance was the step that began turning her mood around and precipitated her re-engagement in social and academic life.

Around this same time, Jae disclosed that she was questioning her gender identity. She described this as a process she had been aware of for some time but which she believed would slowly unfold at its own pace. Jae shared that she did not strongly identify as either male or female, and enjoyed the "moments of confusion" when others weren't sure how to categorize her gender. Jae had begun shopping in the men's section, and expressed pleasure with the different ways these clothes hung on her body. As we talked, Jae conveyed her enjoyment of this gender exploration, making it clear that although she "did not have any answers," this ambiguity was a rich source of play.

I was not entirely surprised to hear about these shifts in Jae's gender identity. Since we had known each other, I had experienced her as androgynous or even masculine. A few sessions into our work together, Jae had tentatively asked about my sexual orientation. Therapists vary in their approaches toward self-disclosure, but I find it can strengthen the therapeutic alliance and help equalize the inherent power differential inherent in this relationship when I respond honestly to these kinds of direct questions. Therapist self-disclosure of sexual minority status has also been linked with more positive client experiences in therapy (Israel et al., 2008). So, when Jae asked how I identified, I told her I identified as queer. I believe this did, in fact, strengthen our therapeutic alliance and may have allowed her to more easily raise issues related to sexuality and gender identity in our sessions.

Following Jae's disclosure, we discussed diversity in transgender and gender nonconforming communities and identities. I celebrated and affirmed her sensations of pleasure and play with respect to gender, appreciating that this play likely doubled as a form of labor with respect to her identity development as she developed constructs to authentically represent her gender, found ways to communicate this and be seen by others, and ultimately balanced these needs for self-expression with her need for self-protection and survival within discriminatory systems (Levitt & Ippolito, 2014). Although sexual orientation and gender identity are distinct constructs, they are also inter-related: transgender and gender nonconforming people may at first assume they are gay, and shifts in one identity may lead to shifts in the other (APA, 2015). Jae and I checked in about the name and pronouns she would like to use in therapy, and she identified that she would like these to stay the same for now (Jae/she), but that she would let me know if this changed in the future. As with her sexual orientation disclosure, I worked to follow Jae's lead, affirming and inviting her exploration of gender into our work without inappropriately defining it as our focus.

Final phase of treatment: Sessions 9–12

Winter thawed into spring, reminding both Jae and myself that the end of our work together was approaching with the end of the school year. Jae's stress and mood symptoms were much improved, and she demonstrated greater capacity to negotiate boundaries in her close relationships. At the same time, an important process in her gender identity was unfolding, and much remained unresolved in her family system. Although Jae had come to trust our therapeutic relationship and open up in a way that was unprecedented for her, this intimacy became more complicated as the end of our work approached. When I raised this issue with Jae, she acknowledged feelings of loss and powerlessness about ending our work and requested that we begin meeting every other week instead of every week to ease the transition. I had mixed feelings about this change: on the one hand, I was impressed by Jae's open communication about her needs and our boundaries; on the other, I was concerned that Jae's stressors might build up and become overwhelming between sessions or that she may check out of therapy entirely. Again, given her vulnerability and the power imbalance between us, I shared my reservations but left the decision up to her, with the understanding that she could change her mind at any point. This is the greatest regret of my work with Jae, as I believe more directly exploring her feelings of loss and attempts to control them by meeting less frequently could have been a rich source of insight and growth for her.

Over the next few months, Jae and I continued to explore what it meant to stay connected in relationship even as the inevitability of loss grew closer. Though we initially met every other week, at times Jae requested longer breaks between our meetings. I could feel Jae pulling away, and although I believed it was critical to support her autonomy, I wondered if she would continue to be able to tolerate the difficult process of saying goodbye, particularly outside the container of our weekly meeting schedule. We also discussed the possibility of Jae continuing ongoing therapy with an outside referral. Although she believed ongoing therapy could be helpful, Jae was reluctant about the idea of opening up to another therapist, which "sounded like a lot of work."

Once again, Jae surprised and impressed me with her maturity and resilience. Conflict between her aunt and uncle escalated during this time, and though they each repeatedly tried to pull her into their fights, Jae was very intentional in managing boundaries and prioritizing her self-care. Jae continued to practice different boundaries with her sister and cousin, enjoying newfound intimacy as her relationship with her cousin became closer and freedom as her sense of responsibility for her sister's well-being decreased. Jae's work on her family relationships became more connected to her exploration of her gender: she identified that she vacillated between idealizing and demonizing the men in her life, and expressed a desire to find a "middle path" in her relationship with men and masculinity, which could perhaps help her better understand how she related to masculinity herself. I do not know where Jae's journey took her with respect to gender, though I would not be surprised if she ultimately came to identify as transgender or genderqueer.

Finally, the time came for our last meeting. The session started off upbeat as Jae shared her summer plans and

excitement about what it might mean for her to practice different ways of relating to family when they were physically spending time together. As the conversation moved toward what it would mean for us to say goodbye, Jae became visibly uncomfortable, looking around the floor in long pauses.

"I don't usually say goodbye," she said. "It's too uncomfortable. When I left for college, I didn't even say goodbye to my girlfriend. I waited until everyone was busy so I could slip away." She paused. "I almost didn't come today."

"I'm really glad you did," I said. Jae smiled. We sat in silence for a few moments, allowing ourselves to feel sadness and loss. I remembered the first time I met Jae, how I was struck by her strength and maturity. Over time, I had come to know her as someone who was defined not only by her resilience, but also by a profound capacity to be vulnerable and a seemingly inherent drive toward growth. I was blown away by how hard she had worked to bring greater authenticity and reciprocity into her relationships, a process that she clearly intended to continue. And here she was, sitting a few feet from me, practicing that dance of vulnerability, strength, authenticity, and reciprocity through all of its discomfort. I could feel how much it meant for her to show up to this goodbye.

As I shared these thoughts with Jae, I teared up with respect for her and gratitude for the opportunity to accompany her through this process of growth. Similar to the end of our first meeting, Jae received this with wide eyes and a smile, but this time I felt the weight of our history and relationship behind my words. This time, she did not just wonder if what I was saying might have a slim chance of being possible; instead, she trusted and internalized my respect for her, quietly tucking it away inside of herself. Although she continued to feel that it was difficult to imagine opening up to another therapist right now, Jae said she would think about it when she returned from her summer vacation.

When our time was up, Jae took a deep breath and walked toward the door. She paused at the threshold, then turned around and met my eyes, her lips pursed, and jaw determined. I could feel her searching for words and knew that she was working hard to say whatever came next. "Thank you," she said, her face and voice softening. "For everything." She gave me one last shy smile, then turned and walked away.

Discussion

Understanding Jae's experiences

Jae's case provides an example of post-traumatic spectrum symptoms (van der Kolk et al., 2009), a pattern which is consistent with emerging understandings of complex posttraumatic stress disorder (PTSD) (Minshew, 2015; Richmond et al., 2012; van der Kolk et al., 2009). Although some trauma survivors present with symptoms consistent with classic PTSD (i.e., flashbacks, nightmares, hyperarousal, American Psychiatric Association, 2013), others' experiences do not fit this typical presentation. This is especially likely for people whose experiences of trauma have been multifaceted, relational, and/or ongoing, such as polyvictimization, interpersonal violence, and structural violence associated with marginalization. In Jae's case, these symptoms presented primarily as affective dysregulation

(including extreme affect states, diminished awareness of her emotions, and experiences of dissociation) and relational dysregulation (including precocious caregiving and lack of reciprocal behavior in relationships; van der Kolk et al., 2009). Jae worked to address these symptoms in therapy, acknowledging how she bottled up her emotions until she experienced incapacitating anxiety or overwhelming sadness and working to establish stronger boundaries and greater reciprocity in her relationships. Other clients may exhibit greater physiological, attentional, and behavioral dysregulation (van der Kolk et al., 2009), and these symptoms may become a greater focus of therapeutic work.

From a feminist perspective, these symptoms can be understood to serve a communicative and relational function in the context of ongoing environmental stresses (Brown, 2004). From this perspective, clients' symptoms can be understood as central to their resilience: without these survival strategies, trauma survivors may experience much greater harm and distress. By conceptualizing Jae's experiences this way in therapy, we were able to underscore her strength and resourcefulness and avoid stigmatizing her experiences or patterns of relating. Rather than pointing to something that was "wrong with her," these symptoms were simply strategies that had outlived their usefulness now that she was living independently and moving into emerging adulthood. For clients who present with complex PTSD, addressing these symptoms in the context of a strong therapeutic alliance is key (Pearlman & Courtois, 2005). Short-term cognitive behavioral therapy (CBT) tends to be less effective for complex PTSD because clients often drop out of treatment (Foa, Keane, & Friedman, 2000; Spinazzola, Blaustein, & Van Der Kolk, 2005).

Given their increased likelihood of experiencing polyvictimization, an awareness of complex posttraumatic stress disorder (PTSD), developmental trauma, and post-traumatic spectrum symptoms is particularly important for clinicians working with SGM people and communities. This is consistent with the APA's guidelines, which highlight the importance of understanding the impact of stigma and victimization on the mental health of SGM people (2012, 2015).

A few other pieces of foundational knowledge may be helpful to highlight for clinicians who work with or are interested in working with SGM clients.

- Conduct an extensive self-assessment about your potential biases, as well as your knowledge, skills, and awareness related to sexuality and gender identity (APA, 2012, 2015; Ecklund, 2012; Singh & McKleory, 2011). This includes an understanding that variations in sexuality and gender are normal human variations and that efforts to change sexual and gender identities are unethical and unsafe (APA, 2012, 2015).
- Understand that sexual and gender identities are distinct but interrelated (APA, 2012, 2015). Given the greater visibility afforded to lesbian and gay identities, gender minority individuals may initially identify as sexual minorities. Coming to understand and express one's own authentic identity is a process that takes a lot of time and effort for many gender minorities, particularly given this lack of representation (Levitt & Ippolito, 2014).
- Incorporate an understanding of intersectionality into clinical work with SGM clients, being particularly aware of

challenges related to potential conflicting cultural norms and values for racial/ethnic minority and religious SGM people (APA, 2012, 2015; Ecklund, 2012; Singh & McKelroy 2011). Clients who experience multiple marginalizations are more likely to have unhelpful experiences in therapy, which underscores the importance of clinicians' awareness and competence around intersectionality.

- Be wary of projecting your own cultural hierarchy and salient identities onto clients (Ecklund, 2012; Singh & McKleory, 2011). Instead, try to understand how clients understand and hold multiple experiences from their perspectives, and do not assume that mental health difficulties are related to SGM clients' identities or experiences of minority stress (APA, 2012, 2015).
- From a developmental perspective, consider the unique needs of SGM children and adolescents and understand that changes in gender and/or sexual identity may not persist into adulthood (APA, 2012, 2015; Ecklund, 2012).
- From a family systems perspective, consider how disclosing a sexual or gender minority identity may impact a young person's relationship with their family of origin (APA, 2012, 2015; Ecklund, 2012). Affirming environments are particularly important for SGM young people, and youth who lack this support from their families early on are at increased risk for mental health difficulties across adolescence and into adulthood (McConnell et al., 2016). Providing this affirmation in therapy and connecting clients to other affirming environments and resources is an important aspect of clinical work with SGM people.

Affirmative therapy with sexual and gender minority clients

To practice affirmative therapy with SGM clients, therapists must go beyond knowledge about clients' cultural backgrounds and identities to incorporate affirmative practices into the process of therapy. Using my work with Jae as an example, I will identify and explore a few of these affirmative practices.

Creating a safe environment is a crucial part of the initial groundwork of affirming therapy with SGM clients. Unconditional positive regard is particularly important to developing the strong therapeutic relationship that is important for effective therapy with SGM clients (Chazin & Klugman, 2014; Israel et al., 2008; Mandel, 2014). Affirmation of SGM identities can be communicated in multiple ways, including institutional forms, language, avoiding assumptions about someone's identities, or pronouns, and explicitly stating a commitment to addressing the harm caused by systems of oppression (Richmond et al., 2012; Singh & McKleory, 2011). Although Jae and I revisited our initial conversation about pronouns when she disclosed questioning her gender identity, I believe an ongoing conversation would have been more helpful. For example, asking Jae a simple question like, "What pronouns would you like to go by today?" at the beginning of each session would communicate an understanding that her gender identity may continue to shift between our meetings and invite this process of exploration into the room.

Given potential experiences of trauma and victimization, it is also important to conduct a thorough assessment of multiple types of violence early on in therapy (Richmond et al., 2012).

Although Jae was forthcoming about her abuse history during our intake, it is possible that she never disclosed experiences of victimization that I did not directly ask about. By using a formal assessment tool, I might have developed a more complete picture of Jae's trauma history and laid the groundwork for bringing these experiences into therapy (Center for Substance Abuse Treatment, 2014).

Connecting clients with resources and social support can be important for SGM clients, particularly those with multiple marginalizations and potentially less access to community like transgender people of color (Richmond et al., 2012; Singh & McKleory, 2011). In addition to providing important information and connection to similar others, these communities can be important sources of resilience for SGM people (Meyer, 2015). Early on in therapy, Jae and I discussed possible referral to a campus support group for SGM students; however, she was not interested in attending. Connecting clients to social and community supports should be done in a manner that is comfortable for the client (Richmond et al., 2012), and I wish I had revisited this conversation with Jae and explored her openness to other groups and community resources, particularly as she questioned her gender identity.

A central feature of my work with Jae was exploring her family connectedness as it both supported and challenged her resilience. Even in the absence of a trauma history like Jae's, family can be a source of both strain and support for SGM people (Singh & McKleory, 2011). There is a bidirectional relationship between identity development and family relationships: families may shape identity development processes through positive and negative reinforcement, and changes in identity can influence how children and adolescents relate to family members (Ecklund, 2012). Transgender people report experiencing pressure to ignore or hide their true self as a stage of their identity development (Levitt & Ippolito, 2014), which underscores the importance of affirmative therapeutic spaces to do this identity development work. College is a time when many adolescents first gain distance and independence from their families and when many important identity development processes often happen. Therapists working in college counseling centers, in particular, may benefit from awareness of these potential complex negotiations, particularly given that college counseling centers were among the most common environments for both helpful and unhelpful experiences with SGM people in therapy (Israel et al., 2008).

Given the impact stigma has on mental health for many SGM people, talking about these experiences is another important feature of affirmative therapy. By acknowledging and exploring the impact of systems of oppression, clinicians can facilitate clients' development of self-acceptance and pride in their intersectional identities (Singh & McKleory, 2011). SGM people are often dealing with both internal and external stigma (Mandel, 2014; Meyer, 2003), both of which can be explored in therapy.

Although Jae denied experiences of external stigma around campus, such as discrimination or violence, the threat of rejection and loss of financial support from her family had a strong impact on her identity development and disclosure. For many SGM people, particularly those with multiple marginalized identities, navigating multiple cultural worlds means that identity development is an ongoing process balancing authenticity and necessity. Clinicians should recognize and respect these

complex identity management processes in order to avoid pressuring clients to conform to a particular model of identity development and disclosure and to hold space for ambiguity and change (Chazin & Klugman, 2014; Levitt & Ippolito, 2014; Minshew, 2015).

Throughout our work together, Jae also grappled with internalized homophobia and transphobia. Jae worried that her identities were pathological, expressing fear that her experience of sexual abuse “caused” her same-gender attraction and that questions about her gender identity were indicative of a maladaptive relationship with masculinity. This is a common pattern for SGM people, who may subsume insidious trauma into narratives about their identities. Although an important area of concern, these patterns are often not addressed in therapy (Richmond et al., 2012). By supporting Jae in identifying how internalized stigma shaped her narratives about her identity, we were able to help her develop a narrative that centered on resilience and strength rather than pathology and brokenness.

I have underscored the importance of a positive therapeutic relationship and strong working alliance for both survivors of complex trauma (Pearlman & Courtois, 2005) and SGM people (Israel et al., 2008). I believe this was the most important element of my work with Jae. By coming to trust me, Jae opened herself up to other ways of seeing her experience, which ultimately increased her trust in herself. Our therapeutic relationship gave Jae a place to practice sharing her feelings, experiencing reciprocity, and negotiating boundaries, which ultimately shaped the way she related to her friends and family. Jae’s trauma had been relational, and ultimately her process of healing was relational too.

Beyond clinical work: Advocacy and social change

Providing affirmative therapy is an important step toward improving SGM mental health and well-being. However, therapy alone is an insufficient response to deeply entrenched, multilevel systems of violence. Better training and education is needed for students and clinicians in continuing education on affirmative practices for SGM people (APA, 2012, 2015; Richmond et al., 2012). Psychologists and others can advocate for affirmative policies and procedures at various systemic levels, from clinics to institutions to public policy and legislation (APA, 2012, 2015; Richmond et al., 2012). As long as structural violence against SGM people and communities continues, even the most affirmative clinical work will only mitigate ongoing harm. As therapists, we must work to create safe spaces not only in our offices, but also in our streets, communities, and institutions.

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