4-2023

# LGBTQ+ Stress and Trauma Within the DSM-5: ACase Study Adaptation of the UConn Racial/Ethnic Stress and Trauma Survey (UnRESTS)

Jenna M. Wolff

RaeAnn E. Anderson
*University of North Dakota*, raeann.anderson@UND.edu

Katya Mickelson

Kara N. Kelley is now at the Department of Psychology, American University, Washington DC.
Jason W. Krompinger is now at the New England Center for OCD and Anxiety, Cambridge MA.
Sriramya Potluri is now at the Department of Psychology, University of Massachusetts Boston.
The authors have no conflicts of interest or funding to report.

***Correspondence to*** Kara N. Kelley, 4400 Massachusetts Avenue NW, Washington DC 20016; kk7071a@student.american.edu



CLINICAL PRACTICE FORUM

# LGBTQ+ Stress and Trauma Within the *DSM-5*: A Case Study Adaptation of the UConn Racial/Ethnic Stress and Trauma Survey (UnRESTS)

Jenna M. Wolff, RaeAnn Anderson, and Katya Mickelson, *University of North Dakota*

THE PINK TRIANGLE marker of death during the Holocaust, the Stonewall Inn discriminatory, violent police raid that sparked protests for gay rights, Harvey Milk's murder for his sexuality, and the murder of Matthew Shepard in 1998 represent only a few of the heinous attacks against LGBTQ+ people. In 2020, more than 1 in 3 individuals and 75% of LGBTQ+ youth experienced some form of discrimination (Mahowald et al., 2020; Trevor Project, 2021). According to the FBI, approximately 20% of hate crimes in the United States are against the LGBTQ+ community (FBI, 2019). These are staggering statistics, considering 7.1% of adults in the United States identify as LGBTQ+ (Jones, 2022).

As the LGBTQ+ community continues to fight for equality, health professionals have an ethical and moral obligation to serve as allies to provide optimal care. Historically, the field of psychology has both advocated for and opposed LGBTQ+ rights. Clinicians and researchers in psychology should strive to provide inclusive, sensitive, and evidence-based mental health care and assessment to the LGBTQ+ population rather than putting the onus on clients to educate their providers. The goal of this article is to promote affirmative clinical care for LGBTQ+ individuals via a case example of how trauma-focused assessment can be adapted to LGBTQ+ specific needs.

## Discrimination and Inadequate Care

The LGBTQ+ population often experiences discrimination in healthcare, such as barriers to routine medical services and insurance and lack of cultural competency in providers (Alizaga et al., 2021; Whittington et al., 2020). Between 40% to 50% of transgender and gender-nonbinary individuals reported verbal harassment, physical assault, or denial of medical care in healthcare settings (Bauer et al., 2014; Shires & Jaffee, 2015). As many as 1 in 5 transgender and gender nonbinary individuals reported educating their healthcare provider about their medical needs (Bradford et al., 2013). Twice as many LGBTQ+ individuals compared to heterosexual individuals reported dissatisfaction with mental health services, usually due to provider discrimination disrespect and failure to consider the client's goals in therapy (Avery et al., 2001; Israel et al., 2008).

## Trauma-Related Care Needs

Identifying as LGBTQ+ has been associated with higher rates of victimization throughout life compared to those with a heterosexual identity, including sexual assault, physical assault, and abuse during childhood (Balsam et al., 2005). The rate of violent crime victimization for the LGBTQ+ population was 71.1 victimizations per 1,000 people, while the rate for the non-LGBTQ+ population was 19.2 victimizations per 1,000 people (Flores et al., 2020). According to the Centers for Disease Control and Prevention National Intimate Partner and Sexual Violence Survey, 26% of gay men and 37% of bisexual men have experienced rape, physical violence, or stalking by an intimate partner compared to 29% of heterosexual men (Black et al., 2011). Forty-four percent of lesbian women and 61% of bisexual women have experienced rape, physical violence, or stalking by an intimate partner compared to 35% of heterosexual women (Black et al.). Nearly half of bisexual women who experienced rape in their lifetime reported the first rape occurring between ages 11 and 17 (James et al., 2016).

Given the high rates of trauma, violence, and abuse, trauma-related care needs are high. As such, LGBTQ+ individuals are 1.5 times more likely to meet criteria for a diagnosis of depression, anxiety, or substance use disorder and two times more likely to have a history of suicide attempts compared to cisgender heterosexual peers

(King et al., 2008; Rutherford et al., 2021). Further, 18%–45% of transgender individuals meet criteria for PTSD compared to approximately 10% of the general population (Barr et al., 2021; Reisner et al., 2016).

In 1981, Virginia Brooks published a book titled *Minority Stress and Lesbian Women*, introducing a multilevel model of how sources of financial, cultural, and social stress contribute to sexual minority women's mental and physical health. Later, Brooks's sexual minority stress theory was applied to sexual minority men (Meyer, 1995) and gender diverse populations (Hendricks & Testa, 2012). Meyer (2003) elaborated on Brooks's work by emphasizing how chronic stress, stigma, and the accumulation of discriminatory experiences associated with living in a predominantly cisgender, heteronormative culture contribute to negative mental health outcomes for LGBTQ+ individuals. This distress is commonly manifested as trauma symptoms (Alessi et al., 2013; Coker et al., 2010; Keating & Muller, 2020; Russell & Fish, 2016). Many standard trauma and PTSD assessment approaches may not capture the unique experiences of repeated discrimination and identity-related harassment. However, some organizations employ a broad definition of trauma. The American Psychological Association (2013) and Substance Abuse and Mental Health Services Administration (2014) define trauma as a direct or observed event that threatens one's physical or psychological safety, produces feelings of anxiety and helplessness, and jeopardizes functioning and well-being. Trauma has also been defined as an event or series of events that threaten one's sense of control, autonomy, self-esteem, and safety (Ellis, 2020; Williams et al., 2018). However, the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) defines trauma as experiencing, witnessing, learning about, or continuous "exposure to actual or threatened death, serious injury, sexual violence" (APA, 2013). Under this definition, discriminatory experiences do not meet DSM-5 criteria for trauma or qualify for a PTSD diagnosis unless they result in tangible injury, threats, or violence. Yet, common discriminatory experiences, such as threats of being outed (i.e., unwanted disclosure of one's sexual orientation), can result in direct harm. For example, approximately one-third of LGBTQ+ youth have become homeless, been kicked out of their family's home, or run away from home after disclosing their LGBTQ+ identity (Morton et al., 2018; Trevor Project, 2021). The current definition of trauma in the DSM-5 maintains a narrow perspective of trauma and stressful experiences that significantly impact the LGBTQ+ population and other marginalized groups.

### *Existing Trauma Assessment for the LGBTQ+ Population*

Thorough assessment of LGBTQ+ clients' trauma history, including discussion about discriminatory and nonaffirmative experiences, is essential for a comprehensive understanding of trauma. Case conceptualization lacking this intersectionally informed, contextual information likely provides an inadequate picture of the client's experiences and symptomology regardless of the diagnostic model (Richmond et al., 2012, 2017).

Livingston and colleagues (2020) reviewed existing evidence-based self-report assessments for trauma, PTSD, and related symptoms. They found none of the commonly used measures to assess PTSD symptoms in relation to discrimination or trauma that may arise as a result of marginalized identities, such as race, ethnicity, sexuality, or gender identity. One remarkable exception is a semistructured interview tool developed by Williams and colleagues (2018) called the UConn Racial/Ethnic Stress and Trauma Survey (UnRESTS). The UnRESTS can be used to promote discussion about racial identity, racial trauma, and discrimination and evaluate whether a PTSD diagnosis is warranted based on experiences related to a traumatizing event, institutional racism or barriers to treatment, invalidation, overt and covert racism, and cultural trauma. Currently, the LGBTQ+ equivalent of the UnRESTS, a tool for assessing racial trauma and discrimination, does not exist. Thus, given the available tools and strengths of the UnRESTS, we adapted the UnRESTS to assess experiences related to gender identity and sexuality in this case study of a young, transgender, queer woman seeking services related to ADHD, mood, and substance use concerns.

## Case Study and Methods

### *Clinic Setting*

The client received services at a training clinic in the upper Midwest for students earning graduate degrees in counseling psychology, clinical psychology, and communication science. Nearly all providers in the clinic are student clinicians who receive supervision from a licensed professional. Because of the rural nature of the upper Midwest, clients may travel long distances to seek help for a diverse range of presenting problems. In 2021, the clinic served 486 children and adults for speech-language pathology, audiology, individual therapy, group therapy, family and couples therapy, and psychological assessments.

### *Referral Question*

The client identified as a White, working class, homoflexible and demisexual transgender women in early adulthood. The client initially sought mental health intervention at a local private practice clinic to address feelings of anxiety, sadness, and financial stress, worsened by furlough due to the COVID-19 pandemic. The client reported she was in a monogamous relationship with her girlfriend. The client's girlfriend identified as polyamorous and was married to her husband. Later, the client identified her relationship as consensual nonmonogamy. The client resides with her girlfriend, her girlfriend's husband, and her girlfriend's two biological children. Due to quarantine and requirement to stay indoors, the client reported heightened levels of sadness and anxiety related to spending more time at home and witnessing romantic interactions between her girlfriend and her girlfriend's husband. The client reported she would often yell, cry, and shake when experiencing elevated sadness and anxiety, which occurred at least three times per week over the previous 3 months. She explained these symptoms increased strain in her relationship. She reported difficulty regulating emotions and self-soothing, stating that time alone with her girlfriend typically calmed her. The client transferred care to the training clinic to maintain consistency with her primary therapist. In late 2021, the student therapist and client collaboratively sought further diagnostic assessment for ADHD and symptoms related to mood and suicidality. The student assessor and student therapist shared a supervisor, a licensed psychologist, and collaborated in gathering collateral information and completing a thorough diagnostic assessment.

### *Background*

The client self-identified as a woman with pronouns she/her/hers, acknowledging most heteronormative cisgender individuals would identify her as transgender. Sexual orientation was self-identified as homoflexible and demisexual, explaining that she is mostly attracted to women and

requires an emotional connection prior to sexual attraction. She reported experiencing gender-identity-related stress starting in early childhood, explaining she felt societal pressure as a child to fit into a stereotypical male gender role (e.g., mock fighting, playing with toys made for boys). She began questioning her gender identity in early adulthood during college and began transitioning shortly thereafter. The client participates in feminizing hormone therapy and has had a vasectomy. Although the client reported desire for further gender affirmation procedures, she reported financial barriers hindering current plans for these procedures.

The client reported a largely happy childhood in the rural Midwest with her mother, father, and two brothers. Throughout childhood, the client and her family belonged to the Lutheran faith. Her father remained heavily involved in the faith, and the client indicated he expressed sadness when she left the religion in young adulthood. She reported a close relationship with her mother and younger brother and positive relationship with her family; she stated her family has supported her LGBTQ+ identities and gender transition. She reported earning high grades throughout school and took medication for ADHD until graduation of high school. She reported a history of bullying during elementary and middle school, which mostly abated during high school. She detailed a history of difficulty in higher education, as she experienced difficulty concentrating, depressive episodes, and alcohol dependence while maintaining high-achieving expectations for herself. The client had difficulty maintaining coursework and discontinued higher education; although the client returned to higher education multiple times, she did not obtain a degree.

During the client's experiences in higher education, she was in a relationship with a previous girlfriend, during which the client experienced emotional abuse and became dependent on alcohol. After this relationship ended, the client became sober and began a polyamorous relationship with her current girlfriend and girlfriend's husband. This relationship soon shifted to a consensual nonmonogamous relationship with the client in a monogamous relationship with her girlfriend, while her girlfriend remained committed to the client and her husband. The client explained she has a nonparental role with the children (e.g., does not provide discipline, is not involved with their education) and has no plans to have biological children.

The client reported she enjoys her full-time job working in a managerial position at a technology company, and often works 40 to 50 hours per week. She would like to stay at the company and expand her role in the company.

Over the last 10 years, the client reported prior mental health interventions for suicidal ideation and historical diagnoses of depression and anxiety. She also

reported previous individual therapy for body dysmorphia, which was a possible misdiagnosis prior to transitioning. The client was also seeing a psychiatrist for medication management of psychological symptoms for ADHD, sleep disturbance, anxiety, and depression.

### *Assessment*

Over the course of eight sessions, the student assessor completed a thorough assessment for presence and severity of ADHD symptoms as well as a differential diagnosis for symptoms unaccounted for by an ADHD diagnosis. The assessment battery included psychosocial background, the UnRESTS, the Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders (DIAMOND; Tolin et al., 2016), and neurocognitive testing. The UnRESTS and DIAMOND were part of the supervisor's standard intake, while the personality and neurocognitive testing battery was selected for this particular client. Data are summarized in Table 2.

#### *Adaptation of the UnRESTS to Assess LGBTQ+ Specific Trauma*

To assess discrimination and stigmatizing experiences related to ethnic and racial identity, the student clinician administered the UnRESTS (Williams et al., 2018). The measure begins with questions regarding the client's racial and ethnic identities to better understand the context of racism and discrimination. The second section of the UnRESTS evaluates the client's socialization to race and ethnicity. This allowed the clinician to better understand the context of the client's identification with the larger group. The following sections of the measure evaluate explicit and overt racism, racism experienced by loved ones, vicarious experiences with racism, and covert racism and microaggressions. The final section of the UnRESTS, based on DSM-5 criteria and the PTSD Symptom Scale–Interview for DSM-5 (PSSI-5; Foa et al., 2016), is similar to a symptom checklist evaluating whether the client is experiencing PTSD symptoms related to racist and discriminatory experiences. The client reported identification as White and denied experiences of discrimination or trauma related to race.

After first discussing racial identity, the student assessor repeated the interview and adapted the tool to evaluate discriminatory and stressful experiences related to the client's self-identified gender and sexual orientation. See Table 1 for example items from a modified UnRESTS. The client reported that her experience of gender dysphoria and transition to womanhood "has been a constant stressor' for as long as she could remember. She endorsed stress and discrimination related to both her sexual identity and her gender identity. The client reported feeling distressed that people treat her girlfriend poorly because of the client's transgender identity. She indicated salient conflict with her girlfriend's mother, who reportedly treats both the client and the client's girlfriend poorly due to their LGBTQ+ identities. Additionally, the client reported that many acquaintances and friends from adolescence now ignore her due to her gender and sexual orientation. The client reported uncertainty about whether these painful experiences were due to reactions to her gender or sexual orientation, highlighting the complexity of their intersectionality. Based on the client's responses, symptoms did not meet PTSD criteria. However, the interview allowed the client and student assessor to engage in conversation about the client's identities, intersectionality, and challenging experiences related to these identities.

#### *Diagnostic Assessment*

Upon intake, the client also completed the DIAMOND (Tolin et al., 2016), endorsing two-thirds of the possible items, suggesting high distress. Nine interview modules were administered based on the most salient reported symptoms. Based on these diagnostic interviews, the client met DSM-5 criteria for ADHD, generalized anxiety disorder (GAD), major depressive disorder (MDD), and moderate risk for suicide. The client did not meet DSM-5 criteria for obsessive-compulsive disorder (OCD), manic or hypomanic episodes, hallucinations, binge eating disorder, or body dysmorphia (Tolin et al.).

Self-report questionnaires were also administered to assess the severity of the diagnoses identified (see Table 2). Finally, trauma history questionnaires were administered as part of the supervisor's standard intake. Scores on the *Childhood Trauma Questionnaire* (Bernstein & Fink, 1998) suggested minimal to no history of child maltreatment, consistent with report (Bernstein & Fink). On the *Life Events Checklist* (Weathers et al., 2013) the client endorsed multiple adult victimization experiences, including a history of multiple unwanted sexual experiences in adulthood; one of these experiences she chose to report to the police. The client also reported a physical assault during adolescence (Weathers et al.).

#### *Personality Assessment*

Due to the complexity of the client's experiences, high distress, varied symptomology, and collateral information from her therapist, the client also completed the *Millon Clinical Multiaxial Inventory*, 4th Edition (MCMI-IV; Millon et al., 2015), and *State-Trait Anger Expression Inventory*, 2nd Edition (STAXI-2; Spielberger, 1999). Consistent with observation, self-report, and collateral information, the STAXI-2 suggested feelings of anger due to current circumstances rather than temperament, suggesting the client may frequently express this anger verbally in the form of criticism, sarcasm, and profanity. The MCMI-IV suggested the client endorsed items related to feelings of emptiness, impulsiveness, self-criticism, depressive cognitions and feelings, uncertainty about self-identity, inner conflict, and behavior that may lead to greater conflict.

As the collected data was suggestive of borderline personality disorder, the client completed the self-report *Borderline Symptom List-23* (BSL-23; Bohus et al., 2009) and the *McLean Screening Instrument* (MSI-BPD; Zanarini et al., 2003). BSL-23 score was 0.7, exceeding the cut point of 0.64 to differentiate between controls and individuals who likely meet criteria for borderline personality disorder (BPD). MSI-BPD score was 7, meeting the cut point of 7, suggesting the client likely meets criteria for BPD. The client endorsed a pattern of interpersonal difficulties, deliberate self-harm, chronic suicidality and a past suicide attempt, impulsivity (e.g., substance use, verbal outbursts), extreme moodiness, frequent feelings of anger, dissociation, and chronic feelings of emptiness (Bohus et al.; Zanarini et al.).

#### *Neurocognitive Assessment*

The client completed a series of standardized cognitive assessments (see Table 2). The battery suggested the client demonstrated exceptional intellectual and memory skills, although performance was significantly poorer on tasks involving working memory. *Weschler Adult Intelligence Scale,* 4th Edition (WAIS-IV; Weschler, 2008) and *Weschler Memory Scale,* 4th Edition (WMS-IV; Weschler, 2009) scores were consistent with previously identified profiles of individuals with ADHD, such as a 10-point difference between General Ability Index (GAI) and Full Scale Intelligence Quotient (FSIQ) as well as significant weaknesses in the *Arithmetic and Digit Span* subtests (Theiling &

Petermann, 2014). Data suggested minimal-to-no difficulty in executive function tasks (e.g., planning, response inhibition, cognitive flexibility).

Self-report psychodiagnostic tests included the *Conners' Adult ADHD Rating Scale – Self-Report: Long Version* (CAARS – S:L; Conners et al., 1999) and *Barkley Deficits in Executive Functioning Scale Short-Form: Self-Report* (BDEFS-SF: Self-Report; Barkley, 2011). Data suggested likely difficulty with inattention, memory, hyperactivity, impulsivity, self-concept, emotional lability, self-management, and organization.

*Collateral Information*

Collateral information was collected from the client's psychiatrist, therapist, and girlfriend. Her psychiatrist suggested an appropriate diagnosis may be bipolar disorder, reporting a history of interpersonal difficulty, variable compliance with medication instructions, and periods of impulsivity and activation. The client's therapist reported information consistent with the client's history and self-report. More specifically, the clinician reported chronic interpersonal and intrapsychic instability, emotional lability, and chronic feelings of emptiness, suggesting borderline personality disorder. Additionally, the clinician supported the client's reports of discriminatory experiences and trauma related to the client's LGBTQ+ identities. Per clinician report, the client was in the early stages of remission for alcohol use disorder. Last, the client's girlfriend completed the *Conners' Adult ADHD Rating Scale Observer-Report: Long Version* (CAARS–O:L; Conners et al., 1999), indicating presence of ADHD symptoms.

### *Case Conceptualization*

The client was referred for assessment in late 2021 for ADHD, anxiety, depressed mood, and suicidality. The client was diagnosed with ADHD in early childhood and discontinued medication for ADHD symptoms in late adolescence. Depressed mood episodes, anxiety, difficulty concentrating, academic-related impairment, and alcohol dependency began in early adulthood, which corresponded with beginning higher education and a romantic relationship in which the client experienced emotional abuse. After this relationship ended, the client began a romantic relationship with her current girlfriend and her husband, which shifted into a consensual nonmonogamous relationship. Depressive symptoms, anxiety, and attentional difficulties continued interfering with work performance and her romantic relationship, which prompted the client to seek professional intervention.

The client's identity as a homoflexible, demisexual, transgender woman in a consensual monogamous relationship challenges Western culture's heteronormative and cisgender norms. Further, the client worked in a male-dominated workplace. Unfortunately, the client reported discrimination and microaggressions related to the client's gender identity, relationship orientation, and sexuality throughout her lifetime. These experiences created a pattern of chronic invalidation beginning in early childhood of the client's innermost experiences and identity, which is a key causative factor of later borderline personality symptomology (Linehan, 1993; Sloan et al., 2017). The client's family and current friends have been supportive of her identities and relationship orientation, which has served as a significant protective factor for this client.

Socially, the client typically engaged with others in a friendly and confident manner; however, she reported feeling frustrated with herself due to interrupting others frequently. Additionally, the client appeared to have difficulty expressing emotional, physical, and social needs in romantic relationships. The client typically placed loved ones' needs before her own. When problems arose in personal relationships, the client typically engaged in self-blame, increasing depressive symptoms, withdrawal, and cravings to drink alcohol. The client reported difficulty navigating her role as a nonparental figure to her girlfriend's children, as she often disagreed with her girlfriend's and husband's parenting style and discipline practices. She reported that her relationship with her girlfriend's husband became strained over time. She reported feeling tasks at home and income were not fairly distributed across adults in the household, as she provided primary income for the five-person family unit.

Financial stress increased during the pandemic, and the client began working over 50 hours per week. The client experienced work-related exhaustion and burnout. She reported difficulty maintaining her physical and mental health and felt she was unable to fully engage in her relationship with her girlfriend. Consequently, conflict increased within their relationship. To cope with relationship strain, the client avoided being home and worked more hours at work, creating a cyclical pattern of burnout, relationship conflict, and depressive and anxiety symptoms. The client typically blamed herself for problems in the relationship. The client endorsed negative cognitions about self (e.g., I am a failure; I must try harder to fix the problem) and the world (e.g., The system is hopeless). She reported feelings of intense anger, self-hatred, and periods of emotional numbness. She was unable to engage in future-oriented thinking and identify personal values and beliefs.

Despite the client's reported symptoms and stressors, the client maintained a strong sense of humor and positive beliefs about others (e.g., People generally have good intentions). The client reported a strong support system including family members, her girlfriend, and coworkers. She enjoyed engaging in hobbies, such as cooking and art. She looked forward to beginning new projects at work and furthering her position in the company. She maintained an open and hopeful perspective regarding therapy and learning new skills.

Based on information gathered during the assessment process and consultation with the student clinician's supervisor, the following diagnoses best fit the client's symptomology: ADHD, combined presentation; BPD; MDD, moderate severity, recurrent episodes; and alcohol use disorder in early remission. Prognosis was favorable, considering the client was highly engaged in previous therapy and open to learning new skills.

### *Feedback and Treatment Plan*

Assessment closed with a feedback session to discuss results, diagnoses, and future treatment with the client. First, psychoeducation was provided regarding the client's diagnoses. The client reported feeling understood and relieved, as she was finding answers to long-held questions (e.g., appropriate mental health diagnoses). The client was advised to revisit her psychiatrist for possible prescription medication changes due to assessment findings. Dialectical behavior therapy (DBT) was recommended, as DBT is particularly effective for BPD (Linehan, 2015). Last, affirmative care using the ESTEEM model was encouraged to promote positive cognitions about her trans and homoflexible identity (Burton et al., 2017). The client expressed openness and hopefulness regarding the recommended treatment plan, expressing a desire to begin DBT soon thereafter.

***Table 1.*** Example Items From Adaptation of the UnRESTS to Assess Gender and Sexual Identity Related Trauma and Discrimination

| Item | Interview Questions | Guide for Interviewer |
|---|---|---|
| **A** | **Introduction to the Interview (Total: 2 items)** | |
| A1 | Sometimes people have very bad experiences that cause feelings of stress or even trauma. Some people have several difficult experiences over a lifetime that are manageable individually, but together they lead to feelings to stress or trauma. I want to talk to you about some of your experiences of stress or trauma as it relates to your gender or sexual identity. *How would you describe your gender? How would you describe your sexual identity?*[1] | Note the difference between *gender and sexual identity.* |
| **B** | **Gender and Sexual Identity Development (Total: 7 items)** | |
| B1 | Are there other *gender identities* or *sexualities* that people assume you belong to based on your appearance? | |
| B2 | When was the first time you became aware of *gender or sexuality*? When was the first time you remember feeling different, excluded, or singled out because of your apparent *gender or sexual identity*? | |
| B3 | What sort of things, positive or negative, did you learn about your *gender or sexual identity* growing up? | E.g., messages from parents, peer-groups, media, stereotypes, etc. |
| B4 | I want to understand a bit more about how you feel about being a(n) [*gender or sexuality]* person.<br>2. Would you say that you have a lot of pride in being a [*gender or sexuality*] person and your accomplishments as a [*gender or sexuality*] person?<br>Very much (2) – Somewhat (1) – No (0)<br>5. Would you say that you think a lot about how life is affected by your *gender and/or sexual identity*?<br>Very much (2) – Somewhat (1) – No (0) | Assess for feelings of pride, stigma, and shame. Get an example for each item.<br><br>Gender & Sexual Identity Total Score: _____ |
| **C** | **Experiences of Direct Overt Discrimination (Total: 14 items)** | |
| C1 | Can you share with me a time you were *discriminated against because of your gender or sexual identity*? This could be something someone else either said or did to you. I am especially interested in any experiences where you were concerned about your safety and the event was very upsetting.<br><br>*Prompt if needed: What about being called names, being followed, harassed at work or school, etc.?* | |
| C2 | How old were you when this happened? | |
| C3 | What led you to believe this event happened due to your *gender or sexual identity*? | |
| C4 | How upset were you by this experience? Are you still upset by it? | Assess for feelings of anger, depression, anxiety, etc. |
| C5 | Did you fear for your life, health, or safety? How? | Determine if experience was a trauma. |
| C6 | How did you cope with this experience? | Assess for adaptive versus maladaptive coping strategies. |
| C7 | How did other important people in your life respond when you told them about this? | Assess for availability and use of support system. |

*—Table continued on next page—*

***Table 1*** *continued*

| F | Experiences of Covert Discrimination (Total: 7 items) | |
|---|---|---|
| F1 | Often minorities are the target of subtle or covert discrimination in the form of what we sometimes call "microaggressions." Microaggressions may be seemingly innocent comments, subtle or dismissive gestures, and tones that send condescending messages. How often would you say that you experience microaggressions based on *gender or sexual identity*? | |
| F2 | Can you give me a recent example? | |
| F3 | Can you give another example? | |
| F7 | Have you experienced any changes in your ability to manage microaggressions? | |
| **G** | **Gender & Sexual Identity Trauma Assessment (Total 25 items)** | |
| | Negative Changes in Cognition & Mood (Need 2 for PTSD diagnosis – count only 1 from #9 and/or #10) | |
| G10 a | Have you blamed yourself for your discriminatory experiences, or for things that have happened afterwards due to *discrimination based on gender or sexual identity*? | Yes No |

[1]Italicized words indicate edits or additions to the original UnRESTS.

## Discussion

Clinical standards in inclusive practice have changed rapidly in recent decades. In February 2021, the American Psychological Association (APA) published updated guidelines for providing competent care for sexual minority individuals, building on prior publications and resources (APA, 2021). There are separate guidelines on working with transgender and gender nonconforming individuals (APA, 2015). These guidelines are based on the theoretical frameworks of sexual minority stress theory, intersectionality, and affirmative care, all to address the unique needs of the LGBTQ+ population (Meyer, 2003; Crenshaw, 1989; Moradi & Budget, 2018). Considering the APA guidelines, the current responsibility of clinicians is to reduce stigma within clinical settings and to open conversations about LGBTQ+ stressors and trauma. This study attempted to bridge the gap between the APA guidelines and cognitive-behavioral therapies specifically, especially the need for culturally sensitive, evidence-based assessment and intervention. This study explored how the UnRESTS could be used to assess trauma specific to LGBTQ+ lived experiences. The client's self-report and our case conceptualization suggest this was a helpful and affirmative approach.

Consistent with extant literature and research, our client endorsed experiencing harassment and discrimination related to her LGBTQ+ identities despite having both a supportive family and social relationships. Although reported symptoms did not meet criteria for PTSD, understanding her experiences of discrimination and harassment was key to developing the case conceptualization and accurate diagnosis of BPD. The biosocial model of BPD (Burrock & Mellor, 2013; Lee et al., 2021) suggests that a chronically invalidating environment may promote symptoms relating to traumatic stress and personality disorders in conjunction with a biological sensitivity. For this client, the chronically invalidating environment was not the home, but the culture. This client reported multiple instances of bullying, abuse, and assault related to her sexual and gender minority identities, starting in childhood. While her home environment was healthy, it could not fully protect her from the stress of a world that saw and continues to see her as "other," an invalidating experience in itself. This is consistent with the minority stress model and epidemiological data investigating disparities in borderline diagnoses. Specifically, minority stress and associated rejection sensitivity would understandably increase emotion regulation needs and subsequent struggles with relationships and impulsivity. Further, given heteronormativity and structural stigma, these responses would be an understandable reaction to chronic invalidation of LGBTQ+ identity. We wholeheartedly concur with Rodriguez-Seijas et al. (2021) that these symptoms should be conceptualized as "expectable reactions to chronic stigma." Thus, we also recommend providers use structured interviews to assess borderline personality symptoms and transdiagnostic approaches, such as the alternative model of personality disorders, which better characterize the distinct, trait-like personality features associated with BPD (e.g., negative affectivity, disinhibition). Structured interviews are less subject to provider bias compared to information that may be elicited during an unstructured interview (Rodriguez-Seijas et al.). When working with a minoritized person, additional tools should be used to help evaluate the possible range of experiences on presenting symptoms. For example, in this study, the UnRESTS was used to evaluate experiences of trauma and discrimination; but, there are other self-report tools, such as the *Everyday Discrimination Scale* (Williams et al., 1997) and *Gender Minority Stress and Resilience Scale* (Testa et al., 2015). Understanding connectedness to marginalized communities can also help provide important context for developing

case conceptualization and identifying sources of strength. Information from these additional sources can help providers better understand the complex interaction between the chronic invalidation experienced by the LGBTQ+ community and symptoms that may be related to other biopsychosocial factors.

Continued efforts to adapt the UnRESTS should be done collaboratively with additional clinical expertise, research, and consultation. This team-based approach should focus on refining the items included in the UnRESTS and collecting normative data. The UnRESTS was somewhat challenging to adapt in order to address intersectionality. The client experienced both sexual and gender minoritized identities. We attempted to inquire about these identities side-by-side rather than rank-ordered and considered separately, but it is unclear if we were successful. We chose this approach to be consistent with the spirit of intersectionality, especially since it may be nearly impossible for some individuals to conclusively identify an experience of trauma or discrimination as related to only one aspect of their identity. For example, if this client was overlooked for a promotion in a male-dominated workplace, it is plausible that discrimination against the client's gender identity, sexual identity, relationship orientation, or a combination of these identities may have contributed. Further, requiring the client to sort these experiences could be emotionally invalidating, as this client, like many others, experiences multiple identities as a whole person in one integrated experience. This approach is also consistent with the findings from Salomaa and colleagues' work (2002) that, for the minoritized person, the difference between identity-based trauma and other experiences of trauma is minimal, as both experiences of trauma were perceived through a minority stress lens. This challenge highlighted one of the issues in conducting evaluations for individuals with multiple minoritized identities. Assuming one element of a client's identity as having precedence over another can be inherently invalidating, thus promoting the nonaffirming environment many clients initially find distressing. However, we recognize that from a precise, scientific perspective, providers would ideally evaluate experiences related to each discrete identity. Future work should focus on how to capture a multitude of minoritized identities rather than focusing on one at the exclusion of others.

### *Conclusion*

In conclusion, this case study demonstrates the importance of assessing LGBTQ-related trauma and discrimination in order to conduct an integrative case conceptualization. By intentionally asking questions about trauma and discrimination commonly experienced by LGBTQ+ individuals, this client felt better understood, validated, and supported. Additionally, investigating how the cultural climate created a chronically invalidating experience for this client was critical to diagnosis of BPD, as many providers misunderstand that abuse or trauma during childhood is a prerequisite for meeting criteria. It is essential to consider identities of clients and potential trauma-related symptoms, despite the limited definition of trauma according to current diagnostic standards. Otherwise, this client's experience of trauma and discrimination related to her

***Table 2.*** Selected Assessment Data

| Domain or Construct | Assessment | Score | Interpretation |
|---|---|---|---|
| Psychopathology | DIAMOND | Screened positive for 2/3 of conditions; met criteria for ADHD, GAD, and MDD | High distress with notable ADHD, anxiety, and depression symptoms |
| | Beck Depression Inventory | 24 | Moderate depression |
| | Dissociation Experiences Measure, Oxford | Numb/Disconnected subscale = 20 | Moderate symptoms |
| | BSL 23 | Mean 0.70 | Moderate severity symptoms |
| | McLean | 7 | Possible borderline personality disorder |
| | STAXI | State Anger – 80th percentile | Significant lability of anger |
| | | Trait Anger – 25th percentile | |
| | Conners | Self-report percentile ranks: 95-99th | Significant inattention (2 SDs above the mean) |
| | Barkley | Observer percentile ranks: 76-98th | |
| | | Total Score 96th percentile | Significant inattention (2 SDs above the mean) |
| Personality | MCMI | Scale C = BR 81 | Significant elevations on borderline, melancholic, dependent, avoidant, negativistic, and masochistic scales |
| | | Scale 2B = BR 83 | |
| | | Scale 3 = BR 81 | |
| | | Scale 2A = BR 80 | |
| | | Scale 8A = BR 78 | |
| Cognition | WAIS | Scale 8B = BR 77 | |
| | | FSIQ = 99th percentile | Superior FSIQ, average working memory |
| | | General ability = 99th percentile | |
| | | Working memory index = 50th percentile | |
| | DKEFS | Trail-making, Scaled score 13-15 | Significant inattention (2 SDs above the mean) |
| | | Tower, Scaled scores 4-13 | |

LGBTQ+ identities would have likely been overlooked.

## References


Alessi, E. J., Martin, J. I., Gyamerah, A., & Meyer, I. H. (2013). Prejudice events and traumatic stress among heterosexuals and lesbians, gay men, and bisexuals. *Journal of Aggression, Maltreatment, and Trauma 22*(5), 510-526. https://doi.org/10.1080/10926771.2013.785455

Alizaga, N. M., Aguayo-Romero, R. A., & Glickman, C. P. (2021). Experiences of health care discrimination among transgender and gender nonconforming people of color: A latent class analysis. *Psychology of Sexual Orientation and Gender Diversity*. http://dx.doi.org/10.1037/sgd0000479

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist 70*(9), 832-864. http://dx.doi.org/10.1037/a0039906

American Psychological Association Task Force on Psychological Practice with Sexual Minority Persons. (2021). *APA guidelines for psychological practice with sexual minority persons*. Retrieved from www.apa.org/about/policy/psychological-practice-sexual-minority-persons.pdf

Avery, A. M., Hellman, R. E., & Sudderth, L. K. (2001). Satisfaction with mental health services among sexual minorities with major mental illness. *American Journal of Public Health 91*, 990-991. http://dx.doi/org.10.2105/AJPH.91.6.990

Balsam, K. F., Rothblum, E. D., & Beauchaine, T. P. (2005). Victimization over the life span: A comparison of lesbian, gay, bisexual, and heterosexual siblings. *Journal of Consulting and Clinic Psychology, 73*(3), 477-487. https://doi.org/10.1037/0022-006X.73.3.477

Barkley, R. A. (2011). *Barkley deficits in executive functioning scale (BDEFS).* Guilford Press.

Barr, S. M., Snyder, K. E., Adelson, J. L., & Budge, S. L. (2021). Posttraumatic stress in the trans community: The roles of anti-transgender bias, non-affirmation, and internalized transphobia. *Psychology of Sexual Orientation and Gender Diversity*. http://dx.doi.org/10.1037/sgd0000500

Bauer, G. R., Scheim, A. I., Deutsch, M. B. & Massarella, C. (2014). Reported emergency department avoidance, use and experiences of transgender persons in Ontario, Canada: Results from a respondent-driven sampling survey. *Annals of Emergency Medicine 63*(6), 713-720. https://doi.org/10.1016/j.annemergmed.2013.09.027

Bernstein, D. P., & Fink (1998). *Childhood trauma questionnaire: A retrospective self-report: Manual*. Psychological Corporation.

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J., & Stevens, M. R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Bohus, M., Kleindienst, N., Limberger, M. F., Stieglitz, R., Domsalla, M., Chapman, A. L., Steil, R., Philipsen, A., & Wolf, M. (2009). The short version of the borderline symptom list (BSL-23): Development and initial data on psychometric properties. *Psychopathology, 42*(1), 32-39. doi: 10.1158/000173701

Bradford, J., Reisner, S. L., Honnold, J. A., & Xavier, J. (2013). Experiences of transgender-related discrimination and implications for health: Results from the Virginia transgender health initiative study. *American Journal of Public Health, 103*(10), 1820–1829. https://doi.org/10.2105/AJPH.2012.300796

Brooks, V. R. (1981). *Minority stress and lesbian women*. Lexington Books.

Burton, C. L., Wang, K., & Pachankis, J. E. (2017). Psychotherapy for the Spectrum of Sexual Minority Stress: Application and Technique of the ESTEEM Treatment Model. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/J.CBPRA.2017.05.001

Coker, T. R., Austin, S. B., & Schuster, M. A. (2010). The health and health care of lesbian, gay, and bisexual adolescents. *Annual Review of Public Health 31*(1), 457-477. https://doi.org/10.1146/annurev.publhealth.012809.103636

Conners C. K. Erhardt D. & Sparrow E. P. (1999). *Conners' adult ADHD rating scales (CAARS): Technical manual.* Multi-Health Systems.

Crenshaw, K. (1989). *Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics.* University of Chicago Legal Forum, 139-167.

Ellis, A. E. (2020). Providing trauma-informed affirmative care: Introduction to special issue on evidence-based relationship variables in working with affectional and gender minorities (AGMs). *Practice Innovations 5*(3), 179-188. http://dx.doi.org/10.1037.pri0000133

Federal Bureau of Investigation (FBI). (2019). *2019 hate crime statistics.* Retrieved from https://ucr.fbi.gov/hate-crime/2019/topic-pages/victims

Foa, E. B., McLean, C. P., Zang, Y., Zhong, J., Rauch, S… Kauffman, B. Y. (2016). Psychometric properties of the Posttraumatic Stress Disorder Symptom Scale Interview for DSM–5 (PSSI–5). *Psychological Assessment, 28*(10), 1159-1165. https://doi.org/10.1037/pas0000259

Flores, A. R., Langton, L., Meyer, I. H., & Romero, A. P. (2020). Victimization rates and traits of sexual and gender minorities in the United States: Results from the National Crime Victimization Survey, 2017. *Science Advances, 6*(40). https://doi.org/10.1126/sciadv.aba6910

Gold, S. D., Dickstein, B. D., Marx, B. P., & Lexington, J. M. (2009). Psychological outcomes among lesbian sexual assault individuals: An examination of the roles of internalized homophobia and experiential avoidance. *Psychological of Women Quarterly 33,* 54-66. https://dx.doi.org/10.1111/j.1471-6402.2008.01474.x

Hendricks, M. L. & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice, 43*(5), 460-467. https://doi.org/10.1037/a0029597

Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M., & Cohen, J. 2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. Professional Psychology, Research, and Practice, 39, 361-368. http://dx.doi.rg/10.1037/0735-7028.39.3.361

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The report of the 2015 US transgender survey. Washington, DC: National Center for Transgender Equality.

Jones, J. M. (2022, February 17). LGBT identification in US ticks up to 7.1%. *Gallup*. https://news.gallup.com/poll/389792/lgbt-identification-ticks-up.aspx

Keating, L., & Muller, R. T. (2020). LGBTQ+ based discrimination is associated with PTSD symptoms, dissociation, emotion dysregulation, and attachment insecurity among LGBTQ+ adults who have experienced trauma. *Journal of Trauma & Dissociation, 21,* 124-141. http://dx.doi.org/10.1080/15299732.2019.1675222

King, M., Semlyen, J., Tai, S. S., Killaspy, HJ., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay, and bisexual

people. *BMC Psychiatry, 8*, 70. http://dx.doi.org/10.1186/1471-244X-8-70

Lee, S. S. M., Keng, S.-L., Yeo, G. C., & Hong, R. Y. (2021). Parental invalidation and its associations with borderline personality disorder symptoms: A multivariate meta-analysis. *Personality Disorders: Theory, Research, and Treatment.* Advance online publication. https://doi.org/10.1037/per0000523

Linehan, M. M. (2015). *DBT skills training manual.* Guilford Press.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* Guilford Press.

Livingston, N. A., Berke, D., Scholl, J., Ruben, M., & Shipherd, J. C. (2020). Addressing diversity in PTSD treatment: Clinical considerations and guidance for the treatment of PTSD in LGBTQ populations. *Current Treatment Options in Psychology, 7*, 53-69. doi: 10.1007/s40501-020-00204-0

Mahowald, L., Brady, M., & Medina, C. (2020). *Discrimination and experiences among LGBTQ people in the US: 2020 survey results.* Center for American Progress. Retrieved from https://www.americanprogress.org/article/discrimination-experiences-among-lgbtq-people-us-2020-survey-results/

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior 36*(1), 38-56.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin 129*(5), 674-697. doi: 10.1037/0033-2909.129.5.674

Millon, T., Grossman, S., & Millon, C. (2015). *MCMI-IV manual*. Pearson.

Morton, M. H., Dworsky, A., Matjasko, J. L., Curry, S. R., Schlueter, D., Chávez, R., & Farrell, A. F. (2018). Prevalence and correlates of youth homelessness in the United States. *Journal of Adolescent Health, 62,* 14 –21. http://dx.doi.org/10.1016/j.jadohealth.2017.10.006

Richmond, K. A., Burnes, T., & Carroll, K. (2012). Lost in trans-lation: Interpreting systems of trauma for transgender clients. *Traumatology, 18*(1), 45–57. https://doi.org/10.1177/1534765610396726

Richmond, K., Burnes, T. R., Singh, A. A., & Ferrara, M. (2017). Assessment and treatment of trauma with TGNC clients: A feminist approach. In A. Singh & L. M. dickey (Eds.), *Affirmative Counseling and Psychological Practice with Transgender and Gender Nonconforming Clients* (pp. 191–212). American Psychological Association. https://doi.org/10 .1037/14957-010

Rodriguez-Seijas, C., morgan, T. A., & Zimmerman, M. (2021). Is there a bias in the diagnosis of borderline personality disorder among lesbian, gay, and bisexual patients? *Assessment, 28*(3), 724-738. https://doi.org/10.1177/1073191120961833

Russell, S. T., & Fish, J. N. (2016). Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. *Annual Review of Clinical Psychology, 12*(1), 465-487. https://doi.org/10.1146/annurev-clinpsy-021815-093153

Rutherford, L., Stark, A., Ablona, A., Klassen, B. J., Higgins, R … Lachowsky, J. (2021). Health and well-being of trans and non-binary participants in a community-based survey of gay, bisexual, and queer men, and non-binary and Two-Spirit people across Canada. *PLoS ONE 16*(2). https://doi.org/10.1371/journal.pone.0246525

Salomaa, A. C., Livingston, N. A., Bryant, W. T., Herbitter, C., Harper, K., Sloan, C. A., Hinds, Z., Gyuro, L., Valentine, S. E., & Shipherd, J. C. (2022). A bottom-up approach to developing a unified trauma-minority stress model for transgender and gender diverse people. *Psychological Trauma: Theory, Research, Practice, and Policy*. http://dx.doi.org/10/1037/tra0001373

Shires, D. A., & Jaffee, K. (2015). Factors associated with health care discrimination experiences among a national sample of female-to-male transgender individuals. *Health & Social Work, 40*(2), 134– 141. https://doi.org/10.1093/hsw/hlv025

Sloan, C. A., Berke, D. S., & Shipherd, J. C. (2017). Utilizing a dialectical framework to inform conceptualization and treatment of clinical distress in transgender individuals. *Professional Psychology: Research and Practice 48*(5), 301-309. http://dx.doi.org/10.1037/pro0000146

Spielberger, D.C. (1999). *State trait anger expression inventory-2, professional manual*. PAR.

Sturrock, B., & Mellor, D. (2014), Perceived emotional invalidation and borderline personality disorder features: A test of theory. *Personality and Mental Health, 8*, 128-142. https://doi.org/10.1002/pmh.1249

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the Gender Minority Stress and Resilience Measure. *Psychology of Sexual Orientation and Gender Diversity, 2*(1), 65-76.

The Trevor Project. (2021). National survey on LGBTQ youth mental health 2021. Retrieved from https://www.thetrevorproject.org/survey-2021/.

Theiling, J., & Petermann, F. (2014). Neuropsychological profiles on the WAIS-IV of adults with ADHD. *Journal of Attention Disorders, 20*(11), 913-924. https://doi.org/10.1177/1087054713518241

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., Schnurr, P. P. (2013). *The PTSD checklist for DSM-5 (PCL-5) – Standard.* [Measurement instrument]. Retrieved from https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Wechsler D. (2008). *WAIS-IV technical and interpretive manual* (4th ed.). Pearson.

Weschler, D. (2009). *WMS-IV technical and interpretive manual* (4th ed.). Pearson.

Williams, M. T., Metzger, L. W., Leins, C., DeLapp, C. (2018). Assessing racial trauma within a DSM-5 framework: The UConn Racial/Ethnic Stress and Trauma Survey. *Practice Innovations, 3*(4), 242-260. http://dx.doi.org/10.1037/pri0000076

Williams, D. R., Yu, Y., Jackson, J. S., & Anderson, N. B. (1997). Racial differences in physical and mental health: Socioeconomic status, stress, and discrimination. *Journal of Health Psychology, 2*(3), 335-351.

Zanarini, M. C., Vujanovic, A., Parachini, E. A., Boulanger, J. L., Frankenburg, F. R., & Hennen, J. (2003). A screening measure for BPD: The Mclean screening instrument for borderline personality disorder (MSI-BPD). *Journal of Personality Disorders, 17*(6), 568-573.

. . .

A draft of this case study was shared with the client before submitting to publication. We thank her for her openness and bravery in life and in scholarship.

We have no conflicts of interests to disclose. Dr. Anderson's work was supported by a grant from the National Institute on Alcohol Abuse and Alcoholism (5K01AA026643). The content is solely the responsibility of the authors and does not necessarily represent the official views of the funding agency.

***Correspondence to*** Jenna Wolff, 501 N Columbia Rd Stop 8380,Grand Forks, ND 58202-8380; j.wolff@und.edu (or RaeAnn Anderson: raeann.anderson@und.edu).