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Trauma-Informed and Affirmative Mental Health Practices With LGBTQ+ Clients

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People with diverse sexual orientations, gender identities, and gender expression are at greater risk for trauma, discrimination, and victimization than heterosexual and cisgender populations. Trauma-informed care (TIC) provides a framework for providing lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ+) mental health services. Substance Abuse and Mental Health Services Administration (SAMHSA)'s principles of TIC guide practitioners to create safety, trust, transparency, collaboration, and empowerment in helping relationships, and to ensure that services have cultural and gender relevance. This article first explores the role of trauma in contributing to behavioral health concerns presented by LGBTQ+ clients. The application of TIC to mental health counseling and social services for LGBTQ+ clients will then be described, with specific suggestions for translating TIC principles into affirmative practice. Through the lens of trauma, clinicians can improve clinical case conceptualization and effective treatment strategies for LGBTQ+ clients.

Keywords: trauma, trauma-informed care, LGBTQ+, therapy, counseling

It has become widely accepted in the mental health fields that a majority of people experience some kind of trauma in their lifetime (Bloom, 2000; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Being a member of a minority group can expose individuals to a unique set of traumagenic experiences (Meyer, 2003). People with diverse sexual orientations, gender identities, and expressions are more at risk for bias, discrimination, harassment, and violence than heterosexual and cisgender populations (Elze, 2019). The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) proposed that mental health professionals and service providers must develop an approach to care that is "based on the knowledge and understanding of trauma and its far-reaching implications" (p. 2).

Trauma can involve distant events like adverse childhood experiences (ACEs) (Felitti et al., 1998), or disruptive and frightening incidents in adulthood such as victimization, natural disaster, accidents, serious illness, or an unexpected loss. Trauma-informed care (TIC) delivers services in a way that incorporates evidence about the prevalence, neuroscience, and impact of trauma on thoughts, feelings, behavior, health, and psychosocial well-being (Bloom, 2013; SAMHSA, 2014). Early advocates for TIC recognized that social and psychiatric services designed to help clients could actually re-traumatize them if providers engaged in paternalistic or disempowering practices (Bloom, 2013; Harris & Fallot, 2001). Mental health care should provide a sanctuary from harm—a place where it is safe to be vulnerable and to heal (Bloom, 2013). Trauma-informed services can help clients build resilience (the ability to effectively adapt to stress and adversity in a healthy and integrated way over the passage of time) (Southwick et al., 2014) and post-traumatic growth (positive psychological transformation due to past challenges) (Tedeschi et al., 2015).

The purpose of this article is to describe the role of trauma in contributing to behavioral health concerns presented by lesbian, gay, bisexual, transgender, and queer (LGBTQ+) clients. After a brief overview of the framework of TIC, its application to mental health counseling and social services for this client population will be detailed. Finally, specific suggestions will be offered for translating TIC principles into practice with LGBTQ+ clients.

Understanding and Defining Trauma

Trauma is not simply a discrete incident; it is often a web of events, experiences, and effects by which individuals define and organize their world view, self-narrative, and sense of identity (Bloom, 2013; SAMHSA, 2014). *Trauma* is described as a direct or observed event that threatens one's sense of physical or psychological safety, produces feelings of anxiety and helplessness, and can compromise an individual's coping skills and well-being (American Psychiatric Association, 2013; Bloom, 2013; SAMHSA, 2014). Trauma exposure can be isolated or repetitive, and traumas vary in their severity and their impacts (SAMHSA, 2014). Many people endure chronic, cumulative, and multiple traumas, which elevate risk for subsequent psychiatric and medical illnesses (Anda et al., 2006; van der Kolk, 2014). Each person has a subjective experience of traumatic stressors and interpersonal trauma; many individuals are quite resilient and thrive despite difficult circumstances.

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Toxic stress occurs when prolonged exposure to traumagenic conditions overloads the body with hormones designed to prepare the body to respond to danger (fight-flight-freeze response) (Bloom, 2013; van der Kolk, 2006). When the nervous system is constantly over-activated, these physiological responses can alter the brain's architecture, hindering the integration of thoughts, feelings, and experiences, and leading to emotional or behavioral dysregulation (Bloom, 2013; van der Kolk, 2006). When trauma is ongoing, some people develop unhealthy ways of thinking about themselves and the world around them. They may engage in maladaptive coping behaviors in response to the demands of an environment that feels threatening (Bloom, 2013). Thus, presenting problems can sometimes represent trauma symptoms in disguise.

Minority Stress Theory

According to minority stress theory (Meyer, 2003), members of sexual and gender minority groups are often marginalized, stigmatized, and discriminated against. These experiences are traumagenic, increasing risk for mental health problems. Minority stress can be repetitive and chronic within interpersonal, institutional, and cultural contexts (Meyer, 2015). LGBTQ+ individuals are at heightened risk for victimization and other stressors such as rejection, stereotyping, and de-valuation (Alessi & Martin, 2017). Commonly reported deleterious outcomes include relationship disruption, job loss, homelessness, financial concerns, and medical problems (Alessi & Martin, 2017). When stigma, shame, and insecurity are internalized, LGBTQ+ individuals may feel unable to live authentically, which can contribute to negative psychological consequences (Pachankis, 2007).

Empirical evidence indicates that the disproportionate levels of distress endured by LGBTQ+ individuals can lead to Post-Traumatic Stress Disorder (PTSD) symptoms (Alessi et al., 2013; Coker et al., 2010; Russell & Fish, 2016). The criteria for PTSD narrowly define trauma as a life-threatening event, serious injury, or sexual violence (American Psychiatric Association, 2013). Thus, many situations causing traumatic stress (including many sources of minority stress) do not explicitly meet the first criterion for PTSD even when a person displays its clusters of persistent and distressing symptoms. These indicators include negative mood states, insomnia, irritability, intrusive thoughts or memories, avoidance of triggers, emotional dysregulation, hypervigilance to environmental cues, and distorted cognitions (Friedman, 2013). It is therefore critical that practitioners be attuned to the unique convergence of sexual/gender minority status and the traumatizing impact of stressors.

Trauma Exposure in LGBTQ+ Populations

In the early 1990s, researchers (Felitti et al., 1998) developed a tool to measure ACEs. Compared to the general population, LGBTQ+ clients are more likely to have a history of childhood trauma than the general population (Craig et al., 2020; Elze, 2019; Merrick et al., 2018). In a study of 248,934 adults in 23 states, the average ACE scores for gay/lesbian and bisexual participants were 2.2 and 3.2, respectively, compared to an average of 1.6 for those identifying as "straight" (Merrick et al., 2018). Data collected in three states (Maine, Washington, Wisconsin; $n = 20{,}060$) via the Behavioral Risk Factor Surveillance System (BRFSS) revealed that gay and lesbian respondents with higher ACE scores were more likely to report higher rates of medical and mental illness (Andersen & Blosnich, 2013). A recent study (Craig et al., 2020) found that LGBTQ+ youth ages 14–18 ($n = 3{,}508$) reported multiple ACEs ($M = 3.14$, $SD = 2.44$), with 39% experiencing 4 or more. High rates of ACEs increase risk factors for psychosocial problems in adulthood, and LGBTQ+ individuals have higher rates of homelessness, suicidality, physical disease, and substance dependence (Andersen & Blosnich, 2013).

Microaggressions are subtle forms of verbal or social discrimination or stereotyping, and though they are often unintentional, they are harmful to the recipient (Nadal, 2013). Microaggressions occur in the form of communications and interactions at school or in the workplace, with friends and family, or with strangers (Austin et al., 2019; Nadal, 2013). They can involve pejorative words, derogatory language, dismissive statements, pathologizing questions, or labeling. Even "positive" stereotypes (e.g., gay men are more compassionate) can be problematic, as they reinforce assumptions that fail to consider individuality (Goldstein & Davis, 2010). Emerging data suggest that consistent and chronic exposure to microaggressions can have detrimental consequences and evoke similar symptoms to severe traumatizing events (Nadal, 2013; Robinson & Rubin, 2016).

Human rights violations against LGBTQ+ people are also common across the globe, and include hate crimes, sexual violence, and traumatizing conversion therapies. In many states, laws do not provide protection from discrimination in housing, public accommodations, and health care, which can undermine feelings of safety (Elze, 2019). In some cases, discriminatory legislation such as "bathroom bills" and military restrictions has been actively introduced. LGBTQ+ people have endured oppression, discrimination, and microaggressions throughout history which remains a prominent problem (Austin et al., 2019; Elze, 2019). This injustice has its roots in cultural and structural transphobia, homophobia, and cisgenderism. After many years of advocacy, it was only in 2020 that a U.S. Supreme Court ruling included protections from employment discrimination for LGBTQ+ individuals. But equally troubling is a 2020 decision by the U.S. administration to roll back healthcare protections for transgender individuals, which re-opened the door to discrimination and denial of services by helping professionals, requiring an executive order by newly elected President Biden to reverse course. Outside of the U.S., some countries incarcerate or execute persons who express gender or sexual diversity. Taken together, LGBTQ+ clients are likely to endure a range of traumagenic experiences that have potential health and mental health impacts, highlighting the need for TIC (Sciolla, 2017).

What Is TIC?

TIC was introduced in the 1990s as a model of sanctuary (safe space) for people seeking psychiatric help for PTSD resulting from adversity and trauma (Bloom, 2013). Sanctuary can counteract the damaging impacts of trauma by creating physical, interpersonal, and moral safety within a social environment that ensures trust, collaboration, choice, and empowerment in the delivery of mental health services (Bloom, 2013). The terms *TIC* and *trauma-informed practice* are often used interchangeably, but there is an important distinction: "*Practice* is more accurately applied to clinical intervention, while *care* refers to the organizational context within which services are provided to clients" (Knight, 2019, p. 4). TIC does not deliver specific trauma-

resolution treatments per se (Butler et al., 2011). It offers a view of clients' presenting problems through the lens of trauma, therefore transcending any particular method of intervention (Butler et al., 2011; Knight, 2015; Levenson, 2020). TIC is an integrative framework to augment existing evidence-based interventions by offering a holistic understanding of clients' problems, strengths, and needs.

SAMHSA's "Four Rs" of TIC (2014, p. 9) suggest that programs and practitioners can become a safe refuge when they (a) *realize* that trauma and its impacts are extremely common and widespread, and that various paths for recovery exist; (b) *recognize* that problematic behaviors are often manifestations, signs, and symptoms of trauma; (c) *respond* to consumer needs by incorporating knowledge about trauma into policies and practices; and (d) actively, intentionally, and strategically *resist re-traumatization* in the helping relationship or service setting. Similar to Bloom's sanctuary model, SAMHSA (2014) provides six guiding principles of TIC: safety, trust and transparency, peer support, collaboration, empowerment, and awareness of cultural, historical, and gender-based trauma.

Evidence-based practices (EBP) begin by consolidating theoretical and empirical knowledge to build a foundation for effective treatment protocols, and then combining research evidence with clinical expertise and patient characteristics (APA Presidential Task Force on Evidence-Based Practice, 2006). Interdisciplinary literature provides a base of support for the use of TIC: the disproportionate prevalence of adversity in samples of LGBTQ+ persons (Merrick et al., 2018), developmental psychopathology and the neuroscience of trauma (Cicchetti & Banny, 2014; Shonkoff et al., 2012; van der Kolk, 2005), and the principles of effective psychotherapy (Wampold, 2015). It can be a challenge, however, to translate TIC principles into operationalized outcomes and measures of effectiveness (Berliner & Kolko, 2016). Experimental designs, which require rigid replicable conditions, do not lend themselves easily to TIC, which entails flexible responses to client needs as they emerge in the treatment setting.

TIC may not seem all that different from good clinical practices in which therapists listen with non-judgmental compassion while emphasizing client strengths and resilience, or affirmative practices that allow LGBTQ+ clients to authentically explore, share, and express all aspects of themselves and their lives. Affirmative evidence-based treatments exist to help LGBTQ+ clients cope with minority stress and achieve self-acceptance by validating their distress, empowering their authenticity, and encouraging them to embrace a more positive construct of personal identity (Austin & Craig, 2015; Craig & Austin, 2016; Crisp & McCave, 2007; Panchankis, 2014). These ideas are concordant with the goals of TIC, as affirmation is an essential aspect of fostering safety and trust. Re-traumatization of clients can be triggered (accidentally and unknowingly) by disempowering conditions in the service environment, agency procedures, or interactions with staff (Butler et al., 2011; Harris & Fallot, 2001; Knight, 2015).

Clients often seek counseling for a crisis or concern that is seemingly separate from other traumatic events in their life history (Butler et al., 2011; Knight, 2015; Levenson, 2017). Some clients may not define certain adverse experiences as traumatizing, and some agencies do not routinely screen for trauma. These factors complicate a practitioner's ability to accurately assess and address the presentation of symptoms. Importantly, integrative trauma-informed practice helps a clinician to consider adverse experiences when conceptualizing presenting problems. As well, interpreting clients' in-treatment behaviors through the trauma lens can help us respond more effectively within the therapeutic process. When clinicians are not attuned to the complexity of trauma, their ability to effectively engage clients can be compromised, impeding successful treatment planning and client progress (Butler et al., 2011; Knight, 2015; Levenson, 2017). This may be particularly true for LGBTQ+ clients whose traumatic experiences may differ in important ways from those of their cisgender and heterosexual counterparts (Meyer, 2003, 2015).

Bloom (2013) emphasized reducing stigmatization by shifting from a symptom-oriented model of "What's wrong with you?" to the curious inquiry of "What happened to you?" Reframing maladaptive coping as survival techniques serves to de-pathologize trauma-related symptoms and behaviors. This may be especially important for members of the LGBTQ+ community who have faced systemic and structural discrimination within a range of social service and health care contexts, including the pathologization of their identities (Elze, 2019). Interactions focused on reducing stigma can help with case conceptualization (Ridley et al., 2017; Sperry, 2016), therapeutic engagement, and bolstering of resilience among LGBTQ+ clients. Case conceptualization of LGBTQ+ clients and their therapeutic needs should be considered within the context of their collective past experiences of trauma and minority stressors.

Framework for TIC With LGBTQ+ Clients

Bloom described *Safety, Emotions, Loss, and Future* (SELF) as the "four fundamental domains of disruption that can occur in a person's life ... Victims of overwhelming life experiences have difficulty staying safe, find emotions difficult to manage, have suffered many losses, and have difficulty envisioning a future" (Bloom, 2007, p. 14). Given LGBTQ+ clients' disproportionate rates of exposure to traumagenic events, these concepts are particularly applicable. Bloom's sanctuary model and SAMHSA's guidelines offer important ideas for conceptualizing mental health services with LGBTQ+ clients, who have often experienced stigma, discrimination, and trauma across a range of interpersonal and structural contexts.

As a result of homophobic and transphobic attitudes, beliefs, and behaviors that permeate society, LGBTQ+ clients often experience disruptions in the domains of the SELF (Bloom, 2007). LGBTQ+ clients experience threats to their physical and emotional *safety* through discriminatory and abusive actions that occur episodically or acutely (Hatzenbuehler & Pachankis, 2016). Many of these experiences occur in the home during childhood or adolescence and continue across settings as bias-based victimization (Mustanski et al., 2011). Constantly feeling under threat can cause hypervigilant monitoring and *emotional* dysregulation (van der Kolk, 2014), and LGBTQ+ persons may lack supportive spaces that allow them to safely process difficult emotions arising from these experiences. Many LGBTQ+ individuals have experienced significant and painful relationship *losses* when they "come out," including rejection from family, friends, and their religious or social communities (Wise et al., 2019). High rates of suicidality may indicate that LGBTQ+ individuals have a hard time sustaining hope and envisioning a positive *future*, especially if they lack role models of successful and happy LGBTQ+ adults (Hirsch et al., 2017).

TIC can build resilience in the face of these challenges. To apply TIC to this population, we will translate SAMHSA's six guiding principles into practices that (a) conceptualize LGBTQ+ client problems, strengths, and coping strategies through the lens of trauma and resilience and (b) enable trauma-informed responses to create an affirming, safe, trustworthy, collaborative, and

Table 1
Trauma-Informed Practices for Working With Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ+) Clients

Case example	Non-TIC approach	LGBTQ+ affirmative TIC approach
Safe spaces A therapist who runs a parenting class must complete an initial intake assessment with all new clients, which requires asking many sensitive questions about presenting problems, family history, and relationship status. The client is a queer-identified person.	The therapist is trying to gather information in a hetero/cis-normative way without tuning in to different definitions of family, family structures, and diverse relationships. Client seems guarded and wary.	The therapist asks about client's preferred pronouns, shares the purpose of the assessment, and asks open-ended affirming questions that allow the client to self-define and describe important identity, family, and relationship concepts.
Trust and transparency Facilitator is running a counseling group with LGBTQ+ youth. One of the clients walks into the group room and makes a comment that this "doesn't seem like a space for us."	The facilitator responds by saying "I'm sorry you feel that way, but this is our standard group room and other youth have not had a problem with it in the past. Hopefully you will get more comfortable once we start to get to know one another."	The facilitator responds by sheepishly saying, "you know, you're right!" He asks the clients for suggestions to help redesign the room so they feel welcome. After getting their input, he goes to a store, and decorates the room with LGBTQ+ specific posters, rainbow pillows, a lamp with softer lighting, and stress toys (e.g., fidget spinners, squeeze balls). The room feels more welcoming, age appropriate, inclusive, and affirming.
Peer support A 22-year-old client began therapy to explore issues related to gender identity. Six months ago, the client began identifying as a transgender woman and often expresses the need to begin her social and medical transition. Client recently came out to family and siblings who do not support her identity or transition. Client has started to express feelings of guilt and self-doubt. In therapy, she often seems to "change her mind," one week being certain of her transition goals, the next week questioning them.	The therapist becomes frustrated and feels like they are not making progress. In response to this perceived lack of progress, the worker tries to focus on setting goals and objectives with a firm timeline for transition-related steps and outcomes.	The therapist patiently starts where the client is, validating how confusing it can be. The therapist helps the client to find online peer support resources for trans women in transition. Through positive online interactions with other trans people, the client begins to explore her fears about the stigma and rejection she might face as she transitions. Online, she talks with peers about her ambivalence, and is helped to work through her self-doubt. She brings back to her therapist what she learned from her online supports, and then is more able to prioritize goals around talking to her parents, putting her own needs above family members' needs, and examining the fears attached to transitioning.
Collaboration A Latinx queer-identified adolescent was referred to the school social worker after a significant number of absences from physical education class. The first thing they say to the white social worker is: "I am not going to talk to you. You will not understand me!"	The school counselor tries to help by calmly explaining choices and consequences: "If you choose not to go to your PE class, you can't graduate. It's a state requirement. Don't you want to graduate?"	The school counselor tries to foster a collaborative connection with the youth in the following way: "I can see you are angry right now, and I know that we seem very different from one another. I get that it's hard to talk to strangers about personal things. I really want to understand what you are going through and how I can support you. Would you be willing to try to help me understand why you haven't wanted to attend your class? I don't want to see you get in trouble. I'm wondering if you are experiencing any challenges in the locker room?"
Empowerment, voice, and choice A middle-aged White lesbian mother of a 10-year-old child seems wary and guarded during her clinical assessment associated with an upcoming court hearing to restore shared custody of her child. The client participated in substance abuse treatment and has been living in a recovery house for a year with only supervised visits. During the assessment, the client answers with one-word responses. She seems depressed and appears to lack insight into the gravity of the situation.	The social worker views the client as unmotivated, resistant, and unable or unwilling to provide proper care to her child. This leads to a recommendation for continued full-time custody for the other parent.	The social worker wonders out loud if mother's caution in sharing is based on past negative experiences with workers who seemed judgmental about her sexual orientation and addiction, as well as shame about her own perceived failings as a mother. The worker praises the mother's success in maintaining sobriety, and asks: "What would you like me to know about your parenting goals, and how to convey to the court your commitment as a mom? Are you afraid the court will make an issue of you being a lesbian? How can I help you advocate for yourself with regard to your identity and parenting?"

Table 1 (*continued*)

Case example	Non-TIC approach	LGBTQ+ affirmative TIC approach
Cultural relevance and gender responsiveness A Black man comes to counseling to discuss his failing marriage due to his infidelity. He says his wife is very hurt and has begged the husband to help her understand why he isn't happy with her. He breaks down and sobs, admitting he's attracted to males and has been secretly meeting men on chat apps. He is distraught that he "could never live as a gay man" and believes he's trapped in an unsatisfying life.	The therapist validates and asks questions but reassures him that being gay is much more accepted in society than it used to be. The therapist tries to be supportive by reminding the client that there are many options, including divorce.	The therapist validated the stress of this dilemma and begins to explore the client's experiences with racism, family messaging around diversity, and facing micro-aggressions as a minority. Together they explore perceptions of gay men in the Black community and of Black experiences in the gay community, as well as the client's fears and guilt about coming out to his wife and family.

Note. Based on the six principles from: SAMHSA (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf: Substance Abuse and Mental Health Services Administration. TIC = trauma-informed care.

empowering therapeutic encounter. Table 1 offers clinical examples of responses in each domain that attend to the unique experiences of LGBTQ+ clients.

Translating TIC to Affirmative LGBTQ+ Practices Using SAMHSA's Principles

Safety

Psychological Safety

Safe relationships are consistent, reliable, accepting, and nonshaming, with boundaries that are clear but not unnecessarily rigid (Levenson, 2020). LGBTQ+ clients who have experienced discrimination, rejection, or victimization are more likely to view the world and other people as unsafe. Asking for help can be anxiety provoking, especially for stigmatized groups or when earlier help-seeking attempts have been futile or dangerous (Pattyn et al., 2014). Practitioners should recognize that disclosing one's sexual orientation and/or gender identity can be stressful, and an unintentionally inappropriate response from a therapist could be detrimental. The clinical atmosphere should establish the client as the expert in their own life, identity, and experiences. Therapists less familiar with LGBTQ+ issues can simply ask open-ended questions, listen, and be willing to learn from their clients: "Tell me more about what it's been like for you? What do you want me to know that will help me understand your experience?"

It is important to remember that clients may seek services for a variety of presenting problems, and their intersection with LGBTQ+ issues may not be apparent until a safe therapeutic alliance has been formed. Your relationship with the client may be the first time there is more to be gained than lost by revealing hidden thoughts and feelings. Teens and young adults might be unsure of the reaction they might receive from others, and therapy can be a way to test a disclosure or question about their emerging identity. For others, therapy might allow the careful unveiling of acknowledgment even to oneself. Given the traumatic impact of identity-based rejection for LGBTQ+ populations (Elze, 2019; Reisner et al., 2016), promoting safety requires that practitioners demonstrate a proactive affirming stance to honor and celebrate sexual and gender diversity: Intake and assessment forms should include a range of diverse sexual orientations and gender identities; the use of the names and pronouns should be consistent with a client's gender identity; and prominent displays of support for diversity should be visible.

Creating psychological safety begins with making it clear that the provider is comfortable working across the spectrum of sexual orientations and gender identities. Once sufficient rapport and safety have been established, the trauma-informed and affirmative therapist should support disclosures and explore minority stressors such as bullying, discrimination, and harassment (Craig & Austin, 2016). The emergence of gay/straight alliances in school settings exemplified how heterosexual and cisgender allies should project support and advocacy for the oppressed group and also for human rights in general (Goldstein & Davis, 2010). Allyship can take the form of a diversity and inclusion statement shared automatically with all clients when establishing informed consent. The clinician can verbalize and demonstrate that clients determine the priority and pace of treatment goals, and the appropriateness of self-identifying, coming out to others, and/or taking steps to live authentically. The therapist does not jump ahead of the client, nor do they hold them back. They allow client self-determination to drive the process regardless of the age of client. Autonomy helps clients to feel safe and in control of their own lives and the information they share.

Physical Environment

Services for LGBTQ+ populations are provided in a range of settings (e.g., mental health centers, schools, health clinics, hospitals, public social service agencies, and private counseling practices). Physical spaces for service provision should strive to have a warm and welcoming milieu with visible representation of LGBTQ+ symbols (e.g., PRIDE flags or posters, books that feature the lives and experiences of LGBTQ+ people) as well as easily accessible, gender neutral restrooms (National Resource Center for Mental Health Promotion and Youth Violence Prevention, 2019). Of course, in some settings, clinicians do not have much control over the physical space or décor. In such cases, being culturally responsive requires taking the initiative to fill in the gaps ignored by the agency. The practitioner can advocate for evidence of acceptance of diversity that is visible to consumers of services. Regardless of the modality of service provision, safe spaces include a workforce trained to reflect an organizational culture of affirmative messaging from the top–down and from the bottom–up (Eckstrand et al., 2017). Trauma-competent staff can enhance feelings of security by creating an environment that is comfortable, inclusive, and communicates that clients are important. One does not have to be a therapist to be therapeutic!

Other Safe Spaces

Practitioners can help connect clients to social media and online communities, which may feel safer than real-life spaces for some clients (and in crisis, online supports may be sought before risking disclosure offline) (Craig et al., 2015). A feeling of safety cultivated in online LGBTQ+ communities can be a sharp contrast to the stigma or social rejection suffered in some homes and communities (Austin et al., 2020). Practitioners should be ready to share online support resources that decrease isolation, normalize feelings, and offer camaraderie, role models, and information. Although many online resources exist, and therapists should search for those that best fit their clients, here are several examples: https://www.thetrevorproject.org/education/; http://www.glnh.org/.

When helping clients find safe spaces, clinicians should be aware of diverse constellations of "family" within the LGBTQ+ community (Hull & Ortyl, 2019). Many create new "chosen families" comprised of other LGBTQ+ people, including partners and supportive allies. These relationships provide familial comfort and support, restore a sense of trust, and offer healing. It is important for the trauma-informed practitioner to acknowledge and encourage the importance and role of chosen family: they foster the development of healthy, safe, and positive relational skills, and become part of the client's affirming network and support system.

Trustworthiness and Transparency

ACEs and early relational trauma by parents or family members violate basic assumptions of trust in interpersonal relationships (Birrell & Freyd, 2006). Betrayal trauma can leave a client feeling afraid, alone, guilty, shamed, unwanted, betrayed, threatened, belittled, or ignored. Protective strategies (e.g., hyper-vigilance, isolation, compartmentalization of identity, distancing from others) may have been adopted to cope with an unsafe environment. Later, these coping skills can become maladaptive, and cognitive schemas of mistrust or self-blame can form a basis for dysfunctional relational patterns (Bloom, 2013; van der Kolk, 2006; Young et al., 2003). LGBTQ+ persons also sometimes encounter situations in which they are mistreated, dismissed, or silenced by professionals. These experiences can further erode trust and cause clients to be wary about engaging in mental health services, regardless of the reason for seeking help. Therefore, relationships with helpers who are trustworthy, strengths-based, and identity-affirming can become corrective relational experiences (Birrell & Freyd, 2006).

On the other hand, not all LGBTQ+ clients have experienced trauma. Some may simply need help clarifying their thoughts and feelings or accepting themselves and their lives as different from what might be "expected" based on a cisgender and heteronormative society. They might need support re-defining their personal vision of the future. A trusting relationship with a helping professional can guide a client through a process of introspection, exploration, and self-determinative decision-making. The therapist might ask: "Tell me what you need from me ... how can I help you sort through your questions, thoughts and feelings?" The goal is to make the therapy encounter feel safe and validating.

Trust of the therapist will be earned if we demonstrate trustworthiness over time. The burden of trust is on the therapist. By eliminating ambiguity and vagueness, clients can anticipate what is expected of them and what they can expect from their service providers (Harris & Fallot, 2001). Say what you mean and mean what you say. Be clear about expectations and ask clients what they want from you. We gain clients' trust by showing that we can listen with curiosity and compassion and without judgment. Consistent boundaries are important, with respectful interactions that allow the processing of therapeutic ruptures if they occur (Safran et al., 2011).

In this way, the counseling relationship itself is a tool for healing. For instance, a client came to a session sullen and quiet, which was unusual. When the clinician probed, the client said that last session, they felt that the therapist ignored or changed the subject related to something they brought up in therapy. The client had interpreted that to mean that the therapist was uncomfortable with the topic because it was related to their non-binary identity. "Last week I brought something up and I felt like you ignored it and took our conversation in a different direction ... I felt angry, shamed, and dismissed ... Why did that happen? It was important to me to discuss the topic, and I wanted you to help me process that." The trauma-informed therapist will non-defensively go back to the topic, but then also return to the process. "I'm glad you told me you felt dismissed. Why do you think you didn't bring it up at the time? How did it feel to let me know how you felt today? Are there other people in your life you feel dismissed by? What do you usually do when that happens?" Therapeutic relationships can have rupture and repair if there is an open opportunity to explore dynamics within the therapeutic relationship. When clinicians make mistakes, we should own them and model healthy communication or conflict resolution. As well, it is helpful to focus back on the relational process, patterns, and themes that might generalize to other areas of the client's life (Safran et al., 2011).

Affirmation and Authenticity

The "helping" professions have a history of adopting an adversarial and pathologizing stance toward sexual and gender diversity. For instance, the DSM included homosexuality among its disorders until 1973, and gender diversity (i.e., Gender Identity Disorder) until 2013. Advocacy efforts to bring about de-pathologizing changes to the DSM were met with resistance by a number of mental health leaders (Davy, 2015; Drescher, 2015). Approaches rooted in homo- and trans-phobia, and hetero- and cis-normativity, along with unrecognized implicit bias, can undermine clients' ability and willingness to build trust in the therapeutic relationship and/or in the services being offered (McDowell et al., 2020).

Stigma and minority stress can discourage help-seeking behavior (Pattyn et al., 2014). Individuals who conceal their stigmatized identity must cope with the continuous threat of being discovered, which can lead to four types of psychological responses: cognitive (vigilance, suspiciousness, preoccupation), affective (shame, guilt, anxiety, depression), behavioral (social avoidance, impaired relationships), and poor self-evaluation (identity ambivalence, negative view of self, diminished self-efficacy) (Pachankis, 2007). Practitioners must be prepared to deal with these dynamics skillfully by recognizing the trauma of a stigmatized identity and projecting external acceptance to promote self-acceptance. When clients are met with warmth and genuine positive regard for all aspects of themselves and their identities, it forms the neuro-psychological foundation of safe interpersonal connection necessary for growth and healing (Birrell & Freyd, 2006; Rogers, 1961; Uhernik, 2016).

Therapists can create explicit opportunities for clients to discuss sexual and gender identity, and to relate openly and honestly (perhaps for the first time) as their authentic selves. An example of identity-affirming exploration could include: "How would you describe your sexual and gender identity? Just so you know, we recognize a multidimensional spectrum of sexuality and gender here, and all are welcome and supported." Or, when a client expresses anger or pain because of a marginalizing experience, the therapist can normalize and validate those emotions. "It makes sense that you feel that way because of what happened to you. No one deserves to be treated that way. I hear the pain in your voice. Can you we take a minute and breathe and then you can help me understand more about what that meant to you?" It is also not uncommon for traumatized clients to make attributional errors and engage in self-blame ("It's my fault; I'm not normal"). As therapists we need to be willing to authentically affirm experiences while collaboratively working through inner conflict and cognitive dissonance.

Peer Support

SAMHSA (2014) highlights how crucial peer support is to helping people heal from trauma. Social and peer supports for LGBTQ+ populations can decrease loneliness and protect against psychological distress (Shilo & Savaya, 2011; Wise et al., 2019). Yalom (1995) described the therapeutic value of group cohesion and mutual aid through socialization and interpersonal learning. The presence of another person describing similar thoughts, feelings, and experiences allows for external validation; Yalom described this powerful phenomenon as *universality* and *disconfirmation of uniqueness*. Thus, group interventions for sexual and gender minorities, who often feel alone and struggle to find a place of belonging, can be particularly effective both in person and online (Austin et al., 2020).

Processing difficult circumstances with someone who has been through similar tough times can be affirming, and at the same time serve to gently challenge distorted beliefs about oneself. Sharing positive experiences with one another provides hope and offers the promise of a better future; peer groups naturally enable mutual aid. Mentoring by those farther along in their healing journey enhances self-efficacy and self-confidence, especially for individuals who have spent years feeling incredibly alone with their experiences and identities. Groups also facilitate sharing of information, which can expand one's repertoire of available resources, especially for those who are cautiously venturing into an LGBTQ+ world which is new to them (Craig & Austin, 2016; Dietz & Dettlaff, 1997). Yalom (1995) also described the catharsis that occurs when suppressed emotions are revealed, empowering acceptance of life circumstances and the search for meaning. Practitioners are encouraged to refer LGBTQ+ clients to local peer support or advocacy groups, start their own groups when feasible, and (as described above) suggest a range of websites and social media platforms known to help connect LGBTQ+ persons in positive and affirming ways. On the other hand, clinicians should be aware that competition, status, and social perceptions within sexual minority communities can also create stress; therefore, preparing clients to anticipate and cope with possible rejection that might be encountered within the LGBTQ+ community itself can be helpful (Pachankis et al., 2020).

Reducing Isolation

LGBTQ+ clients who have concealed their identities are deprived of authentic expressions of self. Those who have been rejected by loved ones and/or their communities may experience social anxiety and an absence of social support systems (Feinstein et al., 2012). As result, many clients feel safer alone. Indeed, data suggest that LGBTQ+ individuals experience greater isolation than their heterosexual and cisgender counterparts (Doty et al., 2010). Helping clients build supportive connections is an integral component of healing. Given the antagonistic realities faced by many LGBTQ+ clients in their families and communities, practitioners should attempt creative strategies for fostering peer connections.

As discussed earlier, peer support for LGBTQ+ populations can also be found online, by which youth, transgender people, individuals in rural settings, or those in hostile religious communities are able to find others like themselves, often for the first time (Austin et al., 2020; Craig et al., 2015). Online peer support can buffer risks to mental health, including suicidality, by providing the opportunity to be seen, heard, validated, accepted, and protected in a manner similar to "real world" support. To identify the range and potential of affirmative supports, therapists can ask questions such as: "Who are the most supportive people in your life, offline or online? Describe how they support you and what feels good about that? How do they specifically help you as a LGBTQ+ person?"

To Disclose or Not?

While some therapists or service providers identify as LGBTQ+ themselves, therapist self-disclosure is not the same as peer support. Therapists usually share personal information with good intentions: to establish rapport through authenticity, to normalize experiences, or to facilitate "more human exchanges . . . compared to 'expert-to-patient' interactions" (Audet & Everall, 2010, p. 328; Knox et al., 1997; Rogers, 1961). It is always important, however, to approach self-disclosure with caution to ensure that the focus remains on the client, and to consider the potential pitfalls of boundary transgressions. For instance, sharing your own coping skills, feelings, assumptions, or opinions might unwittingly project expectations onto a client, leading to a rupture in the therapeutic alliance if a client feels misunderstood or dismissed. Conversely, a client might be surprised by a personal disclosure, creating confusion and role ambiguity (Elder, 2016). An option for disclosing one's identity (if deemed to be in the client's best interest) while maintaining the focus on the client's inner world might be to say: "I (do or do not) identify as LGBTQ+, but my experience of gender identity or sexual expression is unique and so is yours. I'd like to hear about what your journey has been like for you . . . help me understand your thoughts and feelings about your life."

Collaboration and Mutuality

There is a notable power imbalance inherent in mental health services. Clients often perceive therapists as authority figures, and depending on past experiences, power differentials can feel threatening (East & Roll, 2015; Knight, 2015). This inequity is particularly salient when considering care for LGBTQ+ individuals (Scheer & Poteat, 2018). For instance, some LGBTQ+ youth are sent to therapy by their parents with little or no choice in selecting

the practitioner or the approach to intervention (Ryan et al., 2020). Past counseling experiences that offered a lack of mutuality and collaboration may have left someone feeling dismissed and invalidated (e.g., *this is just a phase; you are attention seeking; you don't really know what you want*). Some people have been sent by family members or religious leaders to a range of unethical and emotionally damaging reparative or conversion "therapies" aimed at changing sexual orientation or gender identity. Such experiences are now widely recognized as inappropriate, harmful, and traumatizing (Bhugra et al., 2016). Corrective relationships with professional helpers must allow clients to lead the way in their unique and transformative narrative of healing and recovery (Birrell & Freyd, 2006; Kuelker, 2019).

Several steps can be taken to foster self-determination and enhance the collaborative client experience during sessions (Ryan & Deci, 2000). Using the therapeutic process to elicit client feedback can build trust and foster engagement (Prescott et al., 2017). For example, "Our sessions are an opportunity to set goals together, and you can let me know at any time if we need to change or add anything. At the end of each session, I am going to ask you to share with me the ways in which we made progress toward your goals, what felt good and what did not. That will help me know what works for you. Remember, we are a team." Individualized goal planning respects the individual while coaching the client to explore alternatives, options, and decision-making strategies on the path to self-acceptance. The ambiguity that exists across the sexual and gender spectrum can be uncomfortable and confusing for some clients. They may need help tolerating and accepting that gender and sexuality can be fluid and non-binary, and that exploring their identity and related needs might be more important than a search for definitive labels with which to describe oneself.

Sometimes clients seem less than forthcoming, or not invested in counseling. "Resistance" can be reframed by thinking of it as a simultaneous desire for change and the need to maintain what is familiar. Resistance might also represent an attempt to avoid the anxiety of an uncertain future that often accompanies coming out. A client's ambivalence must be accepted and processed as they strive toward self-determination. Clinicians can validate and process mixed feelings about revealing themselves to the practitioner, coming out to others, or embracing new identities.

Finally, it can be difficult sometimes to recognize our own tendency toward paternalistic case planning or advice-giving. We can avoid these well-intended impulses in ourselves by remembering to ask, not tell, when partnering with clients (Levenson, 2020). A client might ask: "My mother thinks I'm making a mistake by openly coming out as gay. What do you think?" The therapist might reply: "That's a personal decision that only you can make, and you are the one who has to define your authentic self. Can we explore the possible pros and cons together, so you can help me help you figure it out?"

Empowerment, Voice, and Choice

SAMHSA's (2014) TIC guidelines remind us that trauma survivors have lacked agency in many areas of their lives and LGBTQ+ persons might have been recipients of coercive interventions. Vulnerable, minority, and oppressed populations must "cultivate self-advocacy skills [and practitioners] ... must be facilitators of recovery rather than controllers of recovery" (SAMHSA, 2014, p. 11). Voice and choice begin with client involvement in the pace, planning, and execution of the services that they will receive. Given that some LGBTQ+ clients may have felt silenced, dismissed, or ignored by important people in their lives, the therapist can assist clients to speak up, assert themselves, and construct a path to self-efficacy.

It is important to remember that the LGBTQ+ client may be seeking counseling for other reasons—a therapist may be providing services for substance abuse, depression, anxiety, or relationship issues. As the client gains trust in the therapist, they may test the waters and begin to share thoughts and feelings about sexual orientation or gender identity (voice). Long-standing shame, ambivalence, or fear may mean that the client works at a slow pace, treading carefully into revealing ideas that may have long been hidden from others or even oneself (choice). Be patient, start where the client is, and follow their lead, guiding them with affirmation and reassurance toward discovering their genuine self (empowerment).

To counter disempowerment in a trauma-responsive therapeutic context, practitioners should focus on sharing power which occurs by prioritizing client autonomy and decision-making. Practitioners can create opportunities for LGBTQ+ clients to take the lead in framing their own life story and treatment-related needs. This is accomplished by asking many questions (rather than giving information or advice) to coach clients through a personal exploration process that helps shape self-narrative, identify choices, weigh alternatives, discover options, examine goals, and attach meaning to experience (Levenson, 2020; Ryan & Deci, 2000).

The therapeutic relationship has an inherent power imbalance, which can trigger trauma responses in some clients. Seeing the practitioner as an "authority figure" can activate self-protective strategies and flight-flight-freeze responses, manifested in combativeness, passive compliance, deference, or avoidance. As a result of non-affirming and pathologizing practices that have historically permeated health and mental health care, some LGBTQ+ clients have not been safe enough with mental health and medical providers to be honest about their identities and experiences; consequently, their mental and medical needs have not been adequately met.

Enhancing the experience of choice can include strategies such as asking LGBTQ+ clients to share their affirming pronouns and names, and to generate a priority list of their goals for care. It is important for the therapist to be clear that goals are flexible and might change or be modified throughout the process as needed. Furthermore, asking clarifying questions related to the client's experiences can convey respect and value. A therapist could simply ask: "Is it okay if I ask you questions that might seem really personal sometimes? I do this because I want to understand you and your experience ... I want to make sure I'm partnering with you in ways that feel right for you."

Affirmative trauma-informed practitioners are also encouraged to reflect upon our own sources of power and privilege (e.g., race, sexual orientation, gender identity, ability, education, age). These reflections can help us recognize and understand the absence of oppression in our lives. For instance, what would it be like to not have my life partner recognized as my spouse? What would it feel like to have a baker refuse to cater my wedding because he did not approve of my choice of spouse? What if I were denied the ability to adopt because of my gender expression or sexual orientation? Have I ever had to think twice about which bathroom to use? Have I ever worried that a medical doctor might be empowered by law to refuse

to treat me? Have I feared for my own safety because of some characteristic about my identity?

Clinicians must also review their own beliefs about sexual and gender diversity and clients' rights to autonomy and self-determination regardless of age. Concealing and hiding one's gender or sexual identity can be protective in the short term, but the stress can negatively impact clients' long-term emotional health. On the other hand, disclosure can also be stressful as people begin to navigate the world as their new true self (Pachankis et al., 2015). As such, the pace, direction, and steps toward self-disclosure and authenticity must be driven by the client's readiness to ensure that these experiences are empowering and liberating rather than overwhelming.

Cultural, Historical, and Gender Issues

SAMHSA emphasizes making sure that services are culturally relevant, gender specific, and take into account the legacy of historical trauma for oppressed groups. LGBTQ+ populations have experienced egregious discrimination, disempowerment, and pathologization within mental health and health care settings (Elze, 2019). Moving beyond cultural sensitivity and cultural competence requires attention to the sociopolitical context of historical traumas; practitioners must acknowledge the complex intersectionality of sexual, gender, racial, and ethnic diversity (Alessi & Martin, 2017; Bryant-Davis, 2019). Intersectional oppression involves the accumulation of simultaneous forms of discrimination or stereotyping, based on "normative" assumptions (at best) or outright intolerance, contempt, disdain, or violence (at worst). Systemic injustices often combine "racism, sexism, heterosexism, able-bodyism, ageism, classism, religious intolerance, transphobia, and/or xenophobia. Trauma recovery care must attend to the multiple layers of identity within each person" (Bryant-Davis, 2019, p. 400).

In fact, it is likely that some therapists hold stereotypical assumptions or engage in microaggressions, usually without realizing it. For instance, some commonly used terms can be offensive (e.g., transgendered vs. transgender; sexual *preference* implies a choice that can be changed). Referring to "same-sex marriage" rather than just marriage implies that differences exist, and these experiences are somehow not equally legitimate for everyone. Microaggressions can provoke feelings of victimization and represent the continuing legacy of historical and cultural oppression; therefore, these traumas are ongoing realities rather than ordeals located in the past (Bryant-Davis, 2019).

Creating cultural and gender relevance in our interventions involves the ability to personalize our approaches. Social expectations such as gender roles, dress, and concepts of masculinity or femininity can differ in various ethnic and racial groups, creating distinct sets of challenges for each person. Social or familial messages about intolerance for sexual or gender diversity can require specific strategies for helping clients alter their thinking about these narratives. In some communities, real dangers might exist for people who reveal their truth, so clinicians can explore concerns about attitudes and messaging (e.g., has anyone in your church ever come out as gay? What was the response?). For example, LGBTQ+ clients of color often experience challenges finding spaces that acknowledge and support all of their identities. Tuning in to this struggle and validating clients' feelings about this may be helpful (e.g., "I know our work was focused on supporting you around the painful impact of racism, but I image it must be difficult at times to be the only LGBTQ+ person in the room").

SAMHSA advocates for services that are gender specific by appreciating the different experiences, reactions, and needs of men and women who have been exposed to trauma. When considering gender relevance, considerations need to be extended further to attend to the unique feelings and treatment needs of transgender or gender diverse clients. For instance, interventions, modalities, and service delivery approaches rooted in binary, cisgender, or heteronormative assumptions may not sufficiently support the needs and experiences of sexual and gender minority clients.

Conclusion

Innovative solutions must be implemented to help each client: find safe (sanctuary) spaces that validate all dimensions of identity; understand minority stress as a potential source of trauma; resist internalization of oppression by reframing messages that stigmatize identities and responses to trauma; re-define self through a resilience-focused lens that validates LGBTQ+ identities and promotes post-traumatic growth; challenge beliefs rooted in homo/transphobia, racism, and misogyny; engage in specific forms of healthy self-expression and coping; envision a positive future; create affirming social connections; and foster empowerment through the development of collective action and advocacy skills (Austin & Craig, 2015; Bryant-Davis, 2019; Crisp & McCave, 2007).

Research documenting the high rates of ACEs, discrimination, stigma, and historical trauma experienced by LGBTQ+ populations highlights the need for trauma-informed approaches. Applying SAMHSA's six guiding TIC principles within an LGBTQ+ affirmative practice framework creates a foundation for recovery and post-traumatic growth. Therapists can avoid re-traumatization by fostering an atmosphere of safety, trust, authenticity, unconditional positive regard, collaboration, and empowerment to support resilience and healing for LGBTQ+ individuals. Understanding minority stress and trauma are important considerations for mental health professionals, and a strengths-based approach will help accomplish the ultimate goal of resilience, pride, and post-traumatic growth (Meyer, 2015; Tedeschi et al., 2015).

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