It’s Complicated: Navigating Multiple Identities in Small Town America

Angela D. Ferguson and Marie L. Miville

Howard University and Teachers College, Columbia University

During the past few years, research focused on individuals who identify as gay, lesbian, bisexual, and transgender (LGBT) have increased. However, much of this literature focuses on White LGBT individuals, and less on individuals who have intersected identities, such as being both gay/lesbian and a person of color. Consequently, this population becomes obscured in scholarly discourses, thus being made “invisible” with regard to theory, research, and clinical interventions, with the result that clinicians are provided little or no knowledge of theories or best practices when working with individuals who are both sexual minority and people of color. This article discusses an integrated theoretical and treatment process when working with clients who are navigating multiple oppressed identities.

Researchers have found that lesbians and gay men seek out mental health services at higher rates than heterosexuals; however, there is little data about the rate at which lesbians and gay men of color seek out mental health services (American Psychological Association [APA], 2012). Historically, people of color have been suspicious and reluctant to utilize mental health services due to a history of misdiagnosis, experiences of racial discrimination from therapists, and dissatisfaction and unfavorable experiences regarding treatment (APA, 2003). At the same time, despite their higher usage of such services, many sexual minority people (i.e., individuals who identify as lesbian, gay, or bisexual) also may be suspicious of mental health services due to misdiagnosis and experiences with homophobia and heterosexism from therapists. A very conspicuous problem emerges with this situation: Potentially unfavorable experiences with mental health services have been reported from two separate groups, namely, sexual minority people and people of color. Researchers, theorists, and practitioners often discuss various groups of people as if these are separate, independent, and isolated experiences. Consequently, individuals who have intersected identities, such as being both gay/lesbian and a person of color, become obscured in scholarly discourses, thus being made “invisible” with regard to theory, research, and clinical interventions. The result is detrimental to individuals who have intersected identities, particularly when clinicians have little knowledge of theories or best practices when working with individuals who are both sexual minority and people of color.

Many clinicians have worked with sexual minority people of color who sought psychotherapy to discuss a variety of issues. Practitioners are generally aware of the professional mandate that emphasizes the importance of developing cultural competency. However, although some training programs offer multicultural or diversity courses in their curriculum, few if any programs offer courses that provide training to facilitate competence in working with sexual minority individuals, much less sexual minority people of color. Additionally, few therapists have received formal training and education that help develop skills, understanding, and clinical competence when attending to a client’s multiple social identities (e.g., as based on race, gender, or sexual orientation). Unfortunately, some clinicians may assume that there is no need to develop a
particular competence in working with marginalized, oppressed groups, despite evidence that demonstrates that compared to White clients, clients of color are more likely to experience racist, sexist, and homophobic interactions with clinicians, have been disproportionately misdiagnosed, and have a higher rate of premature termination and drop out from therapy (Sue & Sue, 2015).

Marginalized communities, such as those made up of lesbian/gay/bisexual individuals (LGB) or people of color, live in environments that constantly send messages that some part of their identity, their worldview, beliefs, and behaviors are “impaired,” “inadequate,” or “pathological” in some way. Providing mental health services to sexual minority people of color requires knowledge about multiple forms of oppression and discrimination; microaggressions; the “coming out” process of accepting one’s sexual minority identity status; racial, gender, and sexual orientation identity development; and the intersectionality of various identities. To date, little research exists that describes what constitutes effective psychotherapy with sexual minority clients of color.

Theorists and researchers have developed gay affirmative therapy for working with sexual minorities. Bieschke, Perez, and DeBord (2007) broadly defined gay affirmative therapy as “the integration of knowledge and awareness by the therapist of the unique development and cultural aspect of LGB . . . individuals, the therapist’s own self-knowledge, and the translation of this knowledge and awareness into effective and helpful therapy skills at all stages of the therapeutic process” (p. 408). The APA (2003, 2007, 2012) has published separate guidelines for clinicians who work with people of color, sexual minorities, and women, respectively. And some scholars have provided guidance as to how training programs and professionals might integrate these various sets of practice guidelines addressing diversity, including the multicultural guidelines, guidelines for girls and women, and guidelines addressing work with sexual minority populations (Miville et al., 2009). For example, exploring how experiences of oppression and marginalization may cut across several identity domains is one important therapeutic suggestion, as well as attending to possible psychological consequences, such as anxiety, depression, anger, and lower self-esteem. A related suggestion is to assess and explore the kinds of social identities that may be salient or central to an individual rather than presuming the salience or centrality of these identities.

A third suggestion is to be knowledgeable and aware of how multiple types of prejudice and stereotypes may affect a single individual, as in the case of a Black woman who also identifies as sexual minority person. In other words, racial, gender, and sexual orientation stereotypes may individually as well as collectively affect this individual. The term gendered racism (Essed, 1990, in Miville & Ferguson, 2014) has been coined to describe the multiplicative effects that both sexism and racism can have on the lives of women and men of color. Gendered racism may be communicated in multiple ways through the use of familiar stereotypes (e.g., media images of the Mammy, Sapphire, and Jezebel).

Sexual minority individuals of color often must navigate at least three social identities (race, gender, and sexual orientation), and thus they are in positions of developing (a) strategies to maintain a sense of racial–ethnic cultural meaning relative to their respective group members; (b) new or self-defined scripts related to biological sex, gender, and sexual identity within a cultural context; and (c) self-definitions of what it means to be a non-White, sexual minority person (Ferguson, Carr, & Snitman, 2014). Sexual minority people of color experience unique stressors related to personal and interpersonal social tasks through the process of developing a sense of self. Ferguson et al. describe the paradigm of “visibility and invisibility” for sexual minority people of color, in that on the one hand, race may be a visible identity per physical traits, presumed stereotypes, and cultural norms, whereas sexual orientation may be invisible, given heteronormative presumptions that all people are heterosexual.

The process of negotiating and psychologically integrating multiple identities “has the potential to create significant conflict for sexual minorities of color. This is especially true if particular aspects of sexual, racial, and gender identities are incompatible with one another. Thus, choosing to avoid the revelation of certain identities or selves may be among the most effective protective strategies for some individuals” (Ferguson et al., p. 54). As a result, Ferguson et al. caution that social identities may become fragmented in both development and expression. For example, an
individual may present different images of oneself depending on the context (e.g., “straight” at church, openly gay at a party), promoting one’s survival and acceptance in these various communities but also risking the loss of an integrated sense of self. The use of these protective strategies further may be reflective of internalized homophobia and/or racism. The following case will serve as a platform from which to discuss the complexities many sexual minority people of color experience as they develop a sense of self.

Case Illustration

Tara, a 46-year-old African American woman grew up in a semirural community in the Northeast. The community in which she lived was predominantly African American and she had always lived in the area. Tara’s mother and three older sisters lived in neighboring towns; her father left the family when she was 10 years old for reasons that have been unknown to her. For much of Tara’s childhood, her sisters served as her caretakers while their mother worked. Two sisters are married to men, and all three sisters had children in their early twenties. Tara generally had been open about her sexual orientation as “gay” with her family, and her friends, many of whom are heterosexual. When Tara was in her twenties, she had three children by two different men. During the time period that she raised her children, she periodically lived with each of the fathers of her children but had never been married to either of them. Tara also dated two women, but never developed a lasting, emotionally committed relationship with them.

At forty, Tara became involved in a relationship with an African American woman who had no children and had never been in a sexual or romantic relationship with a man. Tara felt romantically and sexually attracted to her girlfriend, with whom she and her children had lived for the past 8 years. At the same time, Tara was very close to her family of origin, and she spent a great deal of her social time with her siblings. She came in for therapy due to longstanding, periodic feelings of depression and loneliness, the future of her relationship with her girlfriend, and a desire for “something more” in her life.

Case Formulation–Data Collection and Therapeutic Framework

Before describing my (first author) formulation of this case, it is important to discuss my therapeutic and clinical framework. I consider myself to be an eclectic therapist, although I primarily use a psychodynamic framework in my therapeutic conceptualization. Many theoretical frameworks subsume this approach and ego psychology and object relations theories have greatly influenced my conceptualization of client issues, conflicts, and resiliency. I am particularly interested in intrapsychic processes, how early childhood experiences shape the present self, unconscious motives, defense mechanisms, and developmental stages of the individual, and less guided by specific psychodynamic therapeutic techniques. Psychodynamic approaches to therapy have often been criticized for several important flaws. For example, feminist approaches have particularly criticized psychodynamic perspectives for its paternalistic position in the therapeutic relationship, its inherent sexist bias, and its emphasis on psychopathology. Multicultural psychologists have often criticized this set of theories as being culturally encapsulated, with little attention paid to the contexts in which clients live. These criticisms are valid in many cases; however, detrimental consequences of these problematic aspects of psychodynamic therapy are especially likely when the clinician is unaware of oppressive microaggressions in the room, as well as unaware of the effects various forms of oppression have on the individual’s personality development.

My conceptual formulations of clients are highly integrated with a cultural perspective and framework. All individuals are cultural beings, and as such must be conceptualized within cultural frameworks that include the individual’s sociohistorical context, social identity context(s), and the sociopolitical context. An individual’s psychological, interpersonal, and social realities are influenced by and are inextricably linked with these contexts. Moreover, Tara’s patterns of feeling, thinking, and behaving are embedded in her cultural realities. Although members of the same group (e.g., race) may be similar, each individual has a unique reality that is important for both the therapist and client to recognize and acknowledge. Understanding how these varying
contexts and identities influence personality development, and subsequent maladjustments are critical when conceptualizing the individual and then developing treatment interventions. Having this understanding is particularly salient when working with clients who belong to oppressed, marginalized social groups (e.g., racial/ethnic, gender, sexual orientation, disability, religion), so that the diagnostic process does not further oppress and/or pathologize the client, and culturally appropriate treatment interventions can be developed.

During the first few sessions with the client, it was important to (a) assess what the problem or problems were to better understand the focus of treatment; (b) gather information about Tara’s psychosocial history; and (c) assess her internal dynamics of identity development. As previously stated, very little research has been conducted on sexual minority people of color. Consequently, one of the ways of using best practices with this population is to integrate existing empirical research and theory with clinical practice. First, as is the case with all clients, it was important to develop a relationship with Tara that was affirming, nonjudgmental, and engaging. Although the therapist may be distant when using a classical psychodynamic approach, research has found that a distant stance with people of color in therapy can convey that the therapist is aloof, disengaged, and judgmental (Helms & Cook, 1999). One of the ways that I typically attempt to create an affirming and engaging relationship is to acknowledge during the very first session that the client is the expert about their life and that the information shared with me can help us move toward the therapeutic goal(s).

Gathering information related to the problem or problems included focusing on Tara’s personal identity and family, early childhood experiences with her family members, and how she coped with anxiety. These data were integral in formulating this case. Tara’s relationship/attachment with her parents and the support from her family serve important roles in her personality development and interpersonal relationships. It was also important to understand how Tara typically coped with anxiety, which Horney (1968) conceptualized as a child’s fear of being alone, helpless, and insecure. Gathering information about Tara’s psychosocial history included asking questions pertaining to her family, community(s), romantic relationships, friendships, religion/spiritual experiences, and the social contexts in which she lived.

My goal in gathering information in these areas was to assess Tara’s understanding of her personal self, her cultural self, and her social self. For example, I attempted to observe if her language included personal references (“I”), collective references (“we”), or some combination thereof. I hoped these references would provide another layer of understanding her sense of self in terms of referencing herself within a collective group or groups, or whether she felt isolated, alone, and separate from a group. Much of the research asserts that sexual minority individuals of color are simultaneously gendered and racialized, relative to their sexual orientation. It was important to understand whether Tara integrated these identities and, if so, how she navigated them. This information could also help assess whether Tara engaged in any splitting behavior, experienced identity fragmentation or invisibility, which all could contribute to psychological distress.

Closely connected to gathering information regarding Tara’s psychosocial history was the assessment of her internal dynamics of identity development. Tara was likely navigating at least three social identities (i.e., gender, race, sexual orientation), but each identity may have emerged in terms of salience and centrality at different ages in her life, may have evolved unevenly, and likely influenced the manner in which she engaged in friendships, family, and sexual/romantic partners (Ferguson et al., 2014).

I thought that it was important to understand when and how Tara became aware of each of her identities and whether a particular event, person, or personal experience was connected to the time in which she became aware of these identities. Some of this inquiry involved asking about family dynamics and her friendship groups. During the first few sessions, Tara was generally forthcoming with information about herself; she was relatively open and appeared genuinely engaged in the process. By the end of the fourth session, I gathered the following information.

- Tara described herself as a “gay woman,” not as a lesbian.
- Tara’s racial identity was most salient for her, particularly given its connection to her family and community. Indeed, she stated that she “found more in common with those with whom
she felt were like her” (i.e., African Americans). Albeit Tara was aware that she was a woman, and that she was “gay,” her gender and sexual orientation identities were not very dominant parts of her psychological identity and sense of self, and thus her interpretation of sexist and homophobic material was not very evident.

- Messages connected to women were primarily focused on motherhood and its importance to the meaning of being a woman; these messages were reinforced by family members, particularly her sisters. The social/cultural imperative for women in general is to maintain and embrace gender role expectations, two of which include becoming a mother and only being sexually attracted to men (Greene, 1997). Regardless of sexual orientation, race, or ethnicity, women are taught to revere the role of mother and that their ultimate success is to have a child (Siegenthaler & Bigner, 2000; Slater, 1995). This imperative may be more compelling for Black women, particularly given the homophobia that exists within the African American community (Mays & Cochran, 1988). Motherhood was a salient identity for Tara because it provided her with connection to her sisters and mother, a framework for her identity as a woman, and was consistent with family and community messages of what “family” meant.

- Her primary social community included her family, heterosexual girlfriends, and gay men; with the exception of her current partner, Tara did not seem to have many relationships with other “gay” women.

- Despite Tara’s knowledge of her sexual orientation, her expression of her sexual orientation was not consistent or always open. She experienced internalized homophobia; although Tara did not consciously conceal her sexual orientation, it was not well developed due to the strong messages she valued about her gendered familial scripts and oppressive language and attitudes she received from family members and her respective communities about “gay” people in general.

- Messages connected to lesbians were often heard in the community, but from time to time, Tara was troubled by descriptions and depictions of lesbians as “not being real females,” male haters, “masculine” and Black “bulldaggers,” particularly when these messages were connected to women who did not conform to stereotypic gender roles and expectations.

- A continued assessment of Tara’s history of periodic depression revealed that she had not contemplated suicide, currently was not suicidal, and had not been hospitalized for psychiatric reasons. At the time of this clinical case, the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition was in use, and the symptoms that Tara described did not meet the criteria for a diagnosis of major depressive disorder or dysthymic disorder. However, a provisional diagnosis of anxiety disorder was provided.

Case Formulation–Clinical Conceptualization

The following formulation integrates Tara’s personal, cultural, and social self. She had experienced periods of depression, loneliness, and anxiety for much of her life. Her earliest memory of feeling depressed occurred during her early adolescence. Throughout her adolescence, she also experienced feelings of loneliness, but these periods were short-lived. During the time Tara’s mother and father lived together, they both worked long hours, contributing to the economic stability of the home. However, their long work hours also meant that they were often away from the home and separated from Tara. Her need for affection and attention heightened with each passing year and was usually unmet, particularly after Tara’s father left the home, leaving her mother to rear four children by herself. Her relationship with her mother was inconsistent, and she often felt abandoned and peripheral to her mother, which intensified her anxiety.

Object relations theorists assert that children deal with unsettling feelings about the mother by maintaining both the good parts and repressing the bad parts of her. The parents provide warmth, support, and safety; however, at some point, they leave the child and the child experiences the world as split–good and bad. This split is internalized and continues throughout one’s lifespan. Tara experienced multiple rejections and disappointments throughout her life. Her early rejections occurred during childhood when her mother and father were not physically and emotionally available to her. These feelings of rejection were exacerbated when her father left
the family. Tara “preserved” her mother and father by generating a mental image of them which was idealized.

Tara may have internalized herself as a “bad girl” and unlovable (which could also be conceptualized as Horney’s “despised self”). As a way of gaining her mother’s attention and love, Tara began to do everything “just right” so that her mother would notice the good job she was doing. Her anxiety, often expressed as the need to “do things just right,” became more and more generalized across several areas of her life. For example, although she did not excel academically, Tara always “behaved” in class and followed the rules. Additionally, although Tara was not particularly competitive, she always wanted to do her best. The internalization of being a “bad girl” was exacerbated by Tara’s internalization of various forms of oppression. Ferguson et al. (2014) observe, “As a fundamental manifestation of internalized prejudice, the process of rejecting the self creates dissonance and, ultimately, reinforces the notion that certain elements of the self are not worthy of being expressed” (p. 55).

The messages Tara received from family, friends, and school personnel about women were incongruent with the way in which she internally felt. The good–bad split was present here in that her sense of worth was “bad” or low. These messages were heteronormative and heterosexist, devaluing and diminishing her inner core. Tara became very aware of the social and behavioral expectations for girls and women but was unsure of how to cope with and navigate these competing feelings—the “should” of conforming to heteronormative expectations; the core of her that rejected these messages, thus resulting in her being a bad woman. The social/cultural imperative was to become romantically involved with a man, have children, thus becoming a mother.

Adolescence was a time when girls her age were expected to date; however, Tara already knew she was attracted to women, and her anxiety heightened as she was unsure of how to meet these heteronormative expectations. Tara’s desire for and attraction to women was nonexistent to family members, increasing her feelings of loneliness and feeling peripheral to her mother and sisters. The development of her sexual orientation identity was repressed and uneven. Tara’s gender identity as a female was supported by important others, but all messages were focused on heterosexuality, making her lesbian identity virtually invisible and concealed. This contradiction was psychologically stressful to Tara; she was aware of the specific heterosexual roles, tasks, and expectations assigned to her gender. Failure to follow these heteronormative expectations created fears of rejection and a sense of shame and fear of disconnection from her mother, sisters, and other community members.

Tara experienced several forms of oppression and marginalization relative to her gender identity and sexual orientation identity, both in and out of her home. Although she experienced forms of oppression regarding her racial identity, the messages she received from her family helped buffer her from internalizing some of those messages. She knew that as long as she was with her family, she would feel safe from the negative racist messages she received outside of her community. However, because she felt more acceptance from her racial community, she marginalized her gender and sexual orientation identity in order to establish psychological safety and stabilization.

Additionally, becoming a mother provided Tara with status and privilege both in her family and in her racial community. Despite these unconscious efforts to establish psychological safety, the internal stressors she experienced manifested in depression, anxiety, and loneliness for much of Tara’s life. Guilt, shame, and fear were dominant intrapsychic conflicts for Tara that dominated her personal feelings of herself and her interactions with others.

Tara’s interpersonal relationships were significantly impacted by her feelings of shame and need to be “good.” Although she did not have much difficulty being in social settings, developing and sustaining emotional connections with romantic partners in particular were problematic. She often felt disconnected and emotionally distant, although she remained in relationships for long periods of time. Her disconnected, distant feelings from romantic partners were often the result of two ways in which she coped with her shame and anxiety in relationships: (a) she attempted to please others in order to gain love and approval from others or (b) she withdrew
It's Complicated

from others in an effort to avoid hurt and possible rejection. These two styles of coping often led her to feel emotionally isolated and unable to express her authentic feelings.

Course of Treatment

The following discussion will highlight some of the more prominent aspects of the therapeutic process of my work with Tara. Therefore, some of the work with her may be viewed as incomplete or absolutely absent. Because of page length and the limited scope of the current discussion, specific elements of the work will be discussed. My work with Tara spanned eighteen months; however, there were several missed appointments throughout that time.

As previously stated, I use a psychodynamic framework to conceptualize clients, but may use a variety of techniques depending on the client. As a way of orienting Tara to the therapy process, and empowering her, I spent time during the beginning sessions to discuss some of the feelings she may experience such as anxiety, frustration, sadness, or displeasure with me. It was also important to discuss Tara's expectations of therapy. My goal was to develop a more collaborative relationship with Tara. I had conceptualized one of Tara's intrapsychic conflicts as internalizing herself as a “bad girl” and that this dynamic would likely emerge in her interactions with me. Although my orienting Tara to therapy could be viewed as me “giving her permission” (a paternalistic perspective) to experience her feelings, my hope was that she would feel more empowered in the room. Transference occurred in the therapeutic relationship even as I was bringing attention to it in the beginning sessions. As repressed material emerges in sessions, clients may feel disempowered due to the strong feelings that are evoked. By developing a collaborative relationship, clients who have felt marginalized may feel added safety to talk about those feelings.

Tara entered therapy because of longstanding, periodic feelings of depression and loneliness, the future of her relationship with her girlfriend, and a desire for “something more” in her life. One of the goals of therapy was to help decrease some of her shame and guilt, thus decreasing her anxiety. In working toward this goal, much of the course of treatment centered on helping Tara accept her real self, which included developing an integrated sense of self. By developing a more integrated sense of self, she could begin to address some of her splitting and allow more of her real self to emerge, which could increase a more authentic construction of herself. As an individual with at least three marginalized identities, Tara had experienced numerous overt and covert messages of prejudice throughout her lifetime. Identifying some of the overt messages, particularly those related to race were generally easier for Tara than identifying the covert, microaggressive messages connected to sexism and homophobia/heterosexism.

When considering many of the microaggressions that Tara may have experienced, it was important to note that many of these microagressions were also intersected. For example, Tara heard messages such as, “Black women can’t be lesbians, that’s a White issue.” Here Tara’s sexual orientation as a lesbian was invisible within not only the context of the Black community but also the cultural role and expectations of being a Black woman. Rather than dissect each of the microaggressions related to her respective identities, more attention was focused on her emotional reactions and how she cognitively processed those remarks. Many of Tara’s beliefs about herself were based on inaccurate and distorted oppressive messages directed at her. Helms and Cook (1999) asserted that in order for marginalized individuals to question previously held beliefs about themselves, they must be introduced to new information that contradicts their current body of knowledge about themselves and others in their social group(s). Many sessions focused on challenging Tara to examine messages she received from family members and community members to assist her in questioning her previously held beliefs about herself.

Early sessions also included discussions of Tara’s formulations of me, particularly with regard to race, gender, sexual orientation, and parenthood. This discussion was an important opportunity to provide an open space for a discussion of Tara’s conceptualizations of how she perceived us to be alike and dissimilar. It provided opportunities for Tara’s defense mechanism of projection to emerge and to explore the extent to which she maintained the role of being “good,” thus suppressing much of her authentic self. I offered brief disclosures of my own experiences of discrimination as a marginalized person, and was mindful that the more Tara
thought we were similar, the less she might discuss authentic aspects of her experiences and consequently engage in a discussion in which she attempted to gain my approval. My hope was that she would feel supported by my disclosures; my goal was to encourage Tara to express her own realities, thus helping to increase her own legitimacy. She initially openly conveyed that she was glad that we shared similar social identities and experiences. In these instances, she was engaging an idealized me. She wanted to answer all questions asked, and attempted to provide me with positive responses. This kind of exchange was rather easy in that during the first few sessions I was gathering a great deal of information that she could readily provide without much psychological discomfort.

As the sessions progressed, I began exploring her feelings about her parents, identities, and feelings about the messages she had received by her family regarding her sexual orientation and her gender (which included her becoming a mother). Tara’s ability to negotiate her negative feelings were challenging and frightening for her because she was not accustomed to talking about her authentic experiences and feelings related to her gender or her sexual orientation. Her anxiety heightened, and she was now faced with having to manage her repressed negative feelings and her shame, which left her feeling psychologically distressed. At these times, Tara became withdrawn, sullen, and silent for long periods during the session. Tara struggled to express her genuine feelings; although she often stated that if she did talk about her genuine feelings, I would reject her, find her unlikeable, and convey that she was not “good.”

At times, Tara conveyed that I could not possibly understand her because I was so “successful.” She projected that I had a perfect life, perfect relationships, and conveyed that I had found ways of navigating discrimination given my current occupation. Idealizing me and devaluing herself emerged, thus continuing the cycle of her perceiving herself as “bad.” I asked Tara how she had managed discrimination, the strategies she used, and how those strategies had been helpful to her. By focusing on the strengths that Tara developed, she could begin to value and acknowledge herself. Tara wrestled with expressing her authentic self, which was disquieting to her, and she would periodically cancel sessions. Interestingly, Tara always called to cancel instead of just not showing up for her session. Her maintenance of the “good client” persevered. The splitting that occurred with me and in Tara’s social relationships were continuous aspects of the therapy because this dynamic pervaded all areas of her emotional and interpersonal life.

During earlier sessions, I asked Tara to describe her family’s communication style. There were few times when family members “talked” with each other. Instead, the general manner of communication was to keep personal problems and feelings to oneself. Despite the fact that Tara and her sisters spent a great deal of social time together, much of this time was spent engaged in board games, relaxation, and talking about their respective children. Not only were her negative feelings difficult for her to express, but this style of talking was not culturally congruent for her. Support and empathy for her resistance was generally in the form of aligning with the fright and discomfort of talking about her feelings out loud, rather than suppressing her inner dialogue.

Outcome and Prognosis

Therapy primarily ended due to Tara’s health benefit compensation, which was time limited. She became much more aware of some of the ways in which her sense of self had been influenced by the numerous microaggressions she received. She was able to express some of her authentic feelings about these messages, but continued to symbolically preserve her mother, in particular. Tara was not accustomed to expressing her authentic feelings. However, as therapy progressed, she was able to describe more of her authentic feelings, but she often stopped short when discussing her relationship with her parents. The idea of describing negative feelings toward her parents was psychologically painful for Tara, despite instances when she described events that left her feeling abandoned and alone. Tara was very proud of her parenting and she was very aligned with this identity. She often stated that she was “always there” for her children, the metacommunication conveying that she did not abandon her children. This allowed Tara to gain a sense of status in her community, as a Black woman, fulfilling her sense of belonging as both a woman and a racial group member.
It's Complicated 983

Clinical Practices and Summary

As can be seen in the case of Tara, effectively intervening with clients who are navigating multiple oppressed identities requires knowledge about the existence and importance of these identities and their psychological impact. It is important to consider the following key issues about Tara and other sexual minority clients of color:

- These various identities may be “visible/invisible” and fragmented to clients and their families/communities to the extent that family/community presumptions (accurate and otherwise) about one’s race, gender, or sexual orientation may serve as the basis for these identities being internalized in positive or negative ways. Here Tara internalized (a) positive images of herself as a Black individual, per family/community norms; (b) positive but limited images of herself as a Black woman, per heteronormative standards emphasizing maternity; and (c) generally negative images of herself as a lesbian, per negative family/community presumptions that Black women cannot be “gay.”

- With sufficient understanding of the possible therapeutic impact of multiple identities, traditional therapeutic approaches still may be effectively utilized—for example, for Tara, incorporating psychodynamic frameworks emphasizing “splitting” with an accurate assessment of which social identities were rewarded as “good” or “bad” by significant others in her life.

- For many sexual minority people of color, there are limited, if any healthy role models (Greene, 1997) or social support both within and outside of the family. Not all families of color intentionally marginalize their sexual minority family member relative to their sexual orientation; however, they most often provide cultural mirroring regarding their racial identity. “Lesbian women of color seldom receive positive cultural mirroring for the sexual-minority aspect of their identity” (Greene, 2000, p. 247). Therapists who focus only on a single identity further marginalize the client, as well as continuing to perpetuate a fragmented sense of self.

- As with any traumatic experience, the difficulty that Tara and other sexual minority people of color may have in articulating their own negative feelings to significant others who may have “punished” them for having identities not in line with family/community norms or standards should be carefully responded to, with a balance of gentle challenge and extensive support. Seemingly small changes, such as acknowledging anger about various microaggressions about being “gay,” are important to recognize and support. It is important to recognize, however, that the client may stop short of openly expressing negative feelings to significant others (e.g., parents) who may have damaged her during her development. Tara likely fears losing the small group of people who have become her supportive community, despite its conditional acceptance of all of who she is, that is, a Black lesbian woman. Therapy certainly can become another important support network that offers a different and even healthier and more self-accepting perspective; however, it is important to be mindful that the loss of the client’s own racial family/community may be experienced as a great risk or not an option at all for LGB clients of color.

References


