Abstract

Trauma-informed Treatment Practices with Bronx-residing LGBTQIA+ BIPOC: An Initial Study

By

Frank Ramon Fuentes Pelay

Dignity and worth, service, social justice, competence, integrity, and using guidance in promoting human relationships are all components of ethical and effective treatment for any person being treated by mental health professionals. When treating trauma, nonetheless, these ethical components can be more effective when mental health practitioners add trauma-informed treatment modalities. This quantitative exploratory study, supported by Queer and Intersectional Feminist Theories, examined the reported choices of 41 convenience-sampled mental health providers employed by NYC-based social service agencies to apply (or choose not to apply) the uses of trauma-informed treatment modalities while having had serviced Bronx-residing BIPOC (Black and/or Indigenous People of Colour) sexual minorities. The treatment modalities measured and analyzed to treat this population are: *Trauma-focused Cognitive-behavioural Therapy (Tf-CbT), the Narrative Therapeutic approach, the Person-in-Environment Therapeutic approach, and the Strengths-based Perspective approach*. The investigation discusses whether mental health providers used these approaches by opting to apply a trauma-informed treatment lens to treat anxiety and depression for the population of focus. An anonymous survey was disseminated to NYC-based MHPs. The collected data was analyzed with bi-variate and multi-variate regression, which revealed statistical significance in substantiating the study's presented hypotheses and study questions.

TRAUMA-INFORMED TREATMENT PRACTICES WITH BRONX-RESIDING BIPOC SEXUAL MINORITIES: AN INITIAL STUDY

By

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INFORMATION TO USERS

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DEDICATION

The specialized guidance and all-around support provided by Dr. Nancy Beckerman, Dr. Shannon Lane, and Dr. Charles Auerbach allowed for a consistent and patient collaboration to complete this dissertation. Their influence encouraged me to stay focused and resolve any unplanned obstacles that happened our way.

Throughout this journey, my husband, Michael Rubin, patiently served as a part-time proofreader, and accompanied me with handling any occurred IT mishaps or complications.

Countless hours of peer collaboration accompanied me throughout this journey, as well. They saved me when the inner 'imposter complex' attempted to drown my efforts.

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Section One: The Dissertation Overview

The aim of this investigation was to better comprehend the choice to apply trauma-informed treatment approaches with persons who identify as LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, and others who identify with being a sexual minority), Black and Indigenous Person of Colour, and who reside in the Bronx, N.Y. The investigator's focal attention to this topic was born from a profound understanding that trauma, in all its forms, has been present throughout our lives, without it being recognized or treated. Individually and collectively, we feel and experience it in unique ways, as no one person relates to their lived experiences in exact likeness. As mental health providers, we may need to further rely on our empathic senses, to better relate with others and the traumas they experience. In turn, as traumas are shared mutually, we, as a learned collective, can pay forward our collective empathic senses in the hopes of benefitting the rest of society.

Given the broadness of this topic, which can relate to most any person and circumstance, the investigator chose to start this study as a quantitative, exploratory design, whereby the aim was to examine the relationship between dichotomous and categorical independent and dependent variables.

Overview of the Methodology Performed for This Investigation

Through virtual interviews and email correspondences with the participating organizations, the researcher established a verbal agreement with the head of the Analysis department of four well-known and respected social service agencies, located in the northeastern region of the United States. The historic formation of these social service agencies has paved a particularly profound foundation toward the social movement of recognizing, celebrating, and

saving the lives of countless LGBTQIA+ individuals since their inceptions; 1982, 1983, 1997, and 2002.

Recruitment for this investigation was attained through the assistance of the administrators of Analysis and Research, as well as each agency's supervisors of mental health practitioners. Each have proactively assisted and encouraged practitioner recruitment and participation.

The data collected for this investigation was retrieved through individual online surveys as an attached Google Form. One survey was disseminated for this study. The single survey was collected from participating practitioners who service/have serviced Bronx-residing LGBTQIA+ BIPOC clients. The investigator observed a one-month grace period after the survey was disseminated to give participants ample time to complete them. Participants were emailed a link to access the Google Form questionnaire via their participating administrator/supervisor, to maintain anonymity. Emailed solicitation included a consent disclosure. Agreement and consent for participating in this investigation was apparent for each participant, as they were solely requested to click on the prompt that ensured their anonymity. All identifying information was securely established, as the survey did not ask for identifying information that would allow for a breach of anonymity. After data collection completion, the investigator analyzed the findings through usage of STATA. The participating agencies were also familiar with the data analysis software of choice.

Two of the participating organizations for this investigation and their founders were responsible for raising nationwide social awareness regarding the lack of inaction for the U.S. government to arrive at the aid of those ravaged by the AIDS crisis. All participating agencies, nonetheless, have addressed (and remain addressing) the dearth of culturally appropriate

treatment needed to efficaciously treat this particular NYC-based population. Because they have gained so much acclaim in their political and social support of sexual minority populations across the United States, they were able to gain financial means to further support LGBTQIA+ individuals through consistent and reputable mental health services. Years of practicing consistent, therapeutic interventions for those in need of facing life-threatening traumas caused by social and institutional homophobia, transphobia, and racism has led these agencies to pilot programs encouraging trauma-informed treatment for those they service. Being that the participating agencies are at the forefront of mental health treatment for this niche population, they share and promote social work ethics in praxis, philosophy, and administrative goals, as stipulated by the National Association of Social Workers (NASW).

NASW Code of Ethics and This Investigation

The NASW code of ethics lists the following as the duty of social workers to abide by, through professional and organizational responsibilities: dignity and worth of a person, duty of service, social justice, importance of human relationships, integrity, and competence. The investigation maintained an observance of the six core values of the social work code of ethics. Because the investigator of this research is focused on the effectiveness of trauma-informed treatment practices, the study observed how this type of therapeutic treatment strives to positively effect and showcase the treated individual's dignity and worth. Tenets of trauma-informed treatment guidelines highlight the essentialness of all the values of the social work code of ethics. Through *Dignity and Worth*, trauma-informed treatment is maintained by obliging the practitioner to lead the therapeutic relationship with trustworthiness and transparency. The treated individuals' mental health progress greatly depends on the occurrence of profound emotional healing that becomes part of the therapeutic dialogue

consisting of the validation of emotions and the treated individual feeling understood and valued by the mental health practitioner (Levenson, 2020).

Social workers treating individuals through a trauma-informed lens would accentuate the importance of their *duty of service*. This investigation aimed to promote the ethical obligation that all social workers would need to apply the best form of treatment available to them through specialized training provided by their participating agency. World renowned therapeutic philosopher, Carl Rogers, in his studies, emphasized the need for psychotherapists to provide a strong sense of the psychotherapist's authenticity of their service and the total progressive communication and unconditional investigation into establishing an empowering therapeutic rapport (Rogers, 1961 commentary in Ferald, 2000).

The social work value of *social justice* served to empower treated individuals and the participating agency to further raise awareness of the importance of creating a socially progressive momentum. This impetus could bring the bills and/or acts which support the need to apply trauma-informed treatment practices in recognition of the basic human rights of LGBTQIA+ BIPOC individuals and communities to legislation.

The human rights of these individuals have been grossly and historically neglected (Knight, 2015). Thus, trauma-informed treatment creates a need for safety – emotional and physical. This is where social policy and presented bills, acts, and legislation, which promote the use of trauma-informed practices, come into action. Treated individuals need both physical and psychological safety in their lives to better function in mainstream society (Bloom & Farragher, 2013, p. 26), and a trauma-informed therapeutic relationship would foster this safety (Brown et al., 2012).

Trauma-informed treatment approaches highlight the *importance of human relationships*. Traumatic experiences, for better or worse, are often shared by more than one person in

occurrence. The treated individual would need to empower other individuals to recognize their strengths and vulnerabilities while having had experienced their own incurred trauma/s. Treated individuals would need to re-establish ego-building practices, to foster new relationships or recreate old ones through a deeper connection of the self, in the face of all tragedies that traumatic experience/s have caused. Trauma-informed treatment promotes one's personal progressive values through an emotionally curative process of fostering an alliance of human connection with the goal of building trust and resilience (Levenson, 2020).

Integrity is gained when one reaches a high level of personal strength, recognizing the truth in themselves and as identified in others. Trauma-informed treatment approaches seek to establish that the treated individual is given the task to recognize and establish or re-establish their truths – their experiences and the emotions attached to the traumatic experience/s as valued and valuable. Integrity flows in a therapeutic relationship, as those who are treated through trauma-informed approaches have the right to exercise their self-determination and communicate their understanding of the risks and benefits of engaging in any type of treatment. Trauma-trained practitioners, through their practice of integrity, focus attention on consistently building the integrity of a therapeutic rapport to establish healthy relationships and self-regulatory skills (Knight, 2015).

The practitioner's *competence* in applying the best form of treatment is also at the forefront of this investigation, as one of its intentions is to demonstrate the essential worth and richness of value that trauma-informed treatment practices can bring to one's therapeutic practice. Trauma-informed treatment philosophy prescribes that practitioner competence must adhere to the practitioner abstaining from advice giving, especially when treated individuals seem prone to repeat unhealthy decision-making. The competent trauma-informed therapist would encourage the treated individual's self-determination, which allows the individual to make

healthy decisions and opt for evaluating their choices in a more mindful manner (Saleebey, 2011, p.480).

Overview of Trauma-informed Treatment Guidelines

The NASW code of ethics should be referenced in all daily activities where social workers practice their craft, of course. The investigator sought to understand if trauma-informed treatment is just as important in application as the other established set of values. The investigator of this study offered all participants a clear description of what comprises trauma-informed treatment (in practice, approach, theory, or philosophy) within the letter of consent, at the start of the survey. The investigator listed six widely practiced guidelines of what trauma-informed treatment should follow (Levenson, 2020):

1. *Safety Ensuring* – The practitioner and client create an environment where they both feel physically and emotionally safe.
2. *Trustworthiness and Transparency* – The practitioner must adhere to the social contract which constitutes the values of the NASW code of ethics. The practitioner must be open to create and build trust at any moment. Observing boundaries between each other is key to developing a trustworthy, therapeutic, and trauma-informed practice.
3. *Peer Support* – Practitioner and client work collaboratively to increase social progress in communities and develop positive peer and community leadership support using outreach methods inspired by trauma-informed philosophy, whereby the persons performing the outreach are exercising and recognizing empathy within themselves and others.
4. *Collaboration and Mutuality* – The practitioner would need to foster a rapport of mutuality, whereby clients take initiative to also lead a therapeutic activity. The trauma-informed

therapeutic practice maintains that the practitioner and the client develop and maintain a checks and balance system, so as to best share power of growth.

5. *Empowerment, Voice, and Choice Prioritizing* – The practitioner is charged to lead the client to exercise their empowerment. Practitioners need to help their clients realize that how they were able to survive their traumatic experience is due to the use of their survival skills – the use of resilience, internal and external voice. The practitioner is charged to assist their client by listening to their concerns and struggles so that the client is clearer to make healthier behavioural choices.

6. *Cultural, Historical, and Gender Issues* – The practitioner would also need to know, understand, and perhaps even live/have lived the cultural experiences similar to what their clients are disclosing. Practitioners need to practice with cultural and social sensitivities toward the wide array of racist, historical, and gender issues which may influence the most intimate or mundane of relationships clients experience.

The intent of this quantitative exploratory investigation was to research if (and when preferred) trauma-informed treatment approaches are utilized by mental health practitioners servicing Bronx-residing BIPOC sexual minorities. This investigation brought a better understanding of whether practitioners feel there are benefits in employing trauma-informed treatment practices. The investigator produced the survey of questions investigating the uses or non-uses of trauma-informed treatment practices. So that the participating practitioner was clear about what constitutes trauma-informed treatment practices, the investigator provided the guideline as a reference for whenever the survey participant finds it fit to use.

Part of the investigation deconstructed the demographic characteristics which may have influenced the decision to employ or not employ trauma-informed treatment practices. The

researcher identified therapeutic treatment modalities presently and historically being used by participating practitioners (as identified by the participating agencies' head administrators of Analysis). The therapeutic philosophies of some of these trauma-informed treatment modalities may not consistently focus on prioritizing trauma-informed treatment. Nonetheless, those practices performed in tandem observance of trauma-informed treatment guidelines have been identified as: narrative therapeutic approach, strengths perspective, and person-in-environment therapeutic approach, and trauma-focused cognitive-behavioural therapeutic approach. The researcher performed exploratory analyses of these approaches in use.

Due to the dearth of literature in this field regarding the targeted population of the investigation, the investigation plans to impress upon social work journals and others (and society at large) that BIPOC sexual minorities who reside in the Bronx may frequently survive many types of discrimination through intersecting traumatic experiences: identifying as a sexual minority with an unsupportive nuclear family and/or residing community, identifying as BIPOC and experiencing frequent racist conduct, many of whom are most likely residing in one of the poorest Congressional districts in all of the United States – Congressional districts 15 and 17 of the South Bronx.

This researcher's aim was to bring attention to the possibility that trauma-informed treatment practices are beneficial to those who experience consistent discrimination related to intersecting identities. All factors of an individual's life experiences, which involve elements of trauma and discrimination, must come to the forefront of therapeutic approaches (Brown et al., 2012). Trauma-informed treatment practices will bring these factors to light and will add further profoundness toward the social movement of the empathic understanding of oneself and the other.

The researcher of this study involved the following inclusionary criteria in determining which participating practitioners could be included in the study sample; they each must hold and practice with (or be in the process of attaining) one or more state mental health state licensures and/or mental health service degrees, be older than 18 years of age, and service LGBTQIA+ BIPOC clients who reside in the Bronx. Exclusionary criteria were considered when it was identified that any one of the participants who do not identify with the chosen inclusionary criteria was discounted from participating in the sample population for this study.

As previously mentioned, the researcher opened the investigation with a consent form at the onset of the survey. The consent form consists of a legal clause which states the participants rights of privacy. After reading the initial informed consent section of the survey, the participant was prompted to click on the designated area to proceed with the survey completion. Once the participant chose to engage in the investigation, the giving of their consent was granted upon following through with the given prompt.

The survey was provided in English only, as all participants would need to have a professional command of the English language, given that the agencies of their employment require it. Further consecutive studies may present a survey in multiple languages, to be accessible to both clients and mental health practitioners alike.

Federal mandates require the researcher (and the educational institution affiliated with the study) to safeguard the collected data of this study through encrypted measures of information technology. Once approved by the dissertation committee and the internal review board, the encrypted data will be stored in the educational institution's data base for three years, after which point the researcher and all others who have participated in the study will have full discretion to its access. All data collected contained no evidence of identifiable nature from the

participants or the participating agency. The researcher coded participant responses, numerically and nominally, to better perform feasible categorization of data analysis.

The findings of the investigation serve to apprise current literature and social work academics of the uses and possible effectiveness of trauma-informed treatment practices with any group of individuals who experience intersecting discriminatory experiences, as have been experienced by Bronx-residing, BIPOC sexual minorities. The investigator intends to publish the findings of this study with indications suggesting that further research into the effectiveness and uses of trauma-informed treatment practices be applied to all administrators of public and social service sectors – that all civil servants practice and meet supervisory guidelines which direct each of us to observe our level of empathy and the learned and earned resilience of those we service.

As social workers, we are often at the forefront and in the trenches with those in need. As social workers, we are charged to be pioneer stakeholders as defenders of the code of ethics we hold and honour. Trauma-informed treatment, via a social worker lens, practices that all levels of social interaction, with those we treat, is most effective when the elements of safety, autonomy, collaboration and mutuality, and the sharing of power is prioritized. Trauma-informed social structures maintain the therapeutic doctrine that safety is paramount and that any perceived unwillingness or reticence from a client can lead to traumatization or re-traumatization. We must solicit the thoughts and emotive reactions of our clients and include their decision-making autonomy with their course of treatment and prognoses. We must always check for mental health symptomology and assist clients to move forward with their trauma-informed decision-making skills.

Section Two: The Study Problem

Problem Statement

Members of the LGBTQ BIPOC community in the Bronx have been potentially traumatized due to reported high rates of discrimination and physical, sexual, verbal, and emotional abuse. Discrimination and overall abuse may continue to devastate these communities. Because south and southeastern neighborhoods of the Bronx have consistently held the position of being the poorest Congressional districts in the United States, LGBTQIA+ BIPOC residing in these areas have been compounded with added intersecting demographic stressors; being who they are in the face of constant heteronormative adversities as well as enduring the throes of economic plight. The combination of these factors may very well lead to an imminent deterioration of their self-esteem/self-concept. On a macro-level, this deterioration unfolds into the community and abroad, and may form subcultures of negative competitiveness and microaggressions. Trauma-informed treatments may redirect this deterioration through working with the individual and LGBTQIA+ BIPOC communities to adopt *trauma-informed treatment approaches* in recognizing their fierce resilience and by using the strengths of their survival coping mechanisms to continue positively building themselves and others.

The focus of the study problem is to recognize and examine how trauma-informed treatment practices have been practiced within the therapeutic relationship between practitioner and client, via the practitioner's perspective. In this study, the client is represented to have three possible intersecting traumatic experiences, being that they are a *sexual minority, Black and Indigenous Persons of Colour*, *gender-related minority*, and *residing in one of the most economically marginalized urban areas in the United States – i.e., Congressional Districts 15*

and 17 of the Bronx. Hence, this study examined the possible overlapping effects of being traumatized via these three types of trauma-causing themes, irrespective of each other.

Problem Explored

Historically, the pathologizing of lesbian, gay, bisexual, transgender, and questioning/Queer, intersex, asexual and more **(**LGBTQIA+) orientations shaped research and professional practice as a psycho-social mental condition which required intense therapeutic attention (Dou, 2019), while the impact of stigma was not considered (King, 2017). Taking into consideration the pervasiveness of stress lived by this minority, mental health and social service professionals who service them may encounter challenges in meeting their social and mental health needs with efficacy when attempting to apply trauma-informed treatments. The challenges may lie in identifying the individual's learned value system as contrary to the identities the individual believes is true to them. Stigma-related prejudice and discrimination experienced by LGBTQIA+ individuals chronically plague their lives. Often, these stressful experiences can lead to negative socio-emotional (and eventually, health/mental health) outcomes. Minority stress has been linked to psycho-sociological distresses among sexual minorities and may contribute to elevated rates of distress frequently observed among these individuals (Dou, 2019).

One of the inclusionary goals for the Center for Disease Control (CDC) for the year 2021 was to achieve health equity, eliminate health disparities, and improve the health of all groups, including those of lesbian, gay, bisexual, transgender, and Queer/questioning (LGBTQ) populations (information retrieved from the CDC's 2021 fiscal report). In 2011, the Commission on Human Rights (CHM) released a report that drew attention to the unique socio-psychological disparities experienced by sexual minorities, which emphasized the need for a comprehensive approach to psycho-sociological research focused on sexual minority experiences (Mink, Lindley & Weinstein, 2014).

Past research regarding the adverse racist and anti-social experiences lived by racial and ethnic minorities consistently reports the pervasive psychological afflictions which have haunted them for centuries (Pieterse, et al., 2012). Previous studies have found occurrences of race-affiliated stress to be in connection with categorized reports of psychiatric and socio-emotional symptomology (Zamboni & Crawford, 2007). Research also demonstrates how in varied locations across the United States (and globally), pockets of neighborhoods/towns/villages populated largely by minority and marginalized racial and ethnic groups also report consistent increases of individuals and groups using and abusing mind-and-mood altering substances (Pieterse et al., 2012). In a meta-analytic review of sixty-six studies, African Americans were found to have more reports of perceived racism than any other minority group (Pieterse et al., 2012). The review revealed that the greater the amount of perceived racist discriminations experienced in the studies, the higher the number of reported trauma-related mental health illnesses rose (Pieterse et al, 2012).

Economic marginalization is no stranger to the Bronx, in particular with Congressional Districts 15 and 17. Because these Congressional Districts have endured decades of high rates of unemployment and low-income earnings per household capita, individuals have had to learn to survive via illegal income-earning lifestyles, e.g., promoting and/or being forced into sex trafficking. Although these black-market subcultures maintain a mutual understanding of economic flow within its mobster administrators, they are fraught with consistent trauma-inducing stressors for those pawned into indentured servitude with little prospects of leaving unscathed or alive (Jaeckl & Laughon, 2020).

Previous investigations have alluded that LGBTQIA+ BIPOC individuals and groups have lived through extraordinary forms of discrimination via socio-emotional and overall mental

health stressors which target their multiple minority statuses (Bostwick et al., 2014). This is evident through intergroup and extra-group relations of a combination of pedestalling White male privilege and heteronormative values. Previous quantitative studies have reported that sampled individuals who identify with more than one minority group have experienced being participants in studies where multiple analytical therapeutic approaches have been performed and analyzed by the studies' researchers (Sutter & Perrin, 2016). The researchers for these studies aimed to decipher the arch effects afflicting LGBTQ BIPOC (Sutter & Perrin, 2016), only to reveal that behavioural nuances related to the intersectional experience are largely uncovered. The majority (or those who hold more social power and privilege over the minority) tends to generalize perceptions of what is believed to be socio-emotional and racially provoked adverse experiences for minorities (Bostwick et al, 2014) who are commonly perceived as a marginalized group of one identity.

The intricacies of being assigned to or belonging to a community that embraces or denigrates its multi-intersected identities may have yet to impress upon the sensibilities and empathies of the majority. It is then hopeful to assess that the importance of this research focuses on the value and contribution that the LGBTQIA+ BIPOC identity in an economically disadvantaged geographic area can make to society. Reporting the use of trauma-informed treatment practices accentuates this awareness. The study aimed to hypothesize that the values and contributions of these communities impress upon society its balance to humanity by choosing the efficacious practices of trauma-informed treatment approaches.

Scope of the problem

A June 2017 report administered through the offices of NYC's Comptroller Scott M. Stringer published pertinent information about LGBTQIA+ communities included in all

metropolitan area populations of New York City (Office of the New York City Comptroller, 2017). The report broadly covers how LGBTQIA+ individuals face challenges in attaining economic security, healthcare, and resolve with discrimination in the workplace and in their residential communities. The researcher has yet to encounter statistics that are particular to LGBTQIA+ communities in the Bronx which identify race, ethnic, gender identities, and economic statuses. Nonetheless, this eminent report should provide a statistical average relevant to that of this investigation.

Many surveys administered in all fifty states since 2015 have reported statistics of at least thirty percent of individuals who identify as LGBTQIA+ BIPOC (Clare, 2017, p.170). The surveys mentioned how these sampled populations have experienced varied types of discrimination (Clare, 2017, p. 171); not receiving a due promotion in the workplace, being let go or dismissed from duties which then lead to unemployment, and transgressions of verbal, physical and psychological harassment. The NYC Comptroller's report divulges findings which reveal forty-two percent (42%) of its surveyed participants who identify as gender non-conforming have also adverted to these experiences of discrimination in their employment histories.

The NYC Comptroller's report also indicated that eighteen percent (18%) of the surveyed participants responded to having experienced homelessness. The racial and ethnic disparities among the LGBTQIA+ respondents reported homelessness as such; twenty-three percent (23%) identified as Asian, twenty-seven percent (27%) identified as Black, forty percent (40%) identified as Hispanic/Latino, and ten percent (10%) identified as White. Thirty-eight percent (38%) of the respondents who experienced homelessness identified as transgender or gender non-conforming. Seventy-nine percent (79%) of surveyed participants revealed in their responses

that the majority of those who had received shelter services offered by the City of New York felt very unsafe in their shelters. These participants reported feeling harassed by their fellow shelter occupants, shelter staff, and residents of the communities housing the shelters.

The 2017 Comptroller's report also disclosed how shared public spaces (i.e., hospitals, mental health clinics, ambulant services, family care facilities, nursing homes, parks, and restaurants) have also largely contributed with how LGBTQIA+ BIPOC have experienced being verbally and/or physically harassed. The surveyed participants reported that they received little, if any, furthered investigations for their reported complaints. Forty-seven percent (47%) of the sampled participants in this survey reported discriminations in these areas. Seventy percent (70%) of that forty-seven percent (47%) identified as gender non-conforming or transgender.

Apart from experiencing a lack of due diligence to their needs and concerns, many LGBTQIA+ BIPOC NYC residents also report experiencing a lack of professionalism and discrimination from government agency employees who administer financial assistance. Government benefit programs are often the source of relief and much needed supports (Clare, 2017, p.172) for LGBTQIA+ BIPOC. Among the programs offered are Supplemental Security Income (SSI), HIV/AIDS services, education/job training, and unemployment insurance. Any NYC resident who is eligible to receive these government benefits should be equally treated with professional etiquette and ethical standards by social service employees, regardless of their identity/ies.

LGBTQIA+ BIPOC who participated in this survey report experiencing inconsistencies in rendered administrative services. They report a cancellation of services without explanation or furthered assistance in resuming their due benefits. The survey revealed that thirty-seven percent (37%) of respondents admit to accepting and receiving these government benefits programs as

reported with the following statistics: eighteen percent (18%) received food assistance, twelve percent (12%) received unemployment insurance, four percent (4%) received SSI, five percent (5%) received education/job training, and seven percent (7%) received HIV/AIDS services. Of those who reported receiving food assistance programs; thirty-three percent (33%) identified as transgender or gender non-conforming and thirty-one percent (31%) identified as Hispanic/Latino. It is also noted that twenty-one percent (21%) of surveyed participants reported receiving health insurance through government programs; Medicare (11%) and Medicaid (10%). The majority of these received healthcare programs were administered through LGBT community health centers (Clare, 2017, p.172).

Historical and Present Concerns of the Bronx

New York City is proudly home to a plethora of cultural institutions, businesses, organization, and gathering places which have been created by and for Black and Indigenous People of Colour (BIPOC). Some of these gathering places are inclusive of LGBTQIA+ BIPOC, who have historically made significant contributions within social settings connected to communities of colour. In doing so, they have slowly and successfully managed and operated LGBT-specific businesses and organizations. The Bronx is now home to many organizations and community-building programs supporting and building Bronx LGBTQIA+ identities. A large percentage of these LGBTQIA+ individuals are BIPOC (Clare, 2017, p.175), and many of them have paved a path of support through recognition of resilience in the face of generations upon generations of condoned and applauded heteronormative abuse and systemic discrimination.

Historically, the Bronx was a fertile land, able to yield multiplicities of produce – onions were its most profitable produce (initially farmed by a Swedish settler in the 17th century Dutch colony of New Netherlands, whose name is attributed to the naming of the borough). Toward the end of the 19th century, European settlers emigrated to New York City, and avoided the

cramped quarters of Manhattan's lower east side by settling in the more ample spaces offered north of 125th street and into the Bronx. The decades spanning much of the early to mid-20th century populated the Bronx with a variety of European, Latin-American, South/East Asian and African American cultures. Many middle-income and upper middle-income families established their homes for decades along its wide boulevards and parks.

In the mid to late 1970s, the Bronx was part of New York City's overall economic decline due to the rise of inflation and socio-political movements fueled by corruption (Mahler, 2007, p.73). However, because the Bronx was largely residential, landowners who were facing bankruptcy or attempting to avoid it during the mid to late 1970s discovered it would be economically feasible for them to collect on property insurance benefits by illegally employing individuals to commit arson on their residential properties. The 'burning of the Bronx' added to the destitution of poverty among its residences (Gelman, 2007). Those who could afford to move out, did. Those who could not, suffered the demise of their landlord's greed and were surreptitiously encouraged to relocate to low-income housing. Crime rose as a result of fierce competition among Bronx residents, and real estate values plummeted (Mahler, 2007, p.73).

New York City's financial decline stretched well into the 1980s. However, while Manhattan regained financial reputability, many businesses and landowners chose not to invest/reinvest their capital in the Bronx, as a result of institutionalized racism lead by corrupt New York City politics (Plunz, 2016, p. 216). Thereupon, the Bronx consistently received the least amount of public funds and services, due to its overall lack of economic flow (Tang, 2013).

Culturally, within the past decade, the borough grew with newer immigrants from African, South Asian, and Eastern European countries who settled in the Bronx. As it grew with the largest variety of nationalities per square mile in the United States (Tang, 2013), its economic

status maintained a low average of total household income (averaging to date just under $30k per year) (Kaplan, Cottrell, & Ward, 2005). The Bronx holds the record for reporting the lowest yearly household incomes in the United States, marking South and Eastern sections of the Bronx as, consistently, the poorest Congressional districts in the United States (Kaplan, Cottrell, & Ward, 2005).

Decades have passed and LGBTQIA+ BIPOC have made the Bronx their home. Because it has been the most affordable borough in which to reside, many homeless LGBTQIA+ youth began their journeys of community building there and have established an indelible mark of pride in the face of generational adversity, discrimination, and trauma inflicted upon them. Resilience is key to their survival and prosperity. Although LGBTQIA+ BIPOC have attempted to establish a socio-economic movement to build LGBTQIA+ BIPOC identities through safe spaces promoted by grass-roots organizations who appeal to corporate investors (Tang, 2013), the Bronx remains largely at a loss for socio-cultural exchanges between heteronormative recent and generational residents and the LGBTQIA+ BIPOC community. Inclusion is paramount for the survival and progress of all. Federal and state political representation must invest in the richness of this inclusivity.

Historical and Current Normative Perceptions of LGBTQIA+ BIPOC

American society is largely based on Puritan values, which can appear to incriminate any cultural values dissimilar to it (King, 2017), most notably LGBTQIA+ BIPOC culture. Corporate sensibilities have latched on to Puritan values throughout the centuries in the United States (Rosales & Langout, 2020). Therefore, much of U.S. corporate funds support the majority through appealing to Puritan values. Many politicians do the same. As a result, minorities are left to compete for majority favor and fray their way into recognition of worthiness within the scope of generationally impacted, Puritan value systems.

Decades during and after the era of post-bellum, socio-political reformation (c. 1864-1900) in the United States, the privileged majority had/has experienced ‘acts of defiance’ generated from minorities who were employed by them. Examples of these threats have transpired through short-lived strikes which forced the privileged majority to take note of inhumane working conditions and illicit, corrupt forms of indentured servitude (Mink et al., 2014). Although these threats were noteworthy at the time, the privileged majority always knew that they would get what they wanted, even if it came at the expense of exploiting minorities in need of dire financial resolutions (Vinthagen & Johansson, 2012).

Throughout this past decade, small revolutions of ‘out loud and proud’ social movements led by BIPOC sexual minorities in the Bronx have consistently been present, but seldom reported or taken seriously (Fine et al., 2014, p.62). The privileged majority, albeit in NYC or abroad, have historically refused to examine social systems and instead dismiss actions, relegating them as social deficits or pathologies in need of psychological cure or social rehabilitation (Cohen, 2004). However, when minorities gather strength in numbers and validate each other with unified passions, change becomes less unavoidable for the privileged majority.

The pathologizing of LGBTQIA+ BIPOC has been historically generalized by the privileged majority as that of a person who was raped/molested by someone of the same sex when a child, or when the opposite sex parent is absent or neglectful, or when the family consistently displays overt psycho-social and behavioural ills (Bostwick et al., 2014). It is a general shock to a nuclear family when it is revealed that their child is LGBTQIA+, and even more so with BIPOC families (Cohen, 2004), as many may feel that is already one strike against them, being BIPOC. The power dynamics of these social constructs leads to damaging internal

and external self-imaging for the individual LGBTQIA+ BIPOC, as well as for the communities they form.

Policy Related to the Problem:

There are four supporting policies at play related to the study problem: **S.674/A.459** (which is most referred to as, *The Survivors of Trafficking Attaining Relief Together Act*, 'The START Act') and **S.5325/A.6193**, (*The Use of Preferred Name and Pronoun Act*). Both were just recently signed into legislation by the Governor of New York.

Separate from the START Act and the PNPA Act, the other two policies which support the presented study are the Comprehensive Sex Education Act (CSEA) (S2584) and the Decriminalizing Sex Work Bill/Stop Violence in the Sex Trades Act (SVSTA)(S3075). Recent political events have resulted in little progress toward achieving legislation for these two bills. These bills have been introduced to legislature and are currently being studied by the Senate Committee, as they have yet to be scheduled for further processing toward the Assembly.

Senate Bill S674, as part of the START Act, requires all public and private agencies to procure the confidentiality of records in proceedings to dispose of any "convictions related to offenses resulting from sex trafficking, labor trafficking and compelling prostitution" (nysenate.gov/legislation/bills/2021/s674). Under this law, the confidentiality of those who have received policed convictions for being a sex worker or a sex trafficked minor is kept honoured and protected. That is, apart from convictions being exonerated, the NY State legislation procures that no agency obtains a confidential record of any of these convictions (Cooke, 2020). This largely impacts LGBTQIA+ individuals in NYC, who may or may not identify as BIPOC, as many face wrongful and dehumanizing policed convictions of sex work. Many LGBTQIA+

individuals rely on sex work due to high levels of discrimination in largely heteronormative workplaces.

The keeping of their police records as confidential would benefit further LGBTQIA+ individuals who could potentially face discrimination during the hiring process by potential employers leading to further trauma. The START Act also helps bring awareness to law enforcement agencies that being better informed about the magnitude of trauma that these individuals have historically faced would ultimately provide better service to them.

Although this bill does not enforce the use of trauma-informed treatment practices, as would be preferably performed by public service professionals who encounter LGBTQIA+ BIPOC sex workers, it provides a platform for that particular population to seek or be provided with trauma-informed treatment practices.

Assembly Bill A6193, the 'Preferred Name and Pronoun' Act (PNPA), was passed by the legislature and signed into law by the New York state Governor, Kathy Hochul. This act would require "utility corporations, municipalities, water-works corporations, and telephone service providers to allow customers to use their preferred name and pronouns (nysenate.gov/legislation/bills/2021/s674). Facilities, such as those, are now legally obligated to address all their customers according to their stated gender identities. Previous bills addressing the theme of appropriate pronoun and proper name usage in the workplace and elsewhere have been brought into legislation in only two states, California, and New York (Clawson, 2019).

Discrimination performed within the agencies can adversely impact a transgender customer's mental health and may augment higher rates of normalized discrimination. Therefore, Assembly Bill A6193 is set to protect the rights of Transgender folk by mandating that the

agencies address Transgender customers appropriately. It will ensure that any acting agent in employment of the agencies address an individual with their name and proper pronouns (Clawson, 2019).

Although this law does not enforce the use of trauma-informed treatment practices, it could encourage these agencies to employ sensitivity training for their employees to consume. Sensitivity and Implicit Bias training will include trauma-informed treatment guidelines for administrators and employees to follow (Knutson, et al., 2019).

CSEA (New York State Senate Bill, 2021): This bill has been introduced to the Senate Committee for consideration of legislature. It proposes a mandate that would enforce every public and charter school in NYC which service children from grades K-12 to provide medically accurate sex education (Atkins & Bradford, 2021). The mandate requires all schools to enact a curriculum which reflects national sexuality education standards and sensitivity toward those who do not identify with the sexual majority. Often time, enacted educational curriculum for public and charter school children employ components of trauma-informed practice guidelines, which accentuate the need for safety ensuring, peer support, collaboration and mutuality, empowerment, and cultural, historical, and gender issues (Atkins &Bradford, 2021).

This mandate would also help prevent premature sexual activity and unwanted, peer pressured sexual demands which may lead to unsafe sexual practices and health/mental health issues. It would allow students to better understand sexual orientations and gender identities and would promote the absence of stigmas related to sexual orientation and gender non-conforming (Atkins & Bradford, 2021).

Education of sexual minority identities along with the promotion of trauma-informed treatment practices may give license to build a stronger sense of entitlement, justice, and self-

worth with LGBTQIA+ BIPOC youth/young adults/individuals. The role of education can instigate further politicization toward LGBTQIA+ BIPOC inclusivity within all social circles. Education should also focus on recognizing the persistence of experienced traumas.

SVSTA (New York State Senate Bill, 2021): This bill has been introduced to the Senate Committee for consideration of legislature. This presented legislation amends Penal Law article 230 for consenting adults who trade sex for funds. It decriminalizes the act of interacting with consenting adults to pay for a service and justifies all anti-trafficking statuses which protect survivors and minors from exploitation (Anderson, 2021).

This legislation will help to decriminalize transgender and gender non-conforming sex workers, who are commonly identified as Black and/or undocumented. Because transgender and gender non-conforming individuals who also identify as BIPOC are so consistently and overtly discriminated and harassed, sex work is often the only way they can earn a living to survive (Anderson, 2021). Decriminalizing them would offer them a chance to build a network of resources which would allow them to thrive and build other opportunities to earn a safer living. Decriminalizing this population would encourage a network of socio-emotional supports which would employ trauma-informed treatment practices performed by mental health and public service professionals (Rigal, 2021). Trauma-informed treatment practices may allow LGBTQIA+ BIPOC individuals to observe fewer incriminating choices for earning a living that would extend the internal language they use to build their self-worth, or to seek legal aid to help resolve their sociopolitical and financial stressors.

Trauma-informed treatment practices, especially when exercised by mental health professionals and their LGBTQIA BIPOC clients, would encourage individuals to continue advocating for their basic human rights, as stipulated in the provisions of the bills.

Role of Social Work

Research can ordain a valued framework and a psychology of resistance by empathizing with commonly performed acts of resistance (Tuck, 2009) – what people desire to change through social justice ethics and values as recognized principally by social workers. Keeping this in practice, social workers servicing the LGBTQIA+ BIPOC population in the Bronx should offer individual and group counseling to support their emotional and physical well-being, referencing social justice ethics. A hard and fast aim for these social workers would be to build self-accreditation of this community for the unique, valuable qualities that it possesses – qualities that have been consistently discredited in their lives (e.g., exercising all components of creative streaks, nurturing empathy, and resilience for themselves and then for others). Social workers would need to commit to providing services that are affirmative, sex-positive, culturally sensitive, consistent with risk reduction principles, and that promote patient self-determination. Social workers would need to be trained as transgender counseling and education professionals who can offer expert information and support regarding the transgender experience, including information about personal planning regarding hormone therapy. Additionally, because LGBTQIA+ BIPOC communities have experienced persistent ravages of substance and alcohol abuse symptomology (Cruz, 2011), social workers would also need to be adept in offering substance abuse/alcohol and internet sex incrimination counseling services.

It would be incumbent upon social workers to work with their LGBTQIA+ BIPOC clients to determine *how* they can come to terms with their experiences of disadvantage. Incontrovertibly, a remedy for research that characterizes marginalized groups as 'helpless and broken' is a social work valued framework for furthered social research. In a social work valued framework, research is concerned with understanding the "complexity, contradiction, and the self-determination of lived lives" (Tuck, 2009). Therefore, research regarding marginalized

communities that are empathized and serviced by social justice reform and a social work valued framework would need to profoundly investigate the wisdom, aspirations, goals, and values that LGBTQIA+ individuals and communities have, in addition to the reality of their oppression.

Social workers servicing this population, at the micro-level, would need to focus on healing internalized discrimination while rebuilding self-esteem and executing plans to exercise and celebrate their continued development of personal strengths. At a mezzo-level, social workers could serve as influencers and assistants in promoting their LGBTQIA+ BIPOC clients to progressively plan the personal growths of others within their community. Their overt, empathic activities would serve to awaken the communal growth of the individual strengths of fellow community members, to create a social movement of personal strengths promotion within their residential communities. The movement could then spur (and/or further policy activation) the need for laws, at the macro-level, to be put in place which would serve to protect and promote city-wide and nation-wide LGBTQIA+ BIPOC needs and civil rights (e.g., participation in public education campaigning about the merits of heteronormative communities supporting LGBTQIA+ BIPOC values).

With these values in action, the social worker is key to reform the humanity, self-images and de-pathologizing of historically marginalized LGBTQIA+ BIPOC communities. The social worker, in service with the LGBTQIA+ BIPOC community, may serve as the optimal socioemotional and social justice support liaison to interacting agencies and community leaders/politicians.

Everyday acts of resistance are diagnostic of desire – they reveal what people want and where they are dissatisfied with existing social conditions (Fine et al., 2014, p.63). In essence,

aspirational assets lend perceptiveness into how people psychologically, behaviourally, and socially come to resist dominant, Puritan social dictates.

Social Work Values

Academics are obligated to be critically reflexive and interrogate their ability/inability to recognize resistance (Ferguson & Maccio, 2015). Key to social work values, being able to recognize and celebrate resistance, which builds their self-images, entails the practice of rejecting critical judgment and maleficence. Specifically, Scott (1990) theorized that the public performance of resistance might be read by those in privileged positions as consent to oppressive social practices and systems (p.60). In this arena, the social worker may triumph through advocating goals of social justice for those they service, which in this study is applicable to the LGBTQIA+ BIPOC communities of the Bronx. Academics must ask how their recording of BIPOC sexual minority treated behaviours have been influenced by contemporary social misconceptions.

This very persistent and majority-privileged ideology requires swift and meaningful social justice advocacy on behalf of the social worker and his/her/their client/s to resist institutional discrimination. The resolve needs to focus on not blaming the individual/client for their socio-behavioural flaws but to emphasize the systemic wrong-doing committed toward them as being the genesis of any socio-behavioural adverse reaction to a culturally limited situation (Tuck, 2009).

Social workers are charged to interject with any social injustice aimed toward denigrating and discriminating LGBTQIA+ BIPOC individuals and their communities, observing the social work value of *justice* (National Association of Social Workers, 2021). Public education may appear as; promotional posters providing insights on healthy interpersonal relationships among LGBTQIA+ BIPOC individuals, campaigning to pressure or advocate for local politicians to

include in their public addresses a reference to the value and worth of LGBTQIA+ BIPOC as included, recognized, and contributing members of their community. Social workers would need to encourage community leaders and politicians to directly and diplomatically address the lack of sensitivity, inclusion, and discrimination that heteronormative community members practice consciously and/or indirectly toward these fellow residents. Community leaders and politicians would then be charged to promote the richness and social progression of a community that embraces cultural and ethnic diversity.

The social work value of individual *dignity and worth* may also come into play (National Association of Social Workers, 2021) as the social worker would be charged to guide individuals (and their communities) to hold high regard for themselves and others in the face of their practiced lack of empathy and mental/emotional/intellectual/cultural limitations. Social workers would need to practice the importance of having their clients recognize the benefits of being mindful of each individual present in their lives as those who are ready to support them, as well as identifying those who are indifferent in supporting them, or not invested in supporting their personal growth or inclusion. The social worker would serve as a guide in identifying the choices that their LGBTQIA+ BIPOC clients make in allowing others to either promote or deny their personal growth. Resilience plays a healthy role in executing this value, as it elevates one's self-worth in recognizing aspects of those who are present in their lives that are healing or toxic, so as to gain the skill of separating the individual from their behaviour.

Understanding the need for social justice reform would likely require expanding research methods and paradigms. For example, Ferguson & Maccio (2015) learned to understand the need for social justice reform in their study of LGBTQ street youth when they noticed how the body language and gender performance of young adults/adolescents was a commonly practiced expression of social justice reform in the face of surrounding heteronormative social standards.

To adopt the complicated, yet important goal of studying/investigating the need for social justice reform, we contend that it is important to start with an approach to solidarity with research participants, and to do our best to collaborate with them, from their point of view. According to Anzaldúa (1999), this solidarity is to be defined as, "those who get pounced on the most; the females, the homosexuals of all races, the dark-skinned, the outcast, the persecuted, the marginalized, the foreign." (Anzaldúa, 1999, p. 180).

Working against the colonial ways of thinking and knowing, embedded in conventional western psychology, socio-political institutions, and corporate monopolies (Langhout, 2005), may yield a sympathetic ear from neutral and/or conservative academics to better understand the need for social reform by justifiably supporting LGBTQIA+ BIPOC communities in the Bronx. Working against coloniality in psychology will also allow for the differentiation of the common practices of socially tolerated and supported ordinances created by historically privileged majority (Rios, 2012), who engage in covert, daily repressive acts (e.g., microaggressions), and not-so-covert repressive acts.

Relationship Between the Problem and the Research Question:

LGBTQIA+ individuals have always been underrepresented in community and mental health organizations, as many have felt they were unempowered to surface their need to identify as such (Tuck, 2009). These individuals often add a great deal of culture and vibrance to their communities. This has been documented on a national level, as well as in the state of New York (Scott, 1990, p. 59). Furthermore, the status and community-building participation of LGBTQIA+ individuals in their residential communities, as well as with mental health organizations, had consistently declined during the decade prior to the inauguration of President Joseph Biden and his administration (Trochman & Millisen, 2021). There are three principal reasons for this;

A) These residential communities are cisgender and heterosexual in majority, they seek to build their LGBTQIA+ community elsewhere, as they are socially alienated and unsupported.
B) Their South and East Bronx residential communities violently target their homosexuality and gender nonconforming identities.
C) Community agencies, largely, have not hosted programs specifically catering toward the LGBTQIA+ community and their needs.

As previously mentioned, the Southern and Eastern communities of the Bronx have remained among the most financially destitute Congressional districts of the United States for the past 5 decades. In 2017, the median household income of these areas was about $30k/year. There are upwards of 57,000 people above the poverty level and more than 185,000 below it (NYC Comptroller Survey report for 2017). Many of these residents have earned only a high school diploma and some college credits – as it is comprised mostly of blue-collar communities with disproportionately larger percentages of undocumented residents who earn much lower household incomes in comparison with other NYC communities/neighborhoods (NYC Comptroller Survey report for 2017).

These same communities of the Bronx rank among the highest in volume of violent crimes performed toward LGBTQIA+ individuals across New York State. The ratio of possibility that an average Bronx resident will be a victim of violent crime is 1/116 (as compared to 1/285 in the overall state of New York). Studies report that LGBTQIA+ individuals residing in these communities are three times more likely to suffer a violent hate crime (NYC Comptroller Survey report for 2017).

As statistics reports have demonstrated, these communities consistently need an alternative to damaging practices which sustain crime, violence/hate crime violence, financial instability, and an overall sub-standard quality of life. Further creative outlets will support the absence of damaging alternatives which currently devalue a repressed Bronx LGBTQIA+ BIPOC population.

Concluding Statement

Our LGBTQIA+ BIPOC communities in the Bronx (and abroad) *can* be regarded as fully integrated members of trauma-informed treatment centers, whether they are in person or participating remotely. The investigator of this study reported on the conscious choice of applying trauma-informed treatment, as recorded by all participating mental health practitioners with their Bronx-residing LGBTQIA+ BIPOC clients. The geographical point of interest in this research falls in concentration of trauma-informed treatment results as recorded by mental health professionals who work and service LGBTQIA+ BIPOC in the Bronx. The reason for the focus on this geographical area of interest is due to it being consistently reported as being among the poorest Congressional districts in the United States.

The disproportionate number of LGBTQIA+ BIPOC experiencing a lack of trauma-informed treatment practices presents moral and ethical dilemmas in that this population has been historically underrepresented and discriminated against, even within social service agencies who allegedly service all residents in their Bronx communities. Historically, this lack of treatment carries shielded emotional and social costs for LGBTQIA+ BIPOC who suffer from a myriad of socio-emotional ills, mental health conditions, and an overall lack of receiving basic human rights.

Rather than solely applying traditional treatment approaches which serve to address the issues, through data collection the researcher uncovered the reported conscious choices of applying or not applying trauma-informed treatment practices with the targeted sample population in tandem with traditional therapeutic approaches known for treating trauma. The researcher aimed to study how the perpetuation of oppression, ostracization, and feelings of emotional impotence may be re-experienced through a trauma-informed treatment lens (e.g., application of resilience as a coping skill).

Bronx LGBTQIA+ BIPOC communities may provide insight into creating systemic justice and socio-communal revisions from a nexus of communal appreciation, empathy, and love in favor of the political push for inclusivity. These trauma-informed treatment practices may greatly benefit from positive extraversion and socially progressive means, which would ideally guide justice and social policy.

Section Three: Literature Review

Every generation in New York City gives birth to new challenges, new perspectives, and new values, even as they are influenced by our past adverse experiences. As a nation, we have caused and experienced various socio-political and cultural conflicts leading to generational adverse experiences, recorded by our neuroreceptors, hearts, and souls. Many of those who have survived these dehumanizing discords have had to incur and adapt varied forms of survival skills in the form of *resilience* and emotional coping techniques to help resolve post-traumatic stress disorders, anxiety, and depressive mood disorders. Past researchers have attempted to measure and report the traumatic effects of these experienced traumas on the livelihoods of individuals in their sample populations. Ultimately, researchers have reported that many have learned to adapt (Mallon, 2017), passively and sometimes reactively, to past and present acts of racism, homophobia, and classism. Many researchers have also reported that their sampled populations consistently continue to experience these societal ills (Mallon, 2017).

As a result of these consistent adverse experiences, mental and emotional scars may have been largely treated by mental health professionals in New York City and recorded in peer-reviewed literary journals. The researcher of this study, in search of like-minded investigations, collected and now presents a list of peer-reviewed literature which supports this investigation. The systematic literature review focuses on the directions that other researchers have collected data with themes similar to that of this researcher. Many components of their researched themes are similar to the interests of this researcher, as they focus on clients who identify as BIPOC, or as a sexual minority, or both. The sampled studies and the data collected from them, however, are dissimilar to the researcher's hypotheses and investigative inquiries. The researcher of this study focused solely on treatment given to Bronx-residing BIPOC sexual minorities.

The researcher of this investigation proceeds this report with a detailed description of the method of systematic literature review which may have uncovered the dearth of studies aimed toward effective and evidence-based trauma-informed treatment practices with individuals and communities who identify as Bronx-residing LGBTQIA+ and BIPOC.

Methods

The researcher conducted a systematic literature review using the detailed direction of our course instructor and modelling after the process as described by the Journal of European Psychology Students (JEPS) Bulletin, and by studying a few different published literature reviews noted by the Cochrane Database of Systematic Reviews.

A search was completed in the following three electronic data bases: YUFind, Google Scholar, and PubMed. The following search criteria for each data base was used: (LGBTQ people of colour – Abstract only) AND (trauma-informed treatment – no selected field of search) AND (Bronx New York – no selected field of search). YUFind yielded eighty (80) peer reviewed, full-length articles, Google Scholar yielded one hundred forty-seven (147) full-length articles, while PubMed yielded 0 articles. Subsequently, the researcher changed the search terms to retrieve the possibilities of finding other relatable articles which would best present the literature which supports the investigation.

The search terms changed three times (adding more variety of relatable terms within the search term, as well as the order in which they had been presented), thereafter. It should be noted that ‘peer-reviewed’ as criteria for the literature is solely accessed in YUFind. The first change in search terms was presented as: (LGBTQ or lesbian or gay or homosexual or bisexual or transgender or homosexual or queer or sexual minority) AND (trauma-informed care or trauma-informed practice or trauma or trauma-informed approach) AND (People of Colour). YUFind

yielded twenty-three (23) peer reviewed, full-length articles, Google Scholar yielded fifty-three (53) articles, PubMed yielded five (5) results.

The second change in search terms was presented as: (LGBTQ and BIPOC community and mental health) AND (trauma-informed care or trauma-informed practice or trauma or trauma-informed approach) AND (Bronx New York). YUFind yielded 150 peer reviewed, full-length articles. Google Search yielded six articles, while PubMed yielded 0 results. The third change in search terms was presented as: (LGBTQ BIPOC) AND (trauma-informed care or trauma-informed practice or trauma or trauma-informed approach) AND (NYC). YUFind yielded 30 peer reviewed, full-length articles. Google Scholar yielded 48 articles, while PubMed yielded 0 results.

In total, YUFind yielded the most relatable peer reviewed, full-length articles which best appropriately supports the need for the researcher's investigation. YUFind provided 24 practicable peer reviewed articles. Google Scholar produced 4 useful peer-reviewed, full-length articles, while PubMed provided one (1).

Inclusion criteria, as previously noted, included peer reviewed, full-length articles where the search terms were in the 'Abstract' of each citation in relation with each of the terms searched, and any single mention of any one of the search term derivatives found in the 'Abstracts' of each citation (e.g., '*Post-traumatic stress disorder*', '*Adverse Childhood Experiences – ACEs*', '*Resilience Work*', '*Black and Indigenous People of Colour – BIPOC*'). Not all articles have *all* the appropriate investigative terms in one piece of literature. Only two had all; 'LGBTQIA+' 'BIPOC' 'trauma-informed treatment', and 'residing in the Bronx'. Exclusion criteria included dissertations or proposals for dissertations, written studies presented other than in English, non-peer reviewed literature, and any literature that was performed out of the United States.

The researcher identified many repeat patterns of yielded citations found in the results of each combination of search terms. After examining all prospective articles which best support the investigation, the researcher of this study narrowed down the choices to twenty-eight (28) articles, separated in four separate sub-themes in reference to the research question and supporting hypotheses. It was noted that few articles were available and appropriate for investigative purposes when using PubMed as a search tool. Hypothetically, then, it is very likely that there is a paucity of related literature to the theme of the investigation.

Results

For better clarity in following through when reviewing the following categorized literature, please note that the following terms have been used interchangeably as a description of the sample of the population of interest for the study and the observed mental health services provided for them. These terms are as followed; 'BIPOC – Black and Indigenous People of Colour' and 'People of Colour', 'LGBTQIA+ - Lesbian Gay Bisexual Transgender Questioning/Queer Intersex and Asexual' and 'Lesbian or Gay or Bisexual or Transgender or Homosexual or Questioning/Queer' and 'LGBT' and 'LGB' and '2 Spirit', 'trauma-informed treatment' and 'PTSD/Anxiety/Mood Disorder Treatment Practices'.

This literature review has been categorized and grouped together to offer a more fluid connection between the collected literature and the researcher's investigation. Throughout this systematic literature review, the researcher has found a variety of four related, yet distinctive themes. The first six articles explore the recognition of trauma within communities of LGBTQIA+ BIPOC individuals and the mental health professionals who service them. The next twelve articles discuss the further need for trauma-informed treatment practices. The third set, encompassing four articles, focuses on the 'comparison studies' between the sexual majority and

the sexual minority (LGBTQ+). The final set explores the applications of trauma-informed treatment practices with varied populations, including that of, but not limited to, members of the LGBTQIA+ BIPOC communities in the United States.

The inclusion of some articles may exclude some sub-populations that the researcher wished to investigate. Nonetheless, all twenty-eight articles have been included in this systematic literature review for the purposes of noting the recognition of, effectiveness of, and necessity for trauma-informed treatment practices servicing any and every LGBTQIA+ BIPOC individual and community in need of mental health resolution and a better quality of life.

Studied Recognition of High Rates of Trauma Within Communities of LGBTQIA+ BIPOC Youth and Professionals

Stults, et al. (2017) report on what is recorded as the 'deadliest mass shooting in American history' - the Pulse massacre. The researchers performed a quantitative study through the administration of a survey, distributed nationwide to LGBTQ individuals, regarding the 'Pulse massacre' a few weeks after it occurred. The survey posed questions about their cognitive knowledge and emotional reactions regarding the massacre. Participants were also categorized and cross-referenced, and represented through cross-sectional data, by how each identified through sexual orientation, gender identity, and race/ethnicity. Overall responses numbered slightly over eleven-hundred online completed surveys and over two-hundred in-person completed surveys.

Results from this study were statistically significant for *personal safety* in the category of gender identity, as females and genderqueer participants reported more concerns than other respondents about their personal safety. Respondents' perceptions about peer safety differed significantly under the categories of 'gender identity' and sexual orientation, but not by

race/ethnicity. Female, genderqueer, and transgender-identified participants discerned more concern for peer safety as compared to male participants.

The researchers hypothesized that because there were many Hispano/Latino/a/x victims and witnesses present at the 'Pulse massacre', that they would be the largest respondent group. However, the study reports that this was not the case, as a larger percentage of Whites (non-Hispanic/Latino/a/x) responded and reported feeling less safe regarding their personal safety and that of their fellow peers. The study revealed that participants of the survey completion who identified as cisgender male reported the least concern for their personal safety, as compared to any of the other categories of individuals.

The researchers concluded that the limitations of the study included the possible lack of validity in responses performed through internet completion, as there is no way of discerning how, if at all, the participants who completed the survey did indeed fit the inclusion criteria. The researchers also consider how the survey may not have been available to many who did not have access to it, either in person or through electronically. Perhaps further surveys related to this study could investigate how and why Latino/a/x and Black LGBTQIA+ individuals did not report as much threat to their personal safety as a result of this massacre (or perhaps any other hate crime experienced related to intersecting identities).

The need for trauma-informed treatment may not be apparent to traumatized LGBTQIA+ BIPOC, particularly when the traumatized person does not allow themselves to be aware of physical or emotional threats to them. They may figure, 'why bother to care anymore'. Based on past experiences of receiving consistent threats to their person and inadequate support, these individuals may have concluded that it is futile to try and resolve their reactions to those threats. Instead, victims of trauma, for example, may express their coping through substance use/abuse.

Girouard, et al. (2019) summarize and interpret secondary data analysis conducted by the delegators of a 2015 National Survey on drug use and health. Surveyors of the collected data reported about the efficacy of cognitive-based and cognitive processing therapeutic (CBT & CPT) approaches in treatment for opioid abuse/misuse in LGBTQ populations in the United States. It is the common perception that opioid use/misuse is an effort to escape strong adverse feelings from traumatic childhood experiences. The 2015 national survey which reported in their findings that there is a statistical prevalence of substance use disorders (SUDs) among general LGBTQ populations in the United States in contrast with their hetero-normative counterparts.

Girouard (2019) also found that sexual-risk behaviours are reported to be more common among gay male opioid users, as they tend to have sex with other men without the use of prophylactics. There is also a mention of how transgender patients may become seriously addicted to prescription opioids, as there has been a 20 percent increase in gender affirmation surgeries performed (reference from 2015-2016, American Society of Plastic Surgeons, Plastic Surgery Statistics Report). Prescription analgesic medications were regularly consumed by transgender patients, which subsequently led to substance abuse behaviours. CBT/CPT treatment is common practice for LGBTQ individuals who experience SUDs, post-traumatic stress disorder (PTSD), and depression (the CBT model is generally used to treat SUDs, while CPT is used to treat trauma-based disorders).

Girouard devised a table that demonstrated the manners in which social service/mental health practitioners use CBT &/or CPT in treatment with LGBTQ populations. During treatment, practitioners, through their work with their clients, become aware of minority stressors, also known as, *triggers*. These triggers provoke behavioural mishaps and further victimized experiences.

Practitioners aim to prioritize the victim's personal goals related to: prescribed medication uses, finding healthy role models, temptation management, diverting sexual-risk behaviours and use of shared intravenous equipment. Through CPT, practitioners focus toward: stigmas causing PTSD, positive substitutions replacing negative internalized self-criticisms, and distinguishing self-incrimination from challenges that are regularly experienced by any existence of minority stress. This study highlighted the importance of practicing CBT and /or CPT in conjunction with trauma-informed treatment guidelines for sexual minorities. Perhaps further research could continue to focus on the added stressors experienced by LGBTQIA+ BIPOC. Further investigation may also warrant attention toward further reasons for the lack of need for CBT/CPT among Lesbians/Lesbian Women of Colour.

Minority stress may be apparent in LGBTQIA+ BIPOC being treated, as well as by those who provide treatment for them. Often time, these traumatized clients benefit from treatment from providers who may have also experienced minority stress trauma, and have, themselves, been treated for it. Senreich, et al. (2020) collected data in 2015 about the behavioural and physical health wellness of 6,112 licensed social workers identified through licensing boards in thirteen states in the United States. A 75-item, online survey was distributed. The respondents described having survived adverse childhood experiences (ACEs), trauma related to substance misuse, and mental health issues.

They used the *Minority Stress Model* framework and compared the experiences of trauma (incurred and on-going) and physical/mental health needs of these social workers further categorized into: gay/bisexual men, lesbian/bisexual women, heterosexual women, and heterosexual men. The researchers examined differences in reported mental health problems, as well as with mental health service utilization and with adverse childhood experiences between

these groups. The researchers found that 37% of LGB respondents reported experiencing some form of mental illness. Thirteen percent (13%) reported a serious mental illness, in contrast with seventeen percent (17%) of heterosexual adults experiencing any form of mental illness. Four percent (4%) experienced being diagnosed with a serious mental illness.

The findings revealed by this research suggest that a large percentage of social workers, who often treat LGBTQIA+ individuals, also identify with a minority sexual orientation and may themselves identify with the need for mental health services. Trauma-informed treatment may be further accessible and effective if LGBTQIA+ clients feel mentored by members of their own community. The study, however, does not discuss the recognition of intersections regarding race and economic-disparity identities among LGBTQIA+ workers and clients, which can profoundly influence and deepen the positive effects of trauma-informed treatment.

Social workers and other mental health providers may have their best intentions in mind when treating traumatized LGBTQIA+ BIPOC individuals. However, some practitioners may not share the values of those they treat. Thus, trauma-informed treatment may not be considered if the values of the practitioner dismiss the values of those LGBTQIA+ BIPOC individuals in need of treatment. Mountz & Capous-Desyllas (2020) discuss how LGBTQ youth are disproportionately over-represented in childcare and foster care services. Yet somehow, they are still ignored. The researchers report that these youth have not yet been receiving appropriately rendered treatment by child welfare and foster care agency workers. They also do not receive proper transitional training preparation into adult self-sufficient independence (Feinstein, et al., 2001). Support systems and safety nets in the community for these individuals are loosely made and improperly connected (Mallon, 2017).

Given data bases collected from nationwide metropolitan areas, LGBTQIA+ BIPOC statistically account for the highest percent of children in foster care (Mallon, 2017). Transition to independent living is not a priority to resolve for many federal, state, and local child welfare agencies. An example of this institutional bias on LGBTQ homeless and foster care youth (who are predominantly BIPOC in metropolitan areas) is the lack of data collection regarding sexual orientation and gender identity and expression (SOGIE) performed by the administrators of the National Youth in Transition Databases.

Mallon (2017) in his research, reports three major reasons why LGBTQ children enter foster care. They are: 1) conflicts with families, 2) LGBTQ youth left home or were rejected by caretakers (e.g., sexual violence) – sexual orientation and gender identity were indeed at the base of their reasons for being rejected, by and large, 3) youth came out and identified as LGBTQ while in the foster care system. His research hypothesized and demonstrated evidence that LGBT young adults and teenagers receive little attention to prepare them for independent living, employment, and access to community support networks.

Mountz & Capous-Desyllas (2020) and Girouard, et al. (2019) focus their aim on the disparate outcomes in social services for LGBTQ BIPOC individuals. Unlike Girouard, et al.'s quantitative performed research, Mountz & Capous-Desyllas (2020), performed a qualitative, community-based participatory research (CBPR) project. The authors and their team interviewed 25 LGBTQ individuals who had all experienced foster care services in the Los Angeles metropolitan area. They recorded the reported trajectories of these LGBTQ interviewed individuals into socially stable lives. Generational mental health and substance abuse traumas are a common deterring factor of their continual struggle to successful living and quality of life. Their findings relate similarly to that of Seinrich, et al. (2019), who recognize the congruence

between practitioners who have also experienced traumas and had, in all likelihood, been treated for it.

Mountz & Capous-Desyllas' team members identified with nine (9) different SOGIE identities, a methodological factor inherently quintessential for the researchers. The team observed practices and knowledge of Intersectional Feminist and Queer theories, to best address the consistent struggle to adapt to socially constructed power regimes and privilege oppressions. The authors use Potts & Brown, (2005)'s 'Anti-Oppressive Practice' (AOP) as anti-aggressive practice approaches with the interviewing process, which focused on social justice, recognition that all knowledge is socially constructed and political, and the integrative influence of the individual and the community as building safe spaces by battling power dynamics.

A community advisory board formed part of the research team, as they were integral members of the LGBTQ community who work and/or reside within the area of the performed study. The team helped create the question guide and recruited the participants. Eighty-five (85%) of participants in this study were BIPOC, as well as LGBTQIA+. Participants were recruited to complete the qualitative interviews through outreach methods of distributed flyers, advertising through social media, as well as through word-of-mouth community influencers.

The main drawback of this article is that it fails to identify the detailed amounts of SOGIE-identified clients studied by the team. There is no way of knowing how pervasive the experienced traumas of being rejected by their birth *and* foster families have directly or indirectly affected them. It is evident that these experiences have negatively impacted their sense of self-worth and identities. However, to what extent does their sense of resilience serve in their benefit? Further studies related to the focus of this study would need to focus on how learned resilience could play a critical role in trauma-informed treatment.

Ferguson & Maccio (2015) report data collection taken from 19 nonprofit social service organizations who aid runaway or homeless individuals. Their collected data was separated into categories and sub-categories, each bridged by the core investigation's focal theme – qualitative data collected (via telephone interviews) from LGBTQ runaway/homeless individuals. The researchers reported that the integrated programs involved presently attending participants and possible group members. The researchers, then, categorically mentioned these programs throughout the interviews and cross-referenced these data with the following themes: health/mental health/substance use, case management, family, legal, education and employment, and housing services.

These cross-referenced categories each contained five themes: reliance on clinical evidence, trauma-informed approach, provision of safe/stable housing, planning the use of LGBTQ community peers to participate in the programs, and providing opportunities for LGBTQ and heterosexual homeless individuals to learn from each other. The findings help to add practical and logical components to present-day policies and social service treatments that would best maintain and more appropriately serve as intervention for LGBTQ homeless individuals.

The study conducted by Ferguson & Maccio, (2015) posed two research questions (related to this investigation):

1) Which promising programs are being used across the United States to serve LGBTQ homeless individuals?

2) What can be learned from these promising programs to guide future practice, policy, and research with LGBTQ homeless individuals?

(Ferguson & Macchio, 2015)

The methodological approach used by the researchers consisted of an internet search to form the 19 chosen, federally-funded agencies which specifically service runaway youth and homeless individuals (heterosexual and LGBTQIA+ constituents). The researchers used snowball sampling. By conducting a literature review for the study, they identified key researchers within the participating agencies who had performed research of their own. All participating agencies maintain and operate programs whose intentions are to serve the needs of LGBTQ homeless individuals (and other sub-groups categorized with them).

The sample represented 24 agencies and their administrative professionals, as well as other staff from 19 unrelated agencies. Results revealed that mental health professionals note that LGBTQ clients were, indeed, given one or more forms of trauma-informed treatment approaches in conjunction with Cognitive-based therapy and Dialectical Behaviour therapeutic approaches. The relevance of this study in connection with that of this investigation is that there is a shared interest in highlighting the need to further research how social service agencies could more deeply consider the impact of applying trauma-informed treatments for their LGBTQIA+ BIPOC serviced populations. Taking into consideration the importance of the data collected from these 24 social service professionals, further research could continue to focus on data collected from community volunteers/volunteer mentors, who may have more access to data-rich information.

Need for Trauma-informed Treatment

Hudson & Romanelli (2020) conducted a study with thirty-eight (38) LGBTQ-identified BIPOC participants in New York City through application of a health equity framework, which examined perspectives of participants into how the role of adopted communities of overall health and socio-emotional support aided their welfare. Community support was identified in three key factors of their overall health and socio-emotional welfare. They are: 1) a general feeling of

safety, acceptance, and support, 2) resource sharing among community members, and 3) advocacy, solidarity within the community, and building the common well-being of the entire community.

This study was a phenomenological, qualitative, multidimensional approach using a health equity promotion model. The model recognizes and highlights the minority stress theory and psychological mediation theory to establish the apparent disparities present in providing equitable health services of all types toward LGBTQ BIPOC. Purposive and snowball sampling was achieved through advertised flyers at 12 LGBTQ-specific health and social service agencies throughout the New York City metropolitan area. Inclusion criteria were established as follows; self-identification of sexual minority status, older than 18 (mean age = 46), and BIPOC. The three previously mentioned themes were accentuated in the results of this study. The first theme, "*Safety, et al.*", reported acknowledgement of impactful proportions toward the health and wellbeing of 14 of the 38 participants. This theme honours and promotes honesty and *realness* (*realness* refers to an individual's ability to relate to what they come to know emotionally and socio-psychologically as true to them). The second theme, "*Resource sharing*", is mentioned as an integral part of the success of the individual and the shared community by 18/38 participants. Through shared resources, this theme is meant to build the community by promoting overall health for the individual. The third theme, "*Advocacy et al.*", promotes policy-enacting cultural recognition of the LGBTQ BIPOC community in NYC through establishing political power with supportive legislators.

Hudson & Romanelli axis their data-rich findings through a sample population similar to what the researcher has also investigated, as they elicit data from NYC resident LGBTQ BIPOC. They used the minority stress theory to further support their findings, which can well relate with

Intersectional Feminist and Queer theories, as the researcher used these theories in support of prospective findings. Although the researchers investigate the triggers which leads these clients to seek mental health services, the study does not define how trauma-informed treatment has positively, neutrally, or negatively aided their present treatment.

Hudson & Romanelli emphasize the importance of community building activities to be included in trauma-informed treatment practices, to create a momentum of solidarity among LGBTQIA+ BIPOC in NYC. Unfortunately, a sense of building community does not assure safe health practices among its members, as is discussed by Bragard, et al. (2020) with their findings. Bragard, et al. comment on the consistent growth of studies reporting the behaviours of adolescent men who have sex with men who choose to disregard condom self-efficacy and contract HIV. The article reviews the effectiveness of behavioural intervention in reaching out to these young men in LGBTQIA+ communities. The studies reveal an overwhelming vulnerability experienced by these young men with their sexual partners, which is characterized as a form of bullying. Their vulnerability is largely characterized by a sense of low self-esteem. If these young men would have had the opportunity to access Hudson & Romanelli's study, they could have been influenced to rely on their community's empathy and self-esteem building.

Bragard's sample population included one hundred forty-three (143) adolescent men, aged 14-17, who have sex with men. A survey was conducted through LimeSurvey software for a duration of four weeks. Recruitment was performed through a Facebook advertisement. There were 1,351 responses and 959 were selected as ineligible.

Their survey included an 11-item questionnaire with close-ended, scaled questions focusing on; experiences of victimization distress, condom-less anal intercourse vulnerability, intercourse frequency and sexual behaviours, and demographics and sexual orientation

disclosure. A multivariate analysis of variance together with Pearson's correlation evaluated participant age, ethnicity, and sexual orientation. Three linear regressions were run.

The purpose of their study was to better focus on the associations between distress and victimization. The population of focus for their study had experienced traumas related to condom-less anal intercourse vulnerability, as influenced by their sexual partner(s). Bragard and researchers investigated the factors leading to this type of victimization. This study's relativity to the researcher's investigation could be explained through the similarities of their interests and implications for further research in recognizing of a need for trauma-informed treatment. Bragard, et al. wish to bring light to the prevention of sexual abuse with this population by utilizing trauma-informed treatment practices. Bragard, et al. solely focus on young Gay men, not specifically with young men of colour. Their findings do not, however, specify a NYC geographical area of focus. There is no mention of further suggestions to study the traumas faced by LBT+ individuals who may also experience similar types of victimization.

Victimization in the LGBTQIA+ BIPOC community may be considered a rite of passage, as discussed by Schneeberger, et al. (2014). Their study captures a sense of nihilism observed in global communities of sexual minorities. In their study, Schneeberger, et al. highlight the secondary data findings of surveyed LGBT adults, from varied countries around the world, who have adversely experienced several different types of traumatic events in their lives. The categories of these traumatic experiences were listed as; childhood sexual abuse, childhood physical abuse, childhood emotional abuse, childhood physical neglect, and childhood emotional neglect. The article reveals and discusses the comparisons between all mentioned categories. The authors hypothesize that from the various findings reported, LGBT populations categorically

reported higher levels of adverse childhood experiences, as compared to their heterosexual and cis-gendered counterparts. Trauma-informed care for these individuals were also reported. However, to what extent it was used was not made apparent.

A prevalence of mental health/psychiatric disorders was reviewed as factors that were likely involved in trauma-induced episodes; revictimization leading to dysfunctional behavioral adjustment, and substance abuse issues. The findings of their reported studies discuss relatability with each other - LGBT populations being the linking factor. Notedly, Schneeberger, et al. are internationally resourced (diverse in sub-populations and with diverse cultures as an 'umbrella term'). Contemporarily, Schneeberger, et al. recognize that mental health professionals may lack regard or sensitivity toward the significance of adverse childhood experiences in mental health treatment. The findings do not focus on the added impact of fear of exposure ('getting outed'), not being psychologically/emotionally available to self-identify as LGBT, which may be pertinent to the presented research.

Schneeberger (2014) recommend that further data collection within the area of trauma-informed care should be practiced. The findings of the reported studies in this article also included little focused attention toward transgender populations, who are reportedly more victimized in most worldwide populations (Anderson, 2021), including within their very own LGBT populations (Ramirez & Paz Galupo, 2019).

Further studies would need to perform qualitative and quantitative analysis through convenience sampling, as opposed to general random sampling. Schneeberger, et al., also recommend that more studies need to be generated to educate mental health professionals regarding the issues which focus on LGBT clients needing to receive more trauma-informed care. Unfortunately, there is no mention of the multiple effects of intersectional experienced trauma regarding the comparisons between White LGBTQ individuals and LGBTQ BIPOC.

Their study is also a global one - quite the opposite of this investigation, as their data collection focused solely on practitioner's knowledge of Bronx, NYC client populations.

Data collection performed by some researchers of trauma-informed practices may be relevant to most researchers collecting data from (or about) sexual minorities, but not with all. The expanse of the umbrella term 'sexual minority' grows periodically in certain research-related circles. BIPOC cultures vary, of course. Although many consider sexual minority to be globally represented, as is the case with Schneeberger, et al.

Some researchers, on the other hand, choose to study the intricacies and influences of specific cultural values practiced by some BIPOC sexual minorities. Schmitz & Charak (2020), as an example of studied, culture-clashed values in conflict, focus on the discreditations and discriminations of LGBTQ 2 Spirit+ individuals within Native American nations. Their study exposed extensive mental health repercussions lived by Native American sexual minorities. Native American LGBTQ2S are often victimized through adverse childhood and young adult experiences of domestic, sexual, and hate-crime violence. These individuals also share the trauma of generational damages caused by colonialism, racism, sexism, homophobia, and classism, a factor which is not reviewed in Schneeberger's study of global data collection. Schmitz & Charak's studied participants view their traumatic experiences as those which have marred their mental health statuses. Their participants marked these traumatic experiences as 'pivotal points' by which they decide to guide their lives.

An intersectional Feminist approach to understanding the extensive causes of mental health symptomology was observed and noted for this study, as it was reported that Native youth experience, on the average, four lifetime traumas. These traumas are caused by systemic and institutional racist practices, poverty, domestic violence, and pervasive substance abuse within

their isolated communities. Case by case data collection reported traumas lived through intersections of discriminatory experiences. Because the interviewees were largely represented as college students, the present study suggests that more studies, like this one, be conducted in more college campuses throughout the U.S. Schmitz & Charak emphasize that future research should explore how the understanding of trauma, as experienced by young adults, may fluctuate throughout tribal groups, which could facilitate tribal health/mental health serviced interventions.

Schmitz & Charak have come to recognize the substantial occurrences of trauma experienced by Native minority groups, and their great need for the facilitation of trauma-informed treatment. It is driven from the Intersectional Feminist Theory model, pertinent with the use of theoretical intentions of this investigation. Although the poignant data collected from this research regarding the experienced traumas of Native LGBTQ2S+ individuals correlate with data collected from nationwide (and/or residential NYC) LGBTQIA+ BIPOC communities, the study marks solely the uniqueness of the needs for only this community.

Providing a brief synopsis of the need for trauma-informed treatment data collection in general BIPOC populations of the United States, Foxen's (2016) report discusses the Hispanic/Latino/a/x oppression and anxiety-producing stressors present in cities and urban populations, around the country. Among young Latino/a/xs, in particular (one out of four American youth), the anxiety provoked by racial and ethnic antagonism has been progressively amplified by the politics, discourses, and traumatic events surrounding the 2016 election cycle. According to Foxen's report, antagonistic reactiveness, bullying, and incidents or threats of violence have pervasively risen since the advent of the 2017 presidential inauguration. These stressors have consistently triggered distress within schools and other public spaces. Foxen's report draws a thorough conclusion about the focus of uncertainty for any form of future multi-

faceted, positive progress that many Hispanic/Latina/o/x experience. For many youths in this population of focus, their parent/s, head of household (if any), or loved one(s) experience more of a sense of urgency and desperation in realizing the fear that any one of them may be deported.

Foxen's 2016 report exacts that using a trauma-informed approach would most beneficially recognize the events, experiences, and adverse effects of trauma (for at-risk Hispanic/Latino/a/x youth, trauma may stem from family migration, acculturation problems, domestic or community violence, or generational trauma related to discrimination). In practice, trauma-informed treatment approaches emphasize safety, trust, collaboration, choice, and healing, as well as the importance of cultural, historical, and gendered aspects of trauma.

Foxen's report references data collected from many community-based mental health programs. The collected data reveals that these agencies lack the financial resources to set up rigorous, controlled research that would prove the effectiveness of trauma-informed treatment practices. The report's data reflects that the controlled methodology required by evidence-based practiced (EBP) research does not translate to the necessities of real-world service provisions. Mainstream EBP evaluation may not pay sufficient attention to cultural validity (how particular mental health treatments are perceived and received by diverse communities) or to the specific ways in which culture is integrated into services.

Most notable about this report is the mention of the great need to provide mentoring and culturally relevant trauma-informed treatment with our Hispanic/Latino/a/x populations. Interestingly and arguably, the report fails to include and recognize the large percentage of LGBTQIA+ Hispanic/Latina/o/x populations comprising the statistics. Notably, the report seems to serve as a good example of the overwhelming presence of institutional homophobia.

The need for trauma-informed treatment may be expansive, as every member of our society may discover that adverse childhood (or young adult) experiences have formed daily counter-productive behavioural patterns. Minorities of every kind may be most at risk with experiencing traumatic events. Hoefinger, et al. (2020) report the systemic need for trauma-informed treatment caused by sex trafficking, resulting in the employment of anti-trafficking interventions and the criminalization of sex work and migration. The study reports results of negative health/mental health impacts on sex workers, migrant workers, and people with trafficking experiences. Due to their stigmatized statuses, sex workers and people with experiences of being 'trafficked' often struggle to access affordable, unbiased, and supportive health care. Hoefinger, et al. used a thematic analysis of qualitative data from in-depth interviews and ethnographic fieldwork with fifty (50) migrant sex workers and trafficked persons. They also mention commentary, regarding this population, as generated from twenty (20) key informants who represent legal and social services in New York City and Los Angeles.

The study highlights the accounts of transgender sex workers regarding the mental health and physical health services they had previously experienced in the U.S. Their responses to interview questions revealed the need for the initiative of providing trauma-informed treatment. They stressed that their study may have internally addressed the gaps in health care and the negative health consequences that result from sexual humanitarian and anti-trafficking interventions. These gaps include; the reduction of the percentage of court-involvements, court-mandated social services, policing, arrests, incarcerations, and immigration detentions. The article's analysis focuses on the impact of criminalizing sex workers. Hoefinger, et al. recorded their experiences with humanitarian efforts. They did so with the intent to protect them, as their ultimate goal is to influence the minimization of policing incidents with this niche population.

The authors of the article argue that these grassroots community-based efforts are a response to the gross mismanagement and lack of appropriate social services provided for trafficked transgender sex workers who are eventually framed for illegal sexual activity. After recognizing the need for systemic change in social services for this sexual minority group, Hoefinger, et al. report the effectiveness of peer-to-peer interventions, as similarly reported by Hudson & Romanelli, (2020). They further discuss how volunteered mentorship programs serve to create solidarity and resilience within these marginalized communities. According to Hoefinger, et al.'s reviewed study, these volunteers successfully act as protective buffers against institutionalized, systemic violence and their resulting negative health outcomes.

The results of the study suggested that broader public health support and funding for community-led health initiatives are needed to reduce barriers to health care resulting from stigma, criminalization, and ineffective anti-trafficking and humanitarian efforts. It was concluded that the decriminalization of sex work and the reform of institutional practices in the U.S. are urgently needed to reduce the overall negative health outcomes with systemic involvement.

Although incredibly relevant to the research of this investigation, this study only focuses on the transgender population, which arguably may be the most vulnerable of LGBTQIA+ communities. It also only includes Latino/a/x/Hispanic populations who are threatened by deportation, excluding the instances of sexual trafficking of Black, Indigenous, and Asian LGBTQIA+ individuals.

Decriminalization of sex workers may afford victims of trauma to be recognized not just for their actions/behaviours/survival coping skills, but for the persons that they are – individuals who have relied on their need to survive in the face of consistent denigration and without

wholistic regard for the individual. Mental health professionals and public service professionals may need to reassess their biases when working with BIPOC sexual minorities, especially their views on the criminalization of sex workers. Blair & Deckman's (2020) research, for example, suggests that teachers are not meeting the needs of transgender students. The study sets out to research the following investigations: *How do pre-service teachers (PSTs) in the United States indirectly construct the experiences of trans and gender creative students? How are their preemptive social constructions informed by and reinscribe broader gender normative practices in educational contexts?*

The article analyzed the responses of five hundred forty-nine (549) pre-service teachers who responded to online discussion posts sent by Blair and Deckman in connection and collaboration with the administrators from an 'educational foundations' course offered at a northeastern university in the United States. The findings reported that public school teachers did not possess a competent amount of cultural familiarity of transgender and gender non-conforming student experiences. As a result, those teachers tended to distance themselves from those students by not asking them to participate as much in class as they would other gender-conforming students. Their prejudice suggested barriers led to a lack of empathy which revealed obstructed teacher-student relationships and a gross lack of promotion of equity. All pedagogical trainings should be obligated to address and begin to resolve any prejudicial social constructs that may limit the instruction of pedagogical practices which influence future licensed instructors.

The study's focus relates to this investigation with the regard for demonstrating the awareness for the lack of cultural recognition experienced by sexual minorities. Eventually, they expressed the notion that discarded uses of trauma-informed treatment practices shouldn't go

unnoticed. Their study impresses the importance of studying how mental health professionals, who service LGBTQIA+ populations, are *not* the only population of professionals who require trauma-informed treatment training. Blair & Deckman, however, do not mention how LGBTQIA+ **BIPOC** may experience added experiences of intersectional traumatic experiences and institutionalized racism and homophobia.

The constant struggle to separate the individual from their counter-productive behaviours is a battle that may persist in our American society. By practicing trauma-informed treatment, the mental health practitioner is obligated to observe the client as a whole and not solely the sum of their behaviours. Upon recognizing and demonstrating credence to the client as a *whole person*, relative to their social surroundings, the mental health practitioner may arrive to the conclusion that prizing their clients' resilience is key to progressive treatment. Having mentioned that, Landers & Kapadia (2017), in connection to resilience as an effective therapeutic tool, focused on secondary data collected regarding the recognition of incurred attributes of valour and resilience of transgender individuals and the injustices they have experienced - currently and throughout history.

Although awareness and recognition of transgender identity is gaining mainstream acknowledgment, oppositional behaviours (i.e., fear, uncertainty, violence/aggression, and indifference) continue to plague transgender individuals and their communities. The abhorrence of this discrimination and victimization may leave them vulnerable to more instances and opportunities for adverse experiences, harm, violence, suicide, suicidal ideation, and homicides (Blair & Deckman, 2020). This reality may then lead to voluminous rates of mental illness, incomparable with any other rates of mental illness experienced by other minority group (e.g., depression, anxiety disorders, Bipolar and other mood, or personality disorders).

Landers & Kapadia (2017) discussed the consistent growing need for mental and physical health representations of transgender individuals. They also suggested that there remains a growing need for the study and promotion of cultural awareness in identity and etiquette toward transgender individuals and other sexual minorities. The article estimates the transgender population in the United States to be about 1.3 million. Taking this large percentage into consideration, Landers & Kapadia (2017) discuss the lack of data and systematic literature reviews performed regarding transgender physical and mental health concerns. They suggest that a gross level of institutionalized homophobia is at fault. They continue to suggest the need for noting, investigating, and funding further research that would better examine how the practice of providing trauma-informed treatment may comprehensively benefit LGBT+ populations in the U.S.

What is most relevant to the researcher's investigation in connection with this study is the mention of referencing best mental health treatment practices - specifically the cultural sensitivities needed to form questionnaires, which would ask about sexual identity for the purposes of social welfare research. Their presented secondary data, however, does not account for the niche of trauma-informed treatment needs required to treat transgender or LGB BIPOC clients.

Mental health practitioners becoming familiar with BIPOC sexual minority cultural and sub-cultural, as well as observing their socio-behavioural practices, may encounter homophobic and transphobic social expressions while treating their clients. Literature discussing this social phenomenon alludes to learned competitiveness in receiving and acknowledging the social privileges given to BIPOC sexual minorities who present as being less apparent with their BIPOC and sexual minority identities. Regan (2019), in support of noting the presence of

internalized racism and homophobia with clients who are BIPOC sexual minorities, performs a critical book review of *Microaggressions and Traumatic Stress: Theory, Research, and Clinical Treatment, (2018).* The review summarizes how the author, Kevin Nadal, emphasizes the gross lack of clinical professionalism present in treatment of minorities, including the intersecting issues which affect LGBTQ+ BIPOC. Regan discusses how the author believes that the effects of microaggressions may be largely responsible for many mental health prognoses. Within and outside nationwide LGBTQIA+ communities, the effects of microaggressions are played out in the formation of psychopathology and traumatic stress for LGBTQIA+ BIPOC (Nadal, 2019, p. 141). Regan (2019) comments on why Nadal sheds a light on the historic formations of these microaggressions (rooted in racist, and homophobic ideology, which is also rooted in colonialism and white supremacy).

In summarization of Nadal's book, Regan noted that culturally competent therapeutic approaches, as practiced by professionals, have rendered effective treatment for LGBTQ+ BIPOC. The microaggressions, from an outsider's point of view, is perceived as incredibly harmful and abrasive. The practice and ideology behind the user and the receiver, however, are purposed to encourage a thicker skin for the recipient to build. Regan (2019) noted that 'Resilience' is key to their physical and mental health survival, as they have learned and practiced (Regan's sample quote in support of Nadal's studies, "…hard love is better utilized to preserve the valued existence of the receiver of the microaggressions"). In this brief and noteworthy book review, Regan elucidates how Nadal categorizes these lived microaggressions. They are separated into three categories: micro-assaults, microinsults, and microinvalidations. Regan (2019) intimates that the main strength of the book lies in the details of the case studies observed. The details revealed in these case studies offer social service professionals key insights

into how best to treat victims of microaggression trauma through applications of trauma-informed treatment practices.

Building and encouraging resilience as a trauma-informed treatment practice may be more common practice, as reported in some social work research literature. Kelly, et al. (2020), for example, led a study which focused on LGBTQIA+ BIPOC individual resilience within their communities while assuming the pressures these individuals incur. Their report showcases how some LGBTQIA+ BIPOC aspire to receive accolades which highlight superficial values of their appearances. The literature review is separated into 5 themes: conceptualization of Queer collective trauma, trauma external to Queer communities (Queer people as a minority, Queer people, and Transgender people), Trauma within Queer Communities, and Portland Oregon as a context of geographical reference for LGBTQ+ BIPOC. The literature review focuses on the internal and external discriminations generally experienced by groups of individuals within Portland, Oregon's LGBTQ+ BIPOC community. Their research discussed how individuals in these communities are often given privileges for appearing more 'White, cisgender (or passing as the gender not assigned to one at birth), heterosexual, masculine, feminine'. Cissexism is analyzed within many of these Queer communities.

Methodologically, Kelly, et al. created a study which involved eighty (80) participants, sampled and interviewed within Portland's LGBTQ+ community. Participants were recruited through flyers and email lists accessed from LGBTQ+ cultural centers. Participants were given a $25 gift card. The interview questions were formed keeping in mind the guidance of S.M.A.R.T. goals (Specific, Measurable, Achievable, Realistic, and Timely), as well as the cultural nuances related to and practiced by the sample population. The authors conducting the interviews, themselves, identified as members of the LGBTQ+ community.

Their findings strongly indicated the adverse effects of racism and cissexism within Portland's LGBTQ+ BIPOC community. Incidents of racism and outright racial discrimination continue to mar the community, causing cultural rifts among them. These rifts and continued enactments of racial discrimination are discussed as continued factors of trauma for LGBTQIA+ BIPOC, within the 'LGBTQ+ metropolitan Portland bubble'.

Outright racism in cultural performances, housing, racial segregation in socialization, and traumas experienced by participants are examples of the consistent themes present throughout the interviews. Political battles, violent attacks, and the consistent deferment to cissexism are ever-present in their transcribed dialogues. Although the study focuses on the key components of traumatic experiences lived by this community, it does not investigate how these participants feel that trauma-informed treatment would be further beneficial for them (or otherwise observed). Although Portland, Oregon is generously populated as a city, its LGBTQ BIPOC population is far less than the size of NYC's, which may require a larger and more distinct aim toward trauma-informed treatment goals.

Analogous with the investigations of reported microaggressions within BIPOC sexual minority populations in the United States, Reisner, et al. (2016) discuss the everyday symptoms experienced by the transgender folk who participated in their study. The grounded theory behind the study suggested how the perpetuity of daily adverse occurrences that transgender folk endure is experienced via physical, emotional, verbal abuse and shaming. Discrimination is experienced daily. Their findings reported that stress and trauma produce acute and/or chronic depression, anxiety, and hypervigilance regarding the threat of future possible traumatic experiences. The individual core needs of these participating transgender individuals are stripped and consistently compromised.

Reisner, et al. (2016) examined experiences of discrimination within the sample. The origins of the discrimination addressed 'passing privilege'. The term 'passing privilege', as previously mentioned, relates to how some individuals experience, and are given/assigned unsolicited privileges, simply for appearing to have White cisgender and/or heteronormative physical and/or behavioural features. Reisner, et al. explored the factors that lead to the most amounts of experiences of discrimination experienced by their sample population regarding the practice of assuming or giving 'passing privilege' and delves into whether it allows for less discrimination. The study discussed how individuals who are given 'passing privilege' experience less mental health prognoses: i.e., depression, anxiety, and lower self-image/consciousness.

Reisner, et al.'s investigation was a mixed methods study, as eighty-eight percent (88%) of the data collected came from on-line completed surveys. The other twelve percent (12%) were data collected from qualitative methods of interviews. The sample size of the participants included eighty (80) transgender individuals, aged 18-75, (mean age = 33).

The study, however, focused only on the adverse experiences of transgender individuals in being assigned 'passing privileges'. No other members of the sexual minority community were included. It also does not elaborate on how the social structures of this hierarchy negatively impacts other members of the umbrella-termed community. Reisner, et al. do not offer suggestions on how to best utilize trauma-informed treatments in servicing the sampled population. Therefore, in these ways, the study's relativity to the research's investigation is rather limited.

Aside from internalized racism and cissexism, the investigations of Ream & Forge, (2014) shed light on added factors which could contribute to mental health diagnoses within LGBTQIA+ communities. Their study focused on regarding other factors leading to mental

health conflicts suffered by LGBTQ BIPOC, in conjunction with substance abuse/alcoholism, homelessness, and sex work. '*Being forced to relocate themselves from their family's residences*' results with 14-39% of nationwide reports of homeless LGBT youth. (Berberet, 2006; Mallon, 2017). The researchers proposed that the factors which genuinely effect LGBTQ individuals are the consistent forms of trauma received from their families of origin and/or their nascent communities (these factors may be personally experienced on their person or with others who are emotionally close to them). Other factors, such as, discrimination with foster care agencies, discrimination in homeless shelters, and institutional racism are also noted to be intersecting catalysts of discrimination, in being both a racial/ethnic and sexual minority. Combined factors of accrued traumatic experiences may negatively impact their emotional and mental health progress to become independent individuals.

Ream & Forge, (2014) consider how the findings of other investigations have concluded that LGBTQ individuals are reported to experience homelessness because of other conflicts, aside from being removed from their family's/guardian's residence (Mallon, 2017). In their literature review, Ream & Forge (2014) mention how LGBTQ BIPOC youth and adults often experience higher rates of disservice from social service agencies. Although it was recorded that forty-seven percent (47%) of 188 intakes at a NYC homeless shelter for LGBT youth experienced homelessness due to experiencing conflicts with family members (unrelated to their identifying as LGBT), much of the trauma they experienced was from being in homeless shelters or living on the streets. Their research concluded that, often time, child welfare workers overlook harassment, discrimination, and violence toward LGBT shelter residents, resulting in their unplanned leaving of the shelter.

Ream & Forge (2014) used secondary data from multiple sources for this literature. Their findings discussed how LGBT youth and adults have been historically and improperly processed to receive mental health care in NYC homeless shelters. Their reported intake research on 'processing intake' touches on the following themes: becoming homeless, becoming homeless for other reasons, 'falling through the cracks' of mainstream social services, LGBT status, and mainstream social services. Ream & Forge highlighted the traumatic occurrences experienced by LGBT homeless individuals (by using a Systems Perspective) through experiences of; living on the streets, striving for economic independence, encounters with law enforcement, sex work and substance use, mental illness, and HIV seroconversion. Well-informed of publication for this article, Ream & Forge also highlighted the prevalence of social services for LGBT homeless youth and adults.

They provided detailed suggestions for further research around the following themes; how emergency shelters report little effort toward this population's aid, the uses and practices of transitional living programs in NYC, how more rigorous and thoroughly scrutinizing program evaluations need to be established, and the archiving of more verbal reports and incidents involving these serviced individuals. Ream & Forge offered much insight and valuable secondary data related to the researcher's area of interest. Their suggestions are very similar to the researcher's investigation in that it encourages further efficacy and promotion of LGBTQIA+ BIPOC communities and individual self-images.

Researchers, like Ream & Forge, have also sought to investigate the need for trauma-informed treatment practices to promote mental health awareness among LGBTQIA+ BIPOC individuals. Although there remains a dearth of research which focuses on this investigation's target population, the few researchers who have performed pioneering data collection with NYC-

residing BIPOC sexual minorities have come to the realization that trauma is largely left untreated within this small but influential portion of our outer borough-residing populations. Ramirez & Paz Galupo (2018), for example, derive data from existing literature which focused on the high rate of need for mental health services for individuals who are LGB and BIPOC. The investigation reiterates what had been previously mentioned regarding the void of data collected (Kelly, et al., 2020) (Regan, 2019) (Landers & Kapadia, 2017) which would more accurately measure and address mental health outcomes for this population.

Ramirez & Paz Galupo focused on the application of Meyer's Minority Stress theory, which helps identify the exposure of how and when adverse experiences are formed when LGB BIPOC populations experience 'distal' and 'proximal' stressors. The study listed and identified various factors related to 'distal' and 'proximal' stress factors which largely influence mental health status of LGB BIPOC. Their study reviews micro-aggressions and heterosexist assimilations as the genesis of 'distal' experiences and 'internal proximal stress processing', which in turn internalizes homophobia and transphobia.

Ramirez & Paz Galupo used a sample size of eighty-eight (88) participants for their study and collected data from quantitative surveys that they administered to individuals via three northeastern metropolitan areas in the United States. Their findings presented percentages of increase of adverse effects of 'distal' and 'proximal' stressors compounding mental health symptomology which had been previously recorded in connection with the social service agencies who administered mental health service reports. The survey findings revealed up to a thirty-three percent (33%) higher rate of measured need for mental health services as compared with their heterosexual, cisgender counterparts. In their reported findings, they further revealed

that bisexual participants are observed to receive an even higher percentage of mental health services for treatment of depression and anxiety.

The Ramirez & Paz Galupo study highlighted how the lack of research regarding the practice of trauma-informed treatment suggests further augmentation of its need among mental health service approaches for LGB BIPOC. They accentuate that a lack of providing this valuable treatment approach significantly perpetuates institutionalized homophobia and racism, as the needs of LGB BIPOC continue to be disregarded. Although the study poignantly supports LGB populations in metropolitan areas, it excludes the transgender experience.

Comparison Studies between Sexual Majority and Sexual Minority LGBTQ+ Individuals

While performing the investigative literature review for this investigation, the researcher did encounter a substantial amount of literature which focused on the comparative differences between social services provided for individuals who identify as a member of the sexual majority and individuals who identify as belonging to a sexual minority (let alone BIPOC sexual minorities). Balsam, et al. (2010), for example, collected data from LGB adults of varied racial identities, age, metropolitan areas, and incomes. Secondary data is used to compare their findings with other studies whose findings are like the findings of the discussed study in their report. Balsam, et al. particularly focus on the grossly under-reported childhood physical and sexual abuses committed toward lesbian and bisexual women (Morris and Balsam, 2003). Childhood sexual abuse among gay and bisexual African American and Latino/x men was a common phenomenon with this study in comparison with others (Brant, 2020, p.40; Muskett, 2014).

Balsam, et al. report that they collected data from their sample population which revealed that there are higher rates of childhood trauma among LGB BIPOC in comparison with their

White LGB counterparts. Comparatively, Eliason & Chinn, (2018) found higher rates of childhood physical abuse among LGB Native Americans as paralleled with heterosexual Native Americans. In Chang, et al.'s (2021) study, rates of emotional maltreatment by a parent were 52.6% for gay and bisexual men and 45.5% for lesbian and bisexual women, and rates of physical maltreatment were 46.7% for gay and bisexual men and 43.6% for lesbian and bisexual women. Much literature, collected from general world populations, reports the adverse adult mental health outcomes in connection with a history of childhood abuse. These mental health outcomes are reported to be as follows; posttraumatic stress disorder (PTSD), depression, anxiety, and increased stress (Bloom & Farragher, 2013, p.27; van Dammen, et al., 2020; Peters, et al., 2021; Shier & Turpin, 2021; Muskett, 2014).

Balsam, et al.'s (2010) study included one thousand two hundred and seventeen (1,217) completed questionnaires. To have sufficient statistical power for all racial/ethnic group comparisons, they included only participants who self-identified as African American, Latina/o/x, Asian-American, or White, excluding those who selected more than one race/ethnicity or other races/ethnicities (n = 207). The study excluded those participants who identified as transgender (n = 184) or were missing data on gender (n = 23) due to insufficient representation within some of the four racial groups.

Their study adds to this investigation in that it provides introductory evidence that childhood emotional abuse is the strongest predictor of current mental health diagnoses among LGBTQIA+ adults, *regardless of their ethnic or racial background*. Their findings uncover that PTSD and anxiety symptoms did show a stronger relationship, nonetheless, with emotional abuse for African American participants. These same variables showed a stronger relationship with physical abuse for Latina/o/x participants.

Balsam, et al. applied a short-form, subscale questionnaire testing for demographics, childhood abuse, depression, anxiety, and PTSD. SPSS was used to analyze the quantitative data. Participant demographics disclosed that most participants were college educated. The mean annual salary was reported to be within the range of $30k-$39k, with a mean age for all participants at 36.5. One possible study limitation was BIPOC from lower-income households may not have had access to the questionnaires. Although the study's findings seem supportive to this investigation, the sample size is too large in comparison with that of the researcher's investigation.

Hagai, et al. (2020) also collected data from sexual minority participants who identified, racially/ethnically, with minority and majority populations in the United States. Hagai, et al. (2020) compared the experiences of White LGBTQ+ individuals with those of LGBTQ+ BIPOC. The study reports how White LGBTQ people tended to see their sexualities as primary to their identity, compared to LGBTQ BIPOC who tended to see their identities as being both a sexual minority and BIPOC - recognizing themselves as having more than one cultural reference identified by the majority population as *minority*. They found that younger LGBTQ people were more inclined to separate sex and gender identity. LGBTQ youth in this study were more inclined to include identities of how they fluidly label their sexual preferences while un-relating with their gender assignments or gender roles or gender identities (pansexual or queer).

Their study finds disparate differences between how LGBTQ racial majorities and LGBTQ+ racial minorities view mental health treatment to address their issues. White LGBTQ participants found that professional support was most effective. Culturally, many Black and Brown people are less inclined to seek mental health treatment (Ramirez & Paz Galupo, 2019) and rely more on their families (or adopted families, or communities) to resolve their conflicts. The

subjective approach to resolution is culturally more relevant to them than that of an objective prospective. Their findings revealed that most participants, regardless of racial identity, felt a need to support their fellow community members with social justice goals – trying to move away from the social construct of treating homophobia and the oppression it brings.

Hagai, et al.'s researched findings uncover trauma-provoking factors which intersect within varied culturally-recognized groups of individuals. They mention that these factors (i.e., religious and heterosexual cultural convictions, sexual, physical, and emotional abuse, and unprovoked violence and discrimination) continue to plague LGBTQ+ individuals of all racial backgrounds. In this 2020 report, Hagai et al.'s findings clearly compare how different ethnic/racial identities prioritize their identities. The study does not, however, discuss what type of treatment was used in servicing the studied individuals. The questionnaire was not focused on treatment. It was focused more on identity and the intersectional experiences of doubled up identities.

In contrast with Hagai, et al.'s investigation, LoSchiavo, et al. (2019) initiate their study by referencing Pilkington & D'Augelli, (1995) and their study which found that White LGBTQ+ men are more likely to face discrimination and sexual orientation and gender identity victimization (SGV) as opposed to their BIPOC counterparts. It may also be that the study, along with those of Mink, et al.'s (2014), does not account for the varied types of victimizations/harassment/discrimination that LGBTQ+ BIPOC face, via intersecting identities. Racism, classism, and sexism serve as the intersections of victimized experiences for LGBTQ+ BIPOC.

LoSchiavo et al. (2019) performed their study as a cross-sectional analysis, reported to be the first of an 18-part study. Recruitment for the study was conducted between 2009-20011. Participants were categorized demographically as: between 18-19 years old, identified as male

from birth, HIV negative, and residents of NYC. The sample size was four hundred eighty-four (484). The survey questions focused on sociodemographic characteristics, sexual orientation, and gender identity victimization (SGV). Data analysis was applied using Stata/IC 15, as univariate and bivariate analyses (including ANOVAs) which comprised of dichotomous and ordinal victimization variables.

The results yielded high percentages of the following demographic information: Hispanic/Latino/a/x participants, self-identifying as 'male from birth', some college, middle class, born in the U.S., HIV negative status, exclusively homosexual, stable housing status, living in Manhattan (29%) and living in the Bronx (10.6%). Survey questions were presented with scaled choice responses offered. The survey responses revealed that an overwhelming percent of the participants reported experiences of being victimized by strangers within their residential neighborhood. These participant responses revealed that they were also verbally assaulted at school or sports events, by members of their residential communities and by strangers attending the events.

Multivariate analyses were compared between sociodemographic differences of SGV experiences. The findings highlighted that participant, whose families were defined as being lower income working class, were more likely to experience SGV as compared to their middle and upper-class counterparts. When adjusting for key demographics in predicting history and frequency of verbal harassment, those who were White had significantly greater odds of undergoing and reporting verbal SGV experiences.

Although this study offers a good amount of evidence identifying socioeconomic factors around experienced traumas, there is no mention of how participants were treated for them. The sample is also only limited to a small representation of the LGBTQIA+ BIPOC NYC population.

Similar to LoSchiavo et al.'s investigations, and performed in another metropolitan U.S. area, Atlanta, Georgia, Forge et al. (2018) focus on the parallelisms between LGBTQ individuals who have a history of homelessness and adverse child welfare experiences with that of their heterosexual, cisgender counterparts. In the description of their study problem, Forge, et al. (2018) concede that LGBTQ individuals have been historically over-represented in child welfare systems. The study sample comprised mostly of Black men with the mean age of twenty-one (21). In comparison with their heterosexual, cisgender counterparts, the sample in this study revealed that 693 LGBTQ Black men from the Atlanta, Georgia metropolitan area reported to experience higher levels of; homelessness, domestic abuse as children, victimization while homeless, indications of mental health issues, and estrangement from birth families, as compared to their White cisgender counterparts. The study further reported that nearly all its participants experienced some form of trauma in their youth.

The findings of Forge, et al. support the need for child welfare professionals to acquire specific, culturally-aware practices which pinpoint trauma-informed practices; the likes of which are, understanding of feeling and being isolated and targeted by family members and others (familiar to them, or not). They presented a thorough literature review with the following themes related to the study sample: homelessness, trauma and violence, mental health and risk behaviors, and social support. The method of recruitment and form of data collection was performed through surveys dispersed through 'capture-recapture' field sampling, where two separate samples were observed by overall collected and completed surveys.

Descriptive statistics reported the following results: **"***60% indicated they had been in foster care because of previous abuse and/or neglect, 38% had been in care because of juvenile delinquency or criminal behavior and 43.2% reported receiving services from the child welfare*

system, other than foster care… Within the CSW-I sample, 29.8% of youth self-identified as LGBQ and 8.8% identified as transgender. 44% of the participants had been experiencing homelessness for over six months and over 60% of the sample reported being homeless between two and three times in the past three years…"

The study further described the comparative differences between data collected within the same metropolitan area between groups of LGBTQ individuals and those who identified as heterosexual and cisgender. The themes in comparison between both groups were categorized as followed: length of time being homeless and the reasons which led them to be homeless, traumatic experiences, mental health and health-risk behaviors, and social supports.

Although the sample size is formidable, it only largely captures the experiences of Black Gay cisgender men, whereas the researcher's investigation captured a larger array of identities within LGBTQ+ populations residing in a large metropolitan area. The study also does not investigate trauma-informed care as a treatment approach, or as a suggested form of treatment.

Trauma-informed Treatment Applied

Recognizing the importance and efficacy of trauma-informed treatment practices has become more mainstream in usage by social service agencies and educational institutions, as reported within social work research circles (Shier & Turpin, 2021). In tandem with these reports, studies are now emerging where trauma-informed care, when applied, results in progressive socio-emotional goal achievements for individuals who seek psychotherapy. Jivanjee, et al. (2020), for instance, focus on two hundred fifty-four (254) participants who have identified with: trauma-informed care, being reported to acquiring/possessing an adept understanding of LGBTQIA+ culture, being promoted/having been promoted with support systems which organically arise within a family, or community, or adopted family, and who also

use/have used culturally responsive practices as most important training needs. Participants were categorized with the following variables: age, years in current job, years in transition work, and race/ethnicity. The authors also analyzed the predicted training needs that mental health professionals would require in servicing individuals aged 18 and over, which would assess the levels of competencies and skills accrued by mental health professionals.

The authors highlighted that peer providers expressed preferences for adult-led training. The qualitative responses highlighted training needs for supporting specific underserved populations, or individuals from communities of colour, individuals with low economic statuses, and those with co-occurring disorders.

The authors used a youth participatory action research (YPAR) framework to conduct the qualitative data collection component of the study. Jivanjee, et al. composed a thorough data collection of a target population who have experienced trauma-informed treatment. However large the sample population was, LGBTQIA+ populations were not central to their study.

In connection with Jivanjee, et al.'s investigations regarding the service needs of a specific target population, Samuels, et al. (2018) investigated, through secondary data collections of mental health studies for transgender individuals, the attention and efforts needed to improve the experiences of transgender emergency hospital visits. Their investigation maintains that there is a need to focus on a myriad of factors to deliver appropriate medical/mental health care from emergency room hospital staff to transgender individuals. These factors are: provider competency and communication training, electronic medical record modifications in identifying the transgender person to their identified sex and not the one assigned to them at birth, and assurance of private means for gender disclosure performed with the efficacy of clinical confidentiality.

Samuels, et al. took the initiative to promote future research directions in studying the experiences of transgender individuals when faced with emergency medical/mental health situations/conflicts. Further research would need to explore the avoidance behaviour of emergency mental health and medical health professionals when treating a transgender person. This could be performed, for example, through quantitative measures. The research would need to cover the quantifiable reasons why medical/mental health emergency professionals choose avoidant behaviours when not treating transgender individuals in life-or-death situations. Further research regarding minority intersected stressors (with increased inclusion of transwomen and BIPOC) is needed to identify themes that may not have been raised in this investigation.

Singh & McKleroy (2011), in their study, also diagnosed the uniqueness of experiences, traumatic events, and treatment best-practices lived by transgender individuals who also identify as BIPOC. The authors mention how BIPOC who are transgender often experience higher rates of discrimination within any given social situation outside of their community - through employment, school culture, and residential community culture.

The authors correspondingly discuss the lack of reporting of 'interpersonal traumatic events', which have tormented the lives of transgender BIPOC. As a result of this underreporting, Singh & McKelroy deduced that treatment for emotional and mental illnesses with transgender BIPOC has been grossly experienced as neglected or disregarded. The researchers discuss geographies of transgender BIPOC in larger cities (Atlanta, Georgia), where they experience the largest rates of violence and sexual assault as compared to any other U.S. city.

Singh & McKelroy call for a 'resilience-based' trauma treatment for transgender BIPOC. The researchers find that transgender BIPOC do not automatically realize their experiences as

'traumatic'. When they begin to research more about their identities (through gender identity and race), they learn to recognize their treatment needs. Singh & McKelroy advise that future researchers need to further investigate trauma-informed treatment needs which would focus on the 'Minority Stress Model' (as an umbrella-term, encompassing intersectional feminist and queer theories) to better understand how transgender BIPOC demonstrate resilience when experiencing symptomologies related to depression. Participant commentary and real-time responses varied in themes throughout the article.

Singh & McKelroy performed a phenomenological approach with a Feminist theoretical lens. Their approach allowed for the sampled participants to disclose expressions of collaboration in the research project by recounting their lived experiences. Their recounted experiences exposed how, through resilience practices and recognition of the multiple identities they individually share as marginalized, transgender BIPOC have persevered through countless victimizations, discriminations, and institutionalized transphobia.

The researchers and their research team generated a circulation of flyers and emails within the urban, Atlanta, Georgia area. The process of their data collection and analysis gave way to define the topic of their thesis; resilience of transgender BIPOC who have survived trauma. The themes found in responses of participants are as followed: pride in one's gender and ethnic identity, recognizing and negotiating gender and racial oppression, navigating relationships with family of origin, accessing healthcare and financial resources, connecting with an activist transgender BIPOC community, and cultivating spirituality and hope for the future. Their study included a sample of eleven (11) participant interviews (6 male-to-female transgender individuals and 5 female-to-male transgender individuals). The sample demographic also revealed that five (5) of the participants were Black, 3 were Latino/a/x/Hispanic, and the

remaining three (3) identified as multiracial. Each participant divulged life encounters related to each mentioned theme. The sample criteria for this study were that each participant must be transgender, older than 18, BIPOC, and a survivor of one or more traumatic experiences.

Compelling as it is, the study may have benefitted from conducting follow-up studies for the same population and at a different geographical location. Although the sample was specific in its criteria, it serves as a strong example of how the researcher would also conduct a phenomenological approach to a similar investigation. Using resilience as a treatment approach is key to the success of trauma-informed treatment plans. Therefore, these findings may positively resonate with the findings of the researcher's investigation.

In contrast with previous studies mentioned, there are some studies which focus on the perpetrator as also one who had experienced being a victim of adverse childhood experiences and would also benefit from trauma-informed treatment practices. Morrison, et al. (2017), for example, discuss the intimacies and intricacies of mental health providers leading groups of *'intimate partner violence perpetrators'*. The treatment addressed is named, 'Batterers Intervention Programs' (BIPs). Morrison, et al. provided results which yielded two categories: 1) group size and duration matters in that group participants build intimacy/emotional progress through lasting meaningful interactions, 2) the optimal group experience in treating intimate partner violence perpetrators is to conduct groups with two facilitators who are trained in intimate partner violence intervention and treatment. They deduced that programs need to be consistent in promoting and ensuring a 'safe space' for all its participants.

Morrison, et al. question the validity and reliability of properly trained facilitators in not acknowledging the need for trauma-informed treatment. Their investigation also questions whether appropriately measured mental health treatment practices were formed prior to the

formation of the BIP groups. The approaches referred to in this study are based on feminist psychoeducational and cognitive behavioural therapeutic practices. Literature regarding the experiences and training efficacies of professionals who run BIP groups is limited.

Morrison, et al. (2017) produced a 2-year ethnographic study (2013-2015), where the investigative team collected data regarding the efficiency and personal experiences of clients and professionals through participant observations, debriefings, and interviews. The sample size was chosen from two BIP groups which treated more than 100 participants at a time. There were 36 semi-structured interviews recorded with professionals who worked as facilitators of the BIP groups (75% White, 70% female).

In promoting safety while challenging their participants, professionals reported that they needed to run BIP groups with a consistent theme of expressing openness and honesty. The results yielded responses from professionals who provided treatment from BIPs. Their reports discussed their thoughts about what would be needed to run the groups efficiently and safely. Group treatment duration and size were key components specified to be of great value to all participants studied.

Although this study does not mention or focus on LGBTQIA+ BIPOC or their traumatic experiences, it did focus on the importance of trauma-informed treatment for other mentally and emotionally vulnerable populations. This study serves as a reminder to the researcher of this investigation (and others) that all survivors of trauma, either as victims or perpetrators (who were also commonly victimized, themselves (Morrison et al., 2017)), would stand to greatly benefit from trauma-informed treatments.

In line with experiences of adverse and damaging sexual experiences, Holloway et al. (2012) focused on the examination of pre-adolescent individuals who had experienced early

sexualization. The study discussed their reported sexual-risk behaviours, as a result of these early sexualized behavioural choices. African American and Latino/a/x/Hispanic participants were recruited through their school/community, residing in the South Bronx, NY. Multiple logistic regression was used in surveying their responses in inquiry of predictive sexual behaviour, kissing, and sexual petting. Their findings revealed that the odds of early sexual behaviour were decreased due to high rates of a scarcity of personal/parental/romantic/peer influences accessible to them.

In comparison, academic focus on sexual health did not yield high rates of effectiveness. The researchers suggested that social workers who treat these youths would need to formulate sexual health promotion within their residential communities, to educate adolescents, their families and communities of the emotional, physical, and social traumas perpetuated by the need to be recognized and accepted for their personal worth and contribution to society. The researchers suggested that sensitivity-training, as a component of trauma-informed treatment modalities, serve as a recommendation in practice toward gender differences and cultural expectancies.

Although the study does not specify that the subjects investigated identified as LGBTQIA+, the relevance of this study relates to the need for trauma-informed practices of any disenfranchised population residing in a U.S. metropolis, albeit pre-adolescent.

Comparatively, Halloway, et al.'s interests of studying the sexual experiences of children in application of trauma-informed treatment plans is reminiscent with Jaeckl & Laughon (2020)'s report on the data collected from a sample set of nurses who had reported to have serviced victims of commercial sexual exploitation of children (CSEC) through practice of trauma-informed treatment. The researchers discussed legislation and legal definitions of how

CSEC is reported - how many states have passed anti-trafficking legislation. Through their investigation of secondary data collected, the researchers of this study unfold the risk factors related to mental illness that are particularly prevalent with LGBTQ victims of childhood sexual abuse (CSA), as they are most vulnerable.

Jaeckl & Laughon (2020) uncovered from the derived secondary data that dysfunctional home environments largely provide the genesis for these victims (as was also reported by Samuels, et al. (2018) and Landers & Kapadia (2017)) to depend mostly on survival skills and learning resilience to continue surviving. Mental health treatment is identified as a dire need for LGBTQ victims of CSEC & CSA, as they reported that high rates of PTSD (and other anxiety disorders), depressive related disorders, sexually transmitted diseases & HIV/AIDS, and substance abuse disorders have been documented.

The researchers stipulated that although CSEC is difficult to detect in a high-volume service agency or emergency room, nurses who come into contact with a victim of CSEC are obligated to use a screening protocol which assesses safety identification status by gently probing with specific and sensitively formed questions.

Jaeckl & Laughon's collected secondary data reports the necessity of nurses (emergency room or otherwise employed), who work with children and young adults, to continue their training to recognize and immediately address safety measures and protocol. They are obligated to initially treat these individuals. The study concluded with further conveying the need to support the increase of legislative power in the U.S. to promote the intervention of continued child sex trafficking. Safety measures to protect them are an ethical and civic responsibility on behalf of local, state, and federal government officials, to preserve and treat victims of these crimes (who commonly identify as LGBTQIA+ youth).

Although this study examined the findings of other studies which focus on the professions who service individuals who have suffered childhood sexual traumas, it does not discuss the influence of one type of trauma snowballing into other forms of experienced traumas – a prevalent factor in the lives of many victimized LGBTQIA+ BIPOC.

Conclusive Statement

BIPOC sexual minority stress, as discussed in the previously summarized articles, were associated with physical/mental health and social welfare results and findings. Thus, some researchers felt the need to further research the elements and benefits of trauma-informed treatment practices for the niche population of this investigation. The clustered and categorical research performed by the researchers who authored these collected articles do not thoroughly identify the health/mental health needs of LGBTQIA+ BIPOC who reside in New York City metropolitan areas, specifically the Bronx.

However, the systematic review of this literature emphasizes three separate traumatic origins of trauma perpetuity; identifying as and/or targeted as LGBTQIA+, identifying as and/or being targeted as BIPOC, and the generational socioeconomic marginality in urban settings. Some articles focus solely on the identified issues and needs facing one or two of these identities but not the treatment methods employed by mental health professionals. Others include these treatment methods for one or two of these identities, but few with all three. Further information is needed to investigate the impact of trauma-informed treatment by mental health professionals with individuals who self-identify as LGBTQIA+, BIPOC, and lower socio-economic status in urban settings and experience personal destruction primarily due to living these varied intersecting cultural identities being lived, simultaneously.

What is known to comprise of trauma-informed treatment is the socio-emotional recognition and encouragement of *resilience* as a therapeutic tool. Various studies refer to it as an effective therapeutic tool which allows the mental health provider to access the origins of thought and behavioural patterns within studied participants (Singh & McElroy, 2011). Being perceived as vulnerable in mainstream society is often the predicament for LGBTQIA+ BIPOC. As previously mentioned, this sexual minority is often obligated to rely on resilience as a form of self-preservation, and ultimately self-worth. Resilience serves, initially, as a mark of experienced deprivation to their souls – a rite of passage, if one wills. Resilience earns the right of trauma-informed classification in that it recognizes experienced traumas and assists in converting adverse experiences as a choice to continue regarding it as a *strength* instead of as a scar. A trauma-informed approach recognizes influences brought on by traumatic events and helps to augment the trauma as a vehicle of strength to which an individual can choose to build through resilience.

The interpretation of resilience, as commonly practiced nowadays, is described as the magnitude to which individuals, communities, and mainstream social systems reach a sense of survival through adaptation. Once adaptation is conceived, individuals would choose to build out their survival skills and use them to thrive, where they otherwise had not. Reaching a state of resilience where one experiences personal growth can be a delicate process, as much also depends on the socio-economic and environmental factors present in the lives of individuals and communities. For individuals who wish to apply a thriving sense of resilience as part of their life practice, they would need to cultivate vigilance in assessing the social environments surrounding them at all times and react according to the perceived positive growth of its direction (Smith, 2018).

Through learned resilience, individuals rebound from traumatic situations. Post-traumatic growth, moreover, can be a markedly different experience than that of being resilient. Purportedly, when individuals experience a traumatic event and have already mastered a strong sense of resilience, their core values and beliefs could be challenged in a way that offsets their sense of resilience. The sense of accomplishment and *growth* following the challenges they faced as a result of the traumatic event is then defined as *post-traumatic growth (PTG)* (Edwards, et al., 2022). Individuals who acquire post-traumatic growth have done so as a result of experiencing an overhaul of their core values and belief systems. PTG with Bronx-residing LGBTQIA+ BIPOC, for example, could be observed when they confront their internalized homophobic or racist belief systems and work toward recognizing and resolving them as they occur. Trauma-informed treatment, hence, could facilitate the processing of PTG.

Culturally aware practices are also within the umbrella-term approaches of trauma-informed treatment, as mental health providers are obligated to recognize, comprehend, and attempt to relate as much as possible with an individual's inherited cultural values. The contributed systematic literature review often mentions the identity crises LGBTQIA+ BIPOC (or otherwise) face while identifying as LGBTQIA+ within BIPOC families and communities (Forge, et al., 2018).

Often time, inherited generational value systems do not support LGBTQIA+ identities. This lack of socio-emotional support leaves the LGBTQIA+ individual in a state of long-endured trauma – constantly devaluing their emotions/feelings/sexual minority identities. Morrison, et al. (2017) reminds us that trained mental health providers using a trauma-informed treatment lens are obligated to recognize and lead therapeutic approaches having in mind the history of trauma related to the ostracization of LGBTQIA+ BIPOC individuals residing in heteronormative

communities. Treating the individual through a trauma-informed treatment approach in recognizing the forced limitation of personal freedom experienced can often be a challenge for the treated individual. A strength's-based or Narrative approach may be most suitable in treatment, as those approaches operate from a trauma-informed stance (historically and current). Trauma-informed treatment approaches would need to also take into consideration the generational marginalization of groups of individuals. Trained mental health professionals, as previously mentioned, would need to also understand the ramifications of generational socioeconomic hardships. The trained mental health provider would be most effective in trauma-informed treatment having lived similar experiences as their client/s – being able to best relate with experienced generational socio-economic trauma. Sensitivity training for those mental health professionals who have never lived those types of experiences would greatly help the therapist/client rapport, ultimately leading to a more effective trauma-informed treatment.

It is key to this investigation to consider how exactly trauma-informed treatment for LGBTQIA+ BIPOC is defined by other researchers, and by all participants involved. Studies commonly define this treatment as the recognition and demonstration of the mental health professional utilizing empathic appropriateness with an extensive knowledge base and personal connection with LGBTQIA+ BIPOC culture and mores. This investigation studied the effectiveness of, or further need to employ, mental health treatment practices which progressively build positive self-images with individuals who have endured adverse experiences in all three previously mentioned categories.

The 'urban setting' of choice for this study is NYC's northernmost borough, the Bronx, as it is geographically most accessible to the researcher and consistently identified as one of the most financially destitute (if not the most) Congressional districts in the United States (Hackley

et al, 2018). For these reasons, the researcher feels it is crucial to ascertain data which addresses the intersecting needs of this niche-researched population.

Considering all the factors contributing to the axis of this investigation, the researcher determined in his investigation how trauma-informed treatment practices serve to augment the progressive-building, therapeutic treatment trajectory of LGBTQIA+ BIPOC residents of the Bronx. The researcher of this investigation, then, primarily delineates the goal of investigating, in any event, if trauma-informed treatment approaches affect the positive therapeutic treatment trajectory benefitting LGBTQIA+ BIPOC who reside/work in the Bronx, NYC.

Section Four: Theoretical Framework

Definition of *Theoretical Framework*

Presentation of theoretical framework is fundamental to the genesis of any study, as the applied theories serve to stage the concept and language of social work investigations. Theories are meant to be tested in any investigation and serve to compliment the presented hypotheses (Merriam, 2001, p.202). Its aim is to provide both a philosophical and pragmatic background to the presented study problem (Creswell, 2003, p.49).

Statement of Intent for Theoretical Framework

Resilience may be learned and earned. By experiencing trauma and victimization, many learn how to survive, physically, psychologically, and emotionally. Behaviours can be recognized as catalysts which shape our thoughts and emotions, as presented by Reactive-Emotive theorists (Flatley, 2008, p.77). Whether or not we react toward trauma through 'fight or flight', we first must learn to care for our basic needs of living - food, water, shelter, health, safety, and love. Through our learning to survive, our humanness gradually adapts us into being resilient individuals. We learn to enjoy the best that a situation could offer. Beings may grow from humble beginnings and share lessons learned with the goal of teaching those who also have experienced traumas/victimizations and identify with LGBTQIA+ BIPOC identities and cultures. Through earned and learned resilience, LGBTQIA+ BIPOC may find themselves, after initial struggles, to perform as mentors for those who are survivors of any traumatic event/s by investing in the identified personal strengths of the survivors they aid through treatment (Escudero-Alias, 2016).

Social work researchers may then conjecture that earning and learning resilience is best conceptualized through the following theories in relation with the presented dissertation investigation - *intersectional feminist theory* and *queer theory*.

Western psychology and philosophical theories have been historically dominated by White, affluent men (Munoz, 1999, p.108), thus creating and maintaining social hierarchies through a largely ever-present patriarchal lens. For centuries, men have dominated the landscape of socially constructed practices, establishing an overwhelming indelibility of male control and power dynamics. Intersectional Feminist theory (IFT) attempts to dispose the pervasiveness of male power dynamics and seeks to resolve traumas/conflicts/social ills through recognition of the damages caused by domineering patriarchal social systems (Escudero-Alias, 2016). Intersectional Feminist theorists (IFT) attempt to develop practices which are inclusionary of all present forms of identities (already discovered, and those yet to be) (Mink, et al., 2014).

IFTs support the shift of accepting and supporting (consciously or subconsciously) a man as the originator, omnipresent, and total leader of any psycho-social or emotional movement to that of others who do not identify with the wills of perpetual patriarchy. They challenge the assumption that the social trend-setter will always be a man. IFT divorces patriarchal dominance from the determinate reference, without disparateness (Mountz & Capous-Desyllas, 2020).

Intersectional Feminist theorists attempt to apply in practice the challenge of identifying systems of power and oppression, how they interact with one another, and how those practices cause devaluation of an individual's worth (Mountz & Capous-Desyllas, 2020). They recognize that systems of power are not solely an issue of gender (assigned), but with any group of individuals who fall under the inequities of power dynamics (e.g., systemic and institutional racism, classism/castes, sexual minority cultures, ageism, ablism, etc.) (Mink, et al., 2016).

Rationale for Intersectional Feminist Theory (IFT):

Because IFT dispels any single form of power dynamics, LGBTQIA+BIPOC communities need to sustain all senses of self-worth and personal power to carry them out of the abusive hierarchy which has systematically dehumanized their self-worth and autonomy. The present social construct of White affluent male privilege exists only to offset a utopian balance of worth through assuming power. IFT provides a base for practitioners, individuals seeking assistance, and the organizations/agencies which espouse them in that it realizes resilience as a power which shares power from one individual to the next. IFT is driven by a practitioner's use of resilience as a form of self-invention, unaccountable to any single power dynamic. It pushes through all the misconceptions that low-income earning LGBTQIA+ BIPOC have learned about only being valued based on the social construction of present-day social hierarchies.

For the purposes of this study (and in general), IFT theorizes that all who have experienced being a victim, focus on reinventing their personal power and growth. Hence, agencies/organizations and public and private policies may need to reference the importance of basing their trauma-informed treatment approaches on IFT. They are charged as responsible, then, to teach/train practitioners to teach/train the low-income earning LGBTQIA+ BIPOC they serve with the gravity that IFT offers. In turn, these learned individuals have the power to teach others and their communities their worth in the face of adversity from others who cling to the status quo of prevalent hierarchical systems. IFT breeds confidence both with the self and the community.

Inclusion of IFT in this investigation:

The gap in literature regarding intersectional feminist theory (IFT) and trauma-informed treatment practices is clear (Warner et al., 2018, p. 524). It is the researcher's belief that IFT can be used within clinical practices and agency/organization structuring that could focus on training

practitioners to reference IFT as the base theory for their treatment practices. The organization/agency, itself could model this theoretical referencing through transparent buy-in conferences which could establish an open plan of administrative procedures – offering all staff (practitioners and administrators alike) to brainstorm policy enactments that would benefit and include all participating members of the agency/organization. Socializing the needs of the community while also socializing concerns using 'roundtable' sensibilities may allow an ambiance of inclusion which could be easily transmitted to practitioner treatment patterns, thus dispelling the allure of power hierarchy (Warner et al, 2018, p.525).

In comprehending the essence of IFT, the agency that chooses to adopt it understands it to serve as a *way of being in relation to serviced individuals*, which would encompass action along with thought. Practitioners would practice an awareness of all disclosed/discovered identities (that of the agency/organization, the practitioner, the serviced individual/s, and the community housing the agency/organization). What must come into light, within IFT ideological parameters, is the historical presence of any power hierarchies present, in conjunction with institutional structures (historically practiced within the agency/organization). The 'coming into light' means that all participants would learn to feel, think, and respond with critical license toward the specificities, concreteness, and contextualization of relationships which consists of the teachings of modern clinical practice.

Practitioners would look to their agency not as a power more worthy than their needs. Practitioners would need to feel legitimized and experience the transparency of those who employ them. They need to feel equal to them. They also need them to assist their practice guidance through uplifting supervision, utilizing IFT as a base.

IFT as aid to the organizations of the investigation:

To adopt IFT in praxis as a framework to its administrative structure, training and supervision, agencies/organizations would need to foster the importance of the disclosed/discovered identities of the serviced individuals as multiple experiences of intertwined social identities. Administrators would also need to foster an unveiling of the practitioner's perceived confidence (or lack thereof) in their ability to conceptualize the identities of serviced individuals based on their multiple social identities. The agency would then emanate a broader worldliness, and perhaps win the trust and confidence of the communities they service.

How IFT Supports the Collected Data

Since the researcher investigated and collected data by using a single survey, the researcher analyzed the collected data as categorized through variables which represent the questions and responses given by participants. Chi-Squared testing methods, including but not limited to OLS regression, and logistic regression pinpointed the differences of independent variables in comparison with a given dependent variable. The researcher of the presented study recognizes these differences as support for the hypotheses that IFT supports evidence that trauma-informed treatment recognizes the power dynamics present within intersections of identities disclosed in the responses to the survey (e.g. Does trauma-informed treatment recognize the power dynamics of varied experienced privileges assigned to an identity – represented by a variable – in comparison with another identity shared by the same treated individual; "trauma-informed treated LGBTQIA+ BIPOC in comparison with LGBTQIA+ BIPOC who have not specifically received trauma-informed treatment for identifying as LGBTQIA+ *and* BIPOC").

Rationale for Queer Theory (QT):

This investigation explores a variety of factors from the evolving debates over trauma-informed treatment practices and the theoretical bases which would best support evidence-based practice data. Queer theory would attempt to influence the practitioner (and their agency of employment) to best understand and recognize how they relate to or define sexuality and gender - recognizing their confines/limitations/judgments, if any. The researcher's intentions for applying Queer theory to the presented study is to recognize any judgments related to inherited, social-constructed, heteronormative values. Practitioners may have experienced recognizing their referencing heteronormative values throughout their treatment practices, which may have affected the efficacy of trauma-informed LGBTQIA+ BIPOC treatment.

The objectives of the investigation in applying Queer theory are:

(1) to directly address the presence of heteronormative values in practice/treatment in as nonjudgmental a manner as possible.

(2) to create a vehicle for disseminating current research as gathered through literature which pinpoints the inherent need for trauma-informed practices to be implemented regarding the awareness of current sexuality and gender non-conforming identities with that of heteronormative identities.

(3) to consider the implications of this research for scholars, teachers, and political activists

(4) to incite further research related to trauma-informed treatment approaches and agency practices/culture.

The investigation contains 28 articles from a variety of interdisciplinary research. Most of the reviewed articles offer a description of trauma-informed treatment (or lack thereof) in practice with practitioners and/or clients who identify as LGBTQIA+, or BIPOC, or both. This

theory was born in the service of liberating persons who wish to challenge sexual and gender heteronormative identities and has shown theoretical importance by having served as the basis for much needed activism. Much of the literature contained in this study articulates the tensions between the adverse experiences experienced by LGBTQIA+ BIPOC with that of a lack of general knowledge or empathy among professionals (whether unreported or not disclosed). Queer theory aptly explains, then, the implications of how LGBTQIA+ BIPOC perform socially, within their community, and within their personal lives.

Inclusion of QT in this investigation:

Mental health providers of trauma-informed treatment practices are obligated to recognize the cultural and historic values of the effects of sexual/gender-norming on Bronx-residing LGBTQIA+ BIPOC. Questions in the survey for this investigation specify the knowledge and practice of underlying QT ideology. The questions investigate whether practitioners feel this acquired (or personally lived) knowledge is key to better understanding and treating their LGBTQIA+ BIPOC clients. QT allows for an in-depth fellowship between practitioner and client; being that the practitioner has lived and has chosen to grow out from categories assigned to them, creating their own. QT supplies the theoretical support for LGBTQIA+ BIPOC mental health providers to transfer their learned resilience as experienced through all types of trauma - from macro to micro aggressions.

The intersecting identities of being a Bronx-resident, LGBTQIA+, and BIPOC fits in the confines of QT, as BIPOC and Bronx communities also commonly value sexuality and gender hetero-normative roles.

QT as aid to the organization of the investigation:

The role of QT as a base for learned empathic sensitivities is quintessential to this study. Mental health providers need to understand and be aware of the existing subculture of microaggressions in LGBTQIA+ BIPOC communities, which continues to deny the individual of self-esteem/self-worth. The sub-culture of microaggressions maintains at high value the affinity for and assignment of privilege with factors representative of White hetero-normative likeness. Many micro-aggressions are based on an ideological thinking (Nadal, 2019, p.141) that devalues any sense of aesthetic that does not resemble the White perception of ideal.

Bronx-residing LGBTQIA+ BIPOC can identify the many types of racial and income earning biases they encounter with LGBTQ communities with examples of; exclusion, dating bias, and exoticization (Nadal, et al., 2017, p. 143). The more White and heterosexual an individual appears to be, the less they experience jeers; emotional, verbal, mental, and physical trauma (Nadal, 2019, p. 143). QT exposes the biases that Bronx-residing LGBTQIA+ BIPOC individuals experience *and* cause. These biases perpetuate the high ranking of White heteronormative values among all peoples, including Bronx-residing LGBTQIA+ BIPOC communities. It would benefit mental health practitioners to understand the root of these biases and help treat trauma with Bronx-residing LGBTQIA+ BIPOC, to un-learn the negativity born with these biases and build pride and strength in the fluid categorization of sexuality, gender, income status, and BIPOC identities.

How QT Will Analyze Collected Data

The researcher of the presented study collected data to better understand if mental health providers feel they provide better service through use of trauma-informed treatment practices with Bronx-residing LGBTQIA+ BIPOC clients. The researcher of the presented study investigated the sexual orientations and gender identities of the mental health service providers

and those they service (confidentiality remaining as a staple to the ethical treatment of the data collection). This will be performed for the same reasons that data regarding ethnic, race, and economic statuses will be collected – that is, to offer a study's perspective on any comparison of differences between the three sets of identities and the level of trauma-informed treatment needed between them all.

Bronx-residing LGBTQIA+ BIPOC have historically experienced dissimilitude in economic status, health/mental health, and other services in comparison with their cisgender heteronormative counterparts. Collecting data on sexual orientation and gender identities specifically relates to the dissimilitude in service needed for each intersecting identity. The researcher of the presented study incurred the use of multiple regression methods which compared two independent variables as reported by the mental health providers who participated in the study – they are, their sexual orientation and their gender identity. Collecting data on the sexual orientation and gender identities of mental health providers offered a window of measure to better understand if their likeness of identity/ies aids their clients' mental health progress when in conjunction with trauma-informed treatment practices/observation/supervision.

QT in Conjunction with IFT

The relationship between Intersectional Feminist theory and Queer theory shares the commonality that supports the dismantling of a homogenous group of individuals assuming and/or assigned to the top of a hierarchical power dynamic. Inclusivity, recognition, and allowing for the value of 'difference' are at the forefront of both these theories. Queer theory uniquely focuses on the effects and limitations of predetermined and socially constructed dictates, regarding sexual majority and gender (Mallon, 2017). Queer theory, principally, investigates the ways in which socio-political institutions carry out preferential treatment which mostly benefit

individuals who identify with the sexual and gender majority (Sedgewick, 2003). This is largely practiced through the creation, maintenance, and administration of social policies, laws, bills presented to legislature, and socio-cultural mores which abhor inclusivity as a goal/objective (Butler, 1990, p.168). Queer theory attempts to challenge the status quo in accepting and supporting women, trans and gender non-conforming people as integral and equally valued members of society, at large. It abhors the mainstream, dominant social construction of gender and sexuality (Mountz & Capous-Desyllas, 2020).

Queer theory and IFT support the presented investigation as their socio-political stances support the investigation of the effectiveness of trauma-informed treatment, practiced by mental health providers. What limitations are present for mental health providers which hinder the dissemination of trauma-informed treatment? Which factors related with gender conformity, sexual minority, racism (institutional and socially promoted), and classism play in keeping the promotion of LGBTQIA+ BIPOC residents of the Bronx at bay?

In theory, researchers seek to explain the psycho-sociological constructs which have presently and historically formed behaviours and behavioural habits, which then give way to the fixed and celebrated practice of any given culture and/or subculture. Socio-behavioural practices are often born from trauma (Sedgewick, 2003, p.50). Depending on the given situation where the traumatic experience is born, behaviours may be influenced to react in ‘fight or flight’ mode. Consistency in the occurrences of the same or similar traumatic event/s influences humans to learn to adapt progressively or digressively (Sedgewick & Frank, 1995, p. 98). Resilience is shaped by the progressive/positive emotional reaction of an individual and/or a collective. Simultaneously, victimization, the empowerment of perpetrator culture, and hierarchical power

dynamics may shape pejorative/negative behavioural practices of any given individual and/or a collective.

Post-traumatic stress disorder, anxiety and depressive (mood) disorders (evidence of melancholia and shame/shaming), and personality disorders may stem from generational pejorative behavioural practices, to establish and reestablish, create, and maintain hierarchical power dynamics. This is evident throughout the cross-cultural anthropological annotations of war, colonization, genocidal events, gender-setting norms, and the attempts to eradicate the presence of sexuality that is not heterosexual in nature.

Queer theory and IFT specifically and intentionally attempt to recognize the societal threads, woven into social norms, which influence an individual and/or a collective to act and procreate gender and sexual stereotyping (Flatley, 2008, p. 78). They attempt to dissolve the custom of maleficence through rebuilding a life, a community of lives, in accepting and celebrating inclusionary and fluid acts/customs which serve to consistently improve an individual's/community's betterment (Flatley, 2008, p. 78). Just as depression and repression may form cultural norms, resilience reveals the 'ying' of a given culture through creativity and artistry. Cvetkovick (2012) purports that a culture coexists with depression and creativity, regardless of western psycho-medical diagnoses (p. 290). Cvetkovick (2012), in her annals, honours the work of renowned choreographer/filmographer, Judith Butler, who creates performance art reverential to the obliteration of conventionalism and the embracing of differences – the very core of Queer theory and Queer Performance (p. 294).

Trauma focused Approaches in Conjunction with IFT and QT, as Practiced in Trauma-informed Treatment

Participating practitioners in the presented study utilize a myriad of therapeutic approaches when treating Bronx-residing LGBTQIA+ BIPOC. The participating agencies' administrators report that their mental health practitioners largely employ the following trauma-focused therapeutic approaches; Trauma-focused Cognitive Behavioural Therapeutic approach (TF-CBT), Narrative Therapeutic approach (NT), Strengths-based Therapeutic approach (SBT), and Person-in-Environment Therapeutic approach (PIET), so this researcher included them in this investigation.

Trauma Focused Cognitive Behavioural Therapeutic Approach (TF-CBT)

Trauma-focused Cognitive Behavioural Therapy is a treatment approach which intends to develop activities and thought processing with individuals, families, and culturally specific groups of individuals, to prevail over the negative effects of traumatic experiences. Recognized as a widely used evidence-based practice method, Tf-CbT has been proven effective for treatment after an individual/groups of individuals experience/s more than one trauma (or have experienced consistent adverse childhood trauma). Mental health practitioners trained in TF-CBT first attend to their client's emotional responses, connecting them to their behaviours and thought patterns while simultaneously helping to resolve them (Gentry et al., 2017). Cognitive Behavioural Therapy (CBT), practiced without the specification of focusing on treatment through trauma healing, can generally assist in treating trauma-related disorders. Trauma-focused Cognitive-based Therapy, however, concentrates further on the methods of treating trauma through utilization of treatment techniques used when practicing family therapy, which also requires an in-depth learned and executed sensitivity to the events which have caused the trauma/s. Like CBT, TF-CBT usually serves a client on a short-term basis (Gentry et al., 2017).

Narrative Therapeutic Approach

Narrative therapy evolved in the family therapy arena in the late 1980s in Australia and New Zealand. Since then, it has been extended to other world-wide counselling settings treating families and communities (including those communities whose members experience consistent marginalization). It sets the stage as a social movement in the social constructionist, postmodern practices to re-evaluate humanist and traditional psychological treatment. Its pioneering authors, Michael White and David Epston, state clearly that, amongst others, they have been influenced by the work of Michel Foucault, Lynn Hoffman, and Noam Chomsky to not only question the

dominant assumptions underlying humanism and psychology, but also to address issues of meaning, subjectivity, power, and ethics (Lindemann, 2020)

In the political realm, both social scientists recognize the need to challenge sources of illegitimate power and authority within their own societies. Sociologists and social work researchers perceive the Narrative approach as a conflict of efficacy between Power and Justice – a major tenet of the Narrative Therapeutic approach (Lindemann, 2020). Do social groups innately seek to overpower another, or is it that they seek to bring logic, law, and political order to all societies according to their inherited values? Narrative Therapy approaches the effects of the societal dictates and the individual's needs.

The narrative approach to trauma (and addictions) recognizes that treatment is experienced as a communal activity, where both the practitioner and the client experience interpersonal growth (Lindemann, 2020). The Narrative approach does not focus on what had caused the trauma, but rather how the individual responds to their trauma. In this way, the perspective is through storytelling. Through storytelling, there is an activity of story re-telling - providing a newly authorized version of their trauma. Narrative approaches remove the therapist from the responsibility of granting progress and focus on the client rebuilding/rewriting their response (Lindemann, 2020).

Strengths-based Therapeutic Approach

Strengths-based approach focuses on an individual's self-determination and emotional strengths to continue to recognize an individual's personal growth. Founded by social work values and social work researchers, SBT builds treatment practice by leading with the client's strength. The recognition of the client's resourcefulness and resilience fuels an individual's

ingenuity, especially when the individual in treatment is faced with consistent prior and present adverse experiences (McCashen, 2005).

Like the Narrative approach, the practitioner is de-centralized, and the client leads their progress via treatment guidelines set by both the client and the practitioner. The main objective of the practitioner using SBT is to allow the client to realize their resolutions through recognition and practice of their learned and earned resilience. Through the process of the client/s utilizing their resilience, change is affected and adopted as a new way of choice living. Resilience leads clients to, eventually, observe their attitudes about general given situations. Clients learn to love their own quirks as gifts, not deterrents. SBT promotes the client as the agent of their own personal growth. Through practice, the client is encouraged to abandon their negative self-perceptions and focus on the gifts they present in any given situation. Once the client realizes and exercises their strengths, they can recognize and encourage the strengths of others who share their lives with them.

Rapp, Saleebey, & Sullivan (2008) present a guideline of steps for determining SBT (p. 480). They are goal orientation - where the clients set their own goals for personal development, strengths assessment – when client assesses their strength as recognized by both themselves and the practitioner, resourcefulness – where the practitioner connects the client to resources in their surroundings that aid their personal progress, and meaningful decision-making – when the practitioner encourages the client to make informed decisions before acting.

Person in Environment Therapeutic Approach

The Person-in-Environment (PIE) approach recognizes that an individual is largely influenced by their surroundings, affecting their decision-making, and observed and/or limiting their choices. Influenced by early social work pioneers, the likes of which can be justly applied to the work of Mary Richmond, mental health professionals recognized that the individual is not

the sole cause of their dilemmas. Individual experiences are the results of their surroundings and the factors which have failed to nurture their personal strengths. The individual is not the source of the dilemma. It is the circumstances which directly or indirectly confront their psyche (van Dammen et al, 2020). PIE focuses on the social factors which cohabit an individual's proximity, leading to their personal development, or lack thereof (van Dammen et al, 2020).

Closing Statement on Theory

The researcher of this dissertation applied the tenets of both Intersectional Feminist and Queer theories to support the use and promotion of trauma-informed treatment practices with LGBTQIA+ BIPOC who reside in the Bronx, New York. The intersectionality of lived traumas birthed from classism, racism, gender norm rigidity, and ethnic and homocentric cleansing have been reported (Mallon, 2017) to be prevalent in many Bronx, New York communities. As previously mentioned, congressional funds for these communities are scarce. Socio-political resources, which would benefit the betterment of all its residents, also remain absent. This causes fierce competition and prejudice among the oppressed – eventually leading to their demise and stunted social growth.

Section Five: The Research Question

Research Question

Have trauma-informed treatment approaches been used in therapeutic practices by mental health practitioners working with LGBTQIA+ BIPOC clients in the Bronx, N.Y.?

Research Question Opening Statement

The aim of this study was to quantitatively assess the application of trauma-informed treatment practices as provided by NYC-based mental health practitioners for their LGBTQIA+ BIPOC (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual + and Black and Indigenous People of Colour) who reside in the Bronx, New York. The researcher's goal was to measure the reported uses of mental health treatment modalities, or lack thereof, offered by mental health practitioners servicing the population of choice focus. The researcher also investigated why mental health practitioners choose to employ trauma-informed treatment practices as observed through therapeutic approaches - which inherently support them in practice (Narrative Approach, Strengths-based perspective, person-in-environment approach, and Trauma-focused Cognitive-based Therapy). These therapeutic approaches have been historically chosen by the participating agencies as best practices shown to help resolve any mental health issues that arise because of lived traumatic experiences.

The researcher provided a single online survey which was disseminated to mental health practitioners employed at four NYC-based social service agencies. The researcher procured the minimum number of participants (at least 25 participants was needed to establish statistical reliability for the study). The survey was provided in English only, as it is a primary requirement for their employment. The researcher also observed a one-month grace period after the survey was disseminated to give participants ample time to complete the survey.

Data was collected from participants who provide therapeutic services for their Bronx-residing LGBTQIA+ BIPOC (Black and Indigenous Persons of Colour) clients. Other generalizable, demographic data was collected from the participating mental health providers. Some of the participating mental health providers also identified as Bronx-residing LGBTQIA+ BIPOC. The researcher took note of any of the demographic data provided by the participants as consequential to the purposes of the study. Online recruitment was performed through each agency's administrators who reportedly encouraged their mental health practitioners to participate in the presented study.

Inclusionary criteria consisted of any mental health practitioner who holds one or more of the following licenses and/or degrees: BSW, MSW, LMSW, CSW, LCSW, MFT, PhD, MD, and PsyD. The list of mental health practitioners included mental health counselors who have not yet earned the previously listed titles but may also perform mental health treatment services for the targeted population under the supervision of someone who holds the title of CSW/LCSW. Information about the study and its goals was shared with each participant at the beginning of the survey. This provided information (as presented in the introductory letter to participants upon opening the survey) thoroughly illustrated the intentions of the study and the important role that each participant plays in encouraging the growth of socio-progression in the residential communities of their Bronx-residing BIPOC sexual minority clients.

The general question for the presented study's research is: *Have trauma-informed treatment approaches been used in therapeutic practices by mental health practitioners working with LGBTQIA+ BIPOC clients in the Bronx, N.Y.?*

The study's sub-questions leading to hypotheses include:

Study Question #1:

Will mental health practitioners who identify as sexual minority opt to choose one or more of the following types of treatment; trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment?

Hypothesis #1: Mental health practitioners who identify as a sexual minority will opt to perform one or more of the following types of treatment; trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment.

Study Question #2:

Will mental health practitioners who identify as gender-related minority opt to choose one or more of the following types of treatment; trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment?

Hypothesis #2: Mental health practitioners who identify as a gender-related minority will opt to perform one or more of the following types of treatment; trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment

Study Question 3:

Will mental health practitioners who identify as Black and/or Indigenous Persons of Colour (BIPOC) opt to choose one or more of the following types of treatment; trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment?

Hypothesis #3:

Mental health practitioners who identify as a Black and/or Indigenous Person of Colour (BIPOC) will opt to perform one or more of the following types of treatment; trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment

Study Question #4:

Do mental health practitioners experience trauma-informed therapeutic approaches to be an effective practice for treatment of *depression* with their Bronx-residing LGBTQIA+ BIPOC clients?

Hypothesis #4:

Mental health practitioners will reveal their experience of trauma-informed therapeutic approaches as effective in treating *depression* with their Bronx-residing LGBTQIA+ BIPOC clients and will identify one or more reasons for this effectiveness.

Study Question #5:

Do mental health practitioners experience trauma-informed therapeutic approaches to be an effective practice for treatment of *anxiety* with their Bronx-residing LGBTQIA+ BIPOC clients?

Hypothesis #5:

Mental health practitioners will reveal their experience of trauma-informed therapeutic approaches as effective in treating *anxiety* with their Bronx-residing LGBTQIA+ BIPOC clients and will identify one or more reasons for this effectiveness.

Section Six: Research Methodological Framework

Research Description and Objective

The data for this investigation was collected from a distributed on-line survey conducted with mental health service providers, regarding the therapeutic rapport they share with their LGBTQIA+ BIPOC clients who reside in the Bronx. Inclusion criteria regarding practitioners for this investigation encompassed a sample of mental health providers presently employed at four NYC-based organizations which primarily service LGBTQIA+ communities. Mental health providers can be represented by those who have at least earned or are in the process of earning a degree and/or license which would serve as criteria for them to work as mental health professionals (i.e., in possession of a BSW, MSW, LMSW, LCSW, MFT, PhD, and PsyD). Some participants reported they have not yet earned these degrees and/or licenses. Nonetheless, their eligibility for participation remained desirable, as the participating agency is obligated to provide appropriate supervision under any of the licenses and/or degrees.

Recruitment was performed through purposive online sampling, as the researcher sought permission from agency administrators to disseminate a survey to all mental health professionals employed by the participating NYC-based organizations. Providers were asked to complete a survey which highlights their contributions to trauma-informed treatment practices.

The advertised survey was promoted by their agency administrators through use of social media, as administrators forwarded the provided link for of the survey to mental health providers via their email. Agency administration consistently encouraged their providers to complete the surveys, after the researcher contacted each administrator with a series of four letters (one per week) and attached promotional flyers to remind mental health providers to complete the survey. The disseminated survey appeared to the participant as an attached Google Form. Virtual flyers

and posted announcements were sent for participants to access information on how to receive and complete the surveys. To provide support for mental health workers in completing the disseminated survey, a $20 gift certificate was granted immediately following its completion. The study was conducted in New York State, with particular focus on the Bronx County of New York City, New York. The survey was provided in English only, as participants are required to be fluent in English to perform their services. The investigator also observed a one-month grace period after the survey was disseminated to give participants ample time to complete it.

The researcher sought the participation from the four NYC-based agencies with prior-approved administrative confirmation of agreement to participate in this investigation. The agencies will remain unnamed, to procure the anonymity of the practitioners and their clients. Any information about the researcher's investigation will be copied and sent to all persons who agreed to participate in the researcher's study.

Measures

The research measures consistently involved the references of the following themes, as they are the focus of the research investigation in all aspects of the study; trauma experiences recorded, trauma-informed treatment applied, intersections of cultural identities of related factors which constitute traumas experienced by LGBTQIA+-related conflicts/racism/classism, frequency of treatment applied, effectiveness of treatment practices, therapeutic relationship, Adverse Childhood Experiences (ACEs), depression, anxiety, Post-traumatic Stress Disorder (PTSD), resilience, mentorship, and transitional living programs in the Bronx.

For the purposes of this study, the researcher has established defining the theme of 'effectiveness of trauma-informed treatment modalities' as how mental health providers would scale their uses of trauma-informed treatments by positively influencing the therapeutic process between the client and worker.

Trauma-informed treatment (TiT) modalities included the use of referencing and applying a strengths-based perspective (among other TiT approaches) on how *resilience* serves as both a survival-coping and ego-building tool. TiT modalities refer toward the use of empathy-recognizing and client-centered practices to build professional rapport (therapist-to-client and client-to-self) (Buchecker & Degenhardt, 2015). The investigation included collected data regarding the possible use of psychometric assessments, client self-reports, and provider's evaluations, administered by the participating practitioners. As reported by the administrators of the participating agency, mental health practitioners regularly perform assessments by administering psychometric tools, like the General Anxiety Disorder – 7 Question survey (GAD-7), which screens for symptomatology of anxiety, and the Patient Health Questionnaire – 9 question survey (PHQ-9), which assess symptomatology of depressive disorders.

The potential difference between practitioner's gender identities in relation with that of their clients was reported and analyzed. This may pose as a performance limitation for this investigation, as the length of client treatment and their desire to stay in treatment with the participating practitioner may be a factor to delayed therapeutic progress. The researcher controlled for the provider's gender, race/ethnic, and sexual identities as covariates in the data analysis. The length of practitioner practice was made evident upon commencement of the investigation. Practitioners who hold lengthy experience in providing treatment did not substantially influence the results of this investigation. The researcher controlled for the length of time the practitioner has been practicing and the length of time the practitioner and client share a therapeutic relationship.

The administrators for each of the participating agencies have reported, nonetheless, that all practitioners use a combination of Trauma-focused Cognitive-based therapeutic approaches,

Narrative therapeutic approaches, person-in-environment, strengths-based perspective, and Feminist theoretical therapeutic approaches.

The psychometric assessment/screening tools measure a depth of emotional damage via a calculatable index, related to traumas experienced. Inquiries were made regarding the uses of the assessment tools as applied by mental health professionals.

The researcher considered the length of time a mental health provider provided services to Bronx-residing LGBTQIA+ BIPOC. Mental health providers may have gained further experience in treating LGBTQIA+ BIPOC clients after completing the survey and before the study completion and analysis. Recognition of the mental health provider's age, professional and personal experiences related with LGBTQIA+ BIPOC cultures, gender identity, sexuality, identified cultures, race and ethnicity was documented. The measures of depression and anxiety includes a reference to all respective disorders from each theme as described in the Diagnostic Statistical Manual – Version 5 (DSM-5).

Within the measurement purposes of the study, the researcher has stipulated the specific and preferred treatment modality/ies used by each participant who has completed the survey.

Variables

The variables used for this investigation in data analysis are coded as; independent, controlled dependent, categorical, and dichotomous.

Independent Variables

The analyzed independent variables are for the most part, categorical and dichotomous in nature. Some prompted responses required the participant to manually provide their demographic response, instead of choosing from multiple choices. Their responses for these questions were coded and further categorized. For example, participating practitioners indicated either 'yes' or 'no' if they use any of the interventions listed as follows (the coding for each

variable will be written in brackets); Trauma-focused Cognitive-behavioural Therapeutic intervention (TfCbT), Narrative Therapeutic intervention (NT), Strengths-based Perspective intervention (SbPT), and person-in-environment intervention (PiET). For those responses that were manually typed, codes were created to represent them in groups related to each other. An example of this was when the survey asked participants to manually describe their race/ethnicity. Some participants responded, 'Hispanic', 'Latino', 'Latina', and 'Latinx'. The researcher grouped these responses and labeled the variable, 'Latina/o/x/Hispanic'.

Dependent Variables

The investigator measured the responses provided by the surveyed practitioners who have responded to questions directed at indicating the effectiveness of TiT after assessing their Bronx-residing LGBTQIA+ BIPOC clients for depression and/or anxiety. The researcher asked practitioners to gauge whether they feel that trauma-informed treatment (TiT) approaches played an efficacious role in their developing a therapeutic treatment trajectory for their Bronx-residing LGBTQIA+ BIPOC clients.

Because all four agency's administrators reported that they mandate their employee mental health practitioners to apply psychometric assessments upon initially meeting with their clients, the researcher found it ethical to mention it as part of the treatment process for the population of interest of this investigation. Thus, it was created as one of the independent variables. According to Carroll, et al., (2020), many agencies exercise this mandate to perform initial treatment, as it establishes thorough therapeutic processing that ultimately benefits both the client and their mental health provider. Carroll (2020), for example, performed a systematic review of globally reported, measured results of PHQ-9 assessments with clients who reside in low-resourced communities. Their findings discuss the prevalence of acute and chronic

depressive symptoms of assessed clients meeting the average score of ten (10) or above for those clients who benefitted from psychotherapeutic treatments for major and moderate depressive disorders. Zhang, et al., (2021) also performed a systematic review of reported findings which concentrated on the reported results of assessment tools with clients who are medical students in China. They studied the reported results of clinicians who assessed symptomology levels of general anxiety disorder among these medical students and found that those who scored above ten (10) benefitted most from psychotherapeutic treatment.

Supervision practicum in all four agencies mandated screening and in-take procedures with stipulations of applying psychometric assessment tools to diagnose both anxiety and depression, as it is a focal point of their mental health practicum. Anxiety and depression are commonly treated with all clients who frequent their services, including Bronx-residing LGBTQIA+ BIPOC. The reporting of diagnostic assessment tools is not a focal point of this investigation. Its reported use, nonetheless, adds further reliability to the findings of this investigation in that the assessment of anxiety and depression leads to specific treatment terms, TiT being one of them.

Primary Investigative Question

Have you serviced LGBTQIA+ BIPOC clients residing in the Bronx throughout your career as a mental health practitioner?

Demographic Data Collection Inquiries

1- What is your age?

2– How do you identify your race/ethnicity?

3- Do you identify as a member of the umbrella term LGBTQIA+?

4 – How do you most accurately identify yourself in terms of your gender?

5 – Which of the following categories best describes the length of time you practiced as a mental health practitioner (open-ended)?

6 - At your present agency of employment, what is your length of employment (open-ended):

7 - Which of the following degrees do you hold as a mental health practitioner: (check all that apply)

8 - Which licenses do you hold and are you currently applying to your present practice in treatment with your clients?

Questions Focusing on the Investigative Topic:

For the following questions, please note that when asking about your clients, it is about those of your clients who are Bronx-residing LGBTQIA+ BIPOC.

9 - Within your present professional role, have you practiced mental health services utilizing trauma-informed treatment approaches with clients who are the subject of this investigation?

10 – If *yes*, why had you chosen to apply trauma-informed treatment practices with the clients who are the subject of this investigation? (Choose all that apply)

11 - If *not*, why had you chosen not to apply trauma-informed treatment practices with the clients who are the subject of this investigation?

12 – As best you can recall, when did you begin utilizing trauma-informed treatment modalities in treatment with clients who are the subject of this investigation?

13 - As best you can recall, was the annual income of the clients focused on for this investigation below the poverty line level?

14 - Within your practice *at the present agency of your employment*, which categorized length of time best describes the length of time you have utilized trauma-informed treatment practices?

15 - Within your practice in treating clients who are the subject of this investigation, have you employed *Trauma-focused Cognitive-behavioural Therapy* (TF-CBT)?

16 – If *yes*, please choose one or more of the categories listed to best respond:

17 – If *not*, please choose one or more of the categories listed to best respond:

18 - Within your practice in treating clients who are the subject of this investigation, have you employed *Narrative Therapeutic* approaches?

19 – If *yes*, please choose one or more of the categories listed to best respond:

20 – If *not*, please choose one or more of the categories listed to best respond

21 - Within your practice in treating clients who are the subject of this investigation, have you employed *Strengths-based perspective* approaches?

22 – If *yes*, please choose one or more of the categories listed to best respond:

23 – If *not*, please choose one or more of the categories listed to best respond:

24 - Within your practice in treating clients who are the subject of this investigation, have you employed *Person-in-Environment therapeutic* approaches?

25 – If *yes*, please choose one or more of the categories listed to best respond:

26 - If *not*, please choose one or more of the categories listed to best respond

27 – As best you can recall, please choose one or more of the following types of traumas you have treated while performing trauma-informed treatment practices with clients who are the subject of this investigation:

28 – Within your practice *at the present agency of your employment*, do you feel you have received sufficient trauma-informed treatment training?

For the purposes of this investigation, please choose one client that you would identify as the subject of this investigation to answer the following questions:

29 - Have you experienced trauma-informed treatment practices to be effective, with the client in question, after their being assessed for ***depression***?

30 – If effective, how did you determine its effectiveness? (Check all that apply)

For the purposes of this investigation, please choose one client that you would identify as the subject of this investigation to answer the following questions:

31 - Have you experienced trauma-informed treatment practices to be effective, with the client in question, after their being assessed for ***anxiety***?

32 – If effective, how did you determine its effectiveness? (Check all that apply)

The group of dichotomous and open-ended demographic independent variables were as such (again, please note that the coded version of each variable will be written in brackets); 'Age of practitioner in years' (Whatisyourage), 'Years in total practice' (LofTPractice), 'therapeutic service performed with Bronx-residing LGBTQIA+ BIPOC clients' (servyes) and (servno), 'professional title held by the practitioner' (LMSW, LCSW, PsyD, and NoLicense) and degree (MSW, CSW, PsyD, BSW, and NoDegree), 'perceived income level of client' (incyes). Possible categories for coding may be as such; 'Gender Queer' (gq) and 'Gender Fluid' (gf), 'Transgender', 'Male', 'Female', 'GenderNonDescript', 'LGBTQIA+' (lgbtqiay) and (lgbtqian), (AfricanAmerican), (Asian), (Latino/a/x/Hispanic), (White), (Multiracial), etc…

Data and Subjects

Data collection was sourced through online survey dissemination, completed by mental health service providers who service Bronx-residing LGBTQIA+ BIPOC clients. Online recruitment was performed by the confirmed participation of providers, as accessed, and made beholden by the agency administrators on behalf of the participating providers. Based on factors which promote statistical significance based on power analysis, the researcher was hoping to receive at least fifty (50) participant responses. After seven weeks of survey dissemination, however, the researcher only received forty-one (41) completed surveys. This amount, nonetheless, was usable for statistical power analysis. All data collected will be used and shared with all involved with the research, including possible journals, in support of further findings of better applicable treatment of trauma.

The command most applied and recognized to produce desirable results for this investigation was that of the logistic regressions, as the command yielded statistical significances between variables and their odds of the probability of progression. Logistic regression was applied to predict dichotomous and categorical variables. Variables were deemed statistically significant when observing the P-value and/or Z statistics for each independent variable.

The logistic regression model is one of regression analysis. Regression analysis is a data measuring tool used to predict the relationship between a dependent variable and a set of independent variables (Garcia, et al., 2020, p.509). Multiple regression, then, predicts the outcome of a dependent variables while employing a correlation with more than one independent variables. Regression analysis can be used for three different occurrences to analyze data; 1) predicting the impact of specific changes in collected data, 2) predicting trends, and 3) determining the strengths of different predictors (Kabacoff, 2011, p. 184).

Regression analysis can adopt either a ‘Linear Regression’ or a ‘Logistic Regression’ model analysis. Linear regression is generally used to ascertain estimations between compared variables by determining the progression to which there is a linear relationship between a dependent variable and one or more independent variables (Kabacoff, 2011, p.184). Logistic regression can be used to calculate the probability of the binary event occurring. For this investigation, binary outcomes represent the collected data where participants responded to the presented query with either a ‘yes’ or ‘no’ response. The independent variables are measured to observe if they influence the occurrence of the dependent variable. The researcher performed a logistic regression, for example, to measure whether any of the independent variables representing the participant’s academic identities had any influence in the occurrence of the participants opting to apply trauma-informed treatment practices with the population of interest. With this example, the investigator applied the measurement with independent, nominal variables, as each represented the named group of different types of degrees earned by each respondent participant (e.g., ‘MSW’, ‘CSW’, ‘PsyD’, ‘BSW’).

The goal of the logistic regression model of analysis is to observe that there are no high correlations between independent variables (Garcia, et al., 2021, p. 510). The logistic regression model of analysis usually requires a relatively large sample size, as a larger sample size would most likely generate more reliable results in data analysis. This investigation, alas, did not achieve a desirable sample size, falling short of 50 completed surveys.

The investigator focused data analysis, nonetheless, with the general application of the logistic regression, as all the dependent variables measured were dichotomous. With the logistic regression measurement, the investigator observed the occurrences of log odds. Log odds offer a variant description of the probabilities occurring for each independent variable measured. Odds

are the ratio of an event either occurring, or not. For this investigation's data analysis, every possible outcome of the dependent variables measured were converted into log odds by finding each's odds ratio.

As previously mentioned, logistic regression was the appropriate regression model of analysis performed when the dependent variable is binary. All of the dependent variables used in the first and second sets of hypotheses testing for this investigation were binary in nature. The dependent variables for the first set of hypotheses testing were representative of each of the four trauma-informed treatment approaches measured (e.g., Narrative Therapy, Person-in-Environment Therapy, Strengths-based Perspective Therapy, and Trauma-focused Cognitive-behavioural Therapy). Like all regression models, the logistic regression (or, command 'logit') is predictive in that it is used to describe collected data, so as to explain the relationship between one dependent binary variable and one or more nominal, ordinal, interval, or ratio independent variables (Nugent, 2021).

With all measured analyses for this investigation, the researcher observed a curb of .05 or below to establish statistical significance. A correlation matrix was applied to demonstrate the relativities between independent and dependent variables. The 'Standard Error' would identify the accuracy of regressions to predict known outcome values from those variables that are predicted (Nugent, 2021). The 'Standard Error', therefore, implies greater confidence with the accuracy of investigated results. With the Logistic regression (logit command), the odds ratio determines the association between an exposure and an outcome. When a logistic regression is measured and analyzed, the exponential function of the regression coefficient is the odds ratio associated with a one-unit increase in the exposure (Kabacoff, 2011, p. 175).

Additionally, the researcher performed Chi-squared testing with choice dependent variables when singularly paired with independent variables to test the hypotheses. Results yielded similar reports of statistical significance for each independent variable tested. Some Chi-squared tests revealed no statistical significance between variables, while Logistic regressions rendered opposite results. The difference between all rendered analyses was observed when the researcher performed each variable for singular rather than multiple correlations. In support of performing Chi-square testing, Pearson's correlation was observed to best understand if the measure used was proper in determining reliable outcomes. Pearson's correlation of statistical analyses relies on the perceived and expected frequencies for each set of paired variables to establish whether there is a lack of model fit or a 'Goodness -of-fit' model (Garcia, et al., 2021, p. 509), as observed in the next section of this dissertation.

For this study, the Logistic Regression model of analyses became the focal point of data analysis, as some variables with direct significance in supporting each hypothesis produced outcomes worth reporting.

Procedures

The researcher utilized a 'Total Design' method. This method gives detailed direction into how every investigative factor best and most accurately categorizes the data collection process (Zmud, 2013, p. 18); from the detailed terminology of the precontact letter to agency administrators, to the formation of each survey question presented in the disseminated surveys. The 'Total Design' method highlights the avoidance of four commonly performed methodology errors, sampling error, measurement error, non-response error, and coverage error. To best reduce a 'Coverage Error', being that an error of bias may occur when survey participants identify as having a non-zero chance of inclusion in the sample (Zmud, 2013, p. 17), the

researcher included the participation of four chosen New York City-based agencies that service LGBTQIA+ communities in all five boroughs but will only include the participation of providers who implement therapeutic services for clients who reside in the Bronx.

To reduce sampling error, the researcher applied recruitment methods to reach as many mental health service providers as possible who work and service Bronx-resident LGBTQIA+ BIPOC. The researcher contacted as large a sample as possible, via agency administration's assistance, to better yield statistically significant data.

A considerable portion of the methodological process of data collection included a detailed and well-informed consent. The letter of consent described the risks and benefits of participating in the investigation. After IRB and Committee dissertation approval, the investigator will offer participants the results and findings of the data collected. The researcher performed a volunteer purposive sample in groups. The general volunteer sampling bias has historically been represented. There may have been volunteer sampling bias, nonetheless. The researcher sent four weekly invitations to agency administrators to then distribute to their mental health providers, the first of which included the researcher's anonymous contact information. The following three invitations served as reminders to complete the survey.

Attempts to reduce 'Measurement Error' was represented by detailed scrutiny of the Wurzweiler School of Social Work administrators who have alerted the researcher to revise vagueness, tangentiality, and overly complex terminology in questions (Groth-Marnat & Wright, 2016, p. 68).

Data Analysis

The data was analyzed through its use of STATA (version 16.0). The survey collected dichotomous, categorical, and open-ended responses which included demographic, professional, experiential, and consequential information. Correlations between presented variables discovered in the data collection were identified through descriptive and inferential statistics. Descriptive statistics provided information regarding the frequencies of observed professional treatment histories as best recollected by the mental health service provider participants. Inferential statistics provided information regarding the effectiveness of applying trauma-informed treatment modalities with their Bronx-residing LGBTQIA+ BIPOC clients.

For the purposes of fulfilling the researcher's investigative curiosity, the researcher opted to apply T-testing for some of the measures performed. STATA's t-test command establishes whether the difference between the means of two independent groups are equal to a target value (Kabacoff, 2011, p. 331). Analysis of two variables in comparison with one constant variable, nonetheless, was soon thereafter performed through chi-squared testing, so that the researcher was able to determine which variables were inadequately matched or the best fit with the constant variable. When a variable serves as the 'constant', correlations of other independent variables in comparison with the dependent (the 'controlled') variable were better accessibly analyzed for the purposes of reaching a more definitive conclusion in response to the researcher's investigation (Nugent, 2021). The performance of the command of 'Chi-Squared testing' by the researcher allowed for other commands in its support (such as, t-test and logistic regression). This served as proof of correlation of variables.

The total amount of participants needed to reach 'statistical power analyses' for the presented study amounted to forty-one (41) completed surveys, to attain statistical significance

with a desired statistical power level of .08, probability level of .05, and number of predictors as three.

Feasibility

Feasibility was attained by the researcher via the approbation of the administrator of 'Analytics' and 'Mental Health Supervision' for each of the four participating agencies. Each of these administrators have agreed to beholden at least twenty (20) mental health providers who have been trained in practice to utilize trauma-informed treatment modalities, in tandem with intervention modalities of their choice. The study would have benefitted from attaining all twenty volunteered mental health providers from each of the four agencies to participate in survey completion. Mental health providers in each of the participating agencies, however, have been exceedingly overworked and over-utilized within their daily practices since the onset of the pandemic (as noted by agency administrators), and have found it difficult to complete a 15-minute survey, let alone prioritize a survey completion before completing their required paperwork.

Alas, barely seven to twelve (7-12) participants from each agency completed the surveys, leading to the final count of forty-one (41).

Therapeutic Intervention Approaches:

Trauma-informed treatment intervention approaches ('Narrative Therapy', 'Person-in-Environment', and 'Strengths-based Approach', and/or 'Trauma-focused Cognitive-based Therapeutic approach')

Limitations to the Therapeutic Intervention Approaches:

Perhaps the most obvious limitation of this investigation was the apparent lack of baseline information pertaining to Bronx-residing LGBTQIA+ BIPOC client information given.

This lack of client information could have presented bias with this investigation, as the client may have already experienced receiving trauma-informed treatment with a different practitioner at an earlier date. Overrepresentation of Bronx-residing LGBTQIA+ BIPOC clients via participant collected data could have also served as a limitation, as participating mental health practitioners could have projected their personal desired needs for the study's outcome to represent the population of focus for this investigation. This may have created possible bias of collected data.

Limitations with the Strengths-based Approach

The concerns which may have become apparent in use within social work practices with this approach may have been the unforeseen and untreated inner conflicts experienced by the individual in treatment with the practitioner (Williams, 2019). While unmonitored, these newly exposed inner conflicts can eventually derail the provider's treatment effectiveness. Another concern which may have arisen by utilizing this approach, was that the practitioner may have focused too much on the client's perceived competency, while insufficiently assessing character (Williams, 2019). While perceived competence may have appeared as the client's socio-emotional skillset and knowledge, the client's character is the behavior which demonstrates their values. The client's *perceived competence* is apparent in the actions performed by the client, while their *character* is made apparent in the way their actions are performed.

Limitations with the Person-in-Environment Limitation (PiET)

The Person-In-Environment approach, despite its aims to incite and progress an individual's stronger sense of self in society, is largely influenced in social work practice through social work ideology and their personal, socio-emotional values. With individual treatment of clients, social workers commonly employ ideological approaches which do not often consider macro-level, socio-emotional factors promoted by the person-in-environment therapeutic

approach. Social workers who have intended to employ PiET, in practice and principle with individuals, may observe PiET as too idealistic for client treatment planning. As a result of these observational critiques, social workers come to understand and practice that planning a clear manner of treatment would be difficult to follow through with clients (Weiss et al., 2003, p.17).

Limitations with Trauma-focused Cognitive-based Therapeutic Approach:

Tf-CbT is a relatively new approach to treating post-traumatic stress disorders, depression, and anxiety (as related to experienced traumas). There remains a scarcity of evidence-based research focused on the effectiveness of this therapeutic approach. As such, it may have presented with unforeseen limitations for social work practice (Peters, et al, 2021). This approach may have proved effective with clients who recognize and wish to treat their anxiety and depression with this TiT approach. It may have, however, fallen short in resolving long-term treatment goals for unforeseen conflicts which may have spiraled out of control for the client in need of treatment (Peters, et al, 2021).

Limitations with the Narrative Therapeutic Approach

Although this approach is being widely utilized in social work therapeutic practices during the past two decades, or so, few practitioners may have admitted to fully applying its therapeutic methodology, as it requires a rigorous amount of discipline from both the practitioner and their clients. Even for some veteran providers who may be more adept at applying NT as intended, it may have been difficult to address its efficacy, especially after practicing other therapeutic treatments for many years (O'Connor, et al., 2004). The Narrative approach may have appeared particularly challenging in application when resolving client's instincts for violence and rationalizing violence. Some practitioners may have also felt that this TiT approach may have appeared to be too time-consuming for both the practitioner and their clients (O'Connor, et al., 2004).

Data Analysis Table

Hypothesis	Variable Name	Definition	Level of Measurement	Variable Use	Analysis
H1: Mental health practitioners who identify as a sexual minority will opt to perform one or more of the following types of treatment; trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment	Applied trauma-informed treatment	*Applied trauma-informed treatment*: the therapeutic practice of practitioner opting to use trauma-informed treatment approaches	Dichotomous Skip logic Categorical and coded	Dependent Variable: trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment Independent Variable: Practitioner's identifying as a sexual minority	Chi-square testing and Logistic Regression model
H2: Mental health practitioners who identify as a gender-related minority will opt to perform one or more of the following types of treatment; trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment	Applied trauma-informed treatment	*Applied trauma-informed treatment*: the therapeutic practice of practitioner opting to use trauma-informed treatment approaches	Dichotomous Skip logic Categorical and coded	Dependent Variable: trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment Independent Variable: Practitioner's identifying as a gender-related minority	Chi-square testing and Logistic Regression model
H3: Mental health practitioners who identify as a Black and/or Indigenous Person of Colour (BIPOC) will opt to perform one or more of the following types of treatment; trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment	Applied trauma-informed treatment	*Applied trauma-informed treatment*: the therapeutic practice of practitioner opting to use trauma-informed treatment approaches	Dichotomous Skip logic Categorical and coded	Dependent Variable: trauma-focused CBT, Narrative Therapy, Strengths-based perspective, and Person-in-environment Independent Variable: Practitioner's identifying as BIPOC	Chi-square testing and Logistic Regression model
H4: Mental health practitioners will reveal their experience of trauma-informed therapeutic approaches as effective in treating *depression* with their Bronx-residing LGBTQIA+ BIPOC clients by identifying one or more reasons for this effectiveness.	Trauma-informed therapeutic treatment experienced as efficacious for treating depression	*Trauma-informed Treatment as Efficacious*: Practitioners will reveal in their surveyed responses if and how they deem trauma-informed treatment therapeutic approaches to be effective in treating depression	Dichotomous Skip logic Categorical and coded	Dependent Variable: Trauma-informed treatment practices effective in treating depression Independent Variable: Practitioner- client self-report, assessment of psychometric tool, practitioner's evaluation	Chi-square testing and Logistic Regression model
H5: Mental health practitioners will reveal their experience of trauma-informed therapeutic approaches as effective in treating *anxiety* with their Bronx-residing LGBTQIA+ BIPOC clients by identifying one or more reasons for this effectiveness.	Trauma-informed therapeutic treatment experienced as efficacious for treating anxiety	*Trauma-informed Treatment as Efficacious*: Practitioners will reveal in their surveyed responses if and how they deem trauma-informed treatment therapeutic approaches to be effective in treating anxiety	Dichotomous Skip logic Categorical and coded	Dependent Variable: Trauma-informed treatment practices effective in treating anxiety Independent Variable: Practitioner- client self-report, assessment of psychometric tool, practitioner's evaluation	Chi-square testing and Logistic Regression model

Section Seven: Findings

The results of this study are reported in this section. They are based upon forty-one (41) completed surveys. Following their consent, the primary investigative question was asked regarding whether the participants had serviced Bronx-residing LGBTQIA+ BIPOC clients.

The investigator then made requests for the participant's demographic data. The first set of questions in the survey (question #2 through question #4) collected personalized data from each participant. These questions asked participants about their racial/ethnic identities, gender identities, sexual identities, and age. The next set of questions (question #5 through question #16), asked participants for professional data. These questions focus on the length of time participants have worked in their present agency of employment, how long they have practiced as mental health providers, whether they have been trained for trauma-informed treatment practices, what type of traumas they have treated with their Bronx-residing LGBTQIA+ BIPOC clients, whether they have identified their Bronx-residing LGBTQIA+ BIPOC clients as low-income earning, and if they have opted to choose trauma-informed treatment approaches with the targeted population and for how long.

Question #17 through #28 ask participants if they have or have not opted to apply any of the four trauma-informed treatment practice (TiTP) approaches with the targeted population; namely, Trauma-focused Cognitive-behavioural Therapy, Narrative Therapy, Strengths-based Perspective Therapy, and the Person-in-Environment Therapeutic approach.

The last set of questions (question #29 through #32) asked participants to choose from the options provided regarding how they came to choose to treat the target population for depression and/or anxiety with trauma-informed treatment practices (or write a reason of their own).

Following the graphics, the researcher offers an interpretation of the connections between the participant demographic collected data and that of TiTP general use and reasoning. With the reported collected data, the researcher presents the correlations to each of the presented hypotheses tested.

The Participants

Participants sought for this investigation were largely derived from four NYC-based social service organizations who have serviced Bronx-residing LGBTQIA+ BIPOC clients.

The researcher was expecting to collect fifty or more completed surveys to reach better results by collecting more data supporting the investigation, as suggested by the power analysis performed. The smaller the sample size, the more difficult it is for the researcher to encounter smaller differences and more variance within the data. Few studies regarding the role of sample size in factor analysis have investigated sample sizes below fifty, as this number is considered a reasonable absolute minimum threshold (Velicer & Fava, 1998, p. 232). A small number of participants in a sample would limit generalizability. The logistic regression model, as used in this investigation, is known to produce biased estimates of coefficients and their probabilities (Velicer & Fava, 1998, p. 232).

Although the sample size was less than desirable, statistical significance was obtained with some of the controlled variables. As such, the researcher was able to successfully reject two of the five null hypotheses.

Descriptive Statistics

Descriptive statistics involve the representing and defining of demographic information collected from surveyed participants. Their use is represented by generated variables which are then measured with other variables. This investigation uses descriptive statistics to form

independent variables used in rejecting (or not) its stated hypotheses. The first three hypotheses tested for this investigation measures the relationships between participant sexual, gender and racial/ethnic identities and that of their choosing to apply any one of the four trauma-informed treatment approaches - the dependent variables. The measurement of these variables will be made more apparent later on in this section. Graphs are visibly accessible when initially describing the collected descriptive data in this subsection.

The following figures and table (located at the end of this section) represent the results of the investigation's participant demographic findings. The first graph represents how participants identified their sexuality. It is followed by a table which demonstrates the percentage of how most participants responded to this query.

Figure 1a

Demographic of participants identification of sexual

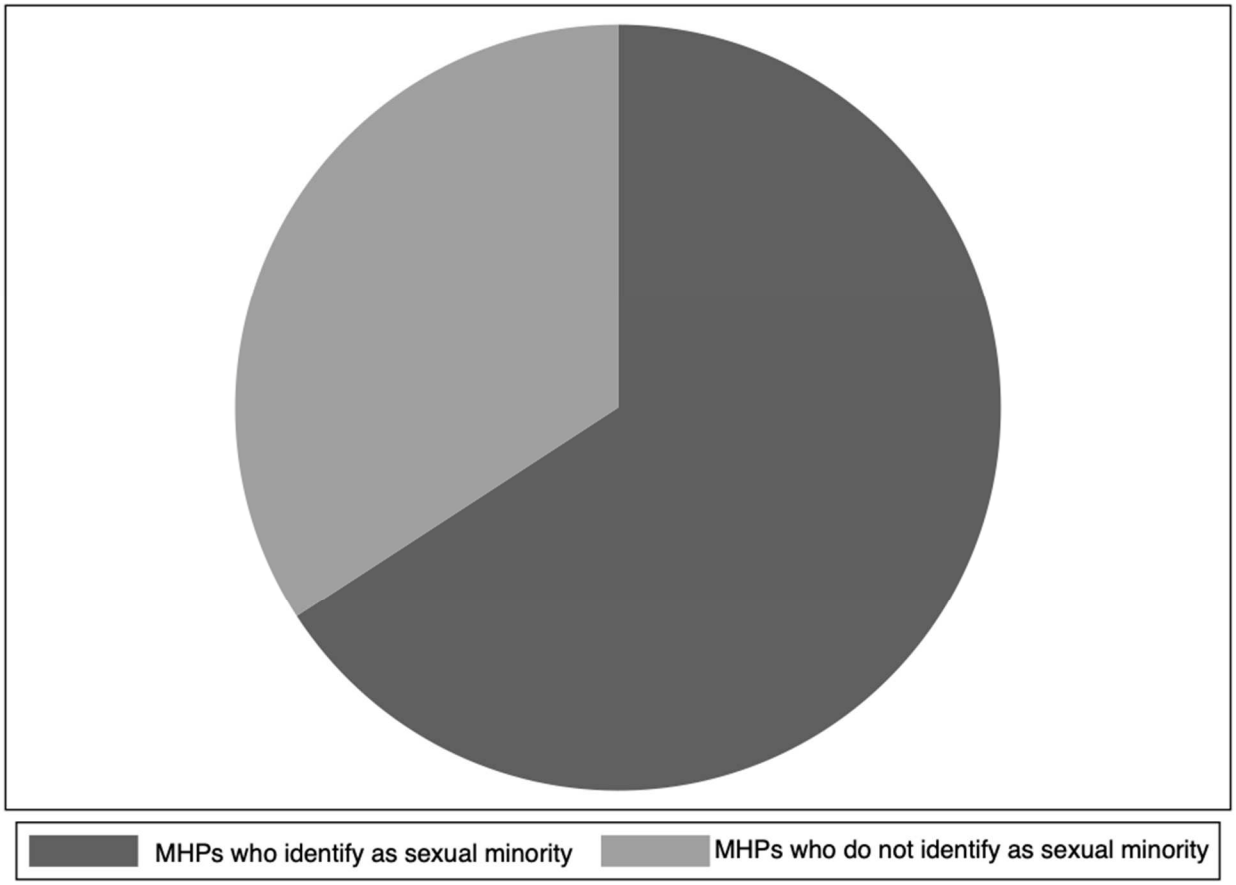


Table 1a displays those forty-one (41) participants who responded to this question. Twenty-seven of them, or a little less than sixty-six percent (65.85%), identified as LGBTQIA+, while the remaining fourteen (14) did not (34.15%). As demonstrated in Figure 1a, most of the participants who completed the survey identified as LGBTQIA+.

Figure 1b displays the median age of the participants. The median age of the participants is 44 years. The youngest participant reported as twenty-five (25) years old, while the oldest reported as seventy-one (71) years old.

Figure 1b

Box Graph of Age of Participants

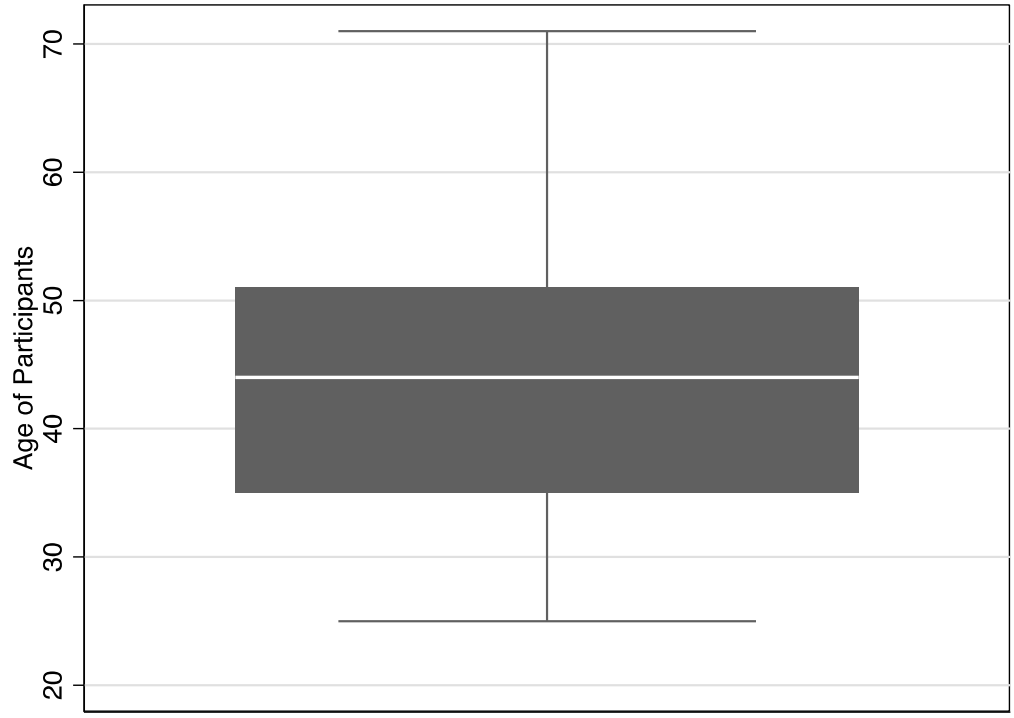


Figure 1c demonstrates, for the most part, the racial/ethnic identities reported by all thirty-eight (38) participants. Almost twenty-two percent (21.95%) of the participants identified as African American or Black. Nearly thirty-two percent (31.71%) identified as Latina/o, Latinx, or Hispanic and was the participants' most prominent racial/ethnic demographic. Over seven percent (7.32%) of the participants identified as Asian or South Asian. Nineteen and a half percent (19.51%) identified as White, White/Jewish, or Caucasian. Another nineteen and a half percent (19.51%) of the participants identified as Mixed ethnicities/Multiracial. Of these multiracial participants, reports of the combinations of races/ethnicities were recorded as such; Black and White, Black and Latina/o, Afro-Latino, Black and Asian, and 'multiracial' - Graph 1c

Figure 1c

Participant Racial/Ethnic Identities

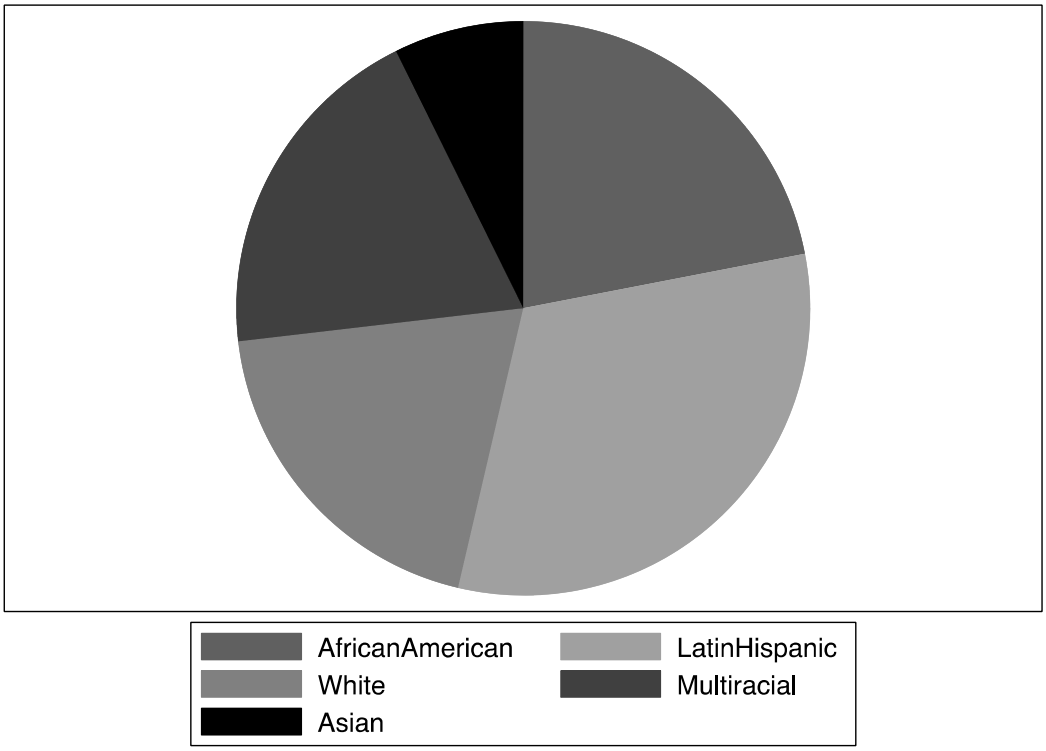
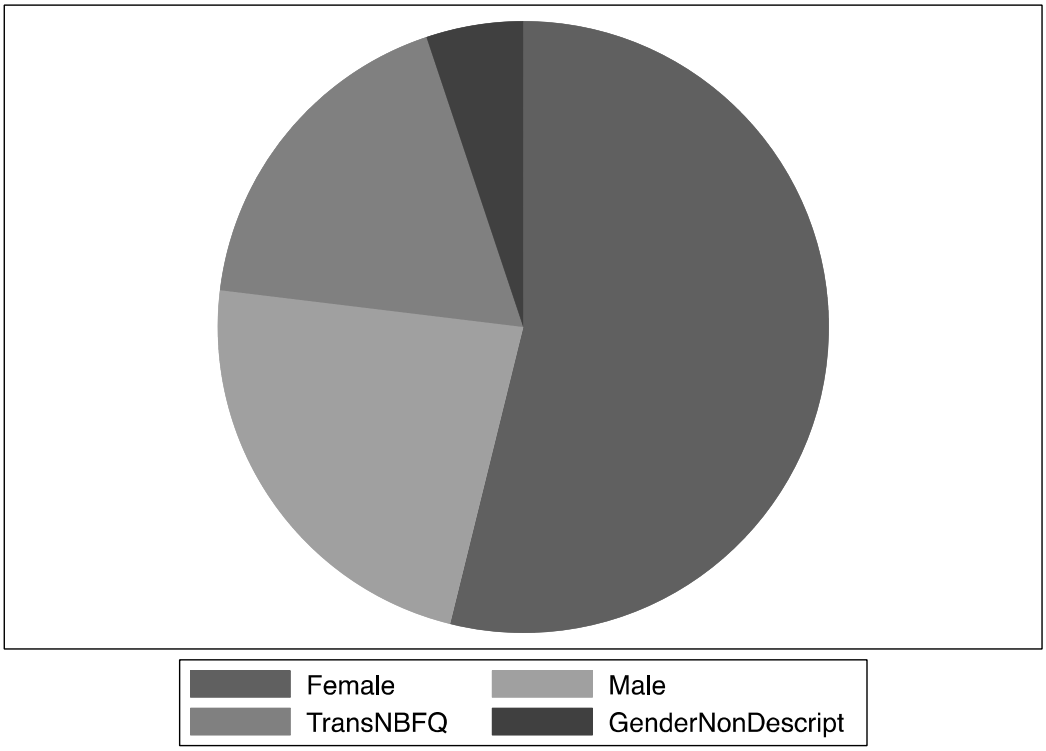


Figure 1d shows the participants' reported gender identities. The largest gender identified population is that of 'Female,' recorded at a bit more than fifty-one percent (51.22%), while the 'Male' population of participants summed up to just under twenty-two percent (21.95%). More than seventeen percent (17.07%) of the participants identified as 'Transgender,' 'Non-binary,' 'Gender Fluid,' and 'Gender Queer.' The remaining participants who answered this question identified their gender as 'Heterosexual' and 'yes,' and were categorized as 'Gender Non-Descriptive. They encompassed less than five percent (4.88%) of the completed surveys.

Figure 1d

Participant Gender Identities



A summary of the demographics of the participants is displayed in Table X. The variable created, which measured whether participants knew if they had serviced clients from the population of interest for this study (individuals who are low-income earning), was also not included as a factor in rejecting any of the first three hypotheses (like that of the 'age' variable). However, the researcher felt this variable to be essential to use in measurement as it is one of the defining factors of traumas experienced within this population. Therefore, the chi-squared test was utilized to measure the relationship of this variable to whether participants used trauma-informed treatment practices with the population of interest. Its results were the following: Thirty-five (35) participants responded to this query. Less than eighty-one percent (80.65%) identified applying trauma-informed treatment practices with the population of interest. However, participants also recognized treating members of this population who were low-

income earning. Although, given a wider sample size, the relationship between the dependent and the independent variables (the dependent being the variable which represents the confirmation of participant's applying TiTPs with the population of interest, the independent being the variable which represents the participant's recollection that the Bronx-residing LGBTQIA+ BIPOC clients they serviced were of low-income earning status). Alas, while applying a chi-square test to measure the relative significance of the relationship between these two variables, the results did not yield statistical significance. The p-value was 0.170.

Inferential Statistics

Inferential statistics aims to test if relationships between variables occurred due to chance (Type I error). For example, table 1a compares the variable sexual identity to whether participants opted to apply trauma-informed treatment practices with the target population. Eighty percent (80%) of the participants who identified as LGBTQIA+ reported using trauma-informed treatment practices with the population of interest. These results, however, were not statistically significant (chi-square = 1.503; p = .22).

The following survey queries are directed toward collected data regarding participants' professional experiences. They inquire about which licenses and degrees they hold, lengths of general practice, time practicing in the present agency of employment, and their experiences being trained for observing trauma-informed treatment guidelines. These queries represent the participant's professional and academic identities. This section of collected data is not intended to support the rejection of any of the null hypotheses. This collected data (turned into dependent and independent variables) does, however, support the investigation's research question.

The survey asked its participants to identify which licenses and degrees they hold. Their responses totaled six (6) categories. It was, again, the researcher's choice to allow participants to

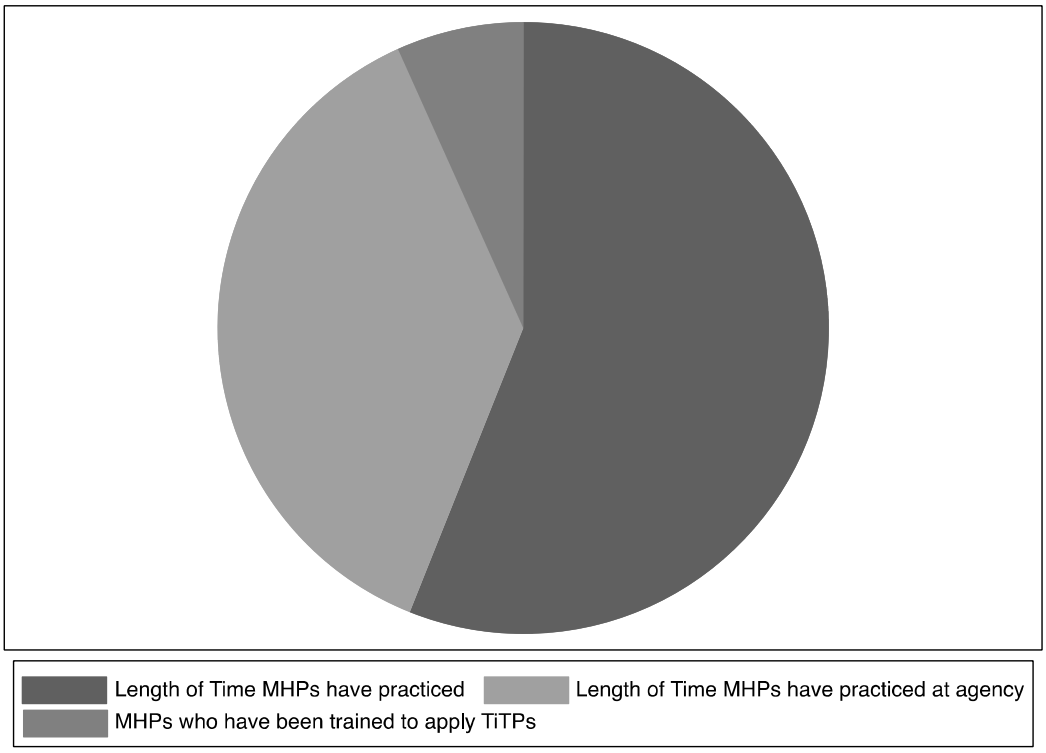
identify their identities on their terms. Participants' responses were categorized as; LMSW, LCSW, PsyD (as a license), No License, and Other License, and CASAC (Credentialed Alcoholism and Substance Abuse Counselor). Thirty (30) of the forty-one participants answered this question. The most populated response was that of 'LCSW' at a bit higher than thirty-three percent (33.33%), followed by the category 'LMSW' at exactly thirty percent (30%). One participant answered this question as 'PsyD' to indicate their license (3.33%), while exactly twenty percent (20%) did not report holding any license. Some respondents revealed holding 'Other License', ten percent (10%), but did not specify which license they hold. Conclusively, one participant reported holding a CASAC license (3.33%).

The degrees earned were categorized as such; MSW, CSW, Other Degrees, BSW, and PsyD (as a degree). Thirty-four (34) participants answered this question. The largest category was 'MSW', at over fifty-four percent (54.55%), followed by the category 'Other Degree' at a little more than thirty percent (30.3%). The degrees specified were listed as 'School Counselor', 'Mental Health Counselor', 'presently earning an MSW', and 'Other degree'. One participant reported 'PsyD' as a degree (the same participant listed 'PsyD' as a license), while another responded with having earned a 'BSW', both at three percent (3.03%). The category 'CSW' comprised a little over nine percent of the total responses (9.09%). The degree MSW and the licenses LMSW and LCSW were all analyzed as being the most influential of the academic and professional credentials. This finding supports the concept that the mental health providers servicing the population of interest are social workers employed at all four participating agencies.

Figure 2a displays how respondents reported their; length of time at their present agency as a mental health provider, their overall length of time practicing as a mental health practitioner, and whether they have received trauma-informed treatment practices training at their present or previous agencies of employment. Most of the forty-one participants answered these questions.

Figure 2a

Participant Professional History and Trauma-informed Treatment Training



Participant's length of time employed as a mental health practitioner at their present agency of employment has the following categories: 'less than one year', 'one year to three years', or 'four years or more'. Forty (40) out of forty-one participants answered this question. The highest percent of responses indicated that forty-two and a half percent (42.5%) have worked as mental health practitioners within their agency for one year to three years. Almost a

third of participants (32.5%) were employed for four years or more at their current agency. The smallest percentage of participant responses for this query was that of twenty-five percent (25%) who chose the subcategory ‘less than one year’.

All participants answered the question about the length of time they have practiced as mental health practitioners. The subcategories for this question are; ‘newly hired to one year’, ‘two to four years’, ‘five to seven years’, ‘eight to ten years’, and ‘eleven or plus years’. The subcategory chosen most was ‘eleven or more years’, at a little over thirty-four percent (34.15%), followed by the two to four years at a little less than thirty-two percent (31.71%). The subcategory ‘newly hired to one year’; was 19.51%, while both remaining subcategories, ‘five to seven years’ and ‘eight to ten years’, were 7.32%.

Thirty-eight (38) responses were recorded for the question asking whether participants had been trained in trauma-informed treatment practices at their present or former agencies. Of those thirty-eight responses, a little over thirty-nine percent (39.47%) reported having been trained in trauma-informed treatment practices.

The researcher has included a full demographic table representing the participants’ personal, academic, and professional identities. Again, the demographics of the sample are displayed in Table X.

First Set of Hypotheses Tested

This subsection focuses on comparing independent descriptive variables with dependent inferential variables. The independent variables include the participant’s sexual minority status, BIPOC, and gender identities and are compared to four dependent trauma-informed treatment

approaches utilized to treat the population of interest. Again, the approaches include Trauma-focused Cognitive-based Therapy, Strengths-based Perspective Therapy, Person-in-Environment Therapy, and Narrative Therapy.

The use of Logistic Regression is best suited for this analysis. The Logistic regression model demonstrates the prediction of linear progression represented by odds that each independent variable will produce the probability of positive or negative outcomes. The Logistic regression model demonstrates the likelihood of an occurrence (with binary outcomes) being actualized by having the odds for the occurrence function within a linear combination of independent variables (Creswell, 2003, p. 159). The predictive variables are all independent variables representing the participant's personal, professional, and academic identities.

The odds or odds ratio is the exponential function of the Logistic Regression model. The odds ratio is analogous to a one-unit increase in the variable's exposure to the occurrence (Creswell, 2003, p. 159). In essence, the probability of the exponential growth of the investigation's independent variables (e.g., 'Female', 'Male', and 'Transgender/Non-Binary/Gender Fluid/Gender Queer') increases the likelihood of the occurrence of the dependent variable (e.g., 'confirmed the application of the use of 'Person-in-Environment' as a Trauma-informed Treatment approach').

The researcher's application of the Logistic regression model was followed by performing Chi-square testing for each measured variable set. Upon performing chi-square testing, the researcher observed that Pearson's chi-square confirmed the relationship between being 'Female' and using the 'Person-in-Environment' trauma-informed treatment approach as statistically significant with a P-value of 0.031.

Typically, any regression model including a categorical independent variable would require omitting one category to create a comparison. Therefore, the category 'GenderNonDescript' was omitted from the set of gender variables tested. The race/ethnic variable 'Asian' was omitted from the measures, as well, for populating too few participants representing their categories. The researcher later performed a chi-square test with each of these variables and the trauma-informed treatment approach variables.

The investigator's goal in performing these continued tests is to understand whether statistical significance exists between those tested measures. The findings of these tests revealed no statistical significance for the two independent gender and race/ethnic variables measured, save for the variables previously mentioned. However, the category 'Female' was statistically significant with only the gender variable in the equation. The following scores resulted from model (OR=10; Std Err.= 9.486833, 95% CI [.0520549], P=0.015). Under the Logistic regression model, the gender variable 'Female' revealed a p-value of .015. The variable 'Gender Non-Descript' was omitted from the measurement. The odds that a female would apply 'Person-in-Environment trauma-informed treatment' was ten times more likely than a participant who was categorized as 'Gender Non-Descript'.

Chi-square testing, as previously mentioned, was performed separately between each independent variable representing the participant's personal, professional, and academic identities while in correlation with each of the four dependent variables representing the trauma-informed treatment practices of interest in this investigation. With the exception of the independent gender variable in correlation with the dependent 'PiETyes' variable, however, chi-square testing did not result in any statistical significance.

For mental health practitioners who identify as LGBTQIA+, there was no statistical significance in their choice to apply any trauma-informed treatment approaches. However, a large percentage of the participants who identified as LGBTQIA+ (65.85%) may have also experienced adverse experiences relatable with their Bronx-residing LGBTQIA+ BIPOC clients. Prematurely, it was assumed that identifying as LGBTQIA+ would influence treatment choices.

Logistic regression for the first set of tested hypotheses demonstrated that race did not yield statistical significance when observing the relationship between their choice of any of the four trauma-informed treatment approaches with their Bronx-residing LGBTQIA+ BIPOC clients. In addition, the independent participant's chosen gender identity did not yield statistical significance when measured with any of the four trauma-informed treatment approaches tested for this first data set of tested variables.

All independent descriptive variables were unable to demonstrate statistical significance when measured with dependent variables representing all four trauma-informed treatment approaches. Race and gender identity did not influence the following three dependent variables: 'Narrative Therapy' (NTyes), 'Strengths-based Cognitive-behavioural Therapy' (SBPTyes), and 'Trauma-focused Cognitive-behavioral Therapy' (TFCBTyes).

As previously discussed, one of the descriptive independent variables defined the participant's perception of servicing Bronx-residing LGBTQIA+ BIPOC clients who are low-income earning and is correlated with the dependent variable trauma-informed treatment approach, 'Narrative Therapy'. The model yielded a p-value of .063. This analysis, however, does not support the rejection of the null hypothesis. Nevertheless, with a larger sample size of mental health providers, this model would most likely demonstrate their opting to apply trauma-

informed treatment practices with the population of interest for this investigation as a confirmation.

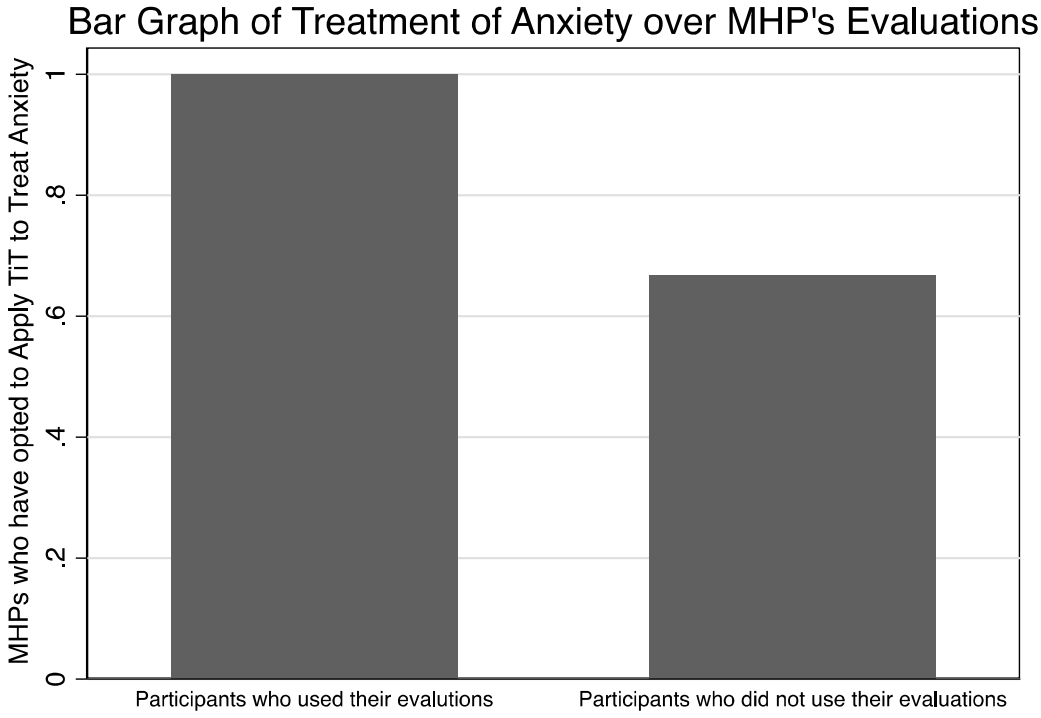
As previously stated, the researcher performed chi-square testing with the ‘gender’ and ‘race’ independent variable and each corresponding dependent ‘TiT approach’ variable (Trauma-focused Cognitive-based Therapy, Strengths-based Perspective Therapy, Person-in-Environment Therapy, and Narrative Therapy). Notedly, most of these analyses did not demonstrate statistical significance.

Tables 2a and 2b display the results from this analysis.

Table 1a visually represents the chi-square testing, measuring the independent variable ‘LQBTQIA+’ and the confirmed the gender identities of the participants with all four of the dependent variables representing TiT approaches. Table 1b represents the chi-square testing measuring ‘perceived low-income earning members of the population of interest’ with that of the confirmed application of ‘Narrative Therapy’.

Figure 2b

Percent of Participants who Opt to Apply the Trauma-informed Treatment Approach, 'Person-in-Environment' to Treat their Bronx-residing LGBTQIA+ BIPOC clients



Second Set of Hypotheses Tested

This section discusses testing the fourth and fifth hypotheses for this investigation. These hypotheses explored the opted application of trauma-informed treatment practices used to treat the population of interest for symptoms of anxiety and depression. The independent variables explain their reason(s) for opting to apply trauma-informed treatment practices.

The queries for these hypotheses, as previously mentioned, were presented as the last four questions of the disseminated survey. Thirty-three (33) participants responded to both questions regarding treatment for anxiety and depression. Of the thirty-three (33) participants who responded to both these queries, thirty-one (31) confirmed that they have opted to apply trauma-

informed treatment practices in servicing the population of interest for both anxiety and depression. Of the thirty-three (33) participants who responded positively to using trauma-informed treatment practices with the population of interest, 63.64% (n=21) reported that they treated these clients because they self-reported their symptoms of depression. Two (6.06%) participants responded that they treated their clients for depression with trauma-informed treatment practices after assessing them for depression by applying the psychometric assessment tool, the Patient Health Questionnaire (PHQ-9). Eight (8) (or 24.24%) participants responded they would treat their clients for depression after assessing them with their evaluation. Three (9.09%) participants responded to this query by indicating 'Other Reason'. They did not, however, specify what the 'Other Reason' would be after being given the opportunity on the survey to explain further.

The researcher performed Logistic regression analyses to measure these four independent variables in conjunction with the dichotomous dependent variable, which represents their option to apply trauma-informed treatment practices to treat the population of interest for depression. Most of the measurements, however, did not yield statistical significance.

Of the participants who reported treating their Bronx-residing LGBTQIA+ BIPOC clients for anxiety, almost thirteen percent (12.91%) said they did so after recording their client's self-report as their only option for assessment. One (3.22%) participant reported they treated the population of interest after applying the psychometric assessment tool, the General Anxiety Disorder (GAD-7). Sixteen (51.61%) participants reported they had treated the population of interest for anxiety after performing their evaluations. Just over thirty-two percent (32.26%) said they treated the population of interest for anxiety after recording their client's self-report in conjunction with their evaluation. The combination of the client's self-report, in conjunction with

their evaluation and the use of GAD-7 psychometric assessments was inconsequential. The only variable that proved statistically significant was the participant's decision to treat their Bronx-residing LGBTQIA+ BIPOC clients for anxiety after evaluating their presenting symptomology as their only option for assessment. These variables were labeled; 'TIT4Anxyes', representing participants who opt to apply trauma-informed treatment practices with the population of interest, and 'Evanx', expressing their choice to treat them for anxiety after performing their evaluations.

Initially, the researcher performed a Logistic regression analysis to measure the variables, demonstrating statistical significance. Although the model's p-value is below the .05 threshold (at 0.002), it also showed that all other measured variables were omitted. All respondents selected the option of using their evaluation to treat the population of interest. Another reason for the demonstration of variable omissions would be that the sample size was too small to measure this variable correctly.

Although data analysis demonstrated a need for further data collection, this finding provides evidence that participants do apply trauma-informed treatment practices to treat the population of interest with at least one of the stated reasons to support their decisions.

Figure 3a represents how participants confirmed that they applied trauma-informed treatment practices to treat their clients for anxiety symptomologies after performing their evaluations.

Figure 3b represents how participants confirmed that they applied trauma-informed treatment practices to treat their clients for symptomologies of anxiety after they had performed their own evaluations.

Figure 3a

Participants who have treated the population of interest for anxiety by using Trauma-informed Treatment Practices after performing their own evaluations

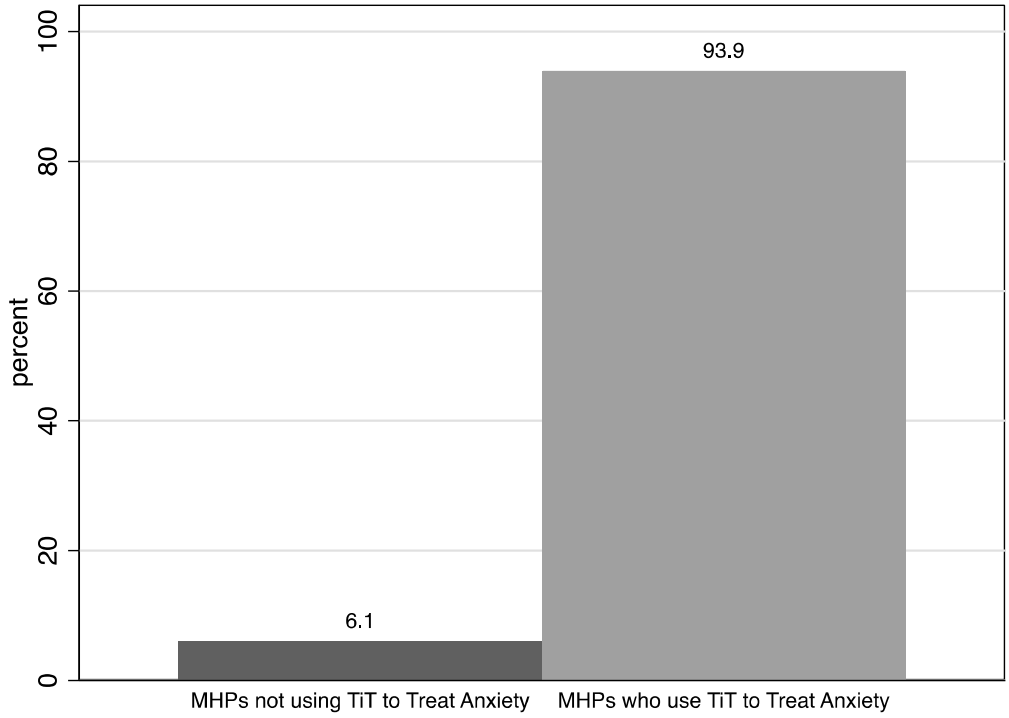
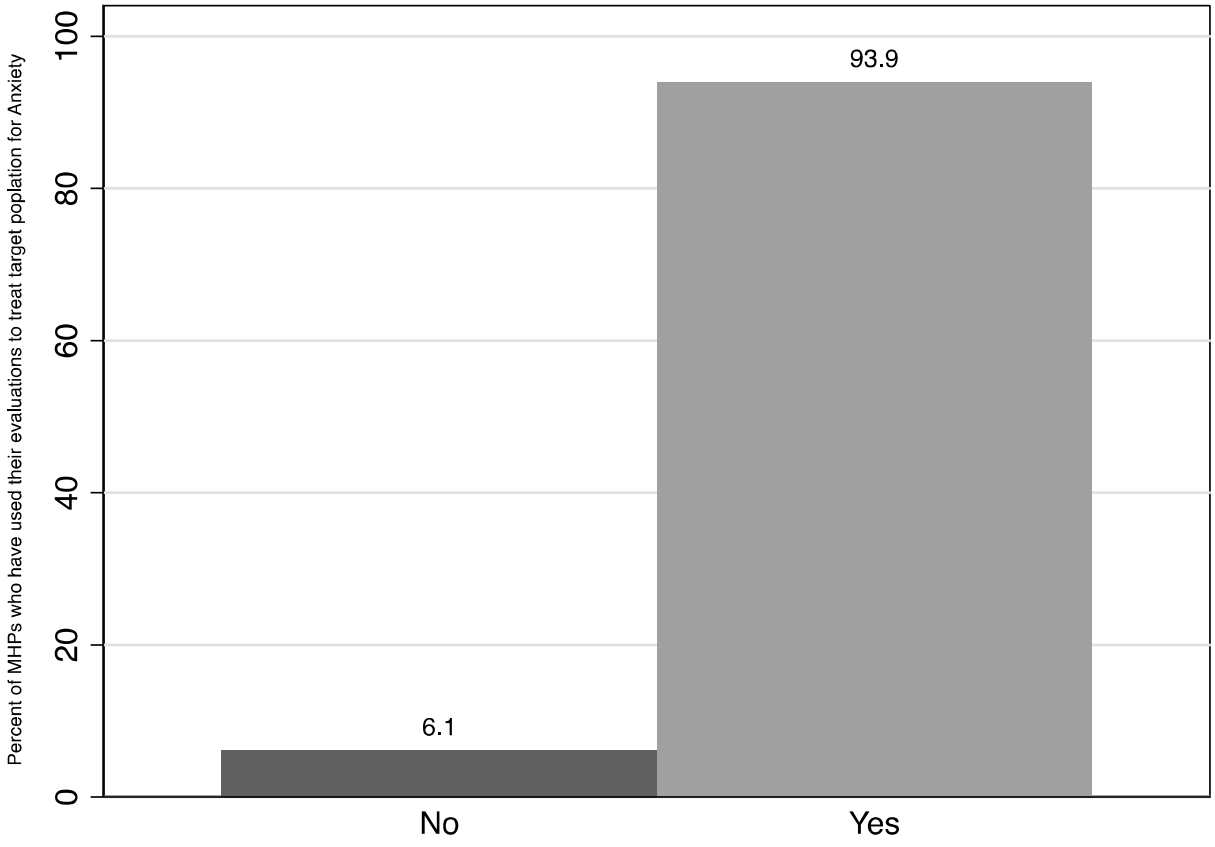


Figure 3b reports the preference of the sampled participants to apply trauma-informed treatment practices with clients who are members of the population of interest.

Figure 3b

Participants who Chose to Treat the Population of Interest for Anxiety Using Trauma-informed Treatment Practices



Conclusion

In conclusion, the data from the provided sample of participants revealed that mental health providers who service Bronx-residing LGBTQIA+ BIPOC clients choose trauma-informed treatment approaches (namely, the Person-in-Environment approach) about one of the reported categories of gender identities (namely, 'Female'). However, the independent variable representing their reported sexual identities as LGBTQIA+ did not reveal statistical significance when measured with any trauma-informed treatment approaches. Nor was any statistical significance observed when measuring the dependent variables, which represented the confirmed use of trauma-informed treatment practices to treat depression, when correlated with the independent variables, which represent their reasons for applying treatment.

The second null hypothesis rejected confirmed the application of trauma-informed treatment practices to treat anxiety when measured with the independent variable representing their opting to do so after their performed evaluations, as statistical significance was observed with the p-value score of 0.030.

The researcher will discuss further the significance of the collected data about the focus of this investigation in the following section.

Table X

Demographic Table

	M (SD)	*N(%)*
LGBTQIA+		27 (65.85)
Sex		
Female		21 (51.22)
Male		9 (21.95)
Transgender/Non-Binary/Gender Fluid & Queer		7 (17.07)
Gender Non-Descript		2 (4.88)
Age	43.70 (10.54)	
Race/Ethnicity		
African American		9 (21.95)
Hispanic/Latina/o/x		13 (31.71)
Asian		3 (7.32)
Multiracial		8 (19.51)
White		8 (19.51)
Education		
BSW		1 (3.03)
MSW		18 (54.55)
CSW		3 (9.09)
PsyD		1 (3.03)
Licenses		
LMSW		9 (30.00)
LCSW		10 (33.33)
PsyD		1 (3.33)
Other License		3 (10.00)
CASAC		1 (3.33)
Years Practicing as a Mental Health Provider		
Newly hired – 1 year		8 (19.51)
2-4 years		13 (31.71)
5-7 years		3 (7.32)
8-10 years		3 (7.32)
11 years +		14 (34.15)
Time Practicing at Present Agency of Employment		
Less than 1 year		10 (25.00)
1-3 years		17 (42.50)
4 years +		13 (32.50)

Table 1a

Table representing the gender variables that have a correlation with the confirmed use of Trauma-informed Treatment Practices and the Reported Sexual Identities of the Participants

Table 1a

Treatment	No	Yes	Total
Participants who have applied Trauma-informed Treatment Practices w/Population & do not Identify as LGBTQIA+	5 (38.46)	5 (20.00)	10 (26.32)
Participants who have applied Trauma-informed Treatment Practices w/Population & Identify as LGBTQIA+	8 (61.54)	20 (80.00)	28 (73.68)
Total	13 (100.00)	25 (100.00)	38 (100.00)

$x^2 = 1.503$, P = .220

Table 1b

Table representing the gender variables that have a correlation with the confirmed use of Trauma-informed Treatment Practices and the Reported Income Status of the Population of Interest

Table 1b

Treatment	No	Yes	Total
Participants who have applied Trauma-informed Treatment Practices w/Population & have *not* identified them as low-income earning	2 (50.00)	6 (19.35)	8 (22.86)
Participants who have applied Trauma-informed Treatment Practices w/Population & have identified them as low-income earning	2 (50.00)	20 (80.65)	27 (77.14)
Total	4 (100.00)	25 (100.00)	38 (100.00)

x^2 = 1.869, $P = .170$

Table 2a for Logistic regression

Table representing the gender variables that have a correlation with the Trauma-informed Treatment Approach of Person-in-Environment

Use of Person-in-Environment Therapy	Odds Ratio	Std.Err.	z	P>|z|	[95%CI]
Gender					
Female	10	9.486833	2.43	0.015*	[1.557684, 64.19788]
Transgender/NB/GF/GQ	2	2.44949	0.57	0.571	[.1813532, 22.0564]
cons	.5	.3535534	-0.98	0.327	[.1250488, 1.999219]

Table 2b for Chi-Squared Testing

Table representing the gender variables that have a correlation with the Trauma-informed Treatment Approach of Person-in-Environment

Treatment	Male(%)	Female(%)	Trans/NB/GF/GQ(%)	Total(%)
Person-in-Environment *not* applied	6 (66.67)	3 (16.67)	2 (50.0)	11 (35.48)
Person-in-Environment Applied	3 (33.33)	15 (83.33)*	2 (50.0)	20 (64.52)
Total	9 (100.0)	18 (100.0)	4 (100.0)	31 (100.0)

x^2 = 6.9750, P = 0.031

Table 3a for Chi-Square testing

Table representing the choice to apply Trauma-informed Treatment Practices to Treat Anxiety with the Population of Interest measured with Chi-Square testing

Treatment of anxiety with TiTPs	MHPs who have *not* used their evaluations to treat the population of interest N(%)	MHPs who have used their evaluations to treat the population of interest N(%)	Total N (%)
MHPs who have chosen *not* to treat anxiety by applying TiTPs	0 (0.00)	1 (33.33)	1 (3.23)
MHPs who have chosen to treat anxiety by applying TiTPs	28 (100.0)	2 (66.67)	30 (96.77)
Total	28 (100.00)	3 (100.00)	31 (100.00)

$x^2 =$ 9.6444, P = 0.002*

Table 3b

Table representing the choice to apply Trauma-informed Treatment Practices to Treat Anxiety with the Population of Interest displayed as a Frequency Table

TiTPs in Treating Anxiety	Frequency	Percent	Cumulative
No	2	6.06	6.06
Yes	31	93.94	100.0
Total	33	100.0	

Section Eight: Discussion

This chapter will focus on the development of this investigation, from its inception to its data analysis and limitations. The researcher hopes this investigation will broaden the avenues of social work research and education. Like many professions, social work invites flexibility and growth to foster creativity in professional therapeutic services rendered. As social workers, we are consistently inclined to comply with our code of ethics as we concede to extend our therapeutic practices to best accommodate our client's needs. We may grow as professionals in conjunction with the growth of our clients. Conscientiously, social workers may assume challenges with addressing, resolving, and treating our client's experienced traumas, as well as our own. For this reason, trauma-informed treatment practices (TiTPs) serve to expand our repertoire of therapeutic techniques. By observing its stated guidelines, trauma-informed treatment (TiT) training will offer further knowledge and expertise to social service collaborations among clients, professionals, and agency administrators.

This investigation, hence, served as an explanatory demonstration, focused on how mental health providers viewed and opted to employ trauma-informed treatment practices. Although the sample size may have lacked in quantity, it packed a punch with its quality reporting of professional perspectives, via quantitative methods and deliveries. This chapter explores what its findings rendered in advances within the field of social work, as well as the apparent needs that would further benefit the future of social work practices.

The trauma-informed treatment practices (TiTPs) chosen as the highlights of this investigation were elected by the participating agencies. Although a variety of therapeutic approaches were suggested by the participating agencies, each consistently mentioned these four

approaches to best represent their model of trauma-informed care (Tf-CbT, SbPT, NT, and PiET).

The investigation also examined how the participating mental health practitioners opted to treat depression and anxiety caused by the adverse experiences of the target population, through trauma-informed treatment practices. The collected data did not provide a well-measured snapshot of their analyses, as many measures did not render statistical significance. Perhaps a remedy for this lack of statistical power would be to attempt collecting data from a larger sample size of population.

Discussion of the Investigated Findings

Bronx-residing BIPOC LGBTQIA+ survivors of trauma may have endured intersecting minority stressors for decades, further elevating their symptomologies for depression, anxiety, and post-traumatic stress disorders (Ramirez & Paz Galupo, 2018). By observing Queer and Intersecting Feminist theories, researchers may note that BIPOC LGBTQIA+ individuals continue to face discriminations and social adversities (Ramirez & Paz Galupo, 2018), both in their domestic environments and social circles. A variety of research has explored the relationships between their depressive and anxious symptomologies and their physical and social surroundings (Pieterse, et al., 2012). Recognizing their struggles is key to opening dialogues with them and exploring tangible resolutions. Utilizing their resilience is instrumental with these processes (Holloway, et al., 2012).

Many BIPOC LGBTQIA+ survivors of trauma harbour feelings of self-doubt, low self-confidence, and symptoms leading to post-traumatic stress disorders (Groth-Marnat & Wright, 2016, p. 69), which often lead to adverse behaviours through alcoholism and substance abuse disorders. These socio-behavioural ills may often lead to a deterioration of their self-concepts,

which may also largely affect their communities and social surroundings. By fostering trauma-informed treatment practices and adhering to its guidelines, social service professionals can serve to ameliorate their client's symptomologies. Advances in applying trauma-informed treatment practices have disclosed the benefits of its application (Scheer & Poteat, 2018), as mental health providers who opt to use the indicated TiT approaches through a trauma-informed treatment lens recognize the enhancements of their client's physical and psychosocial needs (Carastathis, 2016, p. 22).

This investigation provided a window into the prospects of applying TiTP for the population of interest. Participants disclosed their preferences with its application, albeit through quantitative measures. The first item of inspection was to analyze the initial inquiries requested by the survey – that is, whether they have serviced Bronx-residing LGBTQIA+ BIPOC clients. A total of 59 individuals approached the disseminated survey. For the purposes of this investigation, however, the investigator was only able to utilize forty-one (41) of those responses. Two (2) individuals did not provide their consent. The remaining sixteen (16) could not proceed with the survey because they had not serviced the population of interest. There is much to be commented on regarding this observation.

An estimation of the population size of the target population is difficult to achieve, as the nature of the sensitivities supporting the fears and insecurities of the 'coming out' process can hinder some individuals to identify as a sexual minority (Mallon, 2017). This may also ring true for mental health providers who service them (Hoefinger, et al., 2020). It is understandable, then, that many of the participants had not serviced this choice population while being employed at agencies which primarily service these individuals. Many BIPOC sexual minorities may not recognize a need to be supported by mental health providers with their 'coming out' process

(Butler, 1993, p. 169). Being LGBTQIA+ continues to remain taboo in many cultures. Bronx-residing cultures may be no different.

When treating Bronx-residing LGBTQIA+ BIPOC clients, mental health practitioners may often experience countertransference issues. For this reason, clinical supervision within the four participating agencies must address and assist to resolve the practitioner's experience of countertransference issues, as a high percentage of them also identify as LGBTQIA+ and/or BIPOC. Because their clientele seek treatment to assist in resolving intersecting traumatic experiences, each participating agency, as part of their intake and screening procedures, would benefit from advocating clinical supervisors to assist their practitioners by recognizing the probability of countertransference issues occurring during treatment.

The surveyed responses for questions which focus on the participant's personalized data (questions #1 through #4) revealed illuminating results. The average age of participants was about forty-four (44), ranging between ages twenty-five (25) to seventy-one (71). The largest concentration of grouped ages in years fell between thirty-three (33) and fifty-one (51), which may signify a representation of mental health providers presenting as professionally and ethically mature in practice (Capezza & Najavits, 2012). The opposite effect is also a possibility (Capezza & Najavits, 2012), where jaded mental health providers may exacerbate a client's negative reactions or symptomology of anxiety/PTSD and depression (and/or that of the mental health provider), rendering ineffective treatment and unintentional emotional damage/re-traumatization. Data analysis in conjunction with the posed hypotheses did not render statistical significance when performing analyses of varied independent variables and making 'age' the dependent variable.

The questions focusing on the mental health provider's sexual and gender identities had also generated cogent results, as data analyses of participant responses regarding these questions examined the relationship between these identities and that of opting to apply TiTP and TiT approach applications. Although participant responses in the sexual identity category revealed competitive results, the analyzed data showed that sexual identity (as an independent variable) when paired with other variables (including those related to the investigated hypotheses), did not render statistically significant measures. That is not to say, however, that the investigation exposed the reporting of MHP's sexual identities as *not* an influential factor when treating the population of interest, as the survey did not focus on participant reasoning for this query.

The same remains to be true regarding the analyses of the independent variables of gender identities when paired with varied dependent variables. The data collection for independent gender variables demonstrated that roughly twenty-two percent (22%) of respondents identified as Transgender/Non-binary/Gender Fluid/Gender Queer or did not reveal any gender identity responses. Almost sixty-six percent (65.85%) reported identifying as LGBTQIA+, while a little over thirty-four percent (34.15%) did not. That may seem remarkable for the layperson's initial observation, until they become aware that the participating agencies primarily service sexual minorities.

Question #4 requested the participant to identify their race/ethnicity. The survey offered participants to answer questions one through four, manually. As a result, the researcher grouped responses in terms of their stated race/ethnic identities. For example, participants responded 'Black/black, Afro American, and African American'. The researcher grouped those responses under the variable named 'African American', as there were no mentions of identifying as 'Black African', or otherwise. Statistical significance was observed with one of the gender category

variables, as previously discussed in previous sections. The subcategory, ‘Multiracial’ and ‘White’, for example, did not render statistical significance when paired with TiT approaches. The largest group of race/ethnic identities was that of participants who identified as ‘Latina/o/x/Hispanic’, at nearly thirty-two percent (31.71%). This group did not render statistical significance, however, when paired with TiT approaches. Again, it may have been the case that ‘Latina/o/x/Hispanic’ participants were not sufficiently trained with these specific TiT approaches, leading to their not opting to apply any one of the approaches. Similar measures rendered similar results for all other independent variables.

Questions #5 through #16 requested professional data from participants. Responses for these questions are indirectly related to the stated hypotheses, as some of these variables may have indicated their influence in their opting to apply the investigated TiT approaches. Earning an MSW and/or a CSW or PsyD may have influenced mental health providers to opt to apply TiT approaches. It turned out, nonetheless, that earning an MSW did render statistical significance when paired with participants who identified as having received TiTP training. Table 4a, as an example, demonstrates the Logistic regression analysis performed. The dependent variable involved was also dichotomous while measured with nominal independent variables.

A plausible explanation for the reported significance could be that most mental health providers who have earned an MSW hold a more thorough concept of TiTPs (Antebi-Gruszka & Scheer, 2021), as it is a recent aggregate of interest in the curricula of schools of social work (Atkins & Bradford, 2021). Generally speaking, participants who have earned CSWs had completed their social work degrees in advance of one- or two-decades past, when TiT guidelines were not necessarily a subject/topic of interest for administrators of schools of social

work. Similar results demonstrated statistical significance when applying the variables representing participant responses of licenses they have earned. By observing Table 4b, one may see the relevance of statistical significance by having earned and LMSW (similar to that of earning an MSW). Again, the researcher chose to perform a Logistic regression analysis for the same reasons previously mentioned.

The researcher ran a chi-squared test to best understand the paired relationship of the dependent variable representing mental health providers who opt to apply TiTPs with independent variables labeled as 'the length of time that mental health practitioners have worked at their present agency' ('LofTimePract'), 'the length of time that mental health practitioners have worked within their practice' (TimePract') and 'having been trained in TiTPs' ('trained yes'). None of these variables rendered statistical significance when tested.

Apparently, these variables within this sample size do not present with much influence toward the application of TiTPs as used to treat the population of interest. A probable explanation for this would be the lack of awareness of TiTP guidelines and evidence-based research promoting TiTPs. Another plausible explanation would point toward a general sentimentality that TiTPs are already inherently practiced (Anderson, 2021) within daily therapeutic treatments. This may very well be the case. Mental health providers, however, may not be aware of the effectiveness of consistently observing the guidelines for TiTPs (Brown, et al., 2012), even after learning of them.

The researcher included a query regarding the types of traumas they have treated throughout their time as practitioners servicing the population of interest. Variables were generated which represented commonly treated traumas. They are; traumas related to intimate partner relationships, traumas related to familial violence, traumas related to racial/ethnic

discrimination, and traumas related to discrimination of income status. Thirty-seven (37) participants answered this question. The most populated choice was that of treating trauma related to traumas experienced within intimate partner relationships, at almost fifty-seven percent (56.76%).

Within the past decade, traumas related to this type of abuse have generated a growing amount of social work research. Nonetheless, more research is needed to better understand the intricacies of these traumas, in connection with negatively formed, co-dependent behaviours within intimate relationships of individuals who identify as a sexual minority (Forge, et al., 2018). Trauma-informed treatment practices have played a key role in positively influencing these individuals to lead more mentally healthy lives within or outside of intimate partner relationships (Scheer & Poteat, 2018). None of these independent variables rendered statistical significance within the sample size, however. What remains significant, however, is the quantity of cases related to this type of trauma as experienced within BIPOC LGBTQIA+ communities (Antebi-Gruszka & Scheer, 2021) (albeit as experienced with Bronx-residing BIPOC LGBTQIA+ individuals, or geographically otherwise).

The regard for TiTP to be viewed as an efficacious treatment for the population of interest is overwhelmingly noted by the sample size. Twenty-six (26) participants who responded to the survey's query regarding why they chose to practice trauma-informed treatment with the population of interest reported that they did so because they (and the agencies who have employed them) found it to be efficacious. Few reported that their present agency of employment offered the training, and their administrators regaled its effectiveness in treating the population of interest.

There remains a lack of variance between the variables which explains the 0 values when measured in some correlations. The reason for this lack of variance is most likely due to an overwhelming portion of the participants choosing mostly one of the offered multiple choices – which, for this investigation, was the variable that represented their reasons for opting to choose TiT practices as an efficacious act.

Rationale for the Discussion

Trauma-informed care/treatment practices are quickly receiving notoriety, as social service agencies, nationwide, are slowly recognizing the power of utilizing one's resilience (Girouard, et al., 2019) to surpass social ills, bullying in schools (Brant, 2020, p. 40), and deflating concepts low self-image brought on by microaggressions within BIPOC and BIPOC LGBTQIA+ communities (LoSchiavo, et al., 2019) (Bostwick, et al. 2014), worldwide. The significance of reporting these responses from this sample population would add to social work research in that it promotes for social service agencies to enlist and mandate TiTP guidelines as a necessary component of treatment to be observed by their employed mental health providers.

Four (4) participants responded to not having practiced TiTP with the population of interest simply because the agency of their employment had not provided training for it. Their reporting this may support the notion that those providers may have never been made aware of the possibility of being trained and that TiTP application may add effectiveness to their practices. Although TiTP training is being largely promoted by agency administrators, nowadays (LoSchiavo, et al., 2019), many others have not caught on to the benefits it may provide for its clients and employees (Lotte van Dammen, et al., 2020).

The researcher investigated the length of time mental health providers have chosen to practice TiTPs with the target population. Although none of the variables representing the

specified lengths of time offered as choices provided statistical significance, many of the participants who answered this query (64.7%) indicated that they had begun applying TiTPs as soon as one month before taking the survey and as far back as three years. This came as no surprise to the researcher, as TiTP training has become a popular addition to agency personnel professional development curricula. As previously mentioned, social work schools have begun implementing TiT concepts as an integral part of social work intern practica (Eliason & Chinn, 2018).

The next phase of this investigation proposed the themes related to the application of the four trauma-informed treatment approaches as specified by the participating agencies (Tf-CbT, NT, SbPT, and PiET). Informed by recent research, these approaches fostered several concepts related to the theories that support them in this investigation. These concepts represented and promoted the following attributes of those who are treated by them. They are: greater emotional regulation, greater self-empowerment through resilience, and a lessening of discountenance and social withdrawal (Mountz & Capous-Desyllas, 2020). Discountenance is prevalent among BIPOC sexual minorities (Mountz & Capous-Desyllas, 2020) who battle their worth, intimately. Emotional regulation, self-empowerment and social promotion may be consistent short-term and long-term goals as established during the application of trauma-informed treatment approaches. These concepts work to lessen their discountenance and lack of perceived resilience.

It may be conjectured, then, that because the presented sample size of participants chose to add TiT approaches to their therapeutic repertoire of treatments, they did so largely in part because they thought these practices to be efficacious. The evidence of this is indicated in their responses.

Participants treated the population of interest for depression and anxiety with TiTPs as a result of their assessed evaluations and their client's self-reports. The importance of this reporting indicated how the sampled mental health providers responded to their client's needs via application of TiTPs. They may have recognized the value of establishing the TiT guideline modality of fostering mutuality and employing empathy where there seems to be a lack thereof in their lives. This may be evident in practice when the sampled participants 'meet their clients where they are at' - a common mantra practiced by social workers. It remains to be noted and researched if in fact these sampled participants (and others who treat the population of interest) employ all components of TiT guidelines. Are they sufficiently versed and knowledgeable about the histories and experiences of Bronx-residing LGBTQIA+ BIPOC cultures and sub-cultures? Can they mutually relate with one another in terms of shared similar experiences of trauma? Are they encouraging their clients who have benefitted from TiTPs to promote those same guidelines within their social and/or residential communities? Further research will need to be conducted to explore these potential data.

Limitations

This investigation presented with a few limitations which may have skewed the reported findings. Success for survey completion solely depended on completion through internet access, requiring all of participants to possess some type of email account and hold some inclination of computer literacy (Chandler, 2008). Some participants may not have the ability to access or operate information technology and/or social media venues. Although the surveys were given in the practitioner's preferred language, there may have been a strong presence of limitation with excluding those participants who are unable to read, write, and/or comprehend the nature of the survey and aim of the investigation (Wilson, et al., 2017). Participants may have also been unwilling to complete the full survey, due to lack of will, interest, and time, which would then produce missing data, thus compromising the integrity of the investigation (Muskett, 2014). This caused some disparities throughout the investigation's findings, as questions were left unanswered by some.

Lastly, since recruitment of participants depended largely on the trusting rapport shared by practitioner and their participating supervisor or agency administrator, poignant data may have been unavailable due to practitioner concern regarding their anonymity (Capezza & Najavits, 2012). Reasons for practitioner reticence of survey completion were not available to the investigator. Because the investigation utilized exploratory relationships between variables, there may have been presented limitations with completing thorough, conclusive findings, as the relationships between variables may have shifted throughout the periods of its data collection.

Over-identification in participant responses may have also been anticipated, given that mental health practitioners who identify with their Bronx-residing LGBTQIA+ BIPOC clients as either Bronx-residing, or as a sexual minority, or as BIPOC, or a combination of one or more of

these intersecting identities. This over-identification may have created bias in data collection in that practitioners may have projected their personal experiences with desired outcomes for the study in lieu of reporting the generalized data of their Bronx-residing LGBTQIA+ BIPOC clients as requested by the researcher of this investigation.

Sample size calculation was part of the early stages of conducting this investigation. In preparing this research, there were ethical leanings for its use. Having had too small of a sample may have prevented the investigated findings from reaching the desirable outcomes in successfully rejecting the null hypotheses.

Denied access to gift card rewards may have decreased further participation, as it was discovered, through electronic communication between the researcher and two agency administrators, that some participants raised complaints about not achieving access to the monetary gift rewards enabled by the gift card rewards company. The researcher contacted this company's customer support specialists, who then apprised the researcher that a systemic glitch in the dissemination of gift card rewards occurred while the survey was active. This blunder may have caused the likelihood that those who completed the survey without access to the promised rewards would warm their peers not to partake in the survey.

Conclusion

As consistently mentioned, this investigation is but a snapshot, representing the professional experiences of a sampled population of mental health providers who have reportedly treated Bronx-residing LGBTQIA+ BIPOC clients. The researcher sought to investigate reasons for their applying, or not applying, TiTPs and has found that a large percentage of them feel its effectiveness to be noteworthy. A relatively large portion of the participants have already been trained in applying TiTPs, and in doing so will hopefully promote its effectiveness with other clients. Their clients, in turn, may likely opt to practice TiTPs among their peers and social/residential communities. TiTPs guidelines can foster community-built empathies to further encourage trauma-healing for all. With all hope, this research will encourage more researchers and policymakers to explore and promote its effectiveness, as trauma makes its way out of being a habitual ritual of life for this niche population and others.

Table 4a for Logistic regression

Analysis of the correlation of dependent and independent variables which represent the use of TiTPs with the academic identities reported by participants

Trained in applying TiTPs	Odds Ratio	Std. Err.	P>|*z*|	[95% CI]
Participants who have been trained to apply Trauma-informed Treatment Practice Guidelines Participants who have earned **MSW**	.1285714	.1245283	0.034*	[.0192624, .8581801]
Participants who have been trained to apply Trauma-informed Treatment Practice Guidelines Participants who have earned **CSW**	1.2	1.71114	0.898	[.0733517, 19.63144]
Participants who have been trained to apply Trauma-informed Treatment Practice Guidelines Participants who have earned **PsyD**	1 (omitted)			
_cons	1.666667	1.217161	0.484	[.398308, 6.973944]

Table 4b for Logistic regression

Analysis of the correlation of dependent and independent variables which represent the use of TiTPs with the professional identities reported by participants

Trained in applying TiTPs	Odds Ratio	Std. Err.	P>|*z*|	[95% CI]
Participants who have been trained to apply Trauma-informed Treatment Practice Guidelines Participants who hold an **LMSW**	.047619	.0640564	0.024*	[.00341, .6649739]
Participants who have been trained to apply Trauma-informed Treatment Practice Guidelines Participants who hold an **LCSW**	.0714286	.0915528	0.039*	[.0057923, .8808276]
Participants who have been trained to apply Trauma-informed Treatment Practice Guidelines Participants who hold a **PsyD as a license**	1 (omitted)			
_cons	6	6.480741	0.097	[.7223514, 49.83724]

Section Nine: Anticipated Contributions of the Study

Recognizing credence in the statistical significance with some of the findings for this investigation is noted. Although other analyses resulted in not being able to establish statistical significance, multiple regressions revealed relationships between variables which supported the overall direction of the investigated hypotheses.

The entirety of the researcher's presented investigation adds to current nationwide and international literature focusing on trauma-informed treatment modalities in treatment of LGBTQIA+ BIPOC individuals. This investigation's contributions are detailed through its implementation and relation with policies, future research, and client-practitioner therapeutic best practices. This investigation is the first of three or more furthered investigations with the participating agencies, and if possible, continued participation of participating practitioners and their clients. In the event that the researcher and the participating agencies continue collaborating with research interests, the researcher intends to conduct ongoing data collection through use of qualitative methods, mixed methods, and community-based participatory research methods.

Implications for Practice

Within the past two decades, there has been a surge in the publication of much literature and conducted studies including quantitative and qualitative empirical research while regarding trauma-informed treatment approaches in servicing various socio-cultural and socio-economic marginalized groups in the United States and abroad. There is also a growing amount of literature focusing on trauma-informed treatment approaches in servicing LGBTQIA+ communities and BIPOC communities (Clare, 2017, p. 174). There is very little literature, however, which focuses on the experiences of trauma-informed treatment with individuals who identify with intersections of identities, which in the case of this investigation focuses on

treatment with LGBTQIA+ BIPOC who reside in the Bronx. Consequently, a better understanding of this population would add to the importance of further researching Bronx-residing LGBTQIA+ BIPOC individuals and the lessons of emotionally-developed, fierce resilience they can teach us all.

This investigation brings to light the overall importance of applying trauma-informed treatment practices. As noted throughout this study, this investigation concentrates on the practitioner-client relationship. When the investigation grows momentum in the targeted field of service experiences, the direction of further research may then extend to other mental health and physical health service relationships between LGBTQIA+ BIPOC individuals and those who service them in public and social service agencies (i.e., police officers, public defendants, hospital staff, educators, social service workers, etc.).

The results of this investigation added a depth of perception for mental health providers to better understand the role that trauma-informed treatment practices play when observing its use throughout their treatment plans. The investigation aids mental health providers to better understand which facets of their therapeutic relationships, involving direct acknowledgment of trauma-informed treatment approaches, allows them to develop a deeper profoundness in their work.

Implications for Policy

It is crucial to first recognize the factors involved in establishing a therapeutic rapport shared by mental health practitioners and their BIPOC sexual minority clients (Mink, et al., 2014). Mental health practitioners must appear to their clients as someone who can relate to their experiences (Mink, et al., 2014) (National Association of Social Workers, 2015 report). The practitioner's total self-disclosure is not necessary, of course. However, in observing

Intersectional Feminist theory, the practitioner understands that at some point in their relationship with their clients it is important to establish that both client and practitioner have lived relatable experiences (Pieterse, et al., 2012) (Sutter & Perrin, 2016). This may very well serve to build trust and confidence with their therapeutic relationship so that both participants experience growth and meaningfulness. Providers should also serve as a conduit or resource for BIPOC LGBTQIA+ individuals by expanding the network of their therapeutic alliance (Trochmann & Millesen, 2021) with that of other residential communities in New York City and abroad.

A trauma-informed therapeutic lens may provide accessibility and personal strength for anyone who initiates community involvement. A trauma-informed therapeutic lens may also serve as the backbone of motivation toward encouraging treated clients to extend the fruits of their trauma-informed treatment. Treated clients may then feel empowered to share their newly reinforced personal strengths with fellow community members (Rosales & Langhout, 2020). Transgender sex workers, for example, may be encouraged to engage their fellow community members to seek (and perhaps adopt) the benefits of trauma-informed treatment.

Queer and Intersectional Feminist theories, through the very nature of their aim, seek to encourage all aspects of social growth for any minority group that has experienced generational discrimination at the hands of the majority in power (in all aspects of social existence – institutions, governments, social involvement) (Vinthagen & Johansson, 2012). These theories stress the importance of revealing the impact of power imbalances (Rosales & Langhout, 2020) leading to a gross lack of recognition and validity toward BIPOC sexual minorities. Emphasizing the importance of trauma-informed treatment practices with Bronx-residing BIPOC sexual

minorities will encourage other minorities to join its socially-forward momentum (Tuck, 2009) (Fine, et al. 2014, p. 64).

The importance of practicing and promoting a socially progressive momentum through a trauma-informed lens will spark the attention of community leaders who will recognize the cachet of this socially progressive momentum (Tuck, 2009) (Trochman & Millisen, 2021), as observed through encouragement by adopting empathic sensibilities, recognition, and relatability of shared past experiences. The social awareness of communal trauma-informed approaches may then climb to the undeniable recognition and the attention of the legislature and politicians. Creating a strong sense of solidarity is quintessential when practicing trauma-informed treatments. This same sense of solidarity must be present when we push for legislature to recognize and form legal and social avenues that will provide for the inclusion of BIPOC sexual minorities who reside in the Bronx (as well as its neighboring boroughs).

The Comprehensive Sex Education Act (S2584) and the 'Stop-the-Violence-in-the-Sex-Trade' Act (S3075), for example, both could attract further political recognition, when adding to their descriptions of the benefits of trauma-informed treatment approaches with all public and social service employees (Atkins & Bradford, 2021). The present investigation will add to the importance of these bills to move forward in citywide and perhaps nationwide or international legislation. This social work research serves to enhance the necessity of including trauma-informed treatment training and practices as a mandate for social service workers in social policies/bills

Implications for Research

As previously mentioned in this chapter and others preceding it, there remains a dearth of literature regarding research focusing on BIPOC sexual minorities who reside in the Bronx. This

proposed investigation will add to present literature aiming to promote the effectiveness of trauma-informed treatment practices.

It is largely practiced that mental health professionals use standardized assessments, like those previously mentioned in this investigation (the General Anxiety Disorder – 7 questionnaire and the Patient Health Questionnaire – 9), which aid in establishing the need for trauma-informed treatment approaches (Beard & Bjorgvinsson, 2014) (Nugent, 2021). The use of these scales may allow practitioners to proceed with therapeutic intentions by implementing therapeutic tools, such as resilience and empathy – the cornerstones of trauma-informed treatment practice (Bostwick, et al., 2014) (Cohen, 2004) (Fine, et al., 2014, p. 64) (Mink, Lindley, & Weinstein, 2014).

Conclusively, the proposed study will form a niche focus of investigation in present-day therapeutic practices, hence extending the literature which addresses the importance and gained benefits of trauma-informed approaches in practice with LGBTQIA+ BIPOC. The proposed investigation will shed light on the existence and importance of the cultural richness and social contributions that this sexual minority may offer, when given the opportunity to do so. The result of this investigation provides future researchers with an opportunity to add to the existing data to further support their findings.

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