

STAIR Narrative Therapy for Complex Posttraumatic Stress Disorder: Treating Sexual and Gender Minority Trauma

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Abstract

Complex PTSD (CPTSD) is a new diagnosis in the World Health Organization (WHO)'s International Classification of Diseases (ICD-11). This case study describes the delivery of Skills Training in Affective and Interpersonal Regulation and Narrative Therapy (SNT), a flexible, multi-component therapy that addresses the symptoms of CPTSD. SNT balances interventions that address current day stressors with those that reappraise the meaning of traumatic past events. This paper outlines 16 sessions of SNT with a 55-year-old gay man. The treatment introduces client tailored coping skills for current minority stress, discrimination and micro-aggressions as well as trauma-focused interventions regarding events from his childhood and the death of his partner and many members of his community due to the AIDS epidemic. Qualitative and quantitative outcomes are summarized. Implications regarding the relevance of SNT for sexual and gender minority (SGM) individuals is discussed.

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Complex PTSD (CPTSD) is a new diagnosis in the World Health Organization (WHO)'s International Classification of Diseases (ICD-11). This case study describes the delivery of Skills Training in Affective and Interpersonal Regulation and Narrative Therapy (SNT), a flexible, multi-component therapy that addresses the symptoms of CPTSD. SNT balances interventions that address current day stressors with those that reappraise the meaning of traumatic past events. This paper outlines 16 sessions of SNT with a 55-year-old gay man. The treatment introduces client tailored coping skills for current minority stress, discrimination and micro-aggressions as well as trauma-focused interventions regarding events from his childhood and the death of his partner and many members of his community due to the AIDS epidemic. Qualitative and quantitative outcomes are summarized. Implications regarding the relevance of SNT for sexual and gender minority (SGM) individuals is discussed.

KEY WORDS: Complex PTSD, Sexual and Gender Minorities (SGM), STAIR Narrative Therapy, PTSD, Minority Stress

1. INTRODUCTION

1.1 Complex PTSD

Complex posttraumatic stress disorder (CPTSD) is a new diagnosis in the 11th revision of the International Classification of Diseases (ICD-11). CPTSD is a sibling to posttraumatic stress disorder (PTSD) under the general parent category of “disorders specifically associated with stress” (Maercker et al., 2013). The diagnosis of Complex PTSD was introduced to address the kinds of problems that clinicians reported observing related predominately to multiple and chronic forms of trauma exposure as distinct from those related to single event trauma (Keeley et al. 2016). However, research has shown that individuals can develop PTSD rather than CPTSD after multiple and chronic traumas and, conversely, that individuals with single event traumas can develop CPTSD (Cloitre et al., 2013), likely depending on vulnerability and protective factors.

For these reasons, the presence of chronic or repeated traumas is considered a risk factor rather than a requirement for the diagnosis of CPTSD.

ICD-11 PTSD consists of three core symptom clusters: re-experiencing trauma, avoidance of trauma reminders, and a heightened sense of threat. CPTSD consists of the three PTSD clusters as well as three additional clusters described as “disturbances in self-organization” (DSO) symptoms: affect dysregulation, negative self-concept, and disturbances in relationships with the latter symptoms representing the effects of chronic trauma on these three critical psychological and social domains of functioning (Maercker et al., 2013). The presence of childhood trauma (such as sexual or physical abuse) can disrupt socio-emotional development and generate problems in emotion regulation and relational capacities represented in CPTSD. Individuals who experience repeated or chronic trauma beginning in adulthood may have had good emotion regulation, self-concept and relational capacities but these can deteriorate in the context of severe sustained or multiple forms of trauma as is experienced, for example, by refugees (Nickerson et al. 2016). Reviews of current evidence regarding ICD-11 PTSD and CPTSD support the construct validity of these diagnoses and clarify their clinical characteristics (Brewin et al., 2017; Redican et al., 2021).

Individuals with CPTSD will report re-experiencing of traumatic experiences in either nightmares or flashbacks; avoidance of trauma-related reminders (thoughts, feelings or places) and a chronic sense of threat. Affect dysregulation is broadly represented by emotional reactivity in which affected individuals are quick to experience emotions such as anger or sadness and/or report overall emotional numbing. Individuals view themselves in extremely and persistently negative ways, including as worthless or a failure, often associated with feelings of shame and guilt. There are difficulties in managing relationships with a tendency to avoid or withdraw from relationships particularly under conditions of stress or conflict.

The diagnosis of CPTSD as well as PTSD can be assessed via a reliable and valid 18-item self-report measure, the International Trauma Questionnaire (ITQ; Cloitre et al., 2018). It has been translated into over 30 languages and is freely available (see globaltraumameasures.com). A clinician assessed version of the ITQ has been developed and is in the final stages of validation (Roberts et al., 2019).

1.2 STAIR Narrative Therapy Overview

Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy (SNT), is a phase-based intervention which was initially developed for individuals with PTSD related to childhood abuse but now is applied to treat the effects of various types of interpersonal trauma (see Cloitre et al, 2020). The treatment was developed to address not only the symptoms of PTSD but also the commonly observed problems of emotion regulation and interpersonal problems among those with chronic abuse (Cloitre et al., 2002). The first module (STAIR) includes skill training to develop emotional and interpersonal resources that have been compromised by long-term complex trauma. The second module (Narrative Therapy) employs exposure and cognitive restructuring techniques to alleviate PTSD symptoms. Three RCTs have demonstrate the clinical efficacy of SNT for PTSD symptoms, and problems related to emotion regulation and interpersonal functioning among individuals with childhood abuse and interpersonal trauma (Cloitre et al., 2002, 2010; Opriel et al., 2021). Given the problem domains it was developed to resolve, the treatment appears transparently appropriate for the treatment for CPTSD. A pilot study has indicated substantial positive benefits for individuals with CPTSD (Niwa et al., 2022) and other studies are under way.

1.3 STAIR Narrative Therapy Process

SNT is a cognitive behavioral therapy that is based in interpersonal and attachment principles. The treatment was developed following both theory and evidence that early life trauma disrupts attachment and related capacities for emotion regulation, positive self-regard and healthy relationships (see Cloitre et al., 2006). Accumulating research in the trauma field has strongly indicated that trauma which is the result of human design (e.g., war, community violence, genocide and other forms of organized violence), regardless of whether it happened in childhood or adulthood, is particularly pernicious. Compared to non-interpersonal traumas, it is associated with higher rates of PTSD and other adverse effects (e.g., deterioration in social networks) that relate to the capacity to maintain social bonds at an individual and community level

(Charuvastra & Cloitre, 2008).

As described in the case illustration, the *therapeutic alliance* is key to recovery as is repeated *psychoeducation on the nature of trauma*. The therapist's feedback and explanations help the client begin to reframe the nature of their experience from one in which they are to blame (*"How did you let this happen?"*), to something that happened to them and from which they can recover (*"I'm sorry this happened to you. How can I help?"*) The first two sessions of STAIR highlight the negative impact of trauma on emotions, self-identity and relationships. The selection of *emotion regulation skills* is based on client preferences, needs and strengths. Research on depression indicates that the selection of skills that strengthen existing competencies rather than fill a gap (compensatory) result in greater decrease in symptoms (Cheavens et al., 2012). This may be because emphasizing strengths may enhance mastery and positive self-regard, both of which are low among trauma-exposed individuals. There are at least 15 emotion regulation skills available in the protocol (Cloitre et al., 2020) and typically clients comfortably and effectively adopt from 3 to 6.

The sessions on relationships models borrows directly from Bowlby (see Cloitre et al., 2020). The relationship models are viewed in a nonpathological manner. They are described as strategies intended to maintain connections and ensure survival in particular social or interpersonal circumstances. Thus, models like *"If I don't share my feelings, I will be taken care of"* works well for a child with a distant mother or *"Trusting others can get you killed"* ensures survival in a combat zone. Consistent with attachment theory, SNT recommends that a client diversify their attachment models for different relationships and circumstances. It is not necessary to reject or invalidate old models; they may still be useful if the client returns to a trauma-genic environment e.g., (an abusive family, combat zones). The client is encouraged to develop new and alternative schemas that are relevant to their current environment or even as related to an aspirational goal (e.g., *"I would like to make friends."*). As supported in the SNT protocol, several themes can be discussed in the treatment including, for example, power dynamics, shame, and grief. Therapist and client can choose to settle in on one or more of these themes as appropriate.

Last and most importantly, the therapist and client prepare to conduct narratives of the trauma memories. These sessions can number from 4 to 10 depending on the number of events that the client wants to discuss. The sessions also include continued use of the emotion regulation and interpersonal skills learnt during the STAIR phase of the treatment. This can highlight difference between the "old" traumatized self represented in the narratives, and the new evolving self emerging from the STAIR work which is respectful of but different from the person in the stories.

1.4 Application of the treatment to Sexual and Gender Minority (SGM) Clients

Sexual and gender minority (SGM) people are at higher risk for exposure to trauma events compared to their heterosexual and/or cisgender counterparts (Roberts et al., 2010). This is, in part, the result of experiencing trauma earlier in life and experiencing traumas generated by SGM status (e.g., physical assaults) (Roberts et al, 2010). SGM status is associated with minority stress (anticipated discrimination and victimization, internalized stigma, and concealment of stigmatized identity) which is often derive from experiences of discrimination (e.g., denial of equal employment and healthcare) and micro-aggressions (e.g., insults, assumed pathology) (Livingston, 2019; Meyer, 2003). Minority stress has been identified as contributing to adverse mental health effects including DSM-5 PTSD (Solomon et al., 2021) and higher rates of Complex PTSD than other trauma-exposed populations (see Charak et al., in press).

SNT may be a particularly relevant trauma-focused treatment for SGM clients as it addresses traumatic events that have occurred in the past and also supports the individual in managing ongoing minority stress, discrimination and micro-aggressions.

2. CASE ILLUSTRATION

2.1 Presenting Problem and Client Description

Michael is a 55-year-old gay man who has lived in the San Francisco Bay area his entire life. Michael has a history of chronic low-grade depression, with occasional periods of severe depression. He also is HIV+ which

is medically well managed. He has been receiving supportive psychotherapy for the last couple of years at an LGBTQ+ serving outpatient mental health service for his depression. The treatment was helpful. He felt part of a community of sexual and gender minority (SGM) people and, for the very first time in his life, shared something about his past. He described his childhood experiences of family rejection, the euphoria of finding a gay community in late adolescence, that joy being demolished by the onset of the AIDS epidemic and the fear, grief and loss he experienced in the many years since. An ongoing problem is Michael's relentless anger about minor and major ways in which he was degraded, shamed and rejected due to his gay identity. His basic needs such as health care services can be denied him and civility in routine social exchanges cannot be assured. Seeing heterosexual couples holding hands can fill him with rage and depression as he feels he cannot have the experience of showing his affection in a free and easy way.

His first years on his own in his late teens in the gay community were thrilling. He felt accepted and that he was coming into his own. He was experiencing emerging pride in his identity and mastery in his work in the publishing industry. The AIDS crisis increased stigma, criticism and even hatred of the gay community. Michael's "first love" and partner had died during the AIDS epidemic as well as many friends. He saw many men his age with physical wasting and dementia. Worse, he saw his friend's families ignore their deaths, not attend funerals nor make efforts to mark their passing. This period of life defined him. Everyone he loved died. Moreover, the homophobic reaction of families who did not attend funerals sent the message: you are trash, you will never be lovable.

Despite these harrowing experiences, Michael never viewed them as traumas. They were simply events that had shaped his life. His therapist stated that what he had experienced was a trauma and that perhaps a trauma-specific treatment might help move him out of the depression and anger he was experiencing. Michael first rejected this option. The depression felt monolithic and the anger a part of his personality. He noted "The past is the past. I can't change it, so why focus on it?"

The therapist described the process of talking about traumatic events for the purpose of understanding their impact on his life and more importantly critically re-evaluating their meaning in a more adaptive way. The current supportive therapy was in a stable perhaps even stagnant state. The therapist expressed curiosity about whether a trauma-focused treatment might be helpful to him in a new way, different from the work that had been accomplished thus far. Michael became more interested in this option. Complex PTSD symptoms were assessed. Michael was surprised to see that he endorsed all symptoms of CPTSD. The assessment shifted problems that had been on the periphery of his awareness to center view. He had intrusive thoughts and nightmares about the AIDS-related deaths. He experienced reminders of his traumas whenever he went out of his apartment or even when he shut himself away in his apartment as he watched the news on COVID. In addition, the assessment allowed him to consider that his emotional reactivity, some of the negative views he had about himself and the often-negative ways he interacted with people might be related to his traumatic experiences. This made him hopeful that the treatment might work for him. He agreed to the treatment.

2.2. Case Formulation

Michael's mother was angry and dominated the family through verbal intimidation and unprovoked rages. He was physically abused by his mother from his preschool to early adolescence for the slightest infraction of house rules and inevitable behavioral slip-ups such as spilling milk at the dinner table. His father was disengaged and distant and did not protect him or his sister. He believed his mother intensely disliked him but did not think this was necessarily related to his being gay. He coped by ignoring the problems at home, avoiding his mother's attention as much as possible and saying as little as possible. Michael was careful to cover up his attraction to boys. He dated girls and kept an emotional and physical distance from boys. He had superficial friendships with schoolmates. He did not share anything about his home life, his fears, or his sexual feelings. Being unseen and unheard protected Michael in his early years but ultimately led to him feeling like he did not really know who he was or worse, that he really did not have a "self." If asked, he could not have described who he was in any authentic way. He had no ambitions other than a dedicated drive to leave his family home as soon as he could.

Following high school, Michael obtained a job as a fact-checker at a San Francisco newspaper and moved into the city. He was surprised and energized by the presence of a gay community and unexpectedly found himself falling in love with a mentor. They moved in together and Michael began to blossom. Drew, his partner, was his first love and a positive role model as a gay man: confident, gregarious and active in the community. A couple of years into this “perfect life” the AIDS epidemic came full-force and Drew died. Many others in the gay community became sick and died as well. During his therapy, Michael stated that this short period of happiness was also the source of all of his unhappiness and anger. He was angry at this turn of fate, stating he’d rather not have gone through this period than to know happiness and then have it taken away from him.

Drew’s death made him feel that he did not deserve to be loved. Irrational though it was, he felt abandoned. He felt unloved and unlovable, a belief that had been instilled in him during his childhood. His losses left him with deep and enduring feelings of inferiority which were expressed in his anger and his social isolation. He also developed the belief that there was no point in having loving relationships: they only led to loss.

Michael had initially been shocked by the hostility towards the gay community at the height of the AIDS epidemic and the callous, dismissive attitude towards the suffering and deaths of so many. Later, his personal losses stoked an anger that was at first directed towards social injustice but which eventually generalized to almost all social interactions.

By the time that Michael had entered therapy, the many traumas of Michael’s adulthood had resulted in the reinforcement of the old coping strategies from his childhood abuse, namely social withdrawal and emotional numbing. Along with these came the addition of chronic anger and expressions of hostility and disappointment towards everyone with whom he interacted.

In treatment, he talked a lot about straight culture and straight people with a strong focus on negative dynamics between gay and straight communities stating “We are under attack, they are trying to exterminate us.” The emergence of the COVID epidemic heightened these beliefs. He saw himself and all minoritized people as without power, ignored and dismissed by the dominant culture and consequently at increased risk for illness and death. Michael would blow up at instances of discrimination and micro-aggressions. While the anger was justified, the intensity of his reactions left him feeling exhausted and bad about himself. He wanted to be able to handle the chronic minority stressors he experienced in a better way.

There were times when his anger biased his interpretation of neutral situations or created barriers to his intended goals. For example, he’d been at a clothing store and took some time considering his purchase. When he paid for the item and the cashier concluded with “Have a nice day” he could not help but reply: “Oh, you must be happy to get rid of me.” He received feedback from his support group that he was so angry that people were having difficulty supporting him.

Michael was motivated to try the STAIR Narrative Therapy program for many reasons. He felt angry much of the time and bad all the time. He wanted to feel better emotionally. He did not feel he had a purpose and questioned why he had survived. He wanted to have a place in society. He was lonely and wanted to have some social connections but at the same time experienced other people as emotional triggers, who were threatening him or putting him down. The social isolation had left him profoundly unhappy. He wanted to have a relationship without pain.

2.3 Treatment Goals and Plans

One important goal of the treatment was to help Michael manage his anger better. Part of this goal involved helping Michael identify the ways in which his anger actually got in the way of efforts to re-engage socially. In addition, Michael was not aware of emotions other than anger (i.e., “emotionally numb”). A second goal was to increase his exploration and awareness of other feelings. This was intended to help relieve his depression and also support communication and socialization. As a gay man, Michael was subject to minority stressors which included chronic discriminations and micro-aggressions. It was important for him to learn how to handle them in a more adaptive way and with a less negative impact on himself. It was also important for

him to recognize the powerful emotions that came from his traumatic past and determine whether or not they were not helpful in managing day-to-day stressors. Last, most importantly, Michael had not properly grieved the loss of Drew, his friends and community. He had been left feeling unloved and had become dismissive of the idea of ever developing a deep relationship again.

2.4. Course of Treatment

2.4.1 Sessions 1- 5: Emotion Regulation Sessions

The Therapeutic Alliance and Psychoeducation

The first sessions of the treatment require special attention to the therapeutic relationship. While Michael had been working with the SNT therapist in supportive counseling, there was a shift in the emotional and interpersonal dynamics in anticipation of embarking in a treatment process that would focus on Michael's trauma. He was uncomfortable about the prospect of exploring rather than distancing from his feelings. All aspects of the treatment increased Michael's sense of vulnerability, and in particular shame about his anger and social isolation. This initially led to an exaggeration of Michael's tendency to engage in a dismissive and demeaning interpersonal style. For example, Michael's therapist was a lesbian and younger than him. Michael would sometimes chide the therapist on her lack of lived experience regarding the AIDS epidemic, what it meant to be a gay man during this time, and whether the therapist could possibly be of any substantive help.

The therapist was sensitive to all of these issues. First, she quickly highlighted that trauma impacts emotions and emotional well-being. The problems that Michael experienced were common consequences of trauma that many people experienced. A review of a worksheet listing the common emotional consequences of trauma, which included anger, was affirming. Michael's shame and confusion about "Why am I this way?" was replaced by a quiet reflection about the relationship between the loss of his partner and friends, and the onset of his anger problems. While details of this history would come later in the treatment, Michael noted that the connection "felt true." His feelings of shame began to be replaced by curiosity and greater openness to exploring his history.

The therapist also expressed respect for Michael's willingness to explore painful experiences and feelings. Michael associated having feelings with being feminine or weak. He took pride in his masculine appearance and traditional masculine attitudes. It was one way he had hidden his gay identity in his youth and had made him feel safe. The therapist's interest and steadfast connection to Michael as he initiated his emotional exploration provided an antidote to the rising feelings of shame Michael experienced at the beginning of the process. The therapist would make comments such as "Thank you for sharing this with me. Congratulations on these efforts. It takes strength to do this." The therapist provided an alternative perspective about the task in which Michael was engaging: it was not shameful but rather courageous to explore feelings.

The therapist did not combat Michael about his views on her competence in the work. She acknowledged that the LGBTQ+ community was very diverse and that there were substantial life experience differences between them. However, she hoped to be helpful to him and that shared experiences related to living as a member of a minority group as well as her knowledge about ongoing concerns of the LGBTQ+ people would support their work together. She also invited Michael to let her know when she misunderstood him so she could correct her understanding.

Lastly, the therapist did not rush Michael into the world of feelings but followed him as far as he was willing to go and respected his limits in exploration. The first two sessions focus predominantly on increasing awareness of emotions through attention to daily interactions and resulting bodily sensations, cognitions and behaviors. In the early phase of the treatment, every example Michael reported focused on anger. The therapist suggested that the anger might be a protective shield against the emergence of other, more threatening emotions. While Michael agreed in theory, the practice of identifying and experiencing other emotions was a slow process in which small steps were counted as victories.

Emotional Awareness

In the example below, Michael describes a situation to which the therapist responds by suggesting that anger may be connected to feelings of fear. Michael refuses to use the word “fear” but ultimately settles for something similar but less threatening. The therapist uses several tools to support the process including a Feelings Monitoring Form which documented, organized and clarified his emotional experiences and a Feelings Wheel, a figure which provided several feeling words and their relationship to one another. This was used to help Michael recognize or consider feelings that might be relevant to his experience.

Michael (M): Here is my Feelings Monitoring Form, I read an article about COVID that reported very few people are wearing masks anymore. No one taking it seriously makes me so f***ing mad! Therapist (T): I see you rated your anger intensity a 10 out of 10. You must have been really mad. M: This is mainstream society. No one cares that people are dying. I’ve got a cold right now. And you know what? No one cares about that. We are all going to die. T: This may be a good example for us to identify other feelings you experienced. Let’s use the Feelings Wheel as a guide to other emotions you might have been feeling. M [looking at wheel]: Angry, frustrated, annoyed, livid. T: Good, good. All this language describes emotions that are very understandable. I am considering your statement “We are all going to die.” I wonder if you are feeling afraid? M: No, that’s not really it. There is no point to feeling afraid. T: Thank you. So, it sounds like you were not feeling afraid. I am wondering if the report made you feel something like... apprehensive? M [Deep sigh]: You know yes, apprehensive really does hit the mark. I just don’t know what will happen with this pandemic. It reminds me of everything I went through and thought I would never have to face again.

Michael added the word “apprehensive” to his worksheet, which lent strength to the reality of the feeling and also helped Michael understand himself and his actions better. Michael noted that after reading this report, he stayed in his apartment for several days. The therapist reflected that if Michael was feeling apprehensive as well as angry, it made sense that he should try to protect himself. The elicitation of an emotion, apprehension, (an approximation of deeper but not acceptable feelings of fear) allowed Michael to have a sensible explanation for his behaviors and to make a connection between his feelings and behavior.

Over time Michael was able to tolerate even more challenging emotions which gave him greater insight into himself. For example, he felt an increasing sense of purposelessness during the COVID pandemic. With increasing attention to his emotions, he came to understand that these new epidemic awakened feelings of survivor’s guilt that he had not previously acknowledged. Michael made the connection between survivor’s guilt and sense of purposelessness in this early phase of treatment. This helped him feel less confused about his emotions and consequently less depressed. However, it was only during the narrative work that he was able to have compassion for his own survival and to see a path forward for living his life with a sense of purpose.

Emotion Regulation

The remaining sessions in this phase of treatment focused on identifying skills that Michael could learn to help better manage his emotions. STAIR typically provides 5 interventions associated with each channel of experiencing (i.e., body, thoughts, and behavior). The selection of interventions is based on the client’s preferences and those which will support a growing sense of mastery and satisfaction.

Body Interventions. Michael responded well to focused breathing. He liked body-based interventions because they helped him “get out of his head.” He liked the idea of having an exercise that could be integrated into his fitness plan and that helped calm his mind. Michael was open to this intervention as a source of change. It did not require buying into a new ethos. The exercise was consistent with his values as a gay man: keeping fit and attractive was important. He viewed his body as armor against the world as well as a source of pride. In addition, he developed a routine before bedtime that included a nice warm shower and a cycle of focused breathing as a way to down-regulate his physical and mental energies to help him transition to sleep.

Cognitive Interventions . Michael rejected cognitive interventions that focused on critical evaluation and reappraisal of his beliefs. He found them invalidating. The therapist agreed that many of the negative beliefs Michael held resulting from his childhood trauma and the AIDS epidemic were supported by substantial evi-

dence. Michael effectively used Emotion Surfing, a meta-cognitive strategy in which one maintains awareness of the intensity, and ebb and flow of one's feelings. The exercise reinforces a connection to emotions, like a surfer riding a wave, in which being aware of the emotions but not being overwhelmed or "brought under" by them reduces fear and confidence in maintaining a connection to them. In this exercise Michael was asked simply to observe his feelings which he found easier than digging through and analyzing his thoughts. He also reported that through watching his emotions, he was able to more easily change his thoughts (e.g., "Anger is manageable."). Michael recognized that while he had experienced and might continue to experience many traumatic and other stressors, he could better manage his reactions to them. Later, Emotion Surfing proved to be very valuable as Michael addressed sadness and grief related to the loss of his partner and friends.

Behavioral Interventions. Michael had ambivalent reactions to engaging in positive or pleasurable activities. He took on what he viewed as a "masculine" value that you engage in activities to meet a goal rather than to "have fun." However, he was persuaded by the scientific literature on behavioral activation as effective for reducing depression. The therapist needed to be careful about reviewing the options for positive activities because some were not relevant to him (e.g., bowling) or beyond his resources (e.g., taking photos) which generated annoyance and risked disengagement. Michael was familiar with Time-Out and in the context of his growing ability to track his emotional state, He made a genuine effort to use the intervention in situations at the clinic. He was strongly motivated to get along with people there (e.g., case worker and reception staff) because he recognized the value of having a space where he felt at home and accepted. Despite his routine irritations, he felt a sense of belonging at the clinic and decided to make an effort to appreciate it more by interacting in a more positive manner with staff and other clients.

Dealing with Minority Stress

As Michael was learning new emotion regulation skills, their application often focused on managing his distress and anger at micro-aggressions and discrimination. The therapist became aware of these experiences through the Feelings Monitoring Forms that Michael completed between sessions to practice identifying his emotional and cognitive responses to stressors, as well as which coping strategies he employed.

First, he spent some time disentangling the anger he felt arising from his childhood family rejection from the ongoing social rejection he experienced as a gay man. The anger was justified on both counts but might be dealt with in different ways. Michael's therapist modeled compassion for what felt like the inevitable burden and ongoing nature of minority stressors, which, over time, helped Michael experience more self-compassion. With his therapist's guidance and encouragement, Michael practiced using new emotion regulation skills when confronted with microaggressions. A key insight Michael reported was that, unlike his childhood, he now had more choices about how to respond to these situations and more influence in shaping their outcomes. He used emotion surfing to reduce the intensity of his anger so he could respond to the other person more skillfully or choose to invest his energy elsewhere. He understood there were times when he could just walk away from a situation when he could not respond effectively. He began relying on a growing sense of community from the clinic and became more aware and appreciative of a sense of acceptance and safety, which he had not experienced in a very long time.

2.4.2 Sessions 6-10: Relationship Patterns

Michael was apprehensive about starting the interpersonal work. In part this was because he was concerned that the therapist would challenge his relationship beliefs in an invalidating way. More importantly, Michael felt vulnerable. He worried that his therapist would come to see the true and vast extent of his social isolation and think less of him for it. Instead, the therapist simply acknowledged his social isolation, and referenced that they would find practical strategies for working on that later. Most importantly, the therapist took steps to identify Michael's relationship models by exploring their own relationship.

T: So, Michael, today we are going to move into our interpersonal relationship work, and I know that you have found the Feelings Monitoring Forms to be really helpful. You mentioned that having things written down gives you something to look back at, and it actually helps to organize your experience. M: Yeah, it didn't seem like it would work. But having an experience written down on a piece of paper, in black and

white, is powerful. The reality of the situation hits home. It motivates my desire for change and helps identify how to begin that process. T: You've done very well with the Feelings Monitoring Forms so far. We are ready to move into a new worksheet today called the Relationship Patterns Worksheet or the RPW which describes interpersonal situations and problems. As we have discussed, trauma impacts our beliefs about ourselves in the context of the relationships we share with others. M: Well, I don't know how effective this is going to be because I don't have that many people that I talk to. T: Yeah, I know that that's something that you've mentioned before. One of our goals, if you agree, would be to increase the amount of social connections that you have. But for now, I wanted to take a moment and refer back to last week. I thought it was a really important session because you were vulnerable with me and shared how much I might not be able to help you deal with the consequences of the AIDS epidemic because I did not experience it. It is understandable that you have some concerns about that. This is something we could discuss. What do you think? M: Well, I think you're the person I've interacted with most, and you seem to be pretty honest with me. So, I think that might be a good step to try. T: Let's do it then. What specific situation comes to mind? M: You asked me about my thoughts on the interaction that happened at the coffee shop, and I felt like you had an ulterior motive with you wanting to know how I felt. T: I see. Okay, so, the situation we have identified is "The therapist asked me about the interaction at the coffee shop", and the thoughts you had about me were, "The therapist had ulterior motives toward me." I would like to know more about the ulterior motives. What kind of ulterior motives did you think I had? M: Well, in my history, it seems that people who show that they care about you do it because they have a reason to. Since you're a therapist, I know you're getting paid to help me out here, so I guess as long as I continue seeing you and I continue to be happy and you're asking me about my life, I'm going to continue to talk. So, I'm going to keep coming and you could keep making money. T: Thank you for sharing that. And as you tell me that, what are you feeling? M: I've had doctors that I felt the same way about. Every time I go in they push for me to do STD tests even after I tell them I am not sexually active. They are just trying to squeeze that extra fifty bucks out of me. I think my feelings start with anger, and maybe some resentment. T: Okay. And what do you think I was feeling toward you? M: I think you were doing it because you had to do a job. You do seem to care, but I don't know if you care about me anymore than you'd care about anybody else who comes in here. So I can't understand why you'd care about my problems. T: So, did you think I was feeling indifferent? M: Yeah, I do think indifference is something that I felt. T: Alright. You've done a great job identifying what you think I was feeling and thinking, and also what you were feeling. It sounds like what you are thinking is there's no way she actually cares about me, Right? M: Yeah. T: Okay, and then what did you do in response to having those thoughts? M: I realized I was closing up. I didn't want to tell you more. T: Good. Okay. Let's see if we can distill this down to a relationship model or pattern. We could try to take this example as illustrative of a belief you have about other people. Let me help you get started. So maybe something like, "If someone acts like they care about me, then" what? M: If someone acts like they care about me, then I close myself off. T: Alright, Good. Then what do you do? M: I feel my wall going up. T: Yeah, and I felt that, too. I was so grateful that you allowed the opportunity for me to keep talking, and for you to even be curious about how it could potentially be different. Curiosity is really at the heart of this: What could be different now in the present in my life? Because you were curious, we were able to talk it through. I think another trauma-based belief might be, "If I feel close to someone, then" what? M: They are going to leave me. T: Okay. That is what has happened to you in the past, so it makes sense that you have that belief. The good news is that through time and work, these beliefs can be changed as they might apply in the present. But, for now, let's stick with this. What other beliefs about relationships emerge from this example? M: I've got to look out for me. I'm the only person who's gonna look out for me and I'm the only person who ever has looked out for me. That's something that I really do believe is true. T: Right. Part of your old belief is "She doesn't really care about me." Sometimes it's helpful to even just say to yourself, "Maybe she does care, or at least has my best interests at heart." M: Yeah, I could do that. And I think there have been times when I've noticed that people care, but it's so hard to believe that I find that sometimes I push people away, maybe a little too soon. T: Yeah, and again, it makes sense that you would do that, given the things that have happened in your life. It does take tolerating that fear to try something different, even just not putting your walls up automatically. I am wondering what you might feel

instead if you thought, “Maybe she does care about me.” What other emotions might you feel instead of suspicious or angry? M: Well, I think first I’d probably feel intrigued. I’d want to know why you care. Even if I assume it’s for a positive reason, I’m still going to be intrigued by why. Then I think I’d be thankful because whatever issue you are showing care for, I wouldn’t have to go through it alone. I am so used to being alone, and it’s so exhausting. T: Yeah, it really comes at a price. What alternative thoughts could you have about me? Towards the end of our session what did you think I was thinking and feeling? M: We got to talk through some of the problem, so at the end of our session I thought I could have been wrong, and maybe you really did want to know how that interaction went because maybe you thought you might be able to help me. T: Okay, good. So, an alternative thought could be, “She really does want to know how the interaction went.” And the feeling I could be having could be concern, maybe? M: Yeah, that feels right. When we continued the conversation, I realized that it was probably not as bad as I thought it was at the moment. T: That is incredible! Excellent! Finally, let’s get to the new relationship model. So the old belief is “If I get close to someone, then they will leave me.” What could it be instead? M: If I get close to someone, then they might add something to my life that I don’t already have. T: Oh, wow, that’s great. The second old belief was, “If someone cares about me, then they will leave me.” What could it be instead? M: If someone cares about me, then it might not mean that I’m as bad as I think I am.

The therapist anticipates that Michael’s relationship models relate to his trauma history. This will be explored during the narrative work. The relationship models certainly guide his current interactions. If the beliefs are a consequence of his trauma history, the therapist and client can begin the task of determining to what extent and under what conditions the trauma-generated beliefs are still applicable versus when he might feel the freedom to try on some of the alternative models that have been generated in the session.

As the above dialogue indicates, the presence of strong and ongoing relationships is not necessary to identify relationship models. In this case, the therapist used an interaction between the therapist and client to distill the beliefs. Relationship models tend to be stable and highly generalized. The SNT protocol provides guidance about how to work through relationship models related to themes of assertiveness, flexibility/power and intimacy. In this case, the treatment remained focused on themes of abandonment and rejection, because they were so central to Michael’s anger and social isolation.

2.4.3 Sessions 11-16: Narrative Therapy

Michael and the therapist created a memory hierarchy of specific instances of various traumas that had occurred during his childhood and adulthood and ordered them by how much distress he felt for each memory. The death of Drew was the most distressing. This memory was chosen as the first to review because thoughts of Drew had been strong during COVID and Michael wanted an opportunity to talk about Drew. The therapist agreed because she felt that Michael’s beliefs about himself and others, his feelings of abandonment and continuing rejection of and hostility towards others were rooted in Drew’s death.

Narrative of Death of Partner:

T: Today we are going to move on to the highest memory on your hierarchy, and that is Drew’s death at the hospital. Are you ready? M: Yes, I think it’s time. T: I’m going to ask you to use the present tense and incorporate as many details as possible: What you are seeing, what you are hearing, what you are smelling, what you are feeling, all of those things. I might ask you some questions along the way. You will have a record of this story on your phone. Go ahead and press record, when you are ready. Before we begin, what is your level of distress? M: About a ninety-five. T: Very high, okay. If you feel comfortable, close your eyes or you can just keep your eyes open looking down, and tell me about the day that Drew died. M: Okay. I’m going to his hospital room. I brought him flowers because once a week I bring him flowers to remind him that his hospital room doesn’t have to be this stinky, sterile place; especially since he is spending more and more of his time here. T: What do the flowers look like? M: The flowers are red. They are tulips. I’m not able to afford much so they’re in a small vase. I’m thankful I have these flowers to carry with me. It always smells so bad in here, like ammonia and death. The flowers cover up as much as they can. When I bring them into his room, it’s even worse. It smells like urine and feces, and there are nurses in his room. One tells

me I can't be in here. They're taking care of him, and they've tried this s**t before where they don't want us in the rooms caring for each other. I know what they think of us. I usually argue with them, and they'll leave us alone for a few minutes, so I can tell Drew "Hi." But they don't listen to me this time. They start pushing me out of the room. I tell them, "I have to at least give him his flowers today. If you're not going to let me see him, I'm giving him his flowers." I scoot past the nurse standing at the doorway, and I go to set the flowers on Drew's windowsill. I turn and look at him and he already looks dead. His skin has no color. He's emaciated. He always used to have abs. But now he is just skin and bones. He has those sores all over his body now, too. They started on his face, and I know that's gotta upset him because he had such a pretty face. He just looks pitiful. He's just looking off at the room. He doesn't even look up at me. It's like he's not even here. He's brain dead or something. Even when I tell him, "Drew, I brought your flowers", he didn't even move to look at me. It is so hard thinking about all of the times we would go out. Everybody would be all over him because Drew was the lively one. He could make friends with anybody, and he's the reason I met so many people when I started to come out to the scene. It's hard to see him this way. T: What's going through your mind as you see him lying there? M: Well, first I feel very sorry for him, because it's hard seeing somebody you love going through that. I selfishly think about myself because I know that will be me one day. I know I will be the one somebody will pity. As much as I want to be there for him, part of me wants to run. T: What happens next? M: I am leaving the room. I go to the pay phone and I call Thomas, our other friend. I let him know that Drew's not doing good, and I wait in the waiting room for him to swing by. I'm asking everybody what's happening with him. I am sure the nurse is cussing me out because I must be going to the Nurse's Station every five minutes. When Thomas gets to the hospital, I go grab a bite to eat from the cafeteria. When I get back, Thomas tells me that Drew passed. They didn't let me spend any time with him on his last day. T: What's your level of distress right now? M: Eighty. T: Okay. Is there anything else about this memory that would be important to share? M: I feel angry. Angry at the nurses who didn't seem to care. Angry at the world for blaming gay people for this virus. I've never shared this with anyone, but I think as the years went by, I even felt angry at Drew. For leaving me to deal with this mess, this homophobic world by myself. And maybe just for leaving me alone. T: I see, okay. Let's go ahead and stop the recording there. So, Michael, you did it. You got through the worst memory on the hierarchy. I want you to take a deep breath. Look around the room. Now see that you are safe. You're at home. I'm here with you virtually. Let's look at this list of emotions. You mentioned anger. I'm wondering right now, as you have just told me this memory, how much anger are you feeling right now on a scale of zero to ten. M: Well, in regard to Drew, I really don't know what to make of that. Can we skip that for right now? T: Okay. What about the nurses? M: About a two. They didn't have to treat us like they did when we were in the hospital trying to be there for the people that we love that had nobody else. But I know it was a time when I don't think any of us knew what we were dealing with. So, everybody was more scared. T: Okay. That brings us to another emotion, fear or feeling scared. What number would you give that, zero to ten? M: I would say seven, especially with COVID. If AIDS hasn't taken me out yet. Covid will. T: Okay, and what about sadness? M: I would say nine or ten. That's the strongest. T: Tell me more about that. M: I try not to think very much about the people that I lost during that time. If I don't think about it, it's not happening again. I feel like I just re-lived the situation, and I'm losing Drew all over again. I wish he could have seen what's happened in the last forty years in the world that he missed out on. T: You know, I'm so proud of you for acknowledging those feelings. I know that doesn't come easily to you. M: Yeah, I feel like I almost have a friend with me when I'm talking about Drew, because he truly cared about me. He's one of the only people I think I ever could be myself around. T: Yeah, and I know you mentioned he really took you under his wing and helped you navigate the scene. M: Yeah, I didn't know anything about anything. I didn't know how to talk to a guy, he showed me that it wasn't as hard as I thought it was. You know his parents didn't accept him, either, but he cared a lot less than I did and he showed me how to be myself. T: You mentioned that you even felt angry at Drew - for dying. M: I suppose what I really feel is sad. I miss him. Whoah! I think I need to emotion surf for a minute. T: Go ahead. M: It's so painful. I feel pain in my chest. Like my heart is literally breaking. T: Take your time... What do you think he would want to say to you right now? M: He'd probably tell me that he's glad I'm still alive, and that he still loves me. He didn't abandon me. He just died. I think he would say that he wishes he could be here with me. I

wonder if he would have thought I would have turned into this angry person or if he thought I'd have more of the friends that we used to have. T: Sounds like he would want you to have a rich, full life, whatever that would mean for you, just like he showed you how to be free so many years ago. I suspect he'd want you to still be free right now. This reminds me of one of those very important relationship models that we had identified, which is, if I feel close to someone, then they will leave me. That's exactly what happened here and happened a lot in your life. I know you've been working on allowing yourself the possibility to maybe feel closeness with someone. Maybe things can be different now. M: Yeah, I think after Drew died, I realized that if I never would have gotten close to him, I wouldn't have been hurt when he died because I wouldn't have known him. I've missed out on so much of life because I push people away. I want to have relationships with people. I just don't want to lose them anymore. T: Of course. You just said it: if you had never known him, it wouldn't have hurt you when he died; but you would have never known him. What a terrible price to pay! M: Absolutely. Yeah, I can't imagine what my life would be like if I wouldn't have met him. T: I also am thinking about the fact that you weren't allowed to be with him at the very end, and he was alone. I know that's something that now, in the present, you feel safer being alone. I'm wondering if it's also in the service of asking yourself, "what difference does it make, anyway? I'm gonna die alone, too." I am curious if that's a thought that you have had. M: Yeah, and especially the way I pitied him when he was laying in the bed. If I don't have anybody to pity me, then I'm not going to be pitied when I eventually die. T: Pity is one way of putting it. Compassion might be another. M: I guess I do lose the opportunity for somebody to care for me when I die, to bring me flowers. That's right. T: I imagine it brings you some comfort to know that his last day you were there, and he had flowers and some beauty in his life at the very end. M: I would like to think that if he did know what was going on, the flowers might have been the last thing he saw of the world in his final days. T: And what is your level of distress now? M: 20

3. OUTCOMES AND PROGNOSIS

A key outcome was that Michael was able to experience and accept many of the feelings that resulted from Drew's death. During the narration, he is able to experience the terrible grief and the anger he felt towards Drew for abandoning him as a young gay man who was just learning to make his way. Accepting the feelings allows him to explore their meaning and with the therapist's guidance, have compassion for himself as the confused and hurt young man he was at the time of Drew's death. Freed of the burden of his grief and anger, he is able to understand that Drew did not choose to leave or abandon him. The "conversation" with Drew at the end of the narration reframes the relationship and points Michael in the direction of becoming more socially engaged as Drew would have wanted for him. Feelings of guilt for surviving are referenced but not addressed in this narration ("I selfishly think about myself because I know that will be me one day...") and that work may help him understand his need to "find a purpose" and in fact succeed in this task.

The first important intervention in the treatment identified that many of Michael's problems were the result of his multiple traumas and not an indication of a problematic personality, impaired character or being gay. The diagnosis of CPTSD including his anger, social isolation, emotional numbing his "wordlessness" in naming his feelings were typical consequences of trauma. The presence of symptoms such as nightmares, avoid and heightened fear, all of which confused him now made sense and were organized under the diagnosis. The emotional awareness and regulation exercises accelerated a process of connection to his feelings in an accepting and mature way. They also provided him with choices about how to effectively manage ongoing minority stressors and helped him realize that his ability to manage these stressors differed from those he experienced as a child.

Michael substantially benefited from the skills work included in SNT. He had been living in an emotionally shut down manner and had become literally de-skilled over time. This was also perhaps even more true for his social skills. He had become effective in rejecting others. He felt awkward and at a loss in appropriately engaging with others in both social situations and in the task of developing deep and close relationships. The therapist modelled healthy interactions with Michael in which feelings of both vulnerability and safety were experienced.

Table 1 provides a summary of symptom measures which indicated significant reductions in his Complex

PTSD symptoms (ITQ; Cloitre et al., 2018), reduction in depression (BDI-II; Beck et al, 1996) and better emotion regulation (DERS; Gratz & Roemer, 2004) and perceptions and expectations about social support (ISEL; Cohen, 2008). The treatment successfully met the goals of Michael feeling better and improving his social connections. He began engaging with staff at the clinic and with members in his support group in more open and friendly way. The prognosis for Michael is good. He has experienced a radical revision in his self-concept as an angry person with no friends to a person who is struggling with loss, and with discrimination and aggression as a gay man. The challenge is made easier by being in the process of reconnecting with the LGBTQ+ community and recognizing he is accepted there. Challenges that remain are effectively dealing with new traumas and new societal discriminations as they may arise. He also is still figuring out the steps to developing an intimate relationship.

4. CLINICAL PRACTICES AND SUMMARY

One of the benefits of STAIR Narrative Therapy is that it provides intensive work in skills practice in emotional awareness and emotion regulation. It also pairs up behavioral exercises in social skills with changing relationship models so that intellectual understanding or insight can be partnered with real and skilled changes in behavior. The treatment is flexible so that therapist and client can work together in the selection of skills that are tailored to the patient. While the SNT protocol is organized into 16 sessions, the work from each 'protocol session' can be extended as needed over actual session time or therapist and client can cycle back to old skills and exercises as needed. But, as is hopefully demonstrated in this case presentation, the working through of the meaning of the traumas is invaluable to revisions in sense of self and in relational dynamics. For SGM individuals, SNT provides a program that recognizes the importance of and helps manage ongoing minority stressors as well past traumas, leading to increased resilience and a more positive sense of self.

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Table 1. Michael's Symptom Scores at Pretreatment and Posttreatment

Measure	Potential Score Range	Pre- treatment	Post-treatment	Clinical Cut-Off
ITQ Total	(0-48)	31	15	24
ITQ PTSD Symptoms	(0-24)	14	7	12
ITQ DSO Symptoms	(0-24)	17	8	12
BDI-II	(0-63)	25	9	10
DERs	(36-180)	118	90	100
ISEL-12	(0-36)	30	15	17

Note: ITQ = International Trauma Questionnaire; PTSD = Post Traumatic Stress; DSO = Disturbances in Self-Organization; BDI = Beck Depression Inventory; DERs= Disturbances in Emotion Regulation Scale; ISEL = Interpersonal Support Evaluation List. The Clinical Cut-Off represent scores found in the general population and/or are estimated to represent scores outside of a clinical or diagnostic range.