FAMILY PROCESS

Demonstrating Attachment-Based Family Therapy for Transgender and Gender Diverse Youth with Suicidal Thoughts and Behavior: A Case Study

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Suicide is a growing public health issue among adolescents. While the majority of transgender and gender diverse (TGD) youth are healthy, many experience suicidal thoughts and behavior (STB). Due to discrimination and stigma, TGD youth attempt *suicide at higher rates then heterosexual, cisgender and even cisgender, LGBQ youth. Despite this vulnerability to suicide, few treatments have been developed and tested for this population. One treatment, attachment-based family therapy (ABFT) has been adapted to work with LGBQ youth and may be promising for TGD adolescents at risk for suicide. This article provides an overview of our ABFT modifications for TGD youth with thoughts of suicide. Specifically, we illustrate how treatment outcomes, in a single case study, relate to processes within clinical treatment tasks. The case study demonstrates the application of these ABFT modifications with a self-identified, gender nonconforming adolescent (who had recently attempted suicide) and his caregivers. Treatment evaluation measures were collected over the course of 24 weeks to illustrate the youth's clinical progress. The youth's suicidal symptoms diminished markedly by the end of treatment. Further, the family reported an increased ability for problem solving and more open communication by treatment conclusion.*

Keywords: Attachment-Based Family Therapy; Transgender Youth; Suicidality; Case Study

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Suicide is the second leading cause of death for youth (Hoyert & Xu, 2012). Yet only 22% of youth who attempt suicide and 14% with suicidal ideation seek mental health care (Nock et al., 2013). Gender diverse (gender minority) youth are particularly vulnerable (Perez-Brumer et al., 2017). Gender diversity refers to the extent to which someone's gender identity, role, or expression differs from the norms associated with their sex

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assigned at birth (American Psychological Association, 2015). Until recently, transgender and gender diverse (TGD) adolescents have been overwhelmingly absent from suicide treatment research. Yet, due to experiences with discrimination, they are more vulnerable to suicidal thoughts and behaviors (STB) than sexual minority youth (Bauer et al., 2015). Although many TGD youth are healthy and resilient, it is estimated that between 30 and 50% of TGD youth *attempt* suicide during adolescence (Toomey et al., 2018).

SUICIDE AMONG TGD YOUTH

There are several factors that may explain why TGD youth are more vulnerable to suicide than their heterosexual and cisgender peers. Suicidality has been linked to internal (i.e., gender dysphoria, internalized transphobia) and external (i.e., caregiver rejection, discrimination) minority stressors (Grossman et al., 2016). Further, adolescence can be particularly challenging for TGD youth as they begin to solidify their gender identity. Their increasing awareness of transphobic discourses presented in their families, peer groups, media, and/or communities may lead to shame and distress (Yüksel et al., 2017). In addition, secondary sex characteristics develop, potentially exacerbating gender dysphoria (Drescher & Byne, 2012; Steensma et al., 2011). Without supportive resources, many youth may be left managing stigma, discrimination, and distress from gender dysphoria on their own.

Though not all TGD youth are interested in physical transition, significant advances in gender-affirming care (e.g., puberty suppression, cross-sex hormones, affirming surgeries) have allowed many TGD youth to feel more congruent with their gender experience (Steensma et al., 2011). The World Professional Association for Transgender Health (WPATH) (2012) provides standard of care guidelines when working with TGD youth. WPATH states that with proper assessment by a healthcare team, the risks of procedures for physical transition are minimized and mental health benefits are maximized. Unfortunately, access to services is often limited by professional/familial gatekeeping (Klein & Golub, 2016). These barriers lead many TGD youth to feel depressed and powerless, especially when youth must rely on intolerant or ambivalent caregivers for decisions about their care (Drescher & Byne, 2012).

FAMILY SUICIDE INTERVENTIONS WITH SEXUAL AND GENDER MINORITY YOUTH

One factor associated with suicide is the quality of caregiver relationships. Indeed, caregiver support protects against suicide risk (Bauer et al., 2015; Mustanski & Liu, 2013), whereas criticism, unresponsiveness, and rejection contribute to suicidality (Klein & Golub, 2016). The impact of caregivers on the well-being of sexual and gender minority youth suggests there is value in family approaches to suicide intervention. A study with sexual minority adolescents found that youth often attribute their STB to (1) the quality of their relationship with their caregiver(s), (2) family rejection of their identity, (3) negative familial events unrelated to identity, and (4) extra-familial victimization (Diamond et al., 2012). Even when family factors are not the cause of distress, many youth do not turn to their caregivers for help with victimization, fearing caregivers will not protect them (Hammelman, 2008).

ATTACHMENT-BASED FAMILY THERAPY

Attachment-based family therapy (ABFT; Diamond et al., 2014) is one promising approach for TGD youth with STB. ABFT is an empirically supported treatment for adolescent suicide. ABFT has been modified for sexual minority youth (Diamond et al., 2012)

and has been tested within the context of LGBTQ+ focused service settings, where TGD youth receive the bulk of their care (Russon et al., 2021). ABFT addresses suicidality and depression through five treatment tasks (Diamond et al., 2014). The *Relational Reframe* (Task I) occurs in the first session of therapy with the family. After gathering background, the therapist focuses on what prevents the youth from turning to caregivers when in distress. Identifying these ruptures (i.e., what gets in the way of youth going to their caregivers for comfort and support) leads to a commitment to resolve them. In the *Youth Alliance Task* (Task II; 2–4 sessions alone with the adolescent), the therapist seeks to understand how relational ruptures have impacted the youth-caregiver relationship and then builds the adolescent's motivation to address them. The *Caregiver Alliance Task*, (Task III; 2–4 sessions with caregivers) explores caregivers' stressors and their histories of attachment ruptures. The *Attachment Task* (Task IV; 1–4 sessions with family) enables the youth to express thoughts and feelings about relational injustices in a regulated manner. Rather than defending themselves, caregivers help the youth express and explore these emotional topics. The *Autonomy Promoting Task* (Task V; 6–8 sessions) aims to build a strong partnership from which adolescents can explore independence and competency.

ABFT for TGD Youth with STB

Preliminary research demonstrates ABFT may be promising for TGD youth with STB (Russon et al., 2021). However, the unique challenges faced by this population require specific treatment adaptations. Our implementation research revealed several recommendations for providing ABFT to this population (see Russon et al., 2021). While many families may struggle to understand their child's needs, the added stigma associated with being TGD can exacerbate this issue. Indeed, many families are influenced by cisnormative values inherit in their own families of origin, making it more difficult to respond to their TGD children. With this said, the foundational recommendation is maintaining an affirmative stance, which requires an understanding of the lived experiences of TGD people (Harvey & Stone Fish, 2015). Excellent reviews can be found in the American Psychological Association's (2015) *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* and the WPATH (2012) *Standards of Care for Clinical Sensitivity*. Therapists must be prepared to help these families navigate complex issues, including helping caregivers protect youth from a world that maybe hostile to them while promoting their growth. Given these complexities, ABFT with TGD youth often requires 20–24 weeks of treatment and several task-specific modifications.

First, therapists must consider engaging the family in some Task II and III work before Task I. This change in sequence allows the therapist time to begin building the therapeutic alliance with both youth and caregivers as well as time to understand safety and outness in familial relationships. Given the additional considerations with TGD youth and their caregivers, the therapist having individual sessions with the youth and caregivers prior to the relational reframe can help increase the likelihood of the Task I session going well. During initial Task II work, the therapist can engage the youth and help them begin to see the therapist as a trustworthy provider. Youth can also begin to take ownership of treatment by identifying which caregivers to bring to ABFT, including families of choice. Initial Task III work with caregivers serves to soften blame and reduce anxiety. Individual meetings allow an opportunity for alliance-building while the therapist assesses where the caregiver is on the continuum of acceptance (Diamond et al., 2012). For caregivers with frequent rejecting behaviors or who express rigid, cisnormative ideologies, therapists must consider whether to include them. In some cases, family members of choice are invited. In others, the therapist does not conduct a Task I and, instead, works individually with youth and caregivers until repair can be facilitated in Task IV.

Second, the therapist must ensure that the adolescent feels their autonomy is respected in Task I. Specifically, the therapist must help TGD youth stay engaged in difficult conversations about their relationships while honoring their decision to participate in therapy. Many TGD youth have felt a lack of autonomy in their lives. Some have experienced years of being required to conform to cisnormative "standards" that do not fit. Trust is built when youth know they have a say in the direction of their treatment. Therapists can facilitate engagement by providing encouragement and rationale for the ABFT processes. Third, therapists are encouraged to disclose their own identities (e.g., race, gender, sexual orientation) to open dialogue with TGD youth (Watts-Jones, 2010).

Fourth, Task III with cisgender caregivers of TGD youth often involves a "caregiver education" phase. Although many are sensitive and attuned to the needs of their youth, some caregivers need to understand their adolescent's personal and interpersonal challenges. During Task III, we encourage conversations about caregivers' views, beliefs, and fears. Giving caregivers a chance to share strengthens the therapeutic alliance so they feel supported when they are challenged to consider the impact of these views, beliefs, and fears on their adolescent. Fifth, the therapist helps families sequence Task IV content according to how TGD-specific relational ruptures (e.g., "my mom uses the wrong pronouns") correspond with attachment themes (e.g., rejection, abandonment). For TGD youth, ruptures may or may not involve caregivers' responses to their identity. However, for those with TGD-specific ruptures, therapists must help clarify whether these caused the development of attachment themes and/or exacerbated pre-existing ones. Understanding when ruptures happened in relation to key milestones in TGD youths' identity development structures Task IV sessions.

Sixth, Task IV incorporates a "parental disclosure" phase where caregivers provide context and/or apologize for ruptures (Diamond et al., 2014). For caregivers of TGD youth, caregivers are encouraged to voice how their own biases or cisnormative ideology might contribute to misunderstanding. Facilitating such dialogue offers cisgender caregivers an opportunity to reflect on how their youth's experiences might differ from their own. It also can help TGD youth understand their caregiver's struggles might be the result of exposure to dominant discourses. Finally, Task V provides an opportunity to address important topics for many TGD youth, such as navigating stigma, transitioning (e.g., physical, social, psychological, legal), and coming out. Task V also provides a platform for caregivers and youth to discuss what the youth needs to express their gender. Task V is also when caregivers are encouraged to become advocates for their adolescent (e.g., seeking out affirmative providers, connecting with TGD communities, supporting the youth's coming out).

OBJECTIVES AND METHODS

The following case study illustrates how these recommendations are applied in ABFT with TGD youth and their families. Specifically, the objectives of this clinical case study are to (1) illustrate a course of ABFT with a TGD adolescent and his family and to (2) outline how treatment outcomes in a single intrinsic case study are related to treatment tasks. This mixed methods, longitudinal, case study format was used in order to support an in-depth exploration of the complexities associated with conducting this model with a TGD youth (Crowe et al., 2011). We treat the write-up as a self-reflexive quantitative and qualitative inquiry into the specific clinical interventions used to address STB.

Clinical Measures

Progress was monitored throughout treatment. The therapist collected Suicide Ideation Questionnaire-Junior (SIQ-JR—weekly version; Reynolds, 1987) and Beck Depression

Inventory (BDI-II; Beck et al., 1996) scores to track progress. The SIQ-JR measures symptoms of suicidality (e.g., thoughts of killing oneself and writing a suicide note) and has shown high reliability (α = .93; Reynolds, 1987). The BDI-II measures symptoms of depression (e.g., sadness, pessimism, and worthlessness) and has shown high reliability (α = .90) and retest reliability ranging from .73 to .96 (Wang & Gorenstein, 2013). Additionally, alliance with the therapist and perceptions of treatment were collected every eight weeks using the Working Alliance Inventory-Short Form (WAI-SF; Tracey & Kokotowitc, 1989) and the Opinions About Treatment questionnaire (OAT; Borkovec & Mathews, 1988). Scores on the 12-item WAI-SF range from 12 to 84 (Tracey & Kokotowitc, 1989). The WAI-SF has proven high reliability (α = .98; Tracey & Kokotowitc, 1989). The OAT contained three items on a 9-point Likert scale about the family's perceptions of the treatment logic, usefulness, and confidence in the treatment. The OAT is reliable (α = .90; Mooney et al., 2014), and scores range from 3 to 27. For both measures, higher scores indicated greater alliance and perceived treatment credibility. Finally, adolescent attachment anxiety and avoidance toward mother and father was measured every eight weeks using the Experiences in Close Relationships-Relationships Structures Questionnaire (ECR-RS; Fraley et al., 2011). Higher scores (ranging from 1 to 7) indicate greater attachment insecurity. The ECR-RS scale for avoidance and anxiety have good internal consistencies (α = .88 and .85, respectively; Fraley et al., 2011). See Figure 1 for scores.

CASE STUDY

The Jones family was referred to our ABFT program as part of a treatment development pilot study (Russon et al., 2021). All cases were seen in centers specializing in the care of sexual and gender minorities. We had partnered with these programs given their interest in ABFT. Most therapists at these sites focused on individuals and welcomed additional support with suicidal cases. Many cases referred to this project were the most difficult on therapists' caseloads. Many therapists felt the therapy was "stuck" because of challenges with family members. The Jones family participated in a 24-week course of ABFT. Consent for use of their material was obtained for research and educational purposes. Names were changed to protect privacy.

Background and Initial Task II and Task III Meetings

Dylan was 14 and in the 8th grade. He identified as a white, Christian, gender nonconforming person with he/him pronouns. Dylan was questioning his sexual orientation. He

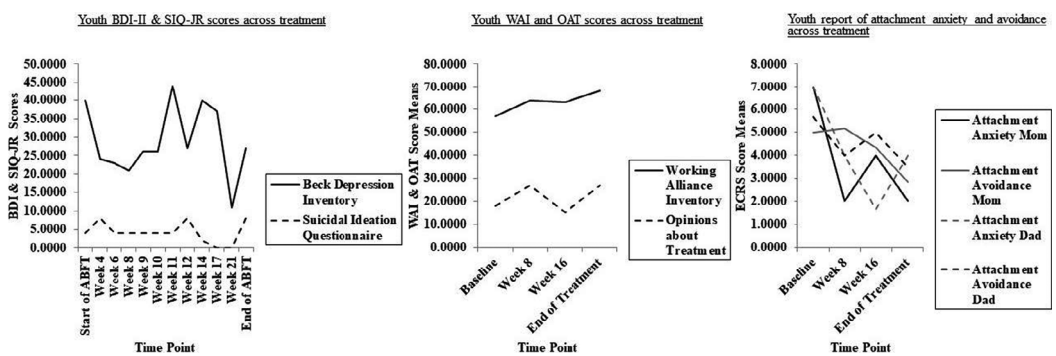

FIGURE 1. Progress Monitored Over 24-Week Course of ABFT.

lived with his biological mother, Susan, step-mother, Donna, and sibling and had periodic contact with his biological father. Dylan was referred to the program after a suicide attempt by taking pills with his trans boyfriend, Adam. After the attempt, Dylan was not allowed to see Adam and this caused significant distress. Dylan reported that, "if Adam didn't want to be alive, then he didn't want to be alive either." Before enrollment in ABFT, Dylan scored a 38 (clinical severe range) on the SIQ-JR and a 35 (severe range) on the BDI-II. He also reported mild symptoms of auditory and visual hallucinations at start of treatment.

The therapist (lead author), a white, cisgender, pansexual woman, first met alone with Dylan (Task II) and then met alone with caregivers, Susan and Donna (Task III) before the first family session (Task I). This was to explore pronouns and names, assess outness within the family, and examine perceptions of acceptance in the parent-child relationships. Dylan's father expressed interest in therapy but only attended one session during task III. Dylan was withdrawn and hesitant to communicate with his caregivers. Susan and Donna were extremely anxious following Dylan's attempt. Dylan had disclosed his gender identity to his family six months prior to his attempt, and all caregivers were concerned that his identity may be a phase. One unspoken area of discord in their relationship was his caregiver's reticence to let him initiate hormone replacement therapy (HRT). Several times, the family went through the motions to begin, but then Susan and Donna would feel apprehensive and pull back. These interactions led to Dylan feeling invalidated and hopeless about his future. He also worried about making his mother's anxious. This was compounded by the fact that all caregivers were in recovery for substance abuse. Although they had been abstinent for years, Dylan's reticence was influenced by his fear of their relapse. At the time of treatment, Dylan's father was actively trying to maintain recovery for substance abuse. In terms of the caregivers' openness to Dylan's gender identity, mother, step-mother and father were all in different places. Father struggled to tolerate his son's identity becoming distressed and tearful when the subject was mentioned. Both mother and step-mother expressed their desire to be affirmative; however, mother's worried about the solidity of her son's identity, therefore, making her reluctant to support him in receiving HRT.

Given all these challenges, the Jones family came to the therapy feeling overwhelmed as they tried to navigate their response to Dylan's suicidality. In the initial assessment meeting, a family safety plan (informed by Stanley & Brown, 2012) was conducted with Dylan and mothers. Dylan was able to identify the situations which triggered his depression and suicidality (e.g., bullying) along with the mitigating factors (e.g., connection with peers and supports). A step-by-step plan was developed for the times when Dylan began to feel suicidal. The plan included coping skills, distractions, and supports to contact if in crisis. The safety plan served as a "band aid" to provide structure for the family while working toward second order change.

Task I. Relational Reframe

The goal of Task I is to shift the focus from "fixing" Dylan's suicidality to improving emotional safety in the caregiver–child relationship. The therapist initiated the reframe by focusing on themes of disconnection. There is a critical point in Task I where the conversation shifts from symptoms to the *caregiver–child attachment relationship* (Diamond et al., 2014). For some TGD youth, like Dylan, this shift causes anxiety. The therapist needs to engage the adolescent in the conversation while honoring their autonomy. In this segment, the therapist encourages Dylan to tolerate the reframe, while asking him to continue the conversation.

Therapist: When you were feeling so devastated that you wanted to kill yourself. . .what stopped you from going to your moms to get comfort and support?

Dylan: I don't know, I just felt like I couldn't.

Therapist: . . .Were you worried you might be a burden to them. . .that you would upset them?

Dylan: Yeah I did. . . Can this session just be with them again? [Dylan is anxious about discussing his suicide attempt in front of his mothers and wants to leave].

Therapist: This is really, really hard to talk about. And I see, even here, you're so worried about your mom's distress and burdening her now. [Susan: It's okay. . .you can say it. . .this is important.] We're doing this therapy for a purpose, and I'm going to be here to help with it. . .I want to switch to talking to your moms for a second, is that okay? [Dylan: Yeah].

In this segment, the therapist offers conjectures to help Dylan identify the rupture. In this directive model, we often offer language to our adolescents in order to help give them a starting place for understanding their experiences. When Dylan was vague, the therapist provided a hypothesis by picking up on the dynamics in the room (Susan's anxiety and Dylan's worry about his mother's fragility was weakening trust). Dylan then asks, while observing mothers' distress, if the session could end. The therapist validates the difficulty of discussing the relationship, reassures Dylan, then asks for his permission to continue.

Therapist: Did you know that these were the reasons why Dylan wasn't coming to you?

Susan: No clue. I've always said to him, we can talk, you can tell me anything.

Donna: There's [teens] that don't go to parents unless their back is up against the wall.

Therapist: Dylan was in a position with his back was up against the wall, and despite you wanting to be there for him. . .he couldn't come to you, and that must be so hard.

The therapist punctuated how their son did not go to them when his attachment needs were activated. She praises their parenting instinct to comfort Dylan, but then intensifies the impact of the rupture.

Susan: That was devastating. I really honestly had no clue that he was in that much pain.

Donna: It's got my anxiety through the roof.

Therapist: And, what has it been like for you Dylan, to not have support from your moms because you were afraid of burdening or worrying them?

Dylan: Well, at the time I had Adam. . .but when I knew he didn't want to live, I just couldn't imagine living. . .without Adam.

Therapist: So, it sounds like you were holding a lot of pain, for Adam and for yourself. What was it like carrying all of that by yourself?

At this point, the therapist is helping the family deepen emotions surrounding the consequences of the rupture. The rupture created fear for Susan and Donna and loneliness for Dylan. After punctuating this, the therapist helped the family access feelings of longing for closeness and contracts them to work on a relational goal first.

Task II: Youth Alliance

During Task II, the therapist met alone with Dylan. This task began with intentional self-disclosure from the therapist, without expecting the client to do the same.

Therapist: In these [individual] sessions, I want to get to know you a bit better, but, first, I would like to tell you a little bit about myself. As a therapist, I work with families of young adults. I focus a lot of my work on LGBTQ+ families, like yours. When I do this, I find that it's important to think about who I am as a person and the ways my own identities affects how I work in my therapy and with you. So, if you know a little bit more about me, it will help us keep an eye on things I don't understand. Am I making sense right now? [Dylan nods]. . .Okay, so, as you can see, I am a white person. . .English, Swiss, and Czech. . .I believe you have an Irish background. . .from what you said on your form. . .is that right? [Dylan smiles and nods]. . .Also I am a pansexual person, cisgender woman. . .so this is a little bit about who I am as a person and as a professional. Are there other things that you would like to know about me or what I do? [Dylan: Umm, no, not right now]. If things come up that you have questions about, let me know. . .so, can you tell me a little bit about you? You don't have to share the types of things I shared, but tell me what you would like me to know about you today. . .

Dylan seemed to relax after the therapist's disclosure and was open to talking about his own identities. This conversation led to discussions about coming out to his two mothers, challenges in Dylan's life (e.g., discrimination and feeling misunderstood), and hopes and dreams (e.g., working with animals and helping people). The therapist validated his experiences. In the next Task II session, the therapist focused on Dylan's depression and suicidality. Though these conversations were challenging for Dylan, his ability to discuss his suicidality increased since the first Task I session. Without exploring identity, punctuating strengths, and affirming Dylan's experiences, therapists risk their clients believing they see a causality between gender identity and suicidality. The shift from discussing background to discussing suicidality must be thoughtful and sensitive. The segment below illustrates how the therapist began the second Task II session.

Therapist: So, we got to know each other a little better last time we met. . .the big take away I learned about you is that, [Dylan], you have a really big heart. You care so much for animals and people. . .you have a gentle spirit. I also know these past years have been hard for you. . . I know the dysphoria has been hard. . .and when you have tried to tell your mothers that. . .you thought they might not understand. You have felt like you are alone at times and without seeing your boyfriend, you have felt that more strongly. . .there is a lot of hard stuff right now. Do you mind if today we talk a little bit more about what this has been like for you?

After several Task II sessions, Dylan was able to begin talking about feeling like a burden to his mothers. Dylan was protective of his caregivers, requiring the therapist to help Dylan know that she was supporting them and "on their side" as well as his. For many TGD youth, caregiver difficulties with pronouns, names, or supporting affirmative care may be seen by the youth as rejection, abandonment, or lack of acceptance. This was true for Dylan. Although his mothers identified as LGBTQ-affirmative and desired to support their son, they had unresolved ambivalences and concerns. In following sessions, the therapist encouraged Dylan to connect how invalidating interactions with his mothers contributed to his feelings of abandonment.

Therapist: It really makes sense why you became so close to Adam. He really understood you. . .Although your moms care so much about you. . .sometimes they didn't understand?

Dylan: Adam always supported me about who I am. My step-mom was kind of understanding, but my mom. . .I thought they would be accepting since. . .they're LGBT too. I was angry at first, but after a while. . . understanding that she wasn't ready for, like, her girl to not be there anymore.

Therapist: Sounds like you have a lot of empathy for your mom and what it was like for her. . .but. . .What was it like when you first told her?

Dylan: Yeah. . .It took her [months]. . . to really start putting stuff in motion and start accepting who I am. . . Her not like accepting that I am a boy. . .makes me stuck and then that makes me angry. . .It feels bad to say this, but I just really want her to get over it and, like, let me move on [becomes visibly angry]. . .It's been a while now. . .over a year since I've told them. . .

Therapist: So, you're like, "I have told you this is who I am. I am a boy. It is loud and clear. . .I want you to see me for who I am. . . And you're not getting that."

Here, the therapist aims to deepen emotion around Dylan not feeling accepted. This also serves to clarify the complexities of Dylan's attachment narrative. For Dylan, Susan and Donna's ambivalence compromised his ability to depend on them for emotional protection.

Task III. Parent Alliance Building

Task III work may last several sessions for caregivers of TGD youth, particularly for those whose adolescents want to initiate gender-affirming medical care (e.g., HRT and puberty inhibitors). For Dylan's family, the therapist helped the caregivers focus on HRT. Initiating HRT can be a complex topic for caregivers. Many caregivers want to be supportive, but might have deep, unprocessed ambivalence. To address this, caregivers' underlying values and fears must be explored. Susan and Donna's ambivalence was rooted in worry about making a "mistake" with their son. They worried that letting Dylan start HRT might cause him to go through physical changes that would lead him to feel more isolated and "different" and, therefore, suicidal. Susan was also aware of her son becoming more "closed off" after he came out to her. She worried that this would continue.

Another source of ambivalence for Susan and Donna stemmed from feeling like they lost their daughter, and their guilt about having these feelings. Some of their "stuckness" about HRT came from not accepting that their daughter was now their son. Early in Task III, the therapist gave Susan "permission" to explore her feelings about her son's gender and coming out. At first, Susan and Donna were afraid to express their longing for their daughter out of fear of sounding unsupportive, but then spoke honestly. The therapist did not challenge Susan and Donna's perspectives. Instead, she punctuated how much they cared about their son and their worries about keeping him safe, helping these mothers recognize how layered their feelings were regarding their son's desire to start HRT. Once caregivers better understand their feelings associated with their adolescent's identity, they can be encouraged to consider how their behavior might impact their TGD adolescent. This next segment illustrates the therapist's use of validation and challenge to help Susan and Donna recognize how fear was getting in the way of their capacity to be a resource for him. This conversation started by revisiting the time when Susan and Donna took Dylan to a gender-affirming care center, got "cold feet." For Dylan, this was a primary

attachment failure that undermined trust. Susan had a different experience of this incident. She described feeling "rushed" by her son's medical providers. She wanted to know more about the assessments, procedures, and plans that would be put in place to support her son in receiving HRT. Worried that these providers would move forward "too quickly," she questioned whether moving forward was in the best interest of her son.

Susan: Well…they brought him in [to the gender affirming care center] and expected him to start that day. They didn't…ask him or us questions. It just seemed too fast.

Therapist: Yes…It all seemed fast when you went to talk about him starting…now we understand better what was happening…It brought up all that fear we talked about…Is that right? [Donna: We wanted to make sure…]. Yeah, you were so worried about him growing up and being sad or upset that you let this happen… I also think it is important for you to know that, when these evaluations about identity are conducted, the strength of the adolescent's identity is a huge part of what they talk about…in other words, the evaluators put a lot of stock in the young person's report of how they feel and how they see themselves and their gender. Then, once they know that the young person has a strong sense of their identity, they start to assess what supports are available if the person were to start HRT or another gender affirming treatment…So, as far as figuring out Dylan's identity…..it is really up to what Dylan says…

Donna: With all the physiology and the side effects and all that would be happening…..we wanted to know all that before we start…like with his meds…

Susan: I don't know. I don't…I mean if that is gonna make him feel better as a person and as a human in his mind, okay, I'll do it. But at the same time, I'm like, "Uh, he's not ready for that…" It's like I don't know what to do, so I'm gonna do nothing at all.

Therapist: And I hear again. "I'm doing something that he's gonna regret. And what does that say about me as a parent?" Yeah? [Susan: Mm-hmm]…We know where this fear comes from…you want to support your son, but you don't want to feel like you made a mistake.

Susan: There was one transgender adolescent we knew…they had the surgery, came out and, then tried to commit suicide.

Therapist: I know your lives were thrown off course by this suicide attempt. It made you question everything. I know you are ambivalent about Dylan starting T. I want to help you expand your thoughts on both sides of your ambivalence. My job is to help you become more aware of these feelings, so you can be better prepared to make choices. Also, from my perspective, I can help…you know…I talk to a lot of trans kids and…I hear some of the same themes over and over again. For the kids that want to start [HRT]…They talk about how it is painful to look in the mirror and feel like your body does not match you…that you just are not *you*. I am not trans myself, so I can't speak fully to this…but…as I understand…it is a feeling that things don't match…don't feel right and it is profoundly…profoundly distressing, and excruciating…Also, to be transparent, I do have my own beliefs…Can I share that with you? [Susan and Donna nod]…In situations like this, we

have to think about what causes what here. . .that is, in terms of feeling bad and wanting to die. Sometimes it may look like feeling suicidal comes from the challenges of being trans in a very cisnormative world. Many times, the painful or distressing feelings. . .are because you are in this body that doesn't fit for you and the world doesn't see how you are. . .

At this point, the therapist has started to empathically challenge Susan and Donna's viewpoint. She helps reframe their thinking on suicidality and gender identity. The therapist is using information and language gained from the youth in Task II to present new information to the caregivers. Without breaking confidentiality, she attempts to promote empathy and perspective taking by speaking about general themes experienced by many TGD youth. In this next segment, the therapist takes on more of an advocate role by presenting a new frame to Susan and Donna. For caregivers of TGD who are less receptive, helping them to sort through the pros and cons of their parenting decisions might be preferable. For Susan and Donna, already LGBTQ+ advocates, the therapist's direct approach seemed to resonate.

Therapist: . . .This is a lot to think about . . .when it comes to mental health, how you identify and see yourself. . .contributes to what you're feeling inside and vice versa. So let's think about this together. . .what if you hold off on this [starting HRT]. Will he continue to struggle?

Donna: I know. . .It'd be detrimental to him to not go on with this. . .I worry about that.

Susan: I do, too. That's right. . .I read up on other parents of trans youth and what they had to say. And they say that their children felt so much better after they started hormone therapy. . .

In the remaining Task III sessions, Susan and Donna's early experiences of invalidation and rejection were explored. Donna specifically discussed her history of having to hide her own sexual orientation out of fear of rejection from her father. Both mothers recognized that, without intending to, they were not fully listening to their son's experiences. At this point, Susan and Donna's anxiety had decreased and they were ready to (1) consider talking more openly and directly with Dylan about HRT and (2) explore emotion coaching methods to prepare for Task IV. Dylan's father also attended a Task III session to discuss the impact of his current stressors on his son's experience but was difficult to engage in the treatment process.

Task IV. Attachment Task

The goal of Task IV is to promote a corrective attachment experience within the family. The process of this task might be the same for both TGD and cisgender youth, but the sequencing of content may look different. For Dylan, Susan and Donna's response to his desire to start HRT exacerbated attachment traumas (i.e., feeling abandoned) originating much earlier. To initiate Task IV sessions, Dylan needed to feel empowered to be honest with his caregivers. Before talking to his mothers about feeling unaccepted by them and his desire to transition, first he was encouraged to talk about why it was difficult to be honest with them.

Therapist: There are big issues that we need to get to but I wanted to start by focusing on some of the things that keep you from opening up with your moms. Can we talk about that first?

Dylan: [Nods] A while ago, when you were using [drugs] I felt like I couldn't trust you.

Susan: What do you mean you couldn't trust us?

Dylan: Like, it was hard to trust you guys because you were putting drugs over me.

Susan: That's how you felt?

Therapist: I'm wondering if you could maybe ask your son about what that was like for him?

The therapist coached Susan to ask more about her son's experiences rather than focus on her own response. This method of listening was discussed during Task III. The therapist interjects here because Susan looked like she needed help knowing what to say next.

Donna: What was that like?

Dylan: I don't know, just. . .It seemed like drugs came first over me.

Therapist: *(Turns to Dylan) You are doing great. I think that there's a lot to say here maybe if you could give specific times when you felt that way, we could get a better understanding.*

Dylan: I remember. . .when you guys were in the basement. . .when it was the party. . .

Donna: Halloween party? Okay, and we were smoking marijuana down there, right?

Therapist: Can you ask a little about what that felt like?

Donna: Yeah, what did it feel like?

Dylan: I felt like you were making me go away. . .shoving me away. . .

Donna: Shoving you away, shooshing you to go away in your own house?

Dylan: Yeah. It was probably strange because—[Donna: That's your house.]

Dylan: Yeah! You're my parents.

Donna: Yeah, you're right. Nobody should be shooshing you away from your own home. You're absolutely right and I am sorry for that. [Dylan: It's okay.]

Therapist: So before we get to apologies. . .[Donna] I heard anger in your voice.

Donna: Yeah, because I lived like that with my dad. He shoved me away a lot. . .And I don't want you to ever feel that. Ever again.

Therapist: So I see how you used your own experiences to connect to your son here—I think we need to understand how Dylan felt. Can you ask him more about his feelings at the time?

Here the therapist redirects the family away from apologies. If apologies from caregivers occur too soon in the Task IV process, youth can leave feeling unheard and the potential for a corrective attachment experience is lost. In this last segment, the therapist picked up on Donna's expression of anger. Donna used her own intergenerational attachment experiences, explored in Task III, to help her connect to her son's emotion. Primed to think about this connection, she affirmatively responded to her son's anger. The therapist's extensive work in Task II with Dylan in expressing his assertive anger also aided the processing of him expressing anger in Task IV. These kinds of conversations continued for several

sessions. After Dylan was able to talk about why he couldn't come to his mothers, the conversations then began to turn to exploration of Dylan feeling unaccepted. Beginning to experience Susan and Donna as supportive and empathic, Dylan began to assert himself more. As Susan and Donna experienced Dylan as assertive, they became less fearful he was keeping secrets and felt more confident in supporting his HRT. Equipped with new ways of interacting, the family was prepared for Task V.

Task V. Promoting Autonomy

In Task V, the focus of therapy shifts from repairing the adolescent–caregiver relationship to navigating the youth's future and autonomy. Sessions centered around (1) evaluating options for further affirmative treatments, (2) managing bullying, (3) accessing social resources at school, and (4) identifying psychiatry services that would understand and support physical transition. In the segment below, Dylan revisits a Task IV topic and speaks with Susan and Donna about the impact of his dysphoria. Susan and Donna tolerate their son's distress and encourage him to share his experiences with minimal assistance from the therapist.

Therapist: So, I'm gonna turn the conversation over to your mom. . .

Donna: Well, you know, you've started the testosterone. . .but I know that you struggle with your dysphoria. And, we wanna know where you're at with it.

Dylan: It's not going to change anything. . .it's uncomfortable to go outside with, uh, this [references chest]. . .no matter what I wear, I can always, like, it's always there. That's difficult.

Susan: Yeah, that's tough. I mean, I can only imagine. . .what it's like. . .So, how are you dealing with it? It sucks. . .And let me bring up the topic that was brought up at S. [another mental health program]. . .You felt like maybe people were saying stuff to you at school. . .

Dylan: So, they called me a girl. . .I said, "boy.". . . And, they started laughing at me. Like, you're a boy? What? I was like, mm, yep. . .You see my chest binding. . .through the shirt I wear. It's, like, just uncomfortable. They were talking bad about trans women on the bus today. . .They were like, it's like the chucky doll that doesn't have any parts. . .And other names.

Donna: Were they saying it with you sitting there?

Dylan: I was right across from them. . .They looked over at me three times. But, it's not like they were talking about me. I'm not a trans woman.

Therapist: . . .You can't, underestimate the fact that when the three of us *(references Susan, Donna, and therapist, herself) look in the mirror, our bodies reflect how we identify. And, for Dylan, that's not the case. When you look in the mirror, what do you see? What does that feel like. . .can you tell your mothers?*

In the segment above, the therapist directs mothers to consider how their son's struggles might differ from their own. The therapist wants Susan and Donna to understand the impact of dysphoria and recognize their limitations in understanding his distress. Caregiver disclosures are encouraged during Task IV and Task V to facilitate perspective taking. For caregivers, these often include "owning" their cisnormative biases or blind spots. With this acknowledgement, caregivers can better attune to the needs of their TGD adolescent.

DISCUSSION

By the end of treatment, Dylan and his mothers reported better communication and an increased ability to problem-solve. While BDI-II scores vacillated throughout treatment, suicidal ideation dropped from a severe to low ranges directly after ABFT initiation (initial Task II and Task III meetings, before Task I). SIQ-JR scores remained in low ranges for the duration of treatment. Alliance and treatment credibility scores remained high over the 24 weeks for both Dylan and Susan. Unfortunately, these measures were not collected for Donna or Dylan's father. There were also substantial decreases in Dylan's reported attachment insecurity with Susan and his father. Changes in these scores across treatment can be seen in Figure 1. At the end of ABFT, Dylan remained in treatment; however, his suicidality had diminished enough so the family could monitor safety without inhibiting his autonomy. Caregivers still had anxiety about their son's transition, but were taking Dylan to receive HRT. Caregivers were also able to provide more support and empathy for Dylan with regard to his gender dysphoria and peer relationships. By end of therapy, Dylan joined a leadership program in the LGBTQ+ youth center, was engaging in new romantic relationships, and had started his first year of high school. Unsurprisingly, these activities supported his treatment gains as peer relationships are associated with youth suicidality (King & Merchant, 2008) and depression (Platt et al., 2013). Though we cannot generalize these results of this case study for other TGD youth and their families, these findings provide preliminary support for a modified version of ABFT for this population.

This case study revealed both strengths and limitations associated with using ABFT and other family treatments for TGD youth presenting with STB. This family approach proved to support high levels of caregiver engagement; however, the needs of TGD with STB are complex. The ability to engage caregivers, as supports, enables youth to negotiate physical, social, and/or legal transition as well as anxiety relating to engaging with potentially stigmatizing social systems (e.g., schools and hospitals). Further, for younger adolescents, like Dylan, caregivers can more effectively address barriers (e.g., insurance coverage, provider access, and financial) to obtaining gender-affirming care. Family engagement also represents a significant limitation of family treatment approaches for TGD youth. Caregivers, who are completely rejecting toward their child, may not be able to be engaged using the adaptations discussed in this case study. In other words, the interventions described here may not be generalizable to caregivers who are rejecting or for those who are not aware of their child's TGD identity.

In sum, the case presented demonstrates a successful course of ABFT with a TGD adolescent and his family. This case study has reflected some of the needs of TGD youth at risk for suicide, the benefits of implementing a family treatment with this population, and recommendations for adapting an evidence-based suicide approach. While Dylan and his family responded well to ABFT, some TGD youth and their families will not respond to treatment in the same way. For cases in which ABFT or other family-centered approaches do not go as expected, it is recommended that the therapist scales back treatment to working with subsystems. Working longer individually with caregivers, focusing on psychoeducation, and processing perceived loss or defensiveness is often enough to prepare family members for therapy together. While this paper provides an overview of our efforts to modify ABFT for the needs of TGD youth experiencing suicidality, future research and clinical implementation is needed to strengthen this approach with TGD youth at risk for STB.

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