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Feminist therapy emphasizes empowerment through an egalitarian therapeutic relationship and collaborative approach of understanding symptoms and treatment. Feminist therapy can be used with all types of clients, including those with severe mental illness (SMI) as well as complex posttraumatic stress disorder (complex PTSD) which refers to the unique presentation of those who have experienced chronic developmental trauma (Herman, 1992). This case example focuses on a feminist therapist's work with a young woman who has both SMI and complex PTSD, resulting in struggles across several domains. Feminist therapeutic interventions of developing an egalitarian relationship, exploration of intersectional multicultural dynamics, building empowerment, supporting community engagement, and implementing relational boundaries were utilized in her treatment demonstrating the applicability of feminist therapy when treating clients with SMI and complex PTSD.

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FEMINIST THERAPY WITH SEVERE MENTAL ILLNESS AND COMPLEX TRAUMA:

A CASE EXAMPLE

A DOCTORAL PAPER

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Abstract

Feminist therapy emphasizes empowerment through an egalitarian therapeutic relationship and collaborative approach of understanding symptoms and treatment. Feminist therapy can be used with all types of clients, including those with severe mental illness (SMI) as well as complex posttraumatic stress disorder (complex PTSD) which refers to the unique presentation of those who have experienced chronic developmental trauma (Herman, 1992). This case example focuses on a feminist therapist's work with a young woman who has both SMI and complex PTSD, resulting in struggles across several domains. Feminist therapeutic interventions of developing an egalitarian relationship, exploration of intersectional multicultural dynamics, building empowerment, supporting community engagement, and implementing relational boundaries were utilized in her treatment demonstrating the applicability of feminist therapy when treating clients with SMI and complex PTSD.

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Feminist Therapy with Severe Mental Illness and Complex Trauma: A Case Example

While there is a body of literature on feminist theory and feminist interventions with clinical examples, the literature applying feminist therapy principles to clinical populations with SMI is currently limited. Further, the literature on complex trauma is growing, yet to be fully recognized as a unique presentation, as it is still not listed as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) published by the American Psychiatric Association (2013). Drawing on the few articles that do explore the ways that feminist therapy can be utilized with individuals who have SMI and trauma histories, this case study aims to add evidence of feminist clinical practice with a woman who has both SMI and complex trauma to this canon. Individuals with SMI and trauma are marginalized on a societal level, and this extends to the field of psychology as well. This case study will center the experiences of Sasha, a young woman with SMI and complex trauma, and her therapeutic work with myself as her feminist therapist.

Literature Review

Adults who have severe mental illness (SMI) are significantly more likely to have a history of interpersonal trauma and posttraumatic stress disorder (PTSD) than the general population according to a meta-analysis that presented literature from the United States and several European countries (Mauritz, Goossens, Draijer, & van Achterberg, 2013). The presence of a trauma-related disorder can negatively impact the course of SMI (Friedl & Draijer, 2000; Muser, Rosenberg, Goodman & Trumbetta, 2002; Mueser, Salyers, Rosenberg, Goodman, Essock, & Osher, 2004). Feminist theoretical frameworks and feminist therapy interventions can be utilized to inform treatment of individuals who experience the comorbidity of SMI and complex PTSD.

Severe Mental Illness

Researchers conducted a study comparing several definitions of SMI and found that the National Institute of Mental Health (NIMH) had the optimal definition (Schinnar, Rothbard, & Kanter, 1990). NIMH defined SMI as a diagnosis of non-organic psychosis or personality disorder, long-term duration and treatment, and disability in at least three of eight criteria. Criteria included social behavior demanding mental health intervention, limited ability to obtain assistance, impaired activities of daily living, impaired social functioning, impaired performance in employment, vulnerability to stress, and disability that causes dependency (Mauritz et al., 2013). Diagnoses commonly included under the umbrella of SMI include schizophrenia, schizoaffective disorder, bipolar disorder, and personality disorders (Mauritz et al., 2013).

Complex Posttraumatic Stress Disorder

The diagnosis of PTSD does not adequately describe the presentation of individuals who have experienced prolonged and repeated trauma, more fully described by a separate diagnosis termed “complex PTSD” by Judith Herman (1992, p. 121). She identified seven areas of impairment which include altered affect regulation, consciousness, self-perception, perception of the perpetrator, relations with others, and systems of meaning (Herman, 1992). People with histories of child abuse are particularly susceptible to developing complex PTSD. This is due to the disruption of early attachment relationships that interrupt identity formation and cause problematic interpersonal dynamics (Herman, 1992). Alan Sroufe conducted a study and found that the essential predictor of coping resources was the security of the relationship established with the primary caregiver in the first two years (Sroufe, 2005), indicating that early child abuse will have a particularly devastating impact on later development (van der Kolk, 2014). Trickett, Noll, and Putnam (2011) conducted a longitudinal study over the course of more than twenty

years specifically examining females who had been sexual abused. The researchers identified effects of cognitive deficits, depression, dissociative symptoms, troubled sexual development, and self-mutilation. These symptoms are consistent with complex PTSD criteria.

Auditory Hallucinations in SMI and PTSD

An article written by Simon McCarthy-Jones and Eleanor Longden (2015) examined the similarities in the nature of auditory verbal hallucinations in schizophrenia and PTSD, further elucidating the relationship between these diagnoses. They conducted a phenomenological comparison of various characteristics of auditory hallucinations and many similarities in symptomology were found between people with PTSD and schizophrenia (McCarthy-Jones & Longden, 2015). The voices heard by participants from both groups were unpleasant, issued commands, were realistic, additional garbled voices were present, and voices used “you” as the form of address when speaking to the client (McCarthy-Jones & Longden, 2015). There is evidence that trauma, particularly child abuse, is common in people with schizophrenia who have auditory hallucinations (Read, Agar, Argyle, & Aderhold, 2003; McCarthy-Jones, 2011; Scheffield, Williams, Blackford, & Heckers, 2013). Auditory verbal hallucinations in both PTSD and schizophrenia tend to have themes that indirectly relate to the trauma, rather than take the form of re-experiencing (McCarthy-Jones & Longden, 2015). Miles, Huberman, and Saldana conducted a study and found that there is often a disruptive thematic match between the content of voices and personal goals of the hearer (2014). For example, one subject’s personal goal was “being a confident and competent person” and they heard a voice saying, “you will never be good at anything,” (as cited in McCarthy-Jones & Longden, 2015, p. 7). These findings have important therapeutic implications. McCarthy-Jones and Longden (2015) asserted that “changing people’s current beliefs and perspectives on themselves in relation to the trauma may both alter

the memories they construct and the ability of voices to arise from these,” (p. 7). It is beneficial to target the complex trauma domain of self-perception and the PTSD symptom of exaggerated negative beliefs about self or others per the criteria in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM-5*; American Psychiatric Association, 2013), particularly when treating someone with trauma-based auditory hallucinations (McCarthy-Jones & Longden, 2015).

Feminist Theory in Clinical Practice

Empowerment. All concepts and interventions discussed thus far have the common purpose of empowerment. Brown stated, “feminist therapy has as its superordinate goal the empowerment of clients,” (1994, p.124). Empowerment can occur on a variety of levels, including the intrapersonal, interpersonal, community, and sociopolitical. Brown asserted that “how empowerment is experienced and nurtured in feminist therapy will vary dramatically from person to person, and even from therapy session to therapy session,” (Brown, 2010, p.37) demonstrating the flexibility in employing feminist therapy techniques and the importance of adapting to the client’s needs. Clients may experience internalized oppression, meaning that they may ascribe to dominant cultural narratives about how to enact their identities. This could be countered with personal empowerment by fostering self-esteem and self-affirmation, positive daily functioning, personal efficacy beliefs, engagement in self-nurturance, access to problem-solving skills, and ability to access community resources. This model “emphasizes personal competence rather than symptom removal,” (Enns, 2004, p.40). Feminist therapy aims to develop empowerment through several central strategies, which include an egalitarian therapeutic relationship, understanding symptoms as communication, and consideration of multiple social identities.

Egalitarian relationship. Laura Brown's (1994) Subversive Dialogues is a canonical book on feminist theory in clinical practice that explores the tenets of feminist case conceptualization and clinical treatment. An egalitarian relationship is a central component of feminist therapy, and Brown carefully differentiated an egalitarian relationship from an equal relationship (1994). The value and respect between participants in the therapeutic process is equal, with an understanding that the exchange moves towards equality by empowering the client and intentionally defining the responsibilities of the more powerful therapist (Brown, 1994). Within the egalitarian therapeutic relationship, the role of the therapist is to support the client in coming to "value her own needs as central and authoritative" (Brown, 1994, p. 104).

Brown explained that one task of the feminist therapist is to learn their client's 'mother tongue' referring to the way they label and explain their struggles in order to uncover the strengths within distress and support the client in renaming and retelling their own narrative in a way that empowers and liberates (Brown, 1994). This process centers the client's knowledge of their own experience. With the "assumption that clients are competent," (Enns, 2004, p.21) collaboration with clients on treatment goals as well as assessment outcomes allows the client to more fully engage with the therapeutic process in an egalitarian manner.

Symptoms as communication. Symptoms are understood as communication rather than pathology (Brown, 1994; Enns, 2004), as symptoms are approached first from the client's perspective, then as a way to understand relational processes (Brown, 1994). Symptoms are also considered in context of precursory internal processes as well as the function of the behavior (Brown, 1994). The therapist must ask questions that place "the symptom within the social and political framework that has informed both its inception and its development," (Brown, 1994, p. 158). These questions include asking about the ways power and powerlessness have impacted

this particular presentation of distress as well as considering how a patriarchal cultural and societal context may have shaped it. Brown gave the example of a client who has a highly dichotomized approach to defining the world around them, and how this may have developed as a result of a traumatic history where it is more functional for them to define a situation as being either dangerous or not rather than attending to a more abstract spectrum of safety (Brown, 1994). The symptom of 'black and white' thinking is thus viewed as a survival strategy that allowed the client to interpret level of safety efficiently, with an understanding of a background of traumatic life experiences where disempowerment was enforced. Enns (2004) explained feminist therapists consider that "coping behaviors that were functional or had survival value at one life stage may become less successful over time and contribute to the person's distress," (p.13).

Brown described diagnosis not as a mere description of symptoms and distress, but rather as a place for therapist and client to begin to understand a larger story (Brown, 1994). Diagnostic thinking is valued over the diagnosis itself, in which therapist and client work together to understand the quality, significance, and roots of the client's distress (Brown, 1994). This creates an understanding of how the client's journey through life has been shaped by structures of power so that both "inter- and intrapersonal power becomes a reality for the client," (Brown, 1994, p. 154). Ultimately, the feminist therapist must collaborate with the client in their journey towards gaining self-knowledge, which will then move the client towards action in the face of oppression (Brown, 1994). In order to accomplish this goal, it is necessary to examine the multiple intersecting identities of both client and therapist as well as consider the social location of the therapeutic relationship.

Intersectionality and social location. Intersectionality is the concept that social identities are intricately related, and that each individual's experiences are shaped by multiple identities which interact in a dynamic way within their societal and cultural contexts. This idea originated in black feminism in the 19th century, and Kimberly Crenshaw coined the term 'intersectionality' in 1989 (Crenshaw, 1989; Warner & Shields, 2018). Intersectionality is essential to deconstructing the notion that there is a monolithic experience of being a woman. It combats "feminist hierarchy, hegemony, and exclusivity," (Nash, 2008, p.2) and brings to the forefront other social identities that shape identity such as race, class, sexual orientation, ability status, documentation, nationality. Warner & Shields (2018) argued for intersectionality as a framework for feminist psychology, asserting that "social identities cannot be studied independently of one another, nor separately from the processes that maintain inequality," (p. 6) and that "experienced identity both reflects and embodies the operation of societal position and privilege," (p. 6). Intersectionality allows for a multi-axial and complex understanding of identity where gender is not the primary identity status, but rather viewed in relation to other identities and how various roles shape social location and experience.

The concept of intersectionality is central to feminist clinical practice, informing conceptualization and interventions. Feminist therapists explore the "narrative and meaning of clients' multiple identities," paying particular attention to the ways in which certain identities become more salient within specific situations (Enns, 2004, p. 293). Identity statuses are not static, but rather "situational and cultural context can make individual identities more or less salient at any given moment," (Warner & Shields, 2018, p. 20). The unique intersection of a given individual's identities will inform their understanding of power dynamics, and how they experience privilege and oppression. A strategy of feminist therapy is social identity analysis,

where the therapist explores with the client which aspects of identity the client view as important or unimportant, with an understanding that the client occupies multiple social locations and identities may be situational and variable (Enns, 2004, p. 294).

The feminist therapist not only considers the intersectional identities of the client, but also examines their own identities and how they inform the therapeutic relationship. Enns discussed the importance of the feminist therapist disclosing personal values pertinent to the therapeutic process, to create the space to openly discuss differences in opinion and/or experience (Enns, 2004, p. 20). Process-oriented discussion about the salient identities of both client and therapist can play an instrumental role in feminist clinical work (Brown, 2010), as it allows for open exploration of intersectional identities and how they may shape the social location of the therapeutic relationship itself.

Treatment of SMI with Feminist Therapy

Although feminist therapy is theoretically applicable to all clients, applying a feminist theoretical framework to the treatment of individuals with SMI is less common. However, it is not unheard of as there have been a few articles published on this topic. The intersection of serious mental illness and sexual objectification is examined in one article, where multicultural feminist theory is utilized to inform therapy recommendations (Carr, Green, & Ponce, 2015). Eastwood (2012) presented a case study demonstrating the utility of feminist perspectives in art therapy in an inpatient setting. Further, there are articles discussing the treatment of people with SMI that include the same ideas and principles touted by feminist therapy that do not label it as such. Authors of one article discussed the ways in which serious mental illness intersects with other social identities such as gender, socioeconomic status, and immigration status and promotes a recovery-oriented approach to treatment that prioritizes community inclusion, which

in turn decreases external and internal stigma (Jansen, McCammon, & Carr, 2014). The author of another article examined ways to modify treatment for women with SMI and trauma histories includes many areas of focus consistent with feminist therapy such as empowerment and gender identity development (Harris, 1994). Feminist therapy can be a useful framework to use in the treatment of individuals with comorbid SMI and trauma histories.

Carr, Green, and Ponce (2017) used a multicultural feminist theoretical framework to examine the intersecting experiences of SMI symptoms and sexual objectification among women. Sexual objectification includes sexual abuse as an extreme form of objectification, and authors discussed how its various forms can impact several domains of symptoms (Carr et al., 2017). They proposed that women who experience high levels of sexual objectification develop subsequent symptoms of self-objectification including body shame, depression, and less internal awareness. They argued that women with this presentation may have internalized a self-perception as an object (rather than as a subject) spurring confusion as to how emotions should be experienced or demonstrated (Carr et al., 2017). Interpersonal ineffectiveness is a common struggle among people with SMI, and this may be particularly prevalent in women with comorbid sexual trauma as they could demonstrate additional difficulties with trust, self-assertion, or intimacy (Carr et al., 2017). The lines between hypervigilance and paranoia may also become blurred in presentation among this population (Carr et al., 2017) and further complicated by additional identity factors such as race or immigration status. Sexual abuse has been shown to be specifically related to hallucinations, providing additional evidence of how symptoms of SMI and sexual objectification are related in women with these intersecting experiences (Carr et al., 2017; Kilcommons & Morrison, 2005).

Carr et al. (2017) put forth several feminist therapy interventions for working with this population. Development of an egalitarian relationship is essential, where collaboration with the client is centralized and clients are regarded as being experts on themselves with their own important knowledge of coping and survival strategies (Carr et al., 2017). Egalitarianism is particularly critical when clients are coping with intersecting areas of discrimination such as sexism, mental health stigma, classism, xenophobia, and other forms of oppression. Thus, multicultural competence is an important facet of treatment. Both client and therapist cultural backgrounds are explicitly considered and explored in how they may shape behavior and the therapeutic relationship (Carr et al., 2017). Empowerment strategies are also an important component of treatment. It is the feminist therapist's role to support and facilitate the development of the client's self-esteem, personal efficacy, self-nurturance, and problem-solving, as well as their ability to use community resources and advocate for environmental change on micro and macro (Carr et al., 2017). By focusing on environmental change in therapy, clients can develop insight into the ways that issues in the environment impact their own functioning (Carr et al., 2017). Feminist therapy that focuses on building healthy relationships and supporting the client's goals will allow for and reinforce empowered self-narratives, as well as support community engagement (Carr et al., 2017). Finally, therapeutic interventions focused on boundary setting can inform and build empowerment. These skills can be practiced both within and outside of the therapeutic relationship (Carr et al., 2017). In conclusion, there are many important ways that feminist therapeutic interventions can inform treatment of women with SMI and trauma histories.

The case example presented by Eastwood (2012) touched on similar themes in feminist therapy such as egalitarianism, empowerment, and recognizing the personal as political in the

context of art therapy in an inpatient group for women with borderline personality disorder. Viewing the client as an insightful contributor to the therapeutic process while recognizing the inequality inherent in the therapeutic relationship is applicable to clients who have SMI. Eastwood (2012) highlighted the importance of attention to power dynamics when using a feminist approach, stating the therapist's role is in "the nurturing of an ongoing process of uncovering disempowerment and developing strategies towards empowerment," (p. 100). This may include confronting oppression experienced by the client, including internalized oppression. Eastwood (2012) explained that internalized oppression "creates distorted images of the self while the repeated oppressive and biased voice of the oppressor becomes mistaken for the voice of the self," (p. 109). This could include internalized sexism and objectification, as well as internalized mental health stigma.

Jansen et al. (2014) found that individuals with SMI may struggle with symptoms of their mental health condition as much as they do with stigma and discrimination due to varying marginalized social identities such as mental health status, gender, or immigration status. Jansen et al. (2014) discussed the ways in which these intersecting social identities contribute to community exclusion as individuals with SMI are frequently denied access to equal employment opportunities, avenues for social engagement, and ability to be fully integrated members of society thus making experiences of isolation, loneliness, and lack of social connection common among this population. Although not labeled as such, this conceptualization encapsulates values of feminist therapy in considering social location. Jansen et al. (2014) recommended addressing these concerns by utilizing interventions that assist in increasing social connectedness. The therapist might facilitate connecting the client to supported employment and vocational rehabilitation services, as well as provide family psychoeducation to enhance social support at

home (Jansen et al., 2014). Recovery and rehabilitation models are helpful as they allow for a paradigm shift from symptom reduction to helping people build competency and social connection (Jansen et al., 2014).

Harris (1994) wrote an article that recommended trauma-informed modifications to treatment for women with comorbid SMI and sexual trauma history, which were consistent with feminist therapy ideas as well. Therapeutic interventions focused on supporting and building social support networks were deemed essential, as was the ability of clients to choose who they do not want contact with in their social networks in order to establish safety and empowerment (Harris, 1994). Discussions in therapy around female identity in terms of cultural and societal stereotypes can be useful in helping women understand how these expectations influence their behaviors (Harris, 1994). Therapy should be a space where sexuality is discussed openly. Women with SMI and sexual trauma may need support in learning how to assert boundaries with others, as well as require support in becoming aware of what their own nonverbal behaviors communicate (Harris, 1994). Self-soothing strategies that emphasize grounding and regaining a sense of self are fundamental to therapy with this population as well, as this is crucial to women being able to live successfully and independently in their communities (Harris, 1994).

The treatment of comorbid severe mental illness and complex trauma requires consideration of many facets, and feminist therapy offers a uniquely holistic clinical framework when working with this population. Feminist therapy tenets of empowerment, an egalitarian relationship, symptoms as communication, and consideration of intersectionality are applicable with additional emphasis on community engagement and social boundary setting when working with this comorbid presentation. The case of Sasha illustrates one course of treatment utilizing a

feminist theory approach to her psychotherapeutic treatment targeting symptoms of severe mental illness and complex trauma.

Case Background

Presenting Psychological Problems

Sasha, a white female, was 19 years old when she began attending therapy at a university-based mental health training clinic in the Rocky Mountain region. She had just moved back in with her parents, and her mother referred her to the clinic. Sasha began therapeutic services in June 2016. She was internally referred to a sub-clinic specializing in severe and persistent mental illness.

She was struggling with significant mental health symptoms, including auditory hallucinations of varying intensity, paranoia, significant social anxiety, lack of social boundaries, cognitive disorganization, comprehension difficulties, extreme difficulty with self-regulation of affect, low self-esteem, problematic coping behaviors, and periodic manic episodes.

Psychosocial History and Previous Psychological Services

Sasha was born in Russia, and likely severely abused and neglected prior to her adoption at the age of four. Sasha's adoptive mother reported information that was provided to her by the orphanage in Russia, including that her birth mother grappled with alcohol dependence and likely drank alcohol during pregnancy. Fetal Alcohol Syndrome has been suggested to client by several previous mental health professionals. Health records provided by the orphanage show that she was infected with syphilis at one year of age and that her birth mother did not have syphilis at this time. Medical records indicate that her birth mother suggested that Sasha was infected by her babysitter, who reportedly slept in the same bed. As a child, Sasha exhibited compulsive masturbation. Her initial psychotic symptoms were sexually graphic in nature and

included sexualizing other young girls. Taken together, it is likely that she suffered extensive sexual abuse at a very young age. She moved to the orphanage in Russia at age three and has memories of another little boy bullying her. She recalls that the caregivers there were very strict, and she often got in trouble.

Sasha was adopted by her mother when she was four years old and brought to live with her in the Rocky Mountain region of the United States. Her mother is a white American woman and citizen of the United States. Sasha is extremely attached to her mother and depends on her for emotional and behavioral support. A few years after the adoption, her mother got married. It took a very long time for Sasha to become accustomed to her new father, and their relationship continues to be characterized by distance and occasional conflict. She has said that this is most likely because older men in general scare her due to trauma from Russia. Sasha is particularly frightened of older men who are fat, balding, and have glasses. Seeing anyone who fits this description continues to trigger Sasha significantly as she responds with anxiety and fear, and if she sees someone like this she will actively avoid them.

While in elementary school, Sasha had behavioral issues and was diagnosed with ADHD. In the fifth grade she got in trouble for throwing crayons out of the window and continuing to do so when the teacher told her to stop. Psychotic symptoms began at age 11 when she was in middle school. She experienced command hallucinations that told her to cut herself and hurt others. Sasha stated that she was watching a lot of violent and sexual anime at this time, and was involved in satanic worship all of which she accessed on the internet. She stated that she also used to steal alcohol from her parents and bring bottles to school. She would smoke cigarettes or rolled up loose leaf paper. She was hospitalized for the first time after cutting herself over 30 times and carving “666” into her arm while at school.

As a result of psychotic symptoms and self-harm behaviors, Sasha was admitted to various residential treatment centers. She stated that in some ways this was even more traumatizing because she witnessed many fistfights between the other kids in these centers. At one point, she got caught in the middle of a fight and her front tooth was knocked out. Sasha continues to be fearful of large groups of teenagers, and has reported feeling particularly afraid of Latino and Black adolescents.

Attending a therapeutic high school in Utah provided a highly structured environment which benefitted Sasha's mental health stability. A behavioral contract was developed at the school for Sasha, and she continues to use a version of this to guide her behavior now. At times she stated she feels that when she does not follow the contract, her symptoms get much worse. At other times, Sasha expressed feeling that her contract actually has a negative impact and caused increased anxiety.

Following graduation, she attended college for one year. Although she received significant support from academic tutors and her therapist there, living in the dorms heightened her anxiety. She had increased auditory hallucinations which included hearing someone screaming. She became friends with a male peer who helped her with her homework, and had sex with him for the first time. When he did not commit to be her boyfriend afterwards as she had anticipated, she became very distressed. She called her mother repeatedly and threw out her iPod speakers, and has since decided that she is done with "bad boys." It was recommended by the school that Sasha would do better in a certificate program rather than a four-year college due to her academic struggles. Sasha continues to maintain a friendship with Mary, a student she met while attending college. Sasha moved in with her parents and began a certificate program for early childhood education in fall 2016.

Course of Treatment

Sasha presented to therapy with this therapist on a weekly basis for two years, from spring 2016 until summer 2018. She attended therapy twice per week during the summer of 2017 to provide additional time to build social skills, and for a few months was attending therapy twice per week. During the first few months of therapy, she was accompanied to sessions by her mother who would sit in the waiting room during the therapy hour. Her mother would occasionally join in sessions. Consistent with feminist therapy principles, the initial goal of therapy was defined by Sasha. She identified self-regulation as the primary facet of her mental health she would like to improve as it would enhance her ability to be independent. Eventually, this therapist and Sasha agreed that one way to move towards this goal would be for her to attend sessions independently. Once she made the transition to attending sessions on her own, she always arrived at least 30 minutes early to session. She explained that she would become highly anxious if she did not arrive early.

In the beginning stages of developing the therapeutic relationship, Sasha was encouraged to collaborate on which approaches work for her and which do not. Initially, she had significant difficulty providing negative feedback to this therapist. However, with encouragement she was able to express feeling that interventions discussed in therapy need to be simplified in order for her to be able to comprehend and retain important information. She requested that information regarding different coping strategies be repeated and revisited to ensure that she learned and remembered them. As the therapeutic relationship developed and moved towards a more egalitarian dynamic over the first few months, she was able to provide feedback without hesitation and inform the therapist immediately when she felt that something was too complicated or difficult for her to understand.

Sasha struggled with auditory hallucinations and experienced several kinds of voices. Sasha was encouraged to describe voices in her own language, per feminist therapy models. The most pervasive and prevalent were voices that she called “bitchy voices,” which criticized her appearance, her actions, and told her that she will end up with a man who is “ugly” or “fat.” Through extensive conversation, Sasha and this therapist determined that these voices tend to arise when Sasha is feeling insecure or disappointed in herself. They also increased in intensity, volume, and frequency when she is in one of her “cycles” which is her language for a manic episode and frequently coincide with menstruation. Sasha also described hearing “mumbled voices,” which whispered nonsense rather than intelligible messages and she heard them “at the back of my head.” These voices sometimes did not bother her, but other times made her feel “confused.” Less frequently, she heard “fear voices” which told her that she is not a good person and that God is not taking care of her. She also occasionally heard “nervous and tight voices” which are more like a feeling than audible voices and cause her to “feel like I can’t make my own choices.” The most severe of her voices were “command voices” and only appeared when she was experiencing a significant increase in psychotic symptoms and told her to do things and sometimes manifested as urges rather than verbal commands. Command hallucinations varied in severity, ranging from a voice telling her to dump the crumbs she just swept up back onto the floor to telling her to jump in front of a car. Throughout treatment, Sasha maintained that she was always able to differentiate voices from reality, although the anxiety and confusion that often accompanied the voices could make it difficult for her to cope with them. Sasha’s coping skills for her voices primarily consisted of telling them to shut up and go away, which often worked well for her. Focusing on a task rather than the voices was also an effective coping

strategy, and she was often motivated to keep busy for this reason. Listening to music, taking a nap, going for a walk, and talking with someone were also helpful at times.

Sasha began attending a community college in Denver in fall 2016 to earn a certificate in early childhood education. During this time, social anxiety and appropriate social interaction were particularly prevalent and problematic. She tended to become extremely overwhelmed and anxious in social situations and become fixated on what others might be thinking of her and whether she appears to be “normal.” She described “verbal vomit,” a tendency to unload her mental health history and struggles with people that she does not know well. She also expressed loneliness and a deep desire to connect with others, but a lack of trust in her own ability to engage in social interaction appropriately and safely. We were able to discuss the ways in which this shows up within the therapeutic relationship, for example by exploring Sasha’s tendency to focus on things she has been doing well rather than the things she has been struggling with in order to present herself in a positive light. By discussing the utility of focusing on her problems while simultaneously providing positive feedback when she did talk about her struggles, this pattern was somewhat disrupted. We also discussed the ways that Sasha could practice appropriate social boundaries in therapy. Sasha requested that she be interrupted if she was speaking too rapidly or changing subjects in a confusing manner. She was very responsive to straightforward redirection, and occasionally was able to recognize these behaviors in herself independently.

Sasha had the language of an “inner circle” and an “outer circle” in her social network, and we built on this concept and helped her to more fully define what this meant for her at this time. Sasha identified that her “inner circle” included her mother, father, therapist, and one female friend, while the “outer circle” included everyone else. We role-played various

conversations with different people that she was interfacing with in her life, such as her boss or roommate, so that she gained practice in maintaining appropriate boundaries. Over the course of therapy and with practice, she was able to define what conversations are appropriate for her inner circle rather than her outer circle.

Sasha had conflict with her three roommates during the spring 2017 semester, where she felt excluded and believed that they were talking badly about her based on conversations she overheard in their apartment. She responded by throwing balls of paper at them and described feeling that she was unable to stop. Her roommates repeatedly asked her to stop and were upset with her after this incident. After the semester, she moved back into her parents' home. Initially, she planned to return to the apartments and have one roommate rather than three in hopes that this would be less overwhelming and more manageable.

Sasha often turned to daydreaming as a coping skill when feeling overwhelmed or lonely, what she termed "visualization." She created elaborate fantasies of her future, which often centered around a relationship with a "good Christian boy." She experienced intensely ambivalent emotions towards daydreaming, and throughout these conversations this therapist affirmed that it is a coping skill developed as a survival strategy, supporting Sasha in deciding what role she wants it to play in her life. Sasha was able to identify that when she becomes emotionally attached to the characters in her daydreams, that is the sign that she is spending too much time engaging in this activity. At one point while living in a university residence hall during the 2016-17 academic year, Sasha was daydreaming for six hours per day. Ongoing discussion of the importance of moderation supported Sasha to limiting her daydreaming to one to two hours per day, which she was able to more effectively maintain after moving back to her parents' home in summer 2017. She frequently became fixated on her appearance and

compulsively re-organized her closet and threw away clothes and make up when she felt anxious, and this was another area where moderation was encouraged and practiced. Sasha tended to view situations in extremes, which is consistent with her complex trauma presentation. The frequency and duration of these coping skills were greatly dependent on the level of distress she was experiencing in her mental health.

When Sasha first began receiving therapeutic services at the clinic, she received a referral from the clinic psychiatrist for a psychiatrist who specialized in SMI and developmental trauma. Sasha always understood the importance of medication for her mental health based on her own experiences of becoming drastically more stable after being prescribed effective antipsychotics medications following her first psychotic break. During the summer of 2017 the psychiatrist recommended a transition from Thorazine to a newer antipsychotic that would have fewer long-term side effects. Sasha was eager to transition to a new antipsychotic as she was very fearful of developing tardive dyskinesia, one of the side-effects cited by the psychiatrist as a reason to switch. When the dosage of Thorazine began to be decreased, Sasha experienced a significant increase in psychotic symptoms including auditory hallucinations, paranoia, and cognitive disorganization. Sasha and her parents decided that while this medication transition occurred, it would be best for her to live at home. She did so for the following year. She continued to take one class per semester, as well as volunteer at a preschool. In this way was able to maintain community engagement with support at home, school and work. Psychotic symptoms presented significant difficulty for Sasha, but her goal of self-regulation and independence continued to be the focus of therapy. This therapist and Sasha discussed her ability to make decisions about which coping skill would work best for her depending on what was going on in the moment, supporting internalization of choice and personal empowerment in the midst of overwhelming

distress. Independence was conceptualized as taking responsibility for herself in identifying when she needed to ask for support and help, further reinforcing empowerment as well as connection to her social support network.

Case Conceptualization

Sasha's social location throughout her development including neglect and sexual abuse in early childhood, international adoption, and early psychotic break with ensuing treatment experiences shaped her presentation as a young adult. Sasha's lack of stable attachment figures early in life resulted in impairment in self-regulation and social functioning. This later manifested as a lack of social boundaries, daydreaming about imaginary relationships, and a tendency to think and act in extremes (black and white thinking, engaging in certain activities excessively). These symptoms are best understood as survival strategies developed as a result of complex trauma, with comorbid psychotic symptoms and mood disorder informed and shaped by social context.

Sasha's early experience of sexual abuse compounded with a patriarchal cultural context contributed to the development of internalized objectification, resulting in Sasha's preoccupation with her appearance. Sasha frequently became anxious about her hair, make-up, and outfit and how she was perceived by others, and relieved this stress by throwing away clothing and make-up. A trauma history combined with internalized mental health stigma informed auditory hallucinations, often manifested in what she called "bitchy voices" telling her that she was ugly, fat, or would never reach her goal of having a boyfriend reflecting core beliefs of a negative self-image. Sasha was aware of her difficulty keeping up with the demands of everyday life and struggled to self-regulate, demonstrating insight into her level of functioning. Sasha was able to identify patterns in her symptomology, for example by identifying that manic episodes often

coincided with her menstrual cycle. She presented as highly motivated to reach her goals and improve her daily functioning, even when struggling with paranoia, auditory hallucinations, and mania.

Feminist Therapy Interventions

Drawing from existing literature on feminist theory in clinical practice, several central concepts of feminist therapy were identified including egalitarian relationship, multicultural considerations, and empowerment. Additional concepts of community engagement and boundary setting, while present in feminist therapy literature, were particularly highlighted when working with comorbid severe mental illness and trauma. Each concept will be explored as it applies to this case, with examples of the ways in which feminist therapy interventions were utilized.

Egalitarian Relationship

Attention to power dynamics and intention in creating a more egalitarian relationship is essential in establishing the feminist therapy space. During initial sessions, Sasha asked for her mother to join in to help explain her mental health history and current struggles. Sasha's ability to know, identify, and request the kind of support she needed was respected. In exploring Sasha's goals for therapy, she identified that she wanted to improve her ability to self-regulate her emotions, anxiety, and mental health symptoms to enhance her independence. This has been the ongoing overarching target of the therapeutic process, and has been revisited as various struggles and coping mechanisms have been discussed. Early in the therapeutic relationship, Sasha requested that her mother help her to verbalize that she felt sessions were focused on concepts and skills that were overly confusing and complicated. After this initial disclosure, Sasha and I discussed the importance of her contributions to the therapeutic process. I discussed my own position as a student therapist and that her participation in providing feedback was an important

way for me to learn. By putting Sasha into the role of being an expert on herself that I needed to learn from in order to support her, we moved closer towards an egalitarian way of relating to each other.

Indeed, Sasha's knowledge of herself and her internal world as well as her feeling empowered to communicate that with me was essential to the therapeutic process. She entered therapy feeling that many of the coping strategies she used were problematic, and this was often the case. These included eating exorbitant amounts of sweets, daydreaming for hours on end, reorganizing her closet compulsively and throwing away her belongings, and listening to music that triggered manic symptoms of excessive energy and lack of sleep. However, these strategies were also what worked to decrease Sasha's anxiety, loneliness, and psychotic symptoms. Therapy became a space where Sasha was asked to explain what it was about each coping strategy that provided her with relief, and where we could discuss ways to make these coping skills more adaptive in her life. "Moderation" became a constant refrain in our sessions, as each of these coping strategies are functional in small amounts. Drinking herbal tea rather than sweet juice or strawberries instead of cookies were modifications to eating sweets. Putting clothes and belongings in bags in the basement while reorganizing and making a decision of whether or not to donate them at a later time allowed for Sasha to engage in this coping skill without an unwanted outcome of needing to buy a new wardrobe every few months. Identifying music that was calming, as well as finding ways to pinpoint the moment when music became too over stimulating, helped Sasha to continue to engage in this coping skill in a way that was more functional for her. Sasha had a particularly difficult time figuring out the role she wanted her daydreams to play in her toolbelt of coping skills, as she was ambivalent towards them. These daydreams encompassed her dreams of having a romantic relationship, a family, and a job in her

future and she expressed fear of losing them as they also relieved her of loneliness. However, she expressed a strong desire to live in reality rather than fantasy. Her relationship to her daydreaming changes over time depending on what she is struggling with, and ultimately she expressed feeling that daydreaming in moderation (for an hour or so before going to sleep) provides her with the comfort she needs without taking away from her ability to live in the present moment. By respecting that Sasha's coping skills have worked for her and modifying them rather than working to eliminate them, her sense of empowerment has been supported as she made the decisions to change them in a way that benefits her most.

Over the course of therapy, the therapeutic relationship evolved to become more egalitarian as Sasha took on a collaborative role in her treatment. Not only did I validate Sasha's feelings about interventions utilized in therapy, I used her feedback to inform future sessions and explicitly explored whether I did so effectively by asking for her input. After receiving her feedback early on in treatment that she needed more scaffolding and simpler explanations, I consistently asked Sasha to give her opinion about the intervention itself as well as her level of functioning on that particular day. Her cognitive and emotional functioning fluctuated depending on prevalence of mood and psychotic symptoms, thus impacting the complexity of therapeutic intervention that she could tolerate in a given session. Habitually asking her to assess her level of functioning served the dual purpose of guiding my therapeutic practice as well as fostering her insight. As I centered her knowledge of herself in treatment, including her assessment of which coping skills work best for her, she became more comfortable taking on a collaborative role in the therapeutic relationship. At times, this manifested as expressing frustration with me as her therapist which provided us with the opportunity to practice interpersonal resolution and create compromise, a social skill that was particularly difficult for Sasha. By supporting Sasha in taking

an active participatory role in her treatment, the therapeutic relationship became more egalitarian over time even as we remained in our inherently hierarchical roles as therapist and client.

Multicultural Conflicts and Resolutions

Sasha was adopted from Russia, and discussion of her connection to her Russian and American identities was one way her self-knowledge was enhanced. During one of her cycles where symptoms were heightened, she became convinced that she needed to fully embrace her American identity and get rid of everything Russian. This was in reaction to media stories about how Russians hacked the 2016 U.S. presidential election, a directly demonstrating how consideration of social location is essential (Brown, 1994; Enns, 2004). She responded with what she thought would make her safe, consistent with Brown's description of individuals who tend to think in dichotomized extremes as a result of trauma (1994). During the session where Sasha described this decision, reminders of being in the gray (rather than thinking in black and white extremes) were not effective. Per my suggestion, Sasha agreed to speak with her mother about the identities she holds, as she is both American and connected to her Danish and Swedish heritage. In the meantime, Sasha would put her Russian belongings which she initially wanted to throw away into the basement as she usually does when reorganizing. Sasha and I also discussed the practical concern about whether being Russian is dangerous in the current political climate. I reminded her that she is an American citizen due to her adoption, and that people cannot tell she is Russian by looking at her or listening to her accent (she does not have an identifiable accent). This reality checking helped to contain Sasha's fears. In the following week's session, Sasha reported that her mother keeps her Danish and Swedish belongings around the house and certain traditions alive. As Sasha's idealized attachment figure, her mother acknowledging her heritage affirmed Sasha's own ability to embrace her Russian identity.

Another struggle for Sasha were the ethnic identities of others. She described herself as being triggered when she saw a group of adolescents of color or a man of color on the street due to her previous experiences of seeing fist fights between clients in residential treatment centers. She would become anxious and try to avoid them by crossing the street. This caused me to have an internal emotional reaction, as this behavior is clearly racist. I have witnessed this precise scenario of a white woman crossing the street, clutching her purse and with fear on her face, in reaction to seeing someone I love on the sidewalk in front of her. I have had conversations with loved ones about how it feels to be feared just for walking down the street, often on the block or in the neighborhood they live in. They have discussed the careful thought put into whether an outfit would be perceived as threatening to the white passersby, including avoiding wearing black hooded sweatshirts and opting for a plaid button-up shirt instead. Knowing that Sasha was perpetuating racial microaggressions put me in a position of being able to support her in both changing her behavior and reducing her own discomfort. We discussed what her behavior communicates to others, and built empathy by exploring how she feels when she thinks someone is looking at her strangely or avoiding her when she is struggling with symptoms of anxiety or psychosis. We also talked about how acting afraid rather than confident can put her at heightened risk. Through collaborative discussion, she decided that a safer way to walk down the street would be to focus on where she is going, ground herself by looking at the sidewalk or sky when she felt triggered, and listen to calming music. This way, she could contain her anxiety while also minimizing racist behaviors. I disclosed my own ethnicity to her, explaining to her that I am not white yet she is not afraid of me. She initially laughed at this disclosure and implied that I am clearly different from the people she is afraid of, demonstrating a common response of white people who do not consider themselves racist. However, she was receptive to my redirection and

explanation that although I know her in a different capacity than someone she is passing on the street, that does not exempt me or people who look like me from being judged based on racial phenotypes. For many months and across many situations we revisited the concept that judging safety based on a person's appearance is inaccurate, and the importance of also examining their behaviors to determine level of safety. This was particularly important as she conversely judged people as safe, based on what they looked like. For example by assuming a cute white young man with blonde hair was safe, at times led to placing herself in risky situations. Although it took time for Sasha to comprehend this concept, she gradually embraced it and would proudly report when she was able to assess others' safety based on the way they acted rather than their weight, style of clothing, or race.

Empowerment

Sasha did not only judge others based on their appearance, she also regularly judged her own appearance harshly. This reflects internalized objectification, an issue that many women with, uniquely impacting women with severe mental illness (Carr, et al., 2017). She worried about her style and throwing out clothes and make-up was one way she coped with low self-esteem. A major motivation for her to stop eating sweets as a coping mechanism was because she did not want to get "fat," as she equated this with being ugly. She fluctuated between "natural beauty," with no make-up and wearing excessive mascara, and struggled with what outfit was appropriate for which occasion. Sasha wanted her style to be "comfortable and cute" and sometimes this meant she wanted to throw away all of her more formal dresses, or she decided that shorts attracted too much attention from men in public so she wanted to throw out all her pairs of shorts. Discussions of the importance of "inner beauty" were frequent in sessions, and Sasha decided to start a "positivity journal" where she wrote about her positive qualities. She

identified that she is caring, compassionate, faithful to God, has a connection with children, and is kind to others. Physical exercise was reframed as a healthy activity that reduces her anxiety, an important tool for her inner wellbeing, rather than as a means to a thinner body. Reviewing basic information about what clothing is appropriate for which occasion allowed Sasha to articulate what feels appropriate and safe to her, and that what she wears is a choice she makes for herself each day. Social and cultural location was also discussed per the feminist therapy principles (Brown, 1994; Brown, 2010; Enns, 2004), as Sasha was able to talk about the ways in which seeing how other young women dress on television or at school influences the way she sees herself, and from there find ways to maintain her own sense of identity in her style in spite of that.

A major focus of therapy was Sasha's responsibility to make her own choices, whether about what she wears, which coping skill she uses at a given moment, what activity she chooses to engage in at a given time, or how she chooses to describe and express her own experiences. She frequently struggled with this process, as when she becomes anxious and overwhelmed her executive functioning is impaired. Review of coping skills and activities were frequent in sessions, and reflecting on which would have been appropriate to use in different situations helped Sasha to internalize the ability to make these choices. She utilized a "healthy guidelines" document that explicitly describe the choices she has in terms of outfits, coping skills, and activities. This document was a collaboration between therapists, her mother, and herself, and was a living document edited according to her changing needs. She was encouraged to ask for support when she was struggling, and making the choice to ask for help was framed as an important aspect of independence. This enabled her to advocate for herself across environments including home, school, and work, implementing helpful environmental changes, which is

viewed as an important aspect of developing self-efficacy in feminist therapy (Carr et al. 2017). Experiences of effective self-advocacy allowed for a felt sense of personal empowerment (Enns, 2004) for Sasha, in addition to making the practical changes necessary to support her in making the accommodations.

Community Engagement

Sasha required additional support at both work and school, and was typically able to successfully navigate these settings with these resources in place. She volunteered at a community center daycare while attending school, as these hours also contributed to earning an early childhood education certificate. Her boss there also became her mentor, and had an understanding of SMI as her own father had schizophrenia. Sasha felt that this personal connection allowed her boss to support her in the workplace, as well as mitigated her social anxiety and fear of others judging her. Because of her boss' understanding, Sasha was able to change her hours from mornings to afternoons as Sasha felt she was more functional at that time of day. She was also able to take breaks when overwhelmed, or request time doing activities outside of the classroom such as washing dishes or preparing projects for the children. On Sasha's self-defined "low functioning" days, she was able to go home early or take the day off. This flexibility enabled Sasha to succeed in this work environment and forge meaningful relationships with her coworkers and the children at the daycare.

At one point, Sasha was planning to switch to a different daycare. Sasha worked there for a mere few days before deciding to go back to working at the original daycare. She reported that one reason for this was that her new employers did not know the true nature of her mental health, as she had only informed them that she had anxiety and needed accommodations for that reason alone. She also felt overwhelmed as the daycare had less structure than what she was used to.

Sasha was able to identify that she needs the support of a boss informed of her mental health status and feels more comfortable with structure in the workplace, both important insights into what she needs in order to function at her best.

Sasha struggled most significantly with peer relationships, as she has a difficult time knowing what is appropriate to speak about. She tried out several different Christian youth groups as she expressed a desire to make connections with peers in the safety of that environment as a sober and faith-based space. However, she frequently only attended once or twice before deciding not to return. Sometimes she would tell her entire life story to someone she met there and then afterwards feel embarrassed about it, and other times she felt self-conscious or judged in the context of a group. Role-playing and practicing appropriate conversations was an important part of therapy. I asked Sasha whether it would be helpful for me to remind and redirect her when she was speaking too quickly, jumping from topic to topic, or otherwise navigating a conversation with difficulty. She stated that it would, and over time she began to self-correct in sessions if she started speaking rapidly or said something inappropriate to the discussion at hand. By building social skills and increasing attention to subtle social cues in therapy, Sasha practiced necessary skills for peer interactions. Discussion of her one friendship was common in therapy as well, and talking through conflict resolution scenarios as well as building empathy supported Sasha in being able to maintain this friendship. Prioritizing social and community connection is central to Sasha's wellbeing, and needs to be supported in therapy.

Boundary Setting

An important skill lacking in Sasha's approach to social interaction is attention to social boundaries. Within the therapeutic relationship, this often became problematic when Sasha was feeling dysregulated and would call me repeatedly without leaving a message, or occasionally

leave a message but continue to call and hang up. She sometimes called seven times in a row. Multiple discussions took place around appropriate alternative behavior, which would be that Sasha call once and leave a message and then wait for me return the call. I explained that calling repeatedly would not make me respond more quickly, as I was usually in class, with clients, or otherwise busy. I also encouraged her to practice her coping skills instead of calling again. If I missed a call from her, I maintained awareness of this boundary and would wait before calling back to give her time to practice the coping skill. As time went on, Sasha only called repeatedly if she was in one of her cycles and responded more quickly to redirection.

Boundaries were often important with her mother, and occasionally Sasha and her mother would request a joint session if this was becoming problematic. Sasha generally responded well to boundaries and her mother's consistency was an important part of this success. Limiting the number of calls and texts to her mother was similarly essential to fostering greater independence and appropriate boundaries. Sasha and her mother scheduled specific times to talk with each other on certain weekday mornings and Saturdays. Sasha was encouraged to write down any questions she had and topics she wanted to discuss, and wait to do so until the scheduled time. This way, Sasha not only practiced boundaries but also her impulse control.

Impulse control is difficult for Sasha, particularly in social situations. She described herself as prone to "verbal vomit" where she talks nonstop about all topics, whether appropriate or not and usually including her own trauma history and mental health status. Revisiting what appropriate topics of conversation are for the "inner circle" (her parents, therapist, and psychiatrist) versus the "outer circle" (everyone else) helped to regulate this. She improved her ability to hold these boundaries in social situations over the course of therapy.

Outcomes

This case demonstrates the application of feminist theory principles in clinical practice when working with severe mental illness and complex trauma. Feminist therapeutic principles of an egalitarian relationship, multicultural considerations, and empowerment were applied in this case, modified to suit the unique characteristics of this case. Collaboration with the client is an essential component of creating appropriate modifications to feminist interventions. Community engagement and boundary setting are two additional components not traditionally included in core feminist theory principles of clinical practice, yet are particularly relevant for working with those with severe mental illness and/or complex trauma. These presentations often manifest as lower functioning on the intrapersonal, interpersonal, and community levels, requiring particular attention and support consistent with a feminist therapy framework.

Over the course of treatment, Sasha made strides towards several goals. Interventions supporting an egalitarian relationship, including collaboration on goals and feedback of treatment, provided space for Sasha to take an active role in her therapy. She developed insight into various coping tools for self-regulation, and determined the way in which she wanted to adapt existing coping mechanisms. This collaborative process supported her ongoing empowerment. Sasha's fixation on her appearance was explored in therapy, and interventions included addressing underlying issues with self-esteem and discussion of internalized objectification from media. Consideration of social location was present throughout treatment, and became particularly salient when issues of national identity came up due to political climate. Judgment and stereotyping of others based on appearance was also addressed, at times through process-oriented discussions of the therapeutic relationship. Explicit boundaries in the therapeutic relationship enabled Sasha to practice addressing a lack of impulse control in social

interactions in order to improve social functioning. Finally, Sasha's ability to advocate for herself through accommodations in both the school and workplace made it possible for her to sustain a job at a daycare as well as graduate with a certificate in early childhood education. Taken together, feminist conceptualization and interventions on this case demonstrate how feminist clinical practice can be flexibly adapted to the needs of those with severe mental illness and/or complex trauma.

Therapist Reactions

Feminist therapy principles emphasize the importance of ongoing reflection of the therapeutic relationship, including the ways in which intersecting identities of both therapist and client interface. Consideration of respective social locations and how this defines the therapeutic relationship is to be consistently revisited, particularly as different situations and themes emerge in therapy. A particularly salient time for me to engage in this process as a feminist therapist was when Sasha struggled with the issue of identifying others as safe or dangerous based on the way they looked, and that this often was determined based on a non-white racial identity. I reflected on my own social location of being a multiracial person with the privilege of being half-white, as well as being in a community where my loved ones were subject to the type of racism that Sasha was perpetuating. These factors caused me to have an internal reaction to Sasha's descriptions of crossing the street, changing her seat on the bus, or walking away quickly whenever she saw a person of color. I felt personally upset, as well as responsible for supporting her in developing an understanding of the impact of her actions, for both her safety and the sake of myself and my community.

Through reflecting on this issue in supervision and receiving support and guidance, I was able to take a process-oriented approach as well as reframe the issue as an opportunity to develop

Sasha's understanding of assessing safety in social situations. By disclosing my own racial identity and ethnicity to Sasha, we were able to openly discuss our differences and use the therapeutic relationship as a model of which interpersonal dynamics made Sasha feel safe. This demonstrated to Sasha in a personal and concrete way the erroneous nature of judging another person based solely on their looks, and allowed for development of her ability to assess which behaviors indicate safety or danger. Taking this approach allowed me to bring myself as a person into the therapy room, so that I could be fully present within the therapeutic relationship. Engaging in a reflective process, both independently and in the context of supervision, enabled me to work with Sasha in a productive way that served both of us as well as the larger community. If these issues had been neglected and unaddressed, they may have escalated rather than presenting a therapeutic opportunity.

Applicability

While this case study highlights a unique individual and presentation, it also demonstrates that feminist therapy techniques are applicable with client populations diverse in their levels of distress and functioning. Empowerment strategies in therapy should not be reserved solely for high-functioning individuals deemed capable of advocating for themselves, but rather for all people who might benefit from gaining a sense of autonomy and power over their own lives. Community integration is essential to the wellbeing of all individuals, and people with SMI are no exception. The purpose of this case study is to exhibit the full breadth of applicability of feminist therapy theory.

Limitations

While this case study aims to illustrate the adaptability of feminist theory in clinical practice, there are several limitations to consider. This is a theoretical and subjective account of a

feminist therapeutic approach, a theory chosen based on how it aligns with my own values as a clinician. Another therapist with a different set of values may be more effective in practicing from their own chosen theoretical orientation. The salient identities of both therapist and client must be considered when determining whether a feminist therapeutic approach would be a good fit for their treatment. While Sasha benefited from our therapeutic work together, she has also benefited from working with past therapists who do not work from a feminist perspective and likely will do so in her future treatment as well. The purpose of this paper is not to say that feminist therapy is more effective than other clinical modalities, but rather to demonstrate how feminist therapy can be applied when working with the unique presentation of comorbid complex trauma and SMI. An area for future research could be to examine the differences between using feminist therapy approaches and treatment as usual when working with this client population.

Further, I was in the first few years of my clinical training when I worked with Sasha and began practicing feminist therapy during that time. It is important to consider how a clinician with more experience and familiarity with feminist theory in clinical practice might approach this case differently, or more effectively implement feminist therapy interventions. The time-limited nature of conducting therapy in a training clinic undoubtedly had an impact on the therapeutic relationship as well, and there may have been different or more long-lasting outcomes if there had been flexibility to continue our clinical work together.

Summary

This case study demonstrates the ways that feminist theory can be applied in clinical practice when working with an individual with comorbid severe mental illness and complex PTSD. Examples of specific feminist therapy interventions illustrated how feminist principles

were applied and modified to address the needs of this client, providing evidence for the utility of feminist therapy with a diverse range of clients. An egalitarian relationship, exploration of intersectional social identities, and empowerment are central components of feminist therapy, which are all relevant and applicable for clients with severe mental illness and complex trauma. Additional areas of community engagement and boundary setting are congruent with feminist therapy principles and are particularly salient for individuals with severe mental illness. This case study may serve as a model for feminist therapists working with lower functioning clients.

Currently, the literature on feminist therapy with clients who have severe mental illness is very limited. This case study aims to add to a growing body of psychological literature that addresses the therapeutic needs of people with severe mental illness, as well as the canon of feminist theory in clinical practice. Additional case studies demonstrating the various ways that feminist theory can be applied to therapeutic work with clients of diverse presentations would further expand this body of work. Future directions could include applying feminist theory principles to critical examination of mental health systems, such as mental health agencies or mental health programs, which would likely further benefit both therapists and clients by addressing systemic issues. Feminist therapy works to dismantle the inherently hierarchical model of treatment in the therapeutic relationship, and this could be extended to address the issues of oppression that arise in the mental health field at large.

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