Professional Psychology: Research and Practice
2012, Vol. 43, No. 3, 256–264

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0735-7028/12/$12.00 DOI: 10.1037/a0028654

# Intersectionality of Identity in Children: A Case Study

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Intersectionality of identity theory applied in the practice of psychotherapeutic services allows clinicians to enhance their clinical conceptualization of patients and provide effective psychological services to individuals with multiple cultural identities. This article explores intersectionality of identity in the provision of services to diverse children. Using a case study of a gender variant, ethnic minority child, the author explores the clinically relevant elements of intersectionality often present in child psychotherapy. The author explores the influence of identity development in children, the influence of developmental and social–contextual factors on multiple identity development, and the influence of oppression in intersectionality in children. In addition, intersectionality of identity in family and the role of intersectionality in the therapeutic relationship are discussed. The author then provides practice implications for providing psychological services to multiply diverse child patients and their families.

*Keywords:* ethnic minority children, intersectionality of identity, multicultural psychotherapy, gender variance, case study

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Psychologists who provide professional services to diverse children with mental health concerns must be attuned to intersecting identities in their clients. Issues of culture, ethnicity, socioeconomic status, gender, sexual orientation, and faith practices are likely to exert an influence in the life of the child and the child's family. Psychological services with children necessarily involve parents in the assessment and treatment of the child (Ecklund & Johnson, 2007). Therefore, the psychologist is working with a diverse family group that is made up of at least two, but often more than two individuals with distinct ethnic identity status and cultural identities.[1] Data on children in the United States indicate that approximately 50% of children in the United States are living in ethnically–culturally diverse or low-income homes (Clay, 2009; McWhirter, McWhirter, McWhirter, & McWhirter, 2007). This suggests that skill in working with diverse clients is necessary for the psychologist that specializes with children.

*Intersectionality of identity* refers to the way in which an individual embodies within the self, multiple, cultural, ethnic, and group identities (Mahalingam, Balan, & Haritatos, 2008). Intersectionality allows one to understand the simultaneous and multiple influences of the diverse cultural group values, norms, and expectations that contribute to the complex individual identity (Narváez, Meyer, Kertzner, Ouellette, & Gordon, 2009; Shih & Sanchez, 2009). In this article, the author uses a case study of a gender variant and ethnically diverse child to explore intersectionality of identity in the provision of services to diverse children with multiple intersecting identities.

When working with children, intersectionality is considered both an individual and family construct. A child may possess multiple intersecting cultural identities, and the child's family members each represent intersectionality of identity within the family unit. For psychologists to work from a culturally responsible framework they must possess an understanding of the different represented client cultures and the implications of those cultures in the professional relationship (American Psychological Association, 2002). They should also demonstrate knowledge of intersectionality of identity and skill in working with multiple cultural identities in those they serve. The following case study illustrates the complexity of treatment with children and families challenged by their intersecting identities.

*Editor's Note.* This is one of 13 accepted articles received in response to an open call for submissions on Multicultural Practice in Professional Psychology.—MCR

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[1] For the purpose of this article, *cultural diversity* will include those domains identified by the American Psychological Association, including race, ethnicity, culture, gender, sexual orientation, ability, low socioeconomic status, and underrepresented age cohorts. *Cultural identity groups* will include ethnic, religious, gender, sexual, ability, age, immigrant, country–region, economic, and/or community groups whose members identify as a group with an articulated culture (see American Psychological Association, 2002, for a definition of culture).

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## Introduction to the Case

This case involved a latency-age male, Max,[2] referred at age 7 due to parental concerns about anxiety and behavioral issues, as well as the referring physician's reports of anxiety, disruptive behavior, gender identity distress, and parenting problems. Max's parents, immigrants from South Korea, presented with traditional Korean and conservative Christian cultural identities (see Kim & Ryu, 2005, for a summary of this cultural group's patterns–traditions).

As young adults both parents immigrated to the United States where they married and had two children. Max's parents were both high school graduates. The father worked outside the home as a self-employed business owner. The mother worked inside the home. At the time of intake Max's family was considered middle socioeconomic status; however, at the time of immigration they were impoverished and spent a number of years in the lower socioeconomic status. Max lived with his parents and older brother (an adolescent).

Max's treating physician referred him for psychotherapeutic services following failed treatment with three previous psychotherapists. In each of the previous therapy efforts, the parents refused to return to the treating therapist because of conflicts related to gender identity concerns expressed by the therapists or because of cultural value conflicts related to child-rearing practices. The child and family were seen in the course of psychotherapy described here for 3 years. The current treating therapist was considered culturally congruent with the family in relation to religious culture but was not of the same ethnicity as the family.

Max's symptoms were noted upon entering school at age 5. Prior to entry into school Max had been primarily enculturated in the traditional Korean and Christian cultures. Max had not been in daycare, preschool, or other socialization environments outside of the Korean-Christian church and community in which his parents were embedded. Parent values, parenting practices, family structure, rules, and norms were all established within the Korean-Christian culture (see Kim & Ryu, 2005).

On entry into kindergarten at age 5, Max's symptoms were reported by his teacher to include significant symptoms of separation anxiety, generalized anxiety, attention difficulties, emotional dysregulation, and significant dysphoria with his male genitals. Max hated touching his penis. Attempts to use the restroom at school without doing so led to persistent problems with voiding on himself and his clothes. In private discussions with Max regarding his odor, the teacher learned of his disdain for touching his penis. He felt his penis was repulsive and felt contaminated after touching it.

At the time of intake, at age 7, Max was found to be highly anxious, exhibiting generalized anxiety across most settings and separation anxiety from his mother when attending school. He demonstrated high levels of inattention, difficulty with focus, emotional dysregulation, rumination, withdrawal into fantasy, emotional distress, self-contempt, and significant dysphoria with his genitals. He stated that he found his penis disgusting, and he hated it. Max now engaged in self-injury to his penis, which his parents reported required medical attention periodically due to penile bruising and pain.

Max was socially isolated, experienced peer rejection at school, and had no friends in the neighborhood or community. He exhibited periods of significant defiance, anger, escalating agitation, and tantrum behavior. Tantrum behavior included crying, yelling, cursing, and self-injurious behavior (hitting himself and head banging).

Assessment with his parents revealed a family context that was significantly stressed by Max's anxiety and behavior. Family dynamics were noted to involve a close, possibly overinvolved relationship between Max and his mother, and a conflicted, fearful relationship between the father and sons. Both parents denied any history of child abuse, domestic violence, substance abuse, or history of mental illness. The parents reported using physical discipline (spanking) and indicated that it was used infrequently and did not leave marks or bruises. They reported the use of this discipline method as congruent with their family background, culture, and religious values. Physical discipline was reportedly used with Max and his brother primarily around issues of disrespect and disobedience toward parents. Parents reported that Max's brother "tries to be an American teenager" and that the disrespecting and disobedient behavior was not tolerated in their home.

Treatment goals for Max involved decreasing symptoms of separation anxiety, anxious cognition and rumination, physiological arousal, and psychomotor agitation. Goals for treatment also involved increasing adaptive coping strategies for managing stress and decreasing self-injurious and tantrum behavior. Addressing parent–child relationship dynamics with the goal of improving the father–child relationship and decreasing anxious overinvolvement with the mother were specified as well. Finally, on the basis of the referring physician's concerns, a goal of treatment was to explore Max's internal world—which was heavily guarded at the time of intake. Specifically, goals to explore feelings in regard to his natal sex and gender affiliation were identified.

At the time of intake both Max and his parents denied gender identity concerns. However, over the course of the first year of treatment, gender related concerns were shared by Max and subsequently explored in therapy. Max was found to demonstrate the following symptoms of gender identity disorder (GID):

> Strong and persistent preference for engaging in gender nonconforming roles in play or fantasy, strong and persistent preference for participation in stereotypical play and activities of the other natal sex, strong preference for playmates of the other natal sex, persistent discomfort with natal sex as evidenced by aversion toward and self injury to genitals. (American Psychiatric Association, 2000)

Max did not overtly express a desire to be the other sex, nor did he indicate interest in dressing as a girl (American Psychiatric Association, 2000). However, by the time Max was referred for this course of therapy, he had clearly internalized the rejecting, punitive, and prohibitive stance of those around him toward his feminine tendencies. Max adapted to this rejection by moving much of his self-expression and play into his internal world–imagination where he did engage in the fantasy of being female.

Over the course of therapy Max's identity development related to his ethnic culture and religious culture also emerged as sources of anxiety and distress. Max's anxiety and behavioral acting-out symptoms, family relationship dynamics, gender variance, and

[2] Case material presented is in compliance with American Psychological Association's standards for presentation of case material.

cultural identity development were considered interrelated. For example, as Max's gender variant identity developed, some of his anxiety symptoms improved. When intersectionality conflicts between Max's identity and that of his parents occurred, or when conflict with his own intersecting identities occurred, his acting-out behavior and anxiety symptoms often increased.

Treatment for this child was extensive, complex, and involved a multidisciplinary treatment team, including a psychiatrist, psychologist, behavioral therapist, and case manager. Aspects of assessment and treatment of Max that do not directly relate to the exploration of intersectionality of identity in the treatment of children will not be discussed here. Treatment for Max involved the use of psychotropic medication, behavioral therapy, and cognitive behavioral therapy to address specific symptoms of self-injurious behavior, anxiety, and behavioral acting out. Interventions that are empirically supported as useful with children were used (see Clay, 2009; Huey & Polo, 2010; LaGreca & Mackey, 2009; Nelson & Steele, 2009, for description of empirically supported treatments for anxiety in children). Treatment for Max also involved the use of best practices for treatment of gender dysphoric, gender variant, and GID children (see Bradley & Zucker, 1997; Di Ceglie, 2009; Lev, 2004; Meyer et al., 2001; Rieger, Linsenmeier, & Bailey, 2009; Vanderburgh, 2009, 2008; Zucker, 1990).

Treatment with Max was particularly challenging in terms of exploration of symptoms and treatment for some of his symptoms of anxiety, cultural identity development, and gender variance issues. These treatment challenges related to the intersecting and conflicting cultural identities within Max, as well as between Max and his parents. These aspects of treatment are used in this article to demonstrate the application of intersectionality of cultural identity in clinical work with children. Table 1 provides a brief overview of the treatment progression with Max.

## Application of Intersectionality of Cultural Identity in Clinical Practice With Children

Intersectionality theory, when applied in clinical practice to patients with multiple cultural group identities can result in case conceptualization and therapy that gives consideration to all of the relevant cultures that define the individual (Mahalingam et al., 2008; Noble, 2009; Shih & Sanchez, 2009). Some of the pertinent ways in which intersectionality theory informs work with diverse children will now be explored.

**Intersectionality produces additional identity properties.** The intersectionality model purports that individual identity is more than the sum of the various cultures in which one is embedded. The interface and reciprocal influence of multiple identities

Table 1
*Overview of Therapy Progression*

| Domain | 0–6 months | 6–24 months | 24–36 months |
|---|---|---|---|
| Symptoms | Anxiety and agitation | Anxiety and agitation | Anxiety |
| | Self-injury and genital aversion | Self-injury and genital aversion | Gender identity and cultural identity conflicts |
| | Tantrums | Gender dysphoria | Anger–Defiance |
| | | Tantrums | Parent–Child conflict |
| | | Parent–Child conflict | |
| Goals | Build rapport | Reduce self-injury and tantrum | Improve adaptive coping skills for anxiety and rejection—interpersonal and intrapersonal skills |
| | Reduce self-injury and tantrums | Reduce anxiety | Explore–Process gender and cultural identities |
| | Reduce anxiety | Explore gender identity issues | Strengthen supportive relationships/contexts |
| | Explore internal world | Improve parent–child relationships | |
| Challenges | Family guarded–Trust concerns | Parent rejection of gender variance | Family crisis impacted anxiety and treatment gains |
| | Inconsistent parent follow through on behavioral interventions | Anxiety, defiant behavior, and parent–child relationship fluctuations | Parent intolerance of Max disagreement with parents cultural hierarchy |
| | Increased agitation when self-expression encouraged in sessions | Cultural values conflicts regarding gender–sexual identity | Internal and family conflicts regarding gender and culture identity |
| Gains | Trust of family and child with therapist | Explored and discussed gender identity and cultural identities | Engaged in affirming contexts and relationships |
| | Decreased anxiety–tantrum in school | Improved behavior and support at school | Increased comfort with integrating gender non-conformity in identity |
| | | Self-injury–Genital aversion remitted | Selective in identity expression based on contextual factors |
| | | Parents as ally for child, actively supported goals of symptom reduction and improved global functioning | Anxiety managed well |
| | | Anxiety decreased; self-confidence increased | Acting out behavior improved |
| | | | Odd behavior remitted |
| | | | Global self-confidence and self-efficacy improved |

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itself creates an element of identity within individuals (Mahalingam et al., 2008; Narváez et al., 2009).

During childhood the primary cultures in which one identifies are typically facilitated by parents through ethnic socialization. *Ethnic socialization* involves experiencing oneself within the context of one's primary ethnocultural groups (Canino & Spurlock, 2000). This occurs within the context of *enculturation* (Rodriguez, Cauce, & Wilson, 2002). Enculturation refers to the process by which the culture of origin becomes established as the psychological baseline or normative culture for a child (Robinson-Wood, 2009).

Through intersectionality one can see the risks to individuals when values of different cultural identities within the individual conflict. As individuals mature, there is a tendency to seek identity integration, a complex self-identity that incorporates all of ones' cultural identities. Identity integration is linked with the process of ethnic–cultural identity development. Until the individual reaches cultural identity integration, typically as an adult (Parker & Sager, 2008), one may struggle with conflicting internalized roles and expectations related to different cultural identities and may experience fluctuations in active–prominent cultural identity expression (Narváez et al., 2009).

In the case presented here, Max is a child with multiple cultural identities—Korean, American, gender variant, and Christian. Max received major enculturation and cultural socialization for his Korean and Christian identity development through his family and family involvement in the Korean-Christian community—their primary social network. He received enculturation and cultural socialization for his American identity development through the influence of his older brother (an adolescent who had developed a prominent American identity), the media, and his experience at public school. Prior to this course of therapy, Max received no support for the development of his gender variant identity.

Max's struggle in developing his gender identity is related to the intersection of his family's primary cultural identities—Korean and Christian—with his gender variant identity. Both cultures tend to hold traditional views on gender, gender roles, gender behavior, gender identity and sexual orientation. These cultures tend to be patriarchical, have clear gender role differentiation, and tend to be heteronormative and homophobic (Kim & Ryu, 2005). These cultural values and their companion biases–prejudices do not converge well with lesbian, gay, bisexual, transgender (LGBT) identity development and cultures. Max's primary identities, based on socialization–enculturation, were rejecting of his gender-variant identity.

This intersectionality conflict within himself, as well as between himself and his parents, contributed to high levels of anxiety and self-contempt within Max. Max was unable to develop his gender identity within the context of his cultural and religious identities. This resulted in an additive property of self-alienation and self-contempt. To cope with these symptoms, Max would spend hours playing "in his imagination" isolated from family and peers. In his internal world he would role play being female. Additionally, his behavior was often odd, as he would respond externally to his internal fantasies and fears, was anxiously overreactive to stimuli, and at times of heightened distress was self-injurious. Previous therapists had diagnosed this behavior as psychotic and delusional. The result of Max's conflict with his intersecting identities involved Max perceiving himself as a severely disturbed child (described by Max as "I'm Crazy").

Through the course of therapy, Max was able to move away from this conceptualization. Max eventually began to engage in gender exploratory play in session. For example, he would role play that he was a female starlet, a female dancer, or other female professionals.

He also began to verbalize his experience of similar self-expression at home. He reported this behavior would result in punitive and prohibitive response by his father. He shared that his "alone time" at home was when he would pretend to be these female characters in his imagination, as he preferred that to being punished for acting out these wishes. In his internal world, Max was free to express himself through altered physical appearance, dance, music, and art in a way that would be classified as an expression of female gender identification. He also shared that he did not enjoy playing with boys, was not allowed to play with girls, and was rejected by his peers—he felt alone.

Eventually, Max began to engage in difficult conversations in regard to intersectionality conflicts with the therapist. For example, Max indicated that the children at school were using racial slurs toward him and calling him, "gay." Max indicated that he is not gay because "being gay is a sin." Max indicated that both his church and his parents had taught him that he couldn't be gay. The existence of people and religious groups that are affirming of LGBT identity was introduced but not vigorously pursued because of the developmental status of the child and the cultural value system of the family. During this phase of therapy, direct conversation about gender affiliation also occurred. Max denied wishing to become a girl, indicating that his parents and church taught him that such a desire is considered wrong.

During the course of therapy, conversations about church, family, school, and peer issues of stigmatization and rejection were processed. Adaptive coping strategies that used both internal (self-talk) and external resources (verbal, self-directed behavior, help seeking from supportive adults) were practiced and implemented.

Throughout therapy, the intersecting identity conflicts were not fully resolved. Max managed his anxiety in regard to cultural and religious rejection for his gender identity by declining to self-define his gender and instead worked on self-acceptance without clear gender self-definition. Although global functioning improved (psychiatric symptoms improved significantly) in regard to intersectionality of identity, Max, by age 10, was taking a tentative stance in his identity as a Korean and Christian. He identified as both but was more cautious with his self-expression in and engagement with his Korean-Christian community. He was also beginning to consider his ability to be Korean and Christian and not endorse all of the values held by his parents and community.

Max had also learned to be cautious in his engagement with his American cultural community at school where he had faced considerable rejection from peers and teachers related to his gender variant self-expression. During the course of therapy Max had found alternative avenues of expression of aspects of his identity that were rejected by his primary cultural groups. He had become actively involved in several artistic clubs that embraced his self-expression. As the case of Max exemplifies, the intersections of identity within a child introduces an element of self that is a product of the intersections, making identity greater than the sum of its constituent parts.

**Intersectionality and identity development in children.** During childhood, enculturation within the family's primary cultures, gender socialization, ethnic identity development, and ac-

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culturation processes all influence the development of overlapping identities (Mahalingam et al., 2008; Noble, 2009). Developmental trajectories of the various aspects of self-identity generally involve a good degree of overlap in most children (e.g., gender identity, cultural identity, sexual identity). Yet, for children with multiple divergent cultural identities this can result in a complex process that is amplified when intersecting identities conflict. With intersectionality of identity, the cultural values of one identity (e.g., ethnic cultural identity) may positively or negatively impact the development of another identity (e.g., gender identity). If a child is striving to develop her identity as an American female (one set of values related to gender identity) within a context of an ethnic culture that values strict male hierarchical-female subservient gender roles (a potentially contradictory set of values related to gender identity), these divergent cultural values may delay identity maturation. Conversely, when multiple cultural identity values and roles converge, they may facilitate the identity maturation process.

In the case of Max, his Korean and Christian cultural identities shared several core values and beliefs that perpetuated the development of both identities. Both Max's gender identity and his American identity were developing at a slower pace. Because of his engagement with the majority culture through his relationship with his older brother and school involvement, his American identity was more developed than his gender identity. However, parenting practices at home diminished Max's confidence in his American identity. As all other primary cultural identities within Max were rejecting of his nonconforming gender identity, this identity was most delayed in development.

**Social–Cognitive developmental issues in intersectionality.** When working with diverse children, a developmental understanding of ethnic–cultural identity is important as well. Most cultural identity models are adult centric. These models presume at least an adolescent cognitive capacity (see Helms, 1990, for a sample model). In children, cultural–ethnic identity development (conceptualization and expression) is dependent on concurrent cognitive and social development (see Rodriguez, Cauce, & Wilson, 2002). Therefore, children's cultural identity and intersectionality of identity will reflect their sociocognitive development.

During early latency, children usually develop a basic self-identity that is linked to their primary ethnic and gender identities. Because of cognitive developmental status these self-identities tend to be fairly concrete. Some children in this stage may develop an emerging awareness of the social significance of their cultural identity (Rodriguez et al., 2002). Attributions regarding the social significance of various cultural identities may be positive or negative at this age.

During later latency, children become mindful of cultural differences among peers and become more conscious of and inquisitive about their own primary cultural groups (Rodriguez et al., 2002). Exploration of one's family cultural identities can take on a positive or a negative valence, which is often linked to enculturation and cross-cultural experiences. Following this stage of comparative inquiry, adolescent development emerges. Major cultural developmental tasks during the adolescent period include: developing adaptive behavioral strategies in response to oppressive and discriminatory experiences (Ecklund & Johnson, 2007; Rodriguez et al., 2002), developing awareness and greater understanding of one's own multiple cultural identities, and renegotiating the parent–child relationship in light of the child's own expression of cultural identities, perhaps distinct from his or her parent's identities (Banks, 2003).

During this course of therapy Max had not achieved a mature position relative to any of his intersecting identities. His family context, as well as his intersecting identities as Korean, American and Christian made it difficult for Max's gender identity to develop. Max's understanding of each of his intersecting identities was fairly concrete, and Max lacked the cognitive capacity to critically consider the internal conflict that he was experiencing as it related to issues of cultural values, beliefs, and biases.

For example, during the first year of therapy, Max discussed his contempt for his physical appearance. Max hated the way he looked, attributing his contempt to his resemblance to his father, whom he experienced as authoritarian, rejecting, and scary. At this age Max lacked the capacity to appreciate the multiple factors influencing his self-contempt. Upon exploration, it appeared that this contempt was also related to his ethnic features (internalized oppression by peers regarding his Korean ethnicity) and was also related to his gender identity dysphoria (he disliked his more prominent masculine physical features, preferring more feminine features represented in his art work). As a child his physical self-contempt reflected the layered effect of his family, gender, and ethnic–cultural identity conflicts, but was concretely conceptualized.

**Intersectionality of identity in family context.** Intersectionality theory also impacts conceptualization of diverse families. Within a systems conceptualization, family is considered a single unit with its own identity. Family members' intersecting identities result in a complex web of intersectionality that impacts family relationships and functioning. When working with families, the variety of cultural identities represented can be wide ranging. As a child's various cultural identities, developmental status, identity salience, and valence are prevalent and intersect with those of other family members, conflict may erupt. For the therapist this means respecting all of the various represented identities in the family. To do this, the therapist must be able to work from a nonhierarchical framework, simultaneously valuing the different cultural identities of all members.

Max's family represented a complex intersection of identities. Max's father appeared to be primarily guided by his Korean, Christian, heterosexual, male, immigrant cultural identities. Max's mother was primarily guided by her Korean, Christian, female, immigrant, and emerging Korean American cultural identities. Max's brother appeared to be primarily guided by his American, heterosexual, male identities. The intersections of these identities in the interpersonal relationships exerted stress in the family.

During the course of therapy these intersecting identities exerted influence on the therapeutic process itself. For example, once therapeutic trust was established, Max's parents were clear that they were not willing to discuss the possibility of Max having gender nonconforming tendencies. Gender variant children often emerge into adulthood gay or bisexually identified (Wallien & Cohen-Kettenis, 2008; Zucker, 1990). Within the parents' primary cultures, affirmation of gender variant identity violated salient values and beliefs. These strongly held values prohibit validation of either gender nonconformity or nonheterosexual identities (Kim & Ryu, 2005).

During one phase of therapy, Max grew more confident in his gender variant self and became more defiant and aggressive with those he felt were rejecting him. Max began to verbalize disagree-

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ment with his father's ideas. His father's agitation with Max's disrespectful behavior increased. Intersecting cultural factors were present in this dynamic. In the father's Korean culture, children are to be obedient when given instruction by authority (Kim & Ryu, 2005; Lee, 1997). Max was developing a majority American culture influence in his identity development and believed that he should be able to share his divergent ideas without appearing disrespectful.

With this increase in conflict over respect, issues of discipline emerged in the therapy. Max reported an increase in use of physical punishment for disrespectful behavior. Here again, the intersectionality of cultural identities created stress within the family. In the context of his American cultural identity, Max felt he should not be physically punished for expressing himself. Whereas his parents, citing their ethnic and religious cultural values, felt that by punishing Max they were functioning as responsible parents.

Eventually, parent sessions were able to focus on building a positive global acceptance of Max. Therapy with parents of GID children typically involves assisting parents in developing an accepting stance with the child's gendered self, helping parents become advocates and allies for their child so they can help decrease stigmatizing and marginalizing experiences of the child. Additional goals include decreasing focus on defining behavior as gender typed and improving interpersonal relationships between family members and the child (Di Ceglie, 2009; Langer & Martin, 2004; Meyer et al., 2001; Zucker, 1990). Max's parents' cultural identities made it difficult for them to work directly on these gender nonconformity-related treatment goals.

By working with his parents to prioritize concerns in regard to Max, the father was able to shift his focus from rejection–punishment for feminine behavior to support Max's work on treatment goals and well-being. Although unable to accept Max's gender variant behavior, he was able to decrease the amount of energy invested in trying to prohibit Max's behavior, as prohibition increased Max's odd and anxious behavior. Instead, Max's father worked on supporting Max in his anxiety management and behavior self-regulation.

Eventually, the parents allowed Max to get involved in extracurricular activities of interest that fell in the fine arts domain. However, this occurred within a context of father's expressed concern that Max accept his Korean-Christian culture and that priority be given to his involvement in those cultural groups. Because of these challenging intersecting identity issues neither parent was able to directly embrace Max's gender nonconformity. They adapted to Max's gender variant self-expression by conceptualizing him as "artistic." Max continued to experience significant stress when the intersecting identity issues were addressed. Conversations in regard to gender identification or sexual orientation caused him to feel cultural and religious rejection for his nonconforming roles or values. At his developmental stage, Max was unable to resolve this dilemma.

**Intersectionality and identity salience.** Intersectionality of identity allows for one to understand fluidity of identity—how one cultural identity becomes more salient–active within an individual when in certain contexts, whereas others may be more active–salient in the same person when in other situations (Narváez et al., 2009; Parker & Sager, 2008). The factors that frequently influence fluidity in developing children include the value of the cultural identity held by others in given contexts, cultural identity development, existential considerations, institutional contexts, family dynamics, and social relationship contexts (Narváez et al., 2009).

Children learn in early childhood that caregivers are responsive to them. Through reinforcement and punishment, children learn which developing identities are valued in specific contexts and tend to express identities that are valued over those that are punished. Children learn the value that specific aspects of their culture and identity hold in the variant cultural referent groups in which they are enculturated, even if they do not yet understand the basis for these values. In childhood, social relationships are largely based on shared enjoyment experiences. In this way children learn what identities to express. As a result of selective reinforcement within the social context, shared cultural identities develop more rapidly than aspects of the self not valued by those in the primary contextual settings. In turn, the shared cultural identities become identities with which children are more comfortable and confident, resulting in cultural identities with greater salience and more positive valence in specific contexts.

Max received positive reinforcement from his parents and their Korean-Christian community for expression of Christian values and beliefs. For instance, Max cited such things as praise for identifying specific behavior as fruitful or "sinful" and for singing religious songs. Max received positive reinforcement from his church community and church school group for his Korean identity as well. DeYoung, Emerson, Yancey, and Kim (2004) highlighted the role of the Korean-Christian church in the preservation and transmission of the Korean culture in the United States. Through experiences in Sunday school and children's choir, Max not only was enculturated in but also reinforced for his participation and role in the community as a Korean young man. These reinforcing experiences increased the positive valence of his Korean identity. These identities carried more positive valence and were expressed publicly with greater confidence and ease than his gender identity. However, for Max, his internal world was overwhelmingly preoccupied with his gender identity. The conflict between his gender identity, and his ethnic and religious identities were a source of considerable distress. Faced with a lack of adequate interpersonal support for working through this intersectionality conflict, Max's gender identity development was delayed.

Because of this lack of contextual support for his gender identity development, Max initially resisted exploration of gender in therapy. However, through the course of therapy Max experienced greater global acceptance from his father. When this occurred, Max's anxiety, acting out, and odd behaviors improved. It was also at this time that Max was able to revisit his gender affiliation and begin to consider his endorsement of his Korean-Christian cultural values in regard to gender identity and sexual orientation at a tentative level. With greater contextual support for Max's global identity, Max was able to explore gender issues in therapy. The salience and valence of his gender identity began to increase for him.

**Intersectionality and oppression.** Intersectionality of identity also sheds light on the concept of internalized biases and the dynamics of privilege, power, oppression, and marginalization. Intersectionality theory holds that identity is developed in cultural group contexts and power–oppression dynamics are inherent in culture. Therefore, intersectionality allows one to understand stress related to multiple identities, which can result in role conflicts and marginalization (Mahalingam et al., 2008; Narváez et al., 2009).

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For example, an individual may simultaneously be identified with oppressed, marginalized cultural groups, and with privileged cultures (Mahalingam et al., 2008).

When working with children, one seeks to understand the experience of racialized social contexts and stressors for the child and family. It is important to be aware that in child group dynamics, there is a tendency for children to use nonconformity to the dominant group expectations as a basis for marginalization, exclusion, or bullying. Biases expressed among youth often include perceptions of ethnic minority identity or nonheterosexual orientation. It is important to be aware that there is often a hierarchy of minority desirability (and undesirability) that guides youth in expressing biases and marginalizing others (Banks, 2003).

Major cultural developmental tasks for diverse children related to intersectionality and oppression occur during the adolescent period. As a latency age child, Max reported feeling rejected, bullied, and targeted by peers and family. In school he was targeted because of racial and perceived sexual orientation biases, and within his family he was targeted primarily for gender variant and "Americanized" behavior. When working with gender nonconforming children, therapy goals involve developing satisfaction with gendered self and improve global self-acceptance (Meyer et al., 2001). This desired outcome began to emerge during Max's therapy. As Max's anxiety symptoms decreased there was a simultaneous increase in defiance toward adults. Max was beginning to develop an understanding of some of the external influences in his self-contempt and self-doubt, specifically peer stigmatization and parental rejection. Max's behavior in school and home indicated that he was less willing to continue in his internalized stance. Developmentally, he was not yet able to understand the dynamic of oppression and integrate it into a resilient cultural identity. However, as therapy continued to progress, Max did develop adaptive coping strategies for managing stigmatization and rejection both internally and interpersonally.

Additionally, Max's parents proactively engaged in support for Max in response to slurs Max experienced at school. Max's father had experienced significant racial oppression in the United States, and convergent intersecting identities of father and son related to marginalization and oppression facilitated the treatment progress. Max's parents were able to engage in advocacy for their son with the school. They met with the teacher and principal to address their concerns. In a therapeutic way this was significant, as it put Max's parents clearly in an ally role with their child.

**Intersectionality and therapist–client relationship.** Intersectionality theory also impacts one's understanding of the therapist–client relationship. Like their clients, therapists hold multiple intersecting identities that have variant salience across contexts. These identities enter into and influence the relationship with the child and family—at times serving to facilitate the therapeutic relationship and at other times undermining the effectiveness of the therapist. When attempting to work with families from a nonhierarchical approach where all cultural identities are valued and respected, therapists must be aware of their own identity valences and biases toward valuing certain identities over others. The therapist should refrain from placing greater value on one client cultural identity over another. For example, if a therapist is in a phase of life where her gender identity holds greater valence than her ethnic identity, there may be an inclination to influence clients' therapy consistent with this hierarchical value.

In addition, the clients' perception of the therapist's identities will influence the therapeutic relationship. For example, initially Max's parents felt an alliance with the therapist in regard to a shared religious cultural identity. However, during the course of therapy, hesitance toward the therapist was observed, related to the divergence of other cultural identities. Although the therapist made effort to work with the family from a nonhierarchical intersecting identity approach, at times Max and his parents felt guarded when it came to their ethnic identity. Awareness of these intersecting identity influences and the ability to discuss them in the therapy enabled the therapeutic relationship to persist.

## Practice Implications for Treatment of Multiple Cultural Identity Children

This case study highlights some of the important considerations for professionals who are engaging in a multicultural intersectionality psychology practice with children. These considerations include the following:

1. Psychologists should be aware of the salience and valence of their own multiple cultural identities and be cautious to avoid using their own hierarchy of cultural identities in guiding their work with clients. Psychologists should work toward a nonhierarchical stance with multiple cultural identity children and their families. This stance must respect the variant identities involved and allow the client to guide the therapist in understanding the salience and valence of the cultural identities of the client at the time of treatment.

2. Psychologists should assess the multiple cultural identities of the child and family and their intersections. This assessment should include an analysis of the strengths and challenges they produce for the individual, family, therapeutic relationship, and treatment progression.

3. Psychologists working with children and their families should be cognizant of the influence of ethnic and cultural identity developmental status on family member's orientation toward each other. Psychologists should assess and monitor within-family cultural identity-based biases as well as oppressive and discriminatory behaviors. Psychologists can then dialog with the child and family, regarding these family-based oppressions.

4. Conceptualization of a child's context should include the assessment of family cultural identities and their intersections and salience in cross-systemic relationships (e.g., school, community). Knowledge of the positive and negative cross-systems relationships and experiences can assist the therapist in identifying supportive community resources for the family as well as help them identify cross-systems problems that may be negatively impacting the child and family such as oppressive behaviors on the part of school personnel or peers.

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5. An assessment of cognitive and developmental capacities for negotiating complex multiple cultural identity contexts (e.g., when majority cultural peers are brought into sustained contact with the family culture) and internal intersecting identities (e.g., conflicts in values between two primary cultural identities developing within the child) should guide expectations for the child's ability to self-manage, as well as guide external supports provided to the child.

6. Treatment priorities set by clients may be related to salient identities in the client's family. Exploration of treatment issues that are minimized may reveal intersectionality conflicts or challenges. For example, parents with dissimilar religious cultures may conflict over this discrepancy when parenting children. Processing the conflict, as it impacts the child, may be avoided in therapy when anxiety around the discrepancy is too high.

7. Psychologists who are working with children should be aware of the influence of positive reinforcement on cultural identity development, expression, and maturation. Children that have identities developing that may not be highly valued within the family may need alternate opportunities to develop and express those identities outside the home (e.g., at school or through other cultural community involvement).

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Received June 9, 2011
Revision received April 4, 2012
Accepted April 18, 2012 ■

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