

CHAPTER 4

The Assessment, Diagnosis, and Treatment of Psychiatric Disorders in Lesbian, Gay, and Bisexual Clients

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Estimates of the prevalence of lesbian, gay, and bisexual (LGB) individuals in the general population have varied from 2% to 10%.¹⁻³ Moreover, it has been estimated that LGB individuals utilize therapy at higher rates than individuals who are not of minority sexual orientation status,^{4,5} and that most therapists report seeing at least one LGB client in their practice.⁶ Therefore, it is of the utmost importance that clinicians know how to appropriately provide mental health services for this population. This is particularly important in light of the past prejudicial treatment of LGB individuals by some mental health organizations.

The historical conceptualization of homosexuality as a mental disorder by the major associations of psychology and psychiatry is one clear example of cultural insensitivity toward LGB individuals by people in the field of mental health. Homosexuality was included as a mental illness in the original *Diagnostic and Statistical Manual of Mental Disorders* (DSM)⁷ under “sociopathic personality disorders”. Interestingly, sociopathic personality disorders were characterized by the absence of distress despite the presence of profound pathology. This meant that, while the current definition of a mental illness requires the experience of distress, the original DSM defined mental illness by the mere presence of a particular behavior. As such, homosexual men and women could still be labeled as mentally disordered even in the absence of significant distress or functional impairment.

Furthermore, the societal view of sexual behavior at the time was that appropriate sexual behavior was limited to only that which could potentially lead to procreation. In the DSM-II,⁸ homosexuality as a mental illness was moved to “Sexual Deviations”. The DSM-II stated that this category included “sexual interests that are directed primarily toward objects other than people of the opposite sex . . .” (p. 44) and also included the diagnoses of pedophilia, exhibitionism, voyeurism, sadism, and masochism. Therefore, the decision to classify homosexuality a mental illness could be conceptualized as a deficit model of mental illness: that is,

a minority group was compared with the majority and where differences existed, that minority group was labeled as disordered, despite lack of evidence that this group was impaired or distressed by their sexual orientation.

In 1973, largely due to the arguments made by gay rights activists (backed by empirical data, e.g., Hooker⁹), the American Psychiatric Association removed homosexuality from its list of mental disorders. It has been over 30 years since homosexuality has been considered a mental disorder, but some mental health professionals continue to practice as though homosexuality and bisexuality constitute mental illnesses. For example, some practitioners still advertise therapeutic cures for homosexuality – usually called reparative or sexual reorientation therapy. Sexual reorientation therapy continues to be practiced by some clinicians,¹⁰ despite the fact that the American Psychological Association (APA) and the American Psychiatric Association have both banned its administration. Reviews of the existing research on sexual reorientation therapy have found that it is not only largely ineffective at changing one's sexual orientation from homosexual to heterosexual, but that it is also connected to some harmful effects on the individual's mental health, such as depression, interpersonal difficulties, internalized homophobia, and suicidal ideation.^{5,11–13} The continued practice of sexual orientation therapy by some therapists serves to maintain the notion that homosexuality is a mental illness, and may make LGB individuals hesitant to seek services.

There are mixed data on the base rates of psychiatric disorders in LGB individuals as compared with heterosexual individuals. In some studies there were no significant differences in psychological functioning between groups,^{14,15} whereas others found that there were higher rates of mental illness among LGB individuals.^{4,16} If LGB individuals are at greater risk for mental disorders, it may be due to factors such as less access to appropriate psychological services or the societal stigma that is associated with having a homosexual or bisexual sexual orientation. The potential heightened risk for mental illness among LGB individuals, therefore, is not to be considered a direct result of one's sexual orientation. Rather, an LGB person's increased experiences with stressors such as discrimination, violence, and prejudice may lead to the development of mental health problems such as mood, anxiety, or substance use disorders. This hypothesis is supported by data that demonstrate a reduction in the disparity between psychological distress in homosexual/bisexual individuals and heterosexual individuals after experience of discrimination is statistically controlled.¹⁷

In 2000, the APA published guidelines for psychotherapy with LGB clients,¹⁸ in an effort “to provide practitioners with (1) a frame of reference for the treatment of lesbian, gay, and bisexual clients, and (2) basic information and further references in the areas of assessment, intervention, identity, relationships, and the education and training of psychologists.” The guidelines note that the APA's 1975 statement, “Homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities . . . and mental health professionals should take the lead in removing the stigma of mental illness long associated with homosexual orientation” was the beginning of a movement to make the field of

mental health more accommodating to LGB clients' needs. However, there are still areas where psychologists are responsible for ensuring that their practice reflects the meaning of this statement. The guidelines identify important areas of consideration for psychologists who work with LGB clients, and also provide resources on the subject matter.

The APA guidelines describe special considerations for assessment, diagnosis, and treatment of mental illness in LGB clients.¹⁸ The first section specifically describes the viewpoint that clinicians are encouraged to have on bisexuality and homosexuality in terms of their practice. First of all, psychologists should understand that homosexuality and bisexuality do not serve as makers of mental illness. That is, even if a client's stressors are related to their sexuality (e.g., discrimination), it is the *discrimination* that is responsible for the distress, not an individual's sexual orientation. In addition, psychologists are encouraged to take time to evaluate their personal views of homosexuality and bisexuality, and determine if their views could impede proper assessment and treatment of LGB individuals. This is where use of dynamic sizing, the therapist's ability to appropriately apply knowledge of the client's background and be aware of how their own biases affect therapy,¹⁹ is necessary for delivery of culturally sensitive services. Clinicians are also urged to develop culture-specific expertise,¹⁹ so that their views of homosexuality and bisexuality are informed by facts. If, after taking these steps to identify one's views and educate oneself with the facts about homosexuality and bisexuality, clinicians cannot divorce their personal views (if different) from the APA's views in practice, they are encouraged to refer their clients elsewhere. This will minimize the chances that LGB clients receive irresponsible or unethical psychological services. Finally, psychologists should strive to understand how inaccurate or prejudicial views of homosexuality and bisexuality, including their own, can propagate harmful stereotypes. Psychologists should be careful to not attribute mental health problems to homosexuality or bisexuality; rather, the problems should be attributed to the correlates associated with LGB individuals (e.g., more likely to be violently attacked, discriminated against).²⁰ Therapists who utilize a scientific mindedness approach (i.e. use the scientific method to investigate one's ideas of how the client's culture may affect assessment, diagnosis and/or treatment)¹⁹ to their treatment of mental disorders in LGB clients will be less susceptible to proliferate harmful views of LGB individuals.

Other areas to be considered when working with LGB clients include family structure differences and diversity within the LGB population. It may be the case that LGB clients more often have family members who are not legally or biologically related to them. In addition, they may have issues related to their family of origin's acceptance or rejection of their sexual orientation. Psychologists are urged to respect these differences and educate themselves about what these family issues might mean by reading resources that are available for working with LGB clients.²¹

Clinicians should also respect differences within the LGB population. Cultures vary in their views of homosexuality and bisexuality, and it is important to be

aware of how such differences can impact the client. The client should serve as the ultimate resource for describing the impact their ethnicity, age, religious views, etc. have on their view of themselves and their experience as an LGB person. Thus, clinicians are encouraged to place the client's behavior in the proper cultural context and ask clients about how these factors might affect them, rather than making assumptions about the client based on stereotypes.⁵

It is also recommended that psychologists put forth an effort to inform themselves about the above issues through reading scientific literature and also by directly asking the client about how these issues may or may not relate to their own experience. The main points of the APA's guidelines¹⁸ can be summarized into three statements:

- Psychologists should not consider homosexuality or bisexuality to be a marker of mental illness
- Psychologists should not attribute distress or impairment to the client's sexuality, but rather the experiences that are often correlated with homosexuality and bisexuality
- Psychologists are responsible for educating themselves on common LGB issues, as well as making themselves aware of individual differences within LGB individuals.

This chapter aims to explain how the important LGB issues mentioned above can be integrated and considered while utilizing empirically supported treatments in LGB clients. First, we will discuss our clinical experiences and hypotheses regarding the assessment, diagnostics, and treatment of mental illness in LGB clients. Second, we will review the existing literature on assessment, diagnostics, and treatment in LGB clients. Third, we will present a case example that ties together our hypotheses with the research literature in the area. Finally, we will conclude and identify avenues for future research. We want to emphasize that we believe that most empirically supported treatments require little, if any, adjustment to be effective with LGB clients because most therapeutic interventions affect basic human processes that exist across people of diverse sexual orientations. Education about LGB issues is important for assessment, diagnosis (specifically, determining if their behavior is normal within cultural norms), and mental health treatment in LGB clients as discussed below.

This chapter focuses on how to adapt treatment in light of these special considerations, and also highlights instances in which treatment does not need to be adapted. Most of the adaptation of treatment concerns the therapist being educated in and aware of particular issues that LGB clients face and potential therapist bias toward LGB clients that may interfere with proper service delivery. Adaptation may also include focus on themes in therapy that may be more common among LGB clients (e.g., sexual identity, impact on family of origin, discrimination). Again, the general *framework* (or *process*) of empirically supported treatments probably does not require much adaptation, but the *content* may be different.

CLINICAL OBSERVATIONS

Assessment

The following section will discuss assessment issues during intake and throughout treatment (e.g., symptom change during treatment). In our clinical experience, the assessment process with LGB clients is quite similar to the assessment process with heterosexual clients. However, there may be a higher likelihood that sexual identity concerns will arise either at the beginning or during the course of therapy. Still, it should not be assumed that these concerns will necessarily be part of therapy with LGB clients – as these clients may be presenting for the treatment of a mental disorder unrelated to their experiences as a LGB individual. For example, a female client presented at our outpatient clinic with bipolar disorder. She, like two-thirds of LGB clients in one survey,²² viewed her problems as having nothing to do with her sexual orientation. Therefore, the assessment process included virtually no discussion of her sexual orientation. She would mention her relationships with females as content in the therapeutic process, but the empirically supported treatment she received for bipolar disorder (social rhythms therapy²³ as adjunctive to antimanic medicines) required no adaptation.

However, when sexual identity issues do come up in therapy, it is important to assess what it is about the sexual identity that is distressing to the client. For instance, one client initially presented with anger problems, but issues about his sexuality arose as therapy progressed. He then wished to devote some time in therapy to his feelings of uncertainty about his sexuality, and distress about the fact that he might be homosexual. Regardless of the presenting problem, it is important for the clinician to consider that prejudice (e.g., stigma or family/friend reaction) may be the cause rather than the individual's sexual orientation. To illustrate, the aforementioned client was not distressed because of his homosexuality, but rather, the implications that he believed came along with being homosexual. For example, this client feared that if he were homosexual, he could not have the family he always wanted or be a successful business person.

Even when sexuality issues are not what prompt an LGB client to seek psychological services, therapists should not be blind to the unique experiences of homosexual and bisexual individuals when conceptualizing cases. Additionally, therapists should feel comfortable talking about same-sex relationships. Some clients may be attuned to even seemingly subtle avoidances of talking about same-sex relationships including: changing the topic, talking around the issue (rather than using plain sexual terms), or physical signs of discomfort (e.g., avoiding eye contact). In the same vein, therapists should not assume that their client is heterosexual. This assumption can manifest clinically in a scenario where the therapist is inquiring about romantic relationships and assumes that the romantic partner is of opposite sex. Therapists should strive to ask questions that do not assume sexual orientation, such as, "Has a *significant other* ever had a problem with your drinking habits?" rather than asking, "Has a *girlfriend* ever had problems with your drinking habits?"

In our clinical experience with the assessment of LGB clients, the standardized measures that are typically used with heterosexual clients can still be utilized. Again, when the clinician is interpreting the results, it is particularly important for the mental health symptoms (e.g., depression, anxiety, etc.) to not be attributed to the sexual orientation of the person. Rather, the clinician should take a scientific-minded approach and formulate hypotheses, as with any client, as to the sources of the distress. The therapist should then look for evidence in support of or against the hypotheses. The mental health symptoms may have nothing to do with events surrounding the sexual orientation of the individual, and practitioners should guard against such assumptions when assessing LGB clients.

With every client they have, clinicians should focus on the mental disorder or source of distress not only in the diagnostic stage, but also when assessing treatment progress. Therapists need to be certain that they are assessing progress toward the client's treatment goals (e.g., symptom remission) when assessing progress in therapy, rather than an issue having to do with their sexual orientation. The client's sexual orientation should not enter into the assessment of mental disorders when they initially present at the clinic or during the course of therapy through termination.

Diagnosis

Diagnostics are part of the assessment process, and even though homosexuality has been taken out of the DSM, prejudice may still exist in practice. The possibility of therapist prejudice (e.g., viewing homosexuality as a mental illness) should be considered during the diagnostic process, and appropriate caution should be taken to avoid this view of homosexuality as a mental illness. For example, a homosexual man who has lost his job due to discrimination or experienced a hate crime may experience a lot of distress, which could act as a negative life event to trigger a major depressive episode. Here it is important to attribute the distress to the negative life event rather than to the person's sexual orientation. It is emphasized that scientific tough mindedness and hypothesis testing using objective facts and diagnostic criteria are of the utmost importance. The natural human temptation to reason and attribute to salient features of the person (e.g., the client's sexuality) can only be overridden by systematic examination of the data.

Finally, the therapist's stance towards clients should be LGB-affirming rather than disapproving. Therapists should try to remain objective and focus on what is necessary to reach the goals of diagnosis – typically including acceptance and respect for the client's views of their own sexuality. When Alfred Kinsey described his research on human sexuality, he captured the essence of sound assessment, "We are the recorders and reporters of facts – not the judges of the behaviors we describe."²⁴

Treatment

At the beginning of the therapeutic process, building rapport with the client is important for motivation and treatment success. The therapist's knowledge of

LGB issues may be particularly important in building rapport with LGB clients. This may be especially true in light of some psychologists' history of attempting to treat homosexuality as a mental illness.¹¹ Therapists need to be aware of their own prejudices and be aware of potential harm when building rapport and in the treatment course (e.g., showing disapproval with facial expression or discomfort talking about homosexual activity). Being mindful of one's biases and prejudice is important in the working with LGB clients, because any slight discomfort on the part of the therapist may make the client feel ill at ease or mistrusting of the therapist. For therapists who have negative views of LGB clients, education and consultation with supervisors and peers is recommended. If the clinician still feels that their biases may interfere with responsible and ethical treatment of LGB clients, they are encouraged to refer LGB clients to another service provider who will be able to provide appropriate services for them.

Many currently used empirically supported treatments focus on basic human processes, and therefore should be effective with clients of various backgrounds. They may require little adaptation because the many empirically supported treatments provide a skill set and the framework for change, and at the same time allow flexibility in that the client chooses the content. For example, cognitive-behavioral therapies²⁵ focus on utilizing empirical information to change maladaptive cognitions. This process of finding evidence for and against maladaptive thoughts can be applied to cognitions on an array of topics. LGB clients may experience cognitions revolving around the special issues that LGB individuals face as a minority group (e.g., their family of origin disapproving of their sexual orientation), but the process by which they can challenge these maladaptive cognitions would remain the same. Similarly, techniques such as behavioral activation²⁶ and exposure for anxiety disorders²⁷ should work without adaptation with LGB clients, because of their effects on basic human processes.

Cognitive behavioral therapy (CBT) can be used to challenge maladaptive cognitions about the self through empirical evidence, rather than through a particular value system. For example, one client in our clinic reported he thought, "None of my friends will like me any more if they find out I am gay." CBT could be used to challenge this cognition. The therapist could help the client to identify this as a distortion (e.g., "fortunetelling," "all-or-nothing thinking")²⁸ and help the client to generate evidence for or against this thought. For instance, perhaps the client's friends have other gay friends, or the client could talk to other LGB people about how their friends reacted when they disclosed that they were gay. Psychologists may also serve as a resource for accurate information about sexual orientation by providing clients with access to empirical data on such topics as the biological data on sexual orientation and statistics about mental health of LGB people and their children.

Other empirically supported therapeutic techniques may be useful in this population. For example, Motivational Interviewing (MI),²⁹ which is traditionally used for substance use disorders but can be used to enhance desire to change behavior in general, focuses on clarifying what is important to the client and how the

client feels, and therefore should be generalizable to LGB clients. In addition, Interpersonal Psychotherapy (IPT),³⁰ a technique that focuses on interpersonal context of depression, contains a role transitions module that may be useful for an LGB client who has recently decided to disclose that they are homosexual. IPT is well-suited to aid the individual in processing feelings associated with the change in roles and relationships that may result on disclosing his or her sexual orientation. For instance, one client decided to come out to his parents, and mourned the loss of his former role as a heterosexual, married son who matched their longstanding expectations for how he would live his life.

Finally, Cognitive Behavioral Analysis System of Psychotherapy (CBASP)³¹ should also generalize to LGB clients, because of the focus on what the client desires as an outcome of a given situation (*see* the comprehensive case illustration for more details on this therapeutic approach). Thus, the content is individualized for each client within a generic framework of each of the aforementioned empirically supported treatments. The presence of the societal stigma associated with homosexuality and bisexuality may also lead to maladaptive cognitions and views of oneself in LGB clients that interfere with them reaching their desired outcomes. CBASP focuses on what the individual wants, so it is guided by the client's values. CBASP can be used as an objective method to help the client to determine what they want from their interpersonal interactions without the therapist's own values being projected.

For example, one of our LGB clients described a situation in which her desired outcome was to tell her sister that she was a lesbian. One of her thoughts was, "I am going to hell because I am gay." CBASP was utilized to identify whether this thought was helpful or hurtful in terms of her chances of reaching her desired outcome. The client identified that this thought was hurtful because it would make it less likely that she would feel enough courage to tell her sister that she was a lesbian. The therapy session then focused on remediation of this hurtful thought. The therapist and client worked together to generate thoughts that would be helpful to her reaching her goal of telling her sister about her sexual orientation (e.g., "My sister loves me very much.").

THE CURRENT STATE OF THE LITERATURE

Assessment

There is some support in the literature for the notion that therapists may mistakenly attribute distress to sexual orientation rather than stress associated with the societal stigma of being an LGB person,⁵ and still conceptualize homosexuality and bisexuality as a mental illness that needs to be cured through therapy. For example, Liszcz and Yarhouse³² conducted a survey among doctoral-level psychologists that involved presenting them with clinical vignettes describing a client who was experiencing same-sex attraction. The psychologists were asked to select the course of action that they viewed as the "best a clinician could make from a professional ethics perspective". Clinicians who were affiliated with a Christian

psychology organization were significantly more likely to disagree with a client's desire to "come out of the closet" and significantly more likely to agree with a client's wishes to undergo therapy focused on changing his sexual orientation than psychologists not affiliated with a religious association for psychology and therapists who specialize in LGB issues. This study suggests that LGB individuals who present for therapy may have had negative therapeutic experiences in the past or have had therapists who attributed their problems to their sexual orientation. The study above demonstrates how clinicians may structure treatment goals based on their own beliefs and desires, rather than focusing on clarifying the client's goals and affirming what the client feels about the situation.

There is some empirical support for the notion that clinicians should not assume that therapy with an LGB client will necessarily include discussion of sexual orientation, and that this focus might actually be harmful to clients. In one of few clinical trials involving a sample of lesbian women, Lewis *et al.*³³ adapted an expressive writing intervention that had demonstrated effectiveness in reducing distress and improving health in individuals dealing with traumatic events or stressors³⁴ to target "lesbian-related stressors". The intervention involved a sample of lesbian women writing about traumatic events related to sexual orientation over a two-month period, in the hope that it might be an effective tool for improving health in lesbian women. Interestingly, the intervention successfully reduced self-reports of confusion and stress over the two-month period for lesbian women who were less open about sexual orientation. However, the intervention appeared to have a negative impact on lesbian women who were already open about their sexual orientation prior to the intervention – they had increases in stress and confusion. This study is a salient sample of the potential danger involved with assuming that a situation (in this case, sexual orientation) is going to be traumatic to an individual. Clinicians should be mindful of the power of human resilience through hardship in the majority of cases, and avoid having an iatrogenic effect on LGB individuals.

Diagnosis

A useful way to improve accuracy of diagnosis is for the clinician to consider base rates of a mental disorder in certain populations when making diagnostic judgments.³⁵ To do this for the treatment of this population, the clinician should be knowledgeable about the rates of mental illness among LGB individuals. Cochran *et al.*⁴ conducted a nationally representative survey (n = 2,917 adults) with the purpose of evaluating potential differences in psychological distress, psychiatric disorders, and use of mental health services among LGB individuals as compared with heterosexual individuals. The homosexual and bisexual women and homosexual and bisexual men were combined for the analysis to increase power, as there were low rates of homosexual and bisexual orientation in the sample. The results indicated that LGB participants had higher rates of psychiatric distress, disorders, and more frequent use of mental health services. However, it is important to emphasize that approximately 60.2% of the LGB group did *not* have any evidence of the five

psychiatric disorders assessed (generalized anxiety disorder, major depressive disorder, panic disorder, alcohol dependence, substance dependence) as compared with 83.3% of the heterosexual group. Still, there were higher prevalence rates of mood, anxiety, and substance use disorders when bisexual and homosexual participants were compared with the heterosexual participants of the same gender. The results indicated that gay/bisexual men had higher rates of depression, panic attacks, and psychological distress than heterosexual men. On the other hand, lesbian/bisexual women had higher rates of generalized anxiety disorder than heterosexual women. Moreover, there were higher rates of comorbid disorders among LGB individuals than heterosexual individuals (i.e., LGB people were three to four times more likely to have comorbid psychiatric disorders than heterosexual people of the same gender).⁴ Thus, clinicians should consider a greater likelihood of comorbid disorders during the diagnostic process with LGB clients.

In addition to the disorders mentioned above, there is some empirical evidence that homosexual men may be at greater risk than heterosexual men for developing eating disorder symptoms such as drive for thinness and body dissatisfaction.^{36–38} One large-scale study found that gay/bisexual adolescent boys were more likely than heterosexual adolescent boys to engage in binge eating and to aspire to look like men in the media.³⁹ In contrast, some studies suggest that homosexual women may be somewhat buffered from particular disordered eating behaviors such as drive for thinness and use of exercise to control weight.⁴⁰ Adolescent girls who identify as bisexual or lesbian also appear to be less prone to body dissatisfaction and less likely to try to look like women in the media than heterosexual girls.³⁹ Despite lower rates of particular eating disorder symptoms (e.g., drive for thinness), some studies suggest that adult homosexual women do not differ from adult heterosexual women on measures of bulimic symptoms, body dissatisfaction, or weight concerns.^{39,41}

Multiple studies suggest that LGB adolescents are at increased risks for suicide attempts compared with heterosexual adolescents.^{42,43} Wichstrom and Hegna⁴³ conducted a large population-based study in Norway with 2,924 participants (grades 7–12) and found that suicide attempts tended to occur at the time the individual realized that they were not exclusively heterosexual. Hypotheses given for this connection were: internalized homophobia, increased risk of bullying, poor social support, and uncertainty/hopelessness about their future. Future studies designed to deepen our understanding of the mechanisms behind the increased rates of suicidal ideation and attempts in LGB adolescents are clearly warranted. In the mean time, the data suggest that clinicians providing services for LGB adolescents may want to carefully assess suicidality, given the heightened risk. This is particularly true if the adolescent has already “come out” or is in the process of “coming out.”

Another study compared a group of bisexual and homosexual youth with youngsters from middle and high school on suicidal ideation and suicide attempt status.⁴² The study found that homosexual or bisexual orientation doubled the risk for suicidal ideation compared with heterosexual youth, and quadrupled the risk

for a suicide attempt compared with heterosexual peers. There was also a main effect for gender, such that being a homosexual or bisexual female particularly increased the risk for suicide attempts. Having peers who were homosexual seemed to reduce the risk for suicidal ideation. The factors highlighted in this study should be considered when conducting risk assessment for suicidal behavior in LGB youth, in addition to using an empirically informed method for categorizing risk.⁴⁴

To reiterate, the fact that there are elevated rates of psychiatric disorders in the LGB population does not imply that being homosexual or bisexual is a mental illness. This is evidenced by two important empirical facts: (i) the majority of LGB individuals do *not* have a psychiatric disorder⁴ and (ii) the correlation between mental disorders and sexual orientation is reduced when controlling for stressors that LGB individuals are more likely to encounter, such as discrimination and violence.¹⁷ Therefore, the elevated rates of mental disorders should be conceptualized as a negative consequence of a society that discriminates against a minority group, rather than as a flaw of the individual who is affected by the discrimination.

Treatment

There is a paucity of empirical research on treating LGB clients with specific treatments. Often, clinical trials do not include data on sexual orientation, and researchers do not typically evaluate whether sexual orientation had an impact on treatment outcome. There is no theoretical reason to believe that empirically supported treatments would not work with LGB clients in a similar fashion to heterosexual clients, because the techniques seem to act on fundamental human processes, as mentioned earlier. Clearly, this is an empirical question in need of systematic data.

Despite the improbability of the specific treatment varying in effectiveness based on sexual orientation, it is reasonable to assume that issues that affect motivation to adhere to treatment in all clients, such as rapport, will affect treatment outcome in LGB clients as well. Therapists should pay special attention to perspective-taking with the client and recognize that the client's perspective may have unique aspects that are connected to being an LGB individual. For example, therapists should be aware of special considerations when working with LGB clients (e.g., identity development, being a LGB parent, prejudice) or particular biases that could exist when assessing, diagnosing, and treating LGB clients.⁵

Pachankis and Goldfried⁵ suggest that mental health problems may manifest in homosexual and bisexual individuals more often because they have internalized societal homophobia. They suggest that sexual minority individuals may manifest this internalized homophobia through substance misuse, anxiety, and depression symptoms. They propose that LGB individuals who have strong social support through their family and peers, and who are around and have more friends who are also LGB, may be somewhat buffered from developing mental health problems. This hypothesis stresses the importance of the APA's guidelines recommending that therapists are aware of local resources for LGB individuals, so that LGB clients can be referred to them. Social support has been demonstrated as a buffer from mental

illness in general, so it stands to reason that it could serve as a protective factor for LGB individuals. Future research should examine the potentially preventive role of social support against mental illness among LGB individuals, because it could have important implications for treatment approaches.

As mentioned above, LGB individuals' experiences with therapy and the therapist can shape their motivation and the effectiveness of treatment. It is suggested that even inadvertent discrimination might negatively impact therapy with LGB individuals. This is supported in analog studies that have found negative effects of subtle discrimination in therapy with LGB clients.⁶ In a study looking at LGB individuals' experience of therapy, Liddle⁴⁵ found that LGB clients tended to rate heterosexual women and LGB female and male therapists as more helpful to them than heterosexual male therapists, a finding that replicated the results of a previous study.⁴⁶ Liddle⁴⁵ proposed that this result might be due to the relatively consistent finding that men have more negative attitudes toward LGB people than women.⁴⁷

Because therapists cannot easily change variables such as their gender or sexual orientation, Liddle⁴⁵ also examined malleable behaviors that therapists can exhibit. Liddle⁴⁵ evaluated 13 suggested guidelines for practice with LGB clients.⁶ Nine were inappropriate practices (e.g., "Your therapist gave some indication that s/he assumed you were heterosexual before you indicated your sexual orientation"; "Your therapist blamed your sexual orientation for your problems or insisted on focusing on your sexual orientation without evidence that your sexual orientation was relevant to your problems"; "Your therapist gave you some indication that having a gay or lesbian identity was bad, sick, or inferior"; "Your therapist argued against or pushed you to renounce your sexual identification as a lesbian or gay man"; "Your therapist suddenly refused to see you any more once you disclosed your sexual orientation") and four statements were exemplary practices (e.g., "Your therapist was not afraid to deal with your sexual orientation when it was relevant"; "Your therapist made you feel good about yourself as a gay or lesbian"; "Your therapist was quite knowledgeable about lesbian and gay communities and other resources"). Of the 13 suggested guidelines, 12 were significantly related to overall outcomes of therapy, as indicated by termination of therapy after one session and overall rated helpfulness. The one statement that was not found to be statistically significant in predicting outcome was, "You believed that your therapist did not recognize the importance of lesbian/gay relationships and/or did not appropriately support these relationships."

Liddle's⁴⁵ findings suggested that the significantly correlated therapeutic behaviors be addressed in training programs. Furthermore, the findings suggest that there are concrete skills that can make the therapeutic process more culturally sensitive with regard to LGB clients. It could therefore be beneficial for LGB clients that therapists develop these skills. Future research should investigate whether training in these practices enhances therapist effectiveness with LGB clients.

COMPREHENSIVE CASE ILLUSTRATION

Joseph was a 21-year-old college student majoring in music, who was court ordered to an outpatient clinic for therapy as the result of being charged with driving under the influence of alcohol. He was assigned a minimum of 10 sessions of therapy, but this could be extended at the discretion of the therapist if he refused to engage in treatment. He initially presented at the clinic with a guarded interaction style, as evidenced by a defensive validity scale profile on the second edition of the Minnesota Multiphasic Personality Inventory (MMPI-2).⁴⁸ Joseph had no scale elevations suggestive of distress or psychological symptomatology (he elevated only Scale 5: Masculinity/Femininity, which, although considered a clinical scale, is not a scale that assesses psychopathology). He also tended to underreport the severity of his drinking habits in therapy compared with the report he gave to a court evaluator. For example, he reported to his therapist that he drank about four beers per week, but he reported to the court evaluator that he drank about eight beers per week. However, with gentle probing about the inconsistencies in his self-report, the inconsistencies were reconciled and the evidence supported a diagnosis of alcohol misuse. He endorsed no anxious or depressive symptomatology or problematic drug use on any of the various symptom measures that were administered at screening: the Beck Anxiety Inventory (BAI),⁴⁹ the Beck Depression Inventory-II (BDI),⁵⁰ and Short Michigan Alcohol Screening Tool (SMAST).⁵¹ The therapist hypothesized that, because Joseph was a court-ordered client whose progress would be reported to his probation officer, he had a motive to portray himself in an overly positive light. The therapist tested this hypothesis when giving Joseph feedback regarding his MMPI-2 profile and other measures by asking if his response pattern accurately depicted his test-taking attitude and whether or not he had any other ideas as to why a defensive response pattern emerged. Joseph responded that he was indeed hesitant to volunteer any information about his mental health because he was not sure who would see the information (in particular, he worried that his judge or probation officer might see it) and because he did not want anyone to think there was “something wrong with” him just because he had to go to therapy. The therapist’s hypothesis that Joseph was withholding information was therefore supported.

Joseph also stated an unwillingness to engage in therapy due to a past negative experience with therapy in which he was counseled for a short time by a psychiatrist whom Joseph found to be self-absorbed and presumptuous about Joseph’s feelings and beliefs, and because treatment was mandatory. Therefore, the primary treatment approach used with Joseph was Motivational Interviewing (MI), a therapeutic technique used to elicit motivation for behavior change by exploring the costs and benefits. This treatment approach was utilized to decrease his defensiveness and increase his motivation to engage in therapy. In particular, Joseph and his therapist examined the “problem” of being mandated to attend therapy. They discussed the facts of the situation:

- weekly therapy sessions were going to cost him a lot of money
- he had to spend an hour a week in a room with a therapist
- and his level of cooperation would be evaluated and reported to his probation officer, among others.

His options were delineated:

1. He could not attend therapy.
2. He could attend, but not engage in therapy.
3. He could attend and engage in therapy.

The pros and cons of each option were examined nonjudgmentally. For example, a pro and a con for option 1 were that he would save the money otherwise spent on treatment but he would violate probation. For option 2, he would complete his requirements of probation, but risk an eventual negative evaluation likely resulting in a longer stay in therapy. For option 3, he might learn something in therapy that would help him solve issues in his life that he felt were problematic, but he might have to discuss very personal things to accomplish this. At the end of three sessions of MI, Joseph decided that, as long as he had to be in therapy and was spending his own money on it, he may as well engage and see what he could get out of it.

Next, it was established that treatment would have to include discussion of Joseph's drinking habits and what factors contribute to his problematic drinking. The rationale for this treatment decision was that he was court ordered to therapy for the purpose of addressing his problematic drinking, and the reports that the therapist would send to his probation officer had to report that this issue was being addressed or he would not meet his probation requirements. However, to maintain his motivation to engage in therapy, Joseph and his therapist agreed that his therapy sessions could include a productive discussion on any issue in his life he wanted to "work on". After some discussion of potential topics, Joseph shared that he was attracted to men and women and engaged in sexual behavior with people of both sexes. Further, he stated that he would like to spend the time in therapy working on this aspect of his life. When asked to elaborate (i.e., to describe what about his attraction to men and women he wanted to "work on"), he stated that he was concerned with the potential negative reaction of his heterosexual friends if he told them he was attracted to men. In addition, regarding those friends who were aware of his bisexual orientation, he stated that he experienced a lot of pressure from his gay male friends to "be gay", and from his heterosexual friends to "be straight". Last, he described himself as effeminate and experienced pressure to "tone it down" when he was around friends to whom he was not out.

Before continuing the case study, two points regarding scientific mindedness and dynamic sizing are worthy of highlighting. First, it must be noted that this therapist, although likely aware of common stereotypes about gay men, exerted restraint in applying these stereotypes to his client. For example, the therapist

made no assumptions about his sexual orientation based on the fact that his client was a fine arts major and that he endorsed little concern in traditionally masculine interests, as evidenced by an elevated 5 MMPI-2 code type. Had the therapist allowed himself to be influenced by his knowledge of stereotypes about gay men, he may have also assumed that Joseph's defensiveness was due to a fear of negative judgments by the therapist due to his sexual orientation and explored this hypothesis (without reason to do so). Had this occurred, the therapist may have unwittingly alienated an already disengaged client early on in the therapy process. Second, after Joseph shared his sexual orientation with his therapist, the therapist did not assume that Joseph meant that his sexual orientation *per se* was the problem he wanted to address. Rather, the therapist asked Joseph to elaborate on his statement, and learned that Joseph wanted to "work on" the anxiety he was experiencing during his coming out process as a result of the pressure from his friends that he experienced and feared. In other words, the therapist learned that it was the societal reaction to his sexual orientation that caused him distress and not his sexual orientation.

After MI had been successfully used to enhance Joseph's motivation for treatment, the primary treatment approach was changed to CBASP to help Joseph identify situational triggers for his problematic drinking, as well as identify those aspects of a situation that made him most fearful of a negative reaction from his peers. In addition, CBASP would be helpful for Joseph to identify more helpful ways of interacting with others that would decrease his vulnerability to problematic drinking and minimize his distress.

Joseph completed weekly homework assignments (Coping Survey Questionnaires [CSQs], which ask for detailed descriptions of his thoughts and behaviors during a brief interpersonal interaction) and in-session exercises that taught him how to conceptualize situations in a CSQ format, such that Joseph could identify his desired outcome, and determine which thoughts and behaviors would increase his chances of achieving his goal for the situation. Throughout therapy, Joseph's situational analyses often involved thoughts about not wanting to appear disloyal to friends or otherwise upset or disappoint his friends. Joseph often stated that his friends were important to him and he did not want them to be upset with him, so if they wanted to him to do something, he usually would do it against his better judgment. This behavior would lead to problematic outcomes such as drinking too much to be able to practice violin the next day, or being pressured to engage in sexual behavior with which he was not comfortable. Later, he would be disappointed with himself for having done these things, leading him to feel like an inadequate violinist and confused about his sexuality. He decided that he wanted to learn how to say no to his friends and others without feeling disloyal. Below is a transcript of a session that discussed the issue.

Therapist (T): So what is your CSQ about this week?

Joseph (J): Well, I went home for the weekend and I went out with an old friend from high school while I was there. I wrote about that.

T: OK. Sounds great. I know your friends are really important to you. Let's start with step 1, describe the situation in a brief, clear way.

J: Ok. During the time Mindy and I were hanging out, we made out and she asked to have sex with me.

T: OK. That's pretty concise and clear now. Let's try step 2. While you and Mindy were making out and she asked to have sex with you, what thoughts were running through your head?

J: Well, she and I had had sex when we were in high school, and she brought up the possibility of having sex now, so I figured I would have sex with Mindy again. Also, I was afraid I'd hurt her feelings if I didn't. Also, because she brought it up, I really wanted her to have a good time.

T: OK. Let me make sure that I have a clear understanding of what was going through your head. I think I heard you describe these three thoughts: (i) I'm going to have sex with Mindy again, (ii) I don't want to hurt her feelings by saying no, and (iii) I want Mindy to enjoy sex with me. Did I understand correctly?

J: Yeah, that's right.

T: OK, so step 3. What were your behaviors in this situation; or rather, what did you do?

J: Well, basically I tried to get an erection but couldn't. I got really nervous and that made things worse.

T: What about step 4: How did the event come out for you – how did it end?

J: Well in the end we didn't have sex and I felt really bad about it. Like I hurt her feelings or something.

T: How did you want the event to come out?

J: I wanted to have and enjoy sex with Mindy.

T: Did you get what you wanted?

J: No!

T: Why not?

J: Because I couldn't get an erection!

T: Alright let's suppose that in spite of getting nervous, being worried that she wouldn't enjoy sex with you, you were still able to get an erection and have sex with Mindy. Would you have gotten what you wanted, which was "to have *and* enjoy sex with Mindy"?

J: Well, I don't know. We would have had sex so "yes" on that part. I don't enjoy doing anything when I feel a lot of pressure to do it or someone might not like it. Like when I'm being tested on the violin.

T: Hmm. That's an interesting thought. Why don't we go back to your thoughts and see how those influenced the outcome too. Let's focus on the part of the outcome about enjoying sex with Mindy now, and let's start with "I'm going to have sex with Mindy." Was thinking that helpful or hurtful to getting you what you wanted, and why?

J: Well, actually it was hurtful, because I felt like I didn't have a choice. It was just going to happen.

T: Hmm. That makes a lot of sense. It's not fun to feel like you don't have a say in what you're doing. What would have been a more helpful thought?

J: How about "I want to have sex with Mindy"?

T: Would that have been helpful for getting you what you wanted, which was to enjoy sex with Mindy?

J: No.

T: Why?

J: Because I didn't want to have sex with Mindy. She wanted to have sex with me.

Remediation of Joseph's other two thoughts went similarly. No interpretation of the situation would lead him to have enjoyed sex with Mindy, because he was only agreeing to have sex because she wanted to. He feared that saying no would hurt her feelings.

T: You know, we gave it a really good go at trying to get you what you wanted, but nothing seemed to work. Why do you suppose that is?

J: I don't know. I guess it would have been hard to enjoy sex with her, if I was just doing it because she wanted to. I have to want it too, and I have to be attracted to her. I just wasn't attracted to Mindy, even though she's a great girl.

T: I'm sure she is. What does that say about the CSQ?

J: I think I was trying to make myself want something I didn't just to avoid making her feel bad.

T: Hmm, like maybe your desired outcome was unattainable?

J: Yeah. There was no way I was going to enjoy sex with her if I was doing it for all the wrong reasons.

T: Hmm, that makes a lot of sense. So what can you take away from your work today?

J: I think I don't have to have sex if I don't want to, and that I probably wouldn't enjoy it anyway if I did it for other reasons. And a good clue that I don't want to is that I'm just not attracted to that person.

T: Hmm, so it's not about who that person is or what other people want? It's about whether or not you want it too and are attracted to that person?

J: Yes. Exactly.

Over time, Joseph learned that his fears of disappointing others led to other problems. He rarely enjoyed playing the violin because he feared his audience would be disappointed by his performance, he would never say no to a drink offered to him by a friend, etc. Therapy also involved having Joseph test his fear of appearing disloyal to friends by doing things like expressing a dissenting opinion, or turning down an invitation to go out, and watching for their reaction. When he would worry about whether or not his behavior appeared disloyal to someone, he would approach the person and ask if they felt he had been disloyal. Most of these exposure exercises led him to believe that many of his worries were unfounded. At the end of 10 sessions of therapy, Joseph had made much progress at identifying situational triggers for drinking and coming up with ways to avoid them. He had completed his court-mandated therapy in the required number of sessions. After that, Joseph decided to continue therapy as a non-court-ordered client and attended another 10 sessions of therapy at our clinic. He was very consistent about completing homework assignments, and began to generate his own homework assignments and therapy goals. At the end of 20 sessions of treatment, Joseph reported an increase in self-esteem and self-efficacy. In addition, his therapist noticed an increase in assertiveness, as he was more willing to correct his therapist whenever the therapist misunderstood him, and was more interested in debating issues with his therapist, rather than asking the therapist what he thought Joseph should do in a given situation.

CONCLUSIONS AND FUTURE DIRECTIONS

The field would greatly benefit from more empirical data on the experience that LGB clients have with psychological services. For example, how often do LGB individuals experience prejudice in assessment, diagnostics, and/or therapy, and what issues are most important for their therapist to know about? In addition to empirical studies focused on evaluating LGB clients' experience in assessment, diagnosis, and therapy, rigorous clinical trials that evaluate the effectiveness of empirically supported treatments (such as CBASP and CBT) in LGB samples would greatly contribute to our understanding of the best services to provide to LGB clients. These data would provide important information, empirically, about whether the same treatments should be used for heterosexual and LGB clients. In addition to evaluating the use of these treatments on mental disorders (e.g., anxiety, depression) in LGB clients, it would be useful to see how helpful these frameworks are with LGB clients who wish to sort through issues of sexual identity.

Safren⁵² calls for the integration of empirically supported treatments in combination with the therapist having an affirmative (i.e., positive, approving)

stance toward client homosexuality/bisexuality. He stated that many gay-affirmative programs do not utilize empirically supported treatments and vice versa. In the future, programs that involve both empirically supported treatments and an affirmative stance toward homosexuality would probably provide the best services to LGB clients. This chapter has discussed the lack of clear-cut evidence supporting the effectiveness of sexual reorientation therapy. However, as Spitzer¹⁰ points out, there is also no empirical evidence for LGB-affirmative therapy. Empirical studies should be conducted on the usefulness and effectiveness of LGB-affirmative therapy to determine if it is beneficial and/or has any harmful effects. Then, clinicians can feel more certain that they are practicing ethical therapeutic techniques with LGB clients.

In addition to more empirical study in this area, a psychoeducational component on LGB individuals' unique life experiences as part of training programs and continuing education should help therapists to feel and act in a more competent way in serving the needs of this minority group. Pachankis and Goldfried⁵ suggest that education on LGB issues be an essential component to clinical training. Without education on LGB issues, therapists are less likely to be competent in working with this population. In the absence of objective information regarding the perspectives of LGB individuals, clinicians may be left to rely on their own biases and personal experiences rather than on science.

Sherry *et al.*⁵³ recently contacted 135 clinical programs and 69 counseling programs and requested that they fill out a survey about their program's training on LGB issues. Of the programs that responded, 67.6% required a multicultural course, and 71% of the programs that required a multicultural course included a section on LGB issues. Regarding clinical practicum options, 89.5% of the programs reported providing opportunities for students to do clinical work with LGB clients, and 94.3% of the programs reported covering issues of sexual orientation in clinical supervision. These percentages must be interpreted with some caution, because there was a 51% response rate, and thus a selection bias may have affected the results. The results of this survey suggest that there is a multicultural component to many mental health graduate programs, and it is hoped that 100% of programs will include multicultural competence components in the future. Therapists who are not educated on LGB issues are encouraged to seek supervision and consult with colleagues so that they can provide a proper standard of care to LGB clients.