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Toward Formulating Evidence-Based Principles of LGB-Affirmative Psychotherapy

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Abstract

In this commentary, we review eight potential LGB-affirmative psychotherapy principles for improving minority stress coping among sexual minority clients. We illustrate these principles with examples from both Mandel's (2014) treatment approach and our clinical research team's recent attempt to create and test the efficacy of a treatment employing these principles in an ongoing randomized controlled trial. These principles are grounded in empirical research regarding the mechanisms through which minority stress compromises the mental health of sexual minority individuals and are supported by clinical expert consensus. The specific principles that we review include: 1) normalizing the mental health impact of minority stress, 2) facilitating emotion awareness, regulation, and acceptance, 3) decreasing avoidance, 4) restructuring minority stress cognitions, 5) empowering sexual minority clients to communicate assertively, 6) validating sexual minority individuals' unique strengths, 7) building supportive relationships, and 8) affirming healthy, rewarding expressions of sexuality. We believe that Mandel's skillful approach to helping her hybrid client Adam cope with minority stressors, such as internalized homophobia, and associated mental health problems such as substance abuse and depression, to form a healthy identity as a gay man represents an exemplary demonstration of these principles in action.

Keywords

minority stress; gay and bisexual men; stigma; intervention; psychotherapy; mental health; cognitive-behavior therapy; case study; clinical case study

Mandel's (2014) hybrid case study provides an exemplary description of targeting minority stressors, such as internalized homophobia, and their mental health sequelae in psychotherapy using multiculturally sensitive cognitive-behavioral principles and techniques. Over the course of therapy, she helps her hybrid client Adam further develop his identity as a gay man while also addressing his dysthymia and marijuana use. It is heartening to read Mandel's (2014) case study, as Adam is lucky to have found a therapist

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who integrated evidence-based practice with an affirmative stance toward the client's sexual identity. While we know that sexual minority individuals (e.g., those who identify as lesbian, gay, or bisexual [LGB] or report same-sex behavior or attractions) utilize therapy at higher rates than heterosexuals (Cochran, Sullivan, & Mays, 2003), we know little about the type of treatments they receive and how effective these treatments are at improving overall mental health and the added mental health burden of minority stress.

Minority stress refers to the unique stigma-related stress that sexual minority individuals face because of their sexual orientation that additively combines with general life stressors to confer disproportionate risk for certain mental health disorders for sexual minorities as compared to heterosexual individuals (Meyer, 2003; Meyer, Schwartz, & Frost, 2008). Sexual minority stigma operates at multiple levels to generate minority stress and compromise the mental health of sexual minority individuals. At the structural level, sexual minorities experience minority stress from discriminatory laws and institutional policies denying sexual minorities the rights of their heterosexual counterparts (Hatzenbuehler, McLaughlin, & Keyes, & Hasin, 2010). At the interpersonal level, sexual minorities report disproportionate exposure to childhood sexual abuse, parental physical abuse, parental rejection, peer assault, and discrimination, compared to heterosexuals (e.g., Friedman et al., 2008; Mays & Cochran, 2001). In fact, controlling for sexual orientation disparities in interpersonal discrimination largely attenuates the sexual orientation disparities in mental health (Mays & Cochran, 2001).

At the individual level, minority stress is associated with cognitive, affective, and social risk factors for psychopathology (Hatzenbuehler, 2009). Specifically, minority stress is associated with cognitive risk factors such as hopelessness (Ploderl & Fartacek, 2005), low self-worth (Wichstrøm & Hegna, 2003), chronic, anxious expectations of rejection (Pachankis, Goldfried, & Ramrattan, 2008), and internalizations of negative societal attitudes about sexual minorities (Newcomb & Mustanski, 2010). Individual affective risk factors related to minority stress include rumination (Hatzenbuehler et al., 2008), poor emotional awareness (Hatzenbuehler et al., 2008), emotional suppression (Matthews, Hughes, Johnson, Razzano, & Cassidy, 2002), and shame (Newcomb & Mustanski, 2010). Social psychopathology risk factors disproportionately reported by sexual minorities compared to heterosexuals and related to poor mental health include social isolation (Safren & Heimberg, 1999), childhood gender nonconformity (Pachankis & Goldfried, 2006), stigma concealment (Pachankis, 2007), and achievement-contingent self-worth (Pachankis & Hatzenbuehler, 2013). These individual-level processes potentially operate as the mechanisms through which sexual minority stigma "gets under the skin" of sexual minority individuals to jeopardize mental health (e.g., Hatzenbuehler, 2009) and, therefore, represent potential treatment targets when conducting psychotherapy with sexual minority clients.

Currently, no evidence-based treatment exists for improving mental health via reducing the mechanisms through which minority stress might compromise mental health as reviewed above. In order to address this dearth, our team recently developed Effective Skills to Empower Effective Men (ESTEEM), a cognitive-behavioral intervention that applies transdiagnostic mental health treatment approaches for emotional disorders, including cognitive restructuring and emotion exposure (e.g., Barlow et al., 2011), and adapts them to

address the mental health burden imposed by minority stress. In order to adapt a standard transdiagnostic cognitive-behavioral treatment approach to address minority stress in an LGB-affirmative manner, we interviewed 21 clinical experts and 20 depressed and anxious gay and bisexual men to gather suggestions for psychotherapeutic principles and techniques that could inform LGB-affirmative cognitive-behavioral treatment, as described elsewhere (Pachankis, 2014).

We see close parallels between Mandel's (2014) affirmative, evidence-based treatment of Adam and our own principle-based approach for improving minority stress coping to improve mental health and related health-risk behaviors in gay and bisexual men. Therefore, our commentary is organized around potential psychotherapy principles for improving minority stress coping among sexual minority clients. We employ examples from both Mandel's (2014) treatment approaches that are consistent with these principles and our clinical research team's recent attempt to create and test the efficacy of a treatment grounded in such principles in an ongoing randomized controlled trial, the development of which is described elsewhere (Pachankis, 2014).

LGB-AFFIRMATIVE PSYCHOTHERAPY PRINCIPLES

1) Normalize The Mental Health Impact Of Minority Stress

When implementing LGB-affirmative psychotherapy with sexual minority clients, therapists might face a challenge of knowing when a client's difficulties are a function of minority stress and when they are a function of other psychosocial mental health determinants. Sexual minority stigma can manifest in insidious ways, such as diffuse feelings of guilt or shame, fears of negative evaluation, self-silencing, or ongoing covering of one's personal life (Pachankis, 2007; Pachankis & Goldfried, 2006; Yoshino, 2006). On the surface, these symptoms might seem irrelevant to the client's sexual orientation—either to the therapist or to the client him- or herself. Therefore, in order to capture the subtle ways that minority stress can erode mental health, therapists can familiarize themselves with minority stress models of mental health (e.g., Meyer, 2003; Hatzenbuehler, 2009) and their application to clinical practice (e.g., Pachankis, 2014), conduct a careful assessment of the minority stressors experienced by each sexual minority client, and tentatively construct and share with the client a case conceptualization that incorporates relevant minority stress processes to raise the client's awareness of the unfair burden that minority stress places on sexual minority individuals.

We encourage therapists to share their minority stress-informed case conceptualization with the client in order to solicit feedback to appraise how well the minority stress model fits the client's understanding of the factors that cause and maintain his or her ongoing difficulties. Some clients readily agree with the minority stress conceptualization and find it easy to identify personal examples of minority stress and its impact on their lives. For these clients, discussing the personal impact of minority stress offers an empowering, consciousness-raising experience that locates the source of personal distress in stigmatizing social structures rather than personal deficits. This discussion can then serve as a key reference point throughout the course of therapy as the therapist or client suspect that minority stress may be relevant to presenting concerns.

Other sexual minority clients, however, have a more difficult time accepting the minority stress conceptualization, seeing their difficulties as resulting from factors such as genetics, neurology, personality defects, or other causes outside of minority stress. It is important to develop a shared understanding of the client's difficulties and recognize that a minority stress conceptualization can be dropped if the client does not see the relevance of this explanation or if it does not, in fact, adequately explain the client's presenting problems. Nonetheless, therapists may want to listen for the relevance of minority stress throughout treatment, keeping in mind that various vulnerabilities for anxiety and depression appear to be activated under conditions of stress (e.g. Lewinsohn, Joiner Jr., & Rohde, 2001), including minority stress (Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009), and that some clients may come to see the relevance of a minority stress framework only over time as they adopt the LGB-affirmative stance modeled by their therapist. Thus, an LGB-affirmative therapist knows when and how to incorporate the relevance of a client's sexual orientation and when a client's sexual orientation is irrelevant to a client's presenting concerns. In fact, failing to recognize that a client's sexual orientation represents just one aspect of his or her overall identity would constitute non-affirmative, and potentially ineffective, treatment (Burckell & Goldfried, 2006).

Mandel (2014) explicitly addresses Adam's internalized homophobia and aims to increase his acceptance of his identity as a gay man, raising his consciousness of the impact that his sexual identity, and particularly his family's and society's views of this identity, have on his thoughts, feelings, and behaviors. The therapist asked for permission early in treatment to discuss Adam's sexual orientation and provided affirmation for his coming out to her and for expressing his distress over his perceived need to be perfect to compensate for being gay. Mandel (2014) also adopts an exemplary approach of explaining to Adam the form and function of sexual minority stigma on his mental health. In this way, she helps Adam to attribute some of his distress to minority stressors while appreciating his initial reticence to discuss his sexual orientation and locating the potential source of this reticence in lessons from his upbringing regarding the impropriety of discussing sexuality.

2) Facilitate Emotion Awareness, Regulation, and Acceptance

Minority stress might influence mental health by hindering sexual minority individuals' emotion awareness, tolerance, and regulation. In fact, accumulating research suggests that emotion regulation difficulties mediate the relationship between minority stress experiences and depression and anxiety among sexual minority individuals both on a day-to-day basis (Hatzenbuehler, Nolen-Hoeksema, and Dovidio, 2009) and longitudinally over several years (Pachankis, Newcomb, Feinstein, & Bernstein, 2014). This suggests that emotion regulation might represent an important intervention target for sexual minority individuals who present with symptoms of anxiety or depression and related emotional disorders. Sexual minority individuals may experience more emotion regulation difficulties compared to heterosexuals for several reasons (Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008). First, society teaches sexual minority individuals that something that feels natural to them (i.e., being attracted to individuals of the same gender) is "wrong," leading them to mistrust themselves and their emotional experiences from an early age. Also, gay and bisexual men might absorb the cultural messages that emotions are feminine and "too gay," which can lead them to

avoid or hide their emotional experiences. The alexithymia, emotional avoidance, and limited affect tolerance sometimes seen in sexual minority clients, and in fact seen across many clients regardless of sexual orientation, also have implications for physical and mental health (e.g., Helmers & Mente, 1999; Pennebaker, 1995).

In our clinical research with depressed and anxious sexual minority male clients, we notice that some of our clients attempt to regulate their emotions through the use of substances and sex (Pachankis, 2014; Pachankis, Rendina, Restar, Ventuneac, Grov, & Parsons, 2015). Substance use and sex might represent particularly common emotion regulation strategies for sexual minority men given the relationship of these behaviors with minority stress (Pachankis, Hatzenbuehler, & Starks, 2014; Parsons, Grov, & Golub, 2012; Parsons, Lelutiu-Weinberger, Botsko, & Golub, 2014), the ability of these behaviors to serve self-regulation functions (Hatzenbuehler, 2009; Hequembourg & Dearing, 2013; Pachankis, Rendina, Restar, Ventuneac, Grov, & Parsons, 2015), and the relatively permissive substance use norms (Green & Feinstein, 2012) and ready availability of sex partners in the gay community (Parsons, Kelly, Bimbi, Muench, & Morgenstern, 2007). We noticed in our work that sexual minority clients sometimes report that these behaviors feel “out of control” as they have come to serve functional, sometimes automatic means of escaping negative affect. Therefore, one way in which our ESTEEM intervention addresses emotion-driven behaviors such as substance use and compulsive or risky sex is through employing emotion regulation strategies such as mindfulness skills and mood labeling exercises in the context of minority stress stimuli, as well as by emphasizing that minority stressors result in predictable, although distressing, emotional responses.

Likewise, Mandel (2014) skillfully teaches Adam emotion regulation skills, and thereby helps him reduce his marijuana use, by modeling emotional acceptance and supporting healthy expressions of emotionality. She specifically implements emotion regulation strategies such as mindfulness and urge surfing to help Adam learn to notice and accept his emotions and to choose adaptive behaviors for responding to them, such as contacting friends from high school and using his loneliness as a cue to develop his social network rather than to smoke. In fact, we have used such strategies across emotion-driven behaviors that our sexual minority male clients would like to change, including sexually compulsive behavior and various types of substance use. These strategies highlight the benefit of taking a transdiagnostic approach to encouraging emotion regulation skills across anxiety and depressive disorders and related emotional problems.

3) Decrease Avoidance

Avoidance behaviors are hallmarks of emotional disorders. In our experience, they often represent important treatment targets in clinical work with gay and bisexual men. Sexual minority stigma can yield avoidance not only in obvious forms, such as avoiding heterosexuals and intimate relationships with other gay and bisexual men, but in more subtle manifestations as well, such as perfectionistic behavior at work or home and ingratiating behavior towards others, both behaviors with which Adam struggled. For Adam, these latter behaviors likely served to stave off the possibility of rejection by his parents or friends due to his sexual orientation and to compensate for the ways in which being gay made him feel

inferior to his heterosexual peers. This avoidance can also manifest within the therapeutic process, such as when a client does not address his gay-specific concerns with the therapist due to shame and fear of rejection rooted in minority stress.

Mandel (2014) directly addresses Adam's various avoidant behaviors, including his substance use, ingratiating behavior, and perfectionistic academic strivings. She effectively balances accepting Adam's current ways of functioning while also helping him to discover ways of dropping his avoidant behaviors, providing affirmative scaffolding upon which he can build his emerging sexual orientation identity. Mandel's (2014) affirmative stance does not collude with Adam's avoidance of his sexual orientation and instead gently helps him to confront, accept, and ultimately embrace his identity as a gay man. Some tasks through which Mandel and Adam achieve this include Adam's attending Marijuana Anonymous LGBT meetings, connecting with other sexual minority individuals through an LGBT center, learning about other gay men's experiences in both monogamous and nonmonogamous relationships, and coming out to his sister and his close college friends.

Our clinical research (e.g., Pachankis, 2014) also highlights the importance of countering avoidance behaviors that interfere with sexual minority men's goals and values. For example, clients in our ESTEEM treatment create a hierarchy of avoidance behaviors with their therapist that includes both cognitive and behavioral forms of avoidance (e.g., avoiding romantic connections with other men, perfectionistic behavior at work or home, using substances during sex, and hypervigilance). The therapist and client then discuss the concept of behavioral exposures both to be conducted in session and practiced between sessions.

After laying this general exposure foundation, ESTEEM specifically targets avoidance that manifests in behavioral unassertiveness. Much like Adam, many of our gay and bisexual clients struggle to affirm their own wants, needs, and rights in their daily interactions. To specifically counter unassertiveness, we again create a hierarchy with clients. This time we include opportunities to demonstrate heretofore-avoided assertive behavior by conducting an in-session role-play to help them practice these skills and bolster their sense of self-efficacy for engaging in these behaviors. These strategies complement Mandel's approach to countering Adam's avoidance behaviors, using behavioral principles to help him behave in ways that are consistent with his goals.

4) Restructure Minority Stress Cognitions

Early and ongoing experiences with minority stress can teach gay and bisexual men powerful, negative lessons about themselves. For example, many sexual minority men are taught from a young age to believe that they are weak, wrong, bad, and unworthy as a result of living in a social context that, at worst, disparages sexual orientations other than heterosexuality, or at best, upholds heterosexuality as the normative sexual orientation while failing to provide visible models and support of healthy sexual identity diversity. Gay and bisexual men might internalize negative schemas about themselves and other gay men over time, coming to anticipate rejecting and discriminatory treatment from others. Our research shows that this type of internalized homonegativity and associated chronic, anxious expectations of rejection are associated with self-silencing behaviors, such as unassertive interpersonal behavior (Pachankis et al., 2008).

In particular, internally homonegative self-schemas might take the form of negative attitudes toward effeminacy (e.g., Sanchez, Greenberg, Liu, & Vilain, 2009; Sanchez, Westefeld, Liu, & Vilain, 2010; Taywaditep, 2001). While many gay men exhibit gender nonconforming behaviors during childhood (Landolt, Bartholomew, Saffrey, Oram, & Perlman, 2004; Skidmore, Linsenmeier, & Bailey, 2007), hegemonic gender role norms communicate that such behavior is unacceptable and inferior to heterosexual masculinity (Skidmore, Linsenmeier, & Bailey, 2006). Thus, gay and bisexual men exposed to these norms might engage in both increased self-monitoring of one's own effeminacy and valorizing masculinity in other men (Bailey, Kim, Hills, & Linsenmeier, 1997; Pachankis & Bernstein, 2012; Skidmore, Linsenmeier, & Bailey, 2006). Gay and bisexual men may be concerned about speaking or acting in "feminine" ways, sharing their emotions, or empathizing with others, as these are stereotypically women's purview (Taywaditep, 2001; Sanchez, Greenberg, Liu, & Vilain, 2009; Sanchez, Westefeld, Liu, & Vilain, 2010). Additionally, it has been argued that misogyny is the root of homophobia (Parrott, Adams, & Zeichner, 2002), indicating that restructuring overly strict gender role beliefs may help to reduce clients' internally homophobic thoughts.

Mandel (2014) does an excellent job of highlighting for Adam how his rigid notions of gender contribute to his internalized homophobia. She questions him about his disapproval of "flamingly gay" men and Adam responds by discussing how being gay makes him "less of a man." Mandel (2014) in turn provides psychoeducation about the socially constructed nature of gender scripts and how they devalue gender diversity, information that was likely very powerful for Adam, who had been raised by his father to value stereotypically masculine behavior.

Therapists working with gay and bisexual men can choose to administer explicit and implicit measures of internalized homonegativity to their sexual minority clients. Explicit measures include the Internalized Homophobia Scale (Herek, Cogan, Gillis, & Glunt, 1997), the Nungesser Homosexual Attitudes Inventory (Nungesser, 1983), the Multi-Axial Gay Men's Inventory—Men's Short version (Theodore et al., 2013), and the Internalized Homophobia Scale (Martin & Dean, 1992). All of these capture homonegative self-schemas with items such as, "I have tried to stop being attracted to men in general." and, "My homosexuality does not make me unhappy" (reverse coded). We believe that implicit measures of internalized homonegativity possess particular promise for overcoming potential social desirability biases that might keep clients from avowing their own negative attitudes toward homosexuality (e.g., Hatzenbuehler, Dovidio, Nolen-Hoeksema, & Phillips, 2009).

Mandel's (2014) free association exercise represents an ingenious, relatively implicit, technique for revealing very useful information about Adam's internally homonegative beliefs and attitudes. Specifically, by asking Adam to freely associate terms with being gay, Mandel and Adam efficiently learn that Adam sees being gay as being "an abomination," "sick," "pervert," "persecuted," and "alone forever." Our clinical research team routinely administers an implicit association task that measures how quickly and accurately participants are able to match images related to being gay or heterosexual with words that are positive or negative. Those with faster response times associating gay images with negative words than heterosexual images with negative images and slower response times

associating gay images with positive words than heterosexual images with positive words are deemed to have higher degrees of internalized homophobia. Therapists and clients can then review the results of this type of implicit measure, comparing the results to normative data, while considering the meaning that the results have for the client. Given Mandel's success with the free association task and our experience with the implicit association task, we believe that such implicit assessment techniques provide a clinically valid complement to more explicit measures of internalized homophobia.

Still, relatively little research thus far has addressed how to target internalized homophobia in a therapeutic context. One exception is Lin and Israel's (2012) development of an online intervention for reducing internalized homophobia. In this intervention, sexual minority men complete three online modules that address myths and stereotypes about sexual minority men. This facilitates cognitive restructuring of internally homonegative schemas, encourages self-reflection about where these misconceptions about sexual minority men originate, and promotes self-affirmation through writing a letter about the positive aspects of being a sexual minority man. Preliminary efficacy data suggest that this combination of techniques represents a promising treatment approach for reducing internalized homonegativity (Lin & Israel, 2012). These techniques are consistent with Mandel's (2014) overarching goal of reducing Adam's internalized homophobia and complement her use of psychoeducation to counter his stereotypes about sexual minority men in conjunction with cognitive restructuring about what it means for him to be gay.

Mandel (2014) also effectively employs cognitive techniques to address Adam's perfectionism. Adam enters treatment believing that his parents' acceptance of him is contingent on his academic perfection. Recent research applies a social developmental model of contingent self-worth among sexual minority male college students that, in fact, seems to validate Adam's experience. This research shows that young sexual minority college men demonstrate more achievement-oriented strivings in academic, appearance-related, and competitive domains than their heterosexual counterparts (Pachankis & Hatzenbuehler, 2013). Additionally, this research demonstrates that the longer that gay and bisexual men conceal their sexual orientation across early development, the more likely they are to invest their self-worth in achievement-related domains.

Achievement-related contingent self-worth may serve as an adaptive stigma-coping strategy in the short-term, leading to academic success and external validation, while deflecting attention away from one's stigmatized sexual orientation. However, these perfectionistic strivings can also hinder other life domains, such as forming genuine relationships and developing an internal sense of self-worth. We see this demonstrated in Adam's case as he seeks validation through his academic success to stave off the threat of being rejected by his parents for being gay. Mandel (2014) astutely recognizes and addresses his perfectionism, using cognitive restructuring early on in treatment to address his view of himself as a failure for having received a 'C' grade on a midterm and his need to be the "perfect child" in order to be loved and accepted by his father.

5) Empower Through Assertive Communication

Coming out as a sexual minority individual represents a potentially profound act of self-assertion. Perhaps one of the most important aspects of Mandel's (2014) treatment of Adam, therefore, focuses on empowering him as a gay man to assert his wants, needs, and rights as he navigates the coming out process. Even today, with greater acceptance of sexual minority individuals in mainstream U.S. society, gay and bisexual men still hide their sexual orientation for about five years, subtracting the age at which they first self-identify as gay or bisexual from the age at which they come out as gay or bisexual (Calzo, Antonucci, Mays, & Cochran, 2011; Pachankis & Hatzenbuehler, 2013). Thus, an essential part of sexual minority young men's identity is hidden from all others for a prolonged period of time with potentially detrimental psychosocial consequences. For example, concealment of a stigma can fundamentally shape one's self-and other-schemas, leading to feelings of guilt and shame, identity ambivalence, fears of being discovered, hypervigilance, unassertiveness, and decreased perceptions of self-efficacy (Pachankis, 2007).

Many of the sexual minority men with whom we have worked are eager to improve their assertiveness skills and to implement these skills outside of therapy. While many of our participants agree in theory with a list of rights that they inherently possess, such as the right to express oneself and the right to say no, a clear disparity often emerges when we ask them how frequently they *assert* these rights. Even for men who have been largely resilient in overcoming stigma-related stress, the behavioral repercussions of that stigma, often manifesting in unassertive interpersonal behavior, sometimes appear to endure even once gay and bisexual men have come to embrace their identities.

Our clients report difficulties in asserting themselves across a variety of daily domains, including with co-workers, roommates, family members, and romantic and sexual partners. Our clients also describe challenges asserting their desire to use condoms with a sex partner, often due to fears of rejection for having asked. In addition to preventing clients from getting what they want, a lack of assertiveness skills in sexual domains can also result in an increased risk for contracting sexually transmitted infections. Thus, by empowering Adam to assert his identity as a gay man, Mandel likely initiates him on a path of continued self-assertion in important life domains, including the domain of sexual health.

6) Validate Sexual Minority Individuals' Unique Strengths

In our work with young gay and bisexual men, we explicitly seek to facilitate the resilience that the vast majority of sexual minority individuals demonstrate against stress and to highlight the resilience that the LGBT community as a whole has demonstrated against stigma and oppression throughout history (e.g., Duberman, Vicinus, & Chauncey, 1990). In this way, we aim to help clients not just accept their sexual minority identities, but to actively embrace them while recognizing the historical legacy of which they are a part. Examples of resilience that we seek to promote, drawing up on the work of Herrick and colleagues (2011), include promoting social activism and volunteerism, social and sexual creativity, and a sense of shamelessness and pride.

Because coming out as a sexual minority individual can involve exiting the prescribed traditions and established life paths of heterosexuality (Cochran, 2001; D'Augelli, 1998), young sexual minority individuals may find themselves embarking on relatively uncharted lives (Siegel & Lowe, 1995). Yet, most manage to navigate this sometimes challenging, maybe surprising, path with remarkable creativity. For example, former romantic and sexual partners may come to form a key part of young gay and bisexual men's social networks, while older generations of sexual minorities may serve as role models for younger sexual minorities who usually do not benefit from the knowing guidance that heterosexuals can receive from their parents, who typically share their sexual orientation.

In many ways, we find ourselves instilling an activist stance among our sexual minority clients simply by virtue of blaming minority stress on social injustice rather than oneself and highlighting the courageous feats that LGBT individuals have demonstrated throughout history to gain access to the rights and protections afforded to heterosexuals. By encouraging Adam to interact with sexual minority peers at the local LGBT center, Mandel (2014) helps Adam connect with other sexual minority individuals who can normalize the challenges of the coming out process, demonstrate a sense of shamelessness and pride, and potentially serve as role models and mentors to him as he navigates the coming out processes.

7) Facilitate Supportive Relationships

Young sexual minority individuals report fewer social supports and less satisfaction with social support than their heterosexual peers, with differences in social support and related social vulnerability factors largely accounting for the sexual orientation disparity in mental health problems among youth (Safren & Heimberg, 1999). Further, sexual minority youth and adolescents consistently report more peer and parental victimization and sexual abuse than heterosexuals (Friedman et al., 2008). However, supportive relationships, such as from parents and peers, can provide an essential buffer against the adverse mental health effects of minority stress (D'Augelli, Grossman, & Starks, 2008; Goldfried & Goldfried, 2001; Grossman, D'Augelli, & Hershberger, 2000; Radkowsky & Siegel, 1997; Ryan, Russel, Huebner, Diaz, & Sanchez, 2010; Toomey, Ryan, Diaz, & Russel, 2011). Therefore, facilitating supportive relationships represents an important task in clinical work with sexual minority clients.

Mandel (2014) expertly guides Adam toward supportive relationships in a variety of ways, including encouraging him to attend a Marijuana Anonymous group, to seek contact with the campus LGBT center, and to develop a sponsor relationship with Jesse, another gay man with a history of substance use. These are all key ways to help Adam feel more supported, accepted, and connected to various communities in order to potentially stave off the adverse mental health effects of social isolation and interpersonal rejection. Because Adam had not yet come out to his parents, we hope that future work with Adam would help him to assess the meaning and relative costs and benefits of coming out to them. Experiential techniques, such as empty chair (Greenberg & Malcolm, 2002), could help Adam access his unmet needs resulting from his lack of sexual orientation disclosure to his parents (Moore & Pachankis, 2012).

In our clinical research, we have found that some sexual minority men also expect social rejection from the gay community (Pachankis, 2014). For example, many of our depressed and anxious gay and bisexual clients in New York City report feeling marginalized or excluded by other gay and bisexual individuals based on factors such as physical attractiveness, age, race, body size, effeminacy, and HIV status. Thus, we commend Mandel (2014) for directing Adam toward support within the gay community, such as the local LGBT center, and encouraging him to reach out to another gay man with a history of substance abuse to serve as a source of emotional support as well as a model for coping with minority stress and recovering from marijuana abuse. Similarly in our work, we have successfully helped our clients to connect with other inclusive and accepting members of the gay community, resulting in greater opportunities for support and companionship. Helping clients to recognize the diversity across the multiple LGBT communities in urban areas can also help them find their own supportive place within those communities.

8) Affirm Healthy, Rewarding Expressions of Sexuality

In our work with sexual minority clients, we strive to serve as sex-positive influences by explicitly communicating views of sex as normal, natural, and healthy while helping our clients to achieve sexual lives that are consistent with their priorities and respect their personal rights and the rights of all others involved. While Mandel (2014) compassionately and sensitively helps Adam integrate his sexual orientation identity into a complete sense of self, we were left wondering about Adam's sexual attractions and behaviors on the other side of the closet door. Previously he had used marijuana to cope with his same-sex fantasies and the feelings of shame that they invoked. In our clinical research, we have found that some sexual minority clients continue trying to escape the shame associated with same-sex sexuality by avoiding sexual contact outright or by using substances before or during sexual activity. We believe that it likely would have been helpful to therapeutically address how Adam wanted to continue exploring and expressing his sexuality and addressing his potential barriers to healthy sexual expression.

CONCLUSION

Mandel (2014) provides an exemplary case study in her treatment of a young gay man who presented for treatment with depression and substance abuse concerns. Her work draws upon emerging principles that are grounded in empirical evidence regarding sexual minority men's lives and that our team is currently testing for efficacy in a randomized controlled trial with young sexual minority men (Pachankis, 2014). Mandel's hybrid case study approach allows for a complex look both at the variety of ways in which stigma can negatively influence the mental and physical health of sexual minorities, and at the potentially effective psychotherapeutic strategies that can be employed to address them. We concur with Mandel (2014) that this approach serves as a useful resource for therapists to learn how to provide effective, affirmative mental health treatment for LGB clients.

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