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The Scientific Pursuit of Sexual and Gender Minority Mental Health Treatments: Toward Evidence-Based Affirmative Practice

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Abstract

The time has arrived for psychological science to translate the accumulating empirical research regarding sexual and gender minority (SGM) mental health into evidence-based affirmative treatments for this population. Far from the unscientific, homophobic theories of the early 20th century, several recent efforts in psychological science are starting to pave the way for evidence-based SGM-affirmative mental health treatments. These efforts include: 1) identifying clear treatment targets for SGM, 2) conducting treatment studies that test the efficacy of therapy for SGM populations, 3) increased reporting of sexual orientation and gender diversity in existing randomized controlled trials conducted with the general population, and 4) reducing stigma itself, which has heretofore impeded the resources necessary to produce scientific evidence about SGM-affirmative treatments. This article reviews this progress and outlines future research directions needed to advance evidence-based practice for SGM, including determining whether and how existing evidence-based treatments need to be adapted to address SGM-specific concerns, why SGM-affirmative treatments work, and for whom and under what conditions SGM-affirmative treatments work best. A program of research is described that attempts to address these questions through randomized controlled trials with strong comparison conditions, psychotherapy process research of current SGM-affirmative practice, and tests of treatment moderators. To the extent that the mental health profession continues to pursue these solutions, it can ensure the continued flourishing of this population, whose visibility and vibrancy likely represent the surest route toward improving public acceptance and therefore its future mental health.

Keywords

lesbian; gay; bisexual; transgender (LGBT); mental health practice; LGBT-affirmative practice; evidence-based treatment; empirically-supported treatment

Science, ideally agnostic to political forces, has in fact been used to both empower and imprison populations over time (Foucault, 1977). The existential validity of sexual and gender minorities (SGM) has long been contested, in democracies and autocracies alike, given the threat that diverse sexual and gender identities have posed to conservative values. Using scientific authority as its tool, the mental health profession (e.g., psychiatry, psychology, social work, mental health counseling), in particular, has historically played a

key role in both supporting and challenging the social and moral validity of this population across the past century. In this article, I review the history of scientific evidence regarding SGM mental health, from the unscientific, homophobic theories of the early 20th century to the pioneering research that now paves the way for evidence-based SGM-affirmative practice. I highlight how recent scientific and professional efforts are removing historic barriers to building the necessary evidence base for SGM-affirmative treatments. Finally, the article suggests a program of future research to advance evidence-based practice for SGM, spanning psychiatric epidemiology to psychotherapy process research.

Deriving scientific evidence amidst political terrain

During the first half of the 20th century, most early psychoanalytic theorists in the US promoted the view that homosexuality was pathological and in need of eradication (e.g., Bieber, 1962; Socarides, 1968). Although this stance directly contradicted Freud's (1935) belief that homosexuality was not an illness, vice, or degradation, the American psychoanalytic community hewed closely to the anti-homosexuality zeitgeist of the time. Indeed, the mental health profession's explicit homophobia, operating under the guise of scientific authority, was used to promote emotionally, and sometimes physically, abusive treatments, such as aversive conditioning and other forms of conversion therapies (Drescher, Shidlo, & Schroeder, 2002). These theories and treatments were not scientific by any standard definition, as they relied on extravagant, unfalsifiable claims (e.g., of homosexuality as an intrapsychic compromise). But without access to the social, legal, or academic power to collect empirical data, SGM were without a necessary voice to refute the profession's widespread, unchecked homophobia.

In the middle of the 20th century, however, psychologists first used empirical approaches to help shift the field toward more affirmative practices. For instance, in the 1950s and 1960s, when the official psychiatric nosology classified homosexuality as a mental illness, visionary researchers (Hooker, 1957, 1958; Siegelman, 1972) gathered scientific evidence to substantiate observations that the psychological profiles of gay men and lesbian women were similar in important respects to those of heterosexuals. Similarly, during later decades, when same-sex relationships were criminalized in many jurisdictions and not treated as equal to heterosexual relationships, psychological researchers again established that same-sex relationships were highly similar to heterosexual relationships in terms of relational goals and quality (Bell & Weinberg, 1978; Peplau & Cochran, 1981). Then, as now, these findings have been used to advance the equitable treatment of SGM, not only within the mental health profession, but in society at large. Here, the goal of equality is not just to remove symptoms of mental health disorders disproportionately experienced by SGM, but to promote the social, emotional, and physical wellbeing, life satisfaction, and open self-expression that follows.

The AIDS epidemic during the 1980s and 1990s in the US brought even more significant empirical attention to the health of sexual minorities, specifically gay, bisexual, and other sexual minority men, who were and remain at greater risk of HIV infection than heterosexuals in much of the world (Centers for Disease Control and Prevention, 2010). During this time, an increasingly robust body of research suggested that the stressful effects

of stigma and discrimination toward this population manifested in greater psychiatric morbidity. Thus, one paradoxical benefit of the AIDS crisis was a body of evidence highlighting the co-occurring epidemic of mental health problems in this population, which in fact had existed long before the AIDS epidemic. Specifically, this research showed that sexual minority men experienced elevations in stress-sensitive mental health disorders such as depression, anxiety disorders, and substance use disorders, that not only co-occurred with HIV-related morbidity and risk but also stood on their own to disproportionately burden this population compared to heterosexuals (D'Augelli, 1989; Garnets et al., 1990; McKirnan & Peterson, 1988; Meyer, 1995). The AIDS era in the US also launched the first psychosocial interventions for sexual minorities tested in randomized controlled trials, with these studies focusing on HIV-related risk reduction and stress management among gay and bisexual men (e.g., Antoni et al., 2000; Lutgendorf et al., 1998).

While this research demonstrated that sexual minorities were disproportionately affected by stress-related mental health conditions, it was often hampered by methodological shortcomings that limited its persuasiveness. Specifically, most early studies on sexual minority mental health relied on non-representative samples of sexual minorities who were disproportionately open about their sexual orientation, educated, white, and recruited from LGBT-focused venues. It was not until the late 1990s and early 2000s that population-based samples of sexual minority men and women overcame this limitation (Cochran & Mays, 2000a; Gilman et al., 2001; Stall et al., 2003). Population-based sampling, which represent all SGM in a population regardless of demographic factors, has repeatedly shown that sexual minorities experience at least a twice greater likelihood of major depressive disorder, anxiety disorders, and substance use disorders compared to heterosexuals (e.g., King et al., 2008). The greater comorbidity in mental health conditions among sexual minorities compared to heterosexuals also potentially indicates that such mental health problems manifest with more severe impairment, treatment resistance, and course (e.g., Cochran, Sullivan, & Mays, 2003). Notably, even to the present day, very few population-based studies have permitted examining mental health disparities and determinants by gender identity (White Hughto, Reisner, & Pachankis, 2015).

In addition to establishing the significant mental health disparities affecting sexual minorities, this latest generation of research has rigorously demonstrated that these mental health disparities are largely accounted for by sexual minorities' disproportionate exposure to stigma-related stress compared to heterosexuals. For instance, this finding has been confirmed using population-based sampling (e.g., Mays & Cochran, 2001), interviewer-based assessments of minority stress experiences (e.g., Meyer, Schwartz, & Frost, 2008), and measures of exposure to structural stigma (e.g., social policies that deny protections based on sexual orientation status; Hatzenbuehler, Keyes, & Hasin, 2009a). This most recent stage of research has found that stigma operates through diverse processes, such as the stress of victimization, identity concealment, and anxious expectations of rejection, to compromise mental health (Meyer, 2003). These mechanisms often emerge in adolescence (D'Augelli, Hershberger, & Pilkington, 1998; Russell, Everett, Rosario, & Birkett, 2014) and can compound general life stress to exert deep psychological effects across the life course (e.g., Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Pachankis, 2007; Pachankis & Hatzenbuehler, 2013; Pachankis, Sullivan, Feinstein, & Newcomb, 2018). While research

on the mental health of people with diverse gender identities and transgender experience has accumulated more slowly, existing research suggests that this population is at least equally burdened with poor mental health for many of the same stigma-related reasons affecting sexual minorities (White Hughto et al., 2015).

As this brief historical review shows, the mental health profession has shifted from unscientific theories influenced by social mores to more empirically sound observations about the distribution and determinants of SGM mental health. This research has laid the empirical foundation for the recent progress in evidence-based SGM-affirmative practice described below.

Progress toward evidence-based SGM-affirmative practice

SGM-affirmative mental health practice recognizes that SGM possess distinct, and diverse, life experiences not experienced by heterosexual or cisgender individuals that can influence mental health. Across numerous clinical accounts, case studies, and clinician surveys (e.g., Fassinger, 2000; Garnets, Hancock, Cochran, Goodchild, & Peplau, 1991; Pachankis & Goldfried, 2004; Ritter & Terndrup, 2002), SGM-affirmative practice is typically characterized by several principles, including helping SGM develop insight into the ways in which stigma generates excess stress to compromise mental health; desensitizing SGM to negative feelings, such as shame and guilt, and countering negative cognitive styles, such as hopeless and low self-worth, that can emerge from stigma-related stress; promoting resilience, pride, and community building as an antidote to stigma-related stress; and therapists providing SGM-specific resources and acting as informed advocates against societal injustice. These SGM-affirmative principles can characterize therapy of any theoretical orientation free of heterocentrism and homophobia.

Currently, professional guidelines for SGM-affirmative practice derive from clinical experience and the application of theory and research regarding SGM mental health to clinical practice, but not from direct tests of the efficacy or implementation of SGM-affirmative practice. Several international professional organizations, such as the American Psychological Association (APA) and the psychological societies of Australia, the UK, and South Africa, among others, have adopted guidelines for SGM-affirmative practice (American Psychological Association, 2017). The APA has also published guidelines for affirmative practice with transgender and gender nonconforming individuals to address the mental health consequences of stigma-related stressors specific to this population given mental health professionals' general lack of familiarity with transgender-affirmative care (APA, 2015). Yet, without direct empirical examinations of the efficacy and implementation of SGM-affirmative practice, the field has lacked concrete guidance for translating SGM-affirmative professional guidelines into practice.

Despite historical barriers, several recent developments suggest that the field is now well-positioned to move forward with evidence-based SGM-affirmative practice. As reviewed in detail below, this progress includes: 1) identifying clear SGM-affirmative treatment targets, 2) conducting treatment studies of the efficacy of SGM-affirmative practice, 3) reporting SGM status in randomized controlled trials conducted with the general population, and 4)

reducing stigma itself, which has impeded the necessary resources required to produce treatment-related evidence. I discuss this recent progress below.

Identifying clear SGM-affirmative treatment targets

Despite clear and consistent evidence that SGM represent one of the highest-risk groups for mental health problems, and that stigma-related stressors contribute to psychopathology among SGM, the mechanisms through which stigma-related stress compromises the mental health of this population have remained unclear until recently. Without knowing these mechanisms, the field lacked clear treatment targets. Recent methodologically diverse studies, however, have identified probable mechanisms shown to underlie the association between stigma-related stress exposure and stress-sensitive mental health outcomes, mechanisms that can be addressed by evidence-based treatments.

Some of these processes, like emotion regulation deficits, rumination, social isolation, and depressogenic cognitive biases, are *universal* risk factors for internalizing psychopathology but are elevated among SGM compared to heterosexuals (Hatzenbuehler, 2009). Elevations in these universal mechanisms among SGM have been found to emerge early in development (Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008) and to explain sexual orientation disparities in mental health problems across the lifespan (Hatzenbuehler, 2009). Processes like rumination and social isolation are known precursors of internalizing psychopathology in the general population (Kawachi & Berkman, 2001; Nolen-Hoeksema, 2000), have been shown to causally mediate the association between stigma experiences and psychological distress among sexual minorities (Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009b), and represent modifiable targets of existing evidence-based treatments, such as emotion-focused and cognitive-behavioral therapies (Elliott, Watson, Goldman, & Greenberg, 2004; Farchione et al., 2012).

At the same time that these universal processes have been found to be elevated among sexual minorities, recent research has identified processes *specific* to sexual minorities that are strongly associated with stigma exposure and internalizing mental health problems, and that statistically mediate the association between stigma exposure and mental health (e.g., Pachankis, 2015). Given that they serve as mediators of the association between stigma and poor mental health, they are also candidate treatment targets. For instance, one of the largest samples of sexual minority men and women, collected across 28 countries, found that sexual minorities were significantly more likely to conceal their sexual orientation in highly homophobic countries, which in turn predicted their lower life satisfaction in those countries (Pachankis & Bränström, 2018). Other studies have similarly identified processes like anxious expectations of rejection and internalized stigma as mediators of the association between stigma exposure and mental health problems (e.g., Pachankis et al., 2015c). Research has extended these findings to outcomes such as body image disturbance (Hamilton & Mahalik, 2009), relationship satisfaction (Newcomb et al., 2017), and HIV risk behavior (Pachankis et al., 2015a). Given that they are distinct to sexual, and potentially gender, minority populations, processes like concealment, rejection hyper-vigilance, and internalized stigma likely demand distinct adaptations to standard evidence-based practice in order to be effectively and sensitively addressed.

Conducting studies on SGM-affirmative treatments

The lack of empirical evidence of distinct, treatment-amendable mechanisms affecting SGM has impeded the case for developing and testing SGM-specific treatments (National Institute of Mental Health, 2010). In fact, a recent systematic review of SGM mental health interventions (Chaudoir, Wang, & Pachankis, 2017) revealed only one such treatment to have been tested for efficacy in a randomized controlled trial. This particular study, of a stigma-related stress coping intervention for young gay and bisexual men (Pachankis et al., 2015b), utilized a waitlist design, not a particularly strong test of efficacy. Several other studies have utilized within-subject designs to examine whether SGM-specific treatments (i.e., those that address the SGM-treatment targets reviewed above) successfully reduce stress-related outcomes, such as depression and suicidal ideation, before and after treatment (e.g., Craig, Austin, & McInroy, 2014; Diamond et al., 2012; Lucassen, Merry, Hatcher, & Frampton, 2014; Ross, Doctor, Dimito, Kuehl, & Armstrong, 2007). Without a control group, though, such studies cannot establish the causal impact of the examined intervention. Nonetheless, they offer a platform for stronger future tests, including randomized controlled trials with strong comparison groups.

In the relative absence of treatment studies, several clinical scholars have reported the results of case studies demonstrating the successful application of empirically-supported treatments to SGM clients (Glassgold, 2009; Kaysen, Lostutter, & Goines, 2005; Safren & Rogers, 2001; Walsh & Hope, 2010). Notably, these studies all described SGM-specific adaptations to cognitive-behavioral therapies (CBT). Such applications are logical given that CBT: 1) locates present maladaptive behaviors in the context of their developmental function and current environmental contingencies, such as seeing stress-sensitive mental health problems as learned responses for coping with stigma, 2) empowers clients to cope with adverse environmental circumstances, such as stigma-related stress, by promoting coping self-efficacy, and 3) encourages the replacement of maladaptive cognitive, affective, and behavioral stress responses, such as those emerging from stigma exposure (Balsam, Martell, & Safren, 2006). These case studies report helping sexual minority clients in the following ways: reworking negative attitudes about themselves and SGM peers that had been internalized across early development; facing fears related to sexual orientation disclosure; reframing self-as-victim narratives into empowered coping narratives; forming relationships with SGM community members as a form of behavioral activation to build resilience and pride; and understanding current symptomatology in the context of societal homophobia while simultaneously promoting an active stance against homophobia.

Despite the current lack of strong efficacy studies, a robust scientific basis now exists from which to further develop and test the efficacy of treatments for SGM populations. Indeed, recent suggestions have been put forth not only for adapting cognitive-behavioral treatments for SGM clients (Pachankis & Safren, in press) but also for adapting several additional forms of existing evidence-based practice for SGM, including dialectical behavior therapy (Pantalone, Sloan, & Carmel, in press), relationship education (Pepping, Lyons, Halford, Cronin, & Pachankis, 2017), parent trainings (Goldberg, Frost, & Noyola, in press), mindfulness- and acceptance-based approaches (Skinta & Curtin, 2016), and attachment-based family therapy (Diamond, Diamond, Levy, Closs, & Siqueland, 2012). Recent

endeavors also illustrate how the growing scientific evidence of stigma-related stressors affecting transgender populations can be addressed through evidence-based practice (Austin & Craig, 2015). Emerging evidence-based suggestions for treating transgender clients are particularly noteworthy given the considerable lack of empirical attention paid to transgender individuals to date, compared to sexual minorities.

Documenting SGM status in existing treatment research

In addition to the historic lack of both clear treatment targets and treatment studies for SGM individuals, another barrier to creating evidence-based practice for SGM has been the lack of collecting and reporting sexual orientation and gender diversity in empirical tests of evidence-based practice in the general population. Without knowing whether general treatments are differentially efficacious across diverse sexual orientations and gender identities, it has been impossible to know whether such treatments required adaptations for these diverse populations (National Institute of Mental Health, 2010). In a recent systematic review, less than one percent of published randomized controlled trials reported sexual orientation as a demographic factor, none reported the presence of non-binary gender identities, and none examined treatment efficacy by sexual orientation or gender identity (Heck, Mirabito, LeMaire, Livingston, & Flentje, 2017).

A few notable recent attempts have been made to examine whether treatment outcomes differ by sexual orientation in naturalistic treatment settings. For instance, in a sample of patients who had received cognitive-behavioral or dialectical behavior therapy in a clinic, SGM patients reported equal treatment outcomes compared to other patients, although bisexual individuals reported more self-injurious and suicidal thoughts and worse perceptions of care after treatment compared to other patients (Beard et al., 2018). In a large national convenience sample of students who had received psychotherapy at a college counseling center, sexual minorities presented with greater symptoms of depression and anxiety, but they did not exhibit differential rates of change compared to heterosexual students (Lefevor, Janis, & Park, 2017). In a secondary analysis of a randomized controlled trial comparing cognitive-behavioral substance use treatment to treatment as usual, sexual orientation moderated treatment efficacy such that sexual minority adolescents experienced greater reductions in internalizing symptoms and drug use than heterosexual adolescents (Grafsky, Letcher, Slesnick, & Serovich, 2011). Taken together, although these studies have begun to examine whether SGM clients fare similarly in treatment as heterosexuals, they are not definitive in painting an overall picture regarding whether sexual minorities might experience differential benefit from existing evidence-based treatments. No studies have examined diverse gender identities as treatment effect modifiers.

Reducing stigma as a barrier to SGM-affirmative treatment research

Stigma itself perhaps represents the ultimate barrier to progress toward effective treatments for SGM individuals. As illustrated below, an essential feature of stigma is its ability to rob the stigmatized of the very knowledge, power, and resources needed to shift the inequities that keep them stigmatized (Bränström, Pachankis, Hatzenbuehler, & Link, 2016; Link & Phelan, 2001).

Accurate data regarding SGM mental health have been slow to accumulate owing to the complications of assessing a relatively hidden population whose members disclose at their own risk. Unlike many other minority populations, SGM individuals are not a readily identifiable population. This fact requires researchers to explicitly ask SGM about their sexual and gender identities at the same time that it requires SGM individuals to trust researchers to adequately protect this sensitive information (Hooker, 1993; Pachankis, Cochran, & Mays, 2015). Arguably for most SGM in the world today, disclosure to strangers is an unwise prospect; in fact, a recent analysis estimates that most SGM individuals in the world are closeted, potentially to avoid harm (Pachankis & Bränström, 2018). Consequently, concealment, driven by stigma, represents a formidable barrier to knowledge regarding SGM mental health and effective treatments.

Historically, stigma has imposed barriers to SGM people attaining prominent positions from which to rectify inequities. For instance, in the latter part of the 20th century, with a few courageous exceptions, very few academic researchers could devote their careers to studying SGM mental health given the career jeopardy that faced those who pursued such research. While today represents the first time in history that a critical mass of mental health researchers has received graduate training in SGM mental health and is largely capable of staking their careers in pursuit of this topic without risk, this progress is mostly limited to the US and a handful of other Western countries. While greater prominence of SGM researchers within academia will at least partially rectify the historic lack of power available to address SGM mental health, the amount of work to be done to address these substantial mental health disparities is formidable.

Stigma has also driven a historic lack of funding devoted to SGM health. Even HIV/AIDS, the most acute public health threat to affect SGM, was itself slow to garner adequate funding and ultimately required the now-famous dramatic acts of protest to bring necessary attention to the dire crisis that struck this population (Epstein, 1996). And now, despite the fact that mental health conditions very well might represent a greater overall health burden to SGM than HIV/AIDS (Hottes, Ferlatte, & Gesink, 2015), nearly three-quarters of the National Institutes of Health funding (NIH) portfolio for SGM health has been restricted to understanding and preventing HIV/AIDS among sexual minorities (NIH, 2015). Funding devoted to understanding and treating SGM *mental* health remains inadequate. Propagating these structural barriers to acquiring adequate funding resources is inconsistent recognition of SGM as a disparity population in federal agencies (Mustanski, 2015). For example, the National Institute on Minority Health and Health Disparities (NIMHD) only recently recognized SGM as a disparity group, which is required to provide research funding targeted at reducing the population health inequities that exist by SGM status (NIMHD, 2016). To date, therefore, most of the highest-quality mental health treatment data for SGM derive from studies explicitly focused on reducing HIV transmission among sexual minority men. In addition to underrepresenting women and gender diverse populations, this focus on HIV transmission potentially overestimates risk. Hopefully, progress toward more equitable recognition and funding will yield the necessary power to continue improving the mental health of SGM, including sexual minority women and transgender individuals.

Future scientific directions in evidence-based SGM-affirmative practice

While the field has started laying a foundation for evidence-based practice for SGM clients, several existing knowledge gaps suggest exciting avenues for future study. A primary future question involves determining whether and how existing evidence-based treatments need to be adapted to address SGM-specific concerns. Other important future directions for bringing a greater evidence base to SGM-affirmative practice include determining why SGM-affirmative treatments work and for whom and in what contexts they work best. These future directions span epidemiological surveys to fine-grained examinations of in-session processes (see Table 1).

Do existing evidence-based treatments need to be adapted to address SGM-specific concerns?

Given limited resources available to develop and test distinct evidence-based psychotherapies and the fact that *universal* psychosocial risks at least partially underlie the mental health of all populations, one might reasonably ask, “Why do SGM need their own evidence-based treatments?” Indeed, if every distinct population required its own evidence-based treatment, the field would be required to support, and providers would be required to learn to deliver, thousands of treatments, an untenable situation (Kazdin, 2000). Further, as growing awareness of intersectional realities highlights the unique experience of finer population subgroups (Pachankis et al., 2017), this challenge multiplies. Therefore, a high threshold is needed to justify the resource outlay required to support the development of distinct evidence-based psychotherapies for any population subgroup. Whether or not SGM treatment needs surpass that threshold remains to be determined.

On the one hand, substantial evidence from the cultural adaptation literature suggests that evidence-based treatments for distinct cultural groups (e.g., racial/ethnic minorities) yield better outcomes, including engagement, retention, and satisfaction in therapy, when they are adapted to address the distinct social ecological contexts, presenting concerns, and symptom manifestations of those cultures than non-adapted versions of those treatments (e.g., Smith, Domenech Rodríguez, & Bernal, 2011). On the other hand, as reviewed above, a small body of emerging research suggests that SGM individuals might derive comparable benefit as heterosexuals from standard, non-adapted evidence-based treatments (e.g., Beard et al., 2017; Grafsky et al., 2011; Lefevor et al., 2017). Also, unlike racial/ethnic minority groups in the US who underutilize mental healthcare services, discontinue prematurely, and receive poorer care compared to non-Hispanic Whites (Institute of Medicine, 2003), recent evidence suggests that SGM populations do not underutilize mental healthcare, even after taking into account SGM mental health disparities (Cochran, Björkenstam, & Mays, 2017), and that they do not perceive worse quality of care (Beard et al., 2017), as compared to heterosexuals.

While these emerging findings do not conclusively answer the question of whether distinct evidence-based treatments are needed for SGM populations, they suggest the need to critically examine this question going forward. At the very least, future studies need to assess SGM status in both randomized controlled trials as well as naturalistic treatment settings to determine if current treatments work comparably across populations or whether

SGM people might experience disparities in treatment benefit, thereby necessitating treatment modifications to enhance efficacy. Further research is also needed to clarify whether SGM experience barriers to treatment access or retention in care, which might necessitate SGM-affirmative adaptations to existing evidence-based treatments even if such treatments show comparable efficacy across sexual orientations and gender identities. Future epidemiologic research is also needed to assess SGM mental health consumers' satisfaction with existing treatments and potential preference for SGM-adapted treatments, which might further justify the need for developing distinct treatments. In fact, for some other minority populations, distinct cultural expectations, experiences, or needs of members of those populations have been shown to interfere with their engagement in those interventions, if not the efficacy of the intervention per se (e.g., Lau, 2006; Miranda et al., 2006; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Knowing whether and which features of existing treatments might interfere with treatment access, retention, and acceptability among SGM can suggest whether and how those treatments might be adapted to best meet the needs of SGM. Importantly, this research ought to consider the possibility that many important ingredients of existing evidence-based practice can be effectively retained in treatment with SGM individuals and that even relatively modest or limited to changes to existing evidence-based practice might be able to better attract and retain SGM in treatment.

How should existing evidence-based interventions be adapted to address SGM-specific concerns?

The question of whether existing evidence-based interventions need to be adapted to address SGM-specific concerns begs the additional question of *how* existing treatments should be adapted if research suggests incomparable benefit from existing treatments. Options include creating brand new treatments for SGM populations or infusing existing treatments with SGM-affirmative adaptations derived from empirical evidence. It is unlikely that SGM-specific treatments need to be created anew given the robust efficacy of existing evidence-based treatments, efficacious adaptations to those treatments for other distinct populations, and the high compatibility between empirically supported theories of SGM mental health and existing evidence-based practice (e.g., Hatzenbuehler, 2009; Meyer, 2003; Pachankis, 2007). Therefore, the most promising option, if distinct treatments are found to be justified, would be to adapt existing evidence-based treatments to meet the distinct needs of SGM individuals.

When considering how existing treatments ought to be adapted, one obvious and promising solution would be to draw on the effective strategies currently being implemented in treatment settings. Practicing clinicians are already addressing their SGM clients' distinct concerns in their day-to-day practice; in fact, doing so is a professional mandate (American Psychological Association, 2012). This situation sets the stage for clinical researchers to employ psychotherapy process research methods to identify expert community clinicians, qualitatively code their treatment strategies, and then quantitatively determine which of their approaches facilitate positive treatment outcomes (Pachankis & Goldfried, 2007). This endeavor would not only yield adaptations for existing evidence-based treatments that could be compared in randomized controlled trials to non-adapted treatments, but also clinically useful principles that can be implemented immediately in the community. In fact, clinicians

might find SGM-affirmative principles more useful than treatment manuals (Westen, Novotny, & Thompson-Brenner, 2004). Such principles have the added benefit of preventing a situation in which dozens of, if not more, distinct treatments are developed and tested for numerous distinct presenting concerns among distinct subpopulations of SGM, placing an undue demand on already constrained treatment resources without appreciably advancing clinical knowledge or science.

Why do SGM-affirmative treatments work?

Another pressing empirical question for improving the evidence base of SGM-affirmative practice asks why SGM-affirmative treatments work. Randomized controlled trials again provide one needed solution for answering this question, for instance by examining whether theoretically-informed treatment mediators (e.g., minority stress processes, universal psychological processes) temporally precede and statistically mediate clinical improvement from an SGM-affirmative treatment. Yet, perhaps an equally promising direction for determining why SGM-affirmative treatments work is, again, to take advantage of the expert SGM-affirmative treatment currently being delivered in the community.

Process research conducted with practicing clinicians might explore, for instance, how minority stress narratives unfold over the course of treatment and which therapist responses are most conducive for promoting healthy, resilient narratives. Another process question is whether therapists who focus on stigma-related stress despite an SGM client's beliefs that stigma is irrelevant to their presenting concerns effect poorer outcomes. Whether, how, and when therapists disclose their own SGM status, and react to their SGM clients' disclosures, can also be linked to treatment outcomes, thereby providing clinicians with concrete guidance for how to handle this particular situation especially relevant to working with SGM clients. These process findings can inform potential SGM-specific adaptations for future randomized controlled trials.

For whom and under what conditions do SGM-affirmative treatments work best?

As important as knowing whether and why various treatments are efficacious for SGM individuals is knowing under what circumstances, and for whom, such treatments are most efficacious. Emerging research suggests potential moderators, such as the structural environment, race/ethnicity, minority stress processes, and developmental stage as areas for future exploration.

Future research might find that the structural environment in which SGM-affirmative treatments are delivered represents a moderator of treatment efficacy. In fact, meta-analytic evidence suggests that the race-related structural conditions (e.g., racial residential segregation of the communities in which treatments are delivered) hinder the efficacy of HIV-prevention interventions for racial minorities (Reid et al., 2014). The SGM-related structural climate in which SGM-affirmative treatments are delivered might similarly influence the efficacy of such treatments. This possibility suggests that treatments might need to be tailored to address the structural context (e.g., by helping clients cope with the unfortunate demands of staying closeted in high-stigma locales) and that treatment providers working in high-stigma locales, who may not readily find guidance for delivering SGM-

affirmative treatments, might need professional support for doing so. High-stigma contexts, in which brick-and-mortar SGM-affirmative clinical venues might be absent or unsafe for SGM to access, also suggest novel treatment dissemination strategies, including online or mobile delivery. The efficient delivery of evidence-based mental health services to high-need, hard-to-reach populations represents a pressing global health need overall and one in which future research on SGM mental health has the potential to lead the way.

Other than a few notable exceptions (e.g., Cochran, Mays, Alegria, Ortega, & Takeuchi 2007), very little population-based data has examined the basic question of whether racial and ethnic minority SGM are disproportionately affected by mental health problems. Further, no mental health treatment studies with SGM have stratified efficacy results by race or ethnicity. Existing data, from randomized controlled trials and naturalistic treatment settings, offer researchers a straightforward means for addressing these gaps. Such research might consider the utility of adopting an intersectional lens to capture the multiple sources of stigma-related disadvantage that affect diverse SGM subpopulations. Minority stress processes themselves represent another potential treatment outcome moderator that has only recently received empirical attention (Millar, Wang, & Pachankis, 2015). Similarly, age and developmental stage, including stage of SGM identity development would be important to consider as treatment moderators in future research using data from existing or ongoing treatment studies.

Toward a program of SGM-affirmative mental health treatment research

A recent program of research highlights several possibilities for how the above questions might be pursued. First, we recently tested the efficacy of an SGM-affirmative adaptation of cognitive behavioral therapy for young sexual minority men experiencing internalizing psychopathology and HIV-risk behavior (Pachankis et al., 2015b). We created this treatment by consulting both the emerging empirical research regarding minority stress mechanisms underlying SGM mental health disparities (e.g., Hatzenbuehler, 2009; Meyer, 2003) and the expert advice of SGM-affirmative clinical experts. Both sources of information yielded several SGM-affirmative techniques and principles (e.g., attributing distress to stigma rather than self, self-monitoring the emotional impact of stigma-related stress on one's daily life; Pachankis, 2014), that we incorporated into an existing cognitive behavioral treatment. In a waitlist controlled trial, this treatment, called ESTEEM, significantly reduced depression, alcohol abuse, and HIV-risk behaviors. This merging of empirical evidence and clinical wisdom in the first randomized controlled trial of an SGM-affirmative mental health treatment lays the groundwork for a future program of SGM-affirmative mental health treatment research.

Drawing upon this initial success, we then set out to address several other pressing research questions, including whether evidence-based SGM-affirmative practice might work: 1) better than standard SGM-affirmative therapy in the community, 2) by reducing minority stress mechanisms, 3) better for some SGM than others, and 4) in high-stigma locales delivered via efficient technologies. For instance, we are now comparing ESTEEM to SGM-affirmative community treatment to determine the comparative benefit of addressing empirically-derived SGM-specific treatment targets. Process data from this study can also

identify themes of highly successful SGM-affirmative community treatment and determine whether in-session behaviors (e.g., therapist reactions to sexuality-related concerns) influence treatment. This trial, with multiple follow-up periods, allows opportunities to test whether reductions in minority stress processes, such as rejection sensitivity and internalized homophobia, mediate treatment outcome, which our waitlist study preliminarily suggests might be the case (Pachankis et al., 2015b). Data from this new study will also suggest treatment moderators, including client race/ethnicity, SGM developmental stage, or therapist-client SGM match. In fact, results from the initial waitlist trial showed that ESTEEM was more efficacious for men who reported higher levels of implicit internalized homophobia, suggesting that SGM-affirmative treatment might be more beneficial for SGM who experience more minority stress (Millar et al., 2015).

Related research, conducted in high-stigma contexts (e.g., Eastern Europe, prisons) has found preliminary support for adapting similar SGM-affirmative interventions to address SGM-related structural barriers in these contexts, training providers to develop SGM-affirmative skills despite these barriers, and delivering evidence-based SGM-affirmative practice via mobile devices (e.g., Lelutiu-Weinberger et al., 2018; Lelutiu-Weinberger & Pachankis, 2017; White Hughto et al., 2017). Pilot studies are also in progress to examine the efficacy of similar approaches for young sexual minority women; hopefully similar studies for gender minorities soon follow. Overall, this program of research provides concrete opportunities for bringing a stronger evidence base to SGM-affirmative practice.

Conclusion

The time has arrived for mental health professionals to deliver evidence-based practice to SGM individuals. The profession's historic perpetuation of harmful practices with SGM alone justifies this endeavor. Far from the field's early manipulation of the varnish of science to attain political ends, recent clinical research triangulates across numerous high-quality methodologies drawn from countless samples of SGM research participants to paint possibilities of the content, mechanisms, and delivery of SGM-affirmative treatments (Pachankis & Safren, in press). For professional and scientific reasons, mental health professionals should continue advocating for the necessary resources to continue collecting empirically sound, clinically useful data for treating SGM in need of mental health treatment. Mental health professionals should also ensure that advancements in evidence-based SGM-affirmative practice reach all SGM, not just those who possess the knowledge, socioeconomic capital, and other resources necessary for attaining high-quality care. Otherwise, inequitable access to treatment advances can exacerbate existing health inequalities (Bränström, Pachankis, Hatzenbuehler, & Link, 2016; Link & Phelan, 2001). By promoting evidence-based SGM-affirmative treatments and their equitable distribution, the mental health profession will ensure the continued visibility, vibrancy, and mental health of the global SGM population.

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Table 1

Future directions in evidence-based practice for sexual and gender minorities

Research Questions	Possible Solutions
<u>Do Existing Evidence-based Treatments Need to Be Adapted to Address SGM-specific Concerns?</u>	
Do SGM clients experience comparable benefit from existing evidence-based treatments as heterosexuals?	Routinely assess sexual orientation in naturalistic treatment settings
Do SGM-adapted evidence-based treatments work better than standard evidence-based treatments and SGM-affirmative non-evidence-based treatments?	Conduct randomized controlled trials comparing SGM-adapted evidence-based treatments to evidence-based and non-evidence-based treatment-as-usual
Are SGM clients optimally satisfied with non-SGM-specific treatments? Do they have a preference for SGM-specific treatments?	Survey consumers of mental health services, ideally in population-based surveys
<u>How Do Existing Evidence-based Treatments Need to Be Adapted to Address SGM-specific Concerns?</u>	
Do SGM-specific treatments need to be created anew or are SGM adaptations of existing evidence-based treatments sufficient?	Determine whether theoretical frameworks of SGM mental health are compatible with theoretical frameworks of existing treatments
What strategies are currently effecting successful outcomes in community practice?	Conduct psychotherapy process research with practicing clinicians (e.g., qualitatively code effective treatment sessions to generate principles)
<u>Why Do SGM-affirmative Treatments Work?</u>	
Do SGM-affirmative treatments reduce minority stress and universal psychological mechanisms?	Measure and track trajectory of minority stressors and universal psychological processes across treatment
Do SGM-affirmative treatments facilitate SGM-affirming narratives and worldviews?	Perform linguistic/textual analysis of session transcripts to monitor shifts in narrative themes and worldviews (e.g., shame/pride)
<u>Under What Conditions Do SGM-affirmative Treatments Work Best?</u>	
Does the structural context (e.g., state policy environment) determine treatment outcome?	Examine structural stigma as a moderator of treatment outcomes in randomized controlled trials and naturalistic treatment settings
How can SGM-affirmative treatments be efficiently disseminated, especially in low-resource, high-stigma locales?	Examine the feasibility and efficacy of delivering SGM-specific treatments in low-resource, high-stigma locales (e.g., developing countries, the US South).
Can SGM-competence therapist training improve SGM treatment outcomes?	Conduct randomized controlled trials of therapist SGM-competence training linked to client outcomes
Does therapist-client match on SGM status affect treatment outcome?	Examine therapist-client match as a moderator of treatment outcomes in randomized controlled trials and naturalistic treatment settings
<u>For Whom Do SGM-affirmative Treatments Work Best?</u>	
Do intersectional identities (e.g., racial minority status) influence SGM-specific treatment outcome?	Examine intersectional identities as moderators of treatment outcomes in randomized controlled trials and naturalistic treatment settings
Do SGM-affirmative treatments work best at certain ages or certain stages of SGM development?	Examine age and developmental stage as a moderator of treatment outcomes in randomized controlled trials and naturalistic treatment settings
Does baseline presence of SGM-specific stressors across individual, interpersonal, and structural levels influence treatment outcome?	Examine SGM-specific stressors as moderators of treatment outcomes in randomized controlled trials and naturalistic treatment settings