

*Commentary on The Targeting Sexual Stigma: The Hybrid Case Study of “Adam”*

**The Hybrid Case Study of “Adam”: Perspectives from Behavioral Activation and the Influence of Heteronormativity on LGB-Affirmative Therapy**

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**ABSTRACT**

In the hybrid case of “Adam,” Mandel (2014) has provided an example of a comprehensive cognitive-behavioral treatment for a depressed, gay, man who is in the process of coming out and disclosing his sexual identity. Affirmative therapies, however, are practiced within a broader context of a culture that presumes that heterosexuality is the norm by which sexual minorities are compared. This commentary suggests an alternative approach to the comprehensive CBT approach, with a briefer behavioral activation treatment possibility. Also, areas wherein a well-meaning, knowledgeable and skilled therapist still made possible missteps because of the influence of the overall heteronormative culture are discussed.

*Key words:* LGB-affirmative therapy; behavioral activation; sexual minorities; sexual stigma; heteronormativity; case study; clinical case study

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**CASE CONTEXT AND METHOD: CONDUCTING THERAPY IN A HETERONORMATIVE CULTURE**

I have been asked to comment on the hybrid case study of “Adam,” from my perspective as an expert in conducting affirmative CBT with sexual minority clients, as well as an expert in treatment for depression. I have approached this case as if I were consulting with the therapist. First, I will make some general comments about conducting affirmative therapy, and the current status of the literature, much of which has already been cited by Dr. Mandel. Second I will make specific comments about the various interventions and strategies discussed in this hybrid case. Finally, I will make concluding remarks about the case as a whole.

Generally, considering conducting therapy with gay men, or generally with sexual minority clients, we must consider that psychotherapy is often provided in a context of heteronormativity (Warner, 1991). This term means that there is an inherent assumption that the values, customs, practices, institutions, and so forth, of the majority heterosexual population is

the norm, and the experiences of sexual minority individuals are then compared to the majority. Even in the context of lesbian, gay, bisexual and transgender (LGBT) affirmative therapy, the expectations of both client and therapist can be dominated by heteronormative standards. Throughout this comment, the concerns of Adam, the strategies of the therapist, and the interactions between client and therapist will be discussed in respect to the heteronormative context with the intent of moving the dialogue to consideration of a homonormative (van Eeden-Moorefield, Martell, Williams & Preston, 2011) approach.

Language can promote heteronormativity. Terms like "non-heterosexual," though understandable, imply that sexual minority individuals are "other" than. "Acceptance" of LGBT people by those who identify as heterosexual is also a function of heteronormativity. One group, the majority, needing to "accept" the minority, can be well-meaning, but is also hierarchical. I prefer the term "affirm" rather than "accept." Often we accept things that are unfortunate, we affirm things that are valid, or that we wish to celebrate.

The author, as a therapist, modeled an affirmative stance toward sexual minorities. Taking an affirmative stance toward sexual minority clients is somewhat more complicated than it may appear at first. One can be affirmative because one is a caring, non-judgmental therapist, or because one is engaged in advocacy for the LGB community regardless of one's own sexual orientation. One can be an affirmative therapist because one is also a proud and open member of a sexual minority and also specializes in work with this population.

Because we live in a heteronormative culture, professionals are typically assumed to be heterosexual unless they state otherwise. The sexual orientation of this therapist is not known, but the assumption, particularly from Adam, may have been that the therapist is heterosexual. With LGB clients, the sexual orientation or identity of the therapist is important and clients often want to know the sexual orientation of their therapist, or they themselves assume that their therapist is heterosexual or "straight." This is an issue that cannot be glossed over with (misguided) cries of ethical problems with therapists disclosing personal information.

The fact is, we disclose personal information by how we dress, by the artwork in our offices, books on our shelves, photographs. Concerns over sharing one's sexual orientation harken back to the days when this would have been considered disclosing a mental illness. Of course it is usually inappropriate and ethically problematic for therapists to share information in order to garner support from their clients, like disclosing that one is in the middle of a terrible break-up. However, when clients are from a mostly invisible minority population and the therapist is as well, it is reasonable that this be shared with the client. A better framework for this is that we are simply sharing demographic information that is not otherwise obvious, nothing more. Some sexual minority clients, who fully buy into the heteronormative, or have a high degree of homo-negative bias (Green & Mitchell, 2002) or homophobia, as was the case with Adam, prefer to work with a therapist that they believe or know is straight.

My work is informed by behavioral assessment, and my approach to any given client is based on an assessment of the function of the client's behavior, and also with a consideration of the function of my behavior as a therapist. For some sexual minority clients who are struggling

with their sexual orientation and who are uncertain of how to identify, working with an openly gay, lesbian, or bisexual therapist may initially be threatening. In these cases they are unlikely to accept a referral to therapists who identify publicly as a member of a sexual minority. This can pose a dilemma for an LGB therapist should the client make statements about the therapist being straight. This issue is complicated, and is beyond the scope of this present commentary, but it does pose a difficulty in some therapeutic relationships. On the other hand, when clients who are not out, but considering it, need the assurances of a therapist whom they perceive to be heterosexual, this promotes a paternalistic culture, where the majority needs to approve of the minority. Therefore, while there can be a healing function in some cases for a client to have an affirming heterosexual therapist who works competently with them, it may also perpetuate internalized homo-negative bias in which the objectivity and competence of a professional who is also a member of a sexual minority is questioned because of their sexual orientation. The need to be told that one is "o.k." by a member of the dominant culture is understandable, and perhaps necessary on an individual basis, but we must be aware at a broader, social level that this promotes heteronormativity.

These comments about affirming rather than accepting, or disclosing therapist's sexual orientation should not be interpreted to mean that only sexual minority therapists should see sexual minority clients. Nor is it sufficient as a matter of training that because one is a member of a sexual minority that one can assume competence in working with sexual minority clients. Neither is it sufficient to be a good-hearted, straight, progressive ally. Therefore, case studies such as the one presented, as well as critique of the strategies and approaches used, are essential for on-going training and consideration of the many issues that arise in our work with sexual minority clients.

## **LGB MENTAL HEALTH**

The case of Adam provides us with an example of a young man who had difficulty coming out, and who had a relatively high degree of negative beliefs about himself. While it is true, as author Mandel states, that the period of coming out can be stressful (DiPlacido, 1998), it is unclear from the literature what percentage of LGB individuals seek professional help during the coming out process. While we know that LGB individuals seek therapy at dramatically higher rates than their heterosexual counterparts (Cochran, Sullivan, & Mays, 2003), we can still conclude that a majority of LGB individuals, just like a majority of heterosexual individuals, do not seek therapy.

Therefore, the problems encountered by Adam have as much to do with his internalized homophobia, depression, and substance abuse as they do with his being gay. An important statistic to consider is that research indicating that lesbian, gay, and bisexual individuals have higher rates of depression and anxiety than their heterosexual peers (Cochran et al, 2003), also suggests that 58% of LGB individuals surveyed did not meet criteria for any diagnosable disorder. In other words, the majority of LGB people are likely to cope well despite the stigma and prejudice that they live with. The higher rate of depression and anxiety is typically associated with having added stress of being a sexual minority, so the fact that a majority of LGB

individuals do not have psychological problems attests to relatively high resilience in this population.

The case of Adam also represents another factor in homophobia. Mandel (2014) says that, “internalized homophobia among gay men is directly related to American culture’s increased distaste toward gay men...” (p. 56). While this is true, the issues are also related to misogyny and sexism as well as to negativity toward gay men. While this is a topic that goes beyond this paper, it is significant that Adam struggled with “flamingly gay” men (Mandel, p. 84). Very often it is gender-atypical behavior that is determined to be “flaming” or “flaunting.” This is not just internalized homophobia, but it is also a perpetuation of the denigration of that which is perceived as feminine to be weak, or less than—feelings and beliefs that are deeply rooted in a misogynist culture.

## GUIDING CONCEPTUALIZATION

Mandel differentiates between sexual orientation, sexual behavior and sexual identity, which is the proper thing to do, and which is a basic concept that is easily overlooked in considerations of sexual minorities. Therapists practicing affirmative therapy know that sexual orientation is a normal variant of human behavior (American Psychological Association, 2009). We know very little about a client’s actual behavior by knowing their sexual orientation. For example it is not uncommon for men and women who identify their sexual orientation as gay or lesbian to be heterosexually married. Knowing this information still tells us very little about their sexual behavior. So behavior needs to be assessed.

Mandel had these discussions with Adam, who reported having a meaningful, intimate, sexual, relationship with a fellow counselor at a summer camp when he was in High School. At the time he was in therapy he was not sexually active. He did identify as gay with his therapist, but he had not publicly identified. Mandel has considered the literature on sexual stigma and on the impact of sexual stigma on Adam. Adam’s scores on the Internalized Homophobia Scale (IHS; Herek et al., 1997) were initially high and decreased over time in therapy. Adam is presented as a client who was gay, experienced a high degree of “internalized homophobia,” used marijuana to excess, and was avoiding school and academic work due to depression. Adam had reported that he sought out a college in a gay-friendly city where he would be more comfortable coming out as gay, since he intended to do so once he had left home and had begun college. This is a relatively common situation, with young people moving away from home with the hopes of living their lives in accordance with their values and understandings of themselves, which may differ from those of their family. In Adam’s case, he became anxious about coming out once he began his freshman year, and he engaged in many types of avoidance behaviors.

## THE OVERALL COURSE OF TREATMENT

### *Affirmative Therapy*

Mandel (2014) provides a good example of a well-thought-out case, with therapy supported by the empirical literature, and utilizing a goal-centered, cognitive-behavioral

approach. I would like to comment on a few aspects of the overall course of treatment, and then I will focus my comment on the individual goals, regarding when and how they were addressed. Because the case of Adam is a hybrid case, fictionalized, but originating from actual cases seen, the treatment is somewhat idealized. I agree with the author's reasoning that it is a useful strategy for teaching about therapy. Even within this hybrid case, many different strategies were used to address Adam's concerns. Granted, there are no empirically based treatment protocols to help someone who is "coming out" or who has internalized negative beliefs based on sexual stigma.

The therapist has clearly sought to work from an LGB-affirming stance. Mandel states that, "There are four central components to affirmative treatment: creating a sense of safety in the therapy environment; supporting open dialogues regarding sexuality; exploring the meanings clients attach to their sexuality; and demonstrating the ability to convey understanding of patients via validation and awareness" (American Psychological Association, 2012, p. 18). A safe environment can be created in a number of ways, as was done in this therapy. I emphasize having LGB-affirming books obviously displayed on bookshelves, LGB literature available in waiting rooms, such as copies of magazines like "The Advocate" or regional publications that are tasteful and appropriate for a clinical setting. I also consider one of the most affirming things a therapist can do is to make sure that assessment material is free of offensive language. Questionnaires that ask about one's history of "homosexual experiences" are not affirming, and were once written to tease out deviancy.

The therapist attempted to support open dialogues and to validate the Adam's experience. I would create open dialogues a little differently, however, and my initial reaction to the therapist telling Adam that he could "speak openly about anything without fear of judgment" is that it may actually convey the opposite. People fear judgment for disclosing something shameful. LGB therapy asserts that there is nothing shameful about anyone's sexual orientation. While the case of Adam suggests that he was able to open up and feel comfortable given that the therapist assured him of not being judged, clinicians need to be aware that such obvious "acceptance" may not necessarily function as intended. It may be preferable to demonstrate the affirmative stance by asking questions about sexuality in a matter of fact way. So, always ask about whether clients date people of the opposite or of the same sex as themselves as they identify. Even when working with couples, or clients who are heterosexually married, asking if they "only have had relationships" with people of the opposite sex demonstrates that the therapist considers it possible, and actually normal, to have done so. Asking matter-of-fact questions about sexual activity is also another way that therapists can demonstrate being non-judgmental, and knowing a little about common sexual practices can help. One caveat, however, is that therapists should never assume they know about sexual experiences based on stereotypes or myths—because somewhere they heard that some outrageous behavior is a common practice—promoting homophobic beliefs about gay male sexual behavior.

Creating an affirming environment and being an affirmative therapist is best done, in my opinion, in a nearly unconscious way. Just as it can be perceived as insincere when therapists try to "show empathy," it can also be perceived as insincere when therapists try to look accepting or affirming. It is most important that one is, in fact, affirming, whether LGB oneself, or an ally,

one should have experience with the cultural aspects of being a sexual minority as well as have specific training in working with sexual minority clients. Mandel (2014) has done a nice job of framing the therapeutic work with Adam in an affirming way.

### *Length of Treatment and Timing of Interventions*

Specific comments about treatment goals and interventions used to achieve the treatment goals will follow, but at this point a comment about the length of treatment and the timing of the various interventions is appropriate. Adam is presented as a client with multiple problems: he is depressed, he is avoidant, he uses marijuana to excess, and he wants to come out but has a number of homophobic beliefs about himself. In other words, Adam is a typical client seen in many practices around the world. Rarely do clients seek therapy for one, "pure" disorder. Anxious clients are often depressed as well, or worry chronically and also have specific phobias. Depressed clients sometimes have high degrees of anxiety, or have difficult life circumstances that contribute to the depression and require active problem-solving to cope. It is appropriate that the problems were delineated and goals set to address them. This is consistent with the case formulation approach proposed by Persons (2008), and is a useful way to work through multiple problems using empirically based treatments.

Adam was engaged in therapy for 40 sessions. Therapy lasting for 40 sessions is becoming rare, and insurance companies in the U.S. and health plans in other countries often reimburse for far fewer sessions. Thus, Adam's treatment is a rather idealized one that allowed for time. There were five phases of treatment including: Building Rapport, Targeting Depression, Addressing Substance Use, Addressing Gay Identity Issues, and Consolidating Gains and Termination. Understanding that there were discussions between the therapist and supervisor, and therapy was conducted in collaboration with Adam it is hard to criticize the therapeutic process. Given everything as explained it is possible that I would have done a very similar treatment. However, I can imagine being presented with a case just like Adam, and doing a very straightforward, LGB-Affirming course of behavioral activation (BA; Martell, Addis & Jacobson, 2001; Martell, Dimidjian, & Herman-Dunn, 2010) in fewer sessions. Rather than conceptualizing phases of treatment, I would look at how all of these problems overlap.

One of the aspects of this case that struck me was how the issues of sexual orientation and identity seemed to be handled with kid gloves, and were not addressed until the fourth phase of treatment. In my role as "armchair" commentator, I will suggest an alternative, while recognizing that one has a much better sense of these things when one is in the room as a therapist or observing as a supervisor. Adam had stated that he intended to come out when he left for college, but now that he was enrolled he was afraid to do so. He also stated that his first depression episode occurred when he was 13, which is significant since this roughly aligns with puberty, and may have been partly generated by distress over emerging sexual urges regarding other boys. While I would in no way impose an agenda on him or any client, I also would be concerned about reinforcing his avoidance.

Coming out is not a one-time event. Whenever an LGB or T person changes context, they are often required to come out again. One can tell friends, but there are always new friends

to make. One can tell family, but there are often extended family who may not know initially. One can be out at work, but then change positions within a company, or take a new job, and need to disclose to new work acquaintances. It could have been a reasonable BA plan to address his avoidance and social isolation by developing a hierarchy of LGB related activities that could feel safer to him, such as browsing titles at a local gay book store and working up to attending a gay group of some kind. Smoking marijuana would also be identified early on as fostering avoidance, especially during the times when Adam was smoking alone.

My main conclusion is that there are many cases like this in which all of these issues can be treated as relating to one another and not necessarily require a phase approach. Just as gay men live their lives and happen to be gay while doing so, treatment could focus on the issues about being gay as they arise during the course of treatment in general. I assume that many of the negative beliefs that Adam had about himself were perpetuated by his avoidance of actually meeting other gay people. He also assumed that he was very different from his roommates because he was gay. While it may be unwise for someone to just tell a bunch of young men in a dorm about one's sexuality without first getting the "feel for the group," Adam could have also attempted conversations with other young men whom he believed were straight whom he met through classes, putting out the kind of "feeler" questions that LGB people often do, such as mentioning gay characters on TV shows or movies and seeing what the reaction is, commenting on a recent news item that has to do with LGBT concerns. By treating the gay identity issue as something that one needs to be assuredly "ready" to deal with, one may perpetuate the fear over dealing with an issue of some enormity, which is better dealt with more directly and earlier in treatment.

Notice that none of the exercises I've suggested would have required Adam to self-disclose in any way until he thought it was safe to do so. Still, he could have gone to the bookstore rather than staying in his room smoking pot, and may even have looked for a book relevant to some of his studies, which would tackle the avoidance of school work and concern over poor grades. In other words, rather than a phase approach, this is more of a multi-dimensional approach, with the strategies of activity monitoring and scheduling, identifying avoidance behaviors, including ruminative thinking patterns, and developing strategies to tackle avoidance would all be part of the treatment package of BA (Martell, Addis & Jacobson, 2001).

### *Therapeutic Goals*

The therapist established a number of treatment goals (Mandel, 2014, p. 66-69) that were addressed during the particular phases of treatment. I will briefly discuss these goals and the interventions used before making some concluding comments.

During Phase 1 of treatment, Goal 1, which was to "Provide rationale for treatment, establish rapport, and create a safe/validating therapeutic environment," was established. In terms of various treatment phases, this goal would be the first in all treatments, and was an appropriate goal for the initial treatment sessions. Certainly maintaining rapport and creating a safe/validating therapeutic environment continues throughout the course of therapy, but it is, indeed, a primary concern in the initial phase of treatment.

In Phase 2, the second Goal, "To decrease Adam's depressive symptoms to a BDI-II score in the absent to minimal range," was addressed using cognitive behavior therapy. While I have proposed that one could also have treated Adam with BA, CBT has robust data support and was a logical choice for helping Adam deal with his negative beliefs about himself. In fact, the choice of CBT, rather than just BA, is a good choice with a client like Adam since his avoidance was a major issue, although there were also so many other negative beliefs and ideas about being gay that he had accepted from the dominant culture, and turned against himself.

Phase 3 of treatment incorporated Goal 3, "To decrease Adam's marijuana use," and Goal 4, "To increase Adam's class attendance and completion of class assignments." I consider these problems and these goals to be closely related. Increasing class attendance is more difficult when a student is smoking marijuana at the level that Adam is admitting to. I was curious about the therapist's decision to use ACT strategies in treating the substance abuse as opposed to following a relapse prevention (Marlatt & Gordon, 1985) or harm-reduction (Marlatt, Larimer, Baer, & Quigley, 1993) program that incorporates, or may actually have originated, some of the same ideas about handling beliefs and urges pertaining to substance abuse. I would have continued with a standard CBT approach given that this was consistent with the initial case conceptualization.

Phase 4 focused on addressing Adam's gay identity issues. I have stated my thoughts about considering this issue so late in the therapy. It is understandable that Adam was anxious about coming out, and it is common for sexual minority individuals to have accepted negative, biased beliefs about themselves. It is unclear exactly what makes one "ready" to deal with these "issues." Adam had wanted to come out and live an openly gay life when he began college, and was disappointed in himself for not doing so. Another approach to treatment would be for the therapist to serve as a coach in his doing this, helping him plan safe strategies, that would still challenge his beliefs and help him face his anxieties early in treatment. This would be done in collaboration with him, of course. I've seen novice therapists, whether working with sexual minority individuals or others, make assignments with clients because they believe they are the right thing to do without ever assessing whether the client has the skill, intention, or desire to complete them. I believe therapists can be both directive and collaborative, and maintain a strong therapeutic relationship and promote client autonomy all at the same time.

Goal 5, "To increase Adam's awareness of his internalized homophobia," Goal 6, "To increase Adam's acceptance of his homosexuality and decrease his IHP score to the low range," and Goal 7, "To decrease Adam's distress level to an OQ-45 score in the 'less than clinical significance' range," were also addressed during this fourth phase of treatment. One minor comment about his has to do with how one changes beliefs and stereotypes. In this therapy the therapist provided psycho-education and conducted cognitive restructuring.

Literature on reducing prejudice has indicated that interpersonal contact with others diverse from oneself is effective (Utsey, Ponterotto, & Porter, 2008). Thus, many of Adam's negative beliefs about gay people, and thus about himself, could also have been addressed through activation assignments and exposure to other sexual minority people introduced in therapy in a hierarchical fashion as noted above. Utilizing behavioral experiments (e.g. Bennet-



Levy, et al., 2004) to test his negative beliefs could also have been helpful, and perhaps better suited to the case than cognitive restructuring.

One of the interventions addressing Goal 6 was to help Adam grieve the loss of heterosexual privilege. In 23 years of conducting therapy with sexual minority clients, I never once did this. First, there are many forms of privilege, and if a client is gay, white, and male, he will still have white male privilege; and he may have economic privilege to boot. Second, many sexual minority clients never really accept that they have heterosexual privilege because they always feel different.

Finally, grieving the loss of some form of heterosexual identity results from living in the heteronormative context. Knowing that "many gay men get married" also supports the heteronormative agenda. Yes, this is recently true, and will likely become a common experience. However, there is an element of assuring sexual minority clients that they can be "just as good as" heterosexual people when we speak in this fashion. Research has been conducted demonstrating that same-sex couples are as happy and committed as opposite sex couples (e.g. Kurdek & Schmitt, 1986) and that they can parent as competently as heterosexual parents (see Matthews & Lease, 2000, for review). This research has been necessitated by a heteronormative culture. Comparing one group of peoples' relationships to another that has close to a 50% divorce rate is ironic. So is comparing the parenting skills and outcomes of same-sex couples who make conscious decisions to raise children and go to great lengths to do so, with a sample from the broad distribution of opposite sex couples, many who may have had children "by accident." While the thinking of the therapist in Adam's case is logical, I would underemphasize any consoling about Adam being able to, essentially, live his gay life just like a straight person, and emphasize helping him learn what is honorable, unique, and to be celebrated about being gay.

The final phase of therapy and Goals 8 and 9 are relatively standard in CBT and demonstrate competent relapse prevention.

## SUMMARY

The hybrid case of Adam illustrates a broad-spectrum, cognitive behavioral approach to working with a depressed, gay male client, from an affirmative stance. While I've critiqued the strategies used in a number of areas, the attention to culturally competent work with this population is to be commended. There is no specific treatment protocol for working with a client like Adam, so therapists will need to rely on their training and experience, a good functional analysis and case formulation, and the existing empirically supported treatments for particular problems in order to develop a solid conceptualization to guide treatment. While there are things that I might have done differently, Adam was treated competently and sensitively. The case shows the complexities of cultural issues that will arise when working with sexual minority clients. Sexual minorities are not a homogeneous group, and come from a variety of backgrounds, ethnicities, and family structures. Many of the guiding features of this case highlight the progression of thought and treatment development that is necessary in working with this population.

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