

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

**Clinical Considerations in Working with
Clients in the Coming Out Process**

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ABSTRACT

Mandel (2014) describes the conceptualization, assessment, and treatment of "Adam," a hybrid client presenting with depression, cannabis abuse, perfectionism, and distress related to his sexual orientation, which appeared to be fueling these psychological problems. In this commentary, we examine theoretical and clinical issues raised by this case regarding clients' experiences with coming out. Drawing on the case and pertinent research, we highlight clinical challenges involved in helping clients navigate issues of identity development and intersection, interpersonal disclosure, internalized homophobia, and community connectedness. We present specific strategies for tailoring interventions to the diverse experiences and needs of sexual minority clients. Throughout the commentary, we reflect on potential intrapersonal, interpersonal, and systemic processes that may impact clients' identity integration and psychological well-being.

Key words: coming out; affirmative therapy; intersectionality; sexual minorities; LGBT; sexual orientation; case formulation; psychotherapy; case study; clinical case study

INTRODUCTION

Recent years have witnessed increasing appreciation of and attention to issues of diversity and multiculturalism within the fields of psychotherapy and counseling, including issues pertaining to lesbian, gay, bisexual, queer, and questioning (LGBQQ) clients, in particular. Harmful and oppressive clinical practices, including the classification of homosexuality as a mental disorder and the practice of conversion or reparative therapy, have been abandoned and formally rejected by mainstream professional mental health organizations. These changes are important given that research suggests that mental health services may be used at higher rates by LGBQQ and other sexual minority clients as compared to heterosexual individuals (Cochran & Mays, 2006; Jones & Gabriel, 1999). In one study, more than half of psychotherapists surveyed

reported having worked with at least one sexual minority individual in their practice over the past week (Murphy, Rowlings, & Howe, 2002).

Despite these factors, there has been limited empirical guidance for mental health practitioners in the delivery of positive, therapeutic interventions for sexual minority clients. Over the past several decades, this situation has begun to improve, with the development and publication of broad guidelines for working with sexual minority clients (APA, 2012; Beckstead & Israel, 2010; Martell, Safren, & Prince, 2004; Pachankis & Goldfried, 2004), as well as theoretical and applied research examining the unique needs and experiences of subgroups within the sexual minority “umbrella” (e.g., Bowleg, Craig, & Burkholder; Kimmel & Yi, 2008; McClean, 2007). While there is a small but growing evidence base for culturally-informed assessment and treatment, many practitioners receive limited or only broad training in this area (Grove, 2009). Research indicates that many psychotherapists perceive themselves to have limited to moderate competency in working with sexual minority clients, with a trend of lower perceived competency in actual therapeutic skills as compared to knowledge and awareness (e.g., Graham, Carney, & Kluck, 2012; Kocarek & Pelling, 2003; Grove, 2009).

The hybrid case study of “Adam” published in this issue of PCSP represents a valuable addition to the small but growing body of literature addressing this need for resources pertaining to clinical work with sexual minorities (Mandel, 2014). Mandel’s work with Adam provides a model of affirmative psychotherapy for LGBQQ clients contending with identity development and the coming out process, as well as with the adverse psychological and social effects of stigma and minority stress. In the case presented, issues with sexual identity and internalized homophobia were clearly implicated as a key factor in the origin and maintenance of the client’s presenting psychological problems with depression, perfectionism, and substance abuse. Mandel’s approach to her work with this client is notable for the unwavering empathic and supportive stance she shows toward the client and his emerging sexual identity. Also notable is the depth of knowledge and appreciation of LGBQQ issues and sociocultural experiences she brings to bear on her treatment with Adam, which provides a necessary foundation for her to tailor the conceptualization and evidence-based treatment interventions to the client’s needs.

Among the many issues in clinical practice highlighted by this case, one of the most prominent involved Mandel’s sustained work with the client through the difficult process of coming out, especially during the later stages of therapy. Coming out represents a complex and challenging process in the lives of many sexual minority individuals, and is one of the most distinctive features of the sexual minority experience, as contrasted not only with that of heterosexual majority group members but also with that of most other minority groups. Sensitive clinical responses to issues arising through the coming out process may be particularly vital to effective clinical work with LGBQQ populations (Pachankis & Goldfried, 2004).

In the broadest sense, coming out refers to the process through which individuals acknowledge and embrace an LGBQQ identity (Pachankis & Goldfried, 2004). This broad concept of coming out can involve multiple related intra- and interpersonal processes over time, including self-recognition, clarification, and integration of one’s own sexual minority identity, and ongoing management and disclosure of the visibility of one’s sexual orientation and identity to others (Matthews & Salazar, 2012; Mohr & Fassinger, 2003). The coming out process is often

conceptualized as a central aspect of the larger process of sexual identity formation for LGBQQ individuals (APA, 2012; Mosher, 2001). In this commentary, we will attempt to elaborate upon key clinical issues raised by this case as they pertain to work with clients navigating coming out processes. Drawing on LGBQQ-affirmative and multicultural literatures along with our own clinical experience, we will highlight attitudes, knowledge, and skills that may come into play when working with clients around this issue.

CULTIVATING AN AFFIRMATIVE STANCE

In working with LGBQQ clients in the process of coming out, it is vital that clinicians adopt an affirmative stance. Fundamental components of this stance, as noted by Pachankis and Goldfried (2004), include comfort with and competence in working with LGBQQ people and a heightened sense of unconditional positive regard, including “explicitly showing respect for the client’s sexual orientation, personal integrity, lifestyle, attitudes, and beliefs” (p. 231). Additional facets of an affirmative stance include awareness of and sensitivity to one’s own sexual orientation and identity; awareness of the insidious influence of prejudice and stereotypes; respect for differences in sexual attractions, behavior, and identities; comfort with differences between clients and oneself; and capacity to be supportive and nonjudgmental (Israel & Selvidge, 2003; Pachankis & Goldfried, 2004).

As with work with other diverse populations, clinicians ought to attend to and become more aware of their own internal assumptions and beliefs about sexual minorities. This process will vary widely depending on the clinicians’ existing beliefs and personal history, and may involve a complex process of reconciling aspects of their own cultural and religious beliefs with those of their profession (Bieschke & Dendy, 2010). Mental health providers must also be cautious in not assuming that issues of sexuality, such as coming out, are at the root of other mental health problems or are even necessarily a presenting problem that the client wishes to address in therapy. Research has shown that, while mental health problems are not caused by sexual orientation, they may stem in part from the particular stressors LGBQQ clients experience, as the case study of Adam clearly illustrates with the client’s depression and substance use (Cochran & Mays, 2006; Cochran, Sullivan, & Mays, 2003; Meyer, 2003). Hence, clinicians must not be too quick to assume that sexual identity is the source of the presenting problem for which client seeks treatment. Nor should we assume, in an attempt to be neutral or blind to sexual orientations, that issues of sexual identity are a non-issue for any given client. Instead, an affirmative approach involves a willingness to discuss these issues openly and collaboratively with the client and conducting a detailed and ongoing assessment of the connections among aspects of a client’s identity, environment, and presenting psychological concerns.

Additionally, clinicians wishing to adopt an affirmative stance must be careful not to assume that all persons are heterosexual unless there is strong evidence to the contrary or until clients disclose they are non-heterosexual. Many sexual minority individuals contend with societal presumptions of heterosexuality on a daily basis, underscoring the need for clinicians to create alternative, welcoming environments where heterosexist assumptions are not perpetuated. Clinicians may be particularly likely to fall into this trap when working with clients who report heterosexual spousal or partnered relationships, as well as with clients whose gender expression

conforms closely to societal stereotypes. Though seemingly benign, this assumption tends to perpetuate heterosexism, potentially creating another barrier to coming out (cf. Israel & Selvidge, 2003).

Work with sexual minority populations is likely to be more successful when clinicians are open to making contact with people of diverse sexual backgrounds, whether in personal or professional contexts, and are willing to seek training, supervision, or consultation when their attitudes interfere with treatment (Israel & Selvidge, 2003; Lyons, 2010). Mandel demonstrated this openness through the familiarity and knowledge about LGBQQ issues she brought to bear in her work with Adam and her use of supervision to address personal biases throughout her work with the client. As this case study suggests, clinicians with positive or accepting attitudes toward sexual minorities (including LGBQQ therapists) might exhibit distinct biases that need to be held in check, such a desire for clients to come out before they feel ready.

ADDRESSING INSTITUTIONAL AND SYSTEMIC ISSUES

In addition to engaging in self-examination of our own individual attitudes and beliefs regarding LGBQQ issues, cultures, and identities, clinicians should consider the ways in which institutional, organizational, and professional beliefs and attitudes may impact clients who may be contemplating coming out in a mental health setting. Such attitudes and beliefs may be conveyed in implicit and explicit ways, and have a powerful impact on an individual's perception of an environment as affirming, indifferent, or hostile to the needs of LGBQQ individuals.

In its introduction, Mandel's (2014) case study discusses several ways clinicians may consider creating more welcoming environments for individuals struggling with issues related to sexual orientation. These include strategies such as posting 'safe space' signs in a clinic office; having LGBQQ-related materials in waiting rooms; and incorporating intake forms that utilize inclusive language, including open fields for clients to identify sexual orientation and gender identity and neutral language regarding romantic and sexual partners. In addition to these important steps, we suggest that clinicians seek out opportunities to critically examine the ways existing services are provided, to whom they are (and are not) provided, and ways greater systemic and institutional forces may impact the experience of individuals who may be in the process of coming out. Clinicians may wish to evaluate clients' experiences with the multiple contact persons leading to and following the initial therapeutic encounter to identify potential needs for sensitivity and awareness training within their institutions.

The questions clinicians ask to assess larger attitudes and beliefs will vary depending on the setting. In a college counseling center such as Mandel's, for instance, a clinician might ask questions such as, "which sexual minority students are and are not accessing mental health services and who is not represented?" and "what clinical, logistical, financial, cultural, and academic resources are provided to support students who may be emotionally or financially cut off from their families of origin when coming out?" They may also ask, "what is the school, local, state, and federal non-discrimination policies for LGBQQ students considering coming out in their workplaces?" Asking these questions, and working to address the issues generated by troubling answers, requires clinicians thinking and moving "outside the consultation room,"

adopting roles as liaisons, case managers, advocates, and outreach staff (Chantler, 2005; Dale, 2008).

UNDERSTANDING IDENTITY FORMATION TRAJECTORIES

In working with clients through the process of coming out, it may be helpful for clinicians to be familiar with models of sexual minority identity development and to consider how these might apply to the client. Considerable research has been devoted to understanding the processes by which gay, lesbian, and, to a lesser extent, bisexual, queer and questioning individuals come to be aware of, make meaning of, and adopt a particular sexual orientation or identity within a societal context in which heterosexuality is normative and non-heterosexual identities are stigmatized or rendered invisible (e.g., Fassinger & Miller, 1996; Hill, 2009; McCarn & Fassinger, 1996; Mosher, 2001).

While different models have been advanced, these models tend to converge on a similar set of stages through which many individuals are believed to pass. These models hold that, often before puberty, many individuals are exposed to societal attitudes toward non-heterosexual orientations and become aware of themselves as being different from same-sex peers, although the difference may not be understood in terms of sexuality. Subsequently, over time (often during adolescence), individuals come to suspect they may be LGBQQ. Due to the influence of heterosexism, homophobia, and/or a lack of respected role models within individuals' sociocultural environments, many come to regard these sexual differences as unacceptable and as a sign that they are sick, deviant, sinful, or otherwise defective (Hill, 2009; Pachankis & Goldfried, 2004). Consequently, many sexual minorities will experience problems with psychological adjustment, including shame, anxiety, depression, substance abuse, and suicidality. Attempts to avoid, eliminate, or distance oneself from non-heterosexual attractions are also common and may appear in various forms, several of which are evident in Adam's history. These may include devoting considerable energy to career or academic success; coping with feelings through substance abuse; seeking reparative therapy or other methods to eliminate homosexual attractions; and pursuing efforts to reaffirm or adopt a heterosexual identity, such as through relationships with opposite-sex partners (Pachankis & Goldfried, 2004).

During a subsequent stage individuals are thought to become increasingly tolerant of their homosexual identity. During this period, people may be motivated to make contacts with other LGBQQ individuals and communities, which may offer means of fulfilling emotional, social, and sexual needs; clarifying feelings; and evaluating stereotypes. When experienced as positive, these contacts are likely to foster greater self-acceptance and stimulate further engagement with other LGBQQ individuals and communities. At the same time, individuals may continue to conceal their sexual orientation from family members and friends, which may, at times, contribute to a sense that they are leading a 'double life' (as was the case for Adam). Many models posit later stages involving increased pride in their sexual orientation and gradual disclosures of identity to other individuals; as well as increasing integration of LGBQQ identity into one's overall sense of self (Hill, 2009).

A relatively newer model by Fassinger and colleagues (McCarn & Fassinger, 1996; Fassinger & Miller, 1996) has proposed that identity development may be separated into two

parallel and distinct but related trajectories, one an internal process of acknowledging and accepting aspects of one's sexual identity and another a social process of establishing group membership within a larger LGBTQ community. A key advantage of this model, as Hill (2009) observes, is its recognition that disclosure may not be an appropriate marker of advanced, or 'mature,' LGBTQ identity development given how strongly dependent disclosure decisions are on contextual factors.

One clear benefit of these stage models for clinical practice is their ability to enhance clinicians' ability to understand and convey accurate empathy for clients' past and present experiences along the journey of coming out. Another benefit may be the possible implications of these models for tailoring therapeutic interventions based on clients' particular point of development. For instance, addressing internalized homophobia and exploring the meaning of and normalizing same-sex attractions are likely to be more central tasks when clients present at earlier stages of the above models. In contrast, a greater focus on building peer and family support and perhaps planning and negotiating disclosures (as appropriate and consistent with the client's values and circumstances) may be more central at relatively later stages. Mandel's work with Adam illustrates a potential progression through these therapeutic tasks, while recognizing that, like many other change processes, they may be undertaken simultaneously and in a non-linear manner. We believe that it is important for clinicians to understand these models and yet to hold them lightly. These models may be best employed as a rough heuristic for understanding certain clients for whom the models appear to fit, with the understanding that the exact progression and timing of the coming out process will vary for different clients.

EXAMINING INTERSECTING IDENTITIES

Intersectionality theory, an important area of focus in recent multicultural-informed research and practice, provides an additional framework for engaging in culturally-sensitive assessment, case conceptualization, and treatment with clients presenting with issues related to their sexual orientation and identities. Intersectionality theory emphasizes the complex ways an individual's identities are interconnected, and the ways they are shaped by temporal, spatial, and sociocultural contexts (Bieschke, Hardy, Fassinger, & Croteau, 2008; Fassinger & Arseneau, 2007). Using this model, we suggest that to develop a working understanding of clients' sexual identities, we must also seek to assess the ways gender and sexuality intersect with clients' other cultural identities, including disability status, race, ethnicity, age, social class, religion, and immigration status, as well as the ways these intersecting identities are related to experiences of oppression and privilege (Fassinger & Arseneau, 2007). A detailed elaboration of this theory is beyond the scope of this commentary. In addition to professional guidelines addressing issues related to multicultural-informed practice, numerous applications of intersectionality theory to clinical practice are available for interested readers, including Bieschke et al. (2008), Chantler (2005), and Fassinger and Arseneau (2007).

Applying intersectionality theory to several clinical issues in Mandel's case study may illustrate how this perspective can yield a multifaceted understanding of a client's sexual orientation. In examining aspects of Adam's sexual and gender identities, Mandel notes interconnections between (1) Adam's beliefs and expression of masculinity; (2) his positionality as a cisgender male; (3) the influence of societal, cultural, and familial gender norms (e.g., being

“less of a man”); (4) his desire to enter into a relationship that transgresses gender and sexual norms of his community of origin, while; (5) striving to remain within a societally acceptable monogamous relationship configuration. By elucidating these interrelated variables, Mandel was able to tailor her conceptualization of Adam’s pattern of interpersonal isolation and schemas related to self and others.

Mandel’s description of Adam’s background information and treatment omits information regarding Adam’s racial and ethnic identities, socioeconomic, immigration, and disability statuses. From the perspective of intersectionality theory, gathering information regarding Adam’s experiences of these components of his identity is a necessary step in developing a conceptualization that situates his presenting issues within their cultural, social, and political contexts.

IDENTIFYING AND CLARIFYING DIMENSIONS OF SEXUAL IDENTITY AND ORIENTATION

For many clients who present with concerns related to sexual orientation, affirmative therapies can provide a space for clients to better understand and clarify dimensions of their sexual identity, including sexual and romantic fantasies, attractions, and behaviors; gender roles, identities, and expressions; relationship configurations, and community identification and engagement. As multiple authors have noted, a central competency in helping clients explore these aspects of their identities involves an open-ended, client-centered approach (e.g., Hill, 2009; Israel & Selvidge, 2003). Clients may utilize a wide range of terms to describe aspects of their identities, including but certainly not limited to questioning, lesbian, gay, bisexual, asexual, queer, pansexual, and omnisexual. Even when working with individuals who define themselves using categorical labels or who experience their sexual orientation as having been established since early age and fairly fixed, sexual identity is a complex and multidimensional construct. Labels and identity constructs have meanings that differ across communities, generations, and cultural contexts. Clinicians are encouraged to explore the range of meanings ascribed to identities by clients, while tolerating ambiguity and complexity inherent in the process of identity exploration and development.

Adam, who presented with a self-identification as “gay,” benefitted from the use of open-ended questioning, normalization, and validation, to help explore previously unexamined notions of gender expression, models of relationships and family configurations, sexual attraction, and avenues to community involvement. Importantly, Mandel’s clinical interventions were sensitive to the fluid nature of Adam’s identity development; she worked closely with Adam to clarify the development of these aspects of his identity over time and across different domains of his life.

Because the process of clarifying their identity in a hostile environment can be confusing and anxiety-provoking, clients may present with a desire to find the “right” category or label that aligns with their lived experiences. In utilizing a client-centered approach, clinicians can strive to meet clients where they are with regard to their sense of self and explore with clients the multiple aspects of their identities, rather than encouraging adoption of a particular label or identity based on the clinician’s own perceptions or theories of the client’s identity.

HELPING CLIENTS RECONCILE SEXUALITY WITH RELIGIOUS BACKGROUNDS AND PRECEPTS

Consistent with the affirmative and intersectional approaches described above, clinical work with clients around issues related to coming out may include examination and integration of various aspects of a client's identity, including aspects that clients hold to be in conflict with one another.

One set of issues to which clinicians should be particularly attuned concerns conflicts regarding religion and sexuality. Mental health professionals should be prepared to encounter clients who are highly distressed about their same-sex attractions and who have tried or are interested in therapeutic services to change their sexuality. Research has shown that the majority of these clients harbor conservative religious beliefs and tend to come from religious traditions (including certain branches of Christianity, Judaism, and Islam) that have been associated with negative strictures regarding homosexual practices and orientations (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. [APA Task Force], 2009). Professional organizations, including the APA, have prepared specific guidelines for addressing this particular issue, on which there is broad professional consensus that these practices are ineffective and often harmful (APA Task Force, 2009).

Notably, many of the same principles and practices outlined throughout the present commentary (e.g., those related to affirmative stance, exploration of different aspects of identity, and addressing internalized homophobia) are thought to apply when working with religious clients presenting with distress regarding their sexual orientations (cf. APA Task Force, 2009). However, when working with clients whose sexual attractions conflict with their religious beliefs and values, the need for multicultural competence and for keeping open a wide variety of possible life choices beyond clear alignments with a "gay" or "lesbian" identity may be especially strong. In addition, the challenges faced by such clients may be immense with respect to such issues as internalized homophobia and risks related to disclosure.

In addition to these general strategies, clinicians are also advised to bear in mind, and beyond that to harness, the positive role that religion may play in these clients' lives. This may be accomplished, for instance, through helping clients to engage actively with religious texts, which some studies suggest can help by decreasing the focus on negative messages about homosexuality and increasing clients' sense of authority or understanding (APA Task Force, 2009). Other strategies include identification of core virtues and values consistent with both their religious and sexual identities (e.g., charity, gratitude) and reframing of experiences of suffering and identity conflict as spiritual challenges rather than punishment from God (APA Task Force, 2009).

As Mandel did with Adam, it may also be useful to help raise clients' awareness of the growing number of affirmative religious communities, congregations, and groups within various faith traditions, as well as alternative interpretations of religious texts and teachings within their religious faiths (such as the so-called "proof texts" that were traditionally construed as evidence for antihomosexual doctrines in Judaism and Christianity). In some cases, clinicians may find it

helpful to consult with religious leaders within the client's faith tradition to increase understanding of the relevant issues and possibly enlist their assistance, where appropriate.

CONFRONTING INTERNALIZED HOMOPHOBIA

As the case of Adam illustrates, internalized homophobia can have powerful negative effects on the psychological well-being of sexual minority clients and can be a key barrier to coming out. Internalized homophobia and related forms of responding to (sexual) minority stress may be associated with negative beliefs about the meanings, causes, or consequences of sexual minority orientations and identities; negative emotions such as shame, self-loathing, and anxiety; and negative behaviors such as self-isolation, substance abuse, self-harm, and various attempts to avoid or distance oneself from one's sexual feelings (Cochran, Sullivan, & Mays, 2003; Herek, Gillis, & Cogan, 2009). In her work with Adam, Mandel illustrates the connections between Adam's internalized homophobia and efforts to conceal his sexual identity around others.

Indeed, the case of Adam is in many ways an ideal hybrid case study in that the composite client, "Adam," at various points in the therapy manifests a number of thoughts and beliefs that represent concerns for many LGBTQ individuals in the process of coming out. These include beliefs associated with isolation, such as beliefs that they are all alone or that no one else is like them or can understand their experience; and construal of sexual attractions, behaviors, and orientations as a sign that one is perverse, sinful, or defective. Also evident are the equation of sexual minority identity with non-normative gender role expression (effeminacy in the case of male homosexuality and masculinity in the case of lesbianism); the associated negative valuation of gender nonconforming behavior; and worries that identifying as a sexual minority implies an inability to enjoy the same kind of lifestyle or milestones in valued domains, such as happy marriage, long-term partnership, and children.

Other views we have encountered in our clinical work have included clients' perceptions of sexual minority communities as monolithic and culturally homogenous and the concomitant view that they are "not like other gay people" (because, for example, they do not like to dance or go to bars); and corresponding expectations that to come out means to change who they are as a person or how they live. As Mandel notes, many of the internalized homophobic beliefs identified through Socratic questioning are rooted in the heterosexist stereotypes that pervade society.

As demonstrated in Mandel's work with Adam, clinicians may employ a variety of therapeutic strategies to address these negative and often dysfunctional attitudes and promote broadened awareness and increased acceptance of the existence of a diverse array of sexual identities, communities, and lifestyles. Such strategies may include psychoeducation; bibliotherapy (and recommendations for suitable videos, films, etc.); self-monitoring of beliefs and attitudes (as through the internalized homophobia scale); Socratic questioning and cognitive restructuring to examine the utility of beliefs and their emotional and behavioral effects; and behavioral experiments (including those that involve meeting other LGBTQ people). Consistent with intersectionality theory, an important strategy in addressing internalized homophobia involves cultivating a deeper understanding of the context of beliefs within a larger sociocultural context. With Adam, Mandel worked to contextualize his beliefs of defectiveness and

abnormality as rooted in societal norms encountered in his family of origin, religious upbringing, and current environment.

HANDLING DISCLOSURES

Many LGBTQ individuals enter healthcare settings with reluctance to disclose information about their sexual orientation, identity, and behaviors. Wariness of healthcare providers may be rooted in earlier homophobic or heterosexist encounters with providers, clients' concerns about confidentiality, and worries about provider's reactions and potential discriminatory treatment (Hill, 2009; Mayer, Bradford, Makadon, Stall, et al., 2008). Mandel notes that Adam initially identified as heterosexual in the initial phone screening, before disclosing his identification as gay in person. Clients may be wary of disclosing sexual minority status in initial encounters with intake and administrative staff members, which underscores the importance of providing multiple opportunities for clients to disclose sexual orientation and other sensitive concerns, including gender identity, sexual practices, relationship configurations, and invisible disabilities, at multiple points during the course of a client's assessment and treatment.

From the very first encounter with clients, clinicians can convey an openness to and acceptance of individuals of all sexual orientations. This can be done by asking about clients' sexual orientations and identities in an inclusive, open-ended manner, while providing validation and normalization for clients who appear anxious or distressed in response to questions. We suggest that specific questions that assess sexual orientation, behavior, and gender identity be incorporated into clinicians' standard intake protocols and utilized with all clients. There are a number of resources regarding sensitive information gathering strategies for clinicians, including guidelines from the Fenway Institute (Bradford, Cahill, Grasso, & Makadon, 2012).

In the case of Adam, Mandel illustrates in detail the collaborative way she and Adam engaged around Adam's decisions to disclose his sexual identity to important people in his life. In working with sexual minority clients, many therapists may find that they are among the first people their clients have chosen to come out to, underscoring the importance of conveying positive regard for, comfort with, and acceptance of such a disclosure. Clinicians should recognize that clients may be particularly attentive to both verbal and nonverbal reactions in these moments. Mandel demonstrates several affirmative therapeutic responses to Adam's disclosures that he identifies as gay and had not previously told anyone which we believe are exemplary. These responses include (1) clearly communicating ongoing acceptance of the client after receiving this information; (2) expressing appreciation of the difficult nature of disclosure in light of prevailing heterosexist societal norms; (3) gathering further information about this client's developmental and interpersonal history with regard to his sexual behaviors, orientation, and identity in a curious and non-judgmental manner. By responding in an affirmative manner, she was able to lay an important foundation of trust and collaborative inquiry that would inform the remainder of treatment. Additionally, her modeling of a positive response may have increased Adam's motivation to disclose to others.

Following Adam's initial disclosure to his therapist, a central component of the case centered on navigating decisions to disclose his sexual orientation to friends, members of his support group, and family members. The case study brings to light several important clinical

issues and interventions that arose during this process. First, Mandel underscores the importance of weighing each decision to disclose independently. This approach requires working with the client to evaluate the contextual risks and benefits of disclosure. Mandel notes that through self-reflection and supervision, she recognized and challenged her own internal bias that Adam should necessarily disclose his sexual orientation to his friends and family. Underlying this bias is a conceptualization of disclosure with others as a linear, unidirectional process, with a supposedly healthy or integrated end point of “complete outness” to family members, friends, and acquaintances. In contrast, recent theoretical and applied research suggests that many sexual minorities engage in an ongoing, adaptive process of *visibility management*, that is, regulating and adjusting exposure of one’s orientation based on characteristics and perceptions of a given situation (Dewaele, Van Houtte, Cox, & Vincke, 2013; Lasser, Ryser, & Price, 2010).

Assumptions similar to those identified by Mandel through her supervision may also be identified in clients presenting with concerns related to disclosure. Clients may have expectations regarding a “right” way to come out, or may express self-critical thoughts if they are not fully or 100% out. Clients may benefit greatly from identifying the situational characteristics that may influence their decisions to disclose their identities, and from understanding the potential advantages and drawbacks of these decisions (Dewaele et al, 2013; Legate, Ryan, & Weinstein, 2012). Socratic questioning and decisional matrices are several interventions that may assist clients in this stage of the disclosure process. In her work with Adam, Mandel facilitated evaluation of each decision to disclose, first to members of his support group, and later to his friends and sister. In a heterosexist society, potential risks of disclosure can include further “outing” if the disclosure is not kept in confidence, social rejection, victimization, economic repercussions including loss of job, housing, and/or financial support, and associated increases in psychological distress (Matthews & Salazar, 2012; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001). Each decision to disclose to should thus be explored carefully and in detail, with respect for clients’ subjective experiences and autonomy.

Further interventions may assist clients who are interested in disclosing aspects of their sexual identities with people in their lives. These can include assertive communication skills, role playing difficult disclosures, and emotion regulation strategies. Clients can also benefit from exploring the range of possible reactions to a disclosure and identifying their own worries and expectations about others’ reactions to their disclosure. Following an initial disclosure, clients may face decisions of whether and how to maintain relationships with hostile or tolerant others. As a number of researchers have noted, initial ruptures in relationships following a disclosure may often be repaired over time (Hill, 2009; Matthews & Salazar, 2012; Pachankis & Goldfried, 2004). Ongoing decisions regarding visibility management, strategies for confronting homophobia and heterosexism in others, and interpersonal effectiveness strategies may also be useful for clients following an interpersonal disclosure. Depending on the clinical setting, augmentative treatment modalities such as couples and family therapy can be powerful vehicles for helping clients who are experiencing ongoing difficulties in these domains (Green & Mitchell, 2008; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010) Crisis management strategies may also be indicated for clients facing more severe negative consequences following a disclosure.

CONNECTING CLIENTS TO COMMUNITIES AND RESOURCES

In addition to the strategies outlined above, fostering client connections to other sexual minority individuals and communities may be one of the most powerful ways of facilitating positive identity development (Matthews & Salazar, 2012). Significantly, affirmative communities can provide a safe space (outside of the therapeutic relationship) where clients can access positive social support, ameliorating feelings of isolation and shame. For clients with limited to no prior involvement in sexual minority communities, participation can also provide powerful challenges to overgeneralized beliefs about sexual minorities, such as those identified in the later stages of Mandel's work with Adam.

Rather than a simple referral out, we suggest that the process of addressing community connectedness be conceptualized as an ongoing process that mirrors a client's own identity development, and should thus be responsive to the unique identities and needs of the client. For Adam, issues of substance abuse and recovery, internalized homophobia, and concerns regarding his spiritual and religious identities led to referrals to the MA group at the local LGBTQ center and Dignity USA. Further exploration of other intersecting identities might have provided additional possibilities for connecting him to community resources. In exploring issues of community engagement, clinicians should be aware that sexual minority clients who also identify with other marginalized identities may experience significant barriers to access based on socioeconomic or disability statuses, as well as interpersonal and institutional racism, sexism, and transphobia in encounters with community organizations (e.g., Han, 2007). In addition to addressing these experiences as they arise in clinical work, clinicians may consider tailored approaches to referrals, including internet resources, which can be invaluable for all clients, particularly those facing geographic or structural barriers to access. Familiarizing oneself with available community resources is a necessary step in providing effective, affirmative treatment.

CONCLUSION

In summary, work with LGBTQ clients through the process of coming out is a challenging and important therapeutic task. Mandel's work with Adam provides important guidance for the provision of affirmative, individualized treatment in this area. We hope that the recommendations we have provided above will provide further clarification of the complexities involved in providing affirmative assessment and treatment.

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