

Response to Commentaries on The Targeting Sexual Stigma: The Hybrid Case Study of “Adam”

The Case of “Adam”: Reflections and Future Directions

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ABSTRACT

Three commentaries on “Targeting Sexual Stigma: The Hybrid Case Study of ‘Adam’ ” (Mandel, 2014) present additional insights into providing psychotherapy for sexual minority clients who struggle with internalized homophobia, minority stress, and identity formation concerns. In his thoughtful response, Christopher Martell (2014) writes about heteronormativity, behavioral activation, multidimensional treatment, and the issue of “readiness” to address sexual orientation and identity in treatment. Rachel Proujansky and John Pachankis (2014) describe their exciting principle- and evidence-based LGB-affirmative psychotherapy, and explain the importance of addressing sexual behavior when working with sexual minority clients. Additionally, Daniel Chazin and Sam Klugman (2014) highlight key issues related to the coming-out process and systemic-level interventions. In the following response, I summarize the psychologists’ comments and provide feedback to further the dialogue regarding how to best serve the needs of sexual minority clients.

Key words: sexual stigma; internalized homophobia; identity formation; LGB clients; LGB-affirmative therapy; multicultural theories; cognitive-behavioral therapy; client-centered therapy; hybrid case study; case study; clinical case study

INTRODUCTION

Although many sexual minority individuals demonstrate resilience and effective coping strategies in the face of prejudice and do not evidence mental health disorders (Schneider, Brown, & Glassgold, 2002; Sue & Sue, 2013), for others, the consequences of living in an environment imbued with discrimination negatively affects psychological well-being and adaptation. I wrote the composite case study of Adam in order to explore the effects of sexual stigma on mental health and to provide corresponding treatment interventions for lesbian, gay, and bisexual (LGB) clients during the coming-out process. I sought to treat Adam within an integrative, flexible, and tailored framework by combining a cognitive-behavioral, client-centered, and multicultural treatment approach. By demonstrating my first-hand clinical

experiences, the case study of Adam adds to the existing knowledge base of best treatment practices that are currently found within the psychological literature.

I am delighted to see the very thoughtful readings and responses to the case of Adam. Each highlights key issues related to sexual stigma and how to combat it clinically. They also build upon the case of Adam by raising important questions regarding treatment strategies and research in the area of LGB mental health. I will respond to the commentators' articles and discuss both clinical and research-related areas of LGB mental health. I hope that this dialogue will offer additional insights into providing effective treatment for sexual minority clients, and continue to inspire others to investigate how to best serve the needs of this at-risk population.

MARTELL ON HETERONORMATIVITY, BEHAVIORAL ACTIVATION, MULTIDIMENSIONAL TREATMENT & READINESS TO ADDRESS SEXUAL ORIENTATION AND IDENTITY

In his comment on the case of Adam, Martell (2014) raises many issues relevant to effective clinical work with an LGB population. My response focuses on four areas of his commentary: i) the problem of working within a heteronormative context; ii) the benefits of behavioral activation treatment (Martell, Addis, & Jacobson, 2001); iii) the advantages of multidimensional treatment; and iv) clients' readiness to address sexual orientation and identity.

Heteronormativity

Martell (2014) writes that in heteronormativity (Warner, 1991), "the majority heterosexual population is the norm, and the experiences of sexual minority individuals are then compared to the majority" (Martell, 2014, p. 106-107). Heteronormativity is a term closely related to that of heterosexism (Herek, 2007), in which LGBs experience inferior status and power as compared to heterosexuals. In the case of Adam, I address the harmful effects of heterosexism and the need to actively avoid using language that may demonstrate heterosexist bias. For example, the media's use of the phrase "that's so gay" perpetuates heterosexism by promoting negative associations with sexual minorities. Additionally, states that do not recognize same-sex marriage and offer only "single" or "married" identification markers on forms deny the mere existence of LGBs within our social context by forcing all LGBs to indicate that they are "single."

Martell (2014) accurately points to my use of the term "nonheterosexual" as an example of heteronormativity, since "nonheterosexual" carries with it the connotation that LGBs are classified as an "other" from the "normal" majority. Martell (2014) reminds us that attending to language is essential because it is through language that we may convey subtle or overt heteronormative bias. Martell (2014) points to the need for clinicians (me included!) to remain open to their own potentially biased thinking, engage in self-reflection, and ponder the meanings and weight that words often carry. Continuing to engage in dialogues with our colleagues and seeking out additional research and knowledge regarding working with sexual minority populations is also essential in order to provide sensitive and culturally competent treatment.

In addition, Martell (2014) suggests that discussions of gay marriage may support a "heteronormative agenda" (p. 114). Although I sought to provide Adam with a multitude of

options throughout his treatment and support his individual longings, it is important to recognize that highlighting that many gay men get married (or engage in other behaviors that are commonly associated with heterosexual "norms") can be a form of heteronormative bias. Alternatives to this heterosexual convention should also be presented in treatment, and celebrated, too. Indeed, "heteronormativity has a totalizing tendency that can only be overcome by actively imagining a necessarily and desirably queer world" (Warner, p. 8).

Behavioral Activation

Martell (2014) writes that had he been Adam's psychologist, he may have opted against a course of integrative, affirmative cognitive-behavioral treatment, and instead have provided LGB-affirming behavioral activation treatment exclusively. Indeed, behavioral activation, an effective treatment for depression and avoidance (Martell et al., 2001), may have been an excellent treatment approach with Adam.

As a firm believer in behavioral interventions, I incorporated many activation strategies throughout Adam's treatment in order to introduce him to feelings of mastery and pleasure (via activity monitoring and scheduling), combat his avoidance, help him engage with a supportive community, and generally increase the positive reinforcement in his environment. However, one reason why I did not choose a behavioral activation treatment format is that I believed that a course of affirmative, integrative cognitive-behavioral therapy would be most appropriate for Adam's presentation given that he struggled with many negative thoughts about himself (e.g., "I'm a failure" and "I'm defective") and the gay community. Later in his article, Martell (2014) also offers that 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" (p. 113). Although my clinical experiences with Adam suggest that the incorporation of other strategies (e.g., cognitive and mindfulness) were effective, it is also possible that a purely LGB-affirming course of behavioral activation could have successfully combatted Adam's depression, substance abuse, and internalized homophobia.

Multidimensional Treatment

I agree with Martell's (2014) perspective on the importance of providing multidimensional treatment, in which several problems can be targeted simultaneously in the therapy as opposed to relying solely on a discrete, phase-like treatment approach. Persons (2008), however, suggests that therapists and patients construct problem lists in order to guide treatment and decisions about which problems to tackle, and in which order. Though it is always an overarching goal of mine to conduct multidimensional, flexible treatment, I find that working within the framework of Persons' (2008) case formulation and problem lists helps to organize therapy and make treatment transparent (which I believe benefits me, as the practitioner, and my clients).

In my work with Adam, I created an idiographic treatment plan based upon our collaboratively constructed problem list, with cognitive-behavioral theory as my guiding conception. As Adam's depression was debilitating, it seemed prudent to provide him with a course of cognitive-behavioral therapy for depression immediately (Young, Rygh, Weinberger,

& Beck, 2008), and prioritize his depressive symptoms over his substance use and sexual identity development. Although the treatment plan followed a five-phase format, it was expected and was oftentimes beneficial when the phases were not linear, and goals from different phases were worked on concurrently. For example, in the "Targeting Depression" phase of treatment, Adam uncovered important thoughts and feelings about his sexual identity, including that he tried to be "perfect" in order to "compensate" for being gay.

Readiness to Address Sexual Orientation and Identity

Martell (2014) raises a fascinating issue regarding waiting for clients to be "ready" to address their gay identity. In his opinion, waiting for a client to be "ready" may lead the patient to fear "dealing" with their sexual identity and could perpetuate avoidance behaviors (p. 113). For this reason, Martell (2014) suggests that perhaps Adam's gay identity should have been focused on earlier and more directly in the treatment.

Given Adam's initial behaviors of avoiding treatment entirely (e.g., no-showing), I was concerned that he was at risk of fleeing therapy if he perceived that I was "pushing" him too much in the treatment. Therefore, it may come across that my work with Adam was tentative or that I handled his internalized homophobia and sexual identity development with "kid gloves." In my and my supervisors' understanding of the case, however, it appeared necessary for me to allow Adam the time and the autonomy to decide when to address his sexual orientation and identity in the treatment.

In general, Adam's treatment followed a five-phase framework, with "Addressing Gay Identity Issues" taking place at a later stage of the treatment once Adam's depressive and substance use behaviors had decreased. However, as Adam's sexual orientation was a highly salient part of his identity, we addressed his sexual orientation and identity throughout all phases of the therapy via frank, open dialogues. For example, during the "Addressing Substance Use" phase of treatment, Adam realized that he used marijuana in order to both allow himself to fantasize about men and to "numb" himself regarding his feelings of shame about being gay. We also spoke of sexual stigma and his fear of discrimination when he considered whether to attend Marijuana Anonymous groups. Noticing that Adam was starting to speak more openly about his sexual orientation, I suggested that he attend an LGBT meeting during this substance use stage of treatment. Adam, however, stated that it would be "too overwhelming" for him to engage with the gay community at that time.

Adam was often ambivalent about addressing his sexual orientation and identity, and was avoidant of engaging with a supportive gay community. As treatment progressed, however, he became less fearful and more open to identity development strategies. I believe that as Adam gradually addressed his gay identity, he was "tackling the lowest rungs on a sexual orientation exposure fear hierarchy," and in time, was able to decrease his avoidance and embrace his sexual identity (Mandel, 2014, p. 82).

In addition to conceptualizing Adam's gay identity development through the lens of a graduated exposure hierarchy, I supported his identity development by embodying a motivational interviewing treatment approach (Miller & Rollnick, 2002). My work with Adam was marked with empathy, open-ended questions, reflections, and attempts to increase his ambivalence about

remaining isolated from the gay community. I allowed myself to “roll” with his resistance regarding his sexual identity development, in order to support his sense of autonomy and self-efficacy to engage in alternative behaviors when he was more willing to do so. When I saw openings in Adam’s manner of speaking about his sexual orientation and identity, I tried to encourage his “change talk” and instill him with confidence that he could become more involved with the gay community. Under different circumstances, with a client who was less at risk of becoming “overwhelmed” and dropping out of treatment, I would see many benefits to more directly addressing internalized homophobia and additional gay identity development strategies from the outset of therapy.

PROUJANSKY AND PACHANKIS ON EVIDENCE-BASED PRINCIPLES OF LGB-AFFIRMATIVE PSYCHOTHERAPY & SEXUAL BEHAVIOR

In their commentary, Proujansky and Pachankis (2014) illustrate eight LGB-affirmative psychotherapy principles, focusing on how to increase minority stress coping among sexual minority clients. I was thrilled to read that their research team developed the principle-based treatment “Effective Skills to Empower Effective Men” (ESTEEM) and is currently testing their treatment in an ongoing randomized controlled trial. The writers describe their compelling principle-based treatment, and highlight interventions from the case of Adam as a “demonstration of these principles in action” (Proujansky & Pachankis, 2014, p. 117). My response to Proujansky and Pachankis (2014) will focus on two areas of their commentary: i) the benefits of employing evidence-based principles in LGB-affirmative psychotherapy and ii) the importance of addressing sexual behavior when working with sexual minority clients.

Evidence-Based Principles of LGB-Affirmative Psychotherapy

Proujansky and Pachankis’ (2014) exciting ongoing research may demonstrate that principle-based, LGB-affirmative psychotherapy interventions are uniquely suited to address the diverse needs of LGB clients who struggle with minority stress. The researchers adapted a standard, transdiagnostic cognitive-behavioral treatment to include minority stress attenuating interventions, including: i) normalization; ii) emotional awareness; iii) decreasing avoidance; iv) restructuring cognitions; v) assertiveness training; vi) validating unique strengths; vii) building support; and viii) affirming healthy expressions of sexuality. Proujansky and Pachankis’ (2014) research builds upon the case of Adam in that it codifies theoretical advances by placing LGB-affirmative interventions within a formal framework and testing these principle-based strategies in a randomized controlled trial.

Proujansky and Pachankis’ (2014) eight LGB-affirmative principles overlap considerably with the psychotherapy interventions I employed throughout my work with Adam. For example, I worked with Adam to help him i) understand the impact of minority stress on his mental health (normalization), ii) reduce his substance use behaviors with the help of mindfulness exercises (emotional regulation), iii) attend Marijuana Anonymous groups (decrease avoidance), iv) challenge stereotypes about gay men (restructuring cognitions), v) assert his identity as a gay man (assertiveness training), vi) embrace his burgeoning friendship with a gay man who increased Adam’s sense of shamelessness and pride (validating unique strengths), and vii) engage with the LGBT community (building support).

Each of the specific interventions listed above were selected to address Adam's unique, complex presentation. Although not every client who struggles with minority stress will evidence a substance use disorder, depression, or academic problems (as Adam did), it appears likely that Proujansky and Pachankis' (2014) principles can be readily adapted to meet the idiosyncratic needs of sexual minority clients who struggle with minority stress. The adaptability of Proujansky and Pachankis' (2014) principle-based treatment model is testament to its potential to provide effective treatment for sexual minority clients who struggle with real-world, multifaceted, and interacting problems.

Currently, no manualized or evidence-based treatments exist for working with sexual minority clients (Martell, 2014; Proujansky & Pachankis, 2014). Proujansky and Pachankis' (2014) ESTEEM treatment protocol and the case of Adam complement each other as both seek to demonstrate efficacious and/or effective treatment practices when working with LGB clients who struggle with minority stress. If Proujansky and Pachankis' (2014) randomized controlled trial proves successful, then their research will provide the psychology field with the first groundbreaking evidence-based treatment for reducing the effects of minority stress among sexual minority clients. Whereas Proujansky and Pachankis' (2014) principle-based approach can provide the guiding framework regarding how to combat the effects of minority stress, the case of Adam can illustrate these principles via a richly detailed case example, thereby bringing the principles to life through actual dialogues between clinician and patient. I hope that therapists will seek out Proujansky and Pachankis' (2014) evidence-based principles and the case of Adam in order to provide affirming psychotherapy with their sexual minority clients.

Sexual Behavior

Although Proujansky and Pachankis' (2014) principles of LGB-affirmative psychotherapy are apparent throughout my work with Adam, the writers astutely point out that this is not the case with regard to their eighth principle of "affirming healthy, rewarding expressions of sexuality" (p. 117). During my work with Adam, he spoke about his previous sexual encounters and the relationship between his sexual fantasies and marijuana use. He did not, however, engage in sexual behavior during the approximate ten-month duration of our treatment. Although he spoke of his romantic longings and desire for a monogamous gay relationship, he did not address the important sexual component of that fantasy relationship, and what he hoped it would resemble.

As Proujansky and Pachankis (2014) insightfully noted in their article, Adam first coped with his negative thoughts and feelings about sexual behaviors by smoking marijuana, and once he became sober, he avoided sexual contact with other men "outright" in order to "escape the shame" he may have still attached to same-sex sexual behavior (p. 127). In fact, by the end of his treatment, it was evident that Adam was still struggling with a lack of fulfillment regarding romantic relationships. Even though Adam's Interpersonal Relations subscale score on the Outcome Questionnaire-45 (OQ-45) decreased to below the clinical cut-off, his initial and final scores on this scale did not indicate a clinically significant "reliable change" (Lambert, Morton, Hatfield, Harmon, Hamilton, Reid, Shimokawa, Christopherson, & Burlingame, 2004). Adam noted a decrease in feelings of loneliness on the OQ-45, yet he continued to indicate dissatisfaction for queries that targeted fulfillment in romantic relationships. In retrospect, I believe that Adam could have benefited from my more fully addressing his thoughts and feelings

about sexual behavior with other men and his reluctance to engage in healthy expressions of his sexuality.

CHAZIN AND KLUGMAN ON THE COMING-OUT PROCESS & SYSTEMIC-LEVEL INTERVENTIONS

In their thought-provoking commentary, Chazin and Klugman (2014) elaborate on the case of Adam, highlighting key clinical issues related to working with clients who are undergoing the coming-out process. Herein, I will summarize their LGB-affirmative treatment guidelines and address their recommendation to incorporate systemic-level interventions when working with sexual minority clients.

The Coming-Out Process

Chazin and Klugman (2014) present nine LGB-affirmative principles related to the coming-out process, integrating the current research literature with their own clinical experiences in the treatment of sexual minority clients. The authors explain that therapists should: i) cultivate an affirmative stance; ii) address institutional and systemic issues; iii) consider identity formation trajectories; iv) examine intersecting identities; v) identify and clarify dimensions of sexual identity and orientation; vi) work with clients to help reconcile sexuality and coming-out with clients' religious/moral backgrounds; vii) confront internalized homophobia; viii) aid in decisions about disclosure; and ix) connect clients to community resources. These guidelines serve as an excellent resource and framework for therapists who seek to provide culturally competent treatment for sexual minority clients during the coming-out process.

Many of the interventions and strategies I utilized in the case of Adam are congruent with Chazin and Klugman's (2014) principles. For example, I conducted treatment from a client-centered stance and sought to uncover my own biases. I also considered Adam's identity within the context of gay identity development models. In addition, I addressed Adam's intersecting gender, sexual, and religious identities. I took care not to label Adam, and allowed him to assign his own sexual orientation label to himself. Furthermore, I provided Adam with information regarding LGB-friendly religious institutions. I also uncovered and challenged Adam's beliefs that he was "abnormal" and "defective" because he desired men. Finally, I assisted Adam in determining whether, when, how and whom to come out to in his life and encouraged him to engage with a supportive LGB community.

Systemic-Level Interventions

Although there are significant overlaps between Chazin and Klugman's (2014) guidelines and my treatment approach, the authors' tenet of "addressing institutional and systemic issues" when working with LGB clients was mostly absent from my work with Adam (p. 135). When working with minority populations, in particular, it is important to think beyond the basic unit of analysis as the individual (i.e., the client) and consider various contexts and their interaction (e.g., exposure to societal heterosexism and its impact on an individual's mental health). Although I focused on the impact of societal stigma in Adam's treatment, I typically viewed him through the lens of individually-based conceptualizations (e.g., his maladaptive cognitions, which led to depressed affect), and chose corresponding individually-g geared interventions (e.g.,

his completion of a dysfunctional thought record). Yet psychological formulations and interventions can also be applied to groups, institutions, and entire communities (Levine, Perkins, & Perkins, 2005).

Had I adopted more of a community-based, systems-level understanding of my client and his presenting problems, I could have ventured "outside the consultation room" in order to serve his psychological needs. As noted by Chazin and Klugman (2014), I could have examined how systemic forces were impacting Adam and other LGB individuals' experiences at the counseling center. For example, Adam endorsed a heterosexual orientation during his initial phone intake at the center. It is possible that Adam felt uncomfortable disclosing his gay sexual orientation due to a lack of trust in the counseling center. Adam may have first encountered the center via its website, which perhaps could have done more to indicate its LGB affirmative stance in posting additional LGB affirmative information and materials online.

Additionally, Chazin and Klugman (2014) raise the important point that clinicians should gather system-level knowledge regarding the resources and rights available to LGBs within their particular contexts. For example, the authors suggest that therapists determine i) clinical, financial, and academic resources accessible to support students who are coming out and ii) school, local, state, and federal policies for LGB students who are deciding whether to come out in their workplace. Had I incorporated these interventions in my work with Adam, my role as a clinician might have also included the potential of acting as liaison, case manager, and advocate.

The area in which I worked from a more systems or community psychology perspective was in my emphasis on providing Adam with a sense of community, which includes group membership, mutual influence, fulfillment of needs, social and emotional connections, mutual concerns, and community values (Levine et al., 2005). All of these experiences protect individuals from chronic feelings of loneliness (Levine et al., 2005), and may be especially helpful for clients who struggle with feelings of isolation and shame. Indeed, sexual minorities typically experience improved psychological functioning as a result of engagement with the LGB community (American Psychological Association, 2012). In fact, the most important variable in the establishment of a positive gay identity is accessing other sexual minority individuals (Ritter & Terndrup, 2002). In my work with Adam, I familiarized myself with relevant community resources, and as soon as he became amenable to seeking support beyond individual therapy, I encouraged his engagement with self-help groups (Marijuana Anonymous, for instance) and helped him develop ties to the gay community via LGBT groups in order to strengthen his network of support.

SUMMARY

Martell (2014), Proujansky and Pachankis (2014), and Chazin and Klugman's (2014) commentaries on "Targeting Sexual Stigma: The Hybrid Case Study of 'Adam'" elaborate on the case of Adam and are valuable psychological resources, in their own right, for those seeking to provide culturally competent and sensitive treatment with sexual minority clients. Each commentator contributes to a much-needed dialogue regarding how best to serve the psychological needs of clients who struggle with minority stress, internalized homophobia, and identity formation concerns. My hope is that the case of Adam and its resultant commentaries will augment the effectiveness of the clinical care provided to sexual minority clients, and inspire

others in our field to advance clinically-applied research in the area of sexual minority mental health.

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