

The Case of Felix: An Example of Gay-Affirmative, Cognitive-Behavioral Therapy

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ABSTRACT

Felix, a Gay Latino man, presented with anxiety and panic attacks, which were addressed as symptoms of minority stress and self-stigma. The client's panic attacks were eliminated and anxiety was reduced by cognitive-behavioral therapy that targeted his concealment of his sexual orientation and that increased his active coping. By facing his fears of the negative impact of self-disclosure of his sexual orientation, Felix improved his mental health and relationships with others. A positive four-month follow-up interview is described.

Key words: gay; Latino; anxiety disorder; panic disorder; affirmative psychotherapy; cognitive-behavioral therapy (CBT); evidence-based therapy; sexual orientation stigma

1. CASE CONTEXT AND METHOD

The Rationale for Selecting This Particular Client for Study

The case of Felix, a Gay Latino man presenting with anxiety and panic attacks, was chosen, as it is representative of the clinical presentation of many gay, lesbian and bisexual individuals. The case highlights the impact of minority stress (DiPlacido, 1998; Herek & Garnets, 2007; Meyer, 2003;) and self-stigma (Herek, 2009) on the psychological distress experienced by clients (Malyon, 1982; Pachankis & Goldfried, 2006). There is a dearth of case studies in the area of lesbian, gay, and bisexual individuals that illustrate evidence-based treatments, so that this case study may be useful in illustrating the best current theories and evidence in the psychotherapy of gay, lesbian and bisexual individuals (American Psychological Association, 2000; Goldfried, 2001; Martell, Safren & Prince, 2004); Pachankis & Goldfried, 2004; Safren, 2005).

The Methodological Strategies Employed for Enhancing the Rigor of the Study

Case progress was ascertained by using concrete and measurable goals of client progress that were mutually determined by myself and Felix related to the presenting problems of anxiety

and panic. In addition, client self-assessment and feedback were utilized to ascertain progress at each session. Case notes recorded progress at each step of treatment.

Case Setting

Felix was self-referred to me. He had received my name through his insurance company and then performed a Google search to determine my qualifications. Felix was seen in an independent practice setting at a frequency of weekly or biweekly sessions, and he used his insurance to pay for treatment.

Sources of data available concerning the client

This was Felix's first psychotherapy experience, so no other records were consulted, and he was the sole source of information about his condition and is considered a reliable informant. My assessment of Felix was based on our therapeutic interviews. In light of other cases published in the *PCSP* journal, and common practice in cognitive-behavior therapy, in retrospect it would have been desirable to include standardized anxiety and self-report questionnaires at the beginning, during, and at the end of treatment, and at follow-up. Such questionnaires could have quantitatively contextualized Felix relative to other clients with similar types of presenting symptoms and allowed for the type of statistical analysis of change as set forth by Jacobson and Truax (1991), to assess whether there was statistically significant change in Felix's symptoms over time.

Confidentiality

Identifying information has been disguised to protect confidentiality.

2. THE CLIENT

Felix is a bilingual, 30 year old Latino gay man who is self-employed in sports marketing. He is currently in a long-term committed relationship with another man he met in college and they own a home together. However, they have not legalized their relationship as they could under current state law. He presented for treatment for problems with anxiety and panic-attacks of a two-year duration. More details about Felix's presenting problems and his history are presented in section 4 below on assessment.

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

Introduction

The guiding conception employed for Felix's case formulation and treatment is consistent with the American Psychological Association's *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients* (2000). These promote what has been termed "multiculturally-competent, gay-affirmative therapy," i.e., therapy for gay, lesbian, and bisexual clients that encourages them to accept their sexual orientation and their same-sex desires and behaviors (e.g., Brown, 2006;

Pachankis & Goldfried, 2004; Herek & Garnets, 2007; Malyon, 1982; Ritter & Terndrup, 2002). Multiculturally-competent affirmative psychotherapy is consistent with the scientific evidence that (a) homosexuality is not a mental illness, (b) same-sex sexual attractions are a normal variant of sexual orientation, (c) these attractions can occur in the context of a variety of sexual orientation identities, (d) same-sex romantic and sexual relationships can be as fulfilling as different-sex relationships, and (e) oppressive stereotypes and their impact on psychological functioning are important to consider in treatment.

In my own work, I do not have an a priori treatment goal for how a client identifies or lives out her or his sexual orientation, and I have worked with clients with same-sex attractions who do not act on their attractions or who are in heterosexual relationships. My approach is founded on the assumption that prejudice and social discrimination play a role in causing psychological distress (American Psychological Association, 2006A; Meyer, 2003) and that lesbian, gay, and bisexual individuals benefit from an approach that understands the contextual factors of their lived experience, most notably sexual orientation prejudice (American Psychological Association, 2000; Brown, 2006).

The conceptual model in Felix's case is consistent with the APA's Evidence-Based Practice in Psychology paradigm (American Psychological Association, 2006b), which states, "Evidence-based practice in psychology (EBPP) is the integration of the *best available research* with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273, emphasis added). Specific approaches for lesbian, gay, bisexual and individuals that are empirically based are found in Martell, Safren and Prince (2004), who focus on cognitive-behavior therapies such as Aaron Beck's model for combating irrational beliefs and David Barlow's model of exposure to reduce excessive anxiety precipitated by nonthreatening situations.

Minority Stress and Stigma

Following Balsam and Mohr (2007) and Herek (2009), I use the terms "sexual stigma" or "sexual orientation stigma," which Herek (2009) defines as "the stigma attached to any non-heterosexual behavior, identity, relationship or community" (p. 3). In formulating this case I viewed the stress due to the stigma associated with homosexuality and bisexuality as creating vulnerability in some individuals (Cochran & Mays, 2006; Herek & Garnets, 2007). This stigma operates both at the societal level and at the individual level. At the societal level sexual stigma is embedded in society's institutions, including civil and criminal law, psychology, psychiatry, medicine, religion, and other social institutions. At the individual level, stigma is communicated through negative actions such as violence, discrimination, and other negative interpersonal interactions, which is termed by Herek (2009) *enacted stigma*. Individuals' expectations about the probability that stigma will be enacted in various situations is defined as *felt stigma*. Individuals may change behavior to avoid enacted and felt stigma. Such strategies may include withdrawing from self (e.g., self-denial or compartmentalization) and withdrawing from others (e.g., self-concealment or closetedness) (Herek, 1996; Pachankis, 2007).

One of the consequences of growing up in a heterosexist culture is *internalized stigma*. Herek (2009) defined internalization as "the process whereby individuals adopt a social value,

belief or prescription for their own conduct, and experience it as part of them” (p. 7). Internalized stigma is the personal acceptance of the denigrating values. Members of the stigmatized groups as well as non-members of the group (i.e., those of the dominant or majority culture) can internalize these values. For those individuals who experience same-sex attractions and who internalize the stigma, the result is *self-stigma* and usually means that a stigmatized individual’s self-concept will match social stigma. Examples of this self-stigma are (a) accepting society’s negative self-evaluation and (b) harboring negative attitudes toward oneself and same-sex attractions (American Psychological Association, 2000; Malyon, 1982).

The Psychological Impact of Sexual Stigma on Lesbian, Gay, and Bisexual Individuals

The study of the impact of stigma on members of stigmatized groups has in recent years focused on the concept of minority stress (e.g., Meyer, 2003). This model has replaced the illness model to frame mental health interventions with this population (Herek & Garnets, 2007). This model proposes that chronic stress due to stigma during the lifespan and in key developmental periods such as adolescence can cause distress in certain sexual minority individuals (D’Augelli & Patterson, 1995; Meyer, 2003). Meyer (2003) described these stress processes as due to: (a) external objective events and conditions, such as discrimination and violence; (b) expectations of such events, and the vigilance that such expectations bring; and (c) internalization of negative social and cultural attitudes.

Recent research by Pachankis and colleagues (Pachankis, 2007; Pachankis & Goldfried, 2004; Pachankis, Goldfried & Ramrattan, 2008) using a minority stress model to understand rejection anxiety, and its influence on social and other anxiety in gay men illustrates the utility of the minority stress hypothesis. This research indicates that some gay men are particularly sensitive to rejection by others and are more vulnerable to fear of negative self-evaluation, social anxiety and lower self esteem than heterosexual men (Pachankis & Goldfried, 2006; Pachankis, Goldfried & Ramrattan, 2008). Significantly, gay men who are less open about their sexual orientation and who are less comfortable with being gay were more likely to experience anxiety in social situations (Pachankis & Goldfried, 2006).

Concealable Stigma and Distress

Most of the literature on stigma has focused on visible stigma; however, sexual orientation stigma is unique in that it can be concealed. Moreover, the stress due to concealment can be significant and is associated with the burdens of hiding, secrecy, and ongoing deliberations regarding disclosure and its consequences. Pachankis (2007) presents a framework that explains the specific potential psychological sequelae of concealed stigma. These sequelae include such factors as the contextual salience of the stigma and the threat of discovery, and negative cognitive implications, such as hypervigilance and preoccupation, and emotional distress. All of these factors can lead to negative views of the self and lack of self-efficacy. Further hiding can have interpersonal impacts, such as isolation and lack of intimacy, and an impact on the self, such as inauthenticity and a sense of dishonesty that prevent engaging in protective factors like community and group identity (Malyon, 1982; Pachankis, 2007).

Mitigating Minority Stress

If lesbian, gay and bisexual individuals are more vulnerable to certain mental health concerns due to minority stress, are there ways to mitigate this stress? Pachankis (2007) identifies several individual coping strategies: (a) attributing distress to stigma or concealing personal stigma rather than attributing it to personal deficits; (b) selective disclosure; and (c) support from similar others. Herek and Garnets (2007) propose that personal and collective identity (often termed social identity) mitigate the impact of minority stress; individuals with a strong sense of collective identity integrate their group affiliation into their core self-concept and will have community resources for responding to stigma in addition to personal resources (cf. Balsam & Mohr, 2007). This proposal is supported by research by Lewis, Derlega, Clarke, & Kuang (2006), who explored factors that affect well-being in lesbian women. Lewis et al found that *not* having a community or relationships to disclose these concerns was positively associated with symptoms of depression, stress, and internalized stigma compared to those who had fewer social constraints.

Similarly, models of sexual identity development usually include provisions for overcoming self-stigma (Cass, 1979; Gonsiorek & Rudolph, 1991; Troiden, 1993). These models, which were developed through clinical experience, propose developmental stages of self-acceptance and openness with others in lesbian, gay and bisexual populations, starting with Uncertainty/Confusion and ending with Pride/Synthesis. Research by Halpin and Allen (2004) appears to indicate that individuals in the higher stages of Pride/Synthesis of Cass's (1979) model report higher levels of well-being.

Current research indicates that ethnic minority individuals who are also sexual minorities may face multiple types of oppression--prejudice and discrimination due to their sexual orientation and ethnic identity (Consolacion, Russell & Sue, 2004; Fukuyama & Ferguson, 2000; Harper, Jernewall & Zea, 2004). Individuals may face prejudice and discrimination from Caucasian lesbian, gay, and bisexual communities, as well as face prejudice and discrimination based on sexual orientation from their own ethnic minority communities (Consolacion, Russell & Sue, 2004; Fukuyama & Ferguson, 2000; Harper, Jernewall & Zea, 2004). Such multiple stigmatized identities may increase the experience of stress in some individuals (Diaz, Ayala, & Bein, 2002). However, integrating such identities may increase resources for coping and social support (Crawford, Allison, Zamboni, & Soto, 2002). Addressing both the challenges and the strengths of these identities may be important in therapy (Bowleg, Craig & Burkholder, 2004).

Psychotherapy Approach

As is my general orientation, I approached Felix's case as an integrative therapist, one who applies a variety of approaches to particular cases depending upon the clinical particulars and client preferences. In this instance, the treatment was conceived of as a collaborative endeavor of the therapist and client, whose goal was to increase overall client agency (see, Glassgold, 1995). Agency is defined as the development of psychological skills that increase goal-oriented behaviors—skills such as cognitive reframing, positive behavior change, insight, increased mastery, strategic planning, active coping skills and increasing social support. This approach is consistent with the literature on concealable stigma and minority stress (see above,

Pachankis, 2007) that postulates that hiding reduces self-efficacy and self-esteem and that therapies that increase self-efficacy are hypothesized to mitigate this stress.

Such a model is similar to feminist (Smith & Douglas, 1990), cognitive-behavioral, and psycho-educational approaches (Hope, Heimberg & Turk, 2006), where the goal is to provide information to clients that they can apply to their own life. In working with Felix, I was aware of the interpersonal dynamic between us as client and therapist, but I did not envision treatment as involving issues as transference and countertransference. However, Felix's relationship with me was considered as potentially indicative of other interpersonal situations. Treatment was both goal-oriented and exploratory, and was envisioned as time-limited. At the time of treatment I had had over 17 years of training and experience with this population.

Incorporated into this case study are research and clinical publications relevant to affirmative therapy with lesbian, gay and bisexual clients and include the domains of affirmative cognitive-behavioral therapy (Martell, et. al., 2004); family therapy (Bowen, 1978), especially addressing families of gay and lesbian individuals (Laird & Green, 1996); information relevant to Latino men and their families (Morales, 1996); and the psychology of men and masculinity (Levant & Pollack, 1995). For instance, the importance of gender roles and stress from societal views of masculinity in individual distress appears to be initially supported in research by Szymanski & Carr (2008). They found that gender role conflict was related directly and indirectly (through self-stigma) to self-esteem and self, and that esteem in turn was directly and indirectly (through avoidant coping) related to psychological distress. Further, Latino culture has many norms for masculinity, and in Felix's case I felt that exploring these concerns might be helpful to him, especially as being gay is both non-conforming in terms of sexual orientation and male ideals in Latino culture (Morales, 1996).

Summary

To summarize, research appears to indicate that some lesbian, gay, bisexual individuals are negatively affected by prejudice and discrimination resulting in minority stress, so that some individuals may be prone to symptoms of anxiety and depression. Some of the factors that appear to mitigate these adverse impacts appear to be: a lesbian, gay, or bisexual identity that is integrated into one's whole personality; connection to a lesbian, gay, bisexual community and support system; lack of shame regarding sexual orientation and non-congruence to traditional gender roles, especially for certain ethnic minority populations; and active coping skills to address sexual orientation stigma. There may also be individual factors related to life circumstance and family history. All these factors will be explored in the particulars of Felix's case presentation that follows.

4. ASSESSMENT OF THE CLIENT'S PROBLEMS, GOALS, STRENGTHS, AND HISTORY

The assessment was achieved through structured interviews and detailed case history, which took place in the first 3 sessions of the therapy.

Presenting Problem & Descriptive Information

As mentioned above, Felix is a 30-year-old Gay man self-employed in sports broadcasting and sports marketing and promotion. He identifies as a Latino man of Spanish-Caribbean ethnicity and is the child of two immigrants who came to this country in childhood. Felix is bilingual in English/Spanish and his heritage is important to him. He is currently in a long-term committed relationship with another man he met in college and they own a home together. However they have not legalized their relationship as they could under current state law.

Felix presented for treatment for problems with “anxiety” and “panic-attacks” of a two-year duration. He reported having “panic attacks” for “no reason” one to two times a week, and said he perceived they had worsened recently as he reported waking up at night with an attack. Felix described his physical symptoms of panic as involving: (a) an increased heart rate and palpitations; (b) shallow, rapid breathing where he felt he could not get enough air; (c) dizziness and light-headedness; and (d) chest pain or discomfort. Initially, these attacks had been infrequent, such as once a month, but had lately been occurring at least once a day, and most recently at night once a week. The client did not experience impairment from these attacks, and did maintain a normal schedule and daily activities. He often hid his symptoms from others. Although he understood that there no underlying medical problems, he was embarrassed and ashamed of these episodes and they felt outside of his control. His anxiety included worries about competence and acceptance by others because of his sexual orientation. However, these thoughts were intrusive, and occurred almost every day. Further, Felix expected the worst outcome of situations he worried about, and often changed his behavior or avoided situations because of these fears. Felix had tolerated his symptoms; however, in speaking with a female friend, she recommended he seek help. Felix reported no other history of mental health problems or distress, and had no prior history of treatment. His goals were to reduce his panic attacks and anxiety in general.

Felix reported his life as “terrific”. He stated that he is very satisfied with his relationship, and feels secure in his home life. He is close to his family and spends a great deal of time with his extended family, as is culturally consistent. However, although his family knows his partner and the client’s living situation, he has never specifically disclosed his sexual orientation to his family. Felix has a small circle of friends who are both gay and straight. He is not involved in the local lesbian, gay, bisexual community. Overall, he does not share his sexual orientation with many people, and usually only does so after a period of time. His partner has disclosed his own sexual orientation to his family, and they subsequently have had a tense relationship with the couple due to their political and religious beliefs. Felix mentioned that a few years ago, his sister did ask him if he was gay, which at that time he denied. He said that he had been less comfortable with himself then and admitted to some significant shame about his sexual orientation. However, now he is embarrassed by this lie, and as a result feels guilt and anxiety around his sister.

In a related vein, Felix reported that he experienced a great deal of stress in his interpersonal relationships related to hiding his sexual orientation. Felix noted that he was hyper-vigilant in public regarding non-verbal and verbal communication with his partner. His hiding

his sexual orientation created tension in his relationship with his life partner who felt that Felix was too worried and constricted in public. This vigilance and constriction was hypothesized as increasing his anxiety in general and increasing the likelihood of panic symptoms.

Felix has ambitions to become involved in sports broadcasting. He has been active in sports since childhood. He is currently targeting a sport that is highly associated with traditional male ideals and cultural norms (see Herek, 1996; Levant & Pollock, 1995) and that is not known for tolerating homosexuality. He has not disclosed his sexual orientation to his current employer, and intends to remain closeted in order to be successful in his career. He reports initial success in his field and anticipates a promising career.

Mental Status

Felix presented as a well-groomed man who showed no signs of a mood or thought disorder. One of the most salient factors was the client's experience of anxiety and panic in the clinician's office around the issue of talking openly about his gay identity and, relatedly, my specialty in treating gay, lesbian, and bisexual clients. More about this aspect of his anxiety is described below in section 6 on the course of therapy. Other than this one clearly anxiety-provoking situation regarding self-disclosure, he could not identify the antecedents to his panic attacks. On a related topic, I also assessed his values about being gay and about gay and lesbian individuals. Felix reported no conscious negative appraisals of being gay, and stated that he had addressed these issues while in college. Based on my past clinical experience, I anticipated that Felix might be struggling with some internalized self stigma that would be assessed in the course of therapy; however, not having to dispute clear prejudices held by him made my therapeutic task more straightforward.

Family and Developmental History

Felix is the youngest child of parents who divorced when he was a toddler. His mother re-married soon after and another son—his stepbrother--was born soon afterwards. Felix's stepfather was an alcoholic who was abusive to his mother. The family lived in an inner-city environment that was perceived to be dangerous, and he was encouraged not to venture out of the house. His sister left the home to live with his maternal grandmother when he was in elementary school and only he and his younger stepbrother remained. He had contact with his biological father regularly but reports significant anger at his father for the divorce. His father remarried while Felix was an adolescent and he had difficulty accepting that relationship. When Felix entered middle school he moved to live with his grandmother and sister in a much safer neighborhood. His mother and stepfather eventually divorced, and his mother came to live with him and his grandmother while he was in high school. Soon after, his stepbrother and stepfather moved to Florida. He stays in touch with his stepbrother, but not his stepfather.

His relationship with his mother and maternal grandmother are strong and positive. His mother, however, has significant mental health concerns. She is diagnosed with a bipolar disorder and does not comply with recommendations for therapy and medication. She appears to be unable to live on her own, and has dependent relationships with her own mother and her ex-husband. Overall, the family is in touch with each other and lives in relative proximity (except

for one of his younger brothers). The family tends not to discuss problems and uses passive or avoidant coping with stressful events. Traumatic incidents, such as divorce, parental dysfunction and mental illness, alcoholism, and family violence were not addressed, and the client simply endured these events until he left for college.

Felix realized he was gay in late elementary school around age eleven. Due to the cultural proscriptions against homosexuality he told no one of his orientation. When he went to college, he chose a large public institution. He came out to his peers though did not become involved in the student gay organizations. Felix met his current partner in college. His partner was also a student. However, due to his partner's high visibility as a student athlete in a very traditional sport, the men were circumspect about their relationship. Felix had not come out to his family when he started therapy. He did have gay and heterosexual friends with whom he had disclosed his sexual orientation, although he seemed not to be connected to the local gay community. Felix's partner had come out to his own family, but due to their religious beliefs, his family had minimal contact with the couple.

Diagnosis

Axis I: 300.01. Panic Disorder without Agoraphobia

Axis II: None

Axis III: Stomach discomfort, occasional diarrhea

Axis IV: Stress at work, stress of hiding sexual orientation

Axis V: GAF: 65 at start of treatment, 85 at end of treatment

Strengths

Felix had many strengths. He was bright and educated and was extremely motivated to resolve his problems. He was able to learn and incorporate therapist feedback and comments. He was cooperative with the treatment plan and tried to implement it. Felix did acknowledge his problems and had insight into some of his situation. Felix also had a support network of friends and family that he relied on, and was employed in a field he enjoyed. Additionally, he had realized that he was gay, had acknowledged these feelings to others, and had formed a long-term relationship.

5. FORMULATION AND TREATMENT PLAN

Formulation

Felix's difficulty and actual inability to disclose his sexual orientation was considered important to understanding this situation. He had no specific stressors in his life that appeared to trigger his anxiety. Given his lack of disclosure of his sexual orientation to significant important figures in his life, his socialization in a culture with strong norms against homosexuality and rigid expectations for masculinity, his interest in sports highly associated with masculine images of strength and aggression, and his current employment in that area, it was hypothesized that Felix's panic attacks and anxiety were related to minority stress. I hypothesized that the panic

attacks and general anxiety were tied to issues with managing a stigmatized identity, specifically to his current coping styles, which involved avoidance and hiding that did not successfully address his fear of felt stigma, and to his fear of rejection by family, his employer, and close friends. For instance, as mentioned above, Felix had not been able to tell his sister about his sexual orientation, resulting in reported guilt and anxiety around her. It was also seen as notable that he had not sought domestic partner status for his relationship with his partner and despite his commitment to his partner. He mentioned that he had not entered into such a legal relationship, because he feared it would become public record.

I considered that there were two related phenomena. The first was internalized stigma, such as self-stigma, where he may have internalized negative attitudes regarding homosexuality. Second, and particularly salient, was the fact that Felix feared the negative impacts of disclosure of his sexual orientation in his life—that is, he manifested fear of enacted stigma and sexual prejudice, to use the terms mentioned above in section 3 on the guiding conception. Further, given his occupation, many of the fears were considered realistic. Felix's symptoms were considered consistent with the minority stress and concealable stigma literature cited above, in that he was vulnerable to stress due to personal characteristics and did not have active coping skills and strategies that could mitigate this stress (e.g., developing comfort with his gay identity and seeking out a community support system).

Treatment Goals and Plan

I viewed Felix's way of coping with stigma as not adaptive to his life situation and future life goals. Thus, one of the therapy goals was to increase his skills in coping with sexual prejudice, and to increase his skills in managing his identity in flexible and adaptive ways (Pachankis, 2007). I conceptualized this as increasing "active coping" strategies (Folkman & Lazarus, 1980), including cognitive, behavioral or emotional responses designed to change the nature of the stressor itself or how an individual perceives it. Research indicates that active coping is superior to other efforts and that individuals use both cognitive and emotional strategies to address stressful events (Folkman & Lazarus, 1980). I hypothesized that Felix had not developed skills in this area, due to the uniqueness of his sexual orientation identity, as well as to the general lack of such skills in his family as a whole.

Consistent with the research literature (Pachankis, 2007; Pachankis & Goldfried, 2004), as mentioned above Felix reported that he experienced a great deal of stress in his interpersonal relationships related to hiding his sexual orientation. His hyper-vigilance in public regarding non-verbal and verbal communication with his life partner created tension in their relationship, with his life partner expressing that he was too worried and constricted. This vigilance and constriction was hypothesized as increasing Felix's anxiety in general and increasing the likelihood of panic symptoms. In light of this hypothesis, an important component of the treatment plan was to overcome Felix's anxiety about his self-disclosure. Similar to other treatments for anxiety (Martell et. al., 2004), some degree of exposure (reframed as "facing one's fears" in lay terms) and the development of active coping and social support were hypothesized to be helpful. These would then generalize to social problem solving and other problem solving skills designed to mitigate minority stress (Pachankis, 2007).

Summary

The treatment goals were to:

1. Reduce panic attacks and symptoms of generalized anxiety
 - a. Reduce anxiety caused by minority stress
 - b. Reduce anxiety regarding self-disclosure
2. Increase active coping skills, including self-disclosure to his family to increase resilience and prevent future problems.

The treatment procedures I planned included providing Felix with relaxation methods to cope with anxiety and panic in the moment; and having him track his anxiety feelings (see for instance, Martell et. al., 2004), particularly the antecedents, both internal (cognitions) and external (events, people), and the context. This was to be a continuation of the assessment process, which was ongoing. Felix and I agreed to meet on a regular basis, which evolved from weekly to biweekly sessions. He traveled frequently for work, so that sessions were not always regular, but also, given his issues, this provided him the opportunity he needed to practice his skills between sessions.

6. COURSE OF THERAPY

Early Phase of Therapy: The Relationship of Anxiety to Sexual Orientation (Sessions 1-5)

In the initial session, I observed Felix's presentation of history and precipitating events and noted he had not mentioned interpersonal relationships other than family of origin. When I tried to direct him to such relationships he became visibly more anxious, but remained vague, and then mentioned my website, though not why (this web-page does have information regarding experience with lesbian, gay and bisexual populations). As the discussion continued, haltingly, Felix became more and more visibly anxious and could not utter words specific to sexual orientation (e.g., "gay," "homosexual"), but rather implied such (e.g., different lifestyle). When asked how he was feeling, Felix reported being very nervous and anxious, and having some physiological symptoms, such as increased heart-rate, sweating, rapid and shallow breathing. When I did utter the word "gay," Felix did appear relieved and could discuss those issues more openly. However, Felix did report significant difficulty with talking about such events. Other than this one clearly anxiety-provoking situation regarding self-disclosure, Felix could not identify the antecedents to his panic attacks.

In the second session, I shared my hypothesis with Felix that the panic attacks and general anxiety were tied to issues with managing a stigmatized identity. Specifically, I suggested that the attacks were tied to Felix's current coping style, which involved avoidance and hiding rather than addressing his fear of felt stigma and the fear of rejection by his family, his employer, and his close friends. For instance, as mentioned above, Felix had not been able to tell his sister about his gay identity, resulting in reported guilt and anxiety around her. Specifically, I explained the concept of social stigma and its impact on gay identity development. Felix resonated to many of the issues presented, and admitted that disclosing his sexual

orientation or being discovered was his greatest fear. He was enthusiastic and said that overcoming this fear would make him feel “that no obstacle could not be overcome.”

After this discussion with Felix about the relationship of his hiding his sexual orientation and anxiety, a decision was made to address his panic symptoms and anxiety in general in the following way. First, through psychoeducation, simply helping him understand the nature of panic and separating it from medical conditions. Second, identify possible triggers, such as worries and fears regarding his sexual orientation, and other interpersonal and situational stressors. Third, use in vivo exposure to help him learn to cope with his anxiety regarding his triggers (see next paragraph for specifics). Fourth, increasing his use of relaxation techniques during the attacks, to help him cope with the physical symptoms of the panic attacks. Felix was very enthusiastic about these techniques and began yoga as a form of exercise and relaxation. He found the breathing techniques and other elements of yoga helpful for general stress as well.

The initial target of treatment in the third and fourth sessions was Felix’s anxiety surrounding discussing gay issues. In line with the behavioral concept of in vivo exposure, I hypothesized that discussing gay issues in therapy would aide in reducing Felix’s anxiety, and was necessary for proceeding in treatment. Over the first group of sessions, we discussed lesbian, gay and bisexual issues, and I encouraged him to use specific language, rather than vague phrases, which did result in reduced anxiety and reported greater comfort with these issues at the end of this period.

Finally, during this initial phase I introduced the concepts of active coping, and linked them to learning new cognitive and emotional skills. In particular, I stressed the development of strategic planning skills around coping with the stigmatized identity in Felix’s social and professional life. For instance, rather than universal avoidance and hiding, he was presented with a model of analyzing the actual costs and benefits of disclosure in each particular situation. This strategy focuses on a variety of factors, such as assessing within interpersonal relationships the costs and benefits related to intimacy, creativity, and spontaneity; and within professional situations, the costs and benefits related to career goals (cf., Herek, 1996; Pachankis, 2007). This can be weighed with the pressures of non-disclosure, such as vigilance, inauthenticity, and hiding. This model included encouraging Felix to separate out the irrational fears surrounding self-disclosure with realistic risks, or if the risks were unknown, developing a plan to gather more information. Some form of cognitive disputation is helpful in these instances, as well as the development with the client of some form of criteria to assess situations and individuals, such as finding out information about political views, social conservatism, and traditional values.

Phase 2: Development of a Strategic Plan for Disclosure (Sessions 5-7)

Felix and I reached a mutual decision to explore coming out to friends and family as a way to develop more adaptive coping skills regarding identity management, and to confront his fears of disclosure and reduce stigma. Fear of disclosure is reduced by strategic disclosure, cognitive disputation, and learning identity management skills that propose a more flexible way of addressing a stigmatized identity (Malyon, 1982). Using a Bowenian family therapy model that focuses on single-person analysis of family systems (Bowen, 1978), a family genogram was explored. The exploration focused on the degree of intimacy and importance of Felix’s current

relationships with his family members, as well as Felix's knowledge of the attitudes of his family members regarding lesbian, gay and bisexual issues and other socially relevant concerns. A hierarchy was then created of easier-to-harder individuals to disclose to, based on importance and closeness of the relationships. Felix was then able to start with the easier individuals (more distant and less important, such as friends), and then to move to those who were more difficult (e.g., father and mother). This is consistent with other treatments for anxiety, where a hierarchy of exposure situations is developed.

Strategic planning based on the social-problem-solving and culturally sensitive assertiveness literatures (D'Zurilla & Nezu, 1999; Wood & Mallinckrodt, 1990) was next undertaken. Felix and I discussed potential scripts of disclosure with different individuals, and he was encouraged to discuss these issues and role-play with his partner and significant friends. Felix was very enthusiastic about this plan, not only to reduce anxiety and stress in general, but also to improve his relationships with his family and friends.

The hypothesis that self-stigma played a role in the Felix's non-disclosure was confirmed by the discussion regarding disclosure. Simply the possibility of disclosure produced great anxiety and fear in Felix that appeared to be based on irrational beliefs. For instance, Felix stated that he did not fear rejection by his family, and he believed that they would all accept him. This seemed to be a reasonable hypothesis as his partner was invited to all family events and parties, and was well liked. His family visited his home and knew that he and his partner bought a house together. Given that insight, Felix had to explore why coming out to his family would provoke such anxiety. Understanding the difference between his rational perceptions of his family and his fear of disclosure helped him to understand the concept of irrational beliefs, automatic thoughts, and subtle self-stigma.

For instance, Felix identified some antecedents to fear around disclosure that were linked to negative views of homosexuality, which we then disputed. Some of the thought processes were: a) "I am telling people a bad thing" [if I tell them I am gay], which we reframed as, "I am sharing something important about my life and allowing people I care about to be closer to me"; b) "If they are upset, it is my fault," reframed as, "If they are upset, it is due to their irrational fears or prejudices regarding homosexuality, which can be reduced"; and c) "If I tell someone, I will lose them as a friend," reframed as, "People are not as prejudiced as I think, and my friends who care about me will be happy I am open with them." These cognitions became the basis of cognitive restructuring that was necessary to undertake before the client attempted to disclose his sexual orientation to friends and family.

In our analysis, the most anxiety seemed to surround disclosure to his father, which can be particularly difficult for gay men (Goldfried & Goldfried, 2001). This latter point seemed most relevant to his relationship with his father, where there was the greatest emotional distance and lack of a positive relationship. Given Latino beliefs regarding masculinity and stereotypes regarding homosexuality (Morales, 1996) it was hypothesized that his father might also be the most disapproving person. I anticipated that Felix and I would evaluate his experience coming out to each person as a tool for further assessment and to consider how to address disclosure to others. We did concur that his father might be the last person to whom he would disclose. Notably, Felix's stepmother was viewed as most likely accepting, and it was anticipated he

would tell them at the same time hoping that her acceptance would be helpful in reducing his father's prejudices.

Felix was very motivated to achieve treatment goals, and he began to discuss his goals with his partner and his best friend, who was female, as her boyfriend was the first person to whom he wished to disclose his sexual orientation. This strategic plan for disclosure also included tools to increase Felix's active coping, which included mobilizing social support (such as his partner and best friend), increasing planning and strategic thinking, and problem solving.

Phase 3: Understanding Anxiety and Implementation of Plan (Sessions 8-18)

Felix and I developed a plan that he would disclose first to his best friend's boyfriend, followed by his brother, and then his aunt and uncle. The first disclosure was heavily planned, and included scripting some possible scenarios and role-playing. The event was successful, as the individual did not care that the client was gay and was not rejecting. Felix was elated after this disclosure and felt very empowered and stated: "I am becoming desensitized to fear."

After this disclosure (and all subsequent ones), Felix and I debriefed the specific process of disclosure, disputed any negative cognitions, confirmed which cognitions or expectations had been disproved and prepared for the next event. He learned to be more relaxed as well as strategic in his planning. For instance he disclosed to his brother spontaneously in a phone call, but planned carefully a conversation with an uncle and aunt. However, I did help him work with a realistic concern that although he would not be rejected, all aspects of his lifestyle might not be embraced. These coming out experiences increased his sense of personal power and accomplishment.

Another major insight early in treatment that aided Felix's commitment to treatment was his realization of the link between cognitions and physical symptoms of anxiety. Felix, after experiencing some progress, came into a session reporting not being able to sleep earlier that week due to an anxiety episode the night before. During that night, he could not identify a stressor so he spent the night berating himself and obsessing about the source of the anxiety. He felt worried that he was now slipping backwards and was puzzled, as his life had been going well. After reviewing the events of the evening, we realized that he had been exercising vigorously before bed and then misidentified the resulting rapid heart rate and physical arousal symptoms after exercise as anxiety. When I explained it was most likely the effects of exercise that were mislabeled as anxiety, Felix fully understood how "labeling" his symptoms changed his emotional reaction to them. In fact, he had not been anxious, but was prone to labeling certain body states as anxiety, and creating a vicious cycle. This insight aided him to cognitively reframe his arousal states, even when legitimately anxious, in order to reduce his anxiety.

During this period of therapy Felix began to identify the thoughts that seemed to precede his experience of anxiety symptoms in a full range of interpersonal situations beyond concerns regarding self-disclosure. For instance, a common thought was: "I can't be a burden to people," "I disappoint people," "I should take care of people," and "I don't want people to be disappointed in me." These thoughts seemed to be predominant in many interpersonal situations and were constant pressures in his interpersonal and work environments.

A more difficult disclosure that came toward the end of this phase was disclosure to his sister. Felix and his sister had had a somewhat contentious relationship growing up and he felt misunderstood by her. He was also embarrassed at having lied to her about his sexual orientation before. Felix experienced quite a bit of anxiety about telling his sister, and as we explored this issue it appeared to be linked to a desire to avoid difficult feelings, such as anger. Felix decided to come out to her by email, so that he could carefully script what he was going to say. This went well and his sister was accepting and did not harbor any negative feelings. However, Felix was still somewhat reluctant to discuss issues with her face-to-face, and this appeared to be due to his negative feelings about their childhood and his fearing that if he spoke to her in person he would become angry. We then explored why anger was seen as so negative or uncontrollable, and this appeared to be linked to his experiences with his step-father, who was physically and verbally abusive.

Felix has a family history involving immigration and refugee status, disadvantaged social class status, loss and trauma, and Latino cultural norms for males to be strong and in control (Morales, 1996). I explored with him how these elements in his family history related to his symptoms and automatic thoughts. For instance, Felix reported experiencing that his stepfather was often drunk and violent, and specifically hearing although not seeing noises made by physical attacks on his mother by his stepfather. Felix reported being terrified by the noises and not being able to see what was going on. He was worried for his mother, and generally avoided his stepfather. The salient feature was that he reported feeling guilty he could do nothing to help his mother, which was inconsistent with the cultural norms for Latino masculinity mentioned above to be strong and in control. This sense of responsibility also appeared to be evident in his irrational thoughts that were linked to anxiety (e.g., "I should take care of people."). We explored the impact of family violence and lack of safety in his family and inner city neighborhood upon his sense of security, anxiety, and coping. I viewed some of these symptoms as anxiety due to past traumatic experiences, so that we discussed these experiences at length, especially the emotions surrounding these events, in order to reduce their impact on present-day events. This discussion also increased the multicultural sensitivity of our therapy.

Phase 4: Expanding Understanding and Conclusion (Sessions 18-26)

Felix also began to recognize and discuss other symptoms of anxiety that he had not identified as anxiety, such as gastrointestinal symptoms. He frequently had gastrointestinal symptoms, yet medical testing revealed no cause for them, and his physician supported Felix's choice of therapy to lessen his symptoms. Felix began to become more aware of physical tension, and began to proactively use relaxation exercises, yoga and other stress-reducing techniques to "quiet" and calm himself. Felix had never addressed how tense and unhappy he could be at times. He had described his life as "terrific," which was mostly his effort to put a positive spin on issues, and avoid negative feelings. Felix was encouraged not to avoid emotions such as anger, worry, fear and loss, but rather to experience negative feelings and to find ways to cope with them. He found learning emotional management skills helpful. I envisioned this strategy as replacing passive coping skills, such as denial, with active ones. Also, we reframed his definition of masculinity, as not avoiding feelings, but learning how to cope and to use feelings as "sense organs" to identify and distinguish important aspects of interpersonal and

social relationships. This was an effort to alter his stereotypes but remain consistent to his cultural image of masculinity, which stressed being strong and in control.

Felix embraced this new strategy and for the first time began to discuss his job stress and some of the uncertainty around his current employment situation. Although self-employed as a free lancer, he had a long-term relationship with his employer and hoped to become a salaried employee, which necessitated moving to a conservative southern state. These discussions not only addressed the stress of not disclosing his sexual orientation, but also about managing interpersonal relationships in a competitive and uncertain industry. Again, treatment focused on increasing active coping skills in such challenging situations rather than the use of avoidance and denial.

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

Progress in therapy was monitored by Felix evaluating his level of anxiety in real-life situations. Felix monitored his own behavior and emotions and this information was reported to me at the start of each session, and we then discussed and analyzed the relevant situations. This permitted us to understand the progress he was making as well as any changes in the treatment strategies that needed to be made. Detailed case notes permitted me to reflect on the progress achieved toward the treatment plan goals. For instance, when Felix reported anxiety in making presentations to his employer, we incorporated additional cognitive and behavioral techniques to reframe the situation and manage stress. Felix also reported on the process of each of his coming out events. We used that information to help plan the next disclosure.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Felix chose to terminate treatment after 26 sessions that occurred over the course of 11 months. He had completed his goals and he no longer had panic attacks. His generalized anxiety was much improved. Felix reported that he no longer was hypervigilant in public about being gay, and that he had fewer physical, cognitive and emotional symptoms of anxiety (such as body tension, worry, and gastric involvement). Felix was much more relaxed in session, could speak easily about being gay, and reported increased ease about such conversations with friends and his partner. He had developed several emotional and cognitive coping skills, such as relaxation techniques, refocusing his thoughts, reframing negatives into positives, and positive self-talk. For instance, he had incorporated relaxation by including daily yoga exercises into his fitness regime to reduce stress. He had also increased his use of social support, such as calling friends and seeking support when under stress. Although he remained closeted at work, he had begun to build closer relationships with some of the younger employees at work, who we hypothesized might be more accepting of his sexual orientation.

A major change was an increase in Felix's strategic thinking, where he evaluated in a more objective way the risk/reward of disclosure and was not inordinately fearful about interpersonal situations. Felix had come out to friends and significant members of his family, including his sister, his brother, and an uncle and aunt. His relationship with his partner had

improved, as he was no longer so tense and vigilant. He seemed to have increased pride in his gay identity, and more faith in the depth of his family relationships. He had learned the importance of reframing his irrational beliefs and developing alternative assumptions about people's behavior. Felix also became more assertive with those who were disapproving. For instance, when his partner's family came to visit, he made sure that he was present and socialized with them, even though their outward politeness was accompanied by an underlying lack of acceptance. Despite the tension, Felix did not experience any anxiety symptoms.

However, Felix had not come out to his parents or to individuals at work. Although it was understood that coming out at work was not necessarily one of our goals, as his therapist, I was concerned that a major task—coming out to his parents—had not yet been completed; and we discussed how he was going to face this and not avoid it. Felix felt he had the skills and was trying to find the time to do this in person. However, I was concerned that he by trying to find a “good” time was avoiding this issue. I did address this with him in a supportive manner, and introduced the idea that trying to control all the situational factors might not improve the experience. I would have preferred continuing therapy longer in order to explore his issues with his parents, including why disclosure was so difficult, and then to see him accomplish this goal. However, in my clinical experience some Latino clients do not explicitly come out to all family members, but often are implicitly out by being included in family activities.

Additionally, with more therapy time, I had wanted to address Felix's lack of connection to the gay and lesbian community, to increase the number of gay friends he had who were similar to him (in longterm relationships), and to engage in some more proactive planning about work and career issues, especially if Felix moved to the southern United States. However, overall Felix had better coping skills and improved self-awareness and self-esteem. He considered his therapy experience successful and positive, as did I.

Conclusion

In the case formulation, Felix's anxiety was seen as related to minority stress. This stress was linked to the stress of concealing his sexual orientation, and the anticipated negative impacts of disclosure of his sexual orientation in his life. Given his occupation, some of the fears were considered realistic, however his anxieties regarding his family were evaluated to be less realistic. Felix's symptoms were considered consistent with the minority stress literature, in that his vigilance and anxiety surrounding his sexual orientation was hypothesized as increasing Felix's anxiety in general and increasing the likelihood of panic symptoms. In light of this hypothesis, an important component of the treatment plan was to overcome Felix's anxiety about self-disclosure of his sexual orientation. Therapy used exposure techniques (reframed as “facing one's fears” in lay terms), both in session and in real-life, to reduce his panic attacks and anxiety symptoms. This strategy was successful. Felix's panic attacks stopped not long after he had disclosed his sexual orientation to a friend, his brother and an uncle and aunt.

Another important part of treatment was the cognitive restructuring that occurred during this process where we examined cognitions tied to self-stigma. Embedded in Felix's thoughts were both cognitive distortions common to depression and anxiety, as well as some subtle negative assumptions about his sexual orientation, e.g., “I am telling someone something bad,”

and “This knowledge is a burden.” Therapy focused on refuting these assumptions and increasing his positive views of his sexual orientation and his friends’ and family’s reaction to it. An additional goal was to increase Felix’s skills in coping with sexual prejudice, and to increase his skills in managing his identity in flexible and adaptive ways (Pachankis, 2007). Felix learned new ways of thinking about his family, reduced his assumptions regarding how others would respond to his disclosure, and learned a variety of cognitive and behavioral strategies for reducing stress.

Case Post-Script

Four months after the case was closed, Felix contacted me for an appointment. When he arrived he said he had a lot to tell me. As a gift to his partner and himself for their 10th anniversary a month before, Felix decided that the most priceless gift he could give was being fully open with his family. He sought the counsel of friends, developed a plan, and overcame his own resistance and that of his sister. In the course of a week, he came out to everyone left in his family: his mother, his father and his stepmother, and his grandmother. In each case he received unconditional support. None of his family members were surprised, but each provided positive responses. None of his worst fears were realized, and Felix feels very accomplished and proud of himself. Felix also noted that he feels closer to those people and has been able to share more details about his life in general. On his anniversary, he gave his partner a card with the news, and his partner was very pleased. Since then, they have gone to family events as a couple, and the events have gone well.

In addition, he has begun to make other friends, especially among gay peers and come out to other acquaintances. He has not had any further panic attacks or other anxiety symptoms. Felix appears to have internalized the overall focus of therapy, and made the changes he wanted. My conclusion is that therapy was successful, and my own concerns about Felix’s ability to follow through were not realized. Rather, Felix had the motivation to come out and had developed the skills to do so. He did not need my support, but rather relied on his own support network. Felix’s one remaining concern about disclosure is in regards to his career. I expect that he will negotiate this issue with greater flexibility and less fear due to his success in addressing this issue with family and friends.

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