

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

**Capturing (and Communicating) Complexity:
Adapting CBT for Clients with Multiple Diversity**^{a,b,c}

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ABSTRACT

Due to the increasing diversity of the U.S. population, practitioners of cognitive-behavioral therapy (CBT) and other evidenced-based psychotherapies are often called on to adapt interventions for use with their diverse clients. There are few tools available to guide what steps are needed to culturally adapt interventions, yet such a framework is needed to move the field forward. In this context, Glassgold (2009) describes her use of gay-affirmative psychotherapy, utilizing adapted CBT interventions and other psychotherapeutic techniques with “Felix,” a Latino gay male client. This commentary uses the case of Felix as a point of departure to add to the discussion of cultural competence as it relates to a client from two minority groups (Latino ethnicity and gay sexual orientation). At the same time, we discuss some of the psychotherapeutic interventions employed by Glassgold and how they relate to merging evidenced-based treatment with traditional psychotherapeutic techniques and the adaptations needed when working with sexual minority and ethnic minority clients.

Keywords: cognitive-behavioral therapy (CBT); affirmative psychotherapy; cultural adaptation; Latino; gay

There are limited resources that address how cognitive-behavioral therapy (CBT) can be culturally adapted for use with minority groups in general (Hays & Iwamasa, 2006) and gay men in particular (Balsam, Martell, & Safren, 2006). Multiple organizations, however, have called for meeting the needs of minority group members both within psychological treatment and psychological research (American Psychological Association, 2003; U.S. Department of Health and Human Services, 2001). As the U.S. population continues to increase in diversity (U.S. Census Bureau, 2006), the field of CBT would benefit from clinical research and practice that better understand what aspects of CBT are appropriate for use with specific minority groups (Hays, 1995; Hays & Iwamasa, 2006). In psychotherapy in general, it is important to consider

the saliency of issues pertinent to a subgroup when conceptualizing a case for both ethnic/racial minority groups as well as for individuals whose sexual orientation differs from the heterosexual majority. The current case study of interest—“The Case of Felix: An Example of Gay-Affirmative, Cognitive-Behavioral Therapy” by Glassgold (2009)—provides the beginning of a needed discussion on applying CBT and traditional psychotherapeutic techniques with a client from two minority backgrounds: ethnic and sexual. This commentary on the Felix case study reviews the case, discusses the application of psychotherapeutic techniques within this case, and provides suggestions for expressing the steps that clinicians take when culturally adapting efficacious interventions.

Using Glassgold’s thoughtful review of sexual minority stress and how it relates to culturally competent psychotherapy in the case of Felix as a point of departure, we briefly present some additional comments about integrating cultural competence with evidence-based psychotherapy. Identified barriers to addressing cultural competence in clinical research and practice are many and include variability in how cultural competence is defined (e.g., S. Sue et al., 2009), the misperception that cultural competence methods are poorly-suited for use within evidence-based practice (e.g., Whaley & Davis, 2007), and a lack of methodologies to guide and communicate steps taken in tailoring an intervention for specific populations (Miranda et al., 2005).

There is substantial variability in how cultural competence has been defined (S. Sue et al., 2009; Vega & Lopez, 2001). This may be due to a lack of empirical research and clear operationalization of terms. The definition of cultural competence that a person uses, however, influences the understanding of and ability to discuss this construct (Guarnaccia & Rodriguez, 1996; S. Sue et al., 2009).

For example, cultural competence has been defined as the ability to incorporate a respect and understanding of participants’ sociocultural context (Hays & Iwamasa, 2006; Vega & Lopez, 2001) and includes the recognition of and appropriate response to key cultural features (Flores, 2000). In the case of Felix, this is articulated by the therapist’s inclusion of issues such as minority stress, stigma, and the coming out process as potential stressors that impact members of a sexual minority group.

Cultural competence can be composed of culture-specific components that are unique to a cultural group and culture-universal components that may apply to more than one cultural group (D.W. Sue, 2001). In Felix’s psychotherapy, minority stress was discussed as a stressor that potentially impacts members of a minority group and can have an additive effect for clients with multiple layers of minority status.

Cultural competence also involves behaviors and skills that a cultural group would perceive as culturally competent (D.W. Sue, 2001). Applied within Felix’s treatment, this was shown in the therapist’s sensitivity to topics that may be difficult for gay clients to discuss, as well as the influence of the gender norm of masculinity with this Latino client. Additionally, comprehensive discussion of cultural competence would also ensure that it is based on more than a deficit perspective and includes culturally based strengths (Hays, 2001; D.W. Sue, 2001). With

Felix, the therapist discussed strengths as including Felix's social support, prior disclosure of his sexual orientation, and his ability to maintain a long-term, same-sex relationship.

Another important barrier to culturally competent clinical research and practice is a misperception that cultural competence and evidence-based interventions are mutually exclusive (Whaley and Davis, 2007). That said, the DSM-IV-TR (American Psychiatric Association, 2000) classifications scheme for anxiety disorders may not quite fit the clinically significant and distressing concerns of sexual and ethnic minority clients coping with discrimination and the coming out process. The therapist diagnosed Felix with panic disorder without agoraphobia due to the recurring panic attacks he reported experiencing in regard to his sexual orientation. From a CBT perspective, however, this is a bit of a departure from the classic presentation of panic disorder. Following a case conceptualization model, the culturally adapted and appropriate treatment, as described in the case study, was not the specific empirically tested approach to treating panic disorder per se. Typically, clients with panic disorder fear the symptoms of anxiety itself (Barlow, 2001) and, as such, a "fear of fear" cycle emerges such that fear of the symptoms causes anxiety, the emergent anxiety causes additional symptoms of anxiety, and the additional symptoms cause more fear/anxiety, spiraling into panic attacks. Accordingly, the recommended approach of using in-vivo exposures are typically interoceptive exposures: exercises to mimic the symptoms of panic so that the client can learn that the fear symptoms are not dangerous, and can learn to stop caring about whether panic attacks happen. This reduces the "fear of fear" and consequently the attacks stop.

In the case of Felix, his panic attacks are described as being related to intense worries about his sexual orientation and acceptance from others. The treatment appropriately did not include interoceptive exposure, but instead included exercises to confront the perceived fear of non-acceptance of his sexual orientation as well as relaxation training to decrease the experience of general anxiety and stress (e.g., stress related to managing interpersonal relationships while concealing his sexual orientation).

Miranda and colleagues (2005) also reported a lack of methodologies to guide tailoring evidence-based interventions for specific populations. An added difficulty in illustrating cultural competence in clinical research and practice is that decisions and the decision-making process of ensuring cultural competence are often left unspoken (Rogler, 1989). A framework for conceptualizing and communicating cultural adaptation of an intervention is the multidimensional model of cultural competence, or "MDCC" (D.W. Sue, 2001). Within this model, Sue posited that cultural competence involves awareness of one's own attitudes and beliefs, cognitive knowledge of the population (i.e., culture, world-view, and expectations about providers), and appropriate helping skills for working with the population of interest (D.W. Sue, 2001; S. Sue et al., 2009). In order to communicate the steps taken to culturally adapt an intervention, practitioners can first discuss how they have addressed these three areas within their adaptation process for a specific minority group. The model can then be applied to consider how these issues may differ for a subgroup of this minority group.

For Felix's case, the therapist clearly noted her experience and beliefs about the influence of discrimination on the client's presenting problem. Additional areas to address could include discussing the therapist's experiences, preconceptions or biases about working with clients who

are gay or those of Latino ethnicity. In the case of Felix, the therapist reported multiple resources, such as the *Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients* (APA, 2000), that she used in formulating her understanding and treatment of this client. She also provided a detailed explanation of how minority stress and stigma have been found to negatively impact the mental health of sexual minorities (e.g., Gay and Lesbian Medical Association and LGBT Health Experts, 2001). In terms of the skills or tactics of the therapist, an example of a culturally competent framework in the case of Felix is that the therapist implemented gay-affirmative CBT with her client as it is a treatment that is sensitive to and counters heterosexist norms (Balsam, Martell, & Safren, 2006; Bieschke, Perez, & DeBord, 2007). Applying gay-affirmative CBT with minority individuals may involve addressing culture at various points of the treatment process (e.g., assessment, treatment planning, and intervention).

The therapist mentioned multiple issues impacting this client as both a gay and Latino male. Using the MDCC model as a framework, however, additional areas of discussion could have also focused, for example, on an explicit discussion of potential Latino cultural variables and how these may have impacted self-stigma. *Familismo*, often noted to be a strong value in Latino culture, involves seeing the family unit as an important part of self-identification (Marín & Marín, 1991). Hypotheses could be made about how Latino interpersonal norms such as *familismo* could influence disclosure of sexual orientation and reasons that disclosure may be most difficult with fathers in this population (e.g., Diaz, 1998; Zea et al., 2004). In addition, in the case of Felix, the focus of disclosure to friends and family within the gay-affirmative CBT appeared to also be in line with recommendations that CBT with Latinos may benefit from inclusion of interpersonal treatment techniques (Organista, 2006; Perez, 1999). Practitioners may have benefited from a discussion on how a focus on interpersonal deficits may especially benefit Latino gay men dealing with minority stress and self-stigma.

In conclusion, adapting gay-affirmative CBT and traditional psychotherapy techniques for use with Felix had added complexity as it required that his therapist consider the applicability of the interventions for a client who identified as both a member of an ethnic group and a sexual minority. Because diverse cases are by definition not necessarily common enough to easily conduct traditional treatment-outcome studies, case studies like the one presented here can add to the clinical knowledge base available to practitioners and clinical researchers. Clear communication like Glassgold's about the steps taken to adapt an intervention is especially important when treating a client with multiple areas of diversity. Such a discussion provides a detailed picture of how such decisions can be made and examples of the thought process to utilize when culturally adapting a psychological intervention.

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