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Clinical intake interviewing: proposing LGB affirmative recommendations

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CLINICAL INTAKE INTERVIEWING: PROPOSING LGB AFFIRMATIVE RECOMMENDATIONS

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by

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DEDICATION

My grandfather was a man who calmly observed the world around him, without ever trying to alter it, welcoming the challenges that came his way. A man with the strength and determination to endure the horrors of a young boy in Auschwitz, he taught me never to judge others based on differences, but rather to remember what makes us all alike.

In loving memory of my grandfather, Saul Birman –

a righteous, honorable and kind man, gone but never forgotten.

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ABSTRACT

The initial impression a client formulates about the therapist is critical to establishing a deep and meaningful working alliance. The traditional intake interview protocol is fraught with heterocentric biases and heteronormative assumptions, thereby failing to provide an affirming experience for non-heterosexual clients or potentially overlooks issues relevant to competently serve the psychological needs of LGB clients. This dissertation endeavors to respond to the growing need for the clinical application of LGB affirmative approaches. An overview of the following bodies of literature is offered: (a) consequences of heterosexism on the lives of LGB individuals, (b) heterosexism and the field of psychology, (c) perceived competence of therapists treating LGB clients, (d) current practices in working clinically with LGB clients, and (e) intersection of multiple cultural considerations. Based on a synthesis of the literature, feedback from experts in the field, and a critical review of existing intake protocols, preliminary suggestions for engaging in an LGB affirming initial therapeutic experience is offered. 4 major areas of clinical considerations for engaging in an affirmative intake process are discussed: (a) creating an affirming environment, (b) the initial intake process, (c) important considerations specific to members of the LGB community; and (d) therapist competencies. Finally, intake questions for consideration in intake forms or during the course of an intake interview are presented.

Chapter 1. Introductory Literature Review

Stigma, discrimination, and homophobia characterize the history of the lesbian, gay, and bisexual (LGB) community in the United States, and these same challenges remain for the citizens of this community today (Cahill, South, Spade, & National Gay and Lesbian Task Force, 2000; Herek, 2007; Herek & Garnets, 2007; Willis, 2004). Community members were subjected to invasive psychiatric interventions, such as lobotomies, castration, and electroshock therapies, to treat their "deviant" behavior, and were the incessant targets of legal and political harassment (Adams, 1995; Duberman, 1993). Given this turbulent history, it is no surprise that many non-heterosexual citizens kept their sexual orientation in secrecy (Adam, 1995).

Years of discrimination and harassment were brought to the consciousness of the public with the occurrence of the Stonewall riots in 1969, in which non-heterosexual individuals outwardly expressed their anger against law enforcement. This event marked the beginning of the gay liberation era (D'Emilio, 1983). In the years following the Stonewall riots, gay activist organizations were established, including the Gay Liberation Front (GLF), the Gay Activists Alliance (GAA), the Society for Individual Rights (SIR), and the National Gay Task Force ([NGTF] Adam, 1995). By the 1970s, the gay liberation movement became increasingly concerned with the protection of human rights. In the 1980s, there was a resurgence of anti-gay political views that were influenced by dogmatic religious principles (Adam, 1995). The moral conservatism of this decade was magnified by the HIV/AIDS epidemic that was taking the lives of gay men at an alarming rate (Centers for Disease Control, 1981). In 1986, the gay liberation movement suffered still another blow after the Supreme Court ruling of Bowers versus Hardwick, a case

from Georgia that argued the right to engage in oral and anal sex in the privacy of one's home (Herek, 1992). In this ruling, the Supreme Court upheld the statute declaring it legal for the state to regulate private sexual behavior among its citizens. Fast forwarding to 2003, Lawrence versus Texas challenged the constitutionality of a similar law, with a different outcome. In this case, the Supreme Court did rule the Texas sodomy law unconstitutional (Herek, 2007).

Cultural heterosexism, i.e., the perpetuation of heterocentric beliefs by sociopolitical systems (Cahill et al., 2000; Herek, 1990; Pachankis & Goldfried, 2004), has been demonstrated by this brief foray into the history of the LGB community in the U.S.; the legal and judicial systems are two such systems that have had significant historical influence in this regard. Other systems of influence include religious systems; the sin of same-sex attraction professed by Judeo-Christian religions, for example, has influenced the political, legal, and judicial spheres (Herek, 1992). Moreover, the economic system has also been influenced by heterosexist attitudes. For example, an analysis of national data found that gay and bisexual males with equivalent occupations, work experience, education, marital status, and geographical residence earn 11%-27% less than their heterosexual counterparts; although not statistically significant, there exists a trend in which lesbian and bisexual women earn less than heterosexual women (Badgett, 1995).

The historical context of non-heterosexual individuals cannot be accurately understood in a vacuum. In spite of the historical changes and advancements of the gay liberation movement, many non-heterosexual individuals continue to conceal their sexual identity, experience internalized heterosexism, and come to expect rejection from others.

The potential psychological consequences of such experiences are certainly concerning (Anhalt & Morris, 1998; Cochran, Mays, & Sullivan, 2003; Herek & Garnets, 2007; Meyer, 2003).

Virtually every clinical psychologist, at some point in their career, will work with a non-heterosexually oriented client, a person who is questioning his or her sexual identity, or a family member of someone who is of a non-heterosexual orientation or questioning. Although members of the LGB community are faced with unique issues and experiences, the research literature on these needs is limited (Pachankis & Golfried, 2004). Through a critical analysis of the literature, this dissertation explores heterocentric assumptions that LGB clients might encounter during the process of clinical intake interviewing and proposes ways in which to mitigate these occurrences.

In order to provide a context for understanding the potential clinical needs of LGB clients, an overview of the following bodies of literature is offered: (a) consequences of heterosexism on the lives of LGB individuals, (b) heterosexism and the field of psychology, (c) perceived competence of therapists treating LGB clients, (d) current practices in working clinically with LGB clients, and (e) intersection of multiple cultural considerations. Furthermore, the specific details of the literature reviewed are presented in Appendix A.

Consequences of Heterosexism on the Lives of LGB Individuals

LGB individuals appear to be at a greater risk than their heterosexual counterparts for a variety of mental health problems including anxiety, mood and affective disorders, substance use disorders, and suicidal ideation and attempts (Cochran et al., 2003; Herek & Garnets, 2007; Meyer, 2003). The minority stress model posits that because non-

heterosexuals are marginalized by society, they face a set of unique challenges and stressors in their lives, which may provide a context for understanding the mental health problems observed within this community. The model highlights three stress processes in a minority individual's life: (a) external, objectively stressful events; (b) vigilance about the expectation of stressful events occurring; and (c) internalization of negative societal attitudes (Herek & Garnets, 2007). Although some levels of stress can lead to the development of adaptive coping strategies, high levels of stress can lead to excessive feelings of personal danger and vulnerability (Herek & Garnets, 2007; Meyer, 2003). This stress experienced by individuals with a bisexual orientation identity may be particularly challenging since the population must not only endure pervasive prejudice and discrimination from the heterosexual population, but the lesbian and gay communities as well (Botswick, 2012; Herek, 2002).

Probability studies of U.S. adults revealed that LGB people were twice as likely as their heterosexual counterparts to experience discrimination or oppression in their daily lives, such as inequity in the workplace (Meyer, 2003). Maltreatment and discrimination can lead non-heterosexual individuals to conceal their sexual identity, guarding themselves from injury or inequity. Concealing one's sexual identity prevents non-heterosexual individuals from connecting and affiliating with others, precluding them from the advantages of social support (Herek, 2007) and leading to feelings of alienation, isolation, and lack of self acceptance (Anhalt & Morris, 1998; Cochran et al., 2003; Herek, 2007; Meyer, 2003). For example, lesbians and gay men frequently suffer from internalized homophobia, i.e., directing negative social attitudes toward themselves.

Internalized biphobia is equally problematic and presents for many both-sex attracted individuals. Bisexual individuals demonstrate an increased propensity to conceal their sexual orientation, which may explain the mental health disparities that exists between bisexual individuals and both same-sex and opposite-sex oriented individuals (Pachankis & Goldfried, 2004; Schrimshaw, Siegel, Downing, & Parsons, 2012). For example, Schrimshaw et al. (2012) examined factors associated with disclosure of sexual orientation and the relationship of this behavior to mental health. Using a sample of 203 non-gay-identified men who endorsed same-sex behaviors, they found that level of disclosure was not associated with their mental well being. Concealment of sexual orientation, on the other hand, was associated with more symptoms of depression and anxiety, as well as lower rates of positive affect. The researchers hypothesized that concealment may: (a) serve as a barrier for bisexual individuals to obtain social support by distancing themselves from others; (b) create stress related to persistent hypervigilance; and (c) prevent opportunity to confront, work through, and resolve internalized biphobia (Schrimshaw et al., 2012).

Other researchers explain the disparities found among bisexual individuals as resulting from the unique nature of stigma and discrimination that face these individuals (Botswick, 2012; Herek, 2002). For example, bisexual individuals may be viewed as: (a) sexually promiscuous or non-monogamous, (b) mediators of HIV infection or other sexually transmitted diseases (STDs) between the gay community and the heterosexual community, and/or (c) threatening of the widely accepted heterosexual-homosexual dichotomy of sexuality (Herek, 2002).

Since early socialization experiences are extremely powerful, internalized homophobia/biphobia remains present for many LGB individuals throughout their lifetime, particularly in the presence of continuous exposure to discriminatory attitudes. Given that there is a positive correlation between internalized homophobia/biphobia and depression, anxiety symptoms, substance use disorders, eating disorders, HIV risk taking behaviors, self blame and poor coping in the face of HIV infection, and difficulties with intimate relationships and sexual functioning, it is no surprise then that non-heterosexual individuals suffer from greater prevalence rates of mental health disorders (Meyer, 2003). Overall, individuals of a non-heterosexual orientation experience 3-4 times greater prevalence rates of comorbid disorders than their heterosexual peers. More recently, significant differences among non-heterosexual groups have emerged (Bostwick, 2012; Bostwick, Boyd, Hughes, & McCabe, 2010). For example, Bostwick et al. (2010) examined differences in prevalence of mental health disorders among men and women across dimensions (i.e., identity, attraction, and behavior) of sexual orientation. They found that among men, all dimensions of sexual orientation were associated with a higher prevalence of lifetime disorder. Among women, however, sexual minority identity was the only dimension associated with higher rates of lifetime and past-year disorders, whereas dimensions of sexual attraction or sexual behavior were not (Bostwick et al., 2010). In a similar study, McCabe, Hughes, Bostwick, West and Boyd (2009) examined the differences is substance use risk among dimension of sexual orientation. Their findings demonstrated increased risk for substance use and dependence based on bisexual behavior. They also concluded no greater risk among individuals reporting same-sex behaviors only, as compared to opposite-sex behavior only (McCabe et al., 2009).

Among youth, those with both-sex behaviors were found to have higher prevalence of suicidal ideation and attempts than youth with either same-sex only or opposite-sex only partners (Robin, et al., 2002). These finding are particularly important since comorbidity is a predictor of illness severity and increased use of mental health services (Cochran et al., 2003).

Victimization related to sexual orientation is still common in our society (Anhalt & Morris, 1998). A national summary report of hate crimes offenses based on sexual orientation in the year 2000 indicated 1,486 hate crimes toward 1,558 known victims. These figures are likely an underestimation as many such crimes remain unreported (United States Department of Justice, 2000). In Herek's (1989) review of the literature on hate crimes against non-heterosexual individuals, findings demonstrated that 92% of non-heterosexual persons reported having been victims of verbal abuse or threats and 24% reported having been victims of physical aggression due to their sexual orientation. Hate incidents can produce fear, initiating restrictions in one's routine behaviors, eventually producing social withdrawal and isolation (Willis, 2004).

The after effects of a hate crime may leave the victim coping with physical injury as well as a variety of somatic and behavioral reactions such as sleep disturbance, nightmares, headaches, agitation, restlessness, diarrhea, increased substance use, uncontrollable tearfulness, and interpersonal difficulties (Garnets, Herek, & Levy, 1990). Victims of hate crimes frequently experience psychological distress, losing their sense of autonomy and control. Victimization frequently generates a chaotic view of one's world. To facilitate order and meaning to one's perception of their world and decrease cognitive dissonance, victims frequently take on a stance of self devaluation, leading to an under-

developed sense of self and feelings of insecurity (Garnets et al., 1990). Moreover, comparisons revealed that victims of hate crimes due to sexual orientation are more negatively affected than victims of other types of crimes, producing higher levels of depressive symptoms, traumatic stress symptoms, anxiety, and anger (Herek, 2007; Willis, 2004). It is important, however, to keep in mind that not all people who experience hate crimes endure long-term outcomes.

It is also critical to consider the consequences of stigma and discrimination on adolescents, as this is the life period during which sexual exploration and development is at its peak. Generational and cohort effects in conjunction with shifts in the social environment demonstrating an increased acceptance of non-heterosexual persons would lead one to believe that later generations would endure fewer challenges. Yet, a close examination of LGB youth literature illustrates that LGB youth are even at a higher risk of victimization than their heterosexual peers and LGB adults (Meyer, 2003). It seems that LGB youth who are in the developmental process of coming out are at particular risk to such victimization from their family members and peers (Anhalt & Morris, 1998; Pilkington & D'Augelli, 1995). Consequently, LGB youth display more fear for their safety at school, and as a result, tend to miss more days of school (Meyer, 2003).

LGB youth also display higher rates of unprotected sex compared to their heterosexual peers, putting them at risk for becoming infected with sexually transmitted diseases (Anhalt & Morris, 1998). They also exhibit higher rates of suicidal ideation and attempts, with prevalence rates significantly higher than their heterosexual counterparts (Anhalt & Morris, 1998); and even higher prevalence rates are reported among adolescents reporting both-sex partners as compared to peers reporting same-sex or

opposite-sex partners only (Robin et al., 2002). Nevertheless, there is no substantial evidence of increased prevalence rates of completed suicides among LGB individuals, which may indicate their suicidal gestures are a cry for help (Meyer, 2003). One strong predictor of suicidal behavior is a greater loss of friends after disclosure of minority sexual orientation (Anhalt & Morris, 1998).

The emotional consequences of coping with societal oppression and stigma are clear (Willis, 2004); the field of psychology has certainly contributed its share to furthering the stigmatization by viewing non-heterosexual behavior as a disorder (American Psychiatric Association [APA], 1952; Meyer, 2003).

LGB Individuals and the Field of Psychology

The subsequent discussion provides an overview of the historical context related to LGB individuals within the field of psychology and the models of non-heterosexual development (both foundational perspective and contemporary models). However, this discussion cannot take place in the absence of defining critical key terms.

Definition of key terms. The American Psychological Association (APA) Committee on Lesbian and Gay Concerns cautions against introducing heterosexist bias in psychological research (APA, 2011; Herek, Kimmel, Amaro, & Melton, 1991). Researchers typically define sexual orientation using one or more of three distinctive aspects: *sexual*/*romantic attraction* or *arousal*, *sexual behavior*, and *sexual identity* (Savin-Williams, 2006). Sexual/romantic attraction is defined as attraction toward one sex or the desire to engage in sexual relations with or to be in a primary loving, sexual relationship with one or both sexes (Savin-Williams, 2006). Sexual behavior represents any mutually voluntary activity with another person involving genital contact or

physiological arousal, regardless of whether sexual intercourse or orgasm occurs (Savin-Williams, 2006). Sexual identity refers to a "personally selected, socially and historically bound label related to the perceptions and meanings a person has about his or her sexuality" (Savin-Williams, 2006, p.41). Savin-Williams (2006) draws attention to an over-reliance on the term sexual identity in the literature on non-heterosexual individuals, thereby excluding many non-heterosexual individuals and misidentifying some heterosexuals. Research has demonstrated the incongruence between self-identification of sexual orientation and sexual attractions and behaviors (Garnets, 2002; Herek & Garnets, 2007; Savin-Williams, 2006).

The term *homosexuality* will appear in this dissertation only in the context of historical discussion and foundational theoretical models due to its long-standing pathological connotation. *Minority sexual-orientation* or *sexual minority* are terms that have been used in an effort to move away from the dichotomous categorization of sexuality and towards language that encompasses the wide spectrum of sexuality. However, these terms are problematic as they highlight the notion of a minority status, which implies that the minority group is lesser than the majority group, thereby accenting discriminatory aspects of being a minority. Moreover, this term holds the assumption that non-heterosexual attraction is, in fact, less common than opposite-sex attraction. Given the absence of consistent operational definitions throughout the literature, it seems nearly impossible to validate such an assumption (Herek & Garnets, 2007; Savin-Williams, 2006). Although terms such as *same-sex orientated*, *same-sex attracted*, or individuals with *same-sex desire* are in line with the broader terminology, they exclude

discussion of bisexual individuals, who experience attraction to both same-sex and other-sex individuals.

As a result of the lack of consistency of operationally defining terms, the term *non-heterosexual* most accurately represents the compilation of findings when two or more sexual attraction, behavior identity, or orientation groups are combined (e.g., self-labeled lesbians, gay, and bisexual individuals, individuals reporting a history of same and/or opposite sex sexual attractions, individuals reporting a history of same and/or opposite sex sexual behavior, etc.). Moreover, the term non-heterosexual is consistent with the affirmative literature, as it serves to highlight the heterogeneity, fluidity, and multiplicity of sexual orientation and move away from simplistic categorization of sexual identities (Floyd & Stein, 2002; Rosario, Schrimshaw, Hunter, & Braun 2006; Rosario, Schrimshaw, Hunter, & Levy-Warren, 2009; Savin-Williams, 2001; Savin-Williams & Diamond, 2000). It is the intent of this author to emphasize that sexuality is multidimensional and multidetermined. For brevity, the acronym LGB will be used in this dissertation to refer to lesbian, gay, and/or bisexual persons. Although an important question in its own right, this dissertation does not address transgender and transsexual individuals as research with these individuals should consider their unique experiences and concerns.

A list of additional terms related to LGB issues is available in Appendix B in order to provide a broader understanding of current knowledge related to lesbian, gay, and bisexual individuals.

History. The pathologizing of same-sex attraction throughout most of the 20th century continues to complicate discussions of sexual orientation. The field of

psychology has exacerbated the stigma associated with homosexuality through its pathologizing view of same-sex attraction, joining with other cultural institutions, such as law and religion, which share similar views (Herek & Garnets, 2007). For example, in *Three Essays on the Theory of Sexuality*, Freud (1905) contended that normal sexual development brought about heterosexuality, thereby purporting that homosexuality is an illness (Herek & Garnets, 2007; Freud, 1905). In spite of his more sympathetic view of same-sex attraction later in his career ("Historical Notes," 1951), many of Freud's disciples held onto his earlier theories inundated with homophobic bias. As psychoanalysis was the dominant perspective in psychiatry throughout the mid-20th century, the notion that homosexuality was pathological continued to permeate though American culture (Herek & Garnets, 2007; Robertson, 2004).

In the 1960s, Irving Bieber and Charles Socarides, the most renowned experts on same-sex attraction of the time, followed the classical Freudian perspective of homosexuality as a mental illness, attributing the cause to dysfunctional family dynamics (as cited in Kauth, 2006). This pathology-based theory was later supported by the guidelines in the first *Diagnostic and Statistical Manual* (*DSM-I,* American Psychiatric Association, 1952). The *DSM-I* classified homosexuality as a "sociopathic personality disturbance" (APA, 1952, p. 38-39) along with substance abuse and sexual disorders, portraying non-heterosexual persons as possessing profound character deficiencies. In the face of beginning efforts to eradicate the notion of homosexuality as an illness by gay-affirmative professionals, such as Alfred Kinsey, Evelyn Hooker, and Wardell Pomeroy (Hooker, 1957; Kinsey, Pomeroy, & Martin, 1948; Robertson, 2004), the *DSM-II*, published in 1968, classified homosexuality as a sexual deviance clustered with

fetishism, pedophilia, transvestitism, exhibitionism, voyeurism, sadism, and masochism (APA, 1968).

The 1970s was a time characterized by learning theories focusing on the "cure" of same-sex attraction, utilizing treatment modalities such as covert sensitization, aversion therapy, electroshock therapy, drug and hormone injections, and electroconvulsive therapy (Callahan & Leitenberg, 1973; Robertson, 2004). Research generally focused on homosexuality as pathology and its treatment and prevention, portraying a clear message of heterosexism in the field (Morin, 1977). Although the APA Board of Directors voted to remove homosexuality from the *DSM-II* in 1973 (Drescher, 2010; Herek & Garnets, 2007), the APA Position Statement was one of reluctant support rather than resounding support, stating: "…by no longer listing it as a psychiatric disorder we are not saying that it is 'normal' or as valuable as heterosexuality…" (APA, 1973, p. 2).

With the *DSM-III* materializing in 1980, a new diagnosis of *Ego-Dystonic Homosexuality* was created in place of the previous categorization of *Homosexuality* as a sexual deviance (APA, 1980). In the revised edition of the *DSM-III*, the diagnosis was removed entirely. In its place was a diagnosis of *Sexual Disorder Not Otherwise Specified*, a diagnosis which could be established in one of three ways, the third of which was recorded as a "persistent and marked distress about one's sexual orientation" (APA, 1987, p. 296). It was during this time that the mental health profession began its metamorphosis into a field that embraced affirmative therapies.

Current literature emphasizes non-heterosexual attraction as normal variations of human sexuality. More recent literature has demonstrated a shift from the view of homosexuality and bisexuality as indicative of psychopathology to the awareness that it is

the incessant discrimination and oppression experienced by these individuals that can affect the mental health of non-heterosexual individuals (Greene, 2005; Phillips, Ingram, Smith, & Mindes, 2003). Research between the years 1990-1999 largely examined the damaging effects of heterosexism on LGB individuals (Phillips et al., 2003).

In spite of such advancements, homonegativity and binegativity still exist in the field of psychology, which continues to influence the assessment and treatment of LGB individuals (Greene, 2005). Morrison and Morrison (2002) propose that homonegativity and binegativity have not subsided, but have undergone a metamorphosis from "old fashioned" biblical sanctions and moral opposition to contemporary abstractions, such as the belief that LGB individuals make unnecessary demands, exaggerate the importance of their sexual orientation, and overemphasize discrimination by others when it is no longer an issue. They conducted a series of studies, which collectively supported change in how homonegativity/binegativity is expressed (Morrison & Morrison, 2002). Although the expressions of homonegativity/binegativity have changed, the negative heterosexist bias that persists in society continues to permeate psychotherapy practice (Greene, 2005).

Methodological problems also influence the quality of the published contemporary research on sexual identity development such as the accuracy of using self-report on issues pertaining to sexuality, a lack of consistent operational definitions for sexual concepts, and an absence of reliable categorizations for sexual orientation. Further compromising research practices is the reliance on operational definitions for concepts such as psychological distress that are based on heterosexual populations, which may not characterize the experience or provide a valid index of clinical significance among individuals with a non-heterosexual orientation (Herek & Garnets, 2007).

The continued deficiency in the literature concerning non-heterosexual individuals is of particular concern, given the increased rates of this population utilizing therapy. The literature that exists is often excluded from the mainstream scholarly outlets, further marginalizing the needs of sexual minority groups. Moreover, there remains substantial gaps in the literature in areas such as life span development and aging, teenage suicide, substance abuse, victimization and abuse, and family and couple relationships (Goldfried, 2001) as well as the effects of trauma, the minimization of its effect on non-heterosexual individuals, and retraumatization (Greene, 2005).

The research literature is limited by the heterosexist theories and assumptions that underlie much of the scholarship produced on non-heterosexual individuals. In the discussion that follows, attention is given to more contemporary theoretical models for understanding the development of same-sex attraction.

Foundational theoretical perspectives. Earlier theories conceptualized same-sex attraction as aberrant and attempted to explain the etiology of the abnormality. These perspectives include: (a) evolutionary theory, which assumed same-sex attraction arises as a strategy to decrease competition between ancestral same-sex groups to facilitate natural selection (Kauth, 2006; Muscarella, 2000); (b) psychoanalytic theories, in which Freud argued that humans are born bisexual, but during their development, same-sex attraction occurred in boys who choose partners who resemble themselves as a way to avoid castration anxiety or girls who rejected their father (and all males) for not giving them a child (Baumeister, Manor, & DeWall, 2006), to later psychoanalytic theorists such as Irving Bieber and Charles Socarides who contended same-sex attraction was due to growing up in a dysfunctional family, typified by overbearing or neglectful parents

(Kauth, 2006); (c) learning theorists such as Douglas Haldeman, Maurice P. Feldman, and Malcom J. MacCulloch who argue that same-sex attraction is intentionally or inadvertently conditioned through systems of rewards and punishments (Kauth, 2006); (d) personality theorists, such as Alfred Adler, who focused on intrapersonal characteristics and contend same-sex attraction is the result of parents who allow young boys to behave in stereotypically feminine ways and fail to encourage more masculine behaviors and vice versa (Kauth, 2006); and (e) biomedical theorists, such as Laura S. Allen, Simon Levay and Dick F. Swaab, who maintained that genetics and hormones are at the root of same-sex attraction (Kauth, 2006). These theories have been criticized on a number of grounds. For example, critics of evolutionary theory argue that this perspective places excessive emphasis on genetic determination and ignores the contribution of individual differences (Baumeister et al., 2006). Psychoanalytic and learning theories have been criticized for the lack of empirical support, and personality and biomedical theories have been criticized for their lack of conceptual robustness, i.e., personality theories fail to explain masculine gay men and feminine heterosexual men, while biomedical theories omit bisexuality from their conceptualization (Baumeister et al., 2006; Kauth, 2006).

In contrast to these earlier theories, contemporary theoretical models for understanding same-sex attraction approach the phenomenon from a developmental perspective. For example, Vivian Cass (1979) proposed one of the first models of homosexual identity development. Her model included six distinct stages: (a) *identity confusion,* during which the individual becomes aware that his or her thoughts and behavior may be defined as homosexual, creating bewilderment and a questioning of

previously held sexual orientation identity; (b) *identity comparison*, which is characterized by the individual beginning to recognize the differences between self and his or her heterosexual counterparts, leading to feelings of alienation; (c) *identity tolerance*, during which the individual begins to commit to the new homosexual identity and seeks out company of other non-heterosexuals to fulfill social, sexual, and emotional needs; (d) *identity acceptance*, which is distinguished by increased contact with non-heterosexual individuals, more acceptance of a homosexual lifestyle, and selective disclosure of one's homosexual identity to others; (e) *identity pride*, in which the individual experiences a great deal of satisfaction with one's homosexual orientation, feels loyalty toward members of the homosexual community, and expresses anger towards a society that stigmatizes and acts prejudicially toward homosexuals; and (f) *identity synthesis*, which is characterized by the acknowledgement that homosexuality is only one component of one's overall identity, and no longer are other individuals either categorized as good or bad, based on their sexual orientation. In her model, Cass (1979) argues that identity foreclosure can occur at any stage of development, preventing further development. Cass' developmental model is linear, i.e., one must negotiate one stage of development before moving to the next stage. In a study assessing the validity of the model, Cass (1984) found that the distinction between stages may be more blurred than clearly defined.

Troiden (1989), like Cass, introduced a developmental model for understanding same-sex attraction. But unlike Cass, Troiden's model is grounded in sociological theory so it takes into account factors external to the individual that influence one's development and may prevent the linear trajectory suggested by Cass. Troiden (1989) suggests four

stages: (a) *sensitization*, which is the point at which the individual gains awareness of his or her differences from other same-sex peers, generally occurring prior to adolescence; (b) *identity confusion*, which is characterized by a period of internal conflict about one's sexual orientation identity, with isolation and alienation common; (c) *identity assumption*, during which the acceptance of one' sexual orientation minority status is taking root, more involvement in the gay community is evidenced, and a period of marked sexual exploration begins; and (d) *commitment*, which is distinguish by the full acknowledgement and acceptance of one's sexual identity.

Contemporary theoretical perspectives. Traditional models of sexual minority identity development, also known as the coming out process, have contended stage-sequential models, which propose a progression of milestones proceeding self-identification as LGB (Cass, 1979, 1984; Troiden, 1989). Although the stage-sequential models vary in their terminology and theoretical orientations, they tend to share a comparable linear sequence of milestones (Rosario et al., 2009; Savin-Williams & Diamond, 2000), beginning with an awareness of attraction to members of the same sex and ending with acceptance, disclosure, and integration of a non-heterosexual identity (Rosario Schrimshaw, & Hunter, 2004; Rosario et al., 2006). The vast majority of this research has utilized retrospective studies, which may overestimate the linear sequence of milestones and under-represent individual variability (Rosario et al., 2006).

Contemporary research, however, has demonstrated that some facets of sexual orientation may be more variable than formerly understood, indicating a great deal of heterogeneity in the timing and sequence of milestones in the process of becoming aware of and accepting of one's sexual identity (Floyd & Stein, 2002; Rosario et al., 2006;

Rosario et al., 2009; Savin-Williams, 2001; Savin-Williams & Diamond, 2000). Such research has highlighted the multiplicity and fluidity of sexual identity, desire, and behaviors that rests upon a continuum of sexual identification, rather than the previously accepted categorical conceptualization of sexual desires that falls into one of three categories – heterosexual, bisexual, or homosexual (Diamond & Butterworth, 2008; Savin-Williams, 2001). For example, Diamond and Butterworth (2008) have applied the theory of intersectionality to sexual identity development, describing a theory of multiple identifications that is "unique, non-additive and not reducible to the original identities that went into them" (p. 366). Researchers have also noted remarkable deviations from the theorized models for bisexual individuals (Botswick, 2012), in particular for bisexual women (Diamond, 1998; Rosario et al., 2009; Savin-Williams & Diamond, 2000), and for LGB ethnic minorities (Fassinger & Miller, 2008; Rosario et al., 2004). For example, bisexual individuals may experience consistent both sex attractions, but not act or identify as bisexual, depending on the dynamics of their current relationship. Moreover, the process of disclosure may be complicated by other factors, such as cultural considerations and the sexual orientation identification of a person's current partner (Grov, Bimbi, Nanín, & Parsons, 2006).

Although contemporary developmental models more effectively characterize the development of same-sex attraction, the vestiges of heterosexist psychological theories continue to influence how the field views and treats LGB clients. In the discussion that follows, the views of therapists and clients on the competency of serving the clinical needs of LGB clients is considered.

Perceived Competency of Therapists Treating LGB Clients

Therapist views. Since same/both-sex attraction has long been stigmatized in the fields of psychology and psychiatry, mental health professionals may still operate from this heterosexist view in making decisions about the diagnosis and treatment of non-heterosexual individuals. For example, Boysen and Vogel (2008) examined implicit bias by assessing diversity attitudes among graduate student trainees, utilizing the Implicit Association Test (IAT). The researchers defined implicit bias as a measure of one's attitude without the use of conscious introspection. The results indicated that, in spite of their perceived multicultural competence, graduate students expressed a strong implicit bias toward both African Americans and sexual minority individuals. These findings suggest that fostering awareness and competence on an implicit level is much more complicated that fostering knowledge and competence on an explicit level. These investigators encourage the assessment of implicit bias to gain more insight into the unconscious attitudes of students in training that may influence their work with clients (Boysen & Vogel, 2008).

Mental health practitioners have reported feeling less competent and less prepared to work effectively with non-heterosexual individuals. Bidell (2005) utilized the Sexual Orientation Counselor Competency Scale (SOCCS) to assess knowledge, attitudes, and skills of counselors working with LGB clients. Results of the investigation demonstrated that skill competencies were over one-third lower than knowledge competencies and one-half lower than awareness competencies. These findings indicate that although counselors may feel they possess awareness and the knowledge for working with this particular minority group, they are less confident with their skills for working effectively

with sexual minority individuals. These findings were corroborated by counseling student reports that their training did not adequately prepare them to work competently with non-heterosexual clients (Bidell, 2005).

In response to the reported deficiency in competence and preparation to effectively work with non-heterosexual individuals, Godfrey, Haddock, Fisher, and Lund (2006) investigated the components of knowledge, experiences, and values that therapists working with LGB clients should possess. Drawing on the contributions of 15 experts in the area of LGB issues, the investigators identified the following issues as important knowledge for therapists to possess: (a) the stress of coming out in a heterocentric society; (b) the absence of legal rights, including marriage; (c) difficulties with adoption and child rearing; (d) problems associated with securing safe housing; and (e) the absence of familial and religious support. Additionally, investigators revealed that the following therapist attributes and skills were critical to offering treatment: (a) being open-minded and self-aware of one's biases; (b) assessing the degree to which the client is out of the closet and taking this issue into account in treatment; (c) utilizing interventions that affirm the client; and (d) ensuring confidentiality. The investigators contend that mental health professionals who are unaware of these challenges in daily living cannot offer competent services to sexual minority clients.

Moreover, research indicates that therapists' fundamental values and personal experiences are particularly helpful when treating LGB individuals (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008). Based on interviews with 14 licensed therapists, researchers identified the subsequent components as essential when treating LGB individuals: (a) possessing a strong therapeutic alliance, (b) utilizing psychoeducation, (c)

utilizing directive and affirmative interventions, and (d) offering empathy and validation. Moreover, therapists reported feeling most effective in situations in which they: (a) possessed sufficient knowledge, (b) had a positive relationship with the client, (c) were able to alleviate symptomology related to the client's presenting problem, (d) helped the client gain insight, and (e) felt non-judgmental.

Client view. A disparity still exists today between the need for competent mental health services for members of the LGB community and the number of clinicians who are sufficiently trained to offer appropriate services to the community (Alcazar-Olan, Deffenbacher, Hernandez-Guzman, Sharma, & De La Chaussee-Acuna, 2010; Bidell, 2005; Goldfried, 2001). As a result, non-heterosexual individuals have often received insufficient or inappropriate treatment, which has left members of the LGB community distrustful of the mental health field. For example, Stein and Bonuck (2001) found that 17% of the participants in their study avoided or delayed seeking mental health care due to reasons pertaining to their minority sexual orientation status. Moreover, Atkinson, Brady, and Casas (1981) found that participants preferred to work with therapists who shared the same sexual orientation and viewed these therapists as more credible. They also found that therapists who hold an LGB affirming view were rated almost as competent as therapist who shared the same sexual orientation, which raises an important implication for those treating LGB individuals.

Research indicates that there are certain qualities that LGB clients desire from therapists, regardless of the presenting problem and the salience of sexual orientation to the presenting problem (Goldfried, 2001). These include being affirming, supportive, and validating; having a strong and authentic therapeutic relationship; having a general

awareness of and comfort with discussing LGB issues; having previous experience working with LGB individuals; and encouraging the exploration of sexuality (Godfrey et al., 2006; Israel et al., 2008; Lebolt, 1999; Ryden & Loewenthal, 2001). Qualities that were consistently identified as undesirable included therapist tentativeness and discomfort in working with LGB clients, reluctance to engage in further inquiry pertaining to a client's sexual identity, use of heterocentric language, failure to recognize that the client is non-heterosexual, and an overemphasis on the client's sexual identity (Goldfried, 2001; Lebolt, 1999; Mair, 2003).

Stein and Bonuck (2001) explored the concerns, perceptions, and experiences that gay men and lesbians report regarding the physician-patient relationship. Overall, 30% of the patients did not disclose their minority sexual orientation to their health care providers, and only 29% of patients were asked their sexual orientation by their health care provider. This latter percentage is likely an overestimation as the sample was recruited from the New York metropolitan area, where a substantial number of sexual minority individuals and gay friendly organizations and health care providers exist (Stein & Bonuck, 2001). These findings argue for the need to increase training on physician-patient communication for issues related to sexual orientation (Stein & Bonuck, 2001).

Current Practices in Working Clinically with LGB Clients

Assessment. The insufficient research on issues related to sexual orientation indirectly attests to the persistence of bias and heterosexism in the mental health field. Unlike many other minority groups, sexual minority groups are often characterized as invisible as you cannot identify an LGB person by the color of their skin or other phenotypic expression. As a result, mental health professionals conducting psychological

assessment do not have overt evidence to caution against the use of assessment measures that contain heterosexist bias, as one might have the ability to do with people of color, for example (Prince, 1997). Although it is imperative to minimize heterocentric language (Bradford, Cahill, Grasso, & Makadon, 2012; Browne, Woltman, Tumarkin, Dyer, & Buchbinder, 2008; California Department of Health Services STD Control Branch & California STD/HIV Prevention training Center [California Department of Health Services], n.d,; Gay and Lesbian Medical Association, n.d.; Group for the Advancement of Psychiatry, 2011; King County, 2011; Pennsylvania Department of Public Welfare's Office of Mental Health and Substance Abuse Services [Pennsylvania Department of Public Welfare], 2009) many of these assessment measures do not have an alternative form that is non-heterosexist; therefore, the measures continue to be administered. One example of such a test is the Yale Brown Obsessive Compulsive Scale (Y-BOCS), which has been deemed heteronormative in some countries since the symptoms checklist includes sexual obsession, which contains items specific to homosexuality but not heterosexuality (Rûck & Bergström, 2006).

Several authors have proposed the development of norms appropriate for LGB people. However, modifying existing instruments to become more appropriate for LGB populations or developing new norms with existing assessment tools may preserve the existing heterosexist bias (Prince, 1997). These rapid solutions run the peril of mistakenly labeling such instruments as culturally competent and free of heterosexist bias. We need to deepen our understanding of the influences of sexual orientation on psychological assessments and testing results. For example, an issue that merits consideration is the client's identity development in regards to his or her sexual

orientation as these data may influence how the client may respond on other measures of psychological functioning. By neglecting to consider such issues, the interpretation of testing data may be distorted, potentially resulting in either over-pathologizing the client or missing key issues relevant to understand the client's psychological needs (Prince, 1997).

The diagnostic assessment of LGB individuals has been an area requiring attention. Of particular interest is the overdiagnosis of Borderline Personality Disorder (BPD). The linking of sexual orientation to BPD is a premise that has existed for over 30 years (Wiederman & Sansone, 2009). One of the primary symptoms of BPD is identity disturbance. A subjective lack of a coherent identity is common among non-heterosexuals going through the coming-out process (Wiederman & Sansone, 2009); hence, it is possible that the stress associated with the coming out process may result in labile mood and the temporary adoption of behaviors that resemble borderline traits. It is particularly important to not prematurely diagnose BPD without fully considering other diagnostic possibilities, or if a diagnosis is even warranted, as a diagnosis of BPD can contribute to negative consequences for the client in the long term (Eubanks-Carter & Goldfried, 2006). Current research demonstrates higher rates of non-heterosexual orientation among BPD patients than in the general population (Eubanks-Carter & Goldfried, 2006). Eubanks-Carter and Goldfried (2006) conducted an experiment using vignettes in which some therapists received a vignette that explicitly identified the client as non-heterosexual while the sexual orientation was left undisclosed in the second vignette. The results of the study demonstrated a bias toward diagnosing BPD in clients who were presumed non-heterosexual versus heterosexual (61% v. 36%, respectively).

Moreover, the incidence rates of BPD are higher among females than males, which may be due to biases in diagnosis or behavioral differences in the manifestation of the disorder among men and women (Wiederman & Sansone, 2009). The authors contend that therapists might be overestimating BPD in gay male clients who exhibit "feminine traits." The findings also revealed a strong heterocentric assumption among therapists, as the majority of the therapists who received a vignette in which the sexual orientation was not specified assumed that the client was heterosexual (Eubanks-Carter & Goldfried, 2006).

Fingerhut, Peplau, and Ghavami (2005) propose a model for improving diagnostic accuracy when assessing lesbian clients. These investigators identified four identity categories that provide information about how a client conceptualizes her identity: (a) assimilated (low in lesbian affiliation and high in heterosexual affiliation), (b) lesbian-identified or separated (high in lesbian affiliation and low in heterosexual affiliation), (c) integrated (high in both affiliations), and (d) marginalized (low in both affiliations). The investigators found the more lesbians were identified with mainstream heterosexual society, the lower the level of discrimination they reported; moreover, a positive lesbian identity was associated with lower levels of internalized homophobia (Fingerhut et al., 2005). The investigators argue that gaining information about the identity category of an individual is essential for accurately assessing client needs and guiding treatment planning of non-heterosexual individuals. Additionally, other researchers have noted the importance of accurately assessing the degree of disclosure with family, friends, and employers (Amico, 1997; Gay and Lesbian Medical Association, n.d.; United States Department of Justice Office on Violence Against Women & LAPTOP [U.S. Department of Justice], 2006).

Psychological treatment. The heterosexist roots of psychology continue to influence the training of psychologists and other clinicians, resulting in both explicit and implicit biases infused in the therapeutic services offered to LGB clients (APA, 2011; Herek, Kimmel, Amaro, & Melton, 1991). In one extreme are interventions such as conversion therapies that intentionally set out to alter the sexual orientation of clients (Callahan & Leitenberg, 1973; Haldeman, 2002; Herek & Garnets, 2007; Kauth, 2006). Recently, the California State Senate passed legislation that was enacted on January 1, 2013, prohibiting conversion therapies with individuals younger than 18 years of age (Leff, 2012). However, most biases exhibited in treatment are more subtle, for example, assuming that one's sexual attraction is a therapeutic issue in need of intervention, regardless if this observation appears related to the client's presenting problem (Goldfried, 2001; Group for the Advancement of Psychiatry, 2011). Furthermore, lacking sufficient knowledge about the unique challenges that affect the lives of LGB clients is another critical oversight (APA, 2010; APA, 2011; California Department of Health Services, n.d.; King et al., 2007; Lyons, Bieschke, Dendy, Worthington & Georgemiller, 2010; Pachankis & Goldfried, 2004).

When clients raise issues related to non-heterosexual attraction, clinicians competent to serve LGB clients engage in affirmative therapeutic practices, which promote self acceptance of one's sexual orientation (Atkinson et al., 1981; Burkell & Goldfried, 2006; Godfrey et al., 2006; Israel et al., 2008). The therapeutic process allows the client to assess the meaning he or she ascribes to his or her experience as a LGB person, his or her feelings about self relative to these experiences, and the degree to which there is an integration of experience with one's identity as a sexual minority

(Atkinson et al., 1981; Godfrey et al., 2006; Israel et al., 2008). During this discovery process, the client's internal and external resources are assessed, and strategies for expanding his or her available resources are essential (Herek & Garnets, 2007).

Kashubeck-West, Szymanski, and Meyer (2008) discuss the construct of internalized heterosexism and its implications for therapy with LGB clients and offer suggestions for practice at micro, meso, and macro levels. At the micro level, the authors express the importance of educating LGB clients about the oppressive nature of sociopolitical systems as a way for clients to gain an understanding of how heterosexism has influenced their lives and self-perceptions, including internalized heterosexism. With this knowledge and awareness, LGB individuals can confront the negative conceptions of minority sexual orientation and move toward the integration of a positive, affirming sexual identity as part of their larger personal schema of self (Herek & Garnets, 2007). Of course, to facilitate such change in clients, therapists must, themselves, gain insight into their own heterosexist biases and the role of society in the inculcation of these values and beliefs (APA, 2011; Kaiser Permanente National Diversity Council and Kaiser Permanente National Diversity Department [Kaiser Permanente], 2004; Kashubeck-West et al., 2008; King et al., 2007; Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing, Department of Mental Health [Ministerial Advisory Committee], 2009; Social Planning Policy and Program Administration Regional Municipality of Waterloo [Regional Municipality of Waterloo], 2008). Moreover, several researchers contend that therapists treating non-heterosexual clients should be familiar with the intersection of LGB issues with identity development, intimate relationships and parenting, family issues including family of choice, the unique

experiences of under-represented sexual minority populations, and legal and workplace issues (Gay and Lesbian Medical Association, n.d.; Kaiser Permanente, 2004; King et al., 2007; Lyons et al., 2010; Pachankis & Goldfried, 2004; Sanders & Kroll, 2000). Kashubeck-West et al. (2008) would add adolescent and adult development, adjustment and psychopathology, substance abuse, and human sexuality.

At the meso level, the authors encouraged client membership in LGB affirming organizations. Through the activism of such organizations, LGB clients contribute to change in heterosexist policies and practices that allow individuals to reconcile the dissonance he or she has experienced as a non-heterosexual person in a heterosexist society. Therapist involvement in such activities can strengthen such benefits, as well as provide powerful role modeling for clients. At the macro level, psychologists and clients must work to reduce societal oppression of LGB individuals by fighting to change laws and institutions that discriminate against LGB persons (Kashubeck-West et al., 2008).

LGB affirmative therapy. LGB affirmative counseling is defined as therapy that "celebrates and advocates the validity of lesbian, gay and bisexual persons and their relationships" (Tozer & McClanahan, 1999, p.736). Identification of LGB affirmative therapeutic practices revealed the utilization of the following elements: (a) engage in advocacy, support, and empowerment of clients; (b) apply knowledge; (c) use up-to-date research to guide practice; (d) communicate a non-pathological view of sexuality; (e) provide a safe space for the exploration of sexuality; (f) be aware and accept one's own limitations in working with the LGB community; (g) engage in unique and idiographic assessment; (h) create a strong therapeutic alliance; (i) approach sexuality with a holistic

view; and (j) familiarize oneself with LGB resources (Dillon, Worthington, Soth-McNett, & Schwartz, 2008; Harrison, 2000; Pixton, 2003; Walker & Prince, 2010).

Biaggio, Orchard, Larson, Petrino, and Mihara (2003) utilized the accreditation standards of the American Psychological Association, which acknowledges the importance of cultural and individual differences, to make recommendations for LGB affirmative educational practice, within the institutional climate and the curriculum. The authors make the following recommendations for creating an LGB affirmative curriculum: (a) integrate information regarding sexual orientation and the needs of LGB persons into the academic curriculum; (b) ensure faculty and clinical supervisors are knowledgeable regarding the unique needs of LGB clients; (c) encourage and support LGB research; (d) promote contact with the LGB community; (e) employ faculty with expertise regarding LGB issues and related topics; and (f) prioritize student and faculty self-awareness in relation to heterocentric biases. With regards to improving climate and support within an institution, the authors make the following recommendations: (a) prioritize affirmation of diversity; (b) ensure affirmative language in the institution's written materials; (c) include sexual orientation in equal employment opportunity and admission and recruitment materials; (d) consider diversity in promotion; and (e) promote support systems for LGB students within the institution.

In looking at LGB affirmative elements from a practitioner standpoint, Dillon et al. (2004) conducted an examination of 10 graduate students participating as members of a research team, in which they explored their heterosexist biases and attitudes toward sexual minorities. Investigators found that all students highlighted the importance of engaging in self-reflective practices in relation to their own beliefs and attitudes about

LGB individuals and how these attitudes might affect LGB clients, as well as colleagues (Dillon et al., 2004). Researchers determined that training experiences that facilitate self-exploration help to foster a deeper understanding and greater sense of comfort with sexuality related issues, concluding that such a practice is an important first step towards working with LGB clients (Dillon et al., 2004). One way to decrease heterosexist bias is to develop continuing education workshops and psychologist training programs that promote self-exploration regarding beliefs about sexuality and enhance gender self-confidence (Kaiser Permanente, 2004; Spokane Regional Health District, Community Health Assessment Program [Spokane Regional Health District], 2006).

Assessment measures, such as the Attitudes Toward Lesbians and Gay Men (ATLG) scale, the Attitudes Regarding Bisexuality Scale (ARBS), the Homosexuality Attitude Scale, Heterosexual Attitudes Towards Homosexuals (HATH) scale, and Modern Homophobia Scale (MHS), provide a rapid and an easily administered self-assessment measure for examining people's attitudes, stereotypes, misconceptions, and anxieties about non-heterosexual individuals (Herek, 1984; Kite & Deaux, 1986; Larsen, Reed, & Hoffman, 1980; Raja & Strokes, 1998). Moreover, assessment measures, such as the Gay Affirmative Practice (GAP) scale, the Lesbian, Gay Bisexual Affirmative Counseling Self Efficacy Inventory (LGB-CSI) and the Lesbian, Gay, and Bisexual Knowledge and Attitudes Scale for Heterosexuals (LGB-KASH), have been developed for evaluating the degree to which practitioners engage in affirmative practice with gay and lesbian individuals. Such measures can be used to assess the usefulness of educational and training interventions for practitioners who work with gay and lesbian

individuals (Crisp, 2006; Dillon & Worthington, 2003; Worthington, Dillon, &Becker-Schutte, 2005).

When studying marginalized groups, there is an inherent risk of excessively focusing on adversity, thereby viewing these individuals through the lens of pathology. It seems impossible to engage in affirmative therapies without shifting attention to the construct of *resilience*. While non-heterosexual individuals do, in fact, face a plethora of unique challenges, they also demonstrate unique strengths and resilience factors that are noteworthy (Adams, Cahill, & Ackerlind, 2005; Balsam, 2008). Contemporary research suggests a minority resilience hypothesis, asserting that members of stigmatized groups are able to maintain effective coping skills, self-esteem, and positive life satisfaction in the face of discrimination (Adams et al., 2005; Balsam, 2008; Cox, Van, Vincke, & Dewaele, 2011; Vaughn, Roesch, & Aldridge, 2009).

In an exploratory study, Anderson (1998) investigated resiliency factors in a sample of self-identified gay male youth that allowed them to effectively cope with developmental challenges. Results demonstrated that these youth developed both internal and external protective factors, suggesting the presence of resilience. In another study, Russell and Richards (2003) studied specific sources of stress and resilience among LGB individuals while confronting antigay politics in a sample of 316 self-identified LGB individuals in Colorado. Results revealed five distinct sources of stress associated with antigay politics: (a) encountering and comprehending the prevalence of homophobia; (b) coping with divisions within the LGB community; (c) navigating difficulties in the assessment of danger; (d) failed witnessing of family of origin, friends and society; and (e) internalizing homophobia. The results also revealed resilience factors implicated with

enduring antigay politics, which include: (a) approached the said politics as a movement by taking on a broader political perspective; (b) confronting internalized homophobia; (c) appropriately expressing affect; (d) successful witnessing; and (e) integrating into the LGB community.

Furthermore, contemporaneous study has revealed that successfully overcoming stress may be perceived as a learning experience with positive outcomes, such as personal growth and the development of personal strength (Bonet, Wells, & Parsons, 2007; Cox et al., 2011; Savin-Williams, 2008). More recently, the concept of stress related growth (SRG) has incorporated research on minority identification as an experience of chronic stress associated with significant experiences of growth (Bonet et al., 2007; Cox et al., 2011), particularly in the following three areas: (a) cognitive or affective growth, (b) religious growth, and (c) social growth (Vaughn , Roesch, & Aldridge, 2009). Cox et al., (2011) demonstrated that SRG operates as a buffer against internalized homophobia. SRG differs from resilience in that it exceeds normative functioning. SRG occur in a variety of areas such as enhanced knowledge base, increased acquisition of coping skills, and a more positive self-concept (Vaughn et al., 2009). The aforementioned discussion of the literature highlights the importance of recognizing and celebrating the incredible resilience that LGB individuals often maintain in the face of cultural, political, and institutionalized homophobia.

Intersection of Multiple Cultural Considerations

Up to this point, the discussion of LGB individuals has been unidimensional, which neglects the complexity of an individual's identity development. In the following discussion, the intersection of other multicultural considerations with sexual orientation,

particularly ethnicity, sex differences, age or generational differences, religiosity, and disability status are considered.

Ethnicity. Currently, there is inadequate research pertaining to LGB people of color (Grov et al., 2006; Phillips et al., 2003; Volpp, 2010). Just as is the case with the field of psychology in general, models for understanding sexual identity development emerge from studies of predominately White samples, not persons of color. Understanding the specific cultural implications of a non-heterosexual orientation is critical when working with LGB persons of color. Latino men, for example, tend to derive sexual identity labels from the role one plays in sex rather than the sex of the partner. In other words, a man would identify as heterosexual in the Latino community if he enacted a penetrative role (Grov et al., 2006).

In an attempt to examine the intersection of ethnicity and non-heterosexual attraction development, Dubé and Savin-Williams (1999) investigated the age and sequence for the following developmental issues among African American, Asian American, Caucasian, and Latino youths: (a) sexual identity milestones, (b) acceptance of same-sex attraction, (c) disclosure of same-sex attraction, (d) involvement in intimate same-sex relationships, (e) the average age of labeling same-sex attraction, and (f) the experience of internalized homophobia. The analysis revealed significant differences in all of the above developmental areas for the four ethnic groups. Latino youths reported having awareness of their sexual identity significantly younger than did African American and Caucasian youths, whereas Asian American youths reported a mean age of their first same-sex experience significantly later than the other three groups (approximately 3 years later). Sequencing of developmental milestones among the

various ethnicities differed as well. The majority of African American youths reported having same-sex experiences prior to labeling their sexual identity. Asian American youths, on the other hand, reported having same-sex encounters only after labeling themselves as gay or bisexual. Caucasian youths exhibited disproportionately high levels of disclosure, whereas African American and Asian American youths exhibited disproportionately low levels of disclosure (Dubé & Savin-Williams, 1999; Grov et al., 2006). The following similarities were also found among the four ethnic groups: (a) the average age same-sex attraction was labeled by youth was between 15-17 years, and (b) the experience of internalized homophobia was experienced by all. These findings argue for the need to consider ethnicity when proposing developmental models for understanding non-heterosexual attraction (Dubé & Savin-Williams, 1999).

The multiple minority status of LGB persons of color raises some unique identity issues as well as increases the potential of experiencing oppression. For example, Chan (1989) conducted a study investigating the experiences of gay and lesbian Asian Americans. The study findings indicate Asian American LGB persons: (a) tend to identify with their LGB identity over their ethnic identity, (b) fear rejection and stigmatization by their family; (c) report Asian communities deny the existence of LGB individuals; and (d) feel their multiple minority status makes them more prone to discrimination by others. Differences were found among male and female respondents, with men reporting more frequent discrimination due to their sexual orientation and women reporting more frequent discrimination due to their Asian identity (Chan, 1989). Respondents also indicated that they kept their sexual orientation hidden from their families and the Asian community as a whole (Chan, 1989). Although Western culture

values individualistic expression, such as the coming out process, the collectivistic nature of Asian cultures would view such self-expression as self serving and incongruent with their cultural worldview. Additionally, Asian cultures tend to view topics of a sexual nature inappropriate for public disclosure; hence, publically identifying one's sexual identification would not meet with approval. The cultural clash that many LGB Asian-Americans endure often results in deep-seated feelings of shame and guilt. This observation would be particularly apt among the less acculturated LGB Asian Americans and is a consideration worthy of careful examination in clinical work with members of this community (Chan, 1989).

Cochran and Mays (2007) examined the rates of distress and suicidal thought among same-sex active African American men and women. They found that same-sex active men who were HIV/AIDS symptomatic reported significantly higher levels of distress when compared to men who were HIV infected by asymptomatic, HIV-negative, or whose HIV status was unknown. Moreover, suicidal thoughts were most prevalent among same-sex active HIV/AIDS symptomatic men. Researchers also compared the participants in their study to Caucasian gay men studied in previous AIDS related research and discovered that the African American participants in their study experience greater levels of depressive distress than the Caucasian gay men in the other studies. Overall, the findings indicate that these individuals experienced higher levels of distress than would be expected based on their ethnic background or sexual orientation alone. The authors hypothesize that these findings may be a result of the interactive nature of stigmatization for their multiple minority statuses (Cochran & Mays, 2007).

Not all persons experience poor health outcomes in the face of oppression (Adams et al., 2005; Balsam, 2003; Mustanski, Newcomb, & Garofalo, 2011; Saewyc, 2011). Although scholars have traditionally argued that LGB people of color experience greater stigma and discrimination as a result of their multiple minority status, others have highlighted that communities of color possess their own set of unique values and experiences that can serve to promote coping skills and resources that can help LGB individuals of color demonstrate resilience in the face of stigma and discrimination (Adams et al., 2005; Huang et al., 2010). Meyer (2010) acknowledges that a multiplicity of identities can generate positive means for coping, as well as heightened stress. He described minority group members as active persons interacting with society rather than passive victims of prejudice (Meyer, 2003). In fact, much research has demonstrated individuals may live healthy and fulfilling lives despite facing societal challenges (Saewyc, 2011). Meyer (2003) makes the argument that the notion that racial/ethnic and non-heterosexual orientation identities are always in conflict with each other are exaggerated. Moreover, there is evidence that non-heterosexual persons of color may have positive racial/ethnic identities and positive sexual orientation identity, and that these individuals can hold multiple identities while maintaining a coherent sense of self (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Meyer, 2010).

Research investigating the resilience generated as a result of multiple minority identifications is of particular interest. In order to cope with the unique challenges of multiple minority identities that some non-heterosexual must face, these individuals often develop a broader repertoire of coping skills and unique resources that have helped them

to effectively cope with earlier experiences with adversity (Balsam, 2008; Bowleg et al., 2003; Meyer, 2010).

In a qualitative study, Wilson and Miller (2002) identified coping strategies that African American gay and bisexual men utilize in order to manage their non-heterosexual identification: role flexing, keeping faith, standing one's ground, changing sexual behavior, and accepting oneself. The authors further identified *avoidance of stigma, building buffers,* and *societal change* as functions of these coping strategies. Lastly, the results revealed a tendency to create alternative social networks and disengage from oppressive social groups.

It is of importance to note the dearth of literature specific to bisexual persons of color (APA, 2011; Cochran et al., 2003). Overall, the available research reveals that both-sex attracted persons of color may be more reluctant to identify as bisexual and to disclose such identification. This information is derived primarily from personal accounts of both-sex attracted individuals, though no methodical data concerning bisexual persons of color exists (Schrimshaw et al., 2012; Volpp, 2010).

Sex differences. Research on the economic condition of families with children neglect to consider the experiences of LGB persons (Prokos & Keene, 2010). Prokos and Keene (2010) investigated differing poverty estimates of cohabitating gay and lesbian couples and cohabitating and married heterosexual couples, taking into account factors such as age, education, and employment patterns. Utilizing the 2000 census data, they found that economically gay and lesbian couples fare worse than married heterosexual couples, but better off than cohabitating heterosexuals. Data also revealed that gay and

lesbian families are on average older and more educated than cohabitating heterosexual couples, which may explain the difference in poverty rates among these groups.

Differences in poverty rates among same-sex, both-sex, and heterosexual couples may also be attributed to gender inequities of the labor force (Prokos & Keene, 2010). For example, the business culture has traditionally valued masculinity and heterosexuality over femininity and homosexuality/bisexuality (Gedro, 2009). Hence, married, heterosexual men are the most rewarded in their earnings (Prokos & Keene, 2010).

To some extent, non-heterosexually oriented women experience greater freedom in career exploration than their heterosexual counterparts, as they are less likely to make career choices that accommodate men or conform to traditional gender roles (Gedro, 2009). Nonetheless, they frequently face discrimination in the work force because of their sexual orientation and sex, which translates to lower earning potential. In fact, same-sex female couples are more likely to experience poverty than same-sex male couples, even when controlling for education (Prokos & Keene, 2010).

Non-heterosexual men face considerable discrimination in the workforce as well. For example, they are frequently stereotyped into female dominated occupations and often face harassment due to their sexual orientation (Gedro, 2009). In fact, many non-heterosexual men elect not to disclose their sexual orientation so they are not denied opportunities for job advancement. Moreover, research indicates that non-heterosexual men earn less than heterosexual men (Badgett, 1995; Prokos & Keene, 2010). Additionally, heterosexual men may possess more negative attitudes toward non-

heterosexual men than non-heterosexual women, which results in more discriminatory behavior toward non-heterosexual men in the work setting (Gedro, 2009).

In addition to differences in earning power, gay and lesbian couples and heterosexual couples exhibit differences in adoption rates. Research indicates that lesbian couples are slightly more likely to adopt a child than heterosexual couples, and gay couples are less likely to adopt than either lesbian or heterosexual couples (Prokos & Keene, 2010). These observations are likely connected to the societal stereotype that women are more interested in and capable of child caretaking than men. When gay men elect to become parents, they challenge the conventions of masculinity and paternity presumed in society (Stacey, 2006). It is assumed that gay men, like heterosexual men, are not socialized to serve as child caretakers; and unlike heterosexual men, gay men cannot rely on women to perform these caretaking responsibilities for them. These societal stereotypes create barriers to adoption for gay men (Ritter & Terndrup, 2002; Stacey, 2006).

A description of sex differences in the absence of a discussion of sexism would be incomplete. As in the case of minority racial/ethnic and non-heterosexual identity, sexism has been identified as an additional source of stress and discrimination (Adams, et al., 2005; Bowleg, et al., 2003). However, as indicated in preceding discussion, multiple identities have potential protective factors for psychological well-being through a variety of mechanisms. Bowleg et al. (2003) qualitatively examined the issue of "triple jeopardy" with Black lesbians, representing the intersection of multiple minority identities. In spite of the small sample size (n= 19) and restricted recruitment practices, their study provides insight into how these women negotiate stress associated with

sexism, racism, and heterosexism. Results revealed that these women demonstrated resilience, despite the stress associated with their multiple identities. For example, participants identified their families and the Black community both as buffers and stressors. To cope with the stresses of their communities, participants reported a variety of strategies used to construct protective environments, such as seeking out Black lesbian resources. Lastly, participants endorsed a variety of internal resiliency factors, such as spiritual characteristics, feelings of uniqueness, self-esteem, behavioral and social competencies, and happiness, optimism, and humor. Participants also engaged in a variety of coping skills honed by previous experiences managing oppression, such as actively and directly confronting oppression, assessing their power to change situations, not allowing others to define reality for them, and choosing not to bear the burden of other people's bigotry (Bowleg et al., 2003).

In another qualitative study of gay and lesbian Latino individuals, Adams et al., (2005) identified a number of themes that fostered resilience in the face of discrimination, including: (a) viewing life's challenges as an opportunity for personal growth; (b) understanding that others' attacks are opinion rather than fact; (c) a yearning to thrive and excel in the face of challenges; and (d) feelings of independence and autonomy.

Older LGB adults. Addis, Davies, Greene, MacBride-Stewart, and Shepherd (2009) completed a meta-analysis of 66 journal articles on the topic of older LGBT adults. Findings demonstrated that partners and friends were a critical element of social gay networks (Shippy et al., 2004) and that daily support was provided by current or ex-partners and friends, rather than family members, even when estrangement was not the case (White & Cant, 2003). With regards to living arrangements, older gay and lesbian

individuals were reportedly more likely to live alone than their heterosexual peers. This is, in part, linked to the reality that older gay and lesbian individuals tend to delay entering residential care. Though most older adults have reported concerns about a loss of independence, lesbian and gay older adults who have historically experienced discrimination, dread dependence on social care and institutions that have long discriminated against them (Addis et al., 2009; David & Knight, 2008; Fredriksen-Goldsen & Muraco, 2010). Moreover, older LGB individuals who have spent the majority of their life protecting the privacy of their sexuality, living arrangement, and other circumstances are likely to have greater concerns regarding social care institutions, as obtaining services may increase the risk of "outing" LGB individuals by healthcare providers (Addis et al., 2009). Johnson, Jackson, Arnette, and Koffman (2005) found that 73% of respondents held the belief that discrimination existed in retirement facilities, 60% of respondents did not believe they truly have equal access to social and health services, and 34% assumed that they would have to hide their sexual identity in a retirement facility. One hypothesis for the discrimination experienced by LGB older adults is the notion that society prefers to view older individuals as asexual. Given that gay and lesbian individuals are often viewed in relation to their sexuality, it follows that they would experience greater homophobia than their younger counterparts (Claes & Moore, 2000).

For many older non-heterosexual men, passing as heterosexual has been a survival technique and the only way in which they have historically been able to circumvent stigma, discrimination, and even hate crimes (Addis et al., 2009; Fox, 2007). This conviction drastically shifted after the AIDS activism movement in the 1980s, in

which numerous non-heterosexual men spoke out against the socio-cultural silencing of LGB individuals. For this generation and the generations following, feigning heterosexuality represented amplification of the marginalization of the LGB community. Given that passing as heterosexuals increased their safety and survival, it is reasonable that older non-heterosexual men struggle to understand why the later generations take pride in baring their same-sex orientation (Fox, 2007; Hajek & Giles, 2002). As a result, many older non-heterosexual men grapple with the resurgence of the term "queer," which exemplifies generational differences.

A number of competing theories exist in the literature pertaining to gay aging; two well documented are the accelerated aging theory and crisis competence theory. The accelerated aging theory contends that gay men view themselves as older at a time when heterosexual men do not. As a result, older gay men may retreat from the community due to their fear of rejection or being perceived as sexual predators, producing feelings of isolation and despair (Hajek & Giles, 2002; Schope, 2005; Quam & Whitford, 1992). Unfortunately, fears of aging may be exacerbated by the seeming invisibility of older gay men from gay culture (Hajek & Giles, 2002). The crisis competence theory, on the other hand, argues that gay men are more capable of effectively coping with aging than heterosexual men, as a result of acquired skills that help one to cope with adjustment during the coming out process (Schope, 2005). It appears that lesbian women do not experience the aging process in the same way. Older lesbian women are more likely welcomed, respected, and appreciated among members of the younger lesbian community (Schope, 2005). Despite these differences, gay men and lesbians expressed fears associated with growing old in the absence of a traditional family and concerns

regarding being alone in old age (Schope, 2005). Lastly, financial issues may also present a concern for older LGB individuals who may experience anxiety about completing documentation to claim benefits for a partner if their relationship is not public (Addis et al., 2009). Moreover, the financial effects on a partner caring for a significant other with a disability may remain unrecognized due to separate living arrangements or the absence of legal documentation (Addis et al., 2009; Ritter & Terndrup, 2002).

Religiosity. Research focusing on the intersection of religion and same-sex attraction demonstrates that numerous factors, such as type of denomination, religious tradition, rate of attendance, and literal views of the bible and images of God, affect attitudes towards LGB individuals (Balkin, Schlosser, & Levitt, 2009; Whitehead, 2010). LGB individuals who were raised in religious traditions that disapprove of same-sex attraction or who reside in regions or communities where disapproving of same-sex attraction is common, face unique challenges. Exposure to non-affirming religious beliefs may contribute to LGB individuals experiencing conflict between their sexuality and their religious views (Halkitis et al., 2009).

To illustrate these challenges, Barton (2010) conducted a qualitative analysis of 46 non-heterosexual individuals who reside in the region of the U.S. referred to as the "Bible Belt." The following findings were reported: (a) participants described their situation as "stuckness" due to their inability to change their sexual orientation, despite their persistent effort to do so; and (b) approximately 50% of the participants reported enduring psychological distress as a result of their fears of rejection by God and marginalization by society. When treating sexual minority persons, it is important to

consider their religious views and how these views may conflict with their non-heterosexual orientation (Haldeman, 2002).

Halkitis et al. (2009) conducted a study exploring the religious and spiritual practices among lesbian, gay, bisexual, and transgender individuals, as well as the meaning they ascribed to religiosity and spirituality. Although over three-quarters of the participants in the study were raised in religious households, only about one- fourth reported holding a current membership in a religious institution. They also found differences among maintenance of a religious affiliation; Christians and individuals raised in European religions were more likely to change their religious affiliation than other religious groups (Halkitis et al. 2009). Furthermore, when defining religion, participants focused on structured and communal forms of worship (Halkitis et al., 2009). When defining spirituality, on the other hand, participants focused on relational features, specifically the relationship of God or a higher power with self and others (Halkitis et al. 2009).

Disability status. Disability research has demonstrated that disabled individuals are susceptible to stigma and discrimination in a variety of life domains, such as housing, employment, public facilities, leisure activities, and social interactions (Gouvier & Coon, 2002). The research demonstrates that the discrimination experienced by disabled individuals has psychological consequences (Corrigan & Watson, 2002). Moreover, the inability to accept one's disability may negatively influence the psychological and physical health of the individual (O'Toole, 2000; O'Toole & Brown, 2003; Whitney, 2006). Although once viewed as a linear process, the integration of a disability identity is now understood as a dynamic experience that is influenced by factors both internal (e.g.,

fear of rejection by others and self-stigma) and external (e.g., prejudice and discrimination) to the individuals (Corrigan & Watson 2002).

When one's disability status intersects with an LGB identity, the exploration of sexual expression is impacted. With the exception of HIV/AIDS, literature concerning disability status or chronic illness in LGB individuals is virtually absent (Fraley, Mona, & Theodore, 2007; Jowett & Peel, 2009; O'Toole, 2000; O'Toole & Brown, 2003; Whitney, 2006), yet the convergence of these two identities brings about a number of unique challenges for disabled LGB individuals.

Various authors have noted that LGB persons with disabilities are often marginalized within the LGB communities (Fraley et al., 2007; O'Toole, 2000; O'Toole & Brown, 2003). Additionally, not unlike any other group, the disability community is not impervious to homophobia. Fraley et al., (2007) discuss barriers resulting from the double minority status of LGB individuals, including barriers to sexual expression, obstacles to establishing sexual relationships, absence of positive role models, and the lack of available resources.

In a survey study of the intersection of sexual orientation identity and disability status or chronic illness, Jowett and Peel (2009) analyzed responses of 190 self-identified non-heterosexually oriented individuals suffering from chronic illness from eight different countries. Although the sample differed on a number of factors (i.e., illness, genders, sexual orientation identification, and country of residence), there were also a number of common experiences found among the respondents. Specifically, the sample shared similar experiences of oppression, a sense of invisibility, and feelings of isolation. Discrepancies among illness framed as 'gay/lesbian health issues' versus those that are

not were highlighting, leaving individuals with illness and disability outside of this frame, ignored within the community. Both feeling of isolation within the LGB community and discomfort participating in support groups with a primarily heterosexual membership were common issues that arose. Overall, the analysis highlights the lack of representation, support and community available for LGB individuals with disability and/or chronic illness (Jowett & Peel, 2009).

Literature concerning disabled lesbians is virtually non-existent and these women may have to face multiple layers of discrimination (O'Toole, 2000; O'Toole & Brown, 2003). Feelings of alienation or lacking community support that many lesbian women with disabilities experience can lead to internalized ableism. In a lead study investigating perceptions of identity in disabled lesbian women, findings indicated that women viewed their sexual orientation as a positive aspect of their identity while they tended to view their disability status in a less favorable light (Whitney, 2006). Although the lesbian community has been a long time pioneer in affirmative action for women with disabilities, these women still face many problems (O'Toole, 2000; Whitney, 2006). For example, disabled women challenge the foundation of the lesbian community's value of self-reliance and autonomy (O'Toole, 2000).

Research Objectives

There is a dearth of research pertaining to the unique issues and experiences of LGB individuals (Pachankis & Golfried, 2004). It is no surprise, then, that novice and more experienced therapists feel ill-equipped to competently serve the needs of non-heterosexual persons. Moreover, given this lack of understanding, it is natural for citizens of the LGB community to view the field of psychology with skepticism. Yet,

virtually every therapist will encounter client issues regarding sexual orientation at some point in their career (Garnets, et al., 1990; Godfrey et al., 2006).

The initial impression a client formulates about the therapist is important to establishing a fruitful working alliance between therapist and client (Alcazar-Olan et al., 2010). The initial stage of the therapeutic process involves an emphasis on rapport building as well as the initial collection of client data to facilitate the identification of client needs, establish an overview of the client's background and experiences, and prioritize and plan the course of treatment. The traditional intake interview protocol is fraught with heterocentric assumptions, which fails to provide an experience that affirms the sexual orientation identity of non-heterosexual clients or potentially overlooks issues relevant to competently serve the psychological needs of LGB clients. This dissertation offers recommendations for a more LGB affirming initial therapeutic experience for non-heterosexual clients. More specifically, this dissertation addresses the following:

1. Critiques current practices for conducting intake interviews, including the assumptive world of the interviewer, the content of the interview itself, and how interview data are used to inform practice.
2. Offers recommendations for both process and content for engaging in an LGB affirming initial intake interviewing experience.

Chapter 2. Review and Analysis Procedures

With the support of the literature, this dissertation addressed two objectives: (a) critiqued current intake practices, and (b) proposed recommendations for engaging in an LGB affirming intake interview. The following discussion delineates the plan for ensuring a comprehensive literature review and the procedure for evaluating the clinical recommendations for engaging in an LGB affirming intake interview.

Identification and Acquisition of Relevant Literature

Data sources. The review of the literature relied on research published in the following literature databases: JSTOR, PsycINFO electronic database, PsycArticles, ProQuest databases, Psychiatry Online, and Sage Journals Online. Worldcat was used to identify books on the topic of psychological assessment and treatment of LGB individuals and heterocentrism. Also, credible online sources such as information available through professional organizations like the American Psychological Association, Division 44, Society for the Psychological Study of Lesbian, Gay, Bisexual, and Transgender Issues, were considered. In order to evaluate the existing literature, empirical studies (quantitative, qualitative and meta-analytic studies), theoretical papers, and literature reviews published in peer reviewed academic journals were utilized. Although the search gave priority to the most current resources available, the search was not confined to a particular time span due to the scarcity of information on heterocentrism and the assessment and treatment of LGB individuals as well as the need to provide a historical context for understanding heterocentrism in American social, political, and psychological institutions.

Search strategy. Words and phrases used to conduct the search included "LGB/ gay/lesbian/bisexual and assessment/therapy/treatment/interventions/mental health outcomes;" "LGB affirming therapy/interventions; "LGB/lesbian/gay/bisexual and ethnicity, religion, age, gender differences; disability status" "Lesbian and Gay and differences;" "LGB and history and mental health field/ psychology;" "mental health field/ psychology and heterocentric attitude/heterocentric values/heterocentric assumptions," "Bisexual/Mental Health," "Bisexual/Affirmative psychotherapy/interventions," "Bisexual/Ethnic Minority" and "Bisexual/Persons of color." Only articles published in the English language were included.

Data Management Strategy

The review of the relevant literature is organized as follows. The search for additional literature continued until the research objectives were met.

1. The review begins with an introductory historical overview of how members of the LGB community have and continue to be treated by society.
2. The first major heading, *Consequences of Heterosexism on the Lives of LGB Individuals*, framed within the minority stress model, discusses the potential emotional consequences of coping with oppression and marginalization.
3. The second major heading, *LGB Individuals and the Field of Psychology*, provides a historical overview of how heterosexist views have influenced foundational psychological theories for understanding non-heterosexual individuals as well as discusses more contemporary perspectives of sexual orientation.

4. The third section, *Perceived Competency of Therapists Treating LGB Clients,* discusses the perceived competence of therapist's in the assessment and treatment of LGB individuals, as well as the LGB community's view of their experience with receiving mental health services.
5. The fourth section, *Current Practices in Working Clinically with LGB Clients,* discusses the current assessment and treatment practices of mental health professionals, including LGB affirmative therapy and practices.
6. The last section, *Intersection of Multiple Cultural Considerations,* reviews the existing, albeit limited, body of literature on the intersection of sexual orientation and ethnicity, sex differences, age or generational differences, religiosity, and disability status.

Data Analysis Strategy

Two major sources of evidence were considered in addressing the research objectives of the dissertation. First, the literature identified and synthesized underwent the following analysis for content.

1. Identification of common issues that may be introduced when providing services to LGB clients; only issues that triangulate across two or more scholars or sources were considered (Creswell, 2007).
2. The identified issues underwent peer debriefing with the researcher's dissertation committee members to further establish credibility (Creswell, 2007; Mertens, 2005).

The second source of evidence is the collection of intake items suggested for inclusion in intake interviews that exist in textbooks, online, or other clinical training materials.

Taking into account the issues identified from the literature, these intake interviews were evaluated by the researcher.

Based on the information from these sources of evidence, recommendations for the development of a LGB affirming intake interview protocol are proposed. The protocol includes both issues related to process and content. Finally, the proposed recommendation underwent an evaluation by mental health professionals with expertise in the treatment of LGB clients, who served as external peer debriefers (Creswell, 2007; Mertens, 2005).

Evaluation of Proposed Clinical Recommendations

Selection criteria. To obtain an external evaluation of the recommendations proposed by the researcher, 5-10 mental health professionals were sought to serve as peer debriefers. After inviting 47 professionals, 5 mental health professional accepted the invitation. To qualify as a peer debriefer, the professional had to possess scholarly and/or practical experience with addressing the psychological needs of LGB clients. Specifically, the professional had to be in an academic appointment for at least 2 years during which scholarship on LGB issues had been produced; or the individual had to be licensed for a minimum of 2 years in his or her profession.

Among the professionals who volunteered to serve as peer debriefers, 3 were Clinical Psychologists and 2 were Licensed Clinical Social Workers, with the following reported years of licensed professional practice: 4, 4, 12, 16, and 38. Four of the 5 debriefers published or presented papers to professional audiences on issues related to the treatment of LGB clients.

Recruitment procedure. Upon obtaining approval from the Graduate and Professional School Institutional Review Board, an email invitation was forwarded to a list of professionals who were identified as experts in the field (see Appendix C). The email included the following: (a) some of the standard IRB related disclosures such as the voluntary nature of accepting the invitation, the inconvenience of participation (i.e., potential risk), and the peer debriefer not benefitting from the experience; (b) information about the researcher, her faculty advisor, and the investigation; (c) the purpose of the invitation; (d) a brief description of what the debriefers will be requested to do and the approximate time commitment required; and (e) the questions posed to elicit the debriefers' opinions on the recommendations proposed by the researcher. In addition, the questions were included as an attachment to the email for the convenience of those individuals who prefer responding in a Word document rather than replying to an email. Finally, a portable document format (pdf) copy of the clinical recommendations was also attached. Appendix D lists the responses to each of the questions asked of the debriefers as well as the action taken by the researcher to address their feedback.

Chapter 3. Clinical Recommendations for Engaging in LGB Affirming Intake Interviewing Practices

Introduction

Although empirical research in the area of affirmative approaches to working with LGB individuals has increased dramatically in the last decade, many questions remain unanswered. Moreover, there are no known guidelines for best practices specific to conducting the initial intake interview in a manner that affirms LGB clients. There are often subtle, and some not so subtle, heterosexist assumptions embedded in the standard queries included in intake interviews. The history of pathologizing non-heterosexual orientation and heteronormative assumptions that pervade the field generate understandable reservations regarding the profession for LGB individuals. In the absence of creating an affirming initial therapeutic experience, there may be no opportunity for treatment.

Conducting the intake interview is a critical stage of the clinical process. First, it is often the first "real" encounter with the clinician, so the interactions of this initial encounter often influence the development of the therapeutic relationship between client and clinician. In the worst case scenario, this encounter may influence whether the client elects to return for further therapy, now or in the future. Even in cases where the individual who conducts the interview may not necessary provide the therapy, first impressions matter and may make the difference between returning for treatment or not. Moreover, even if a client elects to return, he or she might enter into the therapeutic relationship with negative preconceptions about the therapist based on this initial experience. Second, the information uncovered during the intake interview provides

clarity on the client's presenting problems, identifies areas requiring further assessment, and guides planning the course of treatment.

The proposed clinical recommendations are based on an analysis of the literature on LGB affirming clinical practices, a review of intake interview protocols or intake questions commonly used in the field, and input from mental health professional who have expertise with addressing the clinical needs of the LGB communities. Prior to presenting and discussing the specific recommendations, it is important to delimit the scope of the proposed recommendations.

Delimitations of the Recommendations

Before presenting the clinical recommendations for engaging in an LGB affirming intake interview experience, it is important to acknowledge the following delimitations to the scope of the discussion:

1. It is important to acknowledge the assumption that same-sex attractions, feelings, and behaviors are normal variants of human sexuality and that sexual orientation is complex, multidimensional, and fluid over time (APA, 2011; Kaiser Permanente, 2004; King County, 2011; Lyons et al., 2010: Ministerial Advisory Committee, 2009).
2. Although the recommendations focus on the needs of the LGB community, it is important not to assume that one's LGB orientation will be an issue of interest or a relevant concern to the client's presenting problem. In other words, clinicians are cautioned against misattributing a client's distress to their sexuality.
3. The recommendations are not intended to make clinicians unfamiliar with the LGB community competent to serve this population, but rather to increase

awareness of ways in which clinicians can establish an affirming therapeutic relationship and conduct the intake assessment in an inclusive manner without overlooking or misinterpreting critical information.

4. The intent of the proposed recommendations is to focus on the clinical and contextual issues that may have unique relevance to understanding the needs of LGB clients. Although the literature demonstrates a higher prevalence of particular mental health issues (e.g., substance abuse, suicide risk) among members of the LGB communities, inquiring about the existence of these clinical issues is a standard practice in conducting any intake interview. Hence, the recommendations are intended to supplement customary assessment practices. The increasingly common addition of the "T" (transgender), "Q" (queer and/or questioning), and "I" (intersex) to the LGB is demonstrative of the conflation of sexual minority (and gender minority) concerns under a shared umbrella. As clinicians, it is important that we understand the differences between and within these communities (Gay and Lesbian Medical Association, n.d.; Ministerial Advisory Committee, 2009; Walker & Prince, 2010). The recommendations offer general guidelines and were not intended to specifically address the cultural heterogeneity between group and the idiographic dimensions of experience with which each client presents.
5. Finally, the recommendations are neither intended as absolute or prescriptive nor an all-encompassing, universally applicable standard for conducting the intake interview. The proposed recommendations provide a basis from which clinicians can adapt their intake practices to more effectively affirm the personhood of LGB

clients. Moreover, the use of the recommendations devoid of consideration of cultural and linguistic differences introduces the danger of alienating or being misunderstood by clients. This is a particularly important cautionary note since the research with LGB individuals, like much of the psychological research, relies on predominately White, English speaking samples; hence, the recommendations may reflect this bias. As such, the recommendations must be considered hand-in-hand with the particular contextual, cultural, and linguistic considerations of the client; all available sources of clinical data; and the newly emerging clinical research data.

What Do We Mean By LGB Affirming Practices?

To appreciate the relevant clinical issues, it is important to gain an understanding of the historical context and concomitant LGB affirming practices. The following discussion offers this contextual understanding.

LGB individuals and the field of psychology. The pathological view of same-sex attraction, wherein etiology has been attributed to dysfunctional family dynamics, permeated the psychological literature throughout the twentieth century (Herek & Garnets, 2007; Robertson, 2004). During this time, the view of same-sex attraction has transformed from a "sociopathic personality disturbance" (APA, 1952, pp. 38-39), to a deviant state of sexual attraction which can be "cured" (Callahan & Leitenberg, 1973; Morin, 1977; Robertson, 2004), and finally to our current understanding of non-heterosexual orientation as a normal variant of sexual attraction (APA, 2011). Present-day literature has established that it is the incessant discrimination and oppression

experienced by non-heterosexual individuals that can affect the mental health of LGB individuals, not one's sexual orientation itself (Greene, 2005; Phillips, et al., 2003).

Contemporary models of non-heterosexual identity development have come a long way since the traditional linear, stage-sequential models of development (Rosario et al., 2009; Savin-Williams & Diamond, 2000). Current models have highlighted the variability that occurs in sexual identity development, demonstrating a great deal of heterogeneity in the timing and sequence of sexual identity milestones (Floyd & Stein, 2002; Rosario et al., 2006; Rosario et al., 2009; Savin-Williams, 2001; Savin-Williams & Diamond, 2000). Contemporaneous research has emphasized the multiplicity and fluidity of sexual orientation. Such research has facilitated an understanding of sexual identification which rest on a continuum, rather than the previously accepted categorical conceptualization of sexual identification which contended that sexual identification fell into one of three categories – heterosexual, bisexual, or homosexual (Diamond & Butterworth, 2008; Savin-Williams, 2001).

In spite of such great advancements in the understanding of same-sex attraction, the vestiges of heterosexism, homonegativity, and binegativity subsist in the field of psychology, which inevitably continue to influence the assessment and treatment of LGB individuals (Boysen & Vogel, 2008; Greene, 2005). Recognizing the marginalization that non-heterosexually oriented individuals endure, provides a context for understanding the increased prevalence of mental health problems, including anxiety, mood and affective disorders, substance use disorders, and suicidal ideation and attempts within this community (Cochran et al., 2003; Herek & Garnets, 2007; Meyer, 2003).

Current practices in working clinically with LGB clients. The diagnostic assessment and treatment of LGB individuals has been an area requiring attention. Heterocentric language in intake forms and assessment measure, inadequate norms, and overt and subtle biases and other forms of heterosexism are all issues that can potentially lead to inaccurate interpretation of the data, setting in motion the peril of over-pathologizing the client or overlooking key clinical issues germane to understanding the client's needs (Eubanks-Carter & Goldfried, 2006; Prince, 1997). Contemporaneous literature indicates that clinicians must engage in affirmative therapeutic practices when working with LGB individuals. In fact, the California State Senate recently passed legislation that took effect on January 1, 2013, prohibiting reparative therapy with individuals under age 18 in response to the stance of the American Psychiatric Association that reparative therapies pose serious risks to the mental health of LGB individuals, including the exacerbation of anxiety and depression symptoms and self-destructive behaviors (Leff, 2012). Subsequently, similar legislation has been proposed in Pennsylvania ("Philly," 2012), and New Jersey (Bolcer, 2012). Affirmative practices promote self-acceptance through a discovery process, which promotes integration of experience with one's sexual minority identity and assesses and expands one's internal and external resources (Atkinson, et al., 1981; Burkell & Goldfried, 2006; Godfrey et al., 2006; Israel et al., 2008). The following have been identified as vital elements for the application of affirmative therapeutic practice: (a) engage in advocacy, support, and empowerment of clients; (b) apply understanding of LGB development, relationships, and other relevant psychological knowledge; (c) use up-to-date research to guide practice; (d) communicate a non-pathological view of sexuality; (e) provide a safe space

for the exploration of sexuality; (f) be aware and accept one's own limitations in working with the LGB community; (g) apply an idiographic conceptualization while accounting for cultural and contextual factors; (h) create a strong therapeutic alliance; (i) approach sexuality with a holistic view; and (j) familiarize oneself with LGB resources (Dillon et al., 2008; Harrison, 2000; Pixton, 2003; Walker & Prince, 2010). In addition, affirmative therapists must recognize that LGB individuals demonstrate unique strengths and resilience factors, in the face of the unique challenges they may have to overcome (Adams, et al., 2005; Balsam, 2008). Contemporary research has established the veracity of the minority resilience hypothesis, asserting that members of stigmatized groups are able to maintain effective coping skills, self-esteem, and positive life satisfaction in the face of discrimination (Adams et al., 2005; Anderson, 199; Balsam, 2008; Cox et al., 2011; Russell & Richards, 2003; Vaughn et al., 2009). Such research has demonstrated that successfully overcoming adversity related to stigma and discrimination may be perceived as a learning experience with positive outcomes, such as personal growth and the development of personal strength (Bonet et al., 2007; Cox et al., 2011; Savin-Williams, 2008).

Intake Interviewing Process: Recommendations

Though methods and models exist to help improve diagnostic accuracy, we must deepen our understanding of the influences of sexual orientation on psychological assessment, treatment planning, and services provided so that we can apply best practices when working with LGB individuals. To discuss the relevance of sexual orientation in working with LGB individuals, recommendations are offered through a review of the literature. Accordingly, the therapeutic process is delineated into four major areas of

consideration: (a) creating an affirming environment, (b) the initial intake process, (c) important considerations specific to members of the LGB community; (d) therapist competencies, and (e) intake interview questions.

Creating an affirming environment. Creating a LGB affirming environment is essential to establishing rapport, particularly given the history of discrimination within the field of psychology. The following considerations to creating an LGB affirming environment are discussed: (a) creating a welcoming environment; (b) language; (c) confidentiality issues; and (d) referral sources.

Creating a welcoming environment. It is not unusual for LGB individuals to examine an office for signs of heterosexual bias; hence, fashioning offices and waiting areas in an outwardly welcoming manner is an important consideration to make everyone who enters the space feel comfortable (California Department of Health Services, n.d.). For example, displaying a sign with statements such as "Everyone is welcome" is a simple way to affirm others.

Whether in the office or on a website, providing resources of relevance to members of the LGB community (e.g., educational or informational brochures and pamphlets), displaying pictures or art of same-sex couples as well as heterosexual couples, exhibiting symbols associated with the LGB community (e.g., the rainbow flag or the pink triangle of the Gay and Lesbian Medical Association), and listing or advertising services in LGB directories and displaying a visible non-discrimination statement contribute toward creating an affirming experience (APA, 2011; Biaggio, et al., 2003; Bradford et al., 2012; Browne et al., 2008; California Department of Health Services, n.d.; Gay and Lesbian Medical Association, n.d.; Lyons et al., 2010; Ministerial

Advisory Committee, 2009; Regional Municipality of Waterloo, 2008; Spokane Regional Health District, 2006). Non-discrimination policies should be explicitly addressed on all consumer materials, which include a clear statement against bias based on actual or perceived sexual orientation and gender identity (Biaggio, et al., 2003; Browne et al., 2008; Kaiser Permanente, 2004; King County, 2011; Pennsylvania Department of Public Welfare, 2009; Regional Municipality of Waterloo, 2008). A policy against conversion or reparative therapy should also be adopted (APA, 2011; Pennsylvania Department of Public Welfare, 2009). Lastly, a gender unspecified restroom is recommended to avoid people from being harassed for going into the "wrong" restroom (California Department of Health Services, n.d.; Gay and Lesbian Medical Association, n.d.; Ministerial Advisory Committee, 2009; Regional Municipality of Waterloo, 2008).

Although there are obvious ways to present a more welcoming physical environment, even more important is setting the tone of safety and respect in the therapeutic relationship. Clinicians and other mental health professionals are encouraged to disarm clients' apprehension and concerns by directly acknowledging the need to ask a range of questions commonly asked of new clients, including questions that might feel intrusive or make them feel uncomfortable. But at the same time, it is important for the clinician to emphasize it is the client's choice to decline responding to questions, and that their privacy will be respected if they elect not to respond. Moreover, clinicians are encouraged to inform clients that they should feel welcome to raise questions of their own at any point in the process. Prefacing the intake interview with such a disclosure not only empowers the client but demonstrates the clinician's regard for the client's contribution to the therapeutic relationship. Overall, clinicians should strive to create a

safe and respectful environment in which clients can explore any issues they choose at their own pace.

Language. The use of heteronormative language is a challenge to creating an affirming environment. Questions regarding sexual orientation provide important client background information and should be included as part of any intake document; all consumer forms, including the intake document, should be revised to minimize the use of heteronormative language (Biaggio, et al., 2003; Bradford et al., 2012; Browne et al., 2008; Gay and Lesbian Medical Association, n.d., Kaiser Permanente, 2004; King County, 2011; Pennsylvania Department of Public Welfare, 2009). Psychologists and other mental health professionals are urged to consciously use inclusive, gender neutral language when speaking with clients about their self-identification, needs, and relationships. Terms such as *partner*, *parent*/*guardian*, or *sexual activity* can be used rather than heteronormative terms such as *spouse*, *mother/father*, or *sexual intercourse*[1] (APA, 2011; Bradford et al., 2012; California Department of Health Services, n.d.; Gay and Lesbian Medical Association, n.d.; Group for the Advancement of Psychiatry, 2011; Kaiser Permanente, 2004; Lyons et al., 2010; Ministerial Advisory Committee, 2009; Regional Municipality of Waterloo, 2008; Spokane Regional Health District, 2006). It is important for clinicians to carefully listen to how the client constructs his or her understanding of sexuality and mirror his or her terminology in discussing the client's needs. It is also important to note that some in-group or slang terminology used by the client may not be appropriate for use by the clinician and consultation may be warranted

[1] Recent judicial and political developments in Connecticut, Iowa, Massachusetts, New Hampshire, Vermont, Washington, D.C., and Canada may alter the definition of marriage and render the term "spouse" suitable in these regions (Godfrey et al., 2006; Kashubeck-West et al., 2008; Robertson, 2004).

if uncertain (California Department of Health Services, n.d.; Gay and Lesbian Medical Association, n.d.; Group for the Advancement of Psychiatry, 2011; King County, 2011; Ministerial Advisory Committee, 2009).

Furthermore, it is critical that clinicians attend to cultural factors when selecting terms to use for describing a client's sexual orientation. For example, the term *queer*, represents a derogatory term implying deviant behaviors for older LGB adults. However, the resurgence of this term holds a strong, positive sociopolitical connotation for many non-heterosexual young adults who reject distinct sexual and gender identities. Alternatively, many Latin cultures do not have a specific term to illustrate concepts such as *bisexual* or *queer*. Additionally, it is common for Latino men to define sexual orientation identity based on his role as a sexual partner. For instance, men who are recipients of oral sex or who is the penetrator in anal sex with male partners may identify as heterosexual. On the other hand, men who are the recipient of anal sex are often perceived as non-heterosexual. It is important to avoid making any assumptions during the initial intake interview, particularly related to past, current, and future sexual behaviors, sexual orientation, and degree of disclosure (Lyons et al., 2010; Pachankis & Goldfried, 2004; U.S. Department of Justice, 2006). Additionally, it is important to keep in mind that sexual behavior changes over time. For instance, clinicians must be careful not to assume that a person in another-sex relationship with children is necessarily heterosexual. An individual in a current monogamous relationship with an opposite-sex partner does not preclude the possibility that one has been or will be in a same-sex relationship, and vice versa. By assuming that a client is heterosexual, clinicians run the risk of alienating those who are not, resulting in clients not seeking the treatment from

which they might benefit. Additionally, just as in families with heterosexual parents, there are variations in blended and step-families in the LGB community. LGB individuals can become parents in a variety of ways, including having children in a previous other-sex relationship, adoption, donor insemination, and surrogate pregnancy. Clinicians need not assume that pregnant women or individuals with children are necessarily heterosexual. Experts in the field caution against conveying assumptions about past, present, or future sexual attractions and behaviors (California Department of Health Services, n.d.; Group for the Advancement of Psychiatry, 2011; King County, 2011; Lyons et al., 2010).

Although attending to linguistic considerations is important, even more critical for creating an affirming therapeutic experience is respecting how the client elects to describe or refer to oneself and his or her life experiences. Empowering the client's construction of his or her identity conveys the clinician's respect for the client's voice and minimizes the potential of the clinician making erroneous characterizations that may prove damaging to the budding therapeutic alliance.

Confidentiality issues. Issues of privacy may be particularly salient for LGB individuals who have concerns regarding disclosure of sexual orientation in medical records, as some LGB individuals may fear being "outed." Clinicians should thoughtfully review the terms of confidentiality as well as encourage openness so accurate and comprehensive information is ascertained to guide decisions regarding appropriate care (Bradford et al., 2012; California Department of Health Services, n.d.; Gay and Lesbian Medical Association, n.d.; King County, 2011; Ministerial Advisory Committee, 2009).

When meeting with an LGB client for the first time, as with any first meeting with a client, clinicians must take the time to carefully to explain what confidentiality means, how it will be protected, its limits, and who will have access to the medical records. Moreover, providers should develop and distribute a written confidentiality statement that is included with the intake forms (Gay and Lesbian Medical Association, n.d.; Kaiser Permanente, 2004; King County, 2011). But an issue that may have higher salience for an LGB client is obtaining explicit permission to document sexual orientation in the client's records. First, it is important for the clinician to ascertain if documenting sexual orientation is relevant to the client's clinical needs, and if it is deemed unimportant, it might be appropriate to omit such documentation (Bradford et al., 2012; California Department of Health Services, n.d.; Group for the Advancement of Psychiatry, 2011; Kaiser Permanente, 2004; King County, 2011; Ministerial Advisory Committee, 2009). On the other hand, if sexual orientation is considered relevant to meeting the client's needs and planning his or her treatment, it is important for the clinician to explain the relevance of documenting the information. It is important for clinicians to underscore the client's right to refuse to answer any questions that he or she prefers not to answer, while also acknowledging the value of such disclosures for planning appropriate care for the client (Kaiser Permanente, 2004; King County, 2011; Ministerial Advisory Committee, 2009).

Issues of privacy become particularly critical if the disclosure of LGB orientation to the clinician is the first time such information is revealed (King County, 2011). In working with minors, the issues related to a first disclosure are likely more common, raising challenging confidentiality issues, since parents normally have legal access to the

medical records (Kaiser Permanente, 2004). Psychologists and other mental health professionals must be aware of the legal requirements and limitations placed on their relationships with child and adolescent clients, including matters such as mandated reporting, duty-to-protect issues, and access of family members to client records.

When a minor first discloses sexual orientation to a clinician, two chief issues must be considered: the client's deliberation to disclose to his or her parents and the protection of the client's confidentiality when communicating with parents (APA, 2011; Kaiser Permanente, 2004; Pennsylvania Department of Public Welfare, 2009; Regional Municipality of Waterloo, 2008; Sanders & Kroll, 2000). First, when a client is deliberating disclosure to his or her parents, the clinician must carefully assess the family dynamics to ascertain if disclosure is in the best interest of the minor. Some parents may already suspect their child is gay/lesbian or bisexual and welcome the opportunity to acknowledge and support their child. This is not the case, however, for all parents. If rejection following the disclosure is the more likely scenario and the minor risks losing his living arrangement with his or her family, it might be more prudent to postpone the disclosure until he or she is financially self-sufficient and no longer requires the support of his or her parents. Secondly, clinicians must protect the confidentiality of child and adolescent clients when communicating with parents. A discussion regarding confidentiality with children and their parents (or other primary caregiver) should occur at the start of a professional relationship to avoid misunderstandings and/or relationship ruptures later in treatment. Moreover, clinicians should be discrete in noting sensitive information in a minor's record, confining notations only to those details directly relevant to meeting the client's clinical needs. For parents who are supportive and involved in

their child's care, clinicians should respond with sensitivity to their concerns and offer referrals for seeking their own support, if it appears clinically warranted.

Referral sources. Psychologists and other mental health professionals should be familiar with and develop a database of local LGBT referrals and other community resources (APA, 2011; California Department of Health Services, n.d.; Gay and Lesbian Medical Association, n.d.; Kaiser Permanente, 2004; King County, 2011; Ministerial Advisory Committee, 2009; Pennsylvania Department of Public Welfare, 2009; Regional Municipality of Waterloo, 2008; Walker & Prince, 2010). Whenever possible, agencies should consider LGB specific support groups (Ministerial Advisory Committee, 2009) and/or develop partnerships with appropriate local governments and community organizations in order to provide holistic treatment to LGB individuals (Pennsylvania Department of Public Welfare, 2009). Moreover, it is important to be sensitive to the client's cultural background when suggesting resources (Kaiser Permanente, 2004). Whenever possible, clinicians are encouraged to follow-up with clients on their experience with the referral to build knowledge of LGB affirmative networks.

One can begin to identify referrals sources through U.S. based national psychological organizations such as the American Psychological Association (APA); APA Division 44: Society for Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues; The Association for Women in Psychology: Caucus for Bisexuality and Sexual Diversity; and The National Latina/o Psychological Association – Orgullo Latina/o: Sexual Orientation and Gender Identity Interest Group. Additionally, a link to all U.S. state psychological associations can be obtained through the following website: http://www.apa.org/pi/lgbt/resources/associations/index.aspx. Federal resources such as

the U.S. Department of Health and Human Services (DHHS), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA) can provide invaluable healthcare information and resources specific to the LGB community. Lastly, Table 1 provides a list of LGB affirmative resources.

Table 1

LGB Affirmative Resources

Services	Phone Number	Website
American Psychological Association Resources		
APA Office of Lesbian, Gay, Bisexual and Transgender Concerns (LGBTCO) LGBTCO works to improve the health and well-being of LGBT people through the advancement of psychology, by providing support to aspects of American Psychological Association governance on LGBT related issues.		www.apa.org/pi/lgbt/index.aspx
APA Division 44 – Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues (SPSLGBTI) An organization dedicated to understanding of LGBT issues through basic and applied research in the field psychology and to the utilization of this knowledge in advocacy for the welfare of LGBT people.		www.apadivision44.org
Bisexuality		
The American Institute of Bisexuality (AIB) AIB is an institute that encourages, supports, promotes inclusion and celebration of bisexual individuals and assists research and education about bisexuality.		hwww.bisexual.org
Bi-Net USA An umbrella organization and voice that is dedicated to the promotion of inclusivity, visibility and community for non-heterosexual individuals and their allies.	1-800-585-9368	www.binetusa.org

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Bisexual Resource Center Boston based national bi organization that advocates for bisexual visibility and inclusivity, raises awareness about bisexuality, and provides education and information, resources and technical assistance.	617-424-9595	www.biresource.net
Bi.org A worldwide web portal providing links for a variety of bisexual resources, news websites, venues and forums related to a wide range of topics.		www.bi.org
Los Angeles Bi Task Force (LABTF) A non-profit organization that promotes education, advocacy, and support for the bisexual/fluid/pansexual communities in the Los Angeles Metro area.	323-860-5837	www.labtf.org
Civil/Human Rights		
Human Rights Campaign (HRC) Largest national LGBT civil rights organization, striving to end discrimination against LGBT citizens and achieve fundamental fairness and equality for all people regardless of sexual orientation.	(202) 628-4160 (202) 216-1572 TDD: (800) 777-4723	www.hrc.org
National Gay and Lesbian Task Force Organization dedicated to building the grassroots political power of the LGBT community to gain complete equality.	Cambridge, MA: 617-492-6393 Los Angeles, CA: 323-539-2406 Miami, FL: 305-571-1924 New York, NY: 212-604-9830 Washington DC: 202-393-5177	www.thetaskforce.org
Domestic Violence		
Gay Men Domestic Violence Project (GMDVP) The GMDVP is a non-profit organization founded by a gay male survivor of domestic violence with a mission to assist and support victims and survivors of domestic violence, focusing on the GLBTQ community.	1-800-832-1901	www.gmdvp.org
The Netword/LA Red A survivor-led, social justice organization that works to end partner abuse in non-heterosexual communities.	617-742-4911 617-227-4911	http://tnlr.org/

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Education		
Campus Pride Campus Pride serves leadership in campus organizations for reducing anti-LGBT prejudice and discrimination, support programs and services to create safe, inclusive LGBT-friendly colleges and universities.		www.campuspride.org
Consortium of Directors of LGBT Resources in Higher Education A consortium holding the mission to achieve higher education environments in which LGBT students, faculty, staff, administrators, and alumni have complete equity.		www.lgbtcampus.org/resources
Interweave-Unitarian Universalists for LGBT Concerns Organizations, found primarily in North American high schools and universities, that are intended to provide a safe and supportive environment for lesbian, gay, bisexual, and transgender (LGBT) youth and their straight allies (LGBTA).		www.interweavecontinental.org
National Association of Gay and Lesbian Community Centers An organization providing a wide range of informational sources and resources for LGBT consumers and treatment providers.	954-765-6024 **Fax:** 954-765-6593	www.lgbtcenters.Org
Point Foundation Provides financial support, mentorship, and leadership training to venerable students who experienced marginalization due to sexual orientation, gender identity or gender expression.	323-933-1234 TDD: 866-33-POINT 866-337-6468	www.thepointfoundation.org

Families		
AFFIRM A formal network of psychologists affirming their Lesbian, Gay, Bisexual, and Transgender family members, supporting clinical and research work on LGBT issues within psychology and encouraging sensitivity to the role of sexual orientation in all clinical and research work.		http://www.stonybrook.edu/commcms/affirm/index.html
Parents, Families and Friends of Lesbians and Gays (PFLAG) PFLAG is a national organization which promotes the health and well-being of LGBT persons, their families and friends, through resources, support and advocacy.	202-467-8180	www.pflag.org

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Children of Lesbians and Gays Everywhere (COLAGE) COLAGE is a national movement of children, youth, and adults with one or more lesbian, gay, bisexual, transgender and/or queer (LGBTQ) parent/s, which promotes social justice through youth empowerment, leadership development, education, and advocacy.	855-4-COLAGE	www.colage.org
Health Issues		
AIDS Education Global Information System (AEGIS) Clinical AIDS education global information system that is updated hourly on social and clinical information related to AIDS/HIV and other relevant contemporary issues.	1-949-495-1952	www.aegis.com
Association of Gay and Lesbian Psychiatrists (AGLP) Community of psychiatrists providing education on and advocacy for LGBT mental health issues through education and information, research, advocacy, outreach, development of resources, and direct service.	215-222-2800 Fax: 215-222-3881	www.aglp.org
Gay Men's Health Crisis (GMHC) A New York City-based non-profit community-based service organization that provides a variety of services including health information and education, legal services, and advocacy information for individuals with HIV/AIDS.	1-800-AIDS-NYC 1-800-243-7692	www.gmhc.org
St. James Infirmary Located in San Francisco, St. James Infirmary offers free, confidential, nonjudgmental medical and social services for individuals of all genders and sexual orientations.	415-554-8494	www.stjamesinfirmary.org
STOP AIDS San Francisco based organization working to reduce HIV transmission among gay and bisexual men through increasing community assets and support.	415-575-0150	www.stopaids.org
The Gay and Lesbian Medical Association (GLMA) An international organization of LGBT physicians and medical students, centered on combating homophobia and promoting quality health care for LGBT and HIV-positive individuals.	415-255-4547	www.glma.org

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The Gay, Lesbian, Bisexual and Transgender Health Access Project A Massachusetts Department of Public Health funded project that develops and implements culturally appropriate health care policies and programs for LGBT individuals.		www.glbthealth.org
Legal Issues		
American Academy of Matrimonial Lawyers (AAML) Foundation dedicated to issues of matrimonial law, including divorce, prenuptial agreements, legal separation, annulment, custody, property, valuation, support and the rights of unmarried cohabiters.	312-263-6477	www.aaml.org
Lambda Legal Defense and Education Fund A national legal organization dedication to promotion of civil rights of lesbians, gay men and individuals with HIV/AIDS.	Atlanta: 404-897-1880 Los Angeles: 323-937-2728	www.lambdalegal.org
The National Center for Lesbian Rights (NCLR) A national legal organization dedicated to advancing the civil and human rights of LGBT individuals and their families through litigation, public policy advocacy, and public education.	415-392-6257	www.nlcrights.org
LGBT Older Adults		
New England Association of HIV Over 50 (NEAHOF) An organization which promotes engagement and mutual respect among professionals in Aging and HIV policy, education and research, advocacy, prevention and care.		hivoverfifty.org/en
Services and Advocacy for Gay Elders (SAGE) An organization dedicated to improving the lives of lesbian, gay, bisexual and transgender (LGBT) older adults.	212-741-2247	www.sageusa.org
LGBT Persons of Color		
Asian Pacific Islander (API) Equality Location in California APIEquality is a statewide coordination of efforts advocating and organizing for fairness and equality in the Asian and Pacific Islander (API) and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) communities.		www.apiequality.org

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Black Brothers Esteem (BBE) BBE promotes the sexual health and well-being of African American gay and same-gender loving men through a weekly drop-in support group, workshops and community-building activities. BBE addresses not only issues of HIV, but also the challenges of poverty, substance use, homophobia and racism.	415-487-3000	www.sfaf.org/client-services/for-our-community/black-brothers-esteem
Black AIDS Institute Los Angeles based organization intended to strengthen Black organizational and individual capacity to address the HIV/AIDS epidemic in these communities by providing education, advocacy and direct services.	213-353-3610 Fax: 213-989-0181	http://blackaids.org
Black Coalition on AIDS (BCA) An organization dedicated to the advocacy, education and harm reduction for the HIV/AIDS disease of African-American people.	415-615-9945 Fax: 415-615-9943 TTY: 415-568-2082	www.bcoa.org
Latino Commission on AIDS A nonprofit membership organization dedicated to fighting the spread of HIV/AIDS in the Latino community through education, outreach, training, research and direct service.	212-675-3288 FAX: 212-675-3466	www.latinoaids.org
National Minority AIDS Council (NMAC) A non-profit organization dedicated to the development of leadership in communities of color holding the objective to end the HIV/AIDS epidemic. NMAC provides a variety of programs and services, including: a public policy education program, national and regional training conferences, a treatment and research program, numerous electronic and materials and a website.	202-483-6622 Fax: 202-483-1135	www.nmac.org
Our Love Created in 1999 by and for gay and bisexual black men, Our Love promotes social justice, education, advocacy and healthcare wellness and preventions services. Our Love offers a workshop series that addresses specific topics of interest to this community of men.	415-575-0150	www.stopaids.org/ourlove/index.html
Women Of Color Resource Center (WCRC) WCRC, in the San Francisco Bay Area, promotes the political, economic, social and cultural well being of women and girls of color in the US.		coloredgirls.live.radicaldesigns.org

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Men's Resources		
Black Brothers Esteem (BBE) BBE promotes the sexual health and well-being of African American gay and same-gender loving men through a weekly drop-in group, workshops and community-building activizrn b ties. BBE addresses not only issues of HIV, but also the challenges of poverty, substance use, homophobia, racism and other relevant issues.	415-487-3000	www.sfaf.org/client-services/for-our-community/black-brothers-esteem
Magnet An organization located in San Francisco, Magnet's vision is to promote the physical, mental and social well-being of gay men by providing education, resources, advocacy and healthcare services in the community.	415.581.1600	www.magnetsf.org
Our Love Our Love promotes social justice, education, advocacy and healthcare wellness and preventions services. Our Love offers a workshop series that addresses specific topics of interest to this community of men.	415-575-0150	www.stopaids.org/ourlove/index.html
Religious and Denominational LGBT Advocacy and Affinity Organizations		
Association of Welcoming and Affirming Baptists An association for LGBT Baptists and their allies, families, and friends fighting for inclusivity of all Baptists regardless of sexual orientation.		www.awab.org
Church Within a Church Movement A progressive Methodist movement dedicated to being a fully inclusive church, and advocating for inclusivity and egalitarianism.	773-248-3225 312-282-1556	www.cwac.us
Dignity USA Organization for LGBT Catholics and their allies, families, and friends, focused on the integration of sexuality and spirituality.	800-877-8797 202-861-0017	www.dignityusa.org
The Evangelical Network (TEN) TEN is a group of Bible believing churches, ministries, Christian workers and individuals established as a positive resource and support for Christian gays and lesbians.		www.T-E-N.org
Gay Buddhist Fellowship A forum that brings together the diverse Buddhist traditions to address the spiritual concerns of Gay men in the San Francisco Bay Area, the United States, and the world.		gaybuddhist.org

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Gay and Lesbian Vaishnava Association (GALVA) GALVA is an international organization dedicated to the teachings of Lord Caitanya, the importance of all-inclusiveness within His mission, and the Vedic concept of a natural third gender.		www.galva108.org
Institute for Welcoming Resources Ecumenical group with a purpose of providing the resources to facilitate a paradigm shift in multiple denominations whereby churches become welcoming and affirming of all congregants regardless of sexual orientation and gender identity. Sponsored by the NGLTF.	612-821-4397	www.welcomingresources.org
Integrity A nonprofit organization of lesbian, gay, bisexual, and transgender (LGBT) Episcopalians, families and other allies. Integrity is a leading grassroots voice for the full inclusion of LGBT persons in the Episcopal Church and equal access to its rites.	585-360-4512 800-462-9498	www.integrityusa.org
The Institute for Judaism and Sexual Orientation Based at a Jewish seminary, its mission is to achieve the complete inclusion and welcoming of LGBT Jews in communities and congregations and prepare Jewish leadership with the capacity, compassion and skills to change congregational attitudes, policies. Has the largest online resource on the intersection of Judaism, sexual orientation and gender identity.		www.huc.edu/ijso
Lutherans Concerned An organization working for the full inclusion of LGBT Lutherans and their allies, families and friends, in all aspects of the life of their Church and congregations.	651-665-0861	www.lcna.org
Metropolitan Community Churches (MCC) MCC's ministry is provided primarily through 222 local congregations located in 37 countries worldwide, providing a powerful voice to the LGBT community.	mccchurch.org	310-360-8640
Mosaic: The National Jewish Center for Sexual and Gender Diversity Dedicated to increasing visibility, advocacy, education and research related to LGBT Jews and their families.	303-691-3562	www.jewishmosaic.org

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Presbyterian Church (USA) National group of clergy and lay leaders working for a fully inclusive church, regardless of sexual orientation.	800-858-6127	www.pcusa.org
Reconciling Ministries Network (RMN) RMN is a growing movement of United Methodist individuals, congregations, campus ministries, and other diverse groups working for the full participation of all people, regardless of sexual orientation and gender identity, in the United Methodist Church.	773-736-5526	www.rmnetwork.org
Reconciling Pentecostals International A network of Pentecostal ministers, churches, and ministries which seeks inclusion of all Pentecostals without regard to race, gender, political persuasion, economic or educational status, sexual orientation, nationality, religious affiliation, or any other thing that divides.	219-871-1033	www.rpifellowship.com
Seventh-Day Adventist Kinship International A volunteer support organization that champions human rights for all people, which promotes the understanding, affirmation and celebration of LGBTI people through education, advocacy, and reconciliation.		www.sdakinship.org
Starjack A website for LGBT Muslim individuals and their allies, families, and friends providing information, literature, education/research, resources, and organizations.		www.starjack.com/qmr.html
Unitarian Universalist Association's Office for BGLT Concerns Unitarian Universalists organization fighting against the oppression against people of all ages, abilities, colors, and economic classes who are marginalized on the basis of sexual orientation and gender identity—whether the oppression be overt or subtle.	617-742-2100	www.uua.org/obgltc
United Church of Christ Coalition for LGBT Concerns A coalition that provides support and sanctuary to LGBT persons and their families and friends; advocates for their full and equal inclusion in church and society; and promotes justice for all people.	216-861-0779	www.ucccoalition.org

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Youth Services		
California Youth Crisis Hotline Hotline which offers support, encouragement, and referrals to youth needing assistance or in crisis situations, including but not limited to issues related to friends, family, school, pregnancy, rape, violence, depression, suicide, sexual issues, or running away.	1-800-843-5200 415-934-7757	www.youthcrisisline.org
Dimensions Clinic Organization located in San Francisco providing low-cost health Services for queer, transgender and questioning youth ages 12-25.	1-800-843-7743	www.dimensionsclinic.org
GIRLVENTURES A San Francisco based organization committed to helping young girls sustain the clarity, voice and self-confidence that they risk losing during the difficult transition to adolescence.	415-8640780 Fax: 415-861-3464	http://www.girlventures.org
LYRIC Lavender Youth Recreation and Information Center Talkline Free and anonymous talk-line which provides peer support, health and sexuality information, and referrals to youth callers throughout California.	1-800-347-TEEN	www.lyric.org
National Gay, Lesbian, Bisexual Youth Hotline Hotline that provides crisis intervention and referral services to gay and lesbian youth nationwide.	1-800-246-7743	www.glnh.org
National Youth Advocacy Coalition (NYAC) A social justice organization which that advocates with and for LGBTQ youth in efforts to reduce discrimination and increase overall well-being.	Atlanta: 404-815-0551 New York: 212-727-0135 San Francisco: 415-551-9788	www.nyacyouth.org
The Gay and Lesbian and Straight Educational Network (GLSEN) GLSEN is a national network that works with educators, policy makers, community leaders and students on the urgent need to address anti-LGBT behavior and bias in K-12 schools.		www.glsen.org
SCARLETEEN A website dedicated to providing sex education and relevant information, specifically for young women and their parents.		www.scarleteen.com
The Trevor Project A leading national organization that provides crisis intervention to LGBTQ youth.	866-488-7386	http://www.thetrevorproject.org/

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Violence		
The Violence Recovery Program (VRP) at Fenway Community Health The VRP provides counseling, support groups, advocacy, and referral services to LGBT victims of bias crime, domestic violence or intimate partner abuse, sexual assault, police misconduct and other mistreatments.	617-927-6250 **1-800-834-3242** **1-877-785-2020**	http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_srv_services_violence
Women's Resources		
Lesbian Health Research Center An Institute's located in San Francisco and housed in the University of California, San Francisco (UCSF) goals of serving women across the lifespan, and of providing research data for making public policy decisions, improving public education, facilitating vital community interventions and reducing overall LBTQ health disparities.	415-502-5209 Fax: 415-502-5208	www.lesbianhealthinfo.org
Lesbian and Bisexual Women's Sexual Health An institution maintaining the goal of providing information and resources regarding sexual health and STDs in women who have sex with women and to further the overall collective knowledge about lesbian STDs through research.	206-731-3679 Fax: 206-731-3693	www.lesbianstd.com
Mautner Project Organization that improves the health of lesbians and their families through advocacy, education and training, research, and direct service.	202-332-5536	www.mautnerproject.org
The National Center for Lesbian Rights(NCLR) The NCLR is a national legal organization dedicated to advancing the civil and human rights of LGBT individuals and their families through litigation, public policy advocacy, and public education.	415-392-6257	www.nlcrights.org
National Organization For Women (NOW) NOW is the largest women's rights organization in the U.S. dedicated to obtaining full equality for women in society regardless of gender or sexual orientation, including advocacy in areas of reproductive rights, violence against women, economic rights, eliminating sexism, LGBT rights, education discrimination, homemaker's rights, the needs of women and their children, older women's rights, the rights of disabled women, the equal rights amendment, and more.		www.now.org

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Women of Color Resource Center (WCRC) WCRC, headquartered in the San Francisco Bay Area, promotes the political, economic, social and cultural well being of women and girls of color in the United States.		coloredgirls.live.radicaldesigns.org
The Women's Community Clinic Located in San Francisco, the Women's Community Clinic's mission is to improve health by providing free, respectful, quality care for women and by women.	415-379-7800 Fax: 415-379-7804	www.womenscommunityclinic.org

Initial intake process. The initial intake process often times sets the tone of the relationship between the incoming client and the clinician. It is important that clinicians demonstrate attitudes that are respectful and accepting towards LGB individuals, particularly since LGB individuals may approach the assessment process with guardedness due to past mistreatment by mental health professionals (APA, 2011; Group for the Advancement of Psychiatry, 2011; Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing, 2009). Taking a mental health history often provides an opportunity to demonstrate an affirming stance towards the LGB consumer.

In a review of the literature, King et al. (2007) report subtle forms of heterosexism may prevent clients from bringing up important issues regarding their sexuality or relationships. Hence, it is important clinicians engage in personal reflection to increase their awareness of personal biases. Unexplored biases can inadvertently emerge in the therapist-client encounter, thereby reinforcing the client's feelings of internalized homophobia, biphobia, or heterocentrism. Homonegativity, for example, may take the form of a therapist assuming non-sexually monogamous relationships are lacking in devotion. This view invalidates a client who believes fidelity is based on an emotional

commitment, not sexual exclusivity. Similarly, unexplored binegativity may lead to dismissing the veracity of both-sex attraction or postulating that bisexual individuals are promiscuous.

During this initial meeting, it is imperative to create a safe, non-judgmental environment to prevent alienation (California Department of Health Services, n.d.; Gay and Lesbian Medical Association, n.d.; King County, 2011). Additionally, clinicians should be trained to ask intake questions in an affirming manner, while understanding that some individuals choose not to disclose their sexuality due to a variety of reasons, e.g., reservations due to fears of prejudice and discrimination or concerns related to confidentiality issues (California Department of Health Services, n.d.; Regional Municipality of Waterloo, 2008).

In assessing the needs of LGB individuals, a number of unique factors warrant consideration. These factors include: (a) evaluation of one's degree of disclosure of sexual orientation identity, and (b) assessment of the presenting concerns.

Evaluation of one's degree of disclosure of sexual orientation identity. In order to effectively assess the client's comfort with disclosure of his or her sexual orientation over time, it is critical to be familiar with the contemporaneous research on sexual orientation identity development. Although the research on sexual orientation identity development continues to shift, current literature highlights the multiplicity and fluidity of sexual orientation identity and describes the said development as the development as falling along a continuum (Diamond & Butterworth, 2008; Savin-Williams, 2001). Moreover, current research demonstrates that while sexual attraction may show consistency over time, sexual behaviors and sexual identity labels may change over time

(Diamond & Butterworth, 2008; Savin-Williams, 2001; Savin-Williams & Diamond, 2000). This finding has been particularly salient in research with LGB ethnic minorities (Fassinger & Miller, 2008; Rosario et al., 2004) and with both-sex attracted individuals (Botswick, 2012) and for both-sex attracted women (Diamond, 1998; Rosario et al., 2009; Savin-Williams & Diamond, 2000). Such findings highlight the complexity of understanding disclosure and have implications for ensuring an affirmative stance. For example, self-identification as a lesbian does not preclude the possibility of past, present, or future opposite-sex attractions or behaviors. Similarly, prior history of same-sex or opposite-sex relationships may or may not be accompanied by a shift in one's sexual identity labeling.

In working with both-sex attracted individuals, one's previous sexual identity labeling will play a significant role. For example, a woman disclosing bisexual attractions after identifying as heterosexual perceive same-sex attractions as aberrant, may be perceived by others as promiscuous, and may lack available resources. On the other hand, a woman disclosing bisexual attractions after identifying as lesbian may fear losing the support of her lesbian community, experience dismissal of her bisexual orientation as transitional and/or attributable to confusion, and may be accused of lacking commitment to her sexuality and community. Overall, it is critical to understand and embrace the fluidity that exists across the various domains of sexual orientation.

Gaining an understanding of an individual's level of disclosure over time can provide a great deal of insight into one's experience. Of particular importance is the client's first disclosure experience to significant individuals in the client's life. Assessing the degree of integration into the LGB community is helpful in determining the support

systems available to the client as the research has shown a positive correlation between the degree of disclosure and the level of social support; moreover, a lower degree of disclosure and higher level of concealment of sexual orientation has been associated with a higher risk of experiencing depressive and anxious symptoms (Amico, 1997; Anhalt & Morris, 1998; Balsam, 2008; Bonet et al., 2006; Schrimshaw et al., 2012). Increased integration into the LGB community can help to alleviate feelings of isolation that may occur from feeling different from others, a common experience in the early stages of sexual orientation identity development (Floyd & Stein, 2002; Rosario et al., 2009; Savin-Williams, 2001). At the same time, clinicians necessitate an understanding of the developmental adjustment problems associated with the process of disclosure, and know how to distinguish normal adjustment from unrelated mental health problems that may be exacerbated by the process of disclosure.

The degree to which an individual is comfortable with disclosure will likely change as one's social network transforms over time; hence, one must consider not only the client's current situation but also take into account his or her future situation. Many families are able to mitigate the initial disruptions that may arise from the disclosure of one's sexual orientation. Sometimes such disclosure can even strengthen the bonds within a family system. The challenge of coming out does not, however, cease after disclosure to immediate family members. As an individual transverses different segments of his or her network, coming out is a lifelong challenge in a heterosexist society. Although coming out can be a risky process, it can also be one that is empowering. An affirmative therapist supports clients so they navigate this journey in a manner that minimizes risk and maximizes empowerment. When appraising the option

of disclosure, Pachankis and Goldfried (2004) assert that psychotherapists must examine the various contexts in which the decision to come out is made by taking into account the following factors: (a) the values related to sexual orientation within each context; (b) the effect of these values on the relationship between the disclosing individual and those receiving the news; and (c) the conflict resolution mechanisms available to the disclosing individual and for those to whom the individual is making the disclosure. Additionally, clinicians can affirm the client's courage and strength in facing a life challenge that presents with a great deal of stress and uncertainty.

Assessment of the presenting concerns. In assessing the client's presenting problem, it is critical not to misattribute a non-heterosexual client's distress to issues of sexual orientation devoid of supporting evidence (King County, 2011; King et al., 2007; Regional Municipality of Waterloo, 2008). Clinicians must recognize that sexuality is one component of a person's complex life and that one's presenting problems are often not directly related to sexual orientation (King County, 2011; Group for the Advancement of Psychiatry, 2011; Pachankis & Goldfried, 2004; Regional Municipality of Waterloo, 2008). If the client does, in fact, present with concerns regarding sexual orientation identity, it is important to help clients understand their distress in the context of other impacting factors, rather than assuming sexual orientation to be the problem. In assessing if the presenting problem is related to sexual orientation identity, a more detailed assessment may be warranted, covering issues such as the following: (a) sexual orientation identity, (b) history of sexual behavior and expression, (c) degree of integration into the LGB community, (d) history of discrimination and oppression, (e) internalized homophobia, biphobia, and heterosexism, (f) intersection of multiple cultural

identities, (g) support systems, (h) coping skills, and (i) life satisfaction in the face of discrimination (Adams et al., 2005; Amico, 1997; Balsam, 2008; Kaiser Permanente, 2004; King County, 2011; King et al., 2007; Regional Municipality of Waterloo, 2008).

In the case of sexual orientation concerns, the specific nature of the concerns and the persistence and severity of the concerns require clarification. The clinician must capably identify the psychological issues that may contribute to and/or exacerbate conflicts related to sexual orientation identity. For instance, a client with obsessive-compulsive disorder may have intrusive and ruminative thoughts related to being gay that may or may not have a basis in same-sex attractions. Alternatively, a clinician must ably differentiate psychopathology that is unrelated to sexual orientation identity, e.g., a client diagnosed with bipolar disorder may engage in sexual behaviors that are otherwise indiscriminant and atypical for him or her, regardless of his or her sexual orientation.

Equally important is assessing for how the client has coped with his or her conflicts and negative emotions in the past (Adams et al, 2005; Balsam, 2008). It is not uncommon for LGB individuals to have developed internal and external resources to buffer themselves against the discrimination and oppression they have experienced. The clinician should be attuned to both adaptive (i.e., integration into supportive community, detection of positive models, and employment of self-care practices) and maladaptive (i.e. denial, cognitive and affective numbing, and substance use) coping strategies.

Important considerations specific to members of the LGB community. In working with LGB clients, there are issues that might emerge that are specifically germane to the community and should not be overlooked in the initial assessment interview. The following discussion focuses on the more salient of these issues: (a)

intersection of multiple cultural considerations, (b) family of choice, (c) legal issues, and (d) domestic violence.

Intersection of multiple cultural considerations. As mentioned previously, sexual orientation identity is only one dimension within a complex organization of an individual's identity development. The following discussion addresses specific clinical considerations in working with individuals with the intersection of other multicultural considerations with sexual orientation.

Ethnicity. The multiple minority status of LGB persons of color raises some unique identity issues that may present as an area of clinical interest, depending on the presenting concerns of the client. Examination of the literature reveals that same-sex and both-sex attracted persons of color may be more reluctant to self-identify as non-heterosexually oriented due to the fear of being ostracized by family for challenging the cultural beliefs regarding role obligations and collectivistic nature of many communities of color (Chan, 1989; Dubé & Savin-Williams, 1999). The assumption that disclosure is an individualistic expression is often incongruent with the assumptive world of collectivistic cultures (Chan, 1989). Interestingly, it has been observed that as long as one's non-heterosexual orientation is not made explicit, some communities of color demonstrate tolerance (Chan, 1989). For example, both Latino and African American communities demonstrate tolerance of the lesbian members of the community, when one's sexual orientation is left ambiguous (Wilson & Miller, 2002). In addition to the acceptance and disclosure of non-heterosexual orientation, ethnic groups may differ with regards to: (a) sexual identity milestones, (b) involvement in intimate same-sex relationships, (c) the average age of labeling same-sex attraction, and (d) the experience

of internalized homophobia/biphobia. For example, Latino youth demonstrate awareness of same/both-sex attractions at a younger age than their African American, Caucasian, and Asian-American peers (Dubé & Savin-Williams, 1999). With regards to sexual behavior, however, Asian-American youth report involvement in same-sex relationships at a later age than do African-American, Caucasian, and Latino youth. When focusing on the sequence of sexual identity milestones, African-American youth exhibit a disproportionate trend towards participating in same-sex behaviors prior to assuming a non-heterosexual identity, whereas Asian-American youth exhibit a disproportionate trend towards participating in same-sex behaviors after a non-heterosexual identity is assumed (Dubé & Savin-Williams, 1999; Grov et al., 2006). Additionally, evaluation of self disclosure reveals high levels of disclosure in Caucasian youth and low levels of disclosure in African-American and Asian-American youth, with Latino youth falling somewhere in the middle (Dubé & Savin-Williams, 1999).

Furthermore, LGB persons of color may face conflicts between their ethnic community and the LGB community, thwarting the synthesis of identities. Such research elucidates the importance of considering ethnicity when understanding non-heterosexual identity. Clinicians may run the risk of pathologizing non-heterosexual persons of color in the absence of contextualizing cultural factors. While being sensitive to the potential challenges that LGB persons of color may face is valuable, it is equally important to avoid the assumption that such challenges will necessarily result in poor health. The resilience literature has certainly highlighted the strengths that may emerge from navigating multiple minority identities, such as the cultivation of an extensive repertoire of skills to successfully cope with adverse situations as well as increased access to

resources resulting from membership in multiple communities (Adams et al., 2005; Bowleg et al., 2003; Huang et al., 2010; Russell & Richards, 2003).

Sex. Differences in earning power, career choice, and adoption rates are salient issues that arise within the literature when taking into account the intersection of sex and sexual orientation (Badgett, 1995; Gedro, 2009; Prokos & Keene, 2010). For example, the traditional business culture, which values masculinity, has undoubtedly contributed to the elevated rates of poverty among same-sex female couples (Gedro, 2009). Same-sex male couples, on the other hand, are often confronted with the societal stereotype that men are less capable of child caretaking than are women, frequently creating significant barriers to adoption for same-sex male couples (Ritter & Terndrup, 2002; Stacey, 2006). Furthermore, the intersection of sex and sexuality may be further complicated by the intersection of other cultural factors. For example, a self-identified Chinese-American lesbian may feel conflicted between the rejection of traditional gender role conformity values within the lesbian community and the traditional beliefs regarding role obligation valued within the Chinese community.

Aging. LGB older adults face a number of challenges, including managing societal perceptions of older individuals as asexual, while possessing a personal identification leading them to be viewed in relation to their sexuality (Claes & Moore, 2000). For many older non-heterosexual individuals, concealing their sexual identity served as a survival technique, enabling them to circumvent stigma, discrimination, and even hate crimes (Addis et al., 2009; Fox, 2007). Beliefs related to concealment of sexual identity drastically shifted after the AIDS activism movement in the 1980s, characterized by contesting the socio-cultural silencing of non-heterosexual individuals

and combating the marginalization of the LGB community (Fox, 2007; Hajek & Giles, 2002). Such generational effects significantly impact the differences in values, beliefs, lifestyles and fears among generations. Historical context also influences language common among the different generations. For example, the resurgence of the term *queer*, commonly used among LGB youth, is often perceived as a derogatory term associated with political radicalism among older LGB adults.

Furthermore, beliefs and principles about aging significantly differ among the gay, lesbian, and heterosexual communities (Hajek & Giles, 2002; Schope, 2005; Quam & Whitford, 1992). Literature regarding the aging process among bisexual persons is virtually non-existent, illuminating the invisibility of this community. Understanding the distinct challenges that LGB individuals may face throughout the aging process, as well as the resources available to increase support within these communities, are critical factors in working with LGB older adults. In spite of the differences found among gay and lesbian older adults, a number of similarities have been uncovered. These include fears associated with growing old in the absence of a traditional family and concerns regarding being alone in old age, dependence on social care and institutions that have long discriminated against them, concerns related to maintaining the concealment of one's sexual orientation, and financial strains resulting from legal restrictions on the caretaker of the significant other with a disability (Addis et al., 2009; David & Knight, 2008; Fredriksen-Goldsen & Muraco, 2010; Ritter & Terndrup, 2002; Schope, 2005).

Religiosity. When treating sexual minority persons, it is important to consider their religious views and how these views may conflict with their non-heterosexual orientation. For example, research has demonstrated feeling of shame, depression, and

suicidal ideation resulting from religious conflicts (Haldeman, 2002). For these individuals, the resolution of dissonance between their non-heterosexual and faith-based identities is crucial, for their religiosity/spirituality may serve an important protective function in their lives. The attitudes expressed toward LGB individuals may be influenced by a number of religious factors, such as the religious tradition, denomination, frequency of participation, and religious doctrine (Balkin et al., 2009; Whitehead, 2010). Regardless of the presenting factors, clinicians must be cautious in making assumptions regarding the need to make a choice between non-heterosexual orientation and religious affiliation.

Disability. Study dedicated to LGB persons with disability has been grossly overlooked in the research literature, bringing to light the invisible nature of this subgroup (Fraley et al., 2007; Jowett & Peel, 2009; O'Toole, 2000; O'Toole & Brown, 2003; Whitney, 2006). Nevertheless, the intersection of LGB status and disability raises a number of unique challenges for these individuals. For example, these individuals often experience rejection from both the LGB and the disability communities; they may face unique issues in their sexual relationships; and they encounter limited information on sexuality, inadequate resources specific to their needs, and few positive role models (Fraley et al., 2007; O'Toole, 2000; O'Toole & Brown, 2003). Not unlike other groups, the disability community is not impervious to heterosexism, homophobia, and biphobia (Jowett & Peel, 2009; O'Toole, 2000); and it is not uncommon for LGB persons with disability to experience a sense of alienation and even internalized ableism (O'Toole, 2000; Whitney, 2006). This sense of alienation may be exacerbated for bisexual individuals, who commonly endure discrimination from both the heterosexual community

and the gay and lesbian communities (Botswick, 2012; Herek, 2002). Moreover, in a study of disabled lesbians, it has been observed that they must contend with the additional discord between their personal disability status and the values of independence and self-reliance that are highly prized among members of the lesbian community (O'Toole, 2000).

Family of choice. How a person's sexual orientation might have a bearing on the relationship with one's family of origin and extended family may also be a relevant clinical issue (APA, 2011; Pachankis & Goldfried, 2004). When inquiring about the client's family, it is important to broaden how the concept of family is defined and to consider the client's personal construction of family, which may include individuals who are not legally or biologically related to the client (APA, 2011; King County, 2011). Asking a question such as – "Who do you regard as close family?" – can help the clinician with this understanding. It is important to recognize that LGB individuals can become parents in a variety of ways, such as having children through a previous other-sex relationship, adoption, donor insemination, and surrogate pregnancy (Kaiser Permanente, 2004; Pachankis & Goldfried, 2004). Akin to families with heterosexual parents, LGB individuals may present as members of either simple or blended stepfamilies. It is critical that same-sex partners are acknowledged as next of kin and treated accordingly (King et al., 2007; Pachankis & Goldfried, 2004), although legal hurdles may pose challenges.

Legal issues. Same-sex couples often face exclusion from a partner's health care coverage and discrimination in health care systems for things opposite-sex partners take for granted, e.g., limitations to hospital visitation rights. When working with LGB

individuals, it is critical to have an understanding of the numerous legal impediments that may present as real life stressors, as well as become familiar with legal documents that can provide protection for the couple (Kaiser Permanente, 2004; Ministerial Advisory Committee, 2009; Spokane Regional Health District, 2006). For example, clinicians are encouraged to learn about securing an advance directive for clients living with a partner of the same sex (Spokane Regional Health District, 2006).

It is important to recognize that same-sex couples have few, if any, legal protections related to child-rearing and other family issues (Ritter & Terndrup, 2002). For example, courts tend to favor the biological parent, over the non-biological parent, in custody cases. For same-sex couples, this bias is particularly problematic since neither partner might be the biological parent (e.g., artificial insemination). Even in agreements between sperm donors and lesbian/bisexual mothers, the courts may elect to recognize the known donor as the parent, demonstrating substandard safeguards for the mothers raising the children (Ritter & Terndrup, 2002).

To further complicate the issue, some states prohibit same-sex couples from adopting or serving as foster care parents; hence, in these states, agencies may routinely advise same-sex couples to pursue adoption or foster care as a single parent rather than as a same-sex couple, while the other parent is informally designated the "co-parent" (Ritter & Terndrup, 2002). This situation becomes problematic in the event the couple separate or the adoptive parent dies, leaving little or no protections for the parent without legal standing. Psychologists and other mental health professionals are encouraged to familiarize themselves with state or local domestic partner laws and rights, although the advisement of the couple on these issues should be left to those with legal training (Ritter

& Terndrup, 2002). In an attempt to educate same-sex couples about legal methods to solve disagreements, a number of organizations (Lambda; ACLU; NCLR; Family Pride Coalition; Children of Lesbians and Gays Everywhere [COLAGE]; and Gay and Lesbian Legal Advocates and Defender [GLAD]) took part in a collaborative effort and published a set of guidelines entitled, *Protecting Families: Standards for Child Custody Disputes in Same Sex Relationships* available on the Lambda website (see Table 1).

Lastly it is important that clinicians familiarize themselves with the state laws protecting the confidentiality of unemancipated minors who may be placed at risk by disclosing their non-heterosexual identity. Under California State law,

> [T]he parent/guardian of a minor shall not be entitled to inspect or obtain copies of the minor's patient records where the health care provider determines that access to the patient records requested by the parent/guardian would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being. The decision of the health care provider as to whether or not a minor's records are available for inspection under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith. (Cal. Health & Saf. Code § 123115[a][2])

The law emphasizes the importance of protecting clients, which corresponds to the General Principle A of "Beneficence and Nonmaleficence" of the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (APA, 2010).

Intimate partner abuse. LGB individuals, like their heterosexual counterparts, may be subject to intimate partner abuse (Ministerial Advisory Committee, 2009).

Clinicians are urged to increase their understanding of same-sex partner abuse, which is a largely ignored and misunderstood issue in the field (Regional Municipality of Waterloo, 2008; U.S. Department of Justice, 2006). For example, psychotherapists should avoid assumptions such as battering occurs primarily in butch/femme couples, and it is the butch who is the perpetrator of the abuse. Abuse between partners can occur in all types of relationships regardless of identification. Screenings for intimate partner abuse should be conducted as part of the assessment process, particularly if suspicion in this regard exists (California Department of Health Services, n.d.; Gay and Lesbian Medical Association, n.d.; King County, 2011; U.S. Department of Justice, 2006). A question such as – "Do you feel safe with your partner?" – might be a less threatening way to initiate such a sensitive discussion.

Although the dynamics related to remaining in an abusive relationship may have similarities to the dynamics observed in other-sex relationships, there are also important unique considerations. For example, individuals who have not disclosed their LGB orientation to others may remain in an abusive relationship for fear of being "outed" to friends, family, and employers by the batterer (California Department of Health Services, n.d.).

Therapist competencies. Thus far, attention has been directed to awareness in creating a welcoming environment and assessing the needs of the client. It is important to recognize that in order to successfully engage in a productive therapeutic relationship, the therapist must possess a set of competencies. Although many clinical competencies apply to all clients, competencies specific to effectively serving the LGB community include the followings: (a) eliciting and engaging in disclosure in the therapeutic

relationship; (b) seeking knowledge and remaining current on research relevant to serving the LGB community; (c) engaging in self-reflective practices; and (d) respecting the heterogeneity within the LGB community.

Disclosure and the therapeutic relationship. Research on the therapeutic value of therapists disclosing their sexual orientation to the client has resulted in mixed findings. Some research has revealed that knowledge about the therapist's sexual orientation leads to increased feelings of safety and comfort and strengthens the therapeutic relationship between LGB clients and their therapists (King et al., 2007; Mair, 2003). Other research has demonstrated that LGB individuals experience a sense of relief from not knowing their therapists sexual orientation (King et al., 2007). While still other research has demonstrated knowing the sexual orientation of the therapist is not a significant influence on the therapeutic relationship (Mair, 2003). Psychotherapists should judiciously consider the advantages and disadvantages of disclosing one's sexual orientation identity for each individual client rather than following preconceived rules that are applied to all clients (King et al., 2007; Ministerial Advisory Committee, 2009). In other words, clinicians that fall across the spectrum of sexual orientation must carefully consider the implication of disclosure and be aware of the potential powerful emotionality that such a disclosure might yield.

Before disclosing one's sexual orientation, psychotherapist should reflect on the following issues: (a) why the disclosure is necessary within the therapeutic context, (b) what is gained by disclosing one's sexual orientation, and (c) what unforeseen circumstances might result as a consequence of the disclosure (King et al., 2007). For example, in instances in which LGB clients present with internalized

homophobia/biphobia and expect others (including the clinician) to feel the same way, disclosure can help to serve clients with a role model who values a non-heterosexual identity. This may be especially comforting for both-sex attracted clients who may anticipate that their orientation will be judged as unstable rather than an equally valid endpoint. On the other hand, disclosure may be contraindicated in instances where evidence indicates the likelihood that a client might engage in idealization of the clinician, inhibiting the exploration of issues related to sexual orientation. For example, a client who mistakenly assumes that his or her non-heterosexual clinician understands the client's experiences due to a shared sexual identity may limit the clinician's deeper understanding of the idiographic experiences and conflicts of the client.

Other issues may come up when the clinician and client possess different sexual orientation identities. In a study of lesbian women's perception of therapist disclosure conducted by Ryden and Loewenthal (2001), researchers found a number of instances in which participants preferred disclosure of the therapist's heterosexual orientation. In cases in which participants' safety was compromised due to a boundary violation, participants expressed a sense of comfort in knowing of their therapists' heterosexual orientation. In other instances, disclosure of a therapist's heterosexual status enabled participants to begin to explore their own internalized prejudice since they did not assume a shared understanding of sexual orientation experiences. For LGB therapists working with heterosexually-identified clients, it is important to consider the impact of the client's heterocentric statements on the therapeutic alliance (Ryden & Loewenthal, 2001). Regardless of whether the therapist shares the same sexual orientation identification as the client, it is critical to ensure that when disclosure occurs, it is in the best interest of the

client rather than resulting from clinicians' personal reactions, such as over-identification with the client, over-protectiveness, or the clinician's internal feelings of urgency that the client experience self-acceptance.

Finally, it is important to note that disclosures are not always explicit. For example, a client might infer, accurately or inaccurately, the clinician's sexual orientation identity by photographs, art, or other artifacts exhibited in the clinician's office. Hence, it is important to be mindful of such external cues and the implications of such cues for the therapeutic relationship.

Knowledge and research on serving the LGB community. Inadequate education and training on providing culturally congruent services to LGB clients have limited the availability of competent service (APA, 2011; California Department of Health, n.d.; Ministerial Advisory Committee, 2009; Regional Municipality of Waterloo, 2008). To effectively meet the psychological needs of the LGB community, psychotherapists must remain current on their knowledge of the field (APA, 2011; Gay and Lesbian Medical Association, n.d.; King County, 2011; King et al., 2007). The need to remain abreast of the field is particularly true for psychotherapists who have limited clinical knowledge and training related to sexual orientation (Bidell, 2005; Dillon, Worthington et al., 2008; Walker & Prince, 2010).

Clinicians are urged to seek additional education, training, consultation, and supervision concerning culturally competent practices when providing affirmative psychotherapy in working with LGB individuals (APA, 2011; Lyons et al., 2010; Pachankis & Goldfried, 2004; Spokane Regional Health District, 2006). Continuing education and training should consider the following topics: (a) familiarity with the

coming out process; (b) knowledge of the effects of heterocentrism, homophobia, and biphobia and how to effectively work with said concerns; (c) understanding the negative effects of societal prejudice and discrimination on LGB relationships (e.g., legal, medical, and financial barriers); (d) awareness of diverse ways families of choice are defined and come into existence (e.g., insemination, surrogacy, adoption); (e) familiarity with different relationship structures (e.g., non-monogamous relationships); (f) understanding the challenges associated with the intersection of multiple cultural identities; (g) knowledge of unique lifespan and developmental issues (e.g., older adults, youth, and persons with disabilities); (h) understanding the impact of HIV/AIDS on LGB persons; (i) knowledge regarding health disparities affecting LGB individuals; and (j) unique career development and workplace issues experienced by LGB individuals (Amico, 1997; APA,2011; Browne et al., 2008; Gay and Lesbian Medical Association, n.d.; King County, 2011; King et al., 2007; Ministerial Advisory Committee, 2009; Pachankis & Goldfried, 2004; Walker & Prince, 2010). Psychotherapists working with LGB individuals should be prepared to work with all of these issues and not depend on their LGB clients to educate them on the dynamics of lesbian, gay, and bisexual lifestyle and cultures (King et al., 2007).

Self-reflective practices. "Since heterosexism pervades the language, theories, and psychotherapeutic interventions of psychology, conscious efforts to recognize and counteract such heterosexism are imperative in order for optimal assessment and treatment to take place" (APA, 2011, p.9). Both clients and clinicians develop in a heterocentric culture and internalize heterocentric beliefs to varying degrees. Such a heteronormative stance is not necessarily mitigated by professional training and

education. Psychotherapists and other mental health professionals are urged to be conscientious of their own psychological functioning, training, knowledge, experience, and beliefs in order to minimize heteronormative bias (King et al., 2007; Regional Municipality of Waterloo, 2008). Clinicians are encouraged to regularly engage in self-reflection to explore and examine one's beliefs, assumptions, and understanding as a way to minimize implicit and explicit heteronormative biases (APA, 2011; Biaggio, et al., 2003; Kaiser Permanente, 2004; Lyons et al., 2010). Psychotherapists are urged to thoughtfully consider how best to respond to a client's self disclosure about his or her sexuality, as well as consider the therapeutic implications of the interaction (King et al., 2007; Ministerial Advisory Committee, 2009).

Self-assessment measures such as the Gay Affirmative Practice Scale (GAP), the Lesbian, Gay and Bisexual Affirmative Counseling Self-efficacy Inventory (LGB-CSI), the Attitudes Toward Lesbians and Gay Men Scale (ATLG), and the Homosexuality Attitude Scale, which evaluate the degree to which therapists engage in LGB affirmative practices, might facilitate the self-reflective process (Crisp, 2006; Dillon & Worthington, 2003). Table 2 offers a list of such self-assessment measures. Additionally, reflective process teams, in which participants explore their heterosexist biases and attitudes toward sexual minorities, have been shown to foster a deeper understanding and greater sense of comfort with sexuality related issues in preparing clinicians for work with LGB clients (Dillon et al., 2004).

Table 2

Measures for Assessing Affirmative Practices

Measure	Developer	Description	Items	Reliability/Validity Information
Attitudes Toward Lesbians and Gay Men (ATLG)	Herek G.M. (1984)	Assesses hetero-sexuals' attitudes toward gay men and lesbians	20 items requiring a 9-point Likert-scaled response for each item	The ATLG demonstrated alpha level .90 for a college student sample and an alpha exceeding .80 for a non-specific sample. The ATLG has been significantly correlated with other theoretically-relevant constructs: religiosity, lack of contact with gay men and lesbians, adherence and devotion to traditional sex-role attitudes, belief in a traditional family ideology, high levels of dogmatism and AIDS-related stigma. Discriminant validity also has been established for the ATLG.
Attitudes Regarding Bisexuality Scale (ARBS)	Mohr, J.J. & Rochlen, A.B. (1999)	Assesses two dimensions of attitudes towards bisexual men and women: tolerance and stability (of sexual orientation). Shorter versions exist that assess attitudes towards bisexual men only (ARBS-M) and bisexual women only (ARBS-F).	18 items requiring a 5-point Likert-scaled response for each item. Each of the shorter versions consist of 12 items requiring a 5-point Likert-scaled response for each item.	Internal consistency estimates were as follows: Stability, .92; Stability-F, .89; Stability-M, .90; Tolerance, .91; Tolerance-F, .86; and Tolerance-M, .83. Internal consistency reliability estimates were .89 for Stability scale and .77 for Tolerance scale. High internal consistency estimates were obtained for subscales of the three versions of the ARBS (.83 - .91). The following test–retest reliability estimates were calculated for the following subscales: Stability, .85; Stability-F, .71; Stability-M, .86; Tolerance, .91; Tolerance-F, .92; and Tolerance-M, .84.

(Continued)

Gay Affirmative Practice Scale (GAP)	Crisp C. (2006)	Assesses practitioners' beliefs and behaviors when working with gay and lesbian clients	30-items containing two distinct domains (15 items each) requiring a 5-point Likert-scaled response for each item.	The GAP has a cronbach's alpha of .93 for the belief domain and .94 for the behavior domain. Factorial validity for the GAP was demonstrated using confirmatory factorial analysis which revealed that each item loads on its intended domain at .60 or greater. Convergent construct validity has been demonstrated using Pearson's *r* correlation between the belief domain and the Heterosexual Attitudes towards Homosexuals (.624; p=.000) and the behavior domain and the Attitudes Toward Lesbians and Gay Men (.466; p=.000).
Homo-sexuality Attitude Scale	Kite, M.E., & Deaux, K. (1986)	Assesses people's stereotypes, mis-conceptions, and anxieties about homosexuals	21 items requiring a 5-point Likert-scaled response for each item	Scale demonstrated internal consistency of the instrument with alphas >.92 and internal test-retest reliability r = .71
Heterosexual Attitudes Towards Homosexuals (HATH)	Larsen, Reed & Hoffman (1980)	Assesses heterosexual attitude towards non-heterosexual individuals.	20 items requiring a 5-point Likert-scaled response for each item	Scale has demonstrated to possess a split-half correlation of .92 The HATH has been significantly correlated with other theoretically-relevant constructs, including peer attitudes, religiosity, and authoritarianism. Correlates with religious ideology, authoritarianism and feelings of inadequacy.

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Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI)	Dillon F.R. & Worthingt on R.L. (2003)	Assesses self-efficacy to perform LGB-affirmative counseling behaviors	32 items containing five distinct sub-scales requiring a 6-point Likert-scaled response for each item.	A principal-axis factor extraction analysis (EFA) was performed for scale items. Factor stability was confirmed via confirmatory factor analyses. Cronbach's alpha for each of the subscales ranged from .95-.86. Convergent and discriminant validity were also determined.
Lesbian, Gay, and Bisexual Knowledge and Attitudes Scale for Heterosexuals (LGB-KASH)	Worthingt on R.L., Dillon, F.R. & Becker-Schutte, A.M. (2005)	Assess the attitudes and knowledge of non-heterosexual individuals among heterosexual individuals.	28 items requiring a 7-point Likert-scaled response for each item.	Confirmatory factor analysis used to test for the factor structure of the measure. Cronbach's alpha for the subscales are as follows: • Hate: Alpha =.81 • Knowledge of LGB History, Symbols and Community: Alpha =.81 • LGB Civil Rights: Alpha =.87 • Religious Conflict: Alpha =.76 • Internalized Affirmativeness: Alpha =.83 Two Week Test-Retest Reliability for the subscales are as follows: • Hate: r =.76 • Knowledge of LGB History, Symbols and Community: r =.85 • LGB Civil Rights: r =.85 • Religious Conflict: r =.77 • Internalized Affirmativeness: r =.90

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Modern Homophobia Scale – Lesbian (MHS-L).	Raja, S., & Strokes, J. P. (1998).	Assesses attitudes towards lesbians.	24 items containing 3 domains [institutional homophobia towards lesbians (IHL), personal discomfort (PD) and belief homo-sexuality is deviant and changeable (BFHDC)] requiring a 5-point Likert-scaled response for each item.	Cronbach's coefficient alpha for the total measure and subscales are as follows: • IHL: Alpha =.89 • PD: Alpha = .92 • BFHDC: Alpha = .90 • Total MHS-L: Alpha = .95 Measure demonstrates evidence for criterion related validity and known-groups validity.
Modern Homophobia Scale – Gay (MHS-G).	Raja, S., & Strokes, J. P. (1998).	Assesses attitudes towards gay men.	22 items containing 3 domains (IHL, PD, and BFHDC) requiring a 5-point Likert-scaled response for each item.	Cronbach's coefficient alpha for the total measure and subscales are as follows: • IHL: Alpha =.90 • PD: Alpha = .91 • BFHDC: Alpha = .85 • Total MHS-L: Alpha = .95 Measure demonstrates evidence for criterion related validity and known groups validity.

Heterogeneity of the LGB population. It is important to recognize and respect the diversity within the LGB community and recognize that there are distinct differences between the experiences of gay men, lesbian woman, and bisexual men and bisexual women. It is equall

y important to attend to the intersection of multiple cultural considerations that reflect a wide range of dimensions such as age, sex, gender-identity, race, ethnicity,

religion, geographic region of residence or origin, socioeconomic status, immigration history and family cultural values regarding privacy, sexuality, and relationships. These multiple cultural identities can offer support, present challenges, or introduce both supportive and challenging elements. Hence, examining these identities should be an integral component of the assessment process (Gay and Lesbian Medical Association, n.d.; Ministerial Advisory Committee, 2009; Pachankis & Goldfried, 2004; Regional Municipality of Waterloo, 2008; Walker & Prince, 2010). Ritter and Terndrup (2002) recommend assessing the degree of commonality shared among one's various cultural affiliations as well as the shared elements between the client's cultural affiliations and the majority culture. By increasing the client's awareness of the common elements in their various cultural affiliations and to the majority culture, LGB clients improve their ability to effectively integrate their identities (Ritter & Terndrup, 2002). Furthermore, clinicians must ascertain the problem solving skills a client utilizes to successfully navigate within and between his or her different cultural worlds, including resources on which the client relies within his or her communities.

For LGB clients who affiliate with a number of cultural identities, the cultural values he or she elects to emphasize are typically dependent on the context at hand (Greene, 2005). This situation presents a challenge if incongruence exists among the expressed values of the individual's various cultural identities. LGB people with disabilities, for example, have minimally two identities to navigate. One identity is tied to their sexual orientation while the second identity is their disability status, which is often erroneously viewed as asexual (Claes & Moore, 2000). Similarly, psychotherapists often must negotiate the conflicting demands of affirming a client's LGB identity and

affirming the same client's religious values that assert that same-sex attraction is "wrong" (Haldeman, 2002; Halkitis et al., 2009).

Questions for consideration for inclusion in an intake interview. The questions suggested in the discussion that follows include both LGB affirming variations of common intake questions and additional questions that may be relevant to fully understanding the psychological needs of clients. The questions are offered strictly as illustrations and should not be construed as compulsory or used to supersede what is relevant and in the best interest of the client. In other words, the recommended questions should be used in conjunction with what one judges clinically relevant and appropriate queries for better understanding the client's particular needs, and the way the questions are phrased or the selection of terms may require adjustments so as to be more congruent with the cultural and linguistic needs of the client. Finally, it is important to note that not all questions are appropriate for inclusion in a standard intake form that is initially completed independently by the client. The decision as to which of the questions might be included on the form will require taking into account a number of contextual considerations, including the type of setting, the typical demographic of clients served in the setting, and common presenting problems. Moreover, due to the specific nature of some of the questions, unless the issue arises, it would be unnecessary to delve into such areas; but if necessary, these questions are best posed during the course of the intake interview or therapy session.

Affirming variations of common intake questions. The questions that follow are typically part of any standard intake interview, but often exhibit a heteronormative bias as commonly stated. To respect the personal construction of the client, it is important to

note that these questions are open-ended rather than a list of forced-choice categories. The first three questions are suggested for inclusion on most intake forms, while the fourth item is considered optional or an item best asked during the interview.

1. How do you identify your gender identity?_____

   ☐ Decline to respond

2. How do you identify your sexual orientation identity? _____

   ☐ Decline to respond

3. What is your current relationship status?

   ☐ Single

   ☐ Domestic partnership/civil union

   ☐ Married

      ☐ Married to an opposite-sex partner

      ☐ Married to a same-sex partner

   ☐ Partnered

      ☐ Partnered to an opposite-sex partner

      ☐ Partnered to a same-sex partner

   ☐ Involved with multiple partners

   ☐ Separated from partner/spouse

   ☐ Permanently separated/divorced from partner/spouse

   ☐ Widowed

   ☐ Other:_____

4. What is your preferred gender pronoun?_____

(If client appears puzzled by this question, explain why this question is asked and provide illustrations such as she/her, he/him, zie/hir, a preference for no pronouns/address me by name only, other.)

Additional questions. In the questions suggested below, the decision to include items is based on the client's presenting problems or a preliminary assessment of the client's needs. The list of questions is not intended to be exhaustive or assumed essential but to offer illustrations of how the intake process might be adapted to ascertain a more comprehensive understanding of potential LGB related clinical issues. Typically, these questions are best posed during the course of the intake interview rather than included on the intake form. Moreover, the intake process is fluid; hence, not all these items are necessarily posed early in the therapeutic relationship but rather over the course of the therapeutic process as new issues emerge and the client begins to feel safer. These questions are organized by the following themes: (a) self-acceptance, (b) disclosure, (c) couple and family, (d) cultural identities, and (e) sexual experiences.

Self-acceptance. The intake process presents an important opportunity to assess the degree to which there is an integration of experience with one's sexual orientation identity (Atkinson et al., 1981; Godfrey et al., 2006; Israel et al., 2008). When engaging in such evaluation, the client's internal and external resources and strategies for expanding his or her available resources should be assessed (Herek & Garnets, 2007). The following is a list of questions that may be useful for assessing the degree to which the client accepts his or her sexual orientation.

1. How do you feel about your sexual orientation?
2. What are the positive aspects of your sexual orientation?

3. Have you had any negative experiences related to your sexual orientation? If so, can you tell me about the circumstances and what you did to cope with the situation?
4. If you could change your sexual orientation, would you?

    Have you ever identified yourself as having a different sexual orientation than your current self-identification? If so, can you tell me more about how the change came about?

5. Have you ever sought or thought of seeking conversion/reparative therapy?

Disclosure of sexual orientation. Researchers have noted the importance of accurately assessing the degree one discloses sexual orientation identification to family, friends, and employers in order to accurately assess a client's needs and guide treatment planning (Amico, 1997; Gay and Lesbian Medical Association, n.d.; United States Department of Justice Office on Violence Against Women & LAPTOP [U.S. Department of Justice], 2006). The stress of disclosing a non-heterosexual identification in a heterocentric society is a sensitive process that may be complicated by many factors. The following questions might provide insight into his or her degree of comfort with being out.

1. Who among your family, friends, and workplace colleagues know about your sexual orientation?
2. How well have your family, friends, and work colleagues accepted your sexual orientation?

3. Do you feel your hesitancy to disclose your sexual orientation might be related to the family values with which you were raised?
4. Think about the first time you disclosed your sexual orientation to a significant person in your life. How did it go? Did it go as anticipated? How did the experience influence your willingness to disclose to others?
5. How involved are you in the LGB community?
6. Have you gained sources of emotional support as a result of coming out [*or* telling others about your sexual orientation]?
7. Have you lost sources of emotional support as a result of coming out [*or* telling others about your sexual orientation]?

Couple and family. As previously noted, the effects of a person's sexual orientation on the relationship with one's family of origin and extended family may also be a relevant clinical issue (APA, 2011; Pachankis & Goldfried, 2004). Additionally, clinicians must consider the client's personal construction of family, which may include individuals who are not legally or biologically related to the client (APA, 2011; King County, 2011). Understanding that daily support may be provided by current or ex-partners and friends, rather than family members, even when estrangement from family is not the case (White & Cant, 2003), is critical for the appreciation of one's social support networks. The following questions are suggested for assessing the family relationships of clients.

1. Who do you regard as members of your family?
2. Are you co-parenting children with anyone?
    - If yes, who is the biological parent?

- What is the current custody agreement?
- Are you experiencing any legal stressors related to child-rearing issues? If so, please describe.

3. Do you feel safe in your current relationship? Are you ever afraid of your current partner?
4. Is there a past relationship in which you didn't feel safe?
    - If yes, do you still have a relationship with this person?
    - Do you still feel unsafe now?
    - Do you share a residence with this person?
    - Do you feel safe in your home?

Cultural identities. In order to account for the complexity of an individual's identity development, the intersection of other multicultural considerations with sexual orientation, particularly ethnicity, gender, age or generational differences, religion, and disability status must be considered. A multiplicity of identities can generate positive means for coping, as well as heightened stress (Meyer 2010). To fully understand the client's worldview, an examination of the identities meaningful to the client is critical. The following are questions suggested for inclusion to examine these intersections.

1. In what ways have the values and beliefs of your ethnic culture either supported or conflicted with your sexual orientation identity?
    - If the values and beliefs have conflicted, what makes you feel that this tension exists?
    - How have you handled this tension?

2. In your experience, do you believe same-sex female couples [*or* male couples] are treated differently than same-sex male couples [or female couples]? If so, please describe.
3. Do you feel that your sexual orientation is influenced by the generation in which you were raised? If so, please describe.
4. In what ways have the values and beliefs of your religion and/or spiritual path either supported or conflicted with your sexual orientation identity?
    - If the values and beliefs have conflicted, what makes you feel that this tension exists?
    - How have you handled this tension?
5. As a member of the LGB community with a disability, do you feel that others view you as someone with sexual desires?
    - Has your disability status ever come up in your relationships?
    - Do you feel supported by the LGB and/or disability communities?
6. Do you ever feel that your sexual orientation is influenced by other cultural considerations or personal characteristics? If so, please describe.

Sexual experiences. Questions regarding sexual experiences may cause discomfort for some; clinicians must, therefore, be cautious when asking such questions. When relevant, obtaining a comprehensive history related to sexual intimacy and other sexual experiences not only deepens the therapist's understanding of the client's needs but informs the course of treatment. To understand the client's breadth of sexual experiences, the following questions might yield useful clinical insights.

1. Have you ever had a sexual experience that involves genital contact? If yes, was this experience consensual?
2. How old were you when you had your first sexual experience? How old was the other person and what was the person's gender? Describe how you felt about the experience.
3. Describe your first sexual experience as an adult.
4. Have you been sexually active in the past year?
5. Approximately how many sexual partners have you had in the past 6 months?
6. Do you have a current sexual partner or partners?
7. Have you had a sexual partner or a sexual experience that has significantly shaped your sexuality in a positive way? If so, please describe.
8. Have you had a sexual partner or a sexual experience that has negatively impacted you? If so, please describe.
9. Has a partner ever hurt you?
10. Has a sexual partner asked you to do things sexually that made you feel uncomfortable?
11. To who are you most often sexually attracted?
12. If you are dating, what is the gender of the individuals you date most often?
13. What is (are) the gender(s) of your current sexual partner(s)?
14. In the past, what was (were) the gender(s) of your sexual partner(s)?
15. Do you need any information about safer-sex techniques?
16. Are you experiencing any sexual difficulties? If yes, describe why you believe there are problems.

Summary of Recommendations

It is the intent of this discussion to suggest ways in which clinicians can conduct an intake assessment that affirms the personhood and worldview of members of the LGB community while not overlooking or misinterpreting critical clinical information. Although these recommendations are not intended to make clinicians unfamiliar with the LGB community competent to serve this population, these suggestions are offered to help raise awareness of the heterocentrism that continues to influence the profession's assessment practices and to recommend culturally responsive ways to introduce the therapeutic experience to LGB clients.

Based on a synthesis of the relevant literature and the feedback from professionals with clinical and scholarly expertise working with LGB individuals, the following is a summary of the key considerations when conducting an intake with members of the LGB community:

1. An LGB affirming environment is vital for establishing a fruitful therapeutic alliance, particularly given the history of discrimination and current heterocentrism within the field of psychology. To promote an LGB affirming environment, the following recommendations are offered:
    - Create an environment that is welcoming and engenders an atmosphere of inclusiveness. For example, include depictions in the office or on the website that portray same-sex couples and families as well as heterosexual couples and families, clearly display a non-discrimination statement, and explicitly address non-discrimination policies in all consumer materials. Minimize the use of heteronormative language by using gender neutral

references when speaking with clients and revising all consumer forms to use inclusive dialect. Mental health professionals should also avoid making any assumptions about the client's past, current, or future sexual behaviors, attractions, and orientation that might alienate a client and create a barrier for seeking necessary treatment.

- Confidentiality issues should be thoroughly reviewed, the relevance and importance of the information should be discussed, and permission to document sexual orientation in the client's records obtained after ascertaining that such information is relevant to the client's clinical needs. Special considerations are required when working with LGB youth. For example, it is imperative that the minor's privacy is protected in communications with his or her parents, and it is important to assess the family dynamics to determine if disclosure is in the minor's best interest.
- Routine research should be conducted to identify current LGB affirming local referrals and other community resources so that clinicians remain current on relevant sources and can make this information readily available to clients. When providing resources to a client, offering recommendations that are sensitive to the client's cultural background should be considered.

2. When engaging in the assessment of the client's presenting concerns, it is critical to avoid misattribution of a non-heterosexual client's distress to issues of sexual orientation without the client offering evidence to corroborate such a concern.

3. When the LGB client's presenting concerns are directly related to sexual oreintation, the clinician must identify the psychological issues that may contribute to and/or exacerbate conflicts related to sexual orientation identity.
4. Clinicians should be attuned to both adaptive and maladaptive coping strategies the client has used to cope with conflicts and negative emotions in the past.
5. Clinicians must assess a client's degree of comfort with disclosing his or her sexual orientation and integration into the LGB community in order to better undertsand the support systems available to the client.
6. Disclosing one's sexual orientation identity is a lifelong challenge in a heterosexist society and should be revisited and examined when relevant.
7. Considerations that may be relevant in the initial intake process with an LGB client include: (a) how a "family" is defined and with whom the client is close; (b) legal issues that may pose real life stressors, e.g., legal rights of partners in making health care decisions for one another or child custody in cases where neither parent is the biological parent; and (c) intimate partner abuse, which is an issue often ignored or misunderstood in the psychology field. Clinicians should be knowledgeable and remain up-to-date regarding these issues and how they pertain to the LGB community.
8. Research on whether there is therapeutic value of clinicians disclosing their sexual orientation is mixed; hence, clinicians should prudently deliberate the clinical advantages and disadvantages of such disclosure for each individual client rather than following prescribed rules that are inflexibly applied to all clients.

9. Psychotherapists and other mental health professionals must remain abreast of research available on issues relevant to the LGB community. Clinicians are also urged to seek additional education, training, consultation, and supervision to ensure culturally competent practices.
10. To minimize implicit and explicit heteronormative bias, clinicians are urged to engage in self-reflection (including the use of self-assessment measures) in order to regularly examine their own psychological functioning, training, knowledge, experience, and beliefs.
11. When working with members of the LGB community, clinicians must recognize and respect the heterogeneity within the LGB community; appreciate the distinct differences between the experiences of gay men, lesbian woman, and bisexual men and women; and attend to considerations such as the intersection of ethnicity, gender identity, age or generation, religion, disability status, and other cultural and personal factors such as socioeconomic status, which may intersect with the client's sexual orientation.

Discussion

The intake interview is the first interaction that occurs between the client and the clinician. It is from this initial encounter that the clinical relationship begins and both parties form either positive or negative impressions of one another. One's experience during this initial encounter can either hinder or encourage the client to move forth in treatment. In fact, research has demonstrated the more clients ascribe positive attributions toward the clinician during the initial meeting, the higher the likelihood clients remains in therapy (Alcazar-Olan et al., 2010). Hence, in the absence of creating a safe environment, demonstrating an empathic stance, and establishing rapport, the risk of electing not to engage in therapy increases.

Though the intake session is one of the most important elements of the treatment process for all clients, it possesses a unique significance for LGB individuals. Some LGB individuals may have had negative treatment experience in the past, leaving them distrusting of treatment providers and the mental health field in general (Garnets, et al., 1990; Godfrey et al., 2006). In a society where non-heterosexual individuals still cope with heterosexism and homophobia/biphobia, an affirmative initial encounter is critical for establishing a safe treatment environment.

Recommendations for Future Directions

Scientific advancements and political activism have led to a reduction in pathologizing non-heterosexual attractions, behaviors, and identification. Moreover, in the past two decades, LGB affirming interventions are more prevalent. In spite of these advancements, contemporaneous research continues to demonstrate heterosexist bias in clinical theory and practice, demonstrating the need to increase our understanding of the

issues relevant to LGB individuals and our ability to provide competent care. Through the experience of completing this dissertation, two issues appear particularly important to further advance the quality of care offered to members of the LGB communities.

Need to elucidate differences among lesbian, gay, bisexual women, and bisexual men. The research on the variation among non-heterosexual groups remains limited in breadth and scope, which was a challenge in proposing recommendations that comparably serve lesbian, gay, and bisexual communities. Research with both-sex attracted individuals is particularly lacking; hence, the literature may refer to LGB communities but the findings are based primarily on an examination of "L" and "G."

A challenge in reading the research on non-heterosexual groups is how an individual's sexual orientation is operationally defined. Some of the literature defines sexual orientation based on attraction, others on behavior, and still others on self-identification. This issue is particularly problematic for both-sex attracted individuals, as the constructs are typically based on the attraction and behaviors of gay and lesbian individuals. This way of defining sexual orientation perpetuates a dichotomous view of sexual orientation, but most important, points to the binegativity that lingers in research conducted with non-heterosexual groups.

Need for further research investigating the intersection of multiple cultural considerations. Another challenge faced in proposing clinically relevant recommendations for LGB individuals is the limited research completed with LGB persons of color and other key cultural considerations, including linguistic differences. To date, research with LGB communities has relied, in large part, on the study of educated, middle-class, able-bodied Caucasian individuals. One's sexual orientation is

only one of a myriad of factors that has the potential of influencing our personhood. Yet, the research with LGB individuals neglects the potential existence of multiple cultural identities and rarely considers how one's multiple minority status may influence the individual's well being.

The recommendations suggested in this dissertation are predicated on creating a safe environment during the initial client-therapist encounter. Yet, what seems safe may differ between clients. For example, can we assume "safe" would look the same for the lesbian African American with paraplegia; the gay, Latino who is a monolingual Spanish speaker from a religious working class family; or the bisexual woman who is a non-religious, Caucasian college student? Research typically focuses on cultural factors in isolation, but a more realistic understanding requires examining how the intersection of these considerations influences an individual's life experience and psychological well being. To serve the entirety of the LGB communities, future research must move toward understanding non-heterosexual individuals within a multicultural context.

Conclusion

It was happenstance that I elected to address the needs of LGB communities. Early in my matriculation in the doctoral program, I was assigned a number of clients who identified as lesbian, gay, or bisexual, and each week I discussed the cases in clinical supervision. Although I had immense respect for my clinical supervisor, my intuition was telling me that either important issues related to the client's LGB identity were overlooked, or experiences the client reported were misunderstood. Moreover, as I began to hear more about my clients' experiences, I became more aware of how the language I used or the way I saw the world was peppered with heterocentric assumptions. Although

I may have stumbled upon the topic, my desire to not become one of those psychologists who was unaware of her heteronormative ways was intentional. As I delved into the research literature on non-heterosexual groups, it fueled my desire to act rather than resort to the "indifference". Elie Weisel (1986) urges us to avoid – "The opposite of love is not hate, it's indifference. The opposite of art is not ugliness, it's indifference. The opposite of faith is not heresy, it's indifference. And the opposite of life is not death, it's indifference" (p #1).

The field of psychology has a long history of pathologizing non-heterosexual attraction, behavior, and identity (Herek & Garnets, 2007; Robertson, 2004). Despite decades of research disproving these assumptions, homonegativity/binegativity continue to pervade the field and heteronormativity continues to influence the standard of practice (Boysen & Vogel, 2008; Greene, 2005). It is my hope that the proposed recommendations have illuminated important areas for consideration when beginning a therapeutic relationship with clients who identify as non-heterosexual, and that we continue to move beyond the indifference so that the field and its practices affirm rather than marginalize the personhood of LGB individuals.

REFERENCES

Adam, B. D. (1995). *The rise of a gay and lesbian movement* (Rev. ed.). New York, NY: Twayne.

Adams, E. M., Cahill, B. J., & Ackerlind, S. J. (2005). A qualitative study of Latino lesbian and gay youths' experiences with discrimination and the career development process. *Journal of Vocational Behavior, 66*(2), 199-218. doi: 10.1016/j.jvb.2004.11.002

Addis, S., Davies, M., Greene, G., MacBride-Stewart, S., & Shepherd, M. (2009). The health, social care and housing needs of lesbian, gay, bisexual and transgender older people: A review of the literature. *Health & Social Care in the Community*, 17(6), 647-658. doi:10.1111/j.1365-2524.2009.00866.x.

Alcazar-Olan, R. J., Deffenbacher, J. L., Hernandez-Guzman. L., Sharma, B., & De La Chaussee-Acuna, M. E. (2010). The impact of perceived therapist characteristics on patients' decision to return or not return for more sessions. *International Journal of Psychology and Psychological Therapy, 10(3),* 415-426. Retrieved from https://lib.pepperdine.edu/login?url=http://search.proquest.com.lib.pepperdine.edu/docview/821056617?accountid=13159

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

American Psychiatric Association. (1973). *Homosexuality and sexual orientation disturbance: Proposed change in DSM-II* (retired). Retrieved from www.psychiatryonline.com/DSMPDF/DSM-II_Homosexuality _Revision.pdf

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychological Association (2010). *Ethical principles of psychologists and code of conduct.* Retrieved from http://apa.org/ethics/code/index.aspx

American Psychological Association. (2011). *Practice guidelines for LGB clients: Guidelines for psychological practice with lesbian, gay, and bisexual clients.* Retrieved from http://www.apa.org/pi/lgbt/resources/guidelines.aspx.

American Psychological Association. (2011). *Lesbian, gay, bisexual, and transgender concerns.* Retrieved from http://www.apa.org/pi/lgbt/index.aspx

Amico, J. M. (1997). Assessing sexual compulsivity/addiction in chemically dependent gay men. *Sexual Addiction & Compulsivity, 4*(4), 291-300. doi: 10.1080/10720169708404234

Anderson, A. L. (1998). Strengths of gay male youth: An untold story. *Child and Adolescent Social Work Journal, 15*(1), 55-71. Retrieved from http://web.ebscohost.com.lib.pepperdine.edu/ehost/pdfviewer/pdfviewer?sid=ecd37ada-7ed7-43cd-a1e1-59e6134d77c7%40sessionmgr114&vid=2&hid=127

Anhalt, K., & Morris, T. (1998). Developmental and adjustment issues of gay, lesbian, and bisexual adolescents: A review of the empirical literature. *Clinical Child and Family Psychology Review*, *1*(4), 215-230. doi:10.1023/A:1022660101392

Atkinson, D., Brady, S., & Casas, J. (1981). Sexual preference similarity, attitude similarity, and perceived counseling credibility and attractiveness. *Journal of Counseling Psychology, 28*(6), 504-509. doi:10.1037/0022-0167.28.6.504

Badgett, M. V. L. (1995). The wage effects of sexual orientation discrimination. *Industrial and Labor Relations Review, 48(*4), 726-739. Retrieved from http://www.jstor.org/stable/2524353

Balkin, R., Schlosser, L., & Levitt, D. (2009). Religious identity and cultural diversity: Exploring the relationships between religious identity, sexism, homophobia, and multicultural competence. *Journal of Counseling & Development*, *87*(4), 420-427. Retrieved from http://web.ebscohost.com.lib.pepperdine.edu/ehost/pdfviewer/pdfviewer?vid=6&hid=110&sid=1354ae1b-b965-44a6-b91e-aa0faf30fe11%40sessionmgr113

Balsam, K. F. (2003). Trauma, stress, and resilience among sexual minority women: Rising like the phoenix. *Journal of Lesbian Studies, 7*(4), 1-8. doi: 10.1300/J155v07n04_01

Barton, B. (2010). "Abomination"—Life as a bible belt gay. *Journal of Homosexuality, 57*(4), 465-484. doi:10.1080/00918361003608558

Baumeister, R.F., Manor, J.K., & DeWall, C.N. (2006) Theories of human sexuality. In R. D. McAnulty & M. M. Burnette (Eds.), *Sex and sexuality* (pp. 17- 34). Westport, CT: Greenwood Press.

Biaggio, M., Orchard, S., Larson, J., Petrino, K., & Mihara, R. (2003). Guidelines for gay/lesbian/bisexual - Affirmative educational practices in graduate psychology programs. *Professional Psychology Research and Practice, 34*, 548-554. doi: 10.1037/0735-7028.34.5.548

Bidell, M. (2005). The sexual orientation counselor competency scale: Assessing attitudes, skills, and knowledge of counselors working with lesbian, gay, and bisexual clients. *Counselor Education and Supervision, 44*(4), 267-279. Retrieved from http://aca.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,3,6;journal,19,42;linkingpublicationresults,1:112972,1

Bolcer, J. (2012, December 17). New Jersey law makers move to tackle conversion therapy. *Advocate.com.* Retrieved from http://www.advocate.com/politics/2012/12/17/new-jersey-lawmakers-move-tackle-conversion-therapy

Bonet, L., Wells, B., & Parsons, J. (2006). A positive look at a difficult time: A strength based examination of coming out for lesbian and bisexual women. *Journal of LGBT Health Research, 3*(1), 7-14. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18029311

Bostwick, W. (2012). Assessing bisexual stigma and mental health status: A brief report. *Journal of Bisexuality, 12*(2), 214-222. doi: 10.1080/15299716.2012.674860

Bostwick, W.B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health, 100*(3), 468-75. doi:10.2105/AJPH.2008.152942

Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among black lesbians. *Journal of Lesbian Studies, 7*(4), 87-108. doi: 10.1300/J155v07n04_06

Boysen, G., & Vogel, D. (2008). The relationship between level of training, implicit bias, and multicultural competency among counselor trainees. *Training and Education in Professional Psychology, 2*(2), 103-110. doi:10.1037/1931-3918.2.2.103

Bradford, J. B., Cahill, S., Grasso, C., & Makadon, H. J. (2012). *How to gather data on sexual orientation and gender identity in clinical settings*. Retrieved from The Fenway Institute website: http://www.fenwayhealth.org/site/DocServer/Policy_Brief_HowtoGather..._v3_01.09.12.pdf?docID=9142

Browne, D., Woltman, M., Tumarkin, L., Dyer, S., & Buchbinder ,S. (2008) *Improving lesbian, gay, bisexual, and transgender access to healthcare at New York city health and hospitals corporations facilities*. Retrieved from Office of New York Public Advocate website: http://transgenderlegal.org/media/uploads/doc_84.pdf

Burckell, L., & Goldfried, M. (2006). Therapist qualities preferred by sexual-minority individuals. *Psychotherapy: Theory, Research, Practice, Training*, *43*(1), 32-49. doi:10.1037/0033-3204.43.1.32

Cahill, S., South, K., Spade, J., & National Gay and Lesbian Task Force. (2000). *Outing age: Public policy issues affecting gay, lesbian, bisexual, and transgender elders*. Washington, DC: Policy Institute of the National Gay and Lesbian Taskforce. Retrieved from http://www.thetaskforce.org/reports_and _research/outing_age

California Department of Health Services STD Control Branch, & California STD/HIV Prevention Training Center. (n.d.). *Screen, test, diagnose and prevent: A clinician's resource for STDs in gay men and other men who have sex with men (MSM).* Retrieved from http://www.stdcheckup.org/provider/media/stdcheckup_toolkit.pdf

Callahan, E., & Leitenberg, H. (1973). Aversion therapy for sexual deviation: Contingent shock and covert sensitization. *Journal of Abnormal Psychology*, *81*(1), 60-73. doi:10.1037/h0034025

Cass, V. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality*, *4*(3), 219-235. doi:10.1300/J082v04n03_01

Cass, V. (1984). Homosexual identity formation: Testing a theoretical model. *Journal of Sex Research*, *20*(2), 143-167. doi:10.1080/00224498409551214

Centers for Disease Control. (1981). Pneumocystis pneumonia--Los Angeles. *Morbidity and Mortality Weekly Report, 30(*21), 250-252. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/june_5.htm

Chan, C. (1989). Issues of identity development among Asian-American lesbians and gay men. *Journal of Counseling & Development*, *68*(1), 16-20. Retrieved from http://web.ebscohost.com.lib.pepperdine.edu/ehost/pdfviewer/pdfviewer?vid=4& hid=13&sid=acddc751-ceff-4e44-b38f-884019225e29%40sessionmgr11

Claes, J. A., & Moore, W. (2000). Issues confronting lesbian and gay elders: the challenge for health and human services providers. *Journal of Health and Human Services Administration, 23*(2), 181-202. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11481996

Cochran, S., & Mays, V. (2007). Physical health complaints among lesbians, gay men, and bisexual and homosexually experienced heterosexual individuals: Results from the California Quality of Life Survey. *American Journal of Public Health*, *97*(11), 2048-2055. doi:10.2105/AJPH.2006.087254

Cochran, S. D., Mays, V. M., & Sullivan, J. G. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71(*1), 53-61. doi:10.1037/0022-006X.71.1.53

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*(1), 35-53. doi:10.1093/clipsy/9.1.35

Cox, N., Van, H. M., Vincke, J., & Dewaele, A. (2011). Stress-related growth, coming out, and internalized homonegativity in lesbian, gay, and bisexual youth. An examination of stress-related growth within the minority stress model. *Journal of Homosexuality, 58*(1), 117-137. doi: 10.1080/00918369.2011.533631

Creswell, J. W. (2007*). Qualitative inquiry and research design* (2nd ed.). Thousand Oaks, CA: Sage.

Crisp, C. (2006). The gay affirmative practice scale (GAP): A new measure for assessing cultural competence with gay and lesbian clients. *Social Work, 51*(2), 115-126. Retrieved from http://vnweb.hwwilsonweb.com.lib.pepperdine.edu/hww/results/external_link_maincontentframe.jhtml?_DARGS=/hww/results/results_common.jhtml.44

David, S., & Knight, B. G. (2008). Stress and coping among gay men: Age and ethnic differences. *Psychology and Aging*, 23(1), 62-69. doi:10.1037/0882-7974.23.1.62

D'Emilio, J. (1983). *Sexual politics, sexual communities: The making of a homosexual minority in the United States, 1940-1970* (2nd ed.). Chicago, IL: University of Chicago Press.

Diamond, L. M. (1998). Development of sexual orientation among adolescent and young adult women. *Developmental Psychology, 34*(5), 1085-1095. doi: 10.1037/0012-1649.34.5.1085

Diamond, L., & Butterworth, M. (2008). Questioning gender and sexual identity: Dynamic links over time. *Sex Roles, 59,* 365-376. doi: 10.1007/s11199-008-9425-3

Dillon, F., & Worthington, R. L. (2003). The lesbian, gay and bisexual affirmative counseling self-efficacy inventory (LGB-CSI): Development, validation, and training implications. *Journal of Counseling Psychology, 50*(2), 235-251. doi: 10.1037/0022-00167.50.2.235

Dillon, F. R., Worthington, R. L., Savoy, H. B., Rooney, S. C., Becker-Schutte, A., & Guerra, R. M. (2004). On becoming allies: A qualitative study of lesbian-, gay-, and bisexual-affirmative counselor training. *Counselor Education and Supervision, 43*(3), 162-178. Retrieved from http://vnweb.hwwilsonweb.com.lib.pepperdine.edu/hww/results/external_link_maincontentframe.jhtml?_DARGS=/hww/results/results_common.jhtml.44

Dillon, F. R., Worthington, R. L., Soth-McNett, A. M., & Schwartz, S. J. (2008). Gender and sexual identity-based predictors of lesbian, gay, and bisexual affirmative counseling self-efficacy. *Professional Psychology: Research and Practice, 39*(3), 353-360. doi:10.1037/0735-7028.39.3.353.

Drescher, J. (2010). Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the diagnostic and statistical manual. *Archives of Sexual Behavior, 39*(2), 427-460. doi:10.1007/s10508-009-9531-5

Dubé, E., & Savin-Williams, R. (1999). Sexual identity development among ethnic sexual-minority male youths. *Developmental Psychology, 35*(6), 1389-1398. doi:10.1037/0012-1649.35.6.1389

Duberman, M. B. (1993). *Stonewall*. New York, NY: Dutton.

Eubanks-Carter, C., & Goldfried, M. (2006). The impact of client sexual orientation and gender on clinical judgments and diagnosis of borderline personality disorder. *Journal of Clinical Psychology, 62*(6), 751-770. doi:10.1002/jclp.20265

Fassinger, R. E., & Miller, B. A. (1996). Validation of an inclusive model of sexual minority identity formation on a sample of gay men. *Journal of Homosexuality, 32*(2), 53-78. doi: 10.1300/J082v32n02_04

Fingerhut, A., Peplau, L., & Ghavami, N. (2005). A dual-identity framework for understanding lesbian experience. *Psychology of Women Quarterly, 29*(2), 129-139. doi:10.1111/j.1471-6402.2005.00175.x

Floyd, F. J., & Stein, T. S. (2002). Sexual orientation identity formation among gay, lesbian, and bisexual youths: Multiple patterns of milestone experiences. *Journal of Research on Adolescence, 12*(2), 167-191. doi: 10.1111/1532-7795.00030

Fox, R. C. (2007). Gay grows up: an interpretive study on aging metaphors and queer identity. *Journal of Homosexuality, 52,* 3-4. doi: 10.1300/J082v52n0303

Fraley, S. S., Mona, L. R., & Theodore, P. S. (2007). The sexual lives of lesbian, gay, and bisexual people with disabilities: Psychological perspectives. *Sexuality Research & Social Policy, 4(*1), 15-26. doi: 10.1525/srsp.2007.4.1.15

Fredriksen-Goldsen, K. I., & Muraco, A. (2010). Aging and sexual orientation: A 25-year review of the literature. *Research on Aging, 32*(3), 372-413. doi: 10.1177/0164027509360355

Freud, S. (1905). Three essays on the theory of sexuality. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud, Volume VII (1901-1905): A case of hysteria, three essays on sexuality and other works* (pp. 123-246). London, England: Imago.

Garnets, L. D. (2002). Sexual orientations in perspective. *Cultural Diversity and Ethnic Minority Psychology, 8*(2), 115-129. doi: 10.1037//1099-9809.8.2.115

Garnets, L., Herek, G., & Levy, B. (1990). Violence and victimization of lesbians and gay men: Mental health consequences. *Journal of Interpersonal Violence, 5*(3), 366-383. doi:10.1177/088626090005003010

Gay and Lesbian Medical Association. (n.d.) *Creating a safe clinical environment for lesbian, gay. Bisexual, transgender, and intersex (LGBTI) patients.* Retrieved from http://www.glma.org/index.cfm?fuseaction=contentSearch.veritySearch&nodeID=1

Gedro, J. (2009). LGBT Career development. *Advances in Developing Human Resources, 11*(1), 54-66. doi: 10.1177/1523422308328396

Godfrey, K., Haddock, S., Fisher, A., & Lund, L. (2006). Essential components of curricula for preparing therapists to work effectively with lesbian, gay and bisexual clients: A Delphi study. *Journal of Marital and Family Therapy, 32*(4), 491-504. doi:10.1111/j.1752-0606.2006.tb01623.x

Goldfried, M. (2001). Integrating gay, lesbian, and bisexual issues into mainstream psychology. *American Psychologist, 56*(11), 977-988. doi:10.1037/0003-066X.56.11.977

Gouvier, W., & Coon, R. C. (2002). Misconceptions, discrimination, and disabling language: Synthesis and review. *Applied Neuropsychology, 9*(1), 48-57. doi:10.1207/S15324826AN0901_6

Greene, B. (2005). Psychology, diversity and social justice: Beyond heterosexism and across the cultural divide. *Counseling Psychology Quarterly, 18*(4), 295-306. doi:10.1080/09515070500385770

Group for the Advancement of Psychiatry. (2011). *Taking a sexual history with LGBT patients.* Retrieved from http://www.aglp.org/gap/2_sexualHistory/

Grov, C., Bimbi, D., Nanín, J., & Parsons, J. (2006). Race, ethnicity, gender, and generational factors associated with the coming-out process among gay, lesbian, and bisexual individuals. *Journal of Sex Research, 43*(2), 115-121. doi:10.1080/00224490609552306

Haldeman, D. (2002). Gay rights, patient rights: The implications of sexual orientation conversion therapy. *Professional Psychology: Research and Practice, 33*(3), 260-264. doi:10.1037/0735-7028.33.3.260

Hajek, C., & Giles, H. (2002). The old man out: An intergroup analysis of intergenerational communication among gay men. *Journal of Communication, 52*(4), 698-714. doi:10.1111/j.1460-2466.2002.tb02569.x.

Halkitis, P., Mattis, J., Sahadath, J., Massie, D., Ladyzhenskaya, L., Pitrelli, K,...Cowie, S.E. (2009). The meanings and manifestations of religion and spirituality among lesbian, gay, bisexual, and transgender adults. *Journal of Adult Development, 16*(4), 250-262. doi:10.1007/s10804-009-9071-1

Harrison, N. (2000). Gay affirmative therapy: a critical analysis of the literature. *British Journal of Guidance and Counselling, 28*(1) 37-53. doi: 10.1080/030698800109600

Herek, G. (1989). Hate crimes against lesbians and gay men: Issues for research and policy. *American Psychologist, 44*(6), 948-955. doi:10.1037/0003-066X.44.6.948

Herek, G. (1990). The context of anti-gay violence: Notes on cultural and psychological heterosexism. *Journal of Interpersonal Violence, 5*(3), 316-333. doi:10.1177/088626090005003006

Herek, G. (1992). The social context of hate crimes: Notes on cultural heterosexism. In K. Berrill & G. Herek (Eds.), *Hate crimes: Confronting violence against lesbians and gay men* (pp. 89-104). Thousand Oaks, CA: Sage.

Herek, G. M. (2002). Heterosexuals attitudes toward bisexual men and women in the United States. *Journal of Sex Research, 39(*4), 264-74. Retrieved from: http://web.ebscohost.com.lib.pepperdine.edu/ehost/detail?sid=662fc902-d1c3-4151-8068-2e934ab228f7%40sessionmgr12&vid=1&hid=10&bdata=JnNpdGU9ZWhvc3QtbGl2ZSZzY29wZT1zaXRl#db=hch&AN=8894129

Herek, G. (2007). Confronting sexual stigma and prejudice: Theory and practice. *Journal of Social Issues, 63*(4), 905-925. doi: 10.1111/j.1540-4560.2007.00544.x

Herek, G., & Garnets, L. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology, 3,* 353-375. doi:10.1146/annurev.clinpsy.3.022806.091510

Herek, G., Kimmel, D., Amaro, H., & Melton, G. (1991). Avoiding heterosexist bias in psychological research. *American Psychologist*, *46*(9), 957-963. doi:10.1037/0003-066X.46.9.957

Historical notes: A letter from Freud. (1951). *American Journal of Psychiatry, 107*, 786-787. Retrieved from http://ajp.psychiatryonline.org/cgi/reprint/107/10/786

Hooker, E. (1957). The adjustment of the male overt homosexual. *Journal of Projective Techniques*, *21*, 1, 18-31. doi: 10.1080/08853126.1957.10380742

Huang Y.-P., Brewster M.E., Moradi B., Goodman M.B., Wiseman M.C., & Martin A. (2010). Content analysis of literature about LGB people of color: 1998-2007. *Counseling Psychologist, 38*(3), 363-396. doi: 10.1177/001000009335255

Israel, T., Gorcheva, R., Walther, W., Sulzner, J., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice*, *39*(3), 361-368. doi:10.1037/0735-7028.39.3.361

Johnson, M., Jackson, N., Arnette, J., & Koffman, S. (2005). Gay and lesbian perceptions of discrimination in retirement care facilities. *Journal of Homosexuality, 49*(2), 83-102. doi: 10.1300/J082v49n02_05

Jowett, A., & Peel, E. (2009). Chronic illness in non-heterosexual contexts: An online survey of experiences. *Feminism & Psychology, 19(*4), 454-474. doi: 10.1177/0959353509342770

Kaiser Permanente National Diversity Council and Kaiser Permanente National Diversity Department. (2004). *A provider's handbook on culturally competent care: Lesbian, gay, bisexual, and transgender population* (2nd ed.). Retrieved from http://kphci.org/downloads/KP.PHandbook.LGBT.2nd.2004.pdf

Kashubeck-West, S., Szymanski, D., & Meyer, J. (2008). Internalized heterosexism: Clinical implications and training considerations. *The Counseling Psychologist*, *36*(4), 615-630. doi:10.1177/0011000007309634

Kauth M. R. (2006). Sexual orientation and identity. In R. D. McAnulty & M. M. Burnette (Eds.), *Sex and sexuality* (pp. 153- 184). Westport, CT: Greenwood Press.

King, M. B., Semlyan, J., Killaspy, H., Nazareth, I., Osborn, D., & British Association for Counselling and Psychotherapy. (2007). *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual & transgender people*. Lutterworth, Leicestershire: British Association for Counselling & Psychotherapy.

King County. (2011). *Culturally competent care for GLBT people: Recommendations for health care providers.* Retrieved from Public Health – Seattle and King County website: http://www.kingcounty.gov/healthservices/health/personal/glbt/CulturalCompetency.aspx

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male.* Philadelphia, PA: W.B. Saunders.

Lambda Legal. (n.d.) *Getting down to the basics: Tools to support LGBTQ youth in care.* Retrieved from http://www.lambdalegal.org/publications/getting-down-to-basics.

Larsen, K.S., Reed M., & Hoffman S. (1980). Attitudes of heterosexuals toward homosexuality: A likert-type scale and construct validity. *The Journal of Sex Research, 16*(3), 245-257. doi: 10.1080/00224498009551081

Lebolt, J. (1999). Gay affirmative psychotherapy: A phenomenological study. *Clinical Social Work Journal*, *27*(4), 355-370. doi:10.1023/A:1022870129582

Leff, L. (2012). Interest widens in law on gay therapy; other states take note of California's new ban on 'reparative' treatment for teens. *Los Angeles Times*. Retrieved from http://search.proquest.com/docview/1086549962?accountid=13159

LGBTQNation (2012, October 14). Philly lawmaker introduces bill to ban reparative therapy for minors. *LGBTQNation.* Retrieved from http://www.lgbtqnation.com/2012/10/philly-lawmaker-introduces-bill-to-ban-reparative-therapy-for-minors/

Lyons, H. Z., Bieschke, K. J., Dendy, A. K., Worthington, R. L., & Georgemiller, R. (2010). Psychologists' competence to treat lesbian, gay and bisexual clients: State of the field and strategies for improvement. *Professional Psychology: Research and Practice, 41*(5), 424-434. doi: 10.1037/a0021121

MacDonald, A. (1976). Homophobia: Its roots and meanings. *Homosexual Counseling Journal, 3*(1), 23-33. Retrieved from http://psycnet.apa.org/psycinfo/1976-23947-001

Mair, D. (2003). Gay men's experiences of therapy. *Counselling and Psychotherapy Research Counselling and Psychotherapy Research, 3*(1), 33-41. doi: 10.1080/14733140312331384608

McCabe, S. E., Hughes, T. L., Bostwick, W. B., West, B. T., & Boyd, C. J. (2009). Sexual orientation, substance use behaviors and substance dependence in the United States. *Addiction, 104*(8), 1333-45. doi:10.1111/j.1360-0443.2009.02596.x

McGeorge, C., & Carlson, T.S. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy, 37*(1), 14-26. doi: 10.1111/j.1752-0606.2009.00149.x

Mertens, D. M. (2005). *Research and evaluation in education and psychology, integrating diversity with quantitative, qualitative, and mixed methods* (2nd ed.). Thousand Oaks,CA: Sage.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674-697. doi:10.1037/0033-2909.129.5.674

Meyer, I. H. (2010). Identity, stress, and resilience in lesbians, gay men, and bisexuals of color. *Counseling Psychologist, 38*(3), 442-454. doi: 10.1177/0011000009351601

Ministrial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing, Department of Mental Health. (2009). *Well Proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services*. Retrieved from http://www.glhv.org.au/files/WellProud_updated2011.pdf

Mohr, J. J., & Rochlen, A. B. (1999). Measuring attitudes regarding bisexuality in lesbian, gay male, and heterosexual populations. *Journal of Counseling Psychology, 46(*3), 353-69. doi: 10.1037/0022-0167.46.3.353

Morin, S. (1977). Heterosexual bias in psychological research on lesbianism and male homosexuality. *American Psychologist, 32*(8), 629-637. doi:10.1037/0003-066X.32.8.629.

Morrison, M., & Morrison, T. (2002). Development and validation of a scale measuring modern prejudice toward gay men and lesbian women. *Journal of Homosexuality, 43*(2), 15-37. doi:10.1300/J082v43n02_02

Muscarella, F. (2000). The evolution of homoerotic behavior in humans. *Journal of Homosexuality,* 40(1), 51-77. doi:10.1300/J082v40n01_03

Mustanski, B., Newcomb, M. E., & Garofalo, R. (2011). Mental health of lesbian, gay, and bisexual youths: A developmental resiliency perspective. *Journal of Gay & Lesbian Social Services: The Quarterly Journal of Community & Clinical Practice, 23*(2), 204-225. doi:10.1080/10538720.2011.561474

O'Toole, C. (2000). The view from below: Developing a knowledge base about an unknown population. *Sexuality and Disability, 18*(3), 207-224. doi:10.1023/A:1026421916410

O'Toole, C. J., & Brown, A. A. (2003). No reflection in the mirror: Challenges for disabled lesbians accessing mental health services. *Journal of Lesbian Studies, 7*(1), 35-49. doi:10.1300/J155v07n01_03

Pachankis, J., & Goldfried, M. (2004). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychotherapy: Theory, Research, Practice, Training*, *41*(3), 227-246. doi:10.1037/0033-3204.41.3.227

Pennsylvania Department of Public Welfare's Office of Mental Health and Substance Abuse Services. (2009). *Issues of access to an inclusion in behavioral health services for lesbian, gay, bisexual, questioning and intersex consumers.* Retrieved from http://www.pmhca.org/projects/OMHSAS_LGBTQI_Recommendations.pdf

Phillips, J. C., Ingram, K. M., Smith, N. G., & Mindes, E. (2003) Methodological and content review of lesbian-, gay-, and bisexual-related articles in counseling journals: 1990-1999. *The Counseling Psychologist, 31*(1), 25-62. doi:10.1177/0011000002239398

Pilkington, N., & D'Augelli, A. (1995). Victimization of lesbian, gay, and bisexual youth in community settings. *Journal of Community Psychology, 23*(1), 34-56. doi:10.1002/1520-6629(199501)23:1<34::AID-JCOP2290230105>3.0.CO;2-N

Pixton, S. (2003). Experiencing gay affirmative therapy: An exploration of clients' views of what is helpful. *Counselling and Psychotherapy Research, 3*(3), 211-215. doi: 10.1080/14733140312331384372

Prince, J. (1997). Assessment bias affecting lesbian, gay male and bisexual individuals. *Measurement and Evaluation in Counseling and Development, 30*(2), 82-87. Retrieved from http://web.ebscohost.com.lib.pepperdine.edu/ehost/detail?vid=29&hid=13&sid=acddc751-ceff-4e44-b38f-884019225e29%40sessionmgr11&bdata= JmxvZ2lu Lm FzcD9jdXN0aWQ9czg0ODAyMzgmc2l0ZT1laG9zdC1saXZlJnNjb3BlPXNpdGU%3d#db=psyh&AN=1997-06912-003

Prokos, A. H., & Keene, J. (2010). Poverty among cohabiting gay and lesbian, and married and cohabiting heterosexual families. *Journal of Family Issues*, 31(7), 934-959. doi:10.1177/0192513X09360176

Quam, J. K., & Whitford, G. S. (1992). Adaptation and age-related expectations of older gay and lesbian adults. *Gerontologist, 32*(3), 367-74. doi: 10.1093/geront/32.3.367

Raja, S., & Strokes, J. P. (1998). Assessing attitudes toward lesbians and gay men: The modern homophobia scale. *Journal of Gay, Lesbian, and Bisexual Identity 3*(2), 113-134. doi: 10.1023/A:1023244427281

Ritter, K., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York, NY: Guilford Press.

Robertson, P. K. (2004). The historical effects of depathologizing homosexuality on the practice of counseling. *The Family Journal, 12*(2), 163-169. doi:10.1177/1066480703261976

Robin, L., Brener, N. D., Donahue, S. F., Hack, T., Hale, K., & Goodenow, C. (2002). Associations between health risk behaviors and opposite-, same-, and both-sex sexual partners in representative samples of Vermont and Massachusetts high school students. *Archives of Pediatrics and Adolescent Medicine, 156(*4), 349-55. doi:10.1001/archpedi.156.4.349.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2004). Ethnic/racial differences in the coming-out process of lesbian, gay, and bisexual youths: a comparison of sexual identity development over time. *Cultural Diversity & Ethnic Minority Psychology, 10*(3), 215-28. doi: 10.1037/1099-9809.10.3.215

Rosario, M., Schrimshaw, E. W., Hunter, J., & Braun, L. (2006). Sexual identity development among gay, lesbian, and bisexual youths: consistency and change over time. *Journal of Sex Research, 43*(1), 46-58. doi: 10.1080/00224490609552298

Rosario, M., Schrimshaw, E., Hunter, J., & Levy-Warren, A. (2009). The coming-out process of young lesbian and bisexual women: Are there butch/femme differences in sexual identity development?. *Archives of Sexual Behavior, 38*(1), 34-49. doi: 10.1007/s10508-007-9221-0

Rûck, C., & Bergström, J. (2006). 'Is the Y-BOCS discriminatory against gays and lesbians': Erratum. *The American Journal of Psychiatry, 163*(10), 1449-a. doi:10.1176/appi.ajp.163.8.1449-a

Russell, G. M., & Richards, J. A. (2003). Stressor and resilience factors for lesbians, gay men, and bisexuals confronting antigay politics. *American Journal of Community Psychology, 31*(3-4), 313-328. doi: 10.1108/00907321111161403

Ryden, J., & Loewenthal, D. (2001). Psychotherapy for lesbians: The influence of therapist sexuality. *Counselling and Psychotherapy Research: Linking Research with Practice, 1*(1), 42-52. doi: 10.1080/14733140112331385248

Saewyc, E. M. (2011). Research on adolescent sexual orientation: Development, health disparities, stigma, and resilience. *Journal of Research on Adolescence, 21*(1), 256-272. doi:10.1111/j.1532-7795.2010.00727.x

Sanders, G. L., & Kroll, I. T. (2000). Generating stories of resilience: Helping gay and lesbian youth and their families. *Journal of Marital andFamily Therapy, 26*(4), 433-42. Retrieved from http://onlinelibrary.wiley.com.lib.pepperdine.edu/doi/10.1111/j.1752-0606.2000.tb00314.x/pdf

Savin-Williams, R. C. (2001). A Critique of research on sexual-minority youths. *Journal of Adolescence, 24*(1), 5-13. doi:10.1006/jado.2000.0369

Savin-Williams, R. C. (2006). Who's gay? Does it matter? *Current Directions in Psychological Science, 15*(1), 40-44. doi: 10.1111/j.0963-7214.2006.00403.x

Savin-Williams, R. C. (2008). Then and now: Recruitment, definition, diversity, and positive attitudes of same sex-populations. *Developmental Psychology, 44*(1), 135-138. doi: 10.1037/0012-1649.44.1.135

Savin-Williams, R. C., & Diamond, L. M. (2000). Sexual identity trajectories among sexual-minority youths: Gender comparisons. *Archives of Sexual Behavior, 29*(6), 607-27. doi: 10.1023/A:1002058505138

Schope, R. D. (2005). Who's afraid of growing old? Gay and lesbian perceptions of aging. *Journal of Gerontological Social Work, 45*(4), 23-39. doi: 10.1300/J083v45n04_03

Schrimshaw, E. W., Siegel, K., Downing, M. R., & Parsons, J. T. (2012). Disclosure and concealment of sexual orientation and the mental health of non-gay-identified, behaviorally bisexual men. *Journal of Consulting and Clinical Psychology, 31 (1),* 1-13. doi:10.1037/a0031272

Shippy, R. A., Cantor, M. H., & Brennan, M. (2004). Social networks of aging gay men. *The Journal of Men's Studies, 13*(1), 107-120. Retrieved from https://lib.pepperdine.edu/login?url=http://proquest.umi.com.lib.pepperdine.edu/pqdweb?did=791863101&sid=2&Fmt=3&clientId=1686&RQT=309&VName=PQD

Social Planning, Policy and Program Administration Regional Municipality of Waterloo. (2008). *LGBTQ populations and the shelter system*. Retrieved from Region of Waterloo Social Services website: http://socialservices.regionofwaterloo.ca/en/communityProgramsSupports/resources/lgbtq%20and%20shleter%20system.pdf

Spokane Regional Health District, Community Health Assessment Program. (2006). *Health care needs and resources of gay, lesbian, bisexual, transgendered, intersexed and questioning community in Spokane, Washington.* Retrieved from http://www.srhd.org/documents/PublicHealthData/GLBTIQReport.pdf

Stacey, J. (2006). Gay parenthood and the decline of paternity as we knew it. *Sexualities, 9*(1), 27-55. doi: 10.1177/1363460706060687

Stein, G., & Bonuck, K. (2001). Physician-patient relationships among the lesbian and gay community. *Journal of the Gay & Lesbian Medical Assn*, *5*(3), 87-93. doi:10.1023/A:1011648707507

Tozer, E. E., & McClanahan, M. K. (1999). Treating the purple menace: Ethical considerations of conversion therapy and affirmative alternatives. *Counseling Psychologist, 27*(5), 722-42. doi: 10.1177/0011000099275006

Troiden, R. (1989). The formation of homosexual identities. *Journal of Homosexuality, 17*(1-2), 43-73. doi:10.1300/J082v17n01_02

United States Department of Justice. (2000). *Hate crime statistics 2000: Uniform crime reports.* Washington DC: Federal Bureau of Investigation.

Unites States Department of Justice Office on Violence Against Women & LAPTOP (2006). *Survivor-centered advocacy institute: Intake and assessment strategies.* Retrieved from http://www.csaj.org/documents/58.pdf

Vaughn A.A., Roesch S.C., & Aldridge A.A. (2009). Stress-related growth in racial/ethnic minority adolescents: Measurement structure and validity. *Educational and Psychological Measurement, 69*(1), 131-145. doi: 10.1177/0013164408318775

Volpp, S. Y. (2010). What about the "B" in LGB: Are bisexual women's mental health issues same or different? *Journal of Gay & Lesbian Mental Health, 14(1)*, 41-51. doi: 10.1080/19359700903416016

Walker, J. A., & Prince, T. (2010). Training considerations and suggested counseling interventions for LGBT individuals. *Journal of LGBT Issues in Counseling, 4*(1), 2-17. doi: 10.1080/15538600903552756

Weisel, E. (1986). Eli Weisel Foundation. Retrieved from http://www.eliewieselfoundation.org/aboutus.aspx.

White, L., & Cant, B. (2003). Social networks, social support, health and HIV-positive gay men. *Health & Social Care in the Community, 11*(4), 329-334. doi: 10.1046/j.1365-2524.2003.00431.x

Whitehead, A. (2010). Sacred rites and civil rights: Religion's effect on attitudes toward same-sex unions and the perceived cause of homosexuality. *Social Science Quarterly, 91*(1), 63-79. doi:10.1111/j.1540-6237.2010.00681.x

Whitney, C. (2006). Intersections in identity-identity development among queer women with disabilities. *Sexuality and Disability, 24*(1), 39-52. doi:10.1007/s11195-005-9002-4

Wiederman, M., & Sansone, R. (2009). Borderline personality disorder and sexuality. *The Family Journal, 17*(3), 277-282. doi:10.1177/1066480709338292

Willis, D. (2004). Hate crimes against gay males: An overview. *Issues in Mental Health Nursing, 25*(2), 115-132. doi:10.1080/01612840490268090

Wilson, B. D. M., & Miller, R. L. (2002). Strategies for managing heterosexism used among African American gay and bisexual men. *The Journal of Black Psychology, 28*(4), 371-391. doi: 10.1177/009579802237543

Worthington, R. L., Dillon, F. R., & Becker-Schutte, A. M. (2005). Development, reliability, and validity of the lesbian, gay, and bisexual knowledge and attitudes scale for heterosexuals (LGB-KASH). *Journal of Counseling Psychology, 52*(1), 104-118. doi: 10.1037/0022-0167.52.1.104

APPENDIX A

Review of the Literature

Introduction: Sociopolitical history of stigma, discrimination, and homophobia

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Adam, B. D. (1995).	A critical reflection on the existing strategies that have been developed for the protection and welfare of non-heterosexualsin dividuals, considering the historical context.	NA	NA	Historical Literature Review	• Deviant views on homosexuality during the McCarthy period. • The mass media of the time played a great role in homophobic messages. • Thousands of gay men and lesbian women were fired from employment, imprisoned in jails and committed in psychiatric hospitals. • Homosexuals were treated with lobotomies, castration, and electroshock therapies in an attempt to remedy their aberrant way of life. • Police raids on gay and lesbian bars were common, as was persecution and harassment by political and legal institutions. • Police officers frequently coerced non-heterosexual individuals to reveal the names of their non-heterosexual friends. • It was customary for non-heterosexual individuals to take on pseudonyms in order to avoid maltreatment by legal and political agencies. • Many non-heterosexual individuals kept their sexual orientation and identity in secrecy. • In the years following the Stonewall riots, a number of gay activist organizations were established, including the Gay Liberation Front (GLF), the Gay Activists Alliance (GAA), the Society for Individual Rights (SIR), and the National Gay Task Force (NGTF). • The 1980s, however, was depicted by an increase in conservative antigay politics, inundated with dogmatic religion emphasizing inflexible moral principles.
Badgett, M. V. L. (1995).	Analysis of wage	1989-1991 data from	NA	Causal-comparative	• Analysis of national data exposed that when compared to heterosexual male workers with equivalent

	differences between matched heterosexual and non-heterosexualsmales.	random national sample			occupations, work experience, education, marital status and region of residence, gay and bisexual male employees' earnings were 11%-27% less. • There is also evidence that lesbian and bisexual women earned less than heterosexual women. However, the evidence for this is inconsistent and lack statistical significance. • The results indicate that non-heterosexual persons may commonly the decision of whether to conceal their minority sexual identity which may lead to psychological effects or run the risk of financial risk.
Centers for Disease Control (CDC) (1981).	Case reports of 5 patients all treated for Pneumocystic Carinii Pneumonia in Los Angeles, California during the period between October 1980 – May 1981.	5 Homosexual patients diagnosed with Pneumocystic Carinii Pneumonia	NA	Case Reports	• Patients were treated in 3 different hospitals in Los Angeles, CA. • Two of the five patients died. • All 5 patients had laboratory confirmed previous or current cytomegalovirus (CMV) infection and candidal mucosal infection. • Patients did NOT know each other and had no common contacts or knowledge of sexual partners with similar illnesses. • The five patients did NOT have comparable histories of sexually transmitted diseases. • Two of the five patients reported engaging in frequent same-sex behaviors with various partners.
D'Emilio, J. (1983)..	Historical Overview of a minority status of non-heterosexualsindividuals in the United-States.	NA	NA	Historical Literature Review	• Years of discrimination and harassment finally led to the Stonewall Riots. • Many non-heterosexual individuals outwardly expressed their anger against the intolerant police officers that regularly harassed them. • Stonewall was the first event in which gay and lesbian oppression became public. • This marked the beginning of the gay liberation era
Duberman, M. B. (1993).	An overview of Stonewall and the experiences attached from	NA	NA	Historical Narrative	• Police raids on gay and lesbian bars were common, as was persecution and harassment by political and legal institutions. • Police officers frequently coerced non-heterosexual

	the view of six distinct narrative characters.				individuals to reveal the names of their non-heterosexual friends. • Years of discrimination and harassment finally led to the Stonewall Riots, in which many non-heterosexual individuals outwardly expressed their anger against the intolerant police officers. • Stonewall was the first event in which gay and lesbian oppression became public. • This marked the beginning of the gay liberation era.
Herek, G. (1992).	Exploration of how key components of cultural ideologies and sexuality foster heterosexism.	NA	NA	Theoretical Discussion	• Definition of cultural heterosexism: the transmission of heterosexism through cultural institutions. • Religious heterosexism in the U.S. can be found in the Judeo-Christian moral guidelines and principles for living that contain little acceptance and understanding gay males. • Cultural heterosexism has also been found in the institution of law, as depicted by the negative response towards legalizing same-sex marriage. • Heterosexist bias in Supreme court ruling in Bowers versus Hardwick.
Herek, G. (2007).	A framework presented to discuss stigma as a cultural phenomenon with structural and individual manifestations.	NA	NA	Theoretical Discussion	Bowers versus Hardwick: • Georgia's sodomy laws criminalized oral and anal sex between same-sex and different sex couples. • Hardwick was arrested in his home after an officer peered through his bedroom door and spotted him engaging in oral sex with a male companion. • The case reached the Supreme Court in 1985-6. • Winning by a 5-4 majority, the court upheld the statute declaring it legal for the state to regulate private sexual behavior. The outcome was a result of Justice Powell's change of decision to initially side with those who wanted to overturn the statute, a decision made by a man who had claimed never to have personally known anyone who was gay. Lawrence versus Texas: • Texas sodomy law criminalized oral and anal sex only

					between same-sex persons. • Lawrence and his same sex partner were arrested for having consensual sex in Lawrence's bedroom. • Appealed to the Supreme court and his case was heard in Spring, 2003 arguing that sodomy laws were in violation of the constitution. • 3 major conclusions were stressed: 1. Homosexuality is a normal form of human sexuality. 2. Forcing sexual minority peoples to suppress their sexual intimacy with partners deprives them of a very fundamental aspect of human experience. 3. Sodomy statutes reinforce prejudice, discrimination and violence towards LGB persons. • In June 2003, the court rules Texas sodomy law unconstitutional.
Herek, G., & Garnets, L. (2007).	An overview of the current psychological research on mental health and sexual orientation	NA	NA	Literature Review	• The fact the most non-heterosexuals do not exhibit high levels of depression, anxiety, suicidality and substance abuse indicates that they are resilient as they are able to successfully cope with the stress created in their lives. • Group resources for responding to stigma in addition to their personal coping mechanisms have been shown to provide a protective factor psychological distress. Non-heterosexuals who regularly participate in sexual minority community resources report lower levels of psychological distress than those who do not.

Consequences of heterosexism on the lives of LGB individuals

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Anhalt, K., & Morris, T. L. (1998).	Critical review of the literature pertaining to difficulties in adjustment	NA	NA	Literature Review	• Victimization related to sexual orientation is still common in our society. It seems that GLB youths who are in the developmental process of coming out are at a particular risk to such victimization from their family members and peers.

	experiences by LGB adolescents.				• GLB youth are at a higher risk of enduring verbal, physical and sexual victimization than are heterosexual youth. • A review of the literature also indicated that there are high rates of unprotected sex among certain groups of sexual minority youth. These type of sexual practices may place these particular youth groups at a higher risk of becoming infected with sexually transmitted diseases. The literature demonstrates that the greatest proportion of AIDS cases come about as a result of high risk sexual behaviors among men. • The literature also demonstrated that GLB youth are at a higher risk for suicidality than their heterosexual counterparts, with prevalence rates of past suicidal attempts ranging from 11-42%. • One strong predictor of suicidal behavior is a greater loss of friends after disclosure of minority sexual orientation.
Bostwick, W. (2012).	Pilot study testing a new measure assessing stigma and discrimination on bisexual individuals and the relationship to mental health.	47 self identified bisexual women ages 25-66 (Mean=33.5; SD=9.2)	1.Stigma Consciousness Scale. 2. Multi-dimensional Measure of Stigma. 3. Question regarding internalized biphobia. 4. Question assessing cultural condemnation. 5. Community Epidemiologica l Survey of Depression	Pilot Study	• Researchers found a modest relationship between the stigma experienced by bisexual individuals and the individuals' mental health status, with stronger endorsements of experienced stigma associated with higher level of depressive symptoms. • Though the sample was small in size and relatively homogenous, it may serve as preliminary evidence that mental health disparities are attributable to increased stigma that bisexual women face. •

			(CES-D). 6. Demographic Questionnaire.		
Bostwick, W.B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010).	Examination of the dimensions of sexual orientation (identity, attraction, and behavior) and the association with mood and anxiety disorders, and sex.	Analysis of cross sectional data of 34 653 interviews conducted with individuals over age 20 in the United States.	1. Alcohol Use Disorder and Associated Disabilities Interview Schedule-IV (AUDADIS-IV) 2. Questionnaire assessing sexual identity, sexual behavior, and sexual attraction. 3. Demographic questionnaire.	Cross – Sectional Study	• "Nonheterosexuality" (defined by identity, attraction, or behavior) was associated with increased mental health disorders among men as indicated by higher prevalence of lifetime disorders. • Non-heterosexuality among women differed based on dimension, with ONLY sexual minority identity associated with higher rates of lifetime and past-year disorders, but not sexual attraction or sexual behavior. • Exclusive same-sex attraction, as well as exclusive lifetime same-sex behavior, was associated with lower rates of almost all lifetime and past-year mood and anxiety disorders among women.
Cochran, S. D., Mays, V. M., & Sullivan, J. G. (2003).	Using data from a nationally representative survey, the objective of the study was to examine possible differences in morbidity, distress and mental health services use based on sexual orientation.	2,917 Midlife non-institutionalized adults. Ages 25-74	1.Interview modules from the Composite International Diagnostic Interview Short Form (CIDI-SF). 2.MIDUS Questionnaire. 3.Distress Indicators. 4.Demographic Form.	Survey Study	• The results indicated that gay and bisexual men endure higher prevalence rates of depression, panic attacks and psychological distress when compared with corresponding heterosexual men. • The results also demonstrated that lesbian and bisexual women endure higher prevalence rates of generalized anxiety disorder when compared with corresponding heterosexual women. • Overall, individuals with a minority sexual-orientation experiences 3-4 times greater prevalence rates of comorbid disorders than is present among comparable heterosexuals of the same gender. This finding is particularly important since comorbidity is a predictor of illness severity and increased levels of the use of mental health services.
Garnets, L.D., Herek, G.M., and Levy, B.	Description of the challenges the sexual minority	NA	NA	Literature Review	• Victimization produces chaos and disorder in one's view of the world. To facilitate order and meaning to one's perception of the world, victims often take on a stance of

(1990).	survivors of hate crimes must overcome				self devaluation, leading to a deficient sense of security.
Herek, G. M. (2002).	Examination of heterosexual adults' attitudes toward bisexual men and women.	669 individuals recruited using a list-assisted random-digit dialing (RDD) procedure.	1. 101-point feeling thermometer was used to assess attitudes toward bisexual men and women. 2. Thermometers were used for: (a) religious groups ("Protestants," "Catholics," "Jews"); (b) gay people ("men who are homosexual," "women who are lesbian or homosexual"); (c) "people who inject illegal drugs"; (d) "people with AIDS"; (e) racial, ethnic, and national groups ("Blacks," "Mexican Americans," "Puerto	Survey Study	• Respondents' attitudes were more negative toward bisexual men and women than for all other groups assessed except for injecting drug users group. • Overall ratings for bisexual men were somewhat lower than for bisexual women. • Heterosexual women had a more negative view of bisexuals than toward same-sex oriented individuals, regardless of gender. • Heterosexual men, on the other hand, endorsed a more negative view of sexual minority males (whether bisexual or gay) than females (whether bisexual or lesbian). • Researcher presented a number of hypotheses for reason bisexuals might be targets of greater prejudice and hostility than same-sex oriented individuals. One hypothesis is that many heterosexuals may equate bisexuality with sexual promiscuity or non-monogamy. Another is that bisexual men and women might be regarded as mediators of HIV infection or other sexually transmitted diseases (STDs) between the gay community and the heterosexual community. Moreover, some heterosexuals may experience anxiety or discomfort around the notion of bisexuality, which challenges the widely accepted heterosexual-homosexual dichotomy of sexuality.

			Ricans," "Whites," "Haitians"); (f) bisexuals ("bisexual men," "bisexual women"); and (g) groups defined by their stance on abortion rights ("people who call themselves pro-life and are opposed to abortion," "people who call themselves pro-choice and support abortion rights"). 3. Demographic questionnaire.		
Herek, G. (2007).	A framework presented to discuss stigma as a cultural phenomenon with structural and individual manifestations.	NA	NA	Theoretical Discussion	• Enacted stigma can lead to a significant psychological toll as such experiences of overt discrimination and prejudice can lead to psychological trauma. • Studies have shown that non-heterosexual men and women who experienced violent hate crimes as a result of their minority sexual orientation, exhibited higher levels of depressive symptoms, traumatic stress symptoms anxiety and anger compared with those who endured similar experiences not related to their sexual orientation. • Felt stigma can interfere with individuals' personal lives as their fear of discrimination may limit behavioral options, reduce their opportunities for social support,

					heighten their psychological distress or act as a source to pass as heterosexuals. Such consequences are important to consider as 55% of respondents to a national survey reported experiencing felt stigma.
Herek, G., & Garnets, L. (2007). .	An overview of the current psychological research on mental health and sexual orientation	NA	NA	Literature Review	• Based on sexual orientation, individuals do not manifest a greater risk of pathology or psychological distress. Still non-heterosexuals appear to be at a greater risk than heterosexuals for anxiety, mood disorders, suicidal ideation and attempts. • The minority stress model posits that because non-heterosexuals are placed at a disadvantaged place in society they face a set of unique challenges and stressors in their lives. It highlights three stress processes: 1)external, objectively stressful events, 2) the minority individual's expectations of such events and the vigilance such expectations require and 3) the minority individual's internalizations of negative societal attitudes. • Although some levels of stigma can lead to adaptive responses and the development of coping strategies, high levels of it can lead to excessive feelings of personal danger and vulnerability. In such cases, one's sexuality can be perceived as a source of pain and punishment rather than a source of intimacy and community.
Meyer, I. (2003).	Provide a conceptual framework for understanding the greater prevalence rates of disorders in terms of the minority stress model.	*N*=10 All sources were retrieved from PsycINFO and MEDLINE databases. Inclusion criteria were articles: (a) published in the English-language; (b) peer-reviewed journals;(c) reported prevalence of	NA	Meta-Analysis	• A review of the literature demonstrates that compared to heterosexuals, non-heterosexual individuals endure a greater deal of mental health problems, including substance use disorders, affective disorders and suicide. • Minority stress is additive to general stressors endured by all people, and therefore require those who are discriminated against adaptation capacities exceeding those required by people who do not experience discrimination. • Research literature has consistently shown that the greater the levels of stress one endures, the greater the impact on mental health problems. Probability studies of U.S. adults revealed that LGB people were twice as

		mental illness based on *DSM* criteria; and (d) compared LGB individuals with heterosexual comparison group. Exclusion criteria were: (a) studies that reported scores on measures of psychiatric symptoms (e.g., BDI) and/or (b) the absence of comparison to a heterosexual group.			likely as their heterosexual counterparts to experience discrimination or oppression in their daily life, such inequity in the workplace. • Same-sex oriented persons may conceal their sexual identity guarding themselves from injury or inequity, exacerbating stress. Moreover, concealing one's sexual identity prevents same-sex oriented persons from connecting and affiliating with others of sexual minority, precluding them from the advantages of social support. • Studies have demonstrated that stigma causes LGB individuals to experience alienation, isolation and lack of self acceptance. • Lesbians and gay men frequently suffer from internalized homophobia, directing negative social attitude towards themselves. Since early socialization experiences are extremely powerful, internalized homophobia remains present for many LGB individuals throughout their lifetime, particularly in the presence of continuous exposure to antigay attitudes. • There is a positive correlation between internalized homophobia and depression, anxiety symptoms, substance use disorders, eating disorders, HIV risk taking behaviors, self blame and poor coping in the face of HIV infection, and difficulties with intimate relationships and sexual functioning. • Findings demonstrated that suicide ideation and attempt are abundantly prevalent among LGB populations, most remarkably among LGB youth. Nevertheless, there is no substantial evidence of increased prevalence rates of completed suicides among LGB individuals (perhaps concealing or cry for help). **LGB Youth:** • Generational and cohort effects in conjunction with shifts in the social environment demonstrating an increased acceptance of non-heterosexual persons would lead one to believe that later generations would endure fewer challenges. Yet research illustrates that these

					shifts have failed to protect LGB youth as they continue to suffer discrimination and the consequent impacts (Safe Schools Coalition). • Examination of LGB youth literature illustrates that LGB youth are even at a higher risk of LGB adults to be victims of prejudicial behavior and intolerance. Findings also showed that they are more likely to be victims of violent behavior and hostility than their heterosexual peers. • LGB were found to be more fearful for their safety at school and tend to miss more days of school as a result of their fear.
Pilkington, N., & D'Augelli, A. (1995).	Assessment of the prevalence of different types of victimization, social contexts of victimization and the correlates of victimization in GLB youth.	194 GLB youth ages 15-21, Mean = 18.9. 142 Males and 52 Females. Ethnicity: 66% White, 14% AA, 5% Asian American, 6% Hispanic American and 4% American Indian. Recruited from 14 community groups throughout the US.	Instrument surveying 5 areas: 1.Experiences of victimization including verbal harassment. 2. Sexual orientation and behavior. 3.Social aspects of sexual orientation. 4.Disclosure of sexual orientation within the family. 5.Mental health problem.	Descriptive Study	• Overcoming the methodological flaws of previous research pertaining to GLB youth, Pilkington & D'Augelli (1995) studied victimization of GLB youth utilizing an adequate age distribution of adolescents from a diversity of ethnic backgrounds. • Overall, respondents indicated a mean of 2.7 instances of victimization attributed to their sexual orientation. • Participants of ethnic minorities reported significantly less fewer instances and forms of victimization that did Caucasian participants. • Regarding different types of victimization related to sexual orientation, the following frequencies were reported: 80% reported having endures verbal insults, 44% reported one or more threats of physical violence, 33% reported having objects physically thrown at them, 31% reported harassment in the form of being chased or followed, 22% reported being victims of sexual assault, 20% reported being victims of sexual assault and 13% reported being spit on.
Robin, L., Brener, N. D., Donahue, S. F., Hack, T., Hale,	Examination of associations between health risk behaviors and sexual experience	Participants were a representative, population-based sample of	Self report questionnaires assessing demographic information,	Correlational Study	• Sexual orientation was defined behaviorally. • Results indicated that both-sex students were significantly more likely to report health risk behaviors than were opposite-sex students (e.g. 3-6 times more likely than opposite-sex students of being threatened or

K. and Goodenow, C. (2002).	with opposite-, same-, or both-sex partners in a sample of high school students.	high school students from two states: 14,623 from Vermont and 8,141 from Massachusetts.	sexual behaviors, harassment, violence, suicidal behaviors, alcohol and other drug use, and dietary behaviors.		injured with a weapon at school, making a suicide attempt requiring medical attention, using cocaine, or vomiting or using laxatives to control their weight). • Results indicate that both-sex students must be considered at high risk for violence, harassment, suicidal behavior, marijuana and cocaine use, and unhealthy weight control practices. • Researchers discussed the important public health concerns arising from their findings (i.e. both-sex youth bear increased risk of injury, disease, and death).
Schrimshaw, E. W., Siegel, K., Downing, M. r., & Parsons, J. T. (2012).	Examination of factors associated with disclosure and with concealment of sexual orientation and the resulting effects on mental health.	203 non-gay identified men who disclosed sexual behaviors with men ages 18-66. Race/Ethnicity: 27% White, 33% Black, 29% Hispanic, 10% Asian American and 1% Native American.	1. The Mental Health Inventory (MHI). 2. Self-Concealment Scale (SCS) – modified version. 3. Measure of Disclosure of HIV Status – modified to disclose same-sex behavior. 4. Social Support Survey – 5 questions. 5. Revised Nungesser Homosexual Attitudes Inventory (RNHAI) – Personal Homonegativity subscale.	Correlational Study	• Concealment and disclosure were found to be independent constructs. • Concealment of sexual orientation was associated with more symptoms of depression and anxiety, as well as lower levels of positive affect. • Researchers hypothesized that concealment may serve as a barrier for bisexual individuals to obtain social support as a result of their secrecy distancing themselves from others. • Moreover, concealing one's sexual identity prevents opportunity to confront, work through and resolve internalized biphobia. • Results elicited questions regarding the applicability of models of the coming out process to bisexual individuals, which emphasize disclosure. • Implications for work with bisexual individuals highlight the importance of focusing on concealment, reducing hypervigilance and addressing fears related to failure to conceal, rather than on disclosure.

			6. Demographic Questionnaire.		
Willis, D. (2004).	An overview of the knowledge pertaining to hate crime assaults against gay men.	N/A	NA	Literature Review	• US Department of justice definition of hate crime: "criminal acts based on the offender's bias toward individuals, families, groups, or organizations because of their real or perceived racial, ethnic, religious, sexual orientation or disability status". • Definition of hate incidents: non-criminal incidents absent of physical assault, but containing bias (name-calling, verbal harassment, teasing and bullying). • Hate incidents can produce fear initiating restrictions in one's routine behaviors, eventually producing social withdrawal and isolation. • National summary report of hate crimes offenses based on sexual orientation in the year 2,000 indicated 1,486 hate crimes toward 1,558 known victims. These figures are likely an underestimation as many such crime remain unreported (United States Department of Justice, 2000). • Publicized hate crime murders: Matthew Shepard and Billy Jack Gaither. • When heterosexuals display intimacy in a public manner, it is viewed as acceptable and legitimate. However, when non-heterosexual individuals publicly demonstrate intimacy, such as hand-holding and kissing, society perceives them as flaunting their sexuality and disrespecting societal norms. Hate crime assaults against non-heterosexual individuals may be a result of the perceived violation of such societal norms. • The after effects of hate crime may leave the victim coping with physical injury as well as a variety of somatic and behavioral responses such as sleep disturbance, nightmares, headaches, agitation, restlessness, diarrhea, increased substance use, uncontrollable tearfulness and interpersonal difficulties (Garnets et.al. 1990). • They also found that victims of hate crimes frequently

					experience psychological distress, losing their sense of autonomy and control. • Quantitative comparisons revealed that victims of hate crimes due to sexual orientation are more negatively affected than victims of hate crimes devoid of bias or hate. • The psychological literature further demonstrated that hate crime victims are more prone to suffer depression, anxiety, anger , and symptoms of post-traumatic stress when compared to non-bias crime victims. They also displayed more fear and lower levels of self-mastery than non-bias victims. • Not all people who experience hate crimes endure long-term outcomes.

LGB Individuals and the Field of Psychology

Definition of Key Terms.

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Major Findings
(2000).	Recommendations set out by the APA committee on Lesbian, Gay and Bisexual Concerns Joint Task Force for the psychotherapeutic treatment of LGB clients.	NA	NA	NA	• 16 guidelines described when working with LGB clients. • These guidelines were set out as aspirational recommendations or guidelines, rather than mandatory standards. • Empirical studies portraying homosexuality as a mental illness have no valid empirical support due to methodological flaws, yet they serve the foundation for inaccurate representations of LGB persons and the discrimination that follows. • "Psychologists are strongly encouraged to seek training, experience, consultation and supervision when necessary to ensure competent practice with these population". • The APA ethics code (1992) includes a "prohibition against the misrepresentation of scientific or clinical data (e.g. the unsubstantiated claim that sexual orientation can be changed)". In spite of this, conversion therapies

					still exist today. • A gap still remains between the policy and practice in psychotherapeutic treatment of LGB clients. Moreover, graduate students and novice therapists have often reported feeling unprepared to work competently and effectively with LGB clients. Educational systems are encouraged to integrate information about such issues, but are not required to address these issues. • Education, training, practice experience, consultation and supervision that psychologist receive regarding LGB clients is often inadequate and outdate. Psychologists are encouraged to seek out additional education and training experiences to become more competent in this area, yet such information is rarely available.
(2011).	Recommendations set out by the APA committee on Lesbian, Gay and Bisexual Concerns Joint Task Force for the psychotherapeutic treatment of LGB clients.	NA	NA	NA	• 21 guidelines described when working with LGB clients, updated since the previous guidelines which expired in 2010.
Floyd, F. J., & Stein, T. S. (2002)	Examination of variations in the coming out process of gay, lesbian and bisexual youths.	72 participants self-identified as gay, lesbian or bisexual, ages 16-27 (mean age = 20.88). *Ethnicity: 79% European American, 7% Asian American, 6% African	1.Timing of coming out milestones events. 2. Gay, lesbian. Bisexual social immersion. 3. Other milestone events. 4. Sexual Orientation Grid –	Cluster Analysis Research Design	• Authors argue that stage models of sexual identity are overly simplistic and fail to account for variability. • Authors argue that variability occurs as a result of a number of reasons, rather than previous arguments that variability can be accounted for by the early or late trajectory alone. Authors discuss a number of 'disruptions' can occur during the coming out process. For example, inhibition of disclosure to others, inhibition of same-gender sexual activity, and variations in the nature of immersion into gay, lesbian, and bisexual social networks. • Findings highlight the importance of examining both individual differences and lifelong patterns of

		American, 3% Native American, and 6% other.	interview format. 5. Brief symptoms inventory. 6. Rosenberg Self Esteem Scale.		development for LGB individuals. • Moreover, findings highlight the importance of personal experiences and qualities over grouping based on gay, lesbian or bisexual identity.
Herek, G. (1990).	Identification of the key components of the ideologies from which heterosexism is derived.	NA	NA	Literature Review	• *Heterosexism:* Herek (1990) defines heterosexism as "An ideological system that denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity, relationship or community. It operates principally by rendering homosexuality invisible and, when this fails, by trivializing, repressing, or stigmatizing it."
Herek, G., & Garnets, L. (2007).	An overview of the current psychological research on mental health and sexual orientation	NA	NA	Literature Review	• The fact the most non-heterosexuals do not exhibit high levels of depression, anxiety, suicidality and substance abuse indicates that they are resilient as they are able to successfully cope with the stress created in their lives. • Group resources for responding to stigma in addition to their personal coping mechanisms have been shown to provide a protective factor psychological distress. Non-heterosexuals who regularly participate in sexual minority community resources report lower levels of psychological distress than those who do not.
Herek, G., Kimmel, D., Amaro, H., & Melton, G. (1991).	A discussion of heterosexist bias and how it occurs throughout the literature as well as suggestions on how to avoid such heterosexist bias.	NA	NA	Literature Review	• The discussion is organized as a series of questions any researcher should ask to evaluate his or her own research project to avoid heterosexist bias. • Questions relate to the following topics: formulating the research question, sampling, research design and procedures, protection of participants and interpreting and reporting results. • The authors discuss the importance of including human behavior in all of its diversity in the study of psychology. They discuss integrating mention of non-heterosexual perspectives in a variety of pertinent topics

					such as human development, interpersonal attraction, health, attitudes, stress and coping.
Garnets, L. (2002)	Presentation of a new conceptual paradigm that analyzes the complexity of sexual orientation attending to human sexual, affectional, and erotic attractions	NA	NA	Theoretical Discussion	• Author discusses the problems with the current paradigm of sexual orientation. • She discusses multiple causal factors and multiple pathways to sexuality. • Discusses convergence, divergence and intersectionality of sexual orientation.
MacDonald, A. (1976).	A discussion about the various origins of fears of homosexuals.	NA	NA	Literature Review	• *Homophobia:* Homophobia has been defined as the "irrational persistent fear or dread of homosexuals"
Rosario, M., Schrimshaw, E. W., Hunter, J., & Braun, L. (2006)	Examination of the consistency and change of sexual identity over time among LGB youths and the impact on identity integration.	156 participants ages 14-21(mean age=18.3) *Ethnicity: 37% Latino, 35% AA, 22% Caucasian, 7% Asian and other ethnic backgrounds.	1.Sexual Risk Behavior Assessment – Youth (SERBAS-Y) 2. Sociosexual developmental Milestones. 3. The Marlow-Crowne Social Desirability Scale.	Complex Between Group Experimental Design	• LGB sexual identity development is a complex and often difficult process. Unlike other minority groups, LGB individuals are not typically raised in a community of similar others who reinforce and support that identity. • Researchers argue that retrospective studies may overestimate the linear trend and under-represent individual variability. They, therefore, argue the necessity for longitudinal studies. • Overall, results indicated that there is considerable variability regarding sexuality over time. However, three patterns emerged from the current study: consistently gay/lesbian, transitioned from bisexual to gay/lesbian, and consistently bisexual.
Rosario, M., Schrimshaw, E., Hunter, J., & Levy-Warren, A. (2009)	Investigation of Butch – Femme differences during the coming out process.	76 self-identified lesbian and bisexual young women from NYC ages 14–21 years (mean	1.Sexual Risk Behavior Assessment – Youth (SERBAS-Y) 2. Sociosexual developmental	Between Group Longitudinal Study	• Although most models of sexual identity development describe a relatively linear process of identity formation and integration, researchers have more recently begun to examine the diverse paths of the coming out process. • Authors argue that one potential factor influencing variability in the coming-out process of women may be

		age =18.4). *Ethnicity: 38% Latina, 36% African Origin, 20% Caucasian, 3% Asian, and 4% other ethnic backgrounds	Milestones. 3. The Marlow-Crowne Social Desirability Scale.		differences in butch/femme identification. • Results failed to demonstrate significant differences among lesbian butch and lesbian femme participants. They did, however, find differences between bisexual femme participants and lesbian butch/femme participants in the areas of sexual behavior, sexual orientation, and sexual identity integration. Only found few differences in sexual identity formation were found.
Savin-Williams, R. C. (2006)	Discussion of the different components utilized to measure sexual orientation.	NA	NA	Theoretical Dicussion	• Author attends to three distinctive aspects utilized when defining sexual orientation in the literature: *sexual/romantic attraction* or *arousal*, *sexual behavior*, and *sexual identity*. **Sexual/romantic attraction* is defined as attraction toward one sex or the desire to engage in sexual relations with or to be in a primary loving, sexual relationship with one or both sexes. • *Sexual behavior* represents any mutually voluntary activity with another person involving genital contact or physiological arousal, regardless of whether sexual intercourse or orgasm occurred. • *Sexual identity* refers to a "personally selected, socially and historically bound label related to the perceptions and meanings a person has about his or her sexuality (p.41). *Author draws attention to an over-reliance on the term *sexual identity* throughout the literature on non-heterosexual individuals, thereby excluding many non-heterosexual individuals and misidentifying some heterosexuals. • He notes the incongruence between self-identification of sexual orientation and sexual attractions and behaviors
Savin-Williams, R. C., & Diamond, L. M. (2000)	Investigation of gender differences in sexual identity development among non-heterosexual young adults.	164 non-heterosexual young adults: 78 women and 86 men ages 17-25.	1.Semistructured interview 45-90 minutes.	Content Analysis	• Author argues against the universality of the linear progression of the coming out process and highlights the diversity of experiences during this process. • Author argues that rather than interpreting gender and mean age as the contributing factors to different trajectories, it is important to attend to numerous additional factors (such as timing, context, spacing, and

					sequencing of milestones). • Authors studied the following four milestones: first same-sex attractions, first same-sex sexual contact, first self labeling as non-heterosexual, and first disclosure of a non-heterosexual identity to others. Authors broaden past research by attending to the following factors: the contexts of these events, the duration of time between events, and variation in the ordering first same-sex contact and first self-labeling. • Authors conclude that the current study represents an important first step toward differentiating patterns in the timing, spacing, and sequencing of sexual identity milestones that might reveal critical factors shaping female and male sexual identity development. • Moreover, authors conclude that it is important to recognize that although gender is one factor that leads to significant differences, it is not enough to explain developmental trajectories.

History

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
American Psychiatric Association. (1952).	Diagnostic criteria for Homosexuality	NA	NA	NA	• The DSM-I classified homosexuality as a "sociopathic personality disturbance". • It was classified along with substance abuse and sexual disorders
American Psychiatric Association. (1968).	Diagnostic criteria for Homosexuality	NA	NA	NA	• DSM-II was published in 1968. • It classified homosexuality as a sexual deviance. • Homosexuality was clustered with fetishism, pedophilia, transvestitism, exhibitionism, voyeurism, sadism and masochism.
American Psychiatric Association	Provides information related to	NA	NA	NA	• In December 1973, the APA Board of Directors voted to remove homosexuality from the DSM. • They had a 58% majority vote.

(1973)	concerns for Lesbian, Gay, Bisexual, and Transgender communities				• Statement: "…by no longer listing it as a psychiatric disorder we are not saying that it is "normal" or as valuable as heterosexuality…"
American Psychiatric Association. (1980).	Diagnostic criteria for Ego-Dystonic Homosexuality	NA	NA	NA	• DSM-III was published in 1980. • A new diagnosis of *Ego-Dystonic Homosexuality* was created in place of the previous categorization of *Homosexuality* as a sexual deviance. • The criteria representing this new diagnosis were: (a) a persistent lack of heterosexual arousal, which the patient experienced as interfering with initiation or maintenance of wanted heterosexual relationships; and (b) persistent distress from a sustained pattern of unwanted homosexual arousal.
American Psychiatric Association. (1987).	Diagnostic criteria for Sexual Disorder Not Otherwise Specified	NA	NA	NA	• In the revised edition of the DSM-III, the diagnosis was removed entirely. • In its place was a diagnosis of *Sexual Disorder Not Otherwise Specified.* • This diagnosis could be established in one of three ways, the third of which was recorded as a "persistent and marked distress about one's sexual orientation".
American Psychiatric Association. (2000).	Diagnostic criteria for gender identity disorder	NA	NA	NA	• Homosexuality no longer listed. • Gender identity disorder – a strong and persistent cross gender identification. • Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
Callahan, E., & Leitenberg, H. (1973).	Experiment utilizing two different aversion therapy approaches (covert sensitization and contingent shock therapy) in the	6 participants: 2 exhibitionists, 1 transsexual, 2 homosexuals and 1 pedophilic homosexual.	Contingent shock using deviant and heterosexually oriented material. Covert sensitization using	Single-case Experimental Design	• Results indicated that 5 of 6 subjects subjective measures demonstrated a greater reduction in perceived distress by covert sensitization as compared with contingent shock therapy.

	treatment of sexual deviation.		hierarchies of sexually arousing deviant acts.		
Drescher, J. (2010).	Discussion of concerns and criticisms of GID diagnosis, paralleling with earlier historical concerns and events that led to the removal of homosexuality from the *DSM*.	NA	NA	Historical Literature Review	• Three main theories of homosexuality: normal variation, pathology and immaturity. Freud and psychoanalytic view of homosexuality: should be treated as a form of unconscious anxiety. • DSM-I (1952): homosexuality classified as a "sociopathic personality disturbance." • DSM-II (1968): homosexuality classified as a sexual deviance. • December 1973: APA's Board of Trustees voted to remove homosexuality from the DSM with a 58% majority vote. • DSM-III (1980): Ego-dystonic homosexuality • APA Position Statement (1973): …by no longer listing it as a psychiatric disorder we are not saying that it is "normal" or as valuable as heterosexuality… → continued discrimination even after removal as a mental disorder, as is continued to be considered inferior. • Religious Parallel: Homosexuality and GID both rooted in Judeo-Christian religion and is considered a sin and transgression from the norm. Sins are eventually classified into mental illnesses.
Freud, S. (1905).	A discussion of his theory on sexuality and sexual development.	NA	NA	Theoretical Discussion	• Second Essay: a discussion of sexuality in childhood. • Adult sexual aberrations are linked to unexpected and abnormal events during childhood. • Problem with satisfying the instincts taken over by the id.
Freud, S. (1951).	A letter normalizing homosexuality, explaining the non-pathology.	NA	NA	NA	• Freud, who initially viewed homosexuality as less than optimal development, later tool this back changing his view on homosexuality in his famous letter. • "It is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness."
Greene, B.	An examination	NA	NA	Theoretical	• Those in subordinate positions are taught not to trust

(2005).	of oppressive ideologies still existing in the mental health field and their effects on the creation of social injustice.			Discussion	their own perceptions, be "blinded" to their own exploitation and to surrender to the perceptions of the dominant culture. • People fear differences. This is a learned rather than innate fear. Moreover, it is a fear base on assumptions, not real differences. • Some adversity can lead to resilience. Too much can threaten ones psychological well-being. • The myth of equal opportunity for all leads to an erasure of the history of all those that have been oppressed. • Overpathologizing: Pathological environment rather than pathological individual. • The minimization of trauma can lead to a retraumatization. • Miner's Canary Metaphor: problem with gas in the mines, not with the canary.
Goldfried, M. (2001).	Discussion of how mainstream literature has ignored a wide variety of GLB issues and the consequences of this oversight, as well as the benefits of introducing such issues to mainstream psychology.	NA	NA	Literature Review	• Significance of family support and the reduction in symptomology as a result of family support. • Brief history of the conceptualization of homosexuality from the mental health perspective and the changes that have occurred in the DSM over time. • Importance of increasing research on GLB populations stems from the increased rates of utilization of therapy, as they must deal with issues that heterosexuals confront in addition to issues such as stigmatization, family rejection, oppression, sexual identity issues, and internalized homophobia. • Keeping such issues out of the mainstream is analogous to keeping LGB people in the closet. • Continued gaps between mainstream and GLB literature are evident in areas such as: life span development and aging, teenage suicide, substance abuse, victimization and abuse, and family and couple relationships. • Clinical relevance: study of marital conflict attributed to gender differences, domestic violence and eating disorders as a female disorder.

					• Importance: it is our ethical responsibility to assure that we are using the best treatments with our patients. We are using treatment for LGB clients based on heterosexual clients, limiting the generalization and causing us to draw biased conclusions, which can be harmful.
Herek, G., & Garnets, L. (2007).	An overview of the current psychological research on mental health and sexual orientation	NA	NA	Literature Review	• The pathologizing of homosexuality throughout most of the twentieth century continues to complicate discussions of sexual orientation and mental health in present day. • The field of psychology has exacerbated the stigma related to homosexuality through its status as a psychopathology creating an additive effect to other cultural institutions such as law and religion. • Benkert introduced the notion of sexuality into the medical discourse in 1868 contrasting homosexual with "normal sexual". • It was not until Freud introduces his conceptualization of homosexuality in the first of his *Three essays on the Theory of Sexuality* that the modern notion of sexual orientation defined in terms of object choice became the dominant one in the medical discourse. • Freud who initially viewed homosexuality as less than optimal later altered his notion of homosexuality in his famous 1935 letter claiming that "it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness (Freud 1951, p.786). • However, as psychoanalysis was the dominant perspective in psychiatry throughout the mid-twentieth century, the notion that homosexuality was pathological continued to permeate though American culture. • The first DSM listed homosexuality as a sociopathic personality disturbance, along with substance abuse and sexual disorders. • Kinsey was the first to challenge such faulty notions with the groundbreaking studies documenting the

					existence of homosexual behavior and attraction in many nonhuman species and its acceptance in a large number of human cultures. • Hooker then introduces key elements of modern research design to help eradicate the notion of homosexuality as an illness in her innovative study comparing non-clinical homosexual population to non-clinical heterosexual populations using the Rorschach. She utilized experts to interpret the results on the Rorschach, all of whom were unable to determine the sexuality of the respondents and found no differences in ratings of adjustment between the two groups. Based on these results she concluded that homosexuality is not inherently associated with pathology and that it is not a clinical entity. • Hooker brought to light problems with outcomes of previous findings as they were based on clinical or incarcerated samples. In such cases, it is not surprising that such samples presented with more psychological problems. • In the second edition of the DSM, homosexuality was listed as a "Sexual Deviation" along with fetishism and pedophilia. • In 1973, the APA Board of Directors voted to remove homosexuality from the DSM. • Current Problems with sampling still exist" ✧ It is difficult to assess the accuracy of respondents pertaining to their sexuality. ✧ Even when participants provide accurate information about their sexuality, how this information is then categorized into data analysis depends on the operational definition selected by the researchers, which varies. ✧ Operational definitions of psychological distress have been determined predominantly on the basis of heterosexual populations, making clinical inferences about sexual minority individuals based on cutoff scores derived from testing with heterosexual individuals of questionable validity.

Hooker, E. (1957).	A comparison of non-clinical homosexual populations to non-clinical heterosexual populations.	60 unmarked psychological profiles analyzed by 3 experts.	1.Rorschach 2.TAT 3. Make a picture-story test	Experimental Design: Comparative	• Hooker then introduced key elements of modern research design to help eradicate the notion of homosexuality as an illness in her innovative study comparing non-clinical homosexual population to non-clinical heterosexual populations using the Rorschach, the Thematic Apperception Test and the Make-a-Picture-Story Test. • She utilized experts to interpret the results on the Rorschach, all of whom were unable to determine the sexuality of the respondents and found no differences in ratings of adjustment between the two groups. • Based on these results she concluded that homosexuality is not inherently associated with pathology and that it is not a clinical entity. • Hooker essentially brought to light the invalidities with the outcomes of previous findings as they were based on clinical or incarcerated samples
Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948).	Demonstration of homosexual behavior and same-sex attraction across species	NA	NA	Literature Review	• The 1948 Kinsey Report, *Sexual Behavior in the Human Male*, was the first to challenge such faulty notions with the groundbreaking studies documenting the existence of homosexual behavior and attraction in many nonhuman species and its acceptance in a large number of human cultures. • This report immediately produced a great deal of controversy as it was the first of its type in American society.
Mohr, J. J., & Rochlen, A. B. (1999).	A comprehensive assessment of the psychometric properties of the Attitudes Regarding Bisexuality Scale (ARBS), a measure designed to assess two dimensions of	**Study 1:** 110 self identified lesbians and 141 self identified gay men. Ages 15-52 (M=27.71, SD=8.98). Race/Ethnicity: 83% White, 2% Black, 6% Hispanic, 6%	1. Attitudes Regarding Bisexuality Scale (ARBS) 2. Attitudes Towards Lesbian and Gay Men Scale (ATLG). 3.Need for Closure Scale.	Test Validation Study	• An initial pool of 80 items wwas used for the initial reliability estimates. • Authors found that Lesbian women view bisexuality as a more stable sexual than did gay men. No significant differences were found related to the tolerance subscale. • Study 2 revealed high internal consistency estimates, with a significant difference only on the tolerance scale, with females demonstrating a higher level of tolerance than males. • Results demonstrated that the ARBS exhibited factor

	attitudes toward bisexual men and women (tolerance and stability).	Asian/Pacific Islander, 2% Native American and 1% Middle Eastern. **Study 2:** 288 self identified heterosexual undergraduate participants (120 male, 166 female & 2 not disclosed). Ages 18-29. Race/Ethnicity: 55% White, 20% Black, 7% Hispanic, 12% Asian American and 6% Other. **Study 3:** 305 heterosexual undergraduate students from previous samples. **Study 4:** 127 self identified lesbians and 188 self identified gay men. Ages 17-61 (M=30.50, SD=9.07). Race/Ethnicity: 88% White, 2% Black, 3% Hispanic, 5% Asian/Pacific Islander, 1%	4. Marlowe-Crowne Socail Desirability Scale – Short Form (MC-SDS - SF). 5.Homosexual Attitudes Inventory (7 items only to assess internalized homophobia). 6. Muli-group Ethnic Identity Measure –Other Group Orientation Subscale only. 7. Self Monitoring Scale. 8. Need to Evaluate Scale. 9. Demographic questionnaire.		structure stability, moderate-to-high estimates of internal consistency reliability and test–retest reliability over a 3-week period. • Heterosexual sample demonstrated evidence for convergent validity was provided as a result of the significant associations of the ARBS with "attitudes toward lesbians and gay men, NSS, race, frequency of religious attendance, political ideology, personal contact with LGB individuals, and sexual orientation identity" (p.365). • Gender differences in attitude towards bisexuality tend to be most evident regarding to bisexual men.

		Native American and 1% Other. **Study 5:** 26 undergraduate students (16 women, 9 men and 1who did not complete gender item). Race/Ethnicity: 58% White, 27% Black, 3% Hispanic, 12% Asian American and 3% Other.			
Morin, S. F. (1977).	Review of empirical articles addressing gay and lesbian issues between the years 1967-1974.	NA	NA	Content Review	• He found the following trends: 16% (27) of the articles found relating to LGB individuals were on the subject matter of assessment and diagnosis of homosexuality as a pathological condition. 30% (50) of the articles related to discovering the underlying causes of homosexuality in order to uncover methods of prevention. 27% (46) discussed psychological maladjustment of homosexuals with comparison to their heterosexual counterparts. 20% (24) of the articles were on special topics that only tangentially related to homosexuality. Lastly, only 8% (13) of the articles focused on heterosexist attitudes towards gay men and lesbian women; only one focusing on attempting to change such attitudes. It is clear that at this time, the LGB literature was still in its infancy and that heterosexism still existed in the field.
Morrison, M., & Morrison, T. (2002).	A comprehensive assessment of the psychometric properties of the Modern Homonegativity Scale (MHS), a	**1&2:** Self identified heterosexual university students from British Columbia, Canada **Study 1:** 353 (149	1. Modern Homonegativity Scale (MHS) 2. Attitude Towards Women Scale (ATWS) –	Test Validation Study	• Authors propose that homonegativity has not subsided, but has undergone a metamorphosis from 'old fashioned' biblical sanctions and moral opposition to contemporary abstract concerns. • Study 1 demonstrated that the final 13-item version of the MHS is a reliable unidimensional measure of modern homonegativity.

	measure of present-day negative opinions of gay men and lesbian women. An examination of behavioral expression of modern homonegativity.	males & 204 females). Ages 17-45 (M=21.8, SD=4.9) **Study 2:** 308 (148 male & 160 female). Ages 18-51 (M=22.5, SD=4.8) **Study 3:** 233 college students (64 males & 169 females) from Alberta, Canada. **Study 4:** 49 (24 males & 25 females) from study 2, who scored in the top or bottom quartile of the MHS.	traditional measure of heterosexist attitudes. 3.Homonegativity Scale (HS) – traditional measure of negative attitudes towards gay and lesbian women. 4. Marlowe-Crowne Socail Desirability Scale (MC-SDS) – measures the tendency to respond in a culturally appropriate manner. 5.Neosexism Scale (NS) – a measure of modern sexism. 6. Attitudes Towards Lesbian and Gay Men Scale-Short Form (ATLG-S) – a traditional measure of homonegativity. 7. Background		• Study 2 revealed a positive correlation between modern homonegativity (MHS) and modern sexism (NS) that was stronger than the correlation between modern homonegativity and traditional sexism and between and between traditional homonegativity and modern sexism. This study demonstrated that the MHS is conceptually distinct from the previous traditional measures. • Study 2 also revealed that scores on the MHS correlated positively with neosexism, but did not correlate with social desirability bias, strengthening the reliability of the measure and providing an accurate view of negative attitudes toward gay men and lesbians. • Study 3 confirmed that both males and females levels of modern homonegativity is notably greater than their level of traditional homonegativity, as compared using the MHS and ATLG. • Study 4 found demonstrated that those who possessed higher levels of homonegativity (as indicated by a high score on the MHS), had a greater tendency to avoid sitting next to a confederate presumed to be same-sex oriented under covert circumstances, in which they could justify their seating choice based on non-prejudicial arguments. Under overt conditions, in which one would not be able to argue non-prejudicial reasoning, no significant differences in seating choice were found.

			questionnaire. 8. Movie Reaction Questionnaire. 9. Post-Experimental Inquiry.		
Phillips, J. C., Ingram, K. M., Smith, N. G., & Mindes, E. J. (2003).	A review and analysis of the trends in methodology and content of LGB related articles over time and the relationship to American sociopolitical context.	8 Major Counseling Journals - 5628 Articles Years: 1990-1999	NA	Methodological and Content Review	**Historical Overview:** • Morin (1977) conducted the first content review of empirical articles addressing gay and lesbian issues published between the years 1967 and 1974. The trends found were as follows: • 16% (27) Assessment and diagnosis of homosexuality as a pathological condition. • 30% (50) Discovering the underlying causes of homosexuality in order to uncover methods of prevention. • 27% (46) Discussing psychological maladjustment of homosexuals with comparison to their heterosexual counterparts. • 20% (24) Special topics that only tangentially related to homosexuality. • 8% (13) heterosexist attitudes towards gay men and lesbian women; only one focusing on attempting to change such attitudes. • Buhrke (1989) argued the LGB literature was still in its infancy, that training in counseling psychology was still lacking and that the heterosexism still existed in the field. **Current Study:** • Researchers found a deficiency in measures of attitudes towards LGB people. • Current literature emphasizes non-heterosexual attraction as normal variations of human sexuality. *Examination of the damaging effects of heterosexism on non-heterosexual individuals was found to be a

					common trend in the content analysis. • A shift from the view of homosexuality and bisexuality as indicative of psychopathology to the awareness that it is the discrimination and oppression experienced by these individuals that can affect the mental health of LGB people.
Robertson, P. K. (2004).	An overview of the historical events leading up to the removal of homosexuality from the DSM.	NA	NA	Historical Overview and Discussion	• First treatments for homosexuality: aversion therapy, electroshock therapy, drug and hormone injections, and electroconvulsive therapy. • Psychodynamic Perspective: homosexuals were seriously mentally ill and compulsively driven by yearning they cannot control. • Ego-dystonic homosexuality: no specific category for heterosexuals in the DSM-III. • Kinsey Scale (1948): 0 (heterosexual) to 6 (homosexual) on a continuum, causing a shift in the conceptualization of homosexuality due to the prevalence of same sex interaction and fantasies reported. • Evelyn Hooker: found no differences in pathology between heterosexuals and homosexuals using the Rorschach. • Current discrimination: conversion therapies, same-sex marriages, sodomy laws, the ordination of gay ministers, the view of GLB parents as unfit and lack of protection by state and federal laws. • A lack of knowledge among straight therapists regarding LGB issues and heterosexist bias.

Foundational theoretical perspectives

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Cass, V. (1979).	Development of the six-stage model of homosexual identity acquisition.	NA	NA	Theoretical Discussion	• Cass's 6 stage model: 1. Identity Confusion: individuals begin to perceive that their behavior may be defined as homosexual, which brings about a great deal of confusion as this brings into question previously held identities relating to

					sexual orientation. 2. Identity Comparison: The individual begins to recognize the differences between his or herself and those who are heterosexual leading to feelings of alienation. 3. Identity Tolerance: the individual begins to commit to the new nomosexual identity and seeks out company of other non-heterosexuals to fulfill social, sexual and emotional needs. 4. Identity Acceptance: Increased contact with those who are non-heterosexual leads to an increase in acceptance and the individual begins to incorporate a homosexual lifestyle while fitting into society in which selective disclosure is incorporated into daily life. 5. Identity Pride: Pride about one's homosexual orientation is experienced and the individual feels an intense loyalty to homosexuals as a group. In this stage anger is experiences towards a society who stigmatizes and acts prejudicially toward homosexuals and purposeful confrontation with non-homosexuals occurs more frequently. 6. Identity Synthesis: Positive experiences with non-homosexuals help to decrease the dichotomization between the good homosexuals and bad heterosexuals. Individuals begin to see themselves as complex beings in which their sexual orientation is just one piece of their overall identity.
Cass, V. (1984).	Assessment of the validity of the six-stage model of homosexual identity acquisition.	178 participants: 109 males and 69 females.	1.Stage Allocation Measure: A measure developed to assess which stage each subject fits into. 2. Homosexual Identity	Theory Validation Study	• It is important to recognize that identity foreclosure can occur at any stage of development, preventing further development. • The results distinguish among the six groups. • The findings supported the hypothesis that a profile of a particular stage corresponds closely to an individual's particular mode of functioning. • Results also indicated that, at times, there can be a blurring of adjacent stages as opposed to a more

			Questionnaire. 3. Biographical Sheet.		definitive fitting into a particular stage.
Herek, G. (2007).	A framework presented to discuss stigma as a cultural phenomenon with structural and individual manifestations.	NA	NA	Theoretical Discussion	• A framework that discusses stigma as a cultural phenomenon with structural and individual manifestations. • Stigma manifested at the structural level includes society's institutions and ideological systems, such as religion, law and medicine. • Individual manifestations of stigma include enacted stigma, felt stigma and internalized stigma. ✧Enacted Stigma: refers to the overt behavioral manifestations of stigma such as discrimination, ostracism and violence. ✧Felt Stigma: felt stigma refers to the change in behavior that is produced in an individual who may expect enacted stigma at any time. ✧Internalized Stigma: refers to one's personal acceptance of such stigma as part of their value system and self concept. • The framework attempts to highlight the difficulty in eliminating internalized stigma by highlighting society's role in creating such strong longstanding beliefs from an early age. • As a result of the deep-seated nature of sexual stigma, short-term therapy is insufficient for the treatment of such internalized negative beliefs.
Muscarella, F. (2000)	Presentation of a model explaining the evolution of same-sex attraction in humans.	NA	NA	Theoretical Discussion	• The author posits a theory specific for same-sex behaviors, regardless of sexual orientation. • Based on evolution, homoerotic behavior helped to increase status, which in turn increased rates of survival and procreation. • Author claims that homoerotic behavior may have helped low class males climb the social hierarchy.
Troiden, R. (1989).	Outline of a 4-stage model of homosexual	NA	NA	Theoretical Discussion	• 4 Stage model using sociological theory. 1. Sensitization: Generally occurs prior to adolescence,

	identity development, elaborating on previous research.				in this stage the individual begins to realize that he or she is different than same-sex peers. 2. Identity Confusion: This stage is characterized by a period of internal conflict revolving one's sexual orientation identity. During this stage the individual experiences a great deal of isolation and alienation. 3.Identity Assumption: Generally occurs in late adolescence and early adulthood. In this stage the individual begins to accept his or her minority sexual orientation and becomes more involved in and a part of the gay community, setting in motion a period marked by sexual exploration. 4. Commitment: A commitment by the individual to his or her sexual identity and a strive forward to accomplish goals and reach levels of personal success. • In opposition to Cass, Troiden claims that these stages are not linear and can be influences by society and social factors.

Contemporary Theoretical Perspectives

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Diamond, L. (1998).	Investigate the hypothesis that women will fail to meet the features of the traditional model of sexuality and the correlation to degree of same-sex attraction.	89 female participants aged 16-23 who maintained a non-heterosexual identity.	Semi-structured face to face interviews (1-1.5 hours in length) modeled upon existing interview data on sexual identity development.	Experimental Design	• More than ¾ of women failed to report at least one of the following experiences: childhood indicators of sexual orientation, awareness of same-sex attractions prior to sexual questioning and an experience of sexual attraction as stable. • Researchers concluded that their results indicate deviations from the traditional developmental model.
Diamond, L. & Butterworth, M. (2008).	Application of research on non-heterosexual women	NA	NA	Theoretical Discussion	• Traditional theories and sexual identity development and gender identity development have adopted dichotomous

	utilizing the framework of intersectionality for the exploration of transgender identification.				models. However, contemporary research and development has criticized such dichotomous theories for failing to account for the multiplicity and fluidity that many individuals experience and the diversity of experiences that individuals have. • Intersectionality theorizes that practice of multiple identifications is "unique, non-additive and not reducible to the original identities that went into them." (p.366). • Authors argue that societal pressure towards categorization inhibits a process in which individuals can experience a healthy self with multiple identities. They further argue that we do not even have the language to appropriately describe such experiences or states of being. • Moreover, authors argue that each successive life stage, each social location and each intimate relationship should be treated as continually interacting with one's dynamic experience over time.
Fassinger and Miller (2008)	Validation of an inclusive model of sexual minority identity formation involving individual a sexual identity process and a group membership identity process.	34 gay men ages 20-55 (mean age = 31). *Ethnicity: 6% AA, 79% Caucasian, 6% Latino and 9% Asian American. *Religious identification: 29% Protestant, 38% Catholic, 9% Jewish, 3% Muslim/Hindu/Buddhist and 21% no religious affiliation.	1.Demographic Questionnaire. 2. Q-Sort Modified and reworded for gay male sample.	Theory validation	• Authors incorporate but separate the process of internal individual sexual identity development and a more contextual group membership identity development process, facilitating flexibility in sexual identity expression. • Results supported hypothesis. Additionally, results indicated greater clarity in the development of a sense of internal identification rather than the development of a sense of group identification. • Implications of the study allow to separate different factors of sexual identity, which may require different types of interventions

					and support.
Floyd, F. J., & Stein, T. S. (2002)	Examination of variations in the coming out process of gay, lesbian and bisexual youths.	72 participants self-identified as gay, lesbian or bisexual, ages 16-27 (mean age = 20.88). *Ethnicity: 79% European American, 7% Asian American, 6% African American, 3% Native American, and 6% other.	1.Timing of coming out milestones events. 2. Gay, lesbian. Bisexual social immersion. 3. Other milestone events. 4. Sexual Orientation Grid – interview format. 5. Brief symptoms inventory. 6. Rosenberg Self Esteem Scale.	Cluster Analysis Research Design	• Authors argue that stage models of sexual identity are overly simplistic and fail to account for variability. • Authors argue that variability occurs as a result of a number of reasons, rather than previous arguments that variability can be accounted for by the early or late trajectory alone. • Authors discuss a number of 'disruptions' can occur during the coming out process. For example, inhibition of disclosure to others, inhibition of same-gender sexual activity, and variations in the nature of immersion into gay, lesbian, and bisexual social networks. • Findings highlight the importance of examining both individual differences and lifelong patterns of development for LGB individuals. • Moreover, findings highlight the importance of personal experiences and qualities over grouping based on gay, lesbian or bisexual identity.
Leff, L. (2012)	News article related to legislature banning reparative therapy when working with youth in California	NA	NA	News Article	• Senate passed the law in May, 2012. • Governor Jerry Brown signed the law. • Law went to the federal appeals court's order, holding the claim that this law violates the First Amendment rights of therapists and parent. • On December 4, US district judge Kimberly Mueller refused to block the law, concluding that the law does not take away civil rights. • Law to be enacted January 1, 2013.
Rosario, M.,	Examination of	145 participants ages	1. Structured	Experimental	• Authors contend that for ethnic/racial

Schrimshaw, E. W., & Hunter, J. (2004).	racial and ethnic differences in the coming out process.	14-21(mean age=18.3) *Ethnicity: 37% Latino, 35% AA, 22% Caucasian, 7% Asian and other ethnic backgrounds.	Interview (2-3 hours). 2. Sexual Risk Behavior Assessment – Youth (SERBAS-Y) 3. Sociosexual developmental Milestones. 4. Nungesser Homosexual Attitude Inventory Adapted (33 item scale modified for youths by simplifying language). 5. The Marlow-Crowne Social Desirability Scale.	Design	minority LGB individuals, the coming-out process may be complicated by cultural factors that impact the process. • Results indicated that sexual identity, current sexual orientation, and recent sexual activity were not significantly impacted as a result of ethnic/racial affiliation. • Differences in identity integration, however, were demonstrated amongst the several ethnic/racial affiliations.
Rosario, M., Schrimshaw, E. W., Hunter, J., & Braun, L. (2006)	Examination of the consistency and change of sexual identity over time among LGB youths and the impact on identity integration.	156 participants ages 14-21(mean age=18.3) *Ethnicity: 37% Latino, 35% AA, 22% Caucasian, 7% Asian and other ethnic backgrounds.	1.Sexual Risk Behavior Assessment – Youth (SERBAS-Y) 2. Sociosexual developmental Milestones. 3. The Marlow-Crowne Social Desirability Scale.	Complex Between Group Experimental Design	• LGB sexual identity development is a complex and often difficult process. Unlike other minority groups, LGB individuals are not typically raised in a community of similar others who reinforce and support that identity. • Researchers argue that retrospective studies may overestimate the linear trend and under-represent individual variability. They, therefore, argue the necessity for longitudinal studies. • Overall, results indicated that there is considerable variability regarding sexuality over time. However, three patterns emerged from the current study: consistently gay/lesbian, transitioned from

					bisexual to gay/lesbian, and consistently bisexual.
Rosario, M., Schrimshaw, E., Hunter, J., & Levy-Warren, A. (2009)	Investigation of Butch – Femme differences during the coming out process.	76 self-identified lesbian and bisexual young women from NYC ages 14–21 years (mean age =18.4). *Ethnicity: 38% Latina, 36% African Origin, 20% Caucasian, 3% Asian, and 4% other ethnic backgrounds	1.Sexual Risk Behavior Assessment – Youth (SERBAS-Y) 2. Sociosexual developmental Milestones. 3. The Marlow-Crowne Social Desirability Scale.	Between Group Longitudinal Study	• Although most models of sexual identity development describe a relatively linear process of identity formation and integration, researchers have more recently begun to examine the diverse paths of the coming out process. • Authors argue that one potential factor influencing variability in the coming-out process of women may be differences in butch/femme identification. • Results failed to demonstrate significant differences among lesbian butch and lesbian femme participants. They did, however, find differences between bisexual femme participants and lesbian butch/femme participants in the areas of sexual behavior, sexual orientation, and sexual identity integration. Only found few differences in sexual identity formation were found.
Savin-Williams, R. C. (2001)	Critique of current literature and research on issues pertaining LGB sexual development utilizing LGB youth samples	NA	NA	Critique of Literature	• Past research on sexual-minority youths has assumed a categorical conceptualization of sexual desire that is heterosexual, bisexual, or homosexual. Moreover, according to this notion, only one type of homosexuality exists. • Author argues that variability exists among individuals and subgroups, based on biological, personal and social characteristics, and across a range of child and adolescent milestones and transitions. • Review of literature lends to the argument that within group differences are larges that between group differences.

					• He argues that since research has largely investigated difference among gay, lesbian bisexual and heterosexual individuals, that such research is investigating the differences among those who identify as one of the above categories, rather than providing useful implications about sexual attractions, desires and behaviors. • Author argues the importance of using samples with a diverse array of sexual-minority youths demonstrating a continuum of sexual identification, behavior and desire and then explore within-group variations.
Savin-Williams, R. C., & Diamond, L. M. (2000)	Investigation of gender differences in sexual identity development among non-heterosexual young adults.	164 non-heterosexual young adults: 78 women and 86 men ages 17-25.	1.Semistructured interview 45-90 minutes.	Content Analysis	• Author argues against the universality of the linear progression of the coming out process and highlights the diversity of experiences during this process. • Author argues that rather than interpreting gender and mean age as the contributing factors to different trajectories, it is important to attend to numerous additional factors (such as timing, context, spacing, and sequencing of milestones). • Authors studied the following four milestones: first same-sex attractions, first same-sex sexual contact, first self labeling as non-heterosexual, and first disclosure of a non-heterosexual identity to others. Authors broaden past research by attending to the following factors: the contexts of these events, the duration of time between events, and variation in the ordering first same-sex contact and first self-labeling • Authors conclude that the current study represents an important first step toward differentiating patterns in the timing,

					spacing, and sequencing of sexual identity milestones that might reveal critical factors shaping female and male sexual identity development. • Moreover, authors conclude that it is important to recognize that although gender is one factor that leads to significant differences, it is not enough to explain developmental trajectories.

Perceived Competency of Therapists Treating LGB Clients

Therapist View

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Bidell, M. (2005).	An examination of the Sexual Orientation Counselor Competency Scale (SOCCS) as a valid and reliable psychometric measure and the outcome of scale on knowledge, attitudes and skills of counselors working with LGB clients.	312 participants voluntarily recruited from 13 public and 3 private universities: 235 F & 77 M Mean age: 31.9. 15.1% Undergraduate students, 49.4% master's level counseling students, 19.9 doctoral level students, 15.7% doctoral level counselors educators or supervisors.	1. SOCCS ATLG used to validate the awareness subscale. 2.MCKAS used to validate the knowledge subscale. CSES used to validate the skills subscale.	Test Validation Study (*Rational Approach Model used to reduce the initial pool of items to the final 42-items used. Factor analysis to assess the three domains of the assessment. Test retest correlations used to determine reliability).*	• SOCCS was found to be a valid and reliable instrument in assessing the attitude, knowledge and skill competencies of counselors regarding LGB clients. • Individuals with more training and education were found to have higher competency scales. • Results showed that skill competencies were over one third lower than knowledge competencies and one half lower than awareness competencies. This indicates that although many counselors possess the awareness and knowledge about how to work with this particular minority group, a number of counselors still lack the skills to work effectively with LGB clients. • Counseling students consistently reported that the training they received did not prepare them to work in an effective and competent manner with LGB clients.
Boysen, G., & Vogel, D. (2008).	An assessment of the attitudes	105 trainees enrolled in graduate programs	Cross-Cultural Competency	Pre-experimental Design	• The mean score on the CCCI-R was 96.73 indicating a strong belief of multicultural

	that counselor trainee's have toward diversity and measurement of the discrepancies between implicit and explicit bias.	in the Midwest from 4 different universities: 2 large land-grant universities and 2 small urban universities. APA accredited programs (n=53) included: 75% female; Ethnicity: 75% European American, 15% AA, 6% Asian American, 8% Hispanic/Latino and 2% other; sexual orientation: 85% heterosexual, 4% homosexual and 11% bisexual; Mean completed semesters of training = 3.27; practicum = 1.37; counseled 6 minority clients and 1 LGB client. Non-accredited programs (n=52) included: 75% female; Ethnicity: 90% European American, 4% AA, 2% Asian American, 4% Hispanic/Latino and; sexual orientation: 90% heterosexual, 10% homosexual; Mean completed	Inventory – Revised (CCCI-R) – self-report measure of multicultural awareness, knowledge and skill. Implicit Associative Test (IAT) to measure implicit attitudes with African Americans and lesbian and gay men.		competence by participants. • Results of the IAT revealed that participants had a strong implicit bias pertaining to both African Americans and to lesbians and gay men. • Study demonstrated that fostering awareness and competence on an implicit level is much more complicated that fostering knowledge and competence on an explicit level. • Findings also showed an absence of significant differences among trainees who recently completed a multicultural course compared with those who never completed a multicultural course. • Implications: it is essential that we acknowledge the difficulties in assessing attitudes toward minority groups with the use of self-reports, as such measures have proven to be inaccurate and minimize biases. • Measuring implicit bias helps to gain more accurate knowledge and should be implemented into training facilities to assure that unconscious biased attitudes do not cause harm to the patients that seek out help from. • Limitations: All of the universities were in the Midwest, generating a sample lacking sufficient diversity. Participants may have had less access to diversity of clients which may be more readily available in other parts of the country.

		semesters of training = 3.7; practicum = .47; counseled 12 minority clients and 3 LGB clients.			
Godfrey, K., Haddock, S., Fisher, A., & Lund, L. (2006).	Determine the knowledge, experiences and values that therapists working with LGB clients should possess and the components that should be included in training curricula.	15volunteer experts in LGB related issues. 7 family therapists, 5 psychologists, 1 social worker, 1 psychiatrist, 1 professional counselor and 1 other. 4 women & 11 men Ages 30-62; Mean=48.7 13 Euro-American, 1 Asian American and 1 Hispanic. 20% heterosexual and 80% non-heterosexual.	1.Questionnaire with open ended and broad questions with few parameters. 2.Rate themes as to their importance on a Likert scale from 1-7 ranging from unnecessary to essential.	Delphi Method	• Life stressors that are unique to LGB persons include: coming out in a heterocentric society, the absence of legal opportunities and the right to marry, difficulties in adoption and child rearing, problems associated with obtaining safe and non-discriminatory housing, and possible lack of familial and religious support. • With regards to therapist vales and qualities, two items received the highest possible score: being open minded and open to diversity and possessing awareness as to one's own comfort level, biases, prejudices and more. • With regards to theoretical orientation, having knowledge about the many different theories of sexual identity development was found to be important. • Important issues pertaining to LGB individual that received the highest possible score included homophobia as a concern comprising of internalized and institutional homophobia. • With regard to diversity matters, privilege, differences between LGB individuals in general and gender identity issues were found to be most important. • With regards to assessment, assessing the relevance of LGB issues to the presenting problem and client goals and assessing the degree to which the client is out of the closet were found to be most important. • Interventions endorsed were interventions that were positive, holistic and honoring of the client, with normalizing receiving the highest possible

					score. • Confidentiality received the highest possible score in the area of ethical and legal issues. • Experts stressed the importance of having personal interaction with non-heterosexual persons in addition to the classroom experience.
Israel, T., Gorcheva, R., Walther, W., Sulzner, J., & Cohen, J. (2008).	The purpose of the study was to identify a broad range of variables perceived by psychotherapists ' to be helpful or unhelpful when working with LGBT individuals.	14 therapists with either a master's or doctoral degree (7 male, 6 female, and 1 female-to-male transgender). Ethnicity: 10 White, 2 Hispanic, 2 multiracial. Mean age was 44.5 and mean number of years in the field counseling/psychology was 12.5. Sexual Orientation: 7 heterosexual, 3 gay, 2 bisexual, 1 queer and 1 did not identify. Num of LGBT clients seen ranged from 5 yearly to 25 weekly.	Semi-structured interviews ranging from 19-64 minutes (mean: 49 minutes).	Content Analysis	• *Therapist selection:* those in the helpful situations were more likely to find their therapist through a referral (H=28.6%, UH=14.3%), whereas those in the unhelpful situations were more likely to be assigned to a therapist by an agency or other third party (H=21.4%, UH=42.9). • *Theoretical Approach:* CBT (H=42.9%, UH=14.3%); humanistic (H=28.6%), feminist (H=14.3%, UH=7.1%), narrative (H=14.3%, UH=0). Case management was used only in the UH situations. • *Therapeutic Alliance:* most frequently characterized by safety and trust (H=42.9%, UH=7.1%), and being enjoyable including the use of humor (H=35.7%, UH=7.1%). Moreover, the following characterizations were found in the helpful situations: validation, acceptance, empowerment or affirmation (21.5%), satisfactory working relationship (28.6%), initiation of cordial contact after termination (21.5%) and strong working alliance (14.3%). Conversely, in the unhelpful situations the following characteristics were found: negative effects of countertransference (14.3) and failure to produce a connection (21.4%). • *Interventions and Client Response:* In the helpful situations the following trends were found: use of specific techniques (78.6%), psychoeducation and assistance accessing resources (42.9%), directive and structured approaches (35.7%), validation, normalization and empathy (35.7%), and self disclosure (35.7%). Unhelpful situations were

					found to have interpretations and feedback (28.6%), questioning and exploration (28.6%) self disclosure (28.6%) and assessment and testing (28.6%). • Therapists described helpful situations as : situations in which they possessed sufficient knowledge and felt helpful in dealing with the clients sexual orientation or gender identity (64.3%), having a positive relationship with the client (42.9%), alleviation of symptomology (35.7%), helping the client to gain insight (28.6%), appropriate focus on the client's concerns (21.4%), feeling non-judgmental (21.4%), teaching the client new skills (14.3%), disclosing an LGBT related experience (14.3%), providing client with a positive LGBT role model (14.3%), providing LGBT related resources (7.1%), availability outside of session (7.1%), and exploration of difficult topics (7.1%). • Unhelpful situations were described as demonstrating negative reactions to client's sexual orientation (21.4), therapist's evaluation of therapeutic outcome as unhelpful (21.4%), difficulties connecting with the client (21.4%), the therapist viewing the client as LGBT prior to disclosure (21.4%), lack of trust toward therapist (14.3%), lack of preparation to deal with client's possessing complex identity (14.3%), therapist imposing values or judgments on the client (14.3%), client experience of therapist as uncaring (14.3%), incompatible focus of therapy between the client and therapist (7.1%), therapist pushing client to explore topics (7.1%), and agency or setting not being LGBT affirmative (7.1%).

Client View

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Alcazar-Olan, R. J., Deffenbacher, J. L., Hernandez-Guzman. L., Sharma, B., & De La Chaussee-Acuna, M. E. (2010).	Retrospective study comparing two groups of individuals – those who decided to return to therapy after the initial intake process and those who did not.	173 participants attending a public school of psychology in Mexico City: 24 men and 139 women (Mean age = 26.09 years).	1.Demographic Questionnaire. 2. Scale of Patient's perception of Therapist.	Case Control Retrospective Design	• Biological sex was not found to be a factor impacting the decision to return to therapy. • Individuals who decided to return to therapy after the initial intake process perceived therapist to have more positive qualities than those who did not return to therapy. • Motivation to attend therapy was found to be an important factor that impacted the decision to return or not.
Atkinson, D., Brady, S., & Casas, J. (1981).	An examination of the relationship of group membership to attitudes toward group on the perceived credibility and attractiveness of a therapist.	84 gay men. Aged 17-66 (Mean = 26.4 years) Ethnicity: 83% White, 10% Hispanic, 4% Asian American and 1% African American.	1.Shortened version of the Counselor Rating Form (CRF).	Descriptive Study	• Participants preferred therapists who shared the same sexual orientation with them and viewed them as more credible. • Therapist who hold an LGB affirming view were rated almost as competent in their treatment as therapist who shared the same sexual orientation with the client.
Burckell, L., & Goldfried, M. (2006).	Identify therapist qualities preferred by sexual minority clients and determine the influence of presenting problem.	42 non-heterosexual adults recruited from State University of New York at Stony Brook and LGB organizations in the New York metropolitan area. Ages 18-29 (Mean = 20.86). 62% female and 38% male. Ethnicity: 74% Caucasian and 26% ethnic minority.	1.Questionnaire surveying prior therapy experiences and comfort with sexual identity. 2. Internalized Homophobia Scale (IHP).	Descriptive Study	• Lack of services: their still exists today a disparity regarding the need for mental health services from the LGB community and the clinicians who feel sufficiently trained to competently provide them services. • Results indicated that there are certain therapist characteristics and traits that LGB clients desire regardless of the presenting problem and the salience of sexual orientation to the presenting problem. The traits included being affirming and supportive, having a good therapeutic alliance and having a general awareness of LGB issues. • Items that were consistently undesirable no matter what the presenting problem was

					included therapist tentativeness and discomfort in working with LGB clients, reluctance to engage in further inquiry pertaining to a client's sexual identity, use of heterocentric language, failure to recognize that the client is non-heterosexual, and overemphasis of the client's sexual identity.
Lebolt, J. (1999).	An examination of the experiences of gay male who received gay affirmative therapy based on feminist methodology.	9 gay males (no additional information provided).	1.25-2 Hour Semi-structured recorder interview.	Phenomenological Study	• A sense of authenticity and self comfort was an important trait for most of the participants. • Therapists who were able to understand the gay experience, who normalized and validation non-heterosexual orientations, who disclosed previous experiences working with the gay community and who allowed and encouraged clients to explore their sexuality and same-sex relationships were rated as being effective as therapists. Clients reported such therapists made them feel safe and comfortable.
Mair, D. (2003).	An exploration of gay men's perceptions of how their sexual orientation and the sexual orientation of their therapist impinged affected the therapeutic relationship.	14 self identified gay men ranging in age from 22-51 who had been in individual psychotherapy for a minimum of 6 sessions.	All participants were interviewed over a 5 month period. Interview time ranged from 50-60 minutes and was conducted either by phone or in person. The interview schedule covered seven areas of inquiry.	Qualitative Study	• Fidings revelaed significant differences among participants, some of which preferred gay therapists, some of which strongly opposed working with a gay therapist, and some who did not feel strongly about their therapist's sexual orientation. • In the absence of vervbal indicators, participants tended to assume heterosexulaity. • Individuals that were out and more comfortable with their sexual orientation were also more open to working with a gay therapist. • Individuals with a greater deal of internalized homophonia were more likely to project their negative feelings onto a gay therapist.
Ryden, J., & Loewenthal, D. (2001).	Investigate the influence of therapists' sexual orientation	6 self-identified lesbian women; all White and able bodied.	All participants were interviewed using a semi-structured	Qualitative Analysis	• All of the participants made use of stereotypes to make inferences about the sexuality of their therapist (i.e. clothes, hair, etc.). • Having the same sexual orientation as the

	identification on the therapy experience with self-identified lesbian women.		interview time ranged from 1-2 hours and was conducted either by phone or in person. The interview schedule covered three areas of inquiry.		clinician raised a contradiction regarding safety within the therapeutic relationship, as on the one hand the therapist was perceived to be more understanding and accepting but on the other hand presented a threat related to sexual transference issues.
Stein, G., & Bonuck, K. (2001).	Exploration of the concerns, perceptions and experiences that gay men and lesbian women have regarding the physician-patient relationship.	575 Self identified sexual minority individuals from the New-York metropolitan area. *Convenience Sample *61% gay, 31% lesbian and 6% bisexual. *76% White *Religious Background: 30% Catholic, 23% Jewish, 22% Protestant.	Health Care Attitudes in the Lesbian and Gay Community Survey - 64 item questionnaire	Content Analysis	• Men and individuals who were HIV positive were significantly more likely to rate their health care provider as sensitive to LGB concern than women and those with an HIV negative diagnosis. • Individuals under the age of 30 and over the age of 60 were less likely to perceive their healthcare provider to be sensitive to LGB concerns. • A sizeable minority (17%) avoided or delayed seeking mental health care due to reasons pertaining to their minority sexual orientation status. • A substantial minority (30%) did not disclose their minority sexual orientation to their health care providers. • Only 29% were asked their sexual orientation by their health care provider. This undersized number indicates a need to increase training for appropriate physician-patient communication, especially in the discussion of future health care planning, advance directives and family relationships. • As the sample from the study was taken from the New York metropolitan area it was viewed as a best case scenario, as New York possesses a large number of sexual minority individuals and a large number of gay friendly

					organizations and providers.

Current Practices in Working Clinically with LGB Clients

Assessments

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Major Findings
Amico, J. M. (1997).	Differentiate between sexual compulsive behaviors in gay males and behaviors common to the coming out process and to discuss the role of sex addiction.	NA	NA	Clinical Discussion	• When engaging in assessment with LGB individuals, it is essential to have an understanding of the coming out process. • Important questions include the following: 1. Who in your family, friends and workplace knows about your sexual orientation? 2. What is the level of acceptance by family of your sexual orientation? 3. If you could change your sexual orientation, would you? 4. How do you feel about your sexual orientation? 5. How old were you when you had your first sexual experience? How old was the other person? 6. Describe your first sexual experience with an adult. • The author contends that it is important to understand the individuals perception of his or her own sexual orientation. Just because one is out of the closet (Stage 6) does not mean that they are accepting or comfortable with their sexual orientation (Stage 2). It is important to recognize that individuals do not necessarily fit into categories of the coming out process neatly as in the above case. • Moreover, it is important to consider the role of shame in initial assessment- shame is a driving force for addiction and shame due to heterosexism is a force for any non-heterosexual

					individual. • Author identified the following cycle: LGB individual attempts to stay sober from alcohol and drugs, which may lead to sexual acting out in turn producing shame (due to heterosexism). This shame increases the urge to use substances.
Bradford, J. B., Cahill, S., Grasso, C., & Makadon, H. J. (2012)	Guidelines on how to gather sexual orientation and gender identity information in clinical settings.	NA	NA	Clinical Discussion	• Questions regarding sexual orientation should be included in the demographic part of the intake form. • If the individual leaves the question blank, the provider should inquire further about this. • It is important to provide client with education about the importance of disclosing sexual orientation within health services. • Providers should ask clients for permission to

					include information about sexual orientation in the records, reminding the clients of the importance of including this information with regards to the quality of care and to assure clients that information is kept confidential. • Providers should send a welcoming message within clinics and offices, which can be facilitated by visible signs such as posting the rainbow flag, the logo of the Gay and Lesbian Medical Association, and/or a social marketing campaign showing affirming images of LGBT individuals. • It is important to use inclusive or neutral language.
Browne, D., Woltman, M., Tumarkin, L., Dyer, S., & Buchbinder ,S. (2008)	Generate recommendations for change and improvement in working with LGBT individuals attempting to access healthcare in NYC facilities.	NA	NA	Clinical Recommendations	• Authors recommended that institutions require mandatory staff training for sensitivity with working with LGBT individuals. • Facilities should designate an LGBT liaison to monitor staff compliance with LGBT affirmative treatment, deal with complaints, serve as an advocate for clients, and support the institution's outreach to the LGBT community. The presence of an LGBT liaison should be advertised throughout the facility. • It is critical to have the knowledge regarding health disparities affecting LGBT individuals, as well as working with specific subgroups within the LGBT community (i.e. LGBT youth, LGBT elders, closeted LGBT individuals, etc.). • Intake forms should be revised to represent more inclusive language and demonstrate a welcoming and safe environment. • Anti-discrimination policies should be including in writing for clients and staff members. • Advertisement of LGBT affirmative policies through brochures, internet resources, pamphlets, etc.

					• Increased research on LGBT health issues and possible health disparities for LGBT individuals, as well as assessing healthcare access and utilization patterns.
California Department of Health Services STD Control Branch & California STD/HIV Prevention Training Center (n.d.).	Clinical resource guide on screening, testing, diagnosis and prevention of STDs in the LGBT community.	NA	NA	Clinical Recommendations	• Create a welcoming environment – often times LGBT individuals will scan an office for clues to help them determine their sense of comfort within a setting so it is important to present signs and signals that will create a sense of comfort (brochures and educational materials including LGBT relevant information, LGBT affirmative signs (rainbow flag, pink triangle, and other LGBT friendly symbols and posters), posters displaying alternative family structures, visible non-discrimination statement, etc. • Acknowledge relevant days of observance including World AIDS day, LGBT pride day, and national Transgender day of remembrance. • Use gender-neutral language, approach the interview in an empathic, open minded and non-judgmental approach, ask appropriate questions while avoiding unnecessary probing, explain why it is you need information. Moreover, it is important to recognize that certain terminology that the client may use may not be appropriate for use by a mental health provider. • Use the same language that the patient uses in describing self, others, relationships and identity. • Ask patient to clarify terms you are unfamiliar with to reduce any miscommunication. • Be prepared on how to treat LGBT individuals so that when they arrive you are prepared and do not alienate them for the care they need and deserve. • Recognize that trust and rapport may take a longer to build. • Providers should encourage openness by the

					importance of obtaining accurate information in order to provide appropriate care, as well as discussing issues of confidentiality. It is important to specify what, in any, information is retained in records. Moreover, providers should develop and distribute a written confidentiality statement. • It is important to explore to what degree LGBT individuals are 'out' to family, friends, employers, etc. and to assess the extent of social support within the community. • It is important to have knowledge about and be prepared to discuss safe sex techniques relevant to LGBT individuals. • Do not make assumptions! A female that identifies as lesbian, may have had male sexual partners in the past, may have children, may have been or is currently pregnant and not is protected against risk of STDs. Similarly, a man who identifies as gay or bisexual, may have children, may have been married etc. Overall, one should avoid any assumptions about past, present or future. • It is important to recognize that battery occurs in the LGBT community just as it does in the heterosexual community. It is important to conduct a violence screening in LGBT relationships just as in heterosexual ones. Moreover, it is important to recognize that at times, closeted individuals who are battered choose to stay in the abusive relationship for fear of being outed to friends, family and employers by the batterer. As all relationship screening, violence screening should be conducted in a gender-neutral manner. • When possible, it is helpful to have members of the LGBT community as staff members. • Trainings and guidelines for cultural sensitivity in

					working with the LGBT community should be present. • LGBT appropriate referral in the community should be identified – resource list. • A universal gender inclusive restroom is recommended to avoid people being harassed for going into the 'wrong' restroom.
Eubanks-Carter, C., & Goldfried, M. (2006).	Evaluate therapist biases is assessing non-heterosexual persons as more impaired, specifically examining the risk of misdiagnosing borderline personality disorder.	141 Psychologists: 50.7% female & 49.3% male. 92% heterosexual, 2.1% bisexual, 2.8% gay or lesbian, 2.8% not specified. 89% regularly conduct psychotherapy, 56% supervise other therapists, 61% provide clinical consultations. Mean years of experience =25.78. Mean weekly patients hours = 22.05 (caseload of 26 clients). 62% reported working with BPD in their current practice.	1. Vignettes: Therapist read vignettes, gave diagnosis, treatment and prognosis. 2.Demographic from.	Analogue Study	• History: psychoanalytic theories have historically linked homosexuality with borderline personality traits. The DSM listed uncertainty about ones sexual orientation as a criterion for BPD in the third addition • The current DSM recognizes the link between BPD and sexual identity issues, listing sexual identity disturbances as a differential. • Current research demonstrates higher rates of non-heterosexual orientation among BPD patients then in the general population. • It is possible that the coming out process can be an extremely stressful experience for many leading moods to be labile and temporary adoption of behaviors that resemble borderline traits. It is particularly important to assure that we do not over diagnose BPD and consider all other possibilities, as a diagnosis of BPD can cause negative consequences for the client in the long term. • The findings of the experiment demonstrated a bias toward diagnosing BPD in clients who were observed to have strong likelihood of being non-heterosexual (61% v. 36% of those perceived as heterosexual). Moreover, male clients with unspecified partners (i.e. perceived to be gay) had an 85.7% diagnosis of BPD compared to only 33.3% of those perceived to be bisexual. • Past research has demonstrated a bias toward

					diagnosing females rather than males with BPD. The authors argue that it is possible that therapist might be overestimating BPD in gay clients with "feminine traits". • Findings also revealed a strong heterocentric assumption among therapists as the majority of the participants who received a vignette in which the sexual orientation was not specified assumed that the client was heterosexual.
Fingerhut, A., Peplau, L., & Ghavami, N. (2005).	Provide a conceptual analysis of the dual-identity framework and assess the effects of each of identity (homosexual versus heterosexual/ mainstream) on mental health outcomes.	116 Self-identified lesbians. Recruited through Los Angeles gay/lesbian organizations and chat groups (47%) and the lesbian and gay pride parades in Los Angeles and San Francisco (53%). Age range: 17-87; median age: 28. Ethnicity: 5% AA, 4% Asian American, 69% Caucasian, 10% Latina, 12% Other.	1. Adaptation of Phinney's (1992) 20-item Multigroup Ethnicity Identity Measure (MEIM). 2. 5-item Discrimination scale (Frable, Wortman & Jospeh, 1997). 3. 13-item Internalized Homophobia scale (Martin & Dean, 1988). 4. 5-item Satisfaction with Life Scale (Diener, Emmons, Larson & Griffin, 1985).	Theory Validation Study: *(1. Median split correlations.* *2. ANOVA to assess effects of ethnicity).*	• Identified 4 possible identity categories that can help provide information about how a client conceptualizes her own identity: assimilated, lesbian-identified or separated, integrated, and marginalized. • Greater identification with mainstream heterosexual society was associated with lower levels of discrimination. Researchers hypothesized the opposite to be true assuming that more frequent interaction with those from a different sexual orientation would lead to greater levels in discrimination. • A positive lesbian identity was associated with lower levels of internalized homophobia. • Only marginally significant differences among the four different ethnicities were found, with Asian and African American participants showing lower mainstream identity scores that Latina and Caucasian participants.
Gay and Lesbian Medical Association (n.d.)	Recommendations for creating a safe clinical environment for LGBTI patients.	NA	NA	Clinical Recommendations	• Creating a welcoming environment: ✧ Have posters of ethnically diverse same-sex couples, and/or from non-profit HIV/AIDS or LGBTO organizations. ✧ Display symbols such as pink triangle, rainbow flag, unisex bathroom signs, or other LGBTI friendly symbols.

					✧ Have brochures about LGBTI heath concerns. ✧ Visible non-discrimination statement including sexual and gender identity. ✧ Have LGBTI specific media (magazines, newsletters, etc.) • Patient-Provider Relationship: ✧ Encourage openness by discussing issues of confidentiality. ✧ Be aware of possible difficulties in building trust and developing rapport. ✧ Be aware of additional barriers caused by the intersection of multiple cultural identifications and do not make assumptions about literacy, comfort with direct communication, and acculturation issues. ✧ Reflect the patients' language and terminology about sexual identification, partners and behaviors. ✧ Use gender neutral language. ✧ Discuss sexual health issues openly. ✧ Be aware that sexual behaviors of bisexual individuals may not differ significantly from those of heterosexual or homosexual individuals. ✧ Be aware of possible discriminatory or heterocentric language. • LGBTI Specific Issues that should be discussed include the following: ✧ Determine degree to which individual is 'out' to employers, family, friends, and the extent of social support or participation in the community. ✧ Safe sex techniques and issues related to sexually transmitted diseases. ✧ Make no assumptions about past sexual behaviors based on current self identification. ✧ Have knowledge of social stresses and common coping mechanisms in the community (i.e. substances, body image, exercise, eating habits,

					etc.) ✧ Conduct violence screenings to assess for harassment and partner/domestic violence. • Other suggestions: ✧ When possible have LGBTI individuals within the staff. ✧ All employees must understand that discrimination, whether overt or subtle is unacceptable regardless of their own personal beliefs. ✧ Provide trainings on the needs of LGBTI individuals. ✧ Have a universal gender-inclusive restroom if possible. ✧ Have resources for LGBTI individuals within the local community.
Group for the Advancement of Psychiatry (2011).	Recommendations for completing a sensitive sexual history with LGBT patients.	NA	NA	Clinical Recommendations	• Creating a welcoming and safe atmosphere: the therapist must be open-minded, non-judgmental, patient, tactful and respectful. • Therapist should discuss issues of privacy and confidentiality, as well as clarify the limits of confidentiality at the outset. • LGBT individuals may approach the assessment process with guardedness due to past mistreatment by mental health professionals in the past of due to their own internalized homophobia. Clinicians must be patient while building rapport. • Mirroring of the client's language can be beneficial. • One must avoid stereotyping. • Use inclusive or gender-neutral language. • Evaluation of sexual risk, knowledge about STDs, safe sex practices and how certain psychiatric disorders may contribute to inconsistent use or even neglect of safe sex practices.

					• It is important to identify the patient's concerns and to recognize that concerns may or may not be related to sexual orientation. • It is important not to assume the following: that LGBT clients do not have children, that a certain self identification means that one does not engage in sexual behaviors with individuals of the other gender, that early same-sex feelings and fantasies are simply a passing phase, that domestic violence does not occur in same-sex relationships. • It is also important to avoid common stereotypes, such as that all gay men are promiscuous or that lesbian couples experience 'bed death'.
King County. (2011).	Recommendations for health care providers to provide competent care for LGBT individuals.	NA	NA	Clinical Recommendations	• It is important to recognize the sexual orientation is not synonymous with sexual behavior. • It is important to create a sensitive, safe, non-judgmental environment. • Privacy may be particularly salient for LGBT individuals who have concerns regarding disclosure of sexual orientation in medical records. It is important to discuss how and whether or not information related to sexual orientation will be documented and obtain permission before doing so. • Be familiar with LGBT referrals in your area. • A welcoming environment includes outreach and marketing in LGBT directories and publications, including signs and materials in the waiting room that are affirming of the LGBT community, having speakers at meetings of LGBT organizations, and including sexual orientation in non-discrimination policies. • Intake forms should be free of heterosexist assumptions and questions related to family should include alternative families. • Intake forms should include an explanation about

					confidentiality and access to medical records. Individuals should be offered the right to refuse to answer a question on the intake form, which can be further discussed in the office. • It is important to complete a sexual history in a non-judgmental manner. • Ask individuals what terminology they prefer. • If you are the first person that the individual has disclosed their sexual orientation to, information must be treated with great privacy and respect. You should pay special attention to the mental health risk associated with the coming out process. • It is important to recognize that sexual orientation is distinct from gender identity. • Avoid making any assumptions about sexual orientation and gender identity. Do not assume that just because one has children, he or she is heterosexual. • Avoid the assumption that one's health issues revolve around sexuality, STDs or HIV/AIDS. • Avoid the assumption that lesbian women are not at risk for STDs. • Domestic violence occurs in the relationships of LGBT individuals as it does with heterosexual individuals. Screenings for domestic violence should be accordingly.
Pennsylvania Department of Public Welfare's Office of Mental Health and Substance Abuse Services (2009).	Recommendations for inclusive, competent and affirmative health care services for LGBTQI individuals.	NA	NA	Clinical Recommendations	• Non-discrimination policies should include any discrimination based on actual or perceived sexual orientation, gender identity and gender expression for both staff and consumers of service. • Development of training and culturally affirmative environments. Moreover, educational materials should be available. • Adopt a policy clarifying an absence of

					endorsement of conversion or reparative therapy. • Language on all documents should be amended to reflect affirmation of LGBTQI individuals. • Systematic follow-up should occur for any violations of non-discrimination policies. Consumers should be informed about their right to report discrimination. • LGBTQI should be included wherever culture is mentioned, such as including language on sexual orientation and gender identity on forms in order to reduce discrimination. • Include LGBTQI representation on advisory boards. • Include LGBTQI members and content in consumer satisfaction surveys. • Development of needs assessment to determine the capacity, gaps and needs in provider networks. • Providers should have knowledge about appropriate LGBTQI resources in the area. • Development of clinical resources specifically targeted to LGBTQI individuals and subgroups (LGBTQI youth, children of LGBTQI families, etc.) that promote healthy lifestyle choices and promote resiliency. • Development of clinical resources for prevention of behavioral health problems specific to the LGBTQI consumer population. • Suicide prevention should include specific strategies for LGBTQI youth and adults. • Develop partnerships with appropriate local governments and community organizations to enhance implementation among commonwealth. • Change existing forms to eliminate heterocentric bias and non-affirmative language. • Data collection should be in place to establish

					measureable outcomes and assure continuous evaluation.
Prince, J. (1997).	Address the limitations in psychological assessment and testing with LGB clients and suggestions for evaluating bias towards LGB individuals	NA	NA	Literature Review	• The fact that any mention of sexual orientation is evidently lacking in current literature is a clear indication of the continued bias and heterosexism that exists in the psychological testing. • Several authors have proposed development of norms appropriate for LGB people. However, modifying existing instruments to become more appropriate for LGB populations or developing new norms with existing assessment tools may preserve the existing heterosexist bias. These rapid solutions run the peril of mistakenly labeling such instruments as culturally competent and free of heterosexist bias. We need to deepen our understanding of the influences of sexual orientation on psychological assessments and testing results. • Unlike many other minority groups, sexual minority groups are often referred to as the invisible group, as you cannot identify an LGB person by the color of their skin or other surface traits. As a result, mental health professionals conducting testing cannot steer away from certain tests which contain heterosexist bias in the same way that one can with other minorities. At the same time, a great deal of these test do not have any alternative and so continue to be used. • In addition to increasing education about one's own biases in order to acquire the most accurate scores, it is important to consider the level of the individual's identity development. A great deal of measures of psychological functioning can easily reflect a temporary state rather than pervasive characteristics (i.e. depression and self esteem). Gaining an understanding of the stages of sexual identity as well as discovering where the client is

					in this process, will help to generate accurate test results. By neglecting to consider such issues, interpretation of results can be distorted, leading to overpathologizing.
Rûck, C., & Bergström, J. (2006).	A letter to the editor in response to the argument that the Yale Brown Obsessive Compulsive Scale (Y-BOCS) is discriminatory against sexual minorities.	NA	NA	NA	• A Swedish patient filed a complaint arguing that the Y-BOCS is discriminatory based on an item on the symptoms checklist concerning sexual obsession is based on content pertaining to homosexuality. • He filed a complaint to the Ombudsman, a Swedish public agency created to deal with homophobia and discrimination based on sexual orientation. • After investigation the Ombudsman claimed that the Y-BOCS should be discontinued based on the argument that it is "heteronormative and discriminatory". • The authors contend that the Ombudsman failed to distinguish between the sexual orientation of homosexuality and homosexual obsessions as they pertain to a psychiatric disorder. They further argue that gay and lesbian clients never or rarely experience obsessions about heterosexuality which is why no items on the checklist pertain to heterosexual material. They claim that the contrary occurs frequently.
Sansone, R., & Wiederman, M. (2009).	An overview of BPD and the existing research on sexuality among BPD clients. Possible explanations for the research findings.	NA	NA	Literature Review	• Incidence rates of BPD are higher among females than males, which may be due to biases in diagnosis or the behavioral differences in the manifestation of the disorder among men and women. • The theory linking sexuality and BPD was one that has existed for over 30 years. (Gunderson & Kolb, 1978). • Research has demonstrated that rates of sexual victimization among BPD clients are higher than

					those with other personality disorders. • One study showed that although women with BPD measured higher on sexual assertiveness, sexual self esteem, sexual preoccupation, and erotophilia, they also reported more sexual problems and sexual dissatisfaction (Hubert, Apt & White, 1992). • Sexual avoidance was also found in higher rates among BPD clients as compared with non-BPD clients (Zanarini et al., 2003). • A recent longitudinal study of 300 inpatients confirmed a correlation between BPD and homosexuality, as approximately one third of the patients reported engaging in a same-sex relationship over the 10 year study (Reich & Zanarini, 2008). • One of the primary symptoms of BPD is identity disturbance. A subjective lack of a coherent identity is also common among non-heterosexuals going through the coming-out process. (It is therefore, essential to make sure to consider behavioral characteristics across situations and over time, so that we do not attribute a temporary change in behaviors to problems that may be characteralogical in nature). • Fear of abandonment (is there a correlation to fear of being abandoned during the coming out process).

Treatment

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
American Psychological Association	Recommendations set out by the APA committee	NA	NA	NA	• 21 guidelines described when working with LGB clients, updated since the previous guidelines which expired in 2010, including the following issues:

(2011).	on Lesbian, Gay and Bisexual Concerns Joint Task Force for the psychotherapeutic treatment of LGB clients.				***Attitudes Toward Homosexuality and Bisexuality:*** • Guideline 1. Psychologists strive to understand the effects of stigma (i.e., prejudice, discrimination, and violence) and its various contextual manifestations in the lives of lesbian, gay, and bisexual people. • Guideline 2. Psychologists understand that lesbian, gay, and bisexual orientations are not mental illnesses. • Guideline 3. Psychologists understand that same-sex attractions, feelings, and behavior are normal variants of human sexuality and that efforts to change sexual orientation have not been shown to be effective or safe. • Guideline 4. Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated. • Guideline 5. Psychologists strive to recognize the unique experiences of bisexual individuals. • Guideline 6. Psychologists strive to distinguish issues of sexual orientation from those of gender identity when working with lesbian, gay, and bisexual clients. ***Relationships and Families:*** • Guideline 7. Psychologists strive to be knowledgeable about and respect the importance of lesbian, gay, and bisexual relationships. • Guideline 8. Psychologists strive to understand the experiences and challenges faced by lesbian, gay, and bisexual parents. • Guideline 9. Psychologists recognize that the families of lesbian, gay, and bisexual people may include people who are not legally or biologically related. • Guideline 10. Psychologists strive to understand the ways in which a person's lesbian, gay, or bisexual orientation may have an impact on his or her family of origin and the relationship with that family of origin. ***Issues of Diversity:*** • Guideline 11. Psychologists strive to recognize the challenges related to multiple and often conflicting norms, values, and

					beliefs faced by lesbian, gay, and bisexual members of racial and ethnic minority groups. • Guideline 12. Psychologists are encouraged to consider the influences of religion and spirituality in the lives of lesbian, gay, and bisexual persons. • Guideline 13. Psychologists strive to recognize cohort and age differences among lesbian, gay, and bisexual individuals. • Guideline 14. Psychologists strive to understand the unique problems and risks that exist for lesbian, gay, and bisexual youth. • Guideline 15. Psychologists are encouraged to recognize the particular challenges that lesbian, gay, and bisexual individuals with physical, sensory, and cognitive-emotional disabilities experience. • Guideline 16. Psychologists strive to understand the impact of HIV/AIDS on the lives of lesbian, gay, and bisexual individuals and communities. ***Economic and Workplace Issues*** • Guideline 17. Psychologists are encouraged to consider the impact of socioeconomic status on the psychological well being of lesbian, gay, and bisexual clients. • Guideline 18. Psychologists strive to understand the unique workplace issues that exist for lesbian, gay, and bisexual individuals. ***Education and Training*** • Guideline 19. Psychologists strive to include lesbian, gay, and bisexual issues in professional education and training. • Guideline 20. Psychologists are encouraged to increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation. ***Research*** • Guideline 21. In the use and dissemination of research on sexual orientation and related issues, psychologists strive to represent results fully and accurately and to be mindful of the potential misuse or misrepresentation of research findings.

California Department of Health Services STD Control Branch & California STD/HIV Prevention Training Center (n.d.).	Clinical resource guide on screening, testing, diagnosis and prevention of STDs in the LGBT community.	NA	NA	Clinical Recommendations	• Create a welcoming environment – often times LGBT individuals will scan an office for clues to help them determine their sense of comfort within a setting so it is important to present signs and signals that will create a sense of comfort (brochures and educational materials including LGBT relevant information, LGBT affirmative signs (rainbow flag, pink triangle, and other LGBT friendly symbols and posters), posters displaying alternative family structures, visible non-discrimination statement, etc. • Acknowledge relevant days of observance including World AIDS day, LGBT pride day, and national Transgender day of remembrance. • Use gender-neutral language, approach the interview in an empathic, open minded and non-judgmental approach, ask appropriate questions while avoiding unnecessary probing, explain why it is you need information. Moreover, it is important to recognize that certain terminology that the client may use may not be appropriate for use by a mental health provider. • Use the same language that the patient uses in describing self, others, relationships and identity. • Ask patient to clarify terms you are unfamiliar with to reduce any miscommunication. • Be prepared on how to treat LGBT individuals so that when they arrive you are prepared and do not alienate them for the care they need and deserve. • Recognize that trust and rapport may take a longer to build. • Providers should encourage openness by the importance of obtaining accurate information in order to provide appropriate care, as well as discussing issues of confidentiality. It is important to specify what, in any, information is retained in records. Moreover, providers should develop and distribute a written confidentiality statement. • It is important to explore to what degree LGBT individuals are 'out' to family, friends, employers, etc. and to assess the extent of social support within the community.

					• It is important to have knowledge about and be prepared to discuss safe sex techniques relevant to LGBT individuals. • Do not make assumptions! A female that identifies as lesbian, may have had male sexual partners in the past, may have children, may have been or is currently pregnant and not is protected against risk of STDs. Similarly, a man who identifies as gay or bisexual, may have children, may have been married etc. Overall, one should avoid any assumptions about past, present or future. • It is important to recognize that battery occurs in the LGBT community just as it does in the heterosexual community. It is important to conduct a violence screening in LGBT relationships just as in heterosexual ones. Moreover, it is important to recognize that at times, closeted individuals who are battered choose to stay in the abusive relationship for fear of being outed to friends, family and employers by the batterer. As all relationship screening, violence screening should be conducted in a gender-neutral manner. • When possible, it is helpful to have members of the LGBT community as staff members. • Trainings and guidelines for cultural sensitivity in working with the LGBT community should be present. • LGBT appropriate referral in the community should be identifies – resource list. • A universal gender inclusive restroom is recommended to avoid people being harassed for going into the 'wrong' restroom.
Group for the Advancement of Psychiatry (2011).	Recommendations for completing a sensitive sexual history with LGBT patients.	NA	NA	Clinical Recommendations	• Creating a welcoming and safe atmosphere: the therapist must be open-minded, non-judgmental, patient, tactful and respectful. • Therapist should discuss issues of privacy and confidentiality, as well as clarify the limits of confidentiality at the outset. • LGBT individuals may approach the assessment process with guardedness due to past mistreatment by mental health professionals in the past of due to their own internalized homophobia. Clinicians must be patient while building rapport.

					• Mirroring of the client's language can be beneficial. • One must avoid stereotyping. • Use inclusive or gender-neutral language. • Evaluation of sexual risk, knowledge about STDs, safe sex practices and how certain psychiatric disorders may contribute to inconsistent use or even neglect of safe sex practices. • It is important to identify the patient's concerns and to recognize that concerns may or may not be related to sexual orientation. • It is important not to assume the following: that LGBT clients do not have children, that a certain self identification means that one does not engage in sexual behaviors with individuals of the other gender, that early same-sex feelings and fantasies are simply a passing phase, that domestic violence does not occur in same-sex relationships. • It is also important to avoid common stereotypes, such as that all gay men are promiscuous or that lesbian couples experience 'bed death'.
Herek, G., & Garnets, L. (2007).	An overview of the current psychological research on mental health and sexual orientation	NA	NA	Literature Review	• Affirmative practice has become integral to therapy with LGB clients as it assists them in understanding their sexual orientation as an acceptable part of themselves. • Most of the guidelines for working with LGB clients today rely on the minority stress model. • The focus of therapy is to assess the meaning that the person is deriving from his or her experience, feelings about the self, and the degree to which the experience is equated with one's identity as a sexual minority. • Assessing the client's internal and external resources and assisting the client in building upon those resources is an essential ingredient for therapy. • A primary therapeutic task associated with internalized homophobia is to help clients accurately assess, confront and reject the negative conceptions of minority sexual orientation that have been prescribed by society, transforming it into a positive identity that is to be incorporated into the larger schema of the self.

Herek, G., Kimmel, D., Amaro, H., & Melton, G. (1991).	A discussion of heterosexist bias and how it occurs throughout the literature as well as suggestions on how to avoid such heterosexist bias.	NA	NA	Literature Review	• The discussion is organized as a series of questions any researcher should ask to evaluate his or her own research project to avoid heterosexist bias. • Questions relate to the following topics: formulating the research question, sampling, research design and procedures, protection of participants and interpreting and reporting results. • The authors discuss the importance of including human behavior in all of its diversity in the study of psychology. The discuss integrating mention of non-heterosexual perspectives in a variety of pertinent topics such as human development, interpersonal attraction, health, attitudes, stress and coping.
Kaiser Permanente National Diversity Council and Kaiser Permanente National Diversity Department (2004).	Handbook for culturally competent care for providers working with the LGBT population.	NA	NA	Clinical Recommendations	• Sensitivity is key! Open ended question and avoidance of making assumptions is critical. • It is important to recognize the many non-traditional forms of LBT families, which may include foster care, adoption, children from previous heterosexual relationships, artificial insemination, and co-parenting by gay and lesbian couples and individuals. These non-traditional family structures may bring up a variety of issues such as whether non-biological parents will be recognized as parents, how extended families will react to the new family structure, how to deal with surrogate mother or know donor father, whether to allow sperm donor to be known to child, and what to tell children about donors. • Recognition that heterosexual bias often affects the health care coverage of many LGBT individuals in committed relationships. Moreover, LGBT partners do not benefit from Social Security payments after a death of a partner, as do married heterosexuals. • Health care providers must be aware of the fluidity of sexual behavior and that sexual behavior is not synonymous with sexual orientation. Infectious risk is based upon behavior not identity. Providers should obtain current as well as past sexual

					history. • Providers should be aware of the heterosexist bias that occurs in the individual, group and institutional levels. • Providers should have specific knowledge regarding the following special topics: LGBT older adults, LGBT people of color, sexual orientation and religion, LGBT youth, the coming out process and non-traditional families' role in medical decision-making. • Providers should have open discussions about privacy and confidentiality and take the necessary steps to preserve the privacy and confidentiality of the client. This may be particularly sensitive with LGBT youth whose parents have the right to information presented in medical records. • It is important to be sensitive the client's cultural milieu when suggesting resources and referrals. • Intake and other forms should be absent of assumptions and heterocentric bias and use inclusive language. • Providers should use non-judgmental and gender-neutral language. Ask the client to use his or her language to describe relationships. • Become familiar with both slang and technical terms used to define sexual practices. • Questions about families should include options related to alternative families. • Forms should include explanations about how confidentiality will be protected and who has access to information. • Providers should never make assumptions about sexual orientation or gender identity, nor should they make any assumptions about one's history of sexual behavior based on current identification. • It is important to recognize that sexual behavior can change over time (fluidity) and to reassess over time. • If a client appears offended, providers should apologize and provide an explanation as to why the information is necessary. • One should work on having comfort in discussing sex and remember that judgment and condemnation is never helpful.

					• When a provider lacks knowledge about specific LGBT issues, one should seek out a colleague with expertise in this area. • Providers should explain privacy and confidentiality protection, limits and who will have access to information. Moreover, providers should explicitly provide clients with the option to refuse to answer certain questions. Respect a client's wishes or needs to disclose or not to disclose sexual or gender identity. • Providers should advocate for clients to enact durable powers of attorney for healthcare practices and respect of their choices. • Providers should provide access and referral to local LGBT community resources. • Providers' personal religious and/or moral beliefs should be separate from the dynamics of their relationship with LGBT clients. • LGBT individuals may be at an increased risk for substance abuse, so providers should accurately assess, be knowledgeable about substance use patterns and provide services accordingly.
Kashubeck-West, S., Szymanski, D., & Meyer, J. (2008).	Discussion of the construct internalized heterosexism and implications for future training and clinical efforts.	NA	NA	Clinical Discussion	• The authors provide suggestions for practice with LGB clients at the micro, meso, and macro levels. • Micro Level: The authors express the importance of educating LGB clients about the sociopolitical sources of one's problem in order to shift the focus from the individual to the oppressive forces of heterosexism. Through psychoeducation, LGB clients can begin to understand how they themselves have been influenced by a heterosexist society and how that has affected their personal feeling about being non-heterosexual. They advocated using feminist strategies such as "facilitate g awareness of internalized homophobia, attending to the sociocultural context and exploring the negative impact of heterosexism on the lives and presenting problems of LGB clients, challenging internalized homophobia, teaching clients skills for confronting oppression and exploring the multiple identities of LGB clients. • Meso Level: Strategies to deal with internalized heterosexism on the meso level can include encouraging membership in LGB affirming organizations and groups. Such groups can help to

					change heterosexist policies and biases on the meso level as well as decrease internalized heterosexism for the individual. • Macro Level: At this level, psychologists must work to reduce societal oppression of LGB individuals by fighting to change laws and institutions that discriminate against LGB persons. • The authors also address the lack of sufficient training that students receive to competently work with LGB clients, in spite of the numerous appeals to produce more effective training practices for future professionals. The authors provide suggestions to increase the competency of training procedures at the micro, meso and macro levels. • Micro Level: The authors argue that first and foremost, it is essential for every psychologist to recognize the existence of heterosexism within him or herself and to examine how heterosexism has shaped one' s values, attitudes, feelings, and beliefs pertaining to non-heterosexual persons. The authors emphasize that this process is life-long. • Meso Level: Training implications at this level are predominantly at the program level as LGB issues should be addressed throughout the curriculum in areas of relevance such as adolescent and adult development, adjustment and psychopathology, substance abuse, human sexuality, and more. Incorporating LGB issues into the curriculum will help to better prepare psychologists to work with LGB clients in an affirmative way, as well as provide information about how internalized heterosexism is associated with a number of difficulties. • Macro Level: At the macro level, students should be informed about the history of social institutions and the current laws and policies pertaining to LGB persons such as marriage.
King, M. B., Semlyan, J., Killaspy, H., Nazareth, I., Osborn, D., & British Association for	Systematic review of quantitative literature and thematic review of qualitative literature related to LGBT individuals	22 journal articles (14 included quantitative data and 10 included qualitative	NA	Literature Review	• Recommendations set forth by authors include the following: "1. All psychotherapy training institutes regard knowledge of LGBT development and lifestyles as part of core training. a. Heteronormative bias must be recognized and avoided. b. Therapists should increase their knowledge of LGBT issues and keep up to date. c. Psychotherapeutic practice that pathologises homosexuality,

Counselling and Psychotherapy. (2007).		data)			bisexuality and trangenderism should be replaced by more modern understandings of sexual identity. d. Therapists should become aware of internalized bias in the LGBT clients themselves. e. Therapists should receive training on the impact of self disclosure for all clients, including the sensitive issue of their own sexual orientation and gender identity. 2. All psychotherapy training institutes encourage greater numbers of LGBT people to train as therapists in order to improve knowledge in the professional therapeutic community and enable choice of therapists for clients where possible. 3. Psychotherapists consider very carefully the advantages and disadvantages of self disclosure of their sexual identity, gender identity, or lifestyle for each particular client and not expect to follow any general rules. 4. Psychotherapists take care to inform themselves about LBT cultures and lifestyles through their personal or professional lives, rather than expecting their LGBT clients to educate them. 5. More services are provided for transgender people that focus on general psychotherapeutic issues rather than exclusively on the pathway to or from gender change. 6. Affirmative psychotherapy for LGBT people is operationalised in order for it to be evaluated. 7. Funding is made available for the evaluation of the effectiveness of LGBT affirmative therapy in cohort studies and randomized controlled trials. 8. Prospective research should evaluate the degree to which our training recommendations are implemented and determine predictors of their implementation. 9. Mental health and psychotherapy services should routinely audit outcomes for LGBT people, including satisfaction, access, engagement, perceived homophobia, and mental health outcomes, including psychological and emotional wellbeing and functioning." • Review of the literature revealed a concern regarding subtle discrimination under the guise of heterocentrism, which may prevent clients from bringing up important issues regarding

					their sexuality or relationships. • Another important issue was the recognition of same-sex partners as next of kin and treating them accordingly. • Safety issues discussing intimidation, discrimination, sexual harassment, and sexual assault within the mental health system was an important factor to attend to. • The importance of conducting affirmative therapy that normalizes the spectrum of sexual orientation is creating a safe and secure environment was highlighted. Moreover, it is important to have a holistic view of sexuality. • Authors found a deficiency in knowledge about issues related to sexual orientation particularly in heterosexual therapists. Authors cautioned against therapists asking clients to educate them about the LGBT culture and lifestyle and recommended to find other resources to broaden their knowledge on such issues. • Authors cautioned against misattribution of the client's distress to their sexuality. • There is a possibility that clients may have internalized homophobia or heterocentrism. Therapists should be prepared to work with such issues. • Authors highlight the importance of improving training and cultural competence with non-heterosexual clients. This includes gaining an understanding of the implications of growing up with a non-heterosexual orientation, gaining an understanding of LGB psychological development, and understanding the implication of growing up in a heterocentric society. • Therapists are urged to pay careful attention to their own psychological function, training, knowledge and experience in order to minimize heteronormative bias. • It is important to think about the way one responds to a client's self disclosure about sexuality and think through the meaning and implications of the interaction, rather than simply respond in one way.
Lyons, H. Z.,	Discussion of	NA	NA	Clinical	• Author contends that clinicians should increase their

Bieschke, K. J., Dendy, A. K., Worthington, R. L., & Georgemiller, R. (2010).	current practices with LGB individuals and calls for greater levels of competence providing recommendations to increase competencies.			Discussion	knowledge pertaining to the experiences of LGB individuals by consulting with experts, attending community/professional lectures, and seeking out clinically focused literature, documentaries and autobiographies. • Clinicians must resist the assumption that a client is heterosexual, even if in an opposite sex relationship, as there are a number of factors that can influence such relationships (i.e. the dynamic and fluid nature of sexuality, being closeted, and the fact that some individuals engage in relationships with both men and women). • It is important that clinicians market their practices and display signs within their facility of acceptance. • Clinicians must use language free of heterosexist bias providing a safe and welcoming environment for the client, particularly in the initial stages of treatment. • Though the recommendations that clinicians develop their self reflective abilities goes without saying it appear a pre-requisite for the skills and knowledge competencies discussed above.
Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing (2009)	Guidelines for GLBTI sensitive practice and service delivery	NA	NA	Clinical Recommendations	• It is important that mental health professionals demonstrate attitudes that are respectful and accepting towards GLBTI individuals. • It is critical that mental health professionals do not assume heterosexuality. • It is important to recognize the heterogeneity within the LGBTI community and demonstrate respect for the diversity within this population. • Accessible and appropriate services and referrals should be available. It is recommended that institutions and professionals develop a database of resources in the area. • Demonstrating a welcoming environment towards GBLTI individuals is critical, particularly given the history of discrimination within the mental health field. This can include displaying GLBTI affirmative posters, stickers and symbols in waiting areas, providing GLBTI information and images in promotional and educational materials, listing or advertising the service in GLBTI directories.

					• Education and training is important in order to assure that mental health professionals are better skilled in working with GLBTI individuals. Topics should include but not be limited to the following: identification of discriminatory beliefs and behaviors at the personal and organizational level, familiarity with significant GLBTI health and wellbeing issues, and recognition of family of choice and other significant relationships. • Professionals should use inclusive, neutral and non-discriminatory language, as well as demonstrate acceptance. • Moreover, it is important to be sensitive to the different ways in which GLBTI refer to their sexual orientation and use terms that are consistent with the clients' understanding of their sexuality. If unsure, it is recommended that one asks the client how he or she prefers to be addressed. • Demonstrate an understanding of sexuality as fluid. • Regarding documentation, many GLBTI individuals may fear being outed by sharing information about sexual identity. It is important to seek a client's consent when recording information about sexual orientation. Providing the client with education about why the information is necessary, how it will be used and stored, and who has access to that information is important. Moreover, it is important to respect an individual's not to disclose this type of information, but to inform individuals that such disclosure will likely lead to improved quality of care. • When there are available resources, consider facilitation of GLBTI specific groups.
Pachankis, J., & Goldfried, M. (2004).	Identification of key clinical issues for therapists to consider when working with LGB individuals and guidelines for conducting LGB affirmative	NA	NA	Clinical Discussion	• Psychologists today have been trained in a heterocentric society in a historically heterocentric profession. • There are a great deal of explicit and implicit biases that can permeate throughout the therapeutic process with LGB clients. The most barefaced prejudice can be seen in the form of conversion therapies. However, other abuses can take more subtle forms, such as heterocentric assumptions or excess focus on sexual orientation after revelation of sexual orientation.

	therapy.				Lacking sufficient knowledge pertaining to unique issues that affect LGB clients is another mistreatment that occurs frequently in the field. • Some key issues that all therapists should be familiar with according to the authors include identity development, intimate relationships and parenting, family issues, the unique experiences of under-represented sexual minority populations and legal and workplace issues. • It is important to acknowledge the great strides that LGB persons have made over the past few years demonstrated that they possess great resilience in the face of great challenges. • As a profession, we need to prove that we have the competence to effectively treat the unique issues relevant to LGB persons. Such an ability is acquired by familiarizing with the appropriate literature as well as furthering empirical research.
Sanders, G. L., & Kroll, I. T. (2000).	Examination of homophobia and heterosexism manifest and are recovered from in LGB youth.	NA	NA	Clinical Discussion	• Many LGB individuals have a family of choice – it is important to ask about this during intake; using language such as 'family of choice' introduces the concept that individuals can choose family members who are supportive and effective to them rather than simply accept the family that was given to them by nature or by law, the notion of hope, understanding and acceptance are communicated to the clients. • Linguistic practices are central in our interactions with others and we must assure that we are conducting interviews that do not disinvite individuals from feeling safe or understood. • Using gender-neutral and affirming terms such as "partner" or "special friend" rather than "boy/girlfriend"; "relationship" rather than marriage.
Social Planning, Policy and Program Administration Regional Municipality of Waterloo. (2008).	Comparison of LGBT experiences in Waterloo region's shelter system with identified best practices working with LGBT individuals from	Staff members from 5 fixed emergency shelters in the region.	1.Semi-structured interview	Qualitative Study	• The importance of education and training in areas of sexual orientation for staff members working within the mental health services in order to foster a welcoming environment is highlighted. Authors argue that any concrete recommendations will not have the intended effect unless staff members truly understand and appreciate why such steps must be taken. As a result the authors contend the education and training is at the crux of the gap in sensitive services provided.

	the literature.				• Mental health professionals should be trained to ask intake questions appropriately, while understanding that some individuals choose not to disclose their sexuality due to a variety of reasons. • Moreover, they state that staff training in serving this population should be mandatory and ongoing. • Increasing the understanding of same-sex partner abuse, which is a largely ignored and misunderstood issue is important. It is hypothesized that the gap for this information is due to the absence of shelter for men and the necessity of a complex analysis of gender dynamics in lesbian relationships. Regardless, the gap must be addressed. • Appropriate health sex education should be available and LGBT youth. • Issues of safety, including harassment, violence, threats of violence and isolation/discrimination should be appropriately addressed. • It is recommended that institutions, clinics and others services assure that they demonstrate an outward welcoming environment, by providing pamphlets for LGBTQ resources in the community and LGBT affirming pictures, flyers and posters visibly in the intake area or waiting room. • Policies against discrimination on the basis of sexual orientation should be included in all anti-discrimination policy. • Diversity of staff, including staff from the LGBT community should be hired. • It is critical for therapists and other mental health providers examine their own attitudes and beliefs regarding sexual orientation. • it is important not to make any assumptions regarding sexual orientation based on an individual's appearance. • It is important not to make any assumptions that client's presenting problems are directly related to sexual orientation, recognizing that sexuality is one component of a person's complex life. • It is important to be cautious of using heteronormative

					language. • Mental health professionals should be familiar with community resources. • It is important not only to avoid assumptions about the client's sexual orientation, but also to avoid assumptions that clients come from families where traditional male and female genders are represented in the unit.

LGB Affirmative Therapy

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Major Findings
Adams, E. M., Cahill, B. J., & Ackerlind, S. J. (2005).	Investigate the intersection of multiple identities with each other and the career development process.	8 Latino gay and lesbian 5 male and 3 female) ages 18-20	1.Open ended semi-structured interview 60-90minutesin length. 2.Focus group interview session.	Descriptive Qualitative Study	• Transcripts revealed resilience in the face of discrimination and heterosexist bias. • Themes that fostered resilience in the face of discrimination included viewing life's challenges as an opportunity for personal growth, understanding that others' attacks are opinion rather than fact, a yearning to thrive and excel in the face of challenges, and feelings of independence and autonomy.
Anderson, A. L. (1998).	Investigation of the development of strengths to cope with the challenges sexual development in gay male youths.	77 self-identified gay male youths between the ages of 14-20. Ethnicity: 77.9% Caucasian, 10.4% African American, 7.8% Latino, 2.6% Asian American and 1.3% Native American	1.Semi-strcutured interview. 2.Demographic Questionnaire 3. Rosenberg Self-Esteem (RSE) Scale 4. Nowicki-Strickland Locus of Control Scale (N-SLCS) 5. Perceived Social Support	Correlational Study	• Results indicated that these youth developed internal and external resources that were protective in nature, which reveals the presence of resilience. • Author noted the following trends in the resiliency research: (1) high levels of perceived social support, (2) positive self-esteem, (3) self-efficacy as manifested in an internal locus of control, and (4) cognitive abilities that allow to effectively mediate stressful life event.Social skills, self-understanding, and a secure attachment to at least one caring adult have also been associated with resiliency.

			from Family Scale (PSS-FA) 6. Perceived Social Support from Friends Scale (PSS-FR)		
Balsam, K. F. (2008)	Discussion of sexual minority women's status of trauma, stress and resilience.	NA	NA	Literature Review	• Author argues the importance of viewing the important aspects of strengths and resilience to avoid and excessive focus on adversity and pathology. • Non-heterosexual women must learn to cope with unique challenges and stressors, such as "cultural victimization". • Moreover, non-heterosexual women must cope with the conflict between their own internal desires and the expectations presented to them by their families and the society at large. • In order to cope with the unique challenges that these women must face, they often develop a broader repertoire of coping skills utilized to effectively cope with the adversity they face.
Biaggio, M., Orchard, S., Larson, J., Petrino, K., & Mihara, R. (2003).	Development of recommendations for GLB affirmative educational practices in graduate psychology programs, including institutional climate and education about GLB issues.	NA	NA	Literature Review	• Utilize the accreditation standards of the American Psychological Association (APA), which recognizes the importance of cultural and individual differences in training and calls on program to ensure encouraging and supportive environments for training, to make recommendations for GLB affirmative educational practice. ***Recommendations for Improving Climate & Support:*** • "Make affirmation of diversity a priority for the whole institution". • "Appoint a panel of qualified individuals to review the institution's materials" – review of all written materials, policies and practices that may inadvertently convey lack of acceptance towards sexual minority individuals.

					• "Include sexual orientation in equal employment opportunity and admission and recruitment materials." • "Consider diversity in promotion tenure and other personnel decisions." • "Provide support systems for GLB members of the institution" – highlighting the importance of structures, visible and accessible support systems for GLB students. ***Recommendations for Graduate Education:*** • "Integrate and infuse information about sexual orientation and the needs of GLB persons into the program curriculum. • "Ensure that faculty and clinical supervisors are informed about the unique needs of GLB clients." • "Encourage research on GLB topics." • "Promote contact with the GLB community." • "Recruit and retain faculty with GLB expertise and increase faculty knowledge and expertise about GLB issues." • "Make student and faculty self-awareness a priority."
Bonet, L., Wells, B., & Parsons, J. (2006).	Investigation of the impact of Stress Related Growth (SRG) with a number of other factors.	396 female participants: 337 lesbian and 59 bisexual women recruited from LGB community events in Los Angeles and New York	1.Demographic Questionnaire 2. Stress Related Growth (SRG) Scale – Adapted. 3. Survey of sexual and health behaviors.	Correlational Study	• Stress related growth (SRG) was positively correlated with age, ethnic community attachment, number of female partners, generativity, and number of years out to self. • Women with higher levels of education and women of color scored significantly higher on SRG. • Findings demonstrate that SRG may have a greater impact of personal characteristics such as sexual orientation or minority status than general stressful life events.
Cox, N., van, H. M., Vincke, J., & Dewaele, A. (2011).	Investigation of the social environment impacts on stress	502 LGB participants from an online survey. *Ages 14-30	1.14item short version of the SRGS. 2. 9 item	Survey Study	• Successfully overcoming stress may be perceived as a learning experience with positive outcomes, such as personal growth. • Results indicated that individuals who had a greater

	related growth for LGB individuals.		homonegativity scale. 3. Coming out measured through 5 distinct indicators.		affiliation with the LGB community reported learning more from the coming out process. • Moreover, participants who felt a greater deal of acceptance from their significant others perceived to experience more personal growth from the coming out experience. • Lastly, researchers found that an increased sense of personal growth was correlated with a decreased sense of internalized homonegativity.
Crisp, C. (2006).	Development of a measure to assess the degree of utilization of gay affirmative practices among mental health professionals.	488 members of APA (47%) and NASW (53%). Demographic information: 74% women, 69% married, 86 % heterosexual, 69% Democrats, 92% Caucasian.	1.Gay Affirmative Practice Scale (GAP). 2. The Attitudes Toward Lesbians and Gay Men Scale (ATLG). 3. The Heterosexual Attitude Toward Homosexuals Scale (HATH) 4. The Marlowe-Crowne Social Desirability Scale (SDS). 5. Demographic Questionnaire	Instrument Development and Validation Study	• Development of gay affirmative assessment measure based on clinical measurement theory and domain sampling method based on three stage method: 1) draft of initial pool of items; 2) administrations of initial items to a pool of experts; and 3) administration of the scale to clinicians to assess validity and reliability. • Study revealed GAP utility as a rapid and easily administered self-assessment measure to evaluate the degree of affirmative practice with gay and lesbian individuals. • Can also be used to assess the usefulness of educational and training interventions for practitioners' who work with gay and lesbian individuals.
Dillon, F., & Worthington, R. L. (2003).	Development and validation of measure developed to measure LGB affirmative	336 participants: 61.6% graduate counselor trainees in psychology and 38.4% mental health practitioners.	1. The lesbian, gay and bisexual affirmative counseling self-efficacy	Instrument Development and Validation Study	• LGB affirmative counseling self-efficacy included the following factors: (a)applying knowledge of LGB issues; (b) performing advocacy skills; (c) maintaining awareness of one's own and others' sexual identity development; (d) developing a working relationship with an LGB client; and (e)

	counseling self efficacy.	*Ages 21-75 (mean=34.76) *Sexual Orientation: 83.2% heterosexual and 16.2% non-heterosexual.	inventory (LGB-CSI).		assessing relevant underlying issues and problems of an LGB client. • Reliability estimate demonstrated internal consistency within the constructs. However, low test-retest reliability raised questions concerning stability of the measure over time. • Use of this measure would be in the supervision and training of counselors to assess LGB affirmative treatment and develop appropriate levels of efficacy in working with LGB clients. • Including such measures in training would also stimulate interest in LGB affirmative interventions and promote LGB affirmative competency.
Dillon, F. R., Worthington, R. L., Savoy, H. B., Rooney, S. C., Becker-Schutte, A., & Guerra, R. M. (2004).	Investigate a process to facilitate the development of LGB affirmative attitudes and behaviors in training mental health professionals.	10 graduate students in mental health counseling: 2 men and 8 women. Ethnic makeup: 8 European Americans, 1 Latino and 1 Asian Pacific Islander.	Narrative description of one's experience in the self-reflective research team.	Qualitative Analysis	• 10 graduate students participated in a research team, in which they explored their heterosexist biases and attitudes toward sexual minorities. • In analyzing their descriptive narratives, all students highlighted the importance of engaging in self-reflective processes in relations to their own beliefs and attitudes about LGB individuals and how these attitudes may affect LGB clients, as well as colleagues. • Individuals participating in research team concluded that training experiences which facilitate self-exploration of these issues help to foster a deeper understanding and greater sense of comfort with sexuality related issues. • Authors concluded that this type of examination may be an important first step towards working with LGB clients.
Dillon, F. R., Worthington, R. L., Soth-McNett, A. M., & Schwartz, S. J. (2008).	Investigate the correlation between LGB affirmative counseling self-efficacy with	178 Psychotherapists: 135 women/ 43 men. Sexual orientation: 118 heterosexual, 29	1. Measure of Sexual Identity Exploration and Commitment (MoSIEC). 2. Hoffman	Correlational Study (Internet Based Survey).	• LGB affirmative counseling is defined as "therapy that celebrates and advocates the authenticity and integrity of lesbian, gay and bisexual persons and their relationships" (Bieschke, McClanahan, Tozer, Grzegorek, and Park, 2000 p. 328). • LGB affirmative counseling behaviors include:

	gender self-definition and sexual identity commitment.	bisexual, 18 lesbian, 12 gay and 1 other. Race/ Ethnicity: 146 European, 11 Latino, 6 AA, 5 Asian, 4 biracial, 4 Native American, 2 other. Degree: counseling psychology=89; clinical psychology=79; social work=5; school counseling=2; school psychology=1; other=2.	Gender Scale. 3. Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI).		advocacy and support, application of knowledge and up-to-date research, self-awareness, unique and idiographic assessment, and strong therapeutic alliance. • Researchers hypothesized that psychotherapists' with high levels of gender self definition and self acceptance are more likely to engage in LGB affirmative behaviors, as they have explored and committed to a sexual identity. • Researchers make an argument for the value of developing continuing education workshops and psychologist training programs to identify and promote ways in which psychologists can explore and commit to a set of beliefs regarding their sexuality and increase their gender self-confidence, thereby decreasing heterosexist bias. ***Definitions:*** • Identity Development – "an active process of exploring and assessing aspects of one's identity, and to establishing a commitment to one or more of the alternatives considered". • Gender Self Confidence – "the intensity one's belief that she/he meets her/his personal standards for femininity or masculinity" (Hoffman, Borders and Hattie, 2000).
Harrison, N. (2000).	Identification of features of gay affirmative therapy in order to synthesize an integrated model.	33 journal articles and summaries of conference papers published between 1982-1995 in the UK, Europe and Unites States.	5 stages of 'framework' (familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation)	A qualitative critical analysis of the literature and descriptive study	• A gay affirmative approach to therapy was defined as one "which has its core belief as non-pathological view of gay people that is operationalised through the therapist challenging oppression in self and others." • Critical components included empowering clients and serving as their advocate. • A gay affirmative therapist was identified as one who actively engages in self reflective practice and is accepting of his or her own personal limitations in working with the LGB community.

					• A gay affirmative therapist was identified as one who has knowledge in the following areas: issues presented by LGB clients, an understanding of the gay lifestyle, and familiarity with LGB resources.
McGeorge, C., & Stone, C. T. (2011).	Propose a three-step model to help heterosexual therapists become more aware of their own heteronormative biases, heterosexual privilege and heterosexual identity.	NA	NA	Theoretical Discussion	• Explained the complexity of the concept of heterosexism by dividing it into three distinct constructs: 1. Heteronormative Assumptions: "the automatic and unconscious beliefs and expectations that reinforce heterosexuality and heterosexual relationships as the ideal norm." 2. Institutional Heterosexism: "the societal policies and actions by institutions (e.g. governments, health care systems, and educational systems) that (a) promote a heterosexual lifestyle above all others, (b) exclude or discriminate against LGB people as individuals and as a group, and (c) privilege and grant benefits to heterosexuals". 3. Heterosexual Privilege: "unlearned civil rights, societal benefits, and advantages granted to individuals based solely on their sexual orientation." • When providing services to LGB individuals it is critical to assess for gay related stress, defined as "the added stressors experiences by LGB persons as a result of heterosexism that is in addition to the normative life stress experienced by all individuals. • Authors propose a three-step process of involving critical self-exploration: 1. Exploring Heteronormative Assumptions: exploring the societal and familial messages that one were taught since childhood and bring unconscious heteronormative beliefs about sexual orientation into consciousness. 2. Exploring Heterosexual Privileges – the process of acknowledging heterosexist privileges and beginning to deconstruct the influences of the privileges in their personal and professional life.

					3. Exploring the Development of a Heterosexual Identity – involves the process of becoming more aware of one's own heterosexual identity (defined as "the prcess by which people with a heterosexual sexual identity identify with and express numerous aspects of their sexuality"). • In addition to the self-exploration process, the authors present strategies important to the development of an LGB affirmative practice, including: 1. Claiming a public identity as an LGB affirmative therapist/ LGB ally, invlolving both personal and political action. 2. Communicating an LGB stance and demonstrating commitment to providing LGB affirmative services. 3. Deconstructing the Influence of Heterosexism on LGB Clients – the process of helping the client to label the influences of heterosexism in clients' lives and understanding their problems in relation to pathology that exists in a larger social structure rather than within the individual.
Kaiser Permanente National Diversity Council and Kaiser Permanente National Diversity Department (2004).	Handbook for culturally competent care for providers working with the LGBT population.	NA	NA	Clinical Recommendations	• Sensitivity is key! Open ended question and avoidance of making assumptions is critical. • It is important to recognize the many non-traditional forms of LBT families, which may include foster care, adoption, children from previous heterosexual relationships, artificial insemination, and co-parenting by gay and lesbian couples and individuals. These non-traditional family structures may bring up a variety of issues such as whether non-biological parents will be recognized as parents, how extended families will react to the new family structure, how to deal with surrogate mother or know donor father, whether to allow sperm donor to be known to child, and what to tell children about donors. • Recognition that heterosexual bias often affects the

					health care coverage of many LGBT individuals in committed relationships. Moreover, LGBT partners do not benefit from Social Security payments after a death of a partner, as do married heterosexuals. • Health care providers must be aware of the fluidity of sexual behavior and that sexual behavior is not synonymous with sexual orientation. Infectious risk is based upon behavior not identity. Providers should obtain current as well as past sexual history. • Providers should be aware of the heterosexist bias that occurs in the individual, group and institutional levels. • Providers should have specific knowledge regarding the following special topics: LGBT older adults, LGBT people of color, sexual orientation and religion, LGBT youth, the coming out process and non-traditional families' role in medical decision-making. • Providers should have open discussions about privacy and confidentiality and take the necessary steps to preserve the privacy and confidentiality of the client. This may be particularly sensitive with LGBT youth whose parents have the right to information presented in medical records. • It is important to be sensitive the client's cultural milieu when suggesting resources and referrals. • Intake and other forms should be absent of assumptions and heterocentric bias and use inclusive language. • Providers should use non-judgmental and gender-neutral language. Ask the client to use his or her language to describe relationships. • Become familiar with both slang and technical terms used to define sexual practices. • Questions about families should include options related to alternative families.

					• Forms should include explanations about how confidentiality will be protected and who has access to information. • Providers should never make assumptions about sexual orientation or gender identity, nor should they make any assumptions about one's history of sexual behavior based on current identification. • It is important to recognize that sexual behavior can change over time (fluidity) and to reassess over time. • If a client appears offended, providers should apologize and provide an explanation as to why the information is necessary. • One should work on having comfort in discussing sex and remember that judgment and condemnation is never helpful. • When a provider lacks knowledge about specific LGBT issues, one should seek out a colleague with expertise in this area. • Providers should explain privacy and confidentiality protection, limits and who will have access to information. Moreover, providers should explicitly provide clients with the option to refuse to answer certain questions. Respect a client's wishes or needs to disclose or not to disclose sexual or gender identity. • Providers should advocate for clients to enact durable powers of attorney for healthcare practices and respect of their choices. • Providers should provide access and referral to local LGBT community resources. • Providers' personal religious and/or moral beliefs should be separate from the dynamics of their relationship with LGBT clients. • LGBT individuals may be at an increased risk for substance abuse, so providers should accurately

					assess, be knowledgeable about substance use patterns and provide services accordingly.
Pixton, S. (2003).	Investigation of what LGB individuals themselves perceive to be affirming within the therapeutic relationship.	*17 individuals matching inclusion criteria: 1) identification as LGB; 2) experience in a therapeutic relationship; and 3) experiencing the therapeutic relationship as affirming. *Participants consisted of 7 men and 10 women between the ages of 17-56. *All identified as white British.	1.Questionnaire 2. Semi-structured interview	Grounded Theory	• Results revealed 6 main categories emerging from affirming therapeutic relationships: "the counselor communicating a non-pathological view of homosexuality, the counselor providing a space that allows full exploration of sexuality, the specific knowledge and awareness of the issues affecting lesbian, gay and bisexual individuals and the counselor's level of comfort in exploring sexuality, the counselor not having barriers of prejudice so being able to connect fully with the client, the counselor being a positive role model for their own sexuality group and enabling the client to be themselves fully in the relationship, the counselor having a holistic view of sexuality." • It is interesting to note that although all of the above factors have an explicit focus on sexuality, none of the above factors include the sexuality of the counselor. Only 5 of the 17 counselors included identified as LGB themselves.
Russell, G. M. & Richards, J.A. (2003)	Investigation of stressors and resilience factors in LGB individuals when facing explicit and implicit homophobia.	316 self-identified LGB individuals from Colorado recruited through the snowball technique. *Gender: 58.1% female and 41.9% male. *Ethnicity: 86% Caucasian, 8.8%Latino, 1.6% African American, 1.0 Indian, 2.3% biracial, and 0.3% other.	1.130-item survey on stressors and resilience factors. 2. Open ended question demographic form.	Survey Study	• Authors investigated specific sources of stressor and resilience factors for LGB individuals during antigay political campaigns in Colorado. • Authors held the assumption that this would be a time in which LGB individuals were likely to experience explicit and implicit homophobic attacks. • Results indicated 5 distinct sources of distress (1. encountering and recognizing the prevalence of homophobia; 2. coping with divisions within the LGB community; 3. attempts to make sense of perceived danger with vigilance and suspiciousness of others; 4. feeling invalidated by families of origin, friends and society; and 5. coping with internalized homophobia) and 5 distinct resilience factors (1. The movement factor placing antigay

					politics in a broader political perspective; 2. the emotional and psychological value of confronting internalized homophobia; 3. the activating potential of appropriate expression of anger; 4. Feeling validated by witnessing and acknowledgment by heterosexual persons; and 5. benefits from integration into the LGB community).
Savin-Williams, R. C. (2008).	Discussion of long-standing challenges faced by developmental scientists as they investigate same-sex sexuality	NA	NA	Critique of the Literature	• Author speaks to methodological problems in the developmental research on non-heterosexual sexuality, discussing problems in the recruitment and definition of non-heterosexual populations. • The majority of research investigates the differences among heterosexual and non-heterosexual populations, with minimal research investigating the similarities among these populations. Such research lumps all non-heterosexual in one category dismissing the heterogeneity in this group.
Spokane Regional Health District, Community Health Assessment Program. (2006).	Assessment of health disparities of LGBT population	*Consumer survey:* 76 participants: 40.8% gay, 27.6 lesbians, 13.2 heterosexual females, 6.6% transgender, 5.3 bisexual females, 3.9% bisexual males, 1.3 heterosexual males. *BRFFS survey:* 94 LGBTIQ respondents to the BRFFS syrvey: 19.1% gay, 23.4% lesbians, 16% bisexual females, 6.4% bisexual males, 3.2% others,	1.LGBT consumer survey. 2. Behavioral Risk Factor Surveillance System (BRFFS) survey. 3. Provider Survey	Survey Study	Health Issues and Disparities: 1.One-third (33.3%0 of GLBT consumer survey respondents reported that they had an advance directive allowing them to be included in the healthcare decision of their partner. Of those who did not have this, the majority (64.3%) reported that they did not know how to obtain one. 2. Though 62.1% of providers reported that they regularly discuss HIV/AIDS, STDs and safe sex practices with LGBT clients, only 30.4% of LGBT respondents reported that a mental health professional talked about these issues with them in the past year. 3. 39.7% of LGBT respondents indicated that they did not disclose their sexuality to their health provider. Many of these indicated that they were never asked, while some indicated that they did not feel their sexual activity was relevant to their health. • The following recommendations were made in order to eliminate health disparities:

		25.5 % females questioning, and 6.4% males questioning. *Provider Survey;* 102 medical providers			1. Create a welcoming environment or all individuals by presenting signs with statement such as "All are welcome here." 2. Health care providers should teach and assist all clients living with a partner how to obtain an advance directive. 3. There should be an increase in training on cultural competence. 4. Safe sex practices should be discussed with all sexually active patients, regardless of sexual orientation. 5. Intake forms should be revised to use inclusive gender neutral language.
Tozer, E. E., & McClanahan, M. K. (1999)	Discussion of ethical considerations and guidelines regarding sexual orientation conversion therapy for LGB individuals	NA	NA	Guidelines	• Authors discuss the absence of evidence base for conversion therapies, implications of conversion therapy and the important considerations when a client presents with a desire to engage in conversion therapies. • Authors describe affirmative counseling as therapy that "celebrates and advocates the validity of lesbian, gay and bisexual persons and their relationships" (p.736)
Vaughn A.A., Roesch S.C., & Aldridge A.A. (2009).	Validation of Stress Related Growth (SRG) Scale with youth of color	388 participants ages of 14 and 18 (mean =15.46) *Gender: 52% male and 48% female. *Ethnicity: 55.7% Latino/Mexican American, 12.6% African American 11.8% Asian American and Pacific Islander 7.7% biracial, 3.9% Native American and 1.5%	1.Stress Related Growth Scale. 2. Children's Depression Inventory (CDI) 3. World Health Organization Quality of Life Brief Form scale (WHOQOL) 4. COPE scale 5. Children's Dispositional Hope Scale (C-	Correlational Study	• Growth resulting from stress and discrimination can occur in a number of areas such as, enhanced knowledge base, increased acquisition of coping skills, and a more positive self-concept. • Growth is conceptualized differently by different groups of people • Three factors emerged: Religious Growth, Cognitive/Affective Growth and Social Growth

		Caucasian.	DHS).		
Walker, J. A., & Prince, T. (2010).	Recommendations for counseling and training for affirmative LGBT counseling practices.	NA	NA	Clinical Discussion	• Authors contend that providers must recognize that there are distinct differences between the experiences of gay men, lesbian woman and bisexual men and women. • An affirmative therapist should directly confront negative self-talk related to sexual identity. • Providers should provide non-heterosexual individuals who are coming out of the closet with helpful resources, including LGBT organizations and relevant websites. They should also provide psychoeducation to individuals coming out and normalize sexual identity for LGBT individuals. • Providers should help clients examine pros and cons of making disclosures.

Intersection of Multiple Cultural Considerations

Ethnicity and Sex

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Adams, E. M., Cahill, B. J., & Ackerlind, S. J. (2005).	Investigate the intersection of multiple identities with each other and the career development process.	8 Latino gay and lesbian 5 male and 3 female) ages 18-20	1.Open ended semi-structured interview 60-90minutesin length. 2.Focus group interview session.	Descriptive Qualitative Study	• Transcripts revealed resilience in the face of discrimination and heterosexist bias. • Themes that fostered resilience in the face of discrimination included viewing life's challenges as an opportunity for personal growth, understanding that others' attacks are opinion rather than fact, a yearning to thrive and excel in the face of challenges, and feelings of independence and autonomy.
Balsam, K. F. (2008)	Discussion of sexual minority women's status of trauma, stress and	NA	NA	Literature Review	• Author argues the importance of viewing the important aspects of strengths and resilience to avoid and excessive focus on adversity and pathology. • Non-heterosexual women must learn to cope with

	resilience.				unique challenges and stressors, such as "cultural victimization". • Moreover, non-heterosexual women must cope with the conflict between their own internal desires and the expectations presented to them by their families and the society at large. • In order to cope with the unique challenges that these women must face, they often develop a broader repertoire of coping skills utilized to effectively cope with the adversity they face.
Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003).	Investigate the relationship between Black lesbians' experiences of stress due to racism, sexism and heterosexism.	19 Black lesbian women who attended a Black lesbian retreat in southern California. *Ages 26-68 (mean = 45).	Semi structures interview ranging from 30-45 minutes.	Qualitative Study	• External environment context – women reported that sometimes their families and the Black community buffered against the stresses experiences due to racism, sexism and heterosexism, while other times they exacerbated it. • Women reported a number of internal self-characteristics of resilience, such as spiritual characteristics, feelings of uniqueness, self-esteem, behavioral and social competencies, and happiness, optimism and humor. • A number of the women participating in the study described a variety of problem solving skills hones from previous experiences negotiating oppression or adversity. • Respondents also engaged in a number of resiliency processes, such as directly confronting oppression, assessment of internal control and ability to change a situation, and choosing not to allow others' prejudice to affect them. • Researches posit the experience of stress as a necessary catalyst for resilience.
Chan, C. (1989).	An examination of the factors that affect Asian	19 men and 16 women who self identified as gay or lesbian, as well as	4-page questionnaire consisting of 35 questions related	Content Analysis	• Findings indicated that when a choice of identification was required, more respondents identified as gay or lesbian rather than Asian American.

	Americans' choice of identification with either their ethnic identity or minority sexual identity.	Asian American. Age range: 21-36	to community affiliation, coming-out and discrimination. 6 Multiple choice and 29 open ended questions.		• The authors propose that since identity development is a fluid and ever-changing process, such identifications can change over time and depending on the situation and context. • With regards to family expectations, respondents indicated a great fear of rejection and stigmatization from their family. Additionally, many respondents indicated that there was a denial of the existence of sexual minority individuals in the Asian community. • Many indicated that they kept their sexual orientation a secret not only from their families, but from the Asian community as a whole. • When asked whether respondents had been discriminated more frequently due to their sexual orientation or race, men reported being discriminated more frequently due to their sexual orientation, whereas women reported being more frequently discriminated against due to their Asian identity. • Both reported feeling as though they were discriminated more frequently due to their multiple minority status.
Cochran, S., & Mays, V. (2007).	An examination of rates of depressive distress and suicidal thought among homosexually active African American men and women.	603 AA Women who reported at least one same-sex experience. 84% lesbian, 11% bisexual & 5% neither. Mean age: 33.2 829 AA men who reported at least one same-sex experience. 80% gay, 14% bisexual & 5%	1.CES-D Scale. 2.Life problems: frequency of common problems in 12 areas of living were rated on a 5-point Likert Scale.	Causal-comparative	• Men with symptomatic HIV/AIDS reported significantly higher levels of distress as compared with other men. They did not, however, differ from women. • Five percent of the HIV symptomatic men indicated that their most upsetting life problem was having suicidal thoughts, a prevalence rate significantly more frequent than other men and women. • The findings indicated that these individuals experienced higher levels of distress than would be expected based on their ethnic background or sexual orientation alone. The authors speculate

		neither. Mean age: 33.4			that this may be a result of the interactive nature of stigmatization foe their multiple minority statuses.
Dubé, E., & Savin-Williams, R. (1999).	Exploration of how ethnicity influences sexual identity development, looking at timing and sequence of identity milestones, adjustment to sexual identity, and involvement in intimate relationships comparing AA, Asian American, Latino and White youths.	Study 1: 23 ethnic minority youths: 6 AA, 10 Latino, 7 Asian American. Age 18-25, Mean: 21.4. Study 2: 60 ethnic minority youths (23 AA, 20 Latino, 17 Asian American and 56 Whites serving as comparison group. Age 16-26, Mean: 21.1.	1.Demograhic Form. 2.Revised version of the Kinsey Scale. 3. Nungesser Homosexual Attitude Inventory (NHAI) revised to modernize language. 4. Relationship involvement questionnaire.	Causal-comparative	• With regards to timing and sequencing of milestones, Latino youths reported having awareness of their sexual identity significantly earlier than did African American and Caucasian youths. • Asian American youths reported a mean age of their first same-sex experience significantly later than the other three groups (approximately 3 years later). It is important to note that a delay in sexual onset has also been found among Asian American heterosexuals, which may be due to the implicit understanding that sex should be delayed until marriage which exists in many Asian cultures. • Sequencing of developmental milestones: The majority of African American youths reported having same-sex experiences prior to labeling their sexual identity. Asian American youths, on the other hand, reported having same-sex encounters only after labeling themselves as gay or bisexual. • When comparing rates of disclosure among these four different ethnic groups, the results demonstrated that Caucasian youths exhibited disproportionately high levels of disclosure, whereas African American and Asian American youths exhibited disproportionately low levels of disclosure. Similarities: ✧ Timing of developmental milestones: regardless of ethnicity, youths labeled their same-sex attractions during the same period in their lives (ages 15-17). ✧ Internalized homophobia did not vary across ethnic groups. • Overall, the data suggests that sexual identity models must be modified so that they can be appropriately applied to ethnic minority

					individuals.
Grov, C., Bimbi, D., Nanín, J., & Parsons, J. (2006).	Assess age-cohort differences, ethnic differences, and gender differences among LGB adults in terms of the coming out process	2,733 participants at a series of LGB community events in Los Angeles and New York.	1.Demographic questionnaire. 2.Coming out and Sexual Debut.	Cross-Sectional Survey Method Study	• Race and ethnicity have not been adequately addressed in the literature. • Factors such as race, ethnicity, age and gender may interact with the coming-out process. • Younger cohorts are coming out at earlier ages. • Findings demonstrated that Caucasian participants were more likely to come out to their parents when compared with all other ethnic groups. • Asian American/Pacific Islander men and African American men and women were the least likely to come out to their parents. • The data suggests that coming into LGB identity may be delayed due to racial or ethnic identification.
Huang Y.-P., Brewster M.E., Moradi B., Goodman M.B., Wiseman M.C., & Martin A. (2010).	Create a content analysis of literature about LGB people of colore	666 abstracts related to the experiences of LGB people of color published between 1998-2007.	1.Coding Form.	Content Analysis	• Authors founds although scholars have traditionally argued that LGB people of color experience greater stigma and discrimination as a result of their multiple minority status, others have highlighted that communities of color possess their own set of unique values and experienced that can serve to promote coping skills and resources that can help LGB individuals of color demonstrate resilience in the face of stigma and discrimination. • Authors highlight the importance of critically examining the research for resilience perspectives, cautioning about pathologizing LGB individuals.
Meyer, I. (2003).	Provide a conceptual framework for understanding the greater prevalence rates of disorders in terms of the	*N*=10 All sources were retrieved from PsycINFO and MEDLINE databases. Inclusion criteria were articles: (a) published in the English-language; (b) peer-reviewed journals;(c)	NA	Meta-Analysis	• A review of the literature demonstrates that compared to heterosexuals, non-heterosexual individuals endure a greater deal of mental health problems, including substance use disorders, affective disorders and suicide. • Minority stress is additive to general stressors endured by all people, and therefore require those who are discriminated against adaptation capacities exceeding those required by people who do not

	minority stress model.	reported prevalence of mental illness based on *DSM* criteria; and (d) compared LGB individuals with heterosexual comparison group. Exclusion criteria were: (a) studies that reported scores on measures of psychiatric symptoms (e.g., BDI) and/or (b) the absence of comparison to a heterosexual group.			experience discrimination. • Research literature has consistently shown that the greater the levels of stress one endures, the greater the impact on mental health problems. Probability studies of U.S. adults revealed that LGB people were twice as likely as their heterosexual counterparts to experience discrimination or oppression in their daily life, such inequity in the workplace. • Author also discusses the importance of resilience factors in working with LGB individuals. • Author contends that individuals are active participants in the world, rather than passive victims.
Meyer, I. H. (2010).	Exploration of the nuances of the construct resilience	NA	NA	Theoretical Discussion	• Author argues that LGB people of color can have both positive racial ethnic identities, as well as positive sexual orientation identity. • Compared to Caucasian LGB individuals, LGB people of color experience both more stress and more resilience. • Argues that the notion that color and LGB identities are always in conflict with each other are exaggerated. • Argues that people can hold multiple identities while maintaining a coherent sense of self.
Mustanski, B., Newcomb, M. E., & Garofalo, R. (2011)	Investigate two resiliency processes for LGB youths who have suffered victimization	425 LGB participants living in the Chicago metropolitan area using snowball sampling technique. *Ages 16-24	1.Demographics Questionnaire 2. 18 item version of the Brief Symptom Inventory (BSI-18) 3. 10-item questionnaire assessing victimization	Correlational Study	• Results of the study indicate that family support is negatively related to psychological distress, though its effects are not as pronounced as peer support. • These supports, though presenting strong protective factors, are not enough to single-handedly mitigate the effects of victimization. The authors conclude the clinical implications of the study stressing the importance of directly addressing issues of victimization, since the negative effects cannot be completely eradicated by strong social support systems.

			4. Multidimensional Scale of Perceived Social Support (MSPSS) 5. Social and Emotional Loneliness Scale for Adults (SELSA) 6. Family Adaptability and Cohesion Evaluation Scale (FACES) 7. Five items from the Homosexual Attitudes Inventory		
Phillips, J. C., Ingram, K. M., Smith, N. G., & Mindes, E. J. (2003)	A review and analysis of the trends in methodology and content of LGB related articles over time and the relationship to American sociopolitical context.	8 Major Counseling Journals - 5628 Articles Years: 1990-1999	NA	Methodological and Content Review	• Trends have been found in the literature (4:1 proportion examining gay men versus lesbian women, deficiency in research pertaining to LGB people of color, deficits in research pertaining to bisexuality and insufficient geographical representation), leading to faulty generalizations in the literature. • Methodological issues found were a lack of assessment of participants' sexual orientation (polarity of gay/lesbian or heterosexual without any assessment of bisexuality). **Current Study Findings:** • Primary method of assessing sexual orientation was self-identification. • *Race Ethnicity:* 69% reported race/ethnicity for descriptive purposes only, 18% has complete

					absence of information regarding race/ethnicity, 6% reported analysis for one racial/ethnic group, and 6% used race/ethnicity as a variable in their analysis. Also, 82% of the studies were based on a sample of more than 75% of participants who identified if White/European. • *Geographic Location:* 25% did not specify geographic location, 18% were based on National U.S. samples, 6% were based on international samples and 2% was based on a combination or a national and international sample. Within the U.S., the geographic locations of the participants were as follows: 15% Midwest, 13% Northeast, 9% from multiple regions in the U.S., 7% Southeast, 4% Northwest and 2% Southwest. • *Bisexuality:* 45% contained only a superficial mention of bisexuality, 34% did not mention bisexuality at all, 19% integrated bisexuality of bisexual persons in their study and 2% focused exclusively on bisexuality. None of the articles examine the mythology and faulty stereotypes pertaining to bisexuality (looking at empirical studies). • There is a realization that sexuality appears on a continuum, rather than dichotomously, moving away from the previously held belief that bisexuality was a transitional state. Still, further integration of bisexuality into theory and research is needed which requires more complex reasoning than does theory that dichotomizes sexual orientation. For instance, literature regarding the effects of prejudice and discrimination on non-heterosexual people focuses on heterosexism, hardly discussing the effects of biphobia. • Articles addressing LGB people of color have increased significantly when compared to past content analyses. Still, such articles represented

					only 12% of the sample in this study. • Topic neglected included: LBG people with disabilities, transgendered people, family and parenting issues and within group diversity.
Saewyc, E. M. (2011).	Review of the literature related to LGB youth	NA	NA	Literature Review	• Not all LGBQ youth experience poor mental health outcomes. • Protective factors that have been identified include: supportive and nurturing family relationships, supportive friends, connectedness at school and spirituality or religiosity. • Protective factors specific to LGB youth have been involvement in the LGB community and LGB support groups or alliance clubs.
Volpp, S. Y. (2010).	The literature on the mental health of bisexual individuals, particularly bisexual women, is reviewed.	NA	NA	Literature Review	• The methodological problems insufficiency of research related to bisexual research is discussed. • In spite of the caveats, mental health findings suggest elevated rates of mental health problems in bisexual individuals as compared to same-sex and opposite-sex individuals. • The implications of minority stress and stigma on the mental health outcomes of bisexual individuals is discussed.
Whitehead, A. (2010).	Investigation of the effects of religion on beliefs and attitudes toward same-sex orientation	National sample of 1,648 citizens	The Baylor Religion Survey	Survey Study	• Religion was strongly associated with the belief that same-sex orientation is a choice, even when presented with a biological explanation for same-sex attraction. • Males were more likely than females to believe that same-sex attraction is a choice. • Older individuals and more conservative individuals were less likely to support same-sex marriage.
Wilson, B. D. M., & Miller, R. L. (2002).	Exploration of the ways in which African American non-heterosexual	37 self-identified gay and bisexual African American men ages 18-36	1.Semi-structured interview 60-90 minutes in length.	Qualitative Study	• Authors present six strategies that African American gay and bisexual men utilize to manage their non-heterosexual identification: role flexing, keeping faith, standing one's ground, changing sexual behavior and accepting oneself.

	men manage their sexual minority status.				• The functions of these coping strategies were investigated as well and the following functions were noted: avoiding stigma, building buffers and societal change. • Men in this group created alternative social networks and disengaged from oppressive social groups. • Men in this study did not report the need to selecting one group with which to affiliate or alter between affiliations different communities.

Sex Differences

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Adams, E. M., Cahill, B. J., & Ackerlind, S. J. (2005).	Investigate the intersection of multiple identities with each other and the career development process.	8 Latino gay and lesbian 5 male and 3 female) ages 18-20	1.Open ended semi-structured interview 60-90minutesin length. 2.Focus group interview session.	Descriptive Qualitative Study	• Transcripts revealed resilience in the face of discrimination and heterosexist bias. • Themes that fostered resilience in the face of discrimination included viewing life's challenges as an opportunity for personal growth, understanding that others' attacks are opinion rather than fact, a yearning to thrive and excel in the face of challenges, and feelings of independence and autonomy.
Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003).	Investigate the relationship between Black lesbians' experiences of stress due to racism, sexism and heterosexism.	19 Black lesbian women who attended a Black lesbian retreat in southern California. *Ages 26-68 (mean = 45).	Semi structures interview ranging from 30-45 minutes.	Qualitative Study	• External environment context – women reported that sometimes their families and the Black community buffered against the stresses experiences due to racism, sexism and heterosexism, while other times they exacerbated it. • Women reported a number of internal self-characteristics of resilience, such as spiritual characteristics, feelings of uniqueness, self-esteem, behavioral and social competencies, and happiness, optimism and humor. • A number of the women participating in the study described a variety of problem solving

					skills hones from previous experiences negotiating oppression or adversity. • Respondents also engaged in a number of resiliency processes, such as directly confronting oppression, assessment of internal control and ability to change a situation, and choosing not to allow others' prejudice to affect them. • Researches posit the experience of stress as a necessary catalyst for resilience.
Gedro, J. (2009). LGBT Career Development.	Exploration of the unique issues related to LGBT career development.	NA	NA	Literature Review	• Gay men face a unique set of challenges to overcome in their career development. • They are frequently stereotyped into female dominated occupations. • The business culture has traditionally placed high value on masculinity and heterosexuality, viewing femininity and homosexuality in a negative light. • Gay men frequently face harassment, rejection and even violence. • It is not uncommon for a gay man to keep his sexual orientation hidden, fearing risk of potential advancement. • Lesbian women experience greater freedom in career exploration, as they are unlikely to make career choices based on accommodating men or conforming to traditional gender roles. • However, they face unique challenges as they develop their career. • It is not uncommon that lesbian women keep secret their sexual orientation in order to avoid harassment, rejection or even violence. • They face discrimination and bias not only because of their sexual orientation, but because of their gender as well. • Gay men may face a unique type of gender

					bias, as heterosexual men have repeatedly demonstrated more negative attitudes towards gay men than lesbian women.
Prokos, A. H., & Keene, J. (2010).	Investigation of the differing poverty estimates of cohabitating gay and lesbian, and cohabitating and married heterosexual couples, analyzing age, education and employment patterns.	1,365,145 participants – 5% subsamples of the 2000 Census	NA	Survey Study	• Research and literature in the economic conditions of families with children neglect the experiences and gay and lesbian families. • Economically, gay and lesbian couples are worse off than married couples, but better off than cohabitating heterosexuals. • Consensus data reveals that gay and lesbian families are on average older and more educated than cohabitating heterosexual couples, which may explain the significant differences in poverty rates. • Lesbian couples are slightly more likely to have adopted a child than heterosexual couples, and gay couples are less likely to adopt than either lesbian or heterosexual couples. • Gender inequality in the labor force has been well documented. • Research demonstrates that married men experience a premium in earnings, as they are viewed as breadwinners. Conversely, women suffer an additive wage penalty per child, as they are viewed to be less committed to paid work. • Research also indicates that gay men earn less than heterosexual men. It is interesting that, in spite of men's higher earning rates, gay couples are found to fare worse economically than heterosexual married couples. • Gay families are less likely to be poor than lesbian families, even when education is controlled for.
Ritter & Terndrup	A handbook of affirmative	NA	NA	Handbook	• Content of the handbook covers four major headings: 1) social, developmental and political

(2002).	psychotherapy with lesbians and gay men.				foundations; 2)identity formation and psychological development; 3) affirmative practice; and 4) working with couples and families.
Stacey, J. (2006).	Examining gay male narratives for parental desire	NA	NA	Ethnography	• When gay men make the decision to become primary parents to children, they challenge the conventional definitions of masculinity and paternity. • Gay men, like heterosexual men, are not socialized to perform the "feminine" labors of childrearing and nurturance. Unlike heterosexual men, they cannot rely on women to perform these duties for them. • This places them in a position in which they are struggling for means of reproduction, in the absence of the stereotype of achieving skilled parenting.

Older LGB Adults

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/ Design	Major Findings
Addis, S., Davies, M., Greene, G., MacBride-Stewart, S., & Shepherd, M. (2009).	Review of the literature on the health, social care and housing needs for older LGBT adults.	66 journal articles.	Formal assessment using standard quality assessment criteria.	Literature Review – Meta Analysis	• Hughes (2003) showed that 16% of lesbian women compared with 2% of heterosexual females reported they drank more than two drinks per day on average. • Bradford et al (1994): the percentage of those who drank more than once a week was significantly higher for older women. Middle-aged and older women were frequently daily smokers than younger lesbians. • Older people use fewer preventative measures (condoms) and showed a decreased likelihood of STD testing than younger people. • Relationships: A number of studies indicate that older gay and lesbians have greater life satisfaction, lower levels of self-criticism and fewer psychosomatic problems.

					• Shippy et al (2004) found friends were a critical element of social gay networks. White & Cant found that daily support was provided by current or ex-partners and friends, rather than family members, even when estrangement was not the case. • Living Arrangements: older gay and lesbian individuals are more likely to live alone than their heterosexual peers. • Older gay and lesbian individuals are reported to delay entering residential care. In general, older adults have reported concerns about a loss of independence. However, for lesbian and gay people who have historically experienced discrimination, dependence on social care and institutions that have discriminated against them is seen as a real threat. • Johnson et al (2005) found that 73% of respondents indicates that they believe that discrimination existed in retirement facilities. 60% did not believe that they have equal access to social and health services. 34% believed that they would have to hide their sexuality identity in a retirement facility. 98% indicated an interest in a gay or gay friendly retirement facility. • Older LGB client who have spent the majority of their life protecting the privacy of their sexuality are likely to have great concerns regarding the aging process, as the onset of disability may increase the risk of 'outing' of LGB individuals by healthcare providers, by exposing living arrangements or other revealing circumstances. • Older LGB individuals may prefer not to claim benefits for a partner if their relationship is not public and may experience anxiety regarding the completion of documentation involving next of kin. • Financial effects on a partner caring for a significant other with a disability may remain unrecognized due to separate living arrangements or absence of legal documentation.

Claes, J. A., & Moore, W. (2000).	Addressing the knowledge gap for issues directly related to older LGBT individuals	NA	NA	Theoretical Discussion	• Claes & Moore (2000) propose the hypothesis that society prefers to view older individuals as asexual. Given that gay and lesbian individuals are often viewed in relation to their sexuality, it follows that they would experience greater homophobia than their younger counterparts.
David, S., & Knight, B. G. (2008).	Examination of perceived homonegativity, coping style and mental health outcomes young, middle aged and older Black and White gay men.	383 convenience sample.	1.Demographic Information Form 2. Revised Homosexuality Attitude Inventory (AHAI). 3. Index of Race-Related Stress: Brief Version (IRRS-B). 4. The Ageism Survey 5. Brief COPE Scale 6. Center for Epidemiological Studies Depression Scale (CES-D). 7. Trait Anxiety Scale (STAI-T) 8. Health Questionnaire.	3x2 Experimental Design	• As a result of the institutionalization of heterosexism, gay and lesbian older adults often endure challenges in accessing adequate healthcare, social services and affordable housing. • Older Black gay men experienced significantly greater homonegativity and lower sexual identity disclosure that the other groups. • Older Black gay men also experienced significantly more perceived racism than did younger black gay men (perhaps due to cohort differences) and they experiences significantly more perceived ageism than White older gay men. • Overall black gay men were more likely to use disengaged (less effective) coping styles than White gay men (possibly due to their multiple minority status). • In spite of these findings, older Black gay men do not appear to have more negative mental health outcomes. • Further research is indicated in order to examine the resiliency among this population.
Fox, R. C. (2007).	Investigation of intergenerational communication and communication boundaries between young and old members	Approximately 65 men attending the 'Prime Timers' meetings in Phoenix.		Qualitative Research Study	• Participants quickly dismissed the words old and young, which appeared to be perceived as offensive, replacing them with terms such as 'chicken' and 'troll' which appeared more acceptable. • Chicken: Someone who is much younger, naïve, and sexually and emotionally inexperienced. • Chicken Hawk: An older person who pursues younger people. Common metaphor used is "chasing

	of the gay community.				chickens", suggesting that they are hunters while chickens serve as their prey. • Troll: disparaging term used to label old gay men, invoking the image of an old, withered, and sexually inept man. • By referring to young men as chickens and old men as trolls, the gay community perpetuates a system of objectification dehumanization of gay men. • Many older gay men experience difficulties accepting the resurgence of the term queer, which highlights their differences. For these men, passing as heterosexual has been a survival technique and a way in which they have historically been able to distance themselves from stigma and discrimination. Given that passing as heterosexuals increased their safety and survival, it is sensible that older gay men experience difficulties understanding why the younger generations take pride in choosing not to 'pass' as heterosexuals. • As a result, their view of effeminate homosexual men is frequently negative. • This view changes drastically after the AIDS activism in the 1980s, in which numerous gay men spoke of the ignoring HIV and the socio-cultural silencing of LGB individuals. For this and the following generations, passing as heterosexual represented taking part in and exacerbating the marginalization of the LGB community.
Fredriksen-Goldsen and Muraco (2010).	Application of a life-course perspective in a literature review of LGB aging.	58 articles published between the years 1984-2008. Number of participants: 4-198,121; Mean =52.	NA	Literature Review – Meta Analysis	• Findings indicated that older gay male and lesbian individuals are no more depressed than their heterosexual counterparts. • No differences were found regarding diet and exercise among older gay and heterosexual men. • Older lesbian adults reported lower incomes than older gay men. They also were more likely to have partners and larger social networks. Older gay men

		Journal Articles only. Older adults = age 50 and older.			were more likely to live alone. • Older LGB adults consistently reported feeling cynical about health care professionals and hesitant to rely on institutions that have traditionally pathologized and discriminated against them. • Other barriers to obtaining healthcare for older LGB adults included: financial barriers, personal discrimination, and lack of protection of partners or other supports. • Historical trends across the research were found: 1) Focus on dismantling negative stereotypes about older lesbian and gay individuals, (i.e. that they experience depression and maladjustment to the aging process) 2) LGB had a positive psychosocial adjustment to the aging process in spite of the supplementary challenges and discrimination they endure; 3) shifting experiences of identifying as LGB over time according to social context 4) last and current wave focused on examining the social support and community-based needs of older LGB adults.
Hajek, C., & Giles, H. (2002).	Examination of the communication between younger and older gay men in terms of social identity theory.	NA	NA	Theoretical Discussion	• Social identity theory posits that individual group members will engage in a number of strategies to cope with negative social identity and to distinguish themselves in a positive manner from other groups. • This may help to explain the discrimination experienced by older gay men from their younger counterparts. • Once such beliefs are established thy have a self perpetuating effect. Having awareness of the stigma attached to aging in the gay community is likely to exacerbate fear of aging in younger generations. • Additionally, the vision of growing older in a society that rejects the notion of gay marriage may cause fears associated with aging as society defines the birth of children and grandchildren as markers of aging. The absence of such markers may lead to fears of isolation.

					• The seeming invisibility of older gay men from gay culture may serve to exacerbate fears of isolation. Moreover, the absence of older gay men in the gay community deprives gay men the opportunity to engage in intergenerational communication. • Authors suggest that some older gay men may avoid their younger counterparts due to the threat that the new values of the younger generation have on their culture of secrecy. • Also, the stigma that older gay men have as sexual predators may lead to avoidance of contact and communication by older gay men who fear being perceived this way and younger gay men who perceive see them in this light.
Johnson, M., Jackson, N., Arnette, J., & Koffman, S. (2005)	Exploration of the perception of discrimination and bias towards LGBT individuals in retirement care facilities.	127 gay, lesbian, bisexual and transgender participants. *Ages 15-72 (mean= 42)	1.Demographic Questionnaire. 2. Questionnaire about perceptions of discrimination and sources of discrimination in retirement homes.	Survey Study	• Findings reveled that most LGBT individuals viewed discrimination in retirement facilities as a major problem. • Vast majority of respondents indicated that they believed in the necessity of gay friendly retirement facilities. • Results indicated the need for resident education, particular to individuals with lower SES. • Younger respondents tended to be more optimistic than older respondents.
Quam, J.K., & Whitford, G.S. (1992).					• Found that among lesbian and gay older adults, adjustment to late life depends largely on the acceptance of aging, maintenance of high life satisfaction and being active in the lesbian and gay community. • Isolation was found to be a major threat to the well-being of older lesbian and gay adults, leading to increases rates of self neglect and mortality, and decreased quality of life.
Ritter & Terndrup (2002).	A handbook of affirmative	NA	NA	Handbook	• Content of the handbook covers four major headings: 1) social, developmental and political foundations;

	psychotherapy with lesbians and gay men.				2)identity formation and psychological development; 3) affirmative practice; and 4) working with couples and families.
Schope, R. D. (2005).	Examination of how lesbian and gay individuals perceive the aging process.	183 participants – 74 gay men (mean age = 34.4) and 109 lesbians (mean age =39.9). 94% White 93% enrolled in or graduated college.	1.Questionnaire about gay aging. 2. Attitude Toward Aging (ATA). 3. Fear of Negative Evaluation (FNE) scale. 4. Two subscales taken from the Multidimensional Body-Self Relations Questionnaire (MBSRQ).	Correlational Design.	• Two competing theories exist in the literature pertaining to gay male aging: accelerated aging and crisis competence. • Accelerated Aging: this theory contends that gay men view themselves as older at a time when heterosexual men do not. • Crisis Competence: this theory contends that gay men are more capable of effectively coping with aging than heterosexual men, as a result of acquiring skills that help one to cope with adjustment during the coming out process. • Some other suggest that older gay men often retreat from the community and social events due to their fear of being rejected or perceived as sexual predators. As a result, they are more likely to experience isolation and despair. • Older lesbian women, on the other hand, are more likely to be welcomed, respected, and appreciated among the younger lesbian community. • Findings indicate that gay respondents perceived on to be old at a much earlier age that did lesbian respondents. • Findings also showed that gay men have a more negative view of the aging process than do lesbians. They also believe that society views aging more negatively than do lesbians. • Gay men were also found to be more ageist, assign greater significance to physical appearance, and have greater fear of negative evaluations by others than lesbians participants. • It is important to recognize that both gay men and lesbians indicated fears associated with growing old. Researchers hypothesized that such fears may be

					associated with the absence of a traditional family and concerns regarding being alone in old age.
Shippy, R. A., Cantor, M. H., & Brennan, M. (2004).	Investigation of social support networks in aging gay men.	223 gay males age 50-81 (mean=62). *Ethnicity: 79.5% Caucasian, 9.2% African American, 9.2% Latino and 2.2% Native American and Asian.	Survey instrument consisting of four separate measures (demographics, 2 distinct caregiving situations, and type and extent of caregiving assistance).	Survey Study	• Results of the study highlighted the heterogeneity of older LGB adults and the numerous types of families and constellations of networks. • Social networks in which significant others or friends comprised the critical elements were demonstrated to be capable of providing adequate support for most of the men included in the study.
White,L. &Cant, B. (2003).	Exploration of the experiences of social support on the gay men with HIV.	30 HIV positive gay men in the UK *Ages 25-63 (Mean=38)	1.Semi-structured interview lating between 60-90 minutes. 2. Questionnaire assessing social networks.	Content Analysis	• Patners, ex-partners and friends were more likely to provide support more frequently than biological family members. • This finding was consistent for both instrumental and emotional support.

Religiosity

Author/ Year	**Research Questions/ Objectives**	**Sample**	**Instruments**	**Research Approach/ Design**	**Major Findings**
Balkin, R., Schlosser, L., & Levitt, D. (2009).	A national study investigating the relationship between religious identity, sexism, homophobia and multicultural competence.	111 randomly samples counseling professionals and graduate students. 89 women and 21 men.	1.Religious Identity Development Scale (RIDS). 2.Ambivalent Sexism Inventory (ASI). 3.Attitudes	Descriptive Study	• Religious fundamentalism has been found to be a predictor of prejudice against sexual minority individuals, as homosexuality has been regarded as a sin among a great deal of conservative and orthodox sects of many religions. • The findings demonstrated that participants who were more rigid and authoritarian in their religious identity also tended to exhibit more homophobic attitudes.

		Ethnicity: 85% Caucasian, 3* Asian, 5% AA, 0.9% Hispanic, 0.9% Native American and 2% multiracial. Religion: 72% Christian, 6% Jewish and 16% other or no religion.	Toward Lesbians and Gay Men-Revised-Short Form (ATLG-R-S). 4.Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition-Revised (MAKSS-CE-R).		This finding is consistent with previous research on this topic. • Implications from this study are extremely important as they highlight the importance of gaining awareness of one's own religious identity and how those views relate to issues of sexism and homophobia. The importance of gaining awareness of one's own biases and beliefs cannot be stressed enough. • A counselor's religious identity can interfere with his or her ability to provide unconditional positive regard and be open and respectful to a variety of viewpoints if such internal biases and beliefs are not explored thoroughly.
Barton, B. (2010).	Exploration of the experiences of gay and lesbian residents of the Bible belt.	46 participants: 27 lesbians and 19 gay men. Ages 18-74 Ethnicity: 7 AA, 3 Native American, 3 Hispanics, 2 Jewish and 31 Caucasians.	Semi-Structured interview of 45-120 minutes, Mean=90, which was transcribed, coded and analyzed.	Qualitative	• The Bible Belt is a region which includes a variety of racial and ethnic groups and religious denominations residing in large cities, small towns and rural areas. It is a geographic area in the Unites States with a high population of fundamentalist Christians who interpret the bible literally. • The fundamentalist framework is one which threatens ones soul for eternal damnation promoting fear and encouraging secrecy about same-sex attractions. • Bible belt non-heterosexual individuals are constantly exposed to homophobic hare speeches through religious outlets, as well as other outlets in their community, such as schools and places of work. • Many of the participants reported a sense of "stuckness", as they were unable to change their sexual orientation in spite of their persistent efforts o do so. • Approximately 50% of the respondents reported enduring long-term psychological distress as a result of their fears associated with being rejected by god and society due to their same-sex attractions.
Haldeman, D. (2002).	Discussion of the complex issues,	NA	NA	Literature Review	• The major mainstream mental health institutions have all publicized statements asserting that homosexuality

	ethical considerations and social implications pertaining to the intersections of same-sex identity and conservative religious beliefs.				is not a mental disorder and should not be treated as such. Yet there is still a fragment of society, both within and outside of the mental health field, who believe non-heterosexual orientation to be deviant and immoral and contend that conversion therapies must be utilized to help mend these lost souls. • Historically, the most infamous behavioral treatments included aversive therapies such as electric shock therapies (administered to hands and/or genitals) and nausea-inducing substances administered concurrently with homoerotic materials. Less vicious therapies included reconditioning through masturbation, visualization, and social skills training. • Conversion therapies function under the assumption that same-sex attraction is aberrant and undesired. • Such therapies aim to assure that the clients can pacify same-sex behavior, rather than extinct homoerotic fantasies. • There is an absence of empirical research pertaining to conversion therapy, as a great deal of the research supporting conversion therapies have been found to possess methodological issues, sampling bias and response bias. • Reports of patients who have failed conversion therapy have demonstrated that different patients manifest different responses to such experiences. Conversion therapy has shown to be injurious for those patients who have endured chronic victimization traumatic anti-gay experiences and consequences include depression, low self-esteem, interpersonal difficulties and sexual dysfunction. • When treating sexual minority persons with conservative religious beliefs that clash with their sexual orientation, it is important to thoroughly and thoughtfully examine the client's all aspects of the client's personal and social life. The role of the therapist is to facilitate the journey of profound

					examination rather than impose their own beliefs. It is critical that practitioners who support conversion therapy do not assume that any despondent sexual minority person should be treated with such therapies. Conversely, gay-affirmative therapists must assure that they do not trivialize the importance of one's faith or encourage religious abandonment.
Halkitis, P., Mattis, J., Sahadath, J., Massie, D., Ladyzhenskaya, L., Pitrelli, K., et al. (2009).	Exploration of the religious and spiritual practices among lesbian, gay, bisexual, and transgender individuals, as well as the meaning they ascribed to religiosity and spirituality.	498 LGBT identified individuals. --Ethnicity: 8.6% African American, 24.3% Latino, 53% Caucasian, 6.4% other, 7.6% missing. --Gender: 52% male, 47% female, 1% transgender. --Sexual Orientation: 45% gay male, 34.7% lesbian, 7% bisexual male, 12.2% bisexual female, <1% gay or lesbian transgender, <1% bisexual transgender.	1.Socio-demographic form. 2.Religious Affiliation (2 questions). 3.Subjective Religiosity and subjective spirituality (2 questions). 4. Religious participation (2 questions). 5.Organizational religious involvement (2 questions). 6. Qualitative: What does religiosity mean to you? What does spirituality mean to you?	Cross Sectional Survey Study	• Exposure to non-affirming religious beliefs may cause LGB individuals to experience conflict between their sexuality and their religion. • Although the majority of the participants in the study (over three quarters) were raised in religious households, only approximately one fourth reported holding a current membership in a religious institution. • Christians and individuals raised in European religions were the most likely to change their religious affiliation. • When defining religion, participants focused on structured and communal forms of worship. When defining spirituality, on the other hand, participants focused on relational features, specifically the relationship with God or a higher power, with the self and with others.

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Corrigan, P. W., & Watson, A. C. (2002).	Discussion of the paradox of self-stigma and minority status.	NA	NA	Literature Review.	• Authors discuss self-stigma, making use of research from social psychologists on self-stigma in other minority groups to explain this apparent paradox. • Implications for future research related to personal response to mental illness and stigma are discussed.
Fraley, S. S., Mona, L. R., & Theodore, P. S. (2007).	Presentation of issues impacting LGB individuals with disability from a multicultural perspective, offering practical strategies for overcoming barriers presented.	NA	NA	Theoretical Discussion	• Authors highlight the absence of literature regarding LGB persons with disabilities from areas of social policy, sexuality studies, and psychological research and practice. • Fraley, Mona & Theodore (2007) discuss barriers resulting from the double minority status of LGB individuals, including sexual expression, obstacles to establishing sexual relationships, absence of positive role models, deficiency in available resources and more.
Gouvier, W., & Coon, R. C. (2002).	Examination of the relationships among stereotypes, employment discrimination, and language discrimination patterns.	NA	NA	Literature Review	• Authors present a review of the relationships among the following factors: misconceptions, employment discrimination, and language discrimination patterns, as well as the effects of these factors. • Strategies for overcoming the effects of erroneous stereotyping and discrimination are offered.
Jowett, A., & Peel, E. (2009).	Examination of the experiences of LGB	190 individuals living with chronic illness who	1.Online Survey composed of closed and open	Survey Study	• In spite of the myriad of differentiating factors (i.e. illness, genders, sexual orientation identification, and country of residence), a number of common

	individuals living with non-HIV related chronic illness.	completed online survey. Gender: 50% female, 44.1% male, 2.1% trans-male, 0.5% trans-female and 3.2% 'other'. Sexual orientation identity: 44.1% lesbian, 39.4% gay, 10.6% bisexual, and 5.9% 'other'.	ended questions		experiences were found among respondents, representing experiences of oppression, invisibility and isolation from others like themselves. • Discrepancies among illness framed as 'gay/lesbian health issues' versus those that are not were highlighting, leaving individuals with illness and disability outside of this frame, ignored within the community. • Feelings of isolation within the LGB community as well as feelings of discomfort when participating in support groups with a primarily heterosexual membership were common issues that arose. • Overall, the analysis highlights the lack of representation, support and community available for LGB individuals with disability and/or chronic illness.
O'Toole, C. (2000).	Analysis of the intersections between disability status, race, and sexuality.	NA	1.Videotaped interviews 2. Email inquiries 3. Group and individual discussions. 4. Conference proceedings	Ethnographic Study	• Author identified the following themes related to lesbian women with disabilities: boundaries related to lesbian identification, the presumption of heterosexuality, invisibility within the disability community, value of ability and self-reliance within the lesbian community, sex, creativity, visibility, challenges and barriers for intimate relationships, absence of sexuality information, absence of role models and community, unique issues related to survival of sexual abuse, and roles as mothers. • Lesbian women with disabilities may have to face multiple layers of discrimination • Feelings of alienation or lacking community support that many lesbian women with disabilities experience can lead to internalized ableism. • Although the lesbian community has been a long time pioneer in affirmative action for women with disabilities, these women still face many problems. • Disabled women challenge the foundation of the

					lesbian community's value of self-reliance and autonomy.
O'Toole, C. J., & Brown, A. A. (2003).	Exploration of barriers experienced by lesbian women with disabilities in accessing mental health services.	NA	NA	Clinical Discussion	• Authors discuss emergent mental health issues relevant to disabled lesbians, as well as barriers in access to healthcare. • Authors discuss cultural competency in the context of the intersection of sexuality and disability status. • Authors examine how lesbians with disabilities have proactively networked, creatively creating informal supports and resources within their communities.
Whitney, C. (2006).	Examination of the experiences of gay male who received gay affirmative therapy based on feminist methodology.	5 self identified "queer" females with a disability, aged 25-58.	45-65 minute Semi-structured recorded interview.	Phenomenological Study	• In a lead study investigating perceptions of identity in disabled lesbian women, findings indicated that women viewed their sexual orientation as a positive aspect of their identity while they tended to view their disability status in a less favorable light (Whitney, 2006).

APPENDIX B

Definition of Key Terms

Definition of Key Terms

Ally: Any person who supports and stands up for the rights of lesbian, gay, bisexual, transgendered, questioning and/or intersex persons (U.S. Department of Justice, 2006).

Biphobia: Analogous to the term homophobia, biphobia is the fear, hatred, or intolerance of individuals who identify as or are perceived to be bisexual. Biphobia is used by laypeople to describe any form of prejudice against bisexuals (Rust, 2002); however, some prefer the term *bi-negativity* in favor of biphobia (Eliason, 2001).

Bisexual: Bisexual is a term used for an individual who has affectionate and sexual attractions and behaviors towards both same sex and opposite sex individuals.

Coming out: This term is short for "coming out of the closet," and refers to the acknowledgement, acceptance, and disclosure or gay, lesbian, or bisexual orientation. The coming out process is one that takes place in two stages: coming out to oneself and coming out to others. Coming out to oneself refers to developmental milestone in which an individual moves from non-recognition of his minority sexual orientation to self recognition. Coming out to others refers to the individual's disclosure of their minority sexual orientation to others (Anhalt & Morris, 1998).

Commitment ceremony: This observance is a formal ceremony resembling a marriage that recognizes the declaration of members of the same sex to each other.

Domestic partner: This is a term typically used in connection with legal and insurance matters, referring to unmarried cohabitating partners, who may be of the same or of opposite sex. In some countries, municipalities, and states, domestic partners can register to receive some of the same benefits accorded married couples.

Gay: Gay is an adjective that has largely replaced the outdated term 'homosexual' used for a male who has affectionate and sexual attractions and behaviors towards other men.

Gender: Gender typically refers to the social and cultural features and attributes that characterize men and women.

Gender identity: Gender identity refers to an individual's internal sense of being male or female and the degree to which an individual lives his or her life in accordance with these socially constructed roles (Kauth, 2006).

Gender roles: Gender roles are socially constructed collections of roles, attributes, emotions, attitudes and behaviors deemed specific to distinguish masculinity and femininity (Kauth, 2006). Non-traditional gender roles and cross-gender behaviors have historically been associated with sexual orientation.

Heteronormative assumptions: This term refers to unconscious automatic beliefs and expectations that perpetually reinforce heterosexual orientation, attraction, and behavior as an ideal norm (McGeorge & Carlson, 2011).

Heterosexism: Heterosexism is a term created as an alternative to the term *homophobia* in order to highlight the similarities between the oppression that LGB individuals endure and the oppression of women (*sexism*) *and* people of color (*racism*) (McGeorge & Carlson, 2011). Herek (1990) defines heterosexism as "An ideological system that denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity, relationship or community. It operates principally by rendering homosexuality invisible and, when this fails, by trivializing, repressing, or stigmatizing it." (p. 316). Heterosexism can occur at an implicit and/or explicit level against sexual minority

individuals, in which a presumption of heterosexuality as normal and/or superiority exists. Pachankis and Goldfried (2004) argue that the term heterocentrism better captures the concept in that frequently such a bias is not intentional, but rather faulty assumptions made by mainstream society. Such heterocentric beliefs are manifested at the individual and cultural levels. It is important to understand the implications of heterosexism as LGB persons still live in a society of heterosexism and heterosexism is still a fundamental part of the life experiences that LGB persons experience (Cahill, South, Spade, & National Gay and Lesbian Task Force, 2000). Everyday obstacles that non-heterosexuals face as a direct result of heterosexism have been referred to as *heterosexist hassles***.** *Internalized heterosexism* refers to the internalization of heterosexist assumptions.

Heterosexist bias: Heterosexist bias is defined as the limited conceptualization of human experience as heterosexual alone, thereby overlooking and suppressing all non-heterosexual lifestyles, leading to discrimination and injustice (Herek, Kimmel, Amaro & Melton, 1991).

Heterosexist privilege: This term refers to unearned civil rights, societal benefits, and advantages granted to individuals solely based on their heterosexual orientation and/or identification (McGeorge & Carlson, 2011).

Heterosexual: A heterosexual is a person whose affectionate and sexual attractions and behaviors are directed towards persons of the opposite sex.

Homonegativity: Homonegativity refers to the individual's negative affect and beliefs about minority sexual orientations and manages some of the criticisms of the term homophobia. Even with these modifications, the term homonegativity has been criticized for overlooking the systematic and pervasive nature of discrimination within society's

institutions as it focuses on individual attitudes (Szymanski, Chung & Balsam, 2001). *Internalized homonegativity* refers to the internalization of such negative affect and beliefs. Though a useful term, it has been criticized for overlooking the systematic and pervasive nature of institutional prejudice and discrimination (Szymanski et al., 2001).

Homophobia: Homophobia has been defined as the "irrational persistent fear or dread of homosexuals" (MacDonald, 1976, p. 24). Homophobia is similar to other phobias in that the fear is based on irrational myths and stereotypes. In more recent literature, homophobia has been utilized as a term typically used to describe hostility and prejudice towards same-sex attracted individuals. Still, this term has been criticized by many to be inaccurate, as it is not a phobia in the clinical sense, in the same way that would be a fear of snakes or spiders (Pachankis & Goldfried, 2004). More accurately, homophobia is seen as analogous to racism and sexism, as it manifests as prejudice, hatred, and discriminations towards same-sex oriented persons. As a response to the criticisms of the term homophobia, the term *homonegativity* was introduced into the literature.

Internalized homophobia: Herek and Garnets (2007) define internalized homophobia as "An individual's self stigmatization as a consequence of accepting society's negative attitudes towards non-heterosexuals" (p. 361). It is the manifestation of shame about one's sexuality due to the hostility and contempt society exhibits. Children are exposed to these societal notions from a very early age. As a result, upon recognizing the possibility of an LGB identity within themselves, LGB individuals may feel ashamed and hide their sexual identity. In other words, internalized homophobia refers to the internalizations of negative attitudes towards same-sex attracted individuals

by same-sex attracted individuals as a result of growing up in a heterocentric society and absorbing heterocentric values (Pachankis & Goldfried, 2004). Internalized homophobia has been termed internalized heterosexism and internalized homonegativity throughout the literature (Herek & Garnets, 2007).

Institutional heterosexism: This term refers to societal policies and actions by institutions that promote and grant benefits to individuals based on their heterosexual orientation and exclude and discriminate against non-heterosexual individuals based on sexual orientation (McGeorge & Carlson, 2011).

Intersex: Also referred to as *ambiguous genitalia,* this term has replaced the term *hermaphrodite,* which has been discouraged due to its stigmatizing nature. The term intersex refers to a biological condition where a person is born with internal reproductive systems, sex chromosomes, and/or external genitalia that are not exclusively male or female. Intersex persons may have various combinations of genitalia, reproductive organs, secondary sex characteristics, and combinations of sex chromosomes (Kaiser Permanente, 2004).

Lesbian: Lesbian is a preferred adjective used for a female who has affectionate and sexual attractions and behaviors towards other women.

LGB: LGB is an acronym for lesbian, gay, and bisexual.

LGBT: LGBT is an acronym for lesbian, gay, bisexual, and transgender.

Men who have sex with men (MSM): A commonly used term for men who engage in same-sex behaviors, but may not necessarily self-identify as gay or bisexual.

Monosexism: Analogous to the term heterosexism, monosexism refers to the prejudice from both heterosexuals and non-heterosexual individuals based on the premise

that a dichotomous categorization of sexuality is the only legitimate form of sexuality and is, therefore, superior to bisexuality.

Pansexual: Pansexual is a term used for an individual who has affectionate and sexual attractions and behaviors of many kinds.

Queer: A political term, as well as an umbrella term including a range of sexual and gender identities. It is a term which advocates ceasing binary thinking and viewing sexual orientation as fluid. Due to the historical implications related to this term, some members of the LGBT community find this term offensive (U.S. Department of Justice, 2006).

Questioning: A term referring to an individual who is unsure about their sexual orientation or in the process of coming to terms with his or her sexual orientation.

Sex: Sex refers to the organic and physiological feature and attributes that distinguish males from females (Kauth, 2006).

Sexual behavior: Also referred to as *sexual expression* or *sexual activity,* is a term representing any mutually voluntary activity with another person involving genital contact or physiological arousal, regardless of whether sexual intercourse or orgasm occurred (Savin-Williams, 2006). Terminology specifying sexual expression includes terms such as *women who have sex with women* (WSW) and *men who have sex with men* (MSM). In recent literature, such terms are increasingly used to describe individuals who do not identify as LGB but who do engage in same-sex behavior.

Sexual orientation: The enduring experience of emotional, romantic, erotic, sexual or affectional attraction to one or both sexes (American Psychological Association, 2011; Garnets, 2002). Sexual orientation ranges from exclusively same-sex oriented on one end

of the spectrum to exclusively opposite-sex oriented on the other end of the spectrum, with countless forms of bisexuality in between (American Psychological Association, 2011). Contemporary research has begun to consider the plurality and multiplicity of sexualities (Garnets, 2002). The absence of a consistent operational definition of sexual orientation has been problematic. Savin-Williams (2006) highlights that sexual orientation has traditionally been defined in the context of three distinctive aspects: *sexual/romantic attraction* or *arousal*, *sexual behavior*, and *sexual identity*.

Sexual (orientation) identity: This term refers to the cognitive aspect of sexuality (Cass, 1984) and the meanings we derive from language. According to Savin-Williams (2006), sexual identity is defined as a "personally selected, socially and historically bound label related to the perceptions and meanings a person has about his or her sexuality" (p.41). It is the acceptance, recognition and personal identification with a grouping of sexual attraction that reflects a person's sexual values, needs and preferred modes of expression (Worthington,2004). An individual might have a bi-, hetero-, or homosexual (orientation) identity (Kauth, 2006). It is important to keep in mind that an individual may engage in certain sexual behaviors without identifying with that particular sexual identity. The concept of sexual orientation is directly correlated to sex and gender.

Sexual/romantic attraction: Sexual attraction refers to the desire for emotional and physical connection and intimacy, attraction towards, or the desire to engage in sexual relations with or to be in a primary loving, sexual relationship with a person or a particular categorization of persons. (Kauth, 2006; Savin-Williams, 2006).

Transgendered: An umbrella term used to describe a continuum of individuals whose gender identity and gender expression is divergent, to some degree, from

biological sex. Transgendered individuals may choose to receive hormonal treatment and/or may plan to seek surgical treatments to become genitally congruent with their gender identity. Transgendered individuals may identify as bisexual, heterosexual or homosexual (Kaiser Permanente, 2004; U.S. Department of Justice, 2006).

Two-Spirit: This term refers to a person who identifies with the Native American tradition of characterizing certain members of the community as embodying the male and female spirit. This term is inclusive and can refer to both sexual orientation and/or gender identity. Commonly, two-spirited persons do not use terms such as gay, lesbian, bisexual, or transgender because these terms are not culturally relevant to them.

Women who have sex with women (WSW): A commonly used term for women who engage in same-sex behaviors, but may not necessarily self-identify as lesbian or bisexual.

REFERENCES

American Psychological Association. (2011). *Practice guidelines for LGB clients: Guidelines for psychological practice with lesbian, gay, and bisexual clients.* Retrieved from http://www.apa.org/pi/lgbt/resources/guidelines.aspx.

Anhalt, K., & Morris, T. (1998). Developmental and adjustment issues of gay, lesbian, and bisexual adolescents: A review of the empirical literature. *Clinical Child and Family Psychology Review, 1*(4), 215-230. doi:10.1023/A:1022660101392

Cahill, S., South, K., Spade, J., & National Gay and Lesbian Task Force. (2000). *Outing age: Public policy issues affecting gay, lesbian, bisexual, and transgender elders*. Washington, DC: Policy Institute of the National Gay and Lesbian Taskforce. Retrieved from http://www.thetaskforce.org/reports_and _research/outing_age

Cass, V. (1984). Homosexual identity formation: Testing a theoretical model. *Journal of Sex Research, 20*(2), 143-167. doi:10.1080/00224498409551214

Eliason, M. J. (2001). Bi-negativity: The stigma facing bisexual men. *Journal of Bisexuality, 1*(2-3), 136-154. doi: 10.1300/J159v01n02_05

Garnets, L. D. (2002). Sexual orientations in perspective. *Cultural Diversity and Ethnic Minority Psychology, 8*(2), 115-129. doi: 10.1037//1099-9809.8.2.115

Herek, G. (1990). The context of anti-gay violence: Notes on cultural and psychological heterosexism. *Journal of Interpersonal Violence, 5*(3), 316-333. doi:10.1177/088626090005003006

Herek, G., & Garnets, L. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology, 3,* 353-375. doi:10.1146/annurev.clinpsy.3.022806.091510

Herek, G., Kimmel, D., Amaro, H., & Melton, G. (1991). Avoiding heterosexist bias in psychological research. *American Psychologist, 46*(9), 957-963. doi:10.1037/0003-066X.46.9.957

Kaiser Permanente National Diversity Council and Kaiser Permanente National Diversity Department. (2004). *A provider's handbook on culturally competent care: Lesbian, gay, bisexual, and transgender population* (2nd ed.). Retrieved from http://kphci.org/downloads/KP.PHandbook.LGBT.2nd.2004.pdf

Kauth M. R. (2006). Sexual orientation and identity. In R. D. McAnulty & M. M. Burnette (Eds.), *Sex and sexuality* (pp. 153- 184). Westport, CT: Greenwood Press.

MacDonald, A. (1976). Homophobia: Its roots and meanings. *Homosexual Counseling Journal*, *3*(1), 23-33. Retrieved from http://psycnet.apa.org/psycinfo/1976-23947-001

McGeorge, C., & Carlson, T.S. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy, 37*(1), 14-26. doi: 10.1111/j.1752-0606.2009.00149.x

Pachankis, J., & Goldfried, M. (2004). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychotherapy: Theory, Research, Practice, Training*, *41*(3), 227-246. doi:10.1037/0033-3204.41.3.227

Rust, P. C. R. (2002). Bisexuality: The state of the union. *Annual Review of Sex Research, 13,* 180-240. Retrieved from http://gendersex.net/conted-spring2011/wpcontent/blogs.dir/87/files/2011/04/RobertsStudyGuide-sm.pdf

Savin-Williams, R. C. (2006). Who's gay? Does it matter?. *Current Directions in Psychological Science*, *15*(1), 40-44. doi: 10.1111/j.0963-7214.2006.00403.x

Szymanski, D. M., Chung, Y., & Balsam, K. F. (2001). Psychosocial correlates of internalized homophobia in lesbians. *Measurement and Evaluation in Counseling and Development*, *34*(1), 27-38. Retrieved from http://web.ebscohost.com.lib.pepperdine.edu/ehost/pdfviewer/pdfviewer?vid=3&hid=105&sid=fa14785c-4c54-4dc0-9fbd-7f1c8fba1a76%40sessionmgr112

Unites States Department of Justice Office on Violence Against Women & LAPTOP (2006). *Survivor-centered advocacy institute: Intake and assessment strategies.* Retrieved from http://www.csaj.org/documents/58.pdf

Worthington, R. L. (2004). Sexual identity, sexual orientation, religious identity, and change: Is it possible to depolarize the debate?. *The Counseling Psychologist*, *32*(5), 741-749. doi: 10.1177/0011000004267566

APPENDIX C

Email Invitation to External Peer Debriefers

Dear _____:

My name is Sharon Birman and I am a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology. I am conducting a study for my dissertation entitled, "Clinical Intake Interviewing: Proposing LGB Affirmative Recommendations," under the direction of Joy Asamen, Ph.D., my dissertation chairperson.

The purpose of this study is to identify and critique current practices for conducting intake interviews and offer recommendations for engaging in an LGB affirming initial intake interviewing experience.

As part of the development of the recommendations, I am interested in obtaining feedback from individuals who have clinical expertise working with LGB clients. Specifically, I am interested in individuals who have at least 2 years in an academic appointment during which scholarship on LGB issues have been produced, or if a licensed professional, I am interested in individuals who have been licensed at least 2 years and whose practice includes LGB clients. As someone who I believe meets these criteria, I would like to invite you to serve as a reviewer of my effort. Your participation as a reviewer is strictly voluntary. Moreover, your feedback will be kept confidential, i.e., your identity will neither be disclosed nor associated with your responses to the questionnaire or the final copy of the clinical recommendations.

If you agree to participate, you are asked to do two things. First, please review the attached document of the proposed recommendations. And second, please respond to a set of questions that asks for your evaluative comments about the proposed recommendations.

You may provide your responses to the questions in one of two ways. You may either REPLY to this email to provide responses to the questions that are listed below in blue font by inserting your response under each question. Or if you prefer, you may provide your responses to the questions in the attached document entitled, "Questions for Reviewers," and return the document to me as an email attachment.

I anticipate that it will take about 30 minutes to read through the recommendations and another 30-45 minutes to respond to the questions. If you accept the invitation, I would be most appreciative if you could offer your response by _____.

There is no more than minimal risk in electing to consider this invitation, although I realize you are very busy so there is the inconvenience of the amount of time required to read over the recommendations and offer your responses to the questions. Furthermore, you derive no direct benefit from accepting this invitation. I can offer a final copy of the recommendations, when it is available. If you are interested in receiving a copy of the recommendations, please let me know by replying to this email.

Again, I am fully cognizant that you maintain a busy schedule, so I am most grateful for your time, consideration of this request, and any assistance you can provide. If you have any additional questions concerning this invitation, please feel free to contact me or my dissertation chairperson. If you have issues related to your rights as a participant, please contact Doug Leigh, Ph.D., Chairperson of the Pepperdine University Graduate and Professional Schools Institutional Review Board, at doug.leigh@pepperdine.edu or (310) 568-2389.

Sincerely yours,

Sharon Birman, M.A., Doctoral Candidate
Sharon.birman@pepperdine.edu
[redacted]

Joy Asamen, Ph.D., Professor of Psychology
jasamen@pepperdine.edu
(310) 568-5654

Question 1: What is your profession? (Please check what you consider to be your primary profession)

___LCSW ___MFT ___Psychiatrist ___Psychologist

___Other (Please specify:_____)

Question 2: Have you published or presented papers to professional audiences on issues related to the treatment of LGB clients? ___Yes ___No

Question 3: Please indicate the number of years of professional practice. ___ years

Question 4: Are you viewed by peers in the profession as someone with expertise on the treatment of LGB clients? ___Yes ___ No ___Don't know

Question 5: Given your professional experience with this population, do you believe that the proposed recommendations provide an affirming initial intake experience for LGB individuals?

Question 6: Which of the recommendations, if any, require further elaboration?

Question 7: Is there any pertinent information or essential recommendation that you believe has been overlooked? If so, please explain why you believe it to be important to add the recommendation(s).

Question 8: Should any of the proposed recommendations be eliminated? If so, please explain why.

Question 9: Overall, do you feel that the recommendations will be of practical value to mental health professionals conducting a clinical intake with LGB individuals? Why or why not.

Question 10: Please provide any further comments and/or suggestions that you feel are important for me to consider.

APPENDIX D

Reviewer Comments for Questions 5-10

Question 5: Given your professional experience with this population, do you believe that the proposed recommendations provide an affirming initial intake experience for LGB individuals?

Of the 5 respondents, all believed that the proposed recommendations provide an affirming initial intake experience for LGB individuals. One reviewer commented that the recommendations, particularly some of the questions, may be too aggressive for individuals who are closeted and/or highly religious.

Action taken: The intake recommendations, including the questions that were suggested for inclusion on the intake form or in the intake interview, were not intended for use without careful consideration of the client's particular needs and readiness for disclosure or the acknowledgement of his or her sexual orientation. Hence, in the discussion of the recommendations, including Point 6 of the **Delimitations of the Recommendations**, it is stressed that the suggestions should not be construed as compulsory, supersede what is relevant and in the best interest of the client, or applied in a prescriptive or universal manner.

Question 6: Which of the recommendations, if any, require further elaboration?

Reviewer 1: "Function of an Intake: what is an intake for? Why are you focusing on gay affirmative intake and not gay affirmative psychotherapy?

- Clinical issues: it would behoove you as a clinician to speak up more about this. While I would not recommend pathologizing homosexuality (which you have addressed very well in the paper), research does show that LGB people struggle with clinical issues at higher rates (e.g., suicidality, addictions). What are the unique clinical issues that LGB people face and how can this be assessed at Intake in an affirmative manner?
- Identity development: identity is fluid; how can you capture this process in an Intake? Knowing which identities a person has taken on and let go is very clinically appropriate. What was their coming out process, and how does this match on to their presenting problem?
- Cultural issues!!! I ask all my clients to identify their sexual orientation in the Intake form. Many heterosexual Latinos (monolingual Spanish) do not know how to answer this. For them, there is gay, and not gay. Heterosexuality is not a chosen identity for them – a sign of privilege. It would confuse many of them to see bisexual, queer (no such concept in Spanish), or gender neutral pronouns, in an Intake form. Being too gay affirmative in certain cultures may create an unsafe space. We must protect all clients, not just gay ones.
- While there was a brief section on cultural identities, your paper seems to be very "white." Adding ethnicity into the mix gets very complicated. I would recommend either adding more on this, or explaining why you are not going to address it. The word "queer" is a very white, upper SES social identity which many gay people of color do not resonate to.

- Competencies: I think this is what is really needed to have an affirmative Intake…not the politically correct specific questions. In my opinion, a successful intake with a GLB client is the attitude the clinician brings to the room, not the over-inclusive intake form. No clinician can have all the resources, and no intake form can be developed which can be inclusive for all humans. But if a clinician is open, then they can help most any client. From a multicultural perspective, knowing what to say is less important than actually knowing how to be in the room. If you really want to know what resources are out there, go visit them. Be a part of the community, be a part of your world, not just an examiner of it. That, in my opinion, is true competency."

Reviewer 2: "None."

Reviewer 3: "Very thorough...no further elaboration is needed."

Reviewer 4: "Initial intake process (p. 22): You might consider adding one or two descriptions of practical clinical tools clinicians can introduce during the initial intake that might help to *demonstrate attitudes that are respectful and accepting*. It has been my experience that clinicians appreciate new information that is translated into examples of how they might integrate it into their clinical practice "right away" as a practical means of enhancing their skill-set in treating a particular population. This too might demonstrate to your reader the depth of your critical thinking and subtle knowledge about working with the LGB community. Related questions:

- Is a discussion of the clinician's "use-of-self" relevant here?
- What might the clinician say/do/ask that could also demonstrate their acceptance?

Evaluation of one's degree of "outness" (p. 24): You might consider providing the reader with a structure to conceptualize what is meant by a LGB person's *degree of outness*. This may be especially helpful to new clinicians or clinicians who are not intimately aware of the complex process involved with coming-out for LGB individuals. Would Vivienne Cass's Homosexual Identity Formation Model be helpful here? Including such a structure could also create the opportunity to make additional clinical recommendations for the reader by pairing a particular stage of coming-out with a particular clinical tool."

Reviewer 5: "Here are some of the ideas that come to my mind:

- Although I appreciate and understand the use of the term "sexual orientation" in the list of intake questions on pp37-40 especially, I wonder if it too is a somewhat loaded term that carries its own baggage of assumptions. I'm thinking of clients I have worked with who sees themselves as straight, and yet have had sexual experiences with persons of the same gender. Some of this overlaps with cultural issues. For example, in Latin cultures, there are men who define themselves as straight, and yet have had receptive oral sex, or active anal sex with male partners. Yet they do not define themselves as "gay" or "homosexual" in orientation. Another example is men who have had sex with other men in prison. I have had several clients in the past who have defined themselves as mostly heterosexual, were married and had children, and yet had sexual experiences with members of the same gender at different times in their lives. But they didn't necessarily define

their "sexual orientation" as gay, or even bisexual. There are also the cases of people whose orientation has changed over time, sometimes several times, or whose orientation has varied depending on the situation (e.g., from straight, to gay, and back to straight). I am thinking of a couple of cases I worked with where a man was married, had children, divorced, had a male life partner, but still loved his wife and identified strongly with the role of father and ex-husband. I am concerned that terms like "sexual orientation" and "coming out" are a little constricting, and come loaded with certain assumptions about these experiences being fixed and clear, rather than fluid and ambiguous. Of course for some people, these issues are very clear. For others, not so much.

- I'm a fan of the 3 part way of defining sexual orientation, as (1) who a person is sexually and/or emotionally attracted to (including in fantasy), e.g., same and/or opposite sex; (2) who a person actually engages in sexual behavior with, e.g., same and/or opposite sex; and (3) how a person defines or describes him/herself, e.g., straight, gay, bisexual, etc.
- I like the questions in pp37-42, but it would be nice to have a short and long version. As you've indicated, there are some people for whom these issues are not very central in their current distress. For them, a short version might suffice. For others where these issues are more central (e.g., for an adolescent just coming to terms with this, or an older person awakening to these issues for the first time), the longer more detailed version makes a lot of sense. In almost any evaluation, we have to make choices about how much time we spend on any particular topic. The long version might not be warranted in every case.

Action taken: Although on first review the comments appear unrelated, there were clearly themes that emerged upon a more critical review. First, and most important, was the observation that the recommendations did not adequately take into account culture, particularly ethnic culture. This is a valid issue, but poses some pragmatic challenges in a discussion of this type. To more effectively address this issue in a manner that avoided discussions of specific cultural and linguistic groups, an attempt was made to strengthen the point that it is important to take into account the cultural and linguistic needs of clients in asking about one's sexual orientation. For example, for the sexual orientation identity question, two versions of the same item were suggested. In the second option of the question, an attempt was made to use descriptors that are less "White" or "upper SES" oriented, as suggested by two of the reviewers. An illustration for linguistic differences was also added to the ***Language*** discussion, under **Creating and Affirming Environment.** Finally, the discussion of cultural intersections was moved to the section entitled, **Important Considerations Specific to Members of the LGB Community**, and the importance of taking into account cultural intersections was again reinforced as a therapist competency.

The second theme revolved around the need to more clearly articulate why the dissertation focused on the intake process (rather than psychotherapy) and questioned if the suggested intake items addressed or could address the issues of LGB clients. The decision to focus on the intake process over psychotherapy is simple – if during the intake a client is made to feel uncomfortable, the likelihood of the client remaining and

engaging in psychotherapy is diminished. Moreover, the research indicates that members of the LGB community often come into the therapeutic experience with suspicions about mental health professionals, given the history of pathologizing same-sex attraction. Hence, it seemed important to focus on this portion of a client's therapeutic experience, and this point was emphasized in the **Introduction**. Issue was also raised about areas that were not adequately addressed in the suggested intake questions, e.g., specific clinical needs such as suicidality and addictions. Although it is important to acknowledge that the literature demonstrates a higher prevalence rate of such mental health issues, inquiring about such issues is a standard practice with all clients; hence, such items were not included in the suggested intake questions. This issue has been addressed in Point 4, **Delimitation of the Recommendations**. Moreover, a concern was raised that the questions on sexual identity development did not take into account that identity development is a "fluid" process; therefore, questions were either adapted or added that acknowledge this issue and a suggestion was made that these items are better asked during the course of the intake interview rather than included on the intake form. Finally, one of the reviewers asked for a longer and short version of the list of questions. Although this request is understandable, not knowing what questions are relevant to a client makes creating such lists a challenge. Rather than creating separate lists, the questions were separated by method of administration (intake form or intake interview) and it was emphasized that the selection of items should be based on the relevance of the information to meeting the client's clinical needs and they could adapt or choose among the items suggested.

Upon deliberation with my dissertation chairperson, it was decided not to take action on the suggestion offered by Reviewer 4 on the use of Cass's identity formation model to describe a client's willingness to disclose. Current understanding does not view sexual identity development as a linear, stage-based experience but rather a fluid process; hence, the fluid nature of identity development was emphasized in the discussion.

Question 7: Is there any pertinent information or essential recommendation that you believe has been overlooked? If so, please explain why you believe it to be important to add the recommendation(s).

Reviewer 1: Overlooked, no. I think you covered many topics. In fact, I think you covered too many topics. I think what has been, overlooked is a theory or direction in the paper. You briefly touched on many interesting topics, but I was left wanting more. I wondered what made you decide to choose certain topics and not others – like why is domestic violence an important consideration? Why not substance abuse? Or spirituality? Or HIV? What helped you decide to delineate the process into those four areas (affirming environment, initial intake process, competencies, intake questions). Each one of these can be a dissertation paper! Why only three factors to address for assessing needs?!?!? (presenting concerns, outness, important considerations). Why are these three the most pertinent? I think you covered many relevant areas throughout the entire paper. My question is, why? What are you trying to tell us overall? What is the theme/story/purpose/point? Information overload!

Reviewer 2: On Table 1 "LGB Affirmative Resources," under "Bisexuality" section please include: American Institute of Bisexuality (www.aib.org) and the Los Angeles Bi Task Force (www.labtf.org), under "Education," please include Campus Pride (www.campuspride.org), under "LGBT Persons of Color" please include API Equality (www.apiequality.org). Under "Self-reflective practices" on p. 31 and Table 2 following, please include the Attitudes Regarding Bisexuality Scale (ARBS) by Mohr and Rochlen, 1999.

Reviewer 3: I can't think of anything that has been overlooked. I appreciate the questions on parenting, sex and intimate partner violence.

Reviewer 4: I could not find any discussion of clinical recommendations for treating bisexual individuals. Adding some recommendations for working with this specific population might help clinicians find some answers to the following questions:

- What issues are largely specific to the bisexual community?
- How might these issues "show-up" in treatment?
- What are the empirically based recommendations for addressing these issues in treatment?

Reviewer 5: In the section on page 40 called "sexual experiences" I might add a question about the number of lifetime sexual partners, or number of partners over a certain period of time, e.g., last 90 days, or last 12 months. (Number of partners says a lot about a person's sexual life.) In the question on first sexual experience, it might be good to ask about whether the experience was "consensual." It might be good to be clear about what you mean by "sexual experience." Some people interpret this term in different ways, e.g., as any genital contact, vs. mainly sexual intercourse. You might want to ask about whether the person has had the experience of trading sex for money or drugs, or had experiences as a sex worker.

Action taken: The reviewer comments for this question fell into two major themes – (a) comments that suggested additional resources to include on Tables 1 and 2 and derivations to existing intake questions, and (b) comments suggesting areas for inclusion. In regards to the first theme, all suggestions for additional resources were included in the revised draft of the clinical recommendations and the edits suggested to the intake questions were also completed.

In terms of the second theme on suggested areas for inclusion, the comments of Reviewer 4 were taken particularly seriously since an explicit discussion of bisexuality is not only missing from the original set of recommendations but it is a very important one that should not have been omitted, given the purpose of the recommendations were to apply to Lesbian, Gay, **and** Bisexual individuals. Addressing this issue required further review of the literature, and although information specific to the bisexual community remains limited, some new information was uncovered and has been added to the discussion.

Finally, Reviewer 1's comment that the dissertation provided too much information while at the same time desiring more information in some areas as well as wanting more

information on how the topics were selected and the content organized was considered in collaboration with my dissertation chairperson. Although only conjecture, the reviewers did not have access to the **Plan of Action**, where the process for selecting materials and organizing the information was described. The decision was made not to include this information since this point was only raised by one reviewer and for most clinicians, they would likely prefer focusing on the recommendations rather than how the recommendations were specifically derived. Note a general statement was made in the **Introduction** that the literature was used to inform the selection of recommendations and the complete References list would be provided if this material is disseminated to mental health professionals**.**

Question 8: Should any of the proposed recommendations be eliminated? If so, please explain why.

Reviewer 1: "I think that sometimes trying to be politically correct can lead to bias in the opposite (positive) direction. It is important to normalize all sexuality and not revere any one aspect of it. I am responding not with intention of eliminating a specific recommendation (though it wouldn't hurt to cut back on some stuff), but about being more sensitive to the heterogeneity of the LGB community and the function of the Intake. Sometimes being too gay affirmative might scare clients away who are not ready to take that step. It is important to give closeted people a safe place too. Too many rainbows, pink triangles, same-sex couples and Advocate magazines in the waiting room may frighten some people. Or even for out gay people, making an LGB identity "special" takes away from the opportunity to have "normal" whole-object relations. Yes, I do think we need to be more inclusive and aware of heteronormative language at Intake, but going out of our way to make sure not to offend any gay person is unrealistic and clinically inappropriate. We are clinicians, not superheroes, or fountains of all knowledge. We are limited human beings and intakes are crude tools to get a quick snapshot of what is going on – they will not capture everything. If a client cannot tolerate that shortcoming, that is indicative of their issues, not the failures of the therapist. Nonetheless, the therapist should know how to navigate an intake which includes knowing how to ask personal and complex questions about sexuality and identity."

Reviewer 2: "No."

Reviewer 3: "This approach is very detailed, possibly too much so for an intake with someone whose presenting problem is not related to these issues. I assume the intent is to use this approach and adapt it to the brevity of the treatment and the need to focus on the presenting problem in the intake interview. In some agencies, one therapist does the intake interview and a different therapist provides the treatment - not at all unusual. I think this should be discussed....as related to the comfort of the environment in which these questions are asked, and, especially, for what purpose. This is important, I think."

Reviewer 4: “No. I believe that all of the proposed recommendations are valuable and can add to the knowledge-base of clinicians who are, or plan to work with LGB individuals in therapy.”

Reviewer 5: “No.”

Action taken: Concern was again raised about the length and breadth of the intake. If one were to ask all the suggested question in either the intake form or the intake interview, there is no question that both the client and therapist would be overwhelmed by the experience. As mentioned previously, the intake recommendations, including the questions that were suggested for inclusion on the intake form or in the intake interview, were not intended for use without careful consideration of the client’s particular needs and readiness for disclosure or the acknowledgement of his or her sexual orientation. Moreover, the revised set of recommendations attempted to stress that the suggestions should not be construed as compulsory, supersede what is relevant and in the best interest of the client, or applied in a prescriptive or universal manner.

Although Reviewer 4 was the only individual who referred to the fact that not all individuals who conduct the intake necessarily provide the therapy, it seemed an important practical issue that should be addressed and was added to the **Introduction**.

Question 9: Overall, do you feel that the recommendations will be of practical value to mental health professionals conducting a clinical intake with LGB individuals? Why or why not.

Reviewer 1: “Overall, yes. Any effort to make the intake process for any client is valuable. But I am left wondering what is new and unique in what you present. How is your paper going to augment what is already out there?”

Reviewer 2: “Yes, it details step-by-step the internal and behavioral aspects crucial to developing an LGB-friendly approach to conducting the intake and overall treatment with LGB psychotherapy clients. The intake question list provided is a good concrete tool to use in the session, as well as the comprehensive resource list.”

Reviewer 3: “YES! The questions are comprehensive and well-formulated in terms of being affirmative. The language is excellent.”

Reviewer 4: “Yes. I believe that there is much for everyone to be learned about best practices for working with LGB individuals within the mental health milieu. This dissertation helps to shed much-needed light upon what it is we are learning—and need to know—as mental health professionals.”

Reviewer 5: “Yes, because very few clinicians go into any kind of depth into these issues. In fact, most clinicians avoid these questions because they make them uncomfortable. These recommendations are a good way to prompt clinicians to take these issues

seriously rather than ignore them. It's useful to have a series of prompts to help make the assessment as matter-of-fact as possible."

Action taken: No action was required as all five of the reviewers were in general agreement that the recommendations were of practical value. Reviewer 1's observation is an important one, but the dissertation began from reviewing the literature and in conversations with clinicians who work with the LGB communities in which it was identified that a comprehensive discussion of these issues did not exist. Reviewer 5's observation is a particularly powerful reason for pursuing this dissertation – "…most clinicians avoid these questions because they make them uncomfortable. These recommendations are a good way to prompt clinicians to take these issues seriously rather than ignore them."

Question 10: Please provide any further comments and/or suggestions that you feel are important for me to consider.

Reviewer 1: "Your referral list was fantastic!!! A couple more: Metropolitan Community Church (MCC), Human Rights Campaign (HRC), Senior Action in Gay Environment (SAGE). I would stay away from the colloquial term 'coming out'. As a scientific construct, I do not know what 'coming out' is. As a lingo term, I do. This is a scientific paper, and I would recommend clearly defining what you mean by coming out, or using a more technical term like 'disclosure', or 'identifying as LGB'. Coming out is both an interpersonal process and an intrapsychic one – you talk about it as if it was one thing.

I think you took a big bite off of a big topic. You addressed many important points. But it left me wondering why you chose certain topics and not others. This seems to be an exploratory paper, not guided by much theory. I think if you chose one aspect on this topic, instead of covering a broad selection, the paper would be stronger. Are you advocating being gay affirmative, or are you trying to develop better intake standards when working with GLB clients? Is this a paper on assessment or cultural sensitivity? I think it is trying to be both which ends up lacking depth."

Reviewer 2: "In many instances you use the term 'heterosexual relationship,' which I believe is a misnomer, because relationships do not have a sexual orientation, the partners in the relationship do. Also, a couple with a man and a woman does not automatically mean both are heterosexual, because one or both partners could be bisexual. So just like you use "same-sex relationship" when there are 2 men or 2 women in the relationship, you should use the phrase 'other-sex relationship' when there is a man and a woman. Relatedly, on pg 8, 2nd to the last line, you say 'heterosexual families' – families do not have a sexual orientation, the members within the families do, so that should be changed to 'families with heterosexual parents' or 'families with other-sex parents' (depending on what you're trying to emphasize – the gender or the sexual orientation of the parents). Also be very mindful about including bisexual issues throughout the paper when you mention 'gay' or 'lesbian'. For example, on pg. 27, 2nd paragraph, 5th line, you say 'sperm donors and lesbian mothers,' that should be changed to 'sperm donors and

lesbian/bisexual mothers.' On pg 30, 2nd paragraph, 6th line, you say 'heterocentrism and homophobia' – that should be changed to 'heterocentricism, homophobia, and biphobia'. Also, on pg 8, 1st paragraph, line 7, you say 'It is important that some terminology used by the client may not be appropriate for use by the clinician…' – that should be made a little bit clearer about what you mean especially to those not familiar with current LGBT terms or politics. I suggest saying: It is important that some *in-group or slang* terminology used by the client may not be appropriate for use by the clinician…"

Reviewer 3: "A couple of comments:

- Same-sex marriage needs to be included as an option, to be clear that the option 'married' does not only refer to straight couples. There are many married same-sex couples in the US and other countries.
- The questions on intimate partner violence are problematic because they use terms such as 'abuse' and 'intimate partner violence'. These terms are more clearly understood by professionals and 'helpers', but are not usually used by people involved in abusive relationships, for example, if they are in denial that the behavior they experience is 'abuse' or 'violence', or just wouldn't call it that. Most people are reluctant to apply these categories to their own experiences. Descriptive questions usually work better, and you do use some. For example, do you feel safe in your current relationship? Is there a past relationship in which you didn't feel safe? Do you feel unsafe now because of a past relationship? Or questions such as 'Are you afraid of your current intimate partner?"'

Reviewer 4: "Yes…

- On page 7, you might think about briefly discussing the new law in California that has been enacted to protect LGBT clients from the application of "reparative" therapies as well as other states that are moving forward in this direction.
- Questions recommended for inclusion in an intake interview (p. 36): It might helpful to make it clear whether the intake questions on page 37 are meant to be spoken to the client *or* "checked-off" by him/her/Zie/hir and given to the clinician.
- Related questions:
    1. What is the recommended practice here?
    2. What is the clinical rationale for this recommendation?
    3. How does "best practice" inform us in this situation?
- Regarding page 40: There are research studies that suggest that *traditional family values* conflict more often with issues of sexual orientation than do values related to race and ethnicity. Because there are clients who may not identify strongly with their respective racial and/or ethnic backgrounds, it might be helpful to include questions here that specifically relate to family and traditional family values".

Reviewer 5: No additional Comments.

Action taken: The comments that emerged were helpful in identifying the researcher's blind spots and to increase the cultural sensitivity to the LGB communities at large. The

following is an overview of which of the issues were addressed: (a) reference is now made to disclosure over the use of "coming out," and in specific instances where the term "outing" or "coming out" seemed appropriate, the term was placed in quotation marks to acknowledge the use of a colloquialism; (b) references to sexual orientation and the use of the term as an adjective with inanimate nouns have been addressed; (c) reference to bisexuality has been included where appropriate; (d) a cautionary statement about the use of in-group or "slang" terminology by the therapist has been added to the ***Language*** section under **Creating an Affirming Environment**; (e) rewording intake questions to include same-sex marriage, moving to a description of intimate partner abuse over the use of explicit terms in reference to the experience, and adding a question that inquires about the influence of general family values (rather than specific ethnic or religious values) on one's willingness to disclose; (f) the method for administering the intake questions, i.e., intake form versus intake interview, is now addressed, and for the items suggested for the intake form, which items are customary and which might be optional or addressed in the intake interview; and (g) information on the new law in CA that protects LGBT clients from reparative therapies has been added to the section and subsection entitled, **What Do We Mean by LGB Affirming Practices** and **Current Practices in Working Clinically with LGB Clients**, respectively.