Affirmative, Evidence-Based, and Ethically Sound Psychotherapy With Lesbian, Gay, and Bisexual Clients

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Writing from the perspective of heterosexual therapists treating lesbian, gay, and bisexual (LGB) individuals, Eubanks-Carter, Burckell, and Goldfried (this issue) provide important information on how to enhance therapeutic effectiveness with this population. Their manuscript is an example of a refreshing departure from historical views of homosexuality as a pathological psychological condition and from work that supports using therapy to change sexual orientation. Eubanks-Carter et al. document significant improvements both in the provision of psychotherapy, the view of LGB individuals from the mental health field, and the view of LGB individuals from the community. Despite these improvements, continued progress is still needed. The present commentary points to several areas where the science and practice of clinical psychology can further progress regarding the care of LGB clients. This includes improving systems in training and institutions that employ psychologists where bias or discrimination may exist and reducing biased language in psychological research that implies pathology towards homosexual sexual orientations when homosexuality is not a pathological condition. It also includes reducing or eliminating psychological harm that can be caused by psychological interventions that attempt to change sexual orientation by further restricting these practices.

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"Enhancing Therapeutic Effectiveness With Lesbian, Gay, and Bisexual Clients," written by Eubanks-Carter, Burckell, and Goldfried (this issue), is an important step toward improving the provision of psychological care to lesbian, gay, and bisexual clients. The authors comprehensively reviewed the extant literature on the mental health issues facing LGB individuals, as well as issues surrounding bias in psychotherapy that LGB individuals face. Written from the perspective of heterosexual therapists providing affirmative, sensitive treatment to LGB clients, this is a refreshing departure from historical works, which taught psychotherapists to view homosexuality as pathological. It is also an interesting complement to works written by LGB clinicians from their perspective.

Eubanks-Carter and her collaborators appropriately point out that there is a greater acceptance of gay men and lesbians in the U.S. today, referencing both survey data and popular culture. Dramatic advancements seem to be happening daily. Television shows such as *Will and Grace* and *Queer Eye for the Straight Guy* and the legalization of marriage for same-sex couples in Massachusetts, for example, have brought LGB issues into households of the American public, likely resulting in significant improvements on the psychological well-being of substantial minority of human beings in western countries. Dr. Goldfried's group use these changes to help alert the majority of therapists—heterosexual therapists—to the need to become comfortable working with LGB clients, and provide useful suggestions on how to do so.

Despite the improvements in societal acceptance of LGB individuals, we LGB individuals are one of the only minority groups that are met with continued legalized discrimination. The U.S. military, for example, continues actively and legally to discriminate against us (United States Code, Title 10, Section 654), and many states have or are introducing discriminatory laws that seek to prohibit permanently the recognition of same-sex marriages or civil unions, even if enacted in other states where they may be legal. Having state and federal laws that openly and actively discriminate against LGB individuals is likely going to affect how we seek out and make use of psychological care. Eubanks-Carter et al. point out that psychologists may be influenced by subtle bias against non-heterosexual feelings and behavior, referencing analogue studies of psychologists and a survey of psychologists by Garnets, Hancock, Corchran, Goodchilds, and Peplau (1991).

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Gay, lesbian, and bisexual individuals still have justified hesitation when thinking about or deciding upon where to go to for psychological care. Historically, some therapists attempted techniques to implement "sexual reorientation therapy" teaching "heterosocial competence" while using aversive procedures to punish gender-atypical behavior or displays of same-sex attractions. Haldeman (1994) comprehensively reviewed the extant literature on attempts to change sexual orientation with either religious or psychological interventions and not only found no evidence that they are effective, but also evidence of significant iatrogenic effects and even abuses of clients who tried these programs. Despite this evidence, psychotherapists and some religious programs still practice it (e.g., Spitzer, 2003), and it is still a debated issue among mental health professionals (see Bancroft et al., 2003 for comments on Spitzer 2003).

Shildo and Schroeder (2002) further documented the harmful effects of sexual reorientation therapy. The authors interviewed 202 individuals who had participated in these types of interventions between 1951 and 1999. Following an initial phase of hopefulness, 87% considered themselves as treatment failures. Of the 13% remaining (those who considered themselves to be successes), almost half considered themselves to be "successful but struggling," meaning that they had "slips" with respect to fantasies, anonymous homosexual sex, and other behaviors. Thirteen percent of the entire sample did not consider themselves as treatment failures. Approximately half of these 13% felt that they were able to manage their same-sex desire (i.e., it still existed). This left only 8 individuals who appeared to have a shift in their sexual orientation. Seven of these 8 provided ex-gay counseling to others. Significant psychological harm was reported by the sample including depression, suicidal ideation and attempts, worsened self-esteem, and higher internalized homophobia. Social and interpersonal harm emerged, including worsened relationship with parents (some of the "treatments" placed blame for their sexual orientation on faulty parenting), social isolation, loss of intimate relationships and social supports, and fears of becoming an abuser. Finally, in this sample, many reported negative impacts on their religiosity. Interestingly, approximately one quarter of those who underwent sexual reorientation therapy did not request this as their presenting problem, but instead went for treatment for anxiety, depression, or other issues, and the idea of sexual reorientation treatment was suggested by the therapist.

Guidelines published by the American Psychological Association (APA; 1997a, 2000) and other professional agencies caution against performing sexual reorientation therapy. These guidelines include language to require proper informed consent, they specifically state that homosexuality is not pathological, and mental health services with LGB individuals should be free from bias. Shildo and Schroeder's (2002) data and Haldeman's (1994) review, however, raise the question as to whether these guidelines should go one step further. Given what we know at this time—that sexual reorientation therapy can cause harm in clients who try it—additional restrictions should be considered by mental health professional licensing boards.

Additional issues related to the science and practice of clinical psychology with respect to LGB individuals include the use of language in published work and the role of psychologists in the military. Guidelines for publications by the APA include reducing bias in language (2001; see also Herek, Kimmell, Amaro, & Melton, 1991 for guidelines specific to avoiding heterosexual bias in psychological research). However, the term "heterosocial competence," particularly when focusing on adolescence, is still used in clinical psychology and behavior therapy research articles and scientific presentations. The use of this term promulgates the view that heterosocial behavior is the only kind of competent social behavior. Because "heterosexual competence" was a goal of therapy treatments to "cure" homosexuality, this term has offensive connotations to LGB individuals. Heterosexual psychologists who provide treatment or conduct and publish research on human subjects should strive to use unbiased language in their work to improve the science and practice of clinical psychology.

Psychologists serve in the military, which is an organization that openly discriminates against LGB individuals through their "don't ask, don't tell" policy stating that homosexual conduct is grounds for discharge (Policy concerning homosexuality, 2003). This has the potential to cause a conflict of interest for psychologists if a psychologist were to be required to report on sessions to

his or her commanding officer and the sessions involved a discussion of same-sex sexual attractions. It is unclear whether, for psychologists, the reporting structure of the military is against the spirit or content of the ethical guidelines for psychologists (APA, 2002).

Due to stress related to their sexual orientation, many LGB individuals will present for therapy at some point in their lives, perhaps more so than the general population (Bradford, Ryan, & Rothblum, 1994; Jones & Gabriel, 1999). It is possible that these individuals will not receive the best possible care for their problems compared to heterosexual counterparts because of the issues outline above and because training programs that tend to focus on LGB affirmative psychotherapy largely do not have adequate coursework in empirically informed treatments. Conversly, training programs that do focus on empirically informed treatments largely do not have adequate coursework in LGB issues (Anhalt, Morris, Scotti, & Cohen, 2003). Although LGB individuals possibly use mental health services more than their heterosexual counterparts, emerging evidence suggests that the types of presenting problems that appear are similar to those that heterosexual individuals present with (e.g., Rogers, Emmanuel, & Bradford, 2003; Berg, Mimiaga, & Safren, in press).

One central theme of Eubanks-Carter et al.'s paper involves recognizing that distress experienced by LGB individuals related to sexual orientation is really a result of external causes (i.e., stigma, harassment) rather than anything pathological to sexual orientation per se. This perspective is consistent with epidemiological data that suggests that mood and anxiety disorders may be the types of problems that are higher among LGB individuals relative to their heterosexual counterparts (Gilman et al., 2001; Cochran & Mays 2000). Mood and anxiety disorders are two problems that can result from chronic stress, and a study of LGB youth has shown that when controlling for stress, social support, and coping, initial differences in depression and suicidality between LGB youth compared to their heterosexual peers was no longer significant (Safren & Heimberg, 1999).

Because of the societal stress experienced by LGB individuals, they will be your patients and participants in research studies. Hence, it is imperative to become competent in providing affirmative care to and conducting bias-free research with this population. Eubanks-Carter's paper provides an excellent overview of the issues. Other works exist, including a book geared toward general psychotherapy (Ritter & Tendrup, 2002), a book geared toward cognitive behavioral approaches (Martell, Safren, & Prince, 2003), and the set of resolutions issued by the APA regarding LGB issues (APA, 1997b). Clinical psychologists can have a prominent role in improving the lives of LGB individuals and in reducing bias on a societal level. Using manuscripts including Eubanks-Carter's and the references above, introducing and requiring coursework in training programs, and consistently establishing and following ethical guidelines for psychologists that seek to reduce bias, can further the goals of enhancing therapeutic effectiveness in the science and practice of clinical psychology concerning LGB clients.

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