This is a chapter excerpt from Guilford Publications.
Cognitive Behavioral Therapy with Lesbian, Gay, and Bisexual Clients, Christopher R. Martell, Steven A. Safren, and Stacey E. Prince
Copyright © 2004

Chapter 1

Specific Developmental Challenges for Lesbian, Gay, and Bisexual Individuals

To understand the nuances of problems with which LGB clients present, it is helpful to have a sense of the developmental hurdles and related identity issues these clients faced growing up. Ella's case illuminates some of these challenges. By the time Ella first sought therapy, she believed she had conquered many obstacles. Trying to play out her role in her aging parents' life, however, had proven to be more of an obstacle than the others. Now that both her father and mother required 24-hour nursing care, the burden had fallen on her to provide such services. She was glad to help them. Her parents had been mostly good to her, but Ella could remember a time when the relationship with her parents had been strained.

Ella was raised in a middle-class family. Her father was an engineer and her mother, a nurse. Ella had always felt different from her peers. Hers was the only African American family on her block, and she was one of only four African American children in her elementary school. An outgoing child, Ella made friends easily. When she talked about her childhood to her therapist, she said she had never been aware of racism in her school; she assumed it must have existed, but she had been oblivious to it.

When she started high school, Ella believed that race didn't matter. She just wanted to fit in with her peers. The student body at her new school included just 10 more students of color than in her elementary school. In high school, Ella had her first taste of racism when she began

dating. A good student and a strong athlete, Ella was proud to be captain of the girls' basketball team at her school. However, when she developed a crush on the captain of the football team, who was white, and he made it clear that he would never date her because she was black, Ella felt the difference between herself and her peers keenly. Her parents spent a great deal of time consoling her during this period. Her father related stories of how he had challenged racist practices in his profession in the past, and how he continued to face discrimination on his job. He knew he had been passed over for several promotions but never gave up, insisting on recognition for his abilities. After high school, Ella decided to attend a college with a high percentage of African American students, so she might feel she belonged. Her parents supported her decision, and Ella was accepted at a prestigious university.

In college, unfortunately, Ella's dream of belonging was not fulfilled. She had very little in common with many of the students who had grown up in larger urban areas. Eventually, she found a network of friends, mostly through her sports activities. During her junior year, she met Philip, a handsome, friendly, African American accounting major who was the star of the track team. They began dating and married a few months after both graduated. Both got good jobs out of college, which required a move to the West Coast. Again, Ella found herself in an environment in which she and Philip were in the minority, and most of her neighbors and colleagues at work were white. She felt like an outsider once again, but at least she had Philip on which to rely. She gave birth to their first daughter a year after they were married, and a son was born 2 years later.

Ella worked as a computer programmer and loved her work. She and Philip arranged their schedules so that they could have fewer child care needs. During her sixth year of marriage, Ella was assigned to a work team starting an exciting new project. The team leader was a very attractive woman named Sheila. Her beautiful gray-blue eyes and long auburn hair struck Ella the first time she saw Sheila. They were the only two women on the project, and they struck up an instant rapport.

When Sheila invited Ella out for drinks after work, Ella called Philip to make sure he could be home with the kids, then met Sheila at the bar she had suggested. She was so caught up in conversation with Sheila that she didn't even notice that there were no men in the bar. In fact, in recounting the story, Ella was embarrassed at how surprised she had been when Sheila told her she was a lesbian and was relieved that Ella was comfortable meeting her at a lesbian bar: "My eyes must have popped out of my head, I was so naive at that time. I'm surprised Sheila continued to speak to me at all after I had such a reaction." But the two did continue to speak. After a month on the project, Ella realized that

she was falling in love with Sheila. She told her therapist, “It’s not as if I’d never felt an attraction to a woman before. I always had at least one close girlfriend. But I had never fallen in love like that before. When I first started seeing Sheila in that way, I realized that I had not even been in love with Philip like that.”

Within the year, Ella had come out to Philip, who, after initial surprise and disappointment, learned to respect Ella’s courage in coming out and developed a strong friendship with her. Ella also told her parents about Sheila, but they were not supportive. They were happy to see Ella married, with two children. The last thing they expected was for her to tell them she was a lesbian and was leaving Philip for another woman. Her difficult years with her family began. Her brother, Germaine, would not allow Sheila to visit him. He and his wife had become very religious, and he told Ella that he didn’t want his children to be “exposed” to her relationship with Sheila. Ella’s children, however, were not concerned that their mother’s new partner was a woman, and they enjoyed Sheila’s company. They were still young when Ella and Philip separated, and Philip moved into an apartment only two blocks from Ella. It was important to them both that they remain close to the children. Ella remembered this period of her life, however, as one of great stress and sadness. She once again felt like an outsider in the mostly white lesbian community. She didn’t like to identify as a lesbian. She had found it so difficult even to identify as an African American woman and to make meaningful social connections that the switch to this new community felt like a terrible challenge.

Ella’s identity issues put a strain on her relationship with Sheila. They had tried to live together for a couple of years, but the relationship did not last. After their breakup, Ella dated several other women but was relatively content to be single. Philip had remarried and moved several miles away. Ella liked Philip’s new wife, and they had very few conflicts over child rearing. Her children were now ages 14 and 12. Germaine and his wife and children had moved to the South. Ella’s parents had, eventually, got used to the idea that she was lesbian and had even moved out West to be closer to her and the grandchildren. Because the health of both her parents began to fail at the same time, and somewhat prematurely, Ella felt the burden of needing to care for them. Germaine agreed to help out financially, but Ella was left to find proper care and a place for them to live. She felt that it was finally time to seek help from a therapist. Mainly, she believed she was going to fail her parents, and that she was an imposter, not competent to make the right choices. Ella was socially isolated and felt that she relied too much on Philip and his wife for emotional support. She told her therapist, “It has taken me 38 years to discover who I am, and I still don’t really know

where I fit in. I also know I can do my job, raise my kids, but at the same time, I feel like I'm ultimately going to screw up royally. I think these decisions about my folks are going to provide me with that opportunity to make a huge mistake that will result in something terrible. I really need someone to hear me and help me decide what to do."

Ella found a senior housing facility that provided a small apartment for her parents, with increased nursing care available. Her parents liked the location and were relieved that Ella lived within 10 miles of their new home. They did not discuss her relationships with women. Ella's therapist helped her to explore possibilities for becoming more connected with the LGB community, and Ella organized a book group with six other lesbian or bisexual women, two of whom were also women of color. Ella also spoke with her therapist about seeking a black church and speaking with the pastor about his or her views on LGB issues. She found a small church that was neither openly affirming nor hostile, but the pastor welcomed Ella and her children. She ultimately joined the choir and, through the church, enjoyed meeting new friends, who eventually tried to be matchmakers between Ella and other lesbian friends of theirs.

VIEWS ON DEVELOPMENT

Ella's story represents just one of myriad pathways to the development of a lesbian or gay sexual orientation. It also illustrates a debate about the development of sexual orientation and even the validity of using such a term at all. The debate involves two opposing perspectives: essentialism and social constructionism. The essentialist and constructionist viewpoints, from the perspective of providing cognitive-behavioral therapy (CBT), are important for therapists to understand for several reasons. First, simply taking a view that people will fall into a category of straight, gay, lesbian, or bisexual may preclude one from seeing individuals who do not define themselves in any of those ways, and could invalidate a client's experience. Second, a client's understanding of him- or herself is an important part of developing various beliefs about self and world that are crucial to cognitive and behavioral therapies. Third, cognitive-behavioral therapists who are not familiar with the literature on LGB identity should know that there is no agreement on how one should define sexual orientation. Some say it is fixed (the essentialist view); others say that all sexual orientation is socially constructed (constructivist view). Still others claim that it is fluid for some people and not for others.

The fundamental essentialist view is that sexual orientation is a

more or less fixed state, and the property of one's sexuality resides within the individual person and is always there, whether expressed or not as heterosexual, homosexual, or bisexual. Genetic and environmental factors may play a part in the development of sexual orientation, but one's sexual orientation is determined by factors beyond the control of the individual and is a relatively stable characteristic. Ellis and Ames (1987) suggested that biological determination of sexual orientation takes place during prenatal development. Other essentialist views claim that inherited factors (Bailey & Pillard, 1991; Bailey, Pillard, Neale, & Agyei, 1993) have a role in the development of sexual orientations. The belief that variations in sexual orientation are cross-cultural and have occurred at different historical times and places, such as in Greece during the time of Plato, or in medieval Europe (Boswell, 1980), have been considered essentialist.

The social constructionist view rejects the notion that sexual orientation and identity are inherent in the individual, predetermined, fixed, or relevant for different cultures and historical epochs. Social constructionists reject notions of what they consider to be reified distinctions among heterosexuality, homosexuality, or bisexuality. In this view, none of these distinctions represents essential elements of human experience; they are instead socially constructed, as is the construct of gender (Kitzinger, 1995). To the social constructionist, it is impossible to talk of LGB individuals, because one cannot have a fundamental sexual nature that would lend itself to definition. Sexuality is therefore considered a social construction. They do not deny that there are varieties of sexual behaviors, but their view differs from essentialist interpretations of such behaviors. Ella's story provides an example of a woman who did not define herself in any particular way. Her sexual identity shifted as her affectional attraction shifted from Philip to Sheila. To the essentialist, Ella would be considered either bisexual or as one who recognized her lesbian orientation later in life. To the social constructionist, Ella's sexuality would be seen as fluid and not necessarily defined by any terms outside of her experience.

Resolution of this debate is, obviously, beyond the scope of this book; in fact, Kitzinger (1995) suggests that the debate is not resolvable. To most of our readers, the debate may seem more academic than pragmatic when it comes to working with clients who identify as LGB individuals. We define it here, however, because it is relevant to clients' understanding of themselves. Many, if not most, gay or bisexual male clients who so identify report experiencing sexual orientation as fixed. In discussing childhood history, these men report feeling attracted to members of the same sex since an early age. This, per se, does not imply essentialism. Some lesbian or bisexual women, however, report experi-

ences different from those of men. Some women do not define their sexuality in terms of being straight, lesbian, or bisexual. They see their sexuality as determined by the person with whom they fall in love, not the sex of that person. Also, some women choose to be in relationships with women rather than men as a political choice, rejecting male dominance and oppression.

Garnets (2002) points out that the scientific community agrees that human behavior reflects both biological and environmental factors, and that there is no gene or prenatal hormone that controls human sexual orientation apart from the mutual influence of social and environmental factors. It is important to understand the complexity inherent in sexual orientation to grasp the multiple factors that influence development of a healthy sexual identity, whether the client is gay, lesbian, or bisexual, or chooses not to identify him- or herself by any such classification. Therefore, the CBT therapist cannot make assumptions about his or her clients' sexual behavior and orientation, regardless of the terminology clients use to describe themselves. It is important to understand each individual's experience, which makes the idiographic perspective of cognitive-behavioral assessment and treatment particularly useful.

No single theory of development can explain the multiple experiences of gay men, lesbians, and bisexual men and women. There is great diversity in ethnic and cultural variables, individual identity, and variations in communities in rural and urban settings. Some generalizations can be made, however, as a result of what has been learned about the developmental challenges of growing up as LGB individuals in a society that assumes that cross-gender sexual behavior and pairing is the norm. Depending on the culture in which one is raised, there may be more or less understanding of different sexual orientations. Almost all Western cultures assume that heterosexuality is the norm, and that children will grow up to pair with someone of the opposite sex. Although homosexuality and bisexuality are recognized and increasingly popularized in North America (e.g., in television shows such as *Ellen* or *Will and Grace*), it is extremely unusual for heterosexual parents to welcome and allow atypical gender behaviors or to encourage their children, if they suspect that the child may be gay or lesbian. Not all cultures share these sexual identities or make sexual distinctions in this fashion, however (Chan, 1995).

Some developmental models propose stages of coming out in which people progress through a linear process: recognizing one's same-sex attraction, moving into disclosure and development of an LGB identity, then entering a unified LGB community. Many of these models, however, lack generalizable clinical and empirical support. First,

they have largely been based on studies of white, middle-class males (Brown, 1995). Consequently, less is known about understanding sexual orientation differences between men and women, as well as for individuals of different ethnicity. Second, conflating individual identity development with group identity development confuses matters further in gaining a clearer understanding of this process (Fassinger & Miller, 1996). Third, the identity development literature has not included the experiences of people of color.

Using CBT with a mutually determined treatment plan and case conceptualization (instead of attempting to push someone through predefined stages) holds promise for LGB individuals, because it focuses on the individual case rather than relying on hypothetical group traits. From this perspective, the general understanding of LGB development can certainly inform a case conceptualization, but the specifics of each individual case must be examined carefully. Reynolds and Hanjorgiris (2000) warn that "in general therapists need to apply LGB developmental theories with caution. They need to evaluate whether the theory fits the client rather than try to make the client fit the model" (p. 50). Therapists need to be particularly sensitive to differences in cultural experiences regarding sexuality and sexual identity (Fukuyama & Ferguson, 2000).

SEXUAL IDENTITY IN YOUNG CHILDREN

Heterosexual parents have raised most LGB adults. In most cultures, distinctions are made between appropriate masculine and feminine behaviors, although the expected behaviors vary among cultural groups. Not all cultures see male and female as opposite ends of a pole, or as the only two genders. For example, many Native American groups accept individuals who are considered "two-spirited," possessing both male and female spirits (Tafoya, 1992). When children are raised in cultures that view masculinity and femininity based on biological sex, however, they are usually expected to fulfill the roles of their gender. Young boys are discouraged from playing with dolls, or wearing dresses or clothing considered "girls' clothes." To a lesser degree, young girls are discouraged from equivalent cross-gender behaviors. However, the term "tomboy," pertaining to little girls who enjoy the rough-and-tumble games usually reserved for boys, is much less pejorative than the corollary term "sissy." The more patriarchal the culture, the more embarrassing it is for a boy to act like a girl. When women and femininity are disparaged, boys or men who demonstrate cross-gender behaviors are also disparaged, and this may account for the fact that heterosexual men

have more negative attitudes toward homosexuality than do heterosexual women (Kite & Whitley, 1998).

In the heterosexual household, the family typically assumes that all the offspring in the household will also be heterosexual. Family members and friends often tease little girls about whether they have a boyfriend, and boys about whether they have a girlfriend. Parents typically suggest future pairings with friends' children of the opposite sex, even with small infants. Although this is usually done in jest, the assumption is still clear. Little Ted will end up with little Mary, and he won't end up pairing with little Emilio. Heterosexuality is assumed.

For those young girls and boys who recognize differences in their preferences for cross-gender activities, or who are aware of same-gender attractions at young ages, the assumption of heterosexuality by their families can lead to great confusion. Few children think they will grow up to be LGB individuals. However, the child will become aware of appropriate gender behaviors, for example, that boys do not play with dolls, before they begin to recognize sexual attraction to specific individuals, male or female.

From a cognitive-behavioral perspective, the degree of punishment of cross-gender behaviors, or conversely, the amount of pressure to conform to gender stereotypes, by the family or other authority figures results in the child feeling more or less invalidated for his or her behaviors. Gay men and lesbian women often report having known that they were different from their peers at a young age (Gonsiorek & Rudolph, 1991). Without the pressure to conform to gender stereotypes or the expectation of heterosexuality, many of these children would have accepted their natural attractions as appropriate. When a boy is called a "sissy" or "faggot" and is told that it is unacceptable for him to play with dolls (perhaps with the exception of dolls that are marketed as "action figures"), he is punished for his behavior. Although he may stop the behavior, or take it underground by playing dress up only when alone in his room, the thoughts and feelings that seem natural to him will not go away; they, too, may simply go underground.

In many cases, as a result of this learning history, the child or adolescent begins to internalize the negative attitudes about his or her behavior. Developing negative attitudes about one's own LGB identity has been referred to as "internalized homophobia" (Malyon, 1982). In many cases, the term "phobia" would truly apply as the young LGB person works to avoid the appearance of being anything other than heterosexual. Shidlo (1994) suggests that internalized homophobia is associated with other psychological distress. Overt negative statements about other gay or lesbian people reinforce the child's secrecy about his or her

own feelings. If, for example, a boy considered a “faggot” finds another boy who shows gender-atypical behaviors, then hurls similar insults at him, he is likely to be rewarded by his peer group of boys. Such behavior would also be negatively reinforced if the boy’s anxiety over being the object of ridicule can be avoided by identifying himself as anti-gay. Similar phenomena can occur with girls as well.

Negative core beliefs about the self may develop along a paradigm that follows a pattern of increasing recognition of the self as bad or defective. First, a child recognizes him- or herself as different. Second, there is recognition that in social groups, being different is bad, and being “queer” is particularly bad. Third, the child recognizes that he or she is different because of same-sex attractions and/or atypical gender behaviors, internalizing the message “homosexual is bad,” when the recognition that being queer is “bad” intersects with being different is “bad.” The resulting belief that “I am bad because I am different and I am homosexual” can often be associated with a host of affective and behavioral difficulties, such as depression, social withdrawal, and avoidance of people associated with the gay or lesbian community (e.g., Meyer & Dean, 1998).

Many LGB children, unaware of their sexuality, nevertheless have a sense of themselves as being different from their peers. Early socialization shows children that being different is undesirable, and those identified as different are usually targeted for teasing or other abuse. Early awareness of being different can also bring an early belief that one is “bad.” When a child grows to adolescence and does not completely fit with peers because he or she is not exclusively (or not at all) interested in the opposite sex, or in dresses or sports, or whatever the gender-appropriate behavior is for the particular social group, he or she may develop feelings of alienation and judge him- or herself negatively. Ongoing experience of being different can solidify beliefs of inadequacy or abnormality. The coming-out process may reduce the credibility of the belief that being an LGB individual is wrong as alternative beliefs gain increasing credibility. However, coming out does not always change the implicit beliefs that have been reinforced in the person’s life, long before an awareness of sexual orientation. The belief that being different is bad can lead some openly LGB individuals to view themselves as impostors, carrying the tacit idea that they harbor a dark secret regardless of their being “out.” The process of hiding one’s true identity, even when it is in the person’s best interest not to do so, reinforces a pattern of believing that should one be discovered, there will be negative social consequences. In some cases, this may be true, and it would not be in the person’s best interest to disclose. However, when evidence points to the

possibility that there will be support rather than censure, hiding may increase the individual's sense of being different, bad, or even a pariah.

It is important here to consider some basic facts about gender behavior. Behaviors observed in a young child are not necessarily predictive of future behaviors of the adult. Some young children who demonstrate gender-nonconforming behaviors will grow up to be gay or bisexual, and others will not. This is particularly true of girls: Gender nonconforming behavior in young girls is not predictive of adult behavior or sexual orientation. Additionally, many young girls and boys who demonstrate gender-conforming behavior do grow up to be LGB individuals.

Retrospective studies suggest a stronger correlation between adult sexual orientation and childhood gender nonconformity in men than in women (Bailey & Zucker, 1995; Peplau, Garnets, Spalding, Conley, & Veniegas, 1998). Gender nonconformity, furthermore, is not necessarily related to sexual orientation, and a man or woman may show great variation in gender behaviors but consider him- or herself to be heterosexual. There are also harsher biases against male gender nonconformity than against female nonconformity (Katz & Ksananak, 1994), which means LGB nonconforming boys are at greater risk of victimization than girls.

CLINICAL IMPLICATIONS OF SEXUAL ORIENTATION DEVELOPMENT FOR CHILDREN AND ADOLESCENTS

Understanding the complexities of growing up as LGB individuals will help therapists working with adolescents and adults. A CBT therapist will most likely be contacted by the parents of a troubled adolescent, or be sought out by an adult client. Knowing that an openly LGB adolescent or adult has encountered a variety of obstacles prior to making his or her way to therapy is important in developing the case conceptualization and treatment plan. Heterosexual authority figures may have reinforced negative beliefs about the LGB community; consequently, many young men first experience sexual contact with partners in furtive settings and/or anonymously. This has implications for these men's acceptance of their sexuality and is often in conflict with their ideas of moral behavior. There are also usually few options for LGB youth to begin to experiment with sex and dating in healthy ways compared to the many options provided to heterosexual youth. In summary, the therapist must consider the historical–developmental context of the client's behavior prior to making judgments about psychopathology.

COHORT DIFFERENCES IN SEXUAL ORIENTATION DEVELOPMENT

Although generational differences are common among all groups of people, the differences are striking within LGB communities, because the political and cultural climate of tolerance and acceptance has changed radically over the last three decades. Men and women who came of age prior to the rebellion at the Stonewall Inn in New York's Greenwich Village neighborhood, in 1969, are now in their late 50s or older. These individuals grew up in a very different environment than that of the men and women who came of age after 1969, when the "gay rights movement" began, and social change allowed for open gay and lesbian lifestyles. The feminist movement also allowed greater flexibility in sex roles for people of either gender. Further change occurred when the first gay men were diagnosed with GRID (gay-related immune disorder), which later came to be known as acquired immune deficiency syndrome (AIDS) in the late 1970s and early 1980s.[1]

Now, a generation of young gay men has matured and come out in the shadow of AIDS. These gay men differ from their senior brothers, who are now in their 40s or older and survived the devastating loss of entire networks of friends and lovers. Younger gay men may either feel a sense of hopelessness and inevitability about AIDS or, alternatively, have unrealistic ideas about the effectiveness of the protease inhibitors to prevent AIDS-related disorders that have led to the death of so many. Although a variety of reasons beyond fatalistic attitudes increase vulnerability to behaviors that expose a person to human immunodeficiency virus (HIV), the practice of unsafe sex may be more casually accepted by younger gay men than by their older counterparts, who consider themselves to be survivors. However, when the sexual behavior of young gay men today is compared to that of their older counterparts when they were young, a reduction in high-risk sexual behavior is observed (Johnston et al., 1999).

Past research suggested that LGB youth may be at greater risk for certain psychological disorders, particularly suicidal ideation and suicide attempts. Although the data on lesbians are less clear, a study using a male–male twin registry of veterans who served in the U.S. military between 1965 and 1975 indicated that twins who identified as having had sex with another man at some point in their lives reported having had higher incidence of suicidal ideation or suicide attempts than their heterosexual brothers (Herrell et al., 1999).

Despite limitations of this study (such as the use of reported sexual behavior as indicative of sexual orientation, exclusion of women from the sample, and an ethnically homogeneous sample), the authors sug-

gest that higher rates of suicidality are reported even when they account for the confounding effects of comorbid disorders such as depression and substance abuse. The higher rates of suicidality reported by Herrell et al. (1999) could not be explained by abuse of drugs or alcohol, nonsuicidal depressive symptoms, or other psychopathological diagnoses such as anxiety or personality disorders. Other studies have indicated that gay and lesbian youth are likely to report having attempted suicide more than non-gay counterparts (e.g., Remafedi, 1994). Social factors must be considered.

More recently, however, Savin-Williams (2001) has questioned the assumptions based on earlier data. He criticizes much of the published data on LGB youth suicide risk because of problems in sample selection, vague definitions of suicide, and use of unreliable measures of sexual orientation and suicide attempts. The samples in these studies are often drawn from settings in which self-identified LGB youth have sought support and help, such as crisis centers or runaway shelters. Savin-Williams conducted two studies to test his hypotheses about an overestimation of LGB individuals' suicide attempts. He concluded that by distinguishing false attempts from actual attempts and eliminating ideation alone from the definition of suicide, attempt rates were 13% for the young women in his study, which he states is only slightly higher than the rate reported for non-gay-identified youth. In a second study with both male and female participants, Savin-Williams found that young men who rated themselves a Kinsey 2 (predominantly heterosexual, but significantly homosexual)[2] were more likely to report a suicide attempt than other sexual minority male groups. Interestingly, Savin-Williams found that participants who identified themselves as gay or bisexual according to the Kinsey scale (Kinsey 3–6) were no more likely to attempt suicide than heterosexual participants (Kinsey 0). He concluded that professionals need to be aware that LGB youth in support groups may, in fact, be at higher risk of suicide, but that they do not represent all LGB youth, many of whom do not identify themselves as such. He also warns that self-identified LGB youth may be following a suicidal "script" developed from the oft-quoted data indicating that this group is at higher risk than heterosexual youth, thereby inflating their self-reporting.

Safren and Heimberg (1998) compared LGB youth in support programs to demographically similar youth in other types of support programs on suicidality and related variables. They found that there were zero-order differences between groups on depression, hopelessness, and suicidal ideation. However, when social support, coping, and stress were statistically controlled, these differences disappeared. This shows

that other, environmental factors, and not sexual orientation, play a role in distress among this population.

Berman and Jobes (1992) identified eight risk factors in adolescent suicidal behavior: negative personal history, psychopathology, stress, behavior dysregulation, social/interpersonal isolation and alienation, self-deprecatory ideation, dysphoria, and hopelessness and method availability. Several factors that they identified are relevant for LGB youth, who are often socially isolated or alienated by their peers, particularly if they are open about their sexual orientation. Adolescence is a difficult time for most people. Problems often seem insurmountable. A young woman or man who does not believe she or he fits with peers may easily feel hopeless about her or his situation. Suicide could be seen as relief from a destiny of unhappiness. For many years, death by suicide or violence was depicted as the most common death for lesbian and gay characters in literature and film. Plays such as Lillian Hellman's *The Children's Hour* and Tennessee Williams's *A Streetcar Named Desire* (in which it is suggested that Blanche's "boy" killed himself after she saw him with another man and called him "disgusting") and *Suddenly Last Summer* (in which the gay character is cannibalized) are just a few examples. Gay men have often been depicted as lonely predators seeking young men or boys for sexual gratification. Lesbians are depicted as aging spinsters with little romance in life. In a study of homeless youth in Seattle, Cochran, Stewart, Ginzler, and Cauce (2002) found that LGB and transgender youth run away from home more frequently than their heterosexual counterparts and are victims of physical violence from family members (particularly for males) following a period of homelessness. LGB homeless youth also reported higher incidence of substance abuse, higher self-report ratings of symptoms of psychopathology, and more sexual partners than heterosexual homeless youth.

EFFECTS OF CHILDHOOD AND ADOLESCENT EXPERIENCES ON THE LGB ADULT

Whether future research confirms or challenges the notion that LGB youth are at higher risk for suicide, thankfully, the reality is that the majority of them will successfully grow out of adolescence and become adults. Many LGB adults also seek therapy at some time in their lives. Some data suggest that they do so at higher rates than heterosexual adults, which is particularly true for the lesbian community (Bradford, Ryan, & Rothblum, 1994; Cochran, Sullivan, & Mays, 2003; Jones & Gabriel, 1999). We propose three key reasons why LGB adults are seek-

ing therapy at higher rates: (1) Their experience of being different has trained them to be more self-reflective; (2) they seek professional support because there is less natural support in their environment; or (3) they have greater distress in their lives.

Emerging research on the prevalence of mental disorders in LGB adults also points to the need to develop and adapt validated mental health interventions to the needs of these particular individuals. Gilman et al. (2001) recently analyzed data from the National Comorbidity Study and compared rates of mental disorders among people who have had same-sex sexual partners to rates among those who report exclusively opposite-sex partners. These data revealed higher rates of mood and anxiety disorders among respondents who had one or more same-sex sexual partners than among those who did not. One major limitation of this study, however, is that sexual orientation was defined exclusively by sexual behavior. Sexual identity was not considered, and there was no way for the authors to know whether identification as LGB individuals served as a risk or a protective factor. Another limitation was the small number of respondents reporting same-sex partners. Cochran and Mays (2000) also reported higher rates of depression and panic among men with same-sex partners, and higher rates of alcohol and drug dependence among women with same-sex partners. Cochran et al. (2003) found that gay and bisexual men were more likely than heterosexual men to be diagnosed with a mental disorder. Specifically, gay and bisexual men were 3.0 times more likely to be diagnosed with major depressive disorder and 4.7 times more likely to be diagnosed with panic disorder. Lesbian and bisexual women were more likely to be diagnosed with generalized anxiety disorder than heterosexual women. It is noteworthy, however, that approximately 58% of LGB participants in their sample did not evidence any of the five disorders assessed by the MacArthur Foundation National Survey of Midlife Development in the United States (MIDUS) questionnaire.[3] Although LGB individuals may be more vulnerable to behavioral health problems, a significant proportion of them show resilience and do not meet criteria for mental disorders.

Because CBT shows particular utility in the treatment of depression and anxiety disorders, these data point to the importance of assisting clinicians in the use of CBT with LGB individuals. Furthermore, the natural emphasis on the environment in CBT is important, because much of the difference between gay and non-gay populations may be due to environmental factors. Gilman et al. (2001) suggest several explanations for their findings: (1) Lesbian and gay men in general may have a higher incidence of psychiatric disorders as a result of the experience of discrimination, violence, and abuse, or low levels of social sup-

port; or (2) these individuals may simply lead riskier lives than their heterosexual counterparts.

Let's consider the first hypothesis, that lesbians and gay men have higher incidence of psychiatric disorders as a result of the experience of discrimination, violence and abuse, or low levels of social support. Despite changing societal attitudes toward LGB people that are making it easier for adults to live openly and express their sexual orientation, it is still difficult for LGB adolescents to cope with peer pressure and harassment. Whereas racial epithets are typically considered socially inappropriate in polite society, and children and youth in schools are openly discouraged from using them, or are punished for doing so, slurs regarding sexual orientation are common forms of verbal abuse among children and adolescents that seldom meet with adult attention or disapprobation. As a result, children or adolescents who are different or socially isolated in any way (i.e., not necessarily same-sex attracted) are frequently called "faggot," "fairy," "queer,"[4] or "dyke" as a means of insult and social control. When these insults are hurled at a young boy or girl who is beginning to recognize same-sex sexual desires, they can have greater psychological consequences. LGB youth typically maintain secrecy during their adolescent years. During a time when most adolescents are beginning to learn dating skills, and learn from important social and sexual bonds, LGB youth are frequently unable to do so fully because of the stigmatization involved in acknowledging their important homoerotic feelings. D'Augelli (1998) refers to "developmental opportunity loss" and "self-doubt induced by cultural heterosexism" as two results of victimization that LGB youth experience.

D'Augelli (1998) reported four types of victimization that can occur among LGB youth. The first, *marginalization*, occurs because these youths have fewer opportunities to explore their developing LGB identities without risk of rejection or violence by peers or families. The second form of victimization occurs when LGB youth experience *negative reactions from parents* and other family members about their sexual orientation, which can range from mild disapproval or refusal to discuss sexual orientation, to open hostility, physical violence, and/or banishment from the family. A third form of victimization is the *potential for HIV infection*, especially among gay or bisexual male youth. Practicing safer sexual behaviors, such as using condoms during anal and/or oral intercourse, requires negotiation on the part of both partners. The fourth form of victimization cited by D'Augelli is *direct attack*. He cites documented studies of assault on youth presumed to be LGB, on openly gay or lesbian college students, on young gay men in urban areas, and on young women. Comstock's (as cited in D'Augelli, 1998) analysis of victimization patterns among college students suggested that LGB stu-

dents are victimized at four times the rate of the general college population. Many young LGB people are victimized by their families as well. Some are forced to leave home after disclosing their sexual orientation to their parents.

Whereas family, friends, and faith all typically provide means of solace, education, and support for most adolescents, many LGB youth are denied such support. They may have a restricted network of friends who are aware of their sexual orientation and guard their secret loyally. In rural communities, for example, it is common for LGB youth to believe that there are no other sexual minority peers in the community. In urban areas, there may be more support for openly LGB adolescents, but the risks of disclosure are still high. Youth may face particular challenges in families that belong to conservative religious groups, such as some Protestant Christian denominations (Hoge, 1996) or Orthodox Judaism (Dworkin, 1997), in which opposition to homosexuality is prevalent based on literal interpretations of scripture.

Whereas children and youth from other minority groups can rely on family to provide cohesion and support, LGB youth often hide their sexual identity from family or face rejection, if their identity is disclosed. It is important to note that youth of color face double or triple minority status (for lesbians of color) and have the added burden of self-identity that may be determined primarily by race/ethnicity, gender, or sexual orientation (Greene, 1994).

Therefore, it is probable that LGB clients will present in therapy with a history that includes some type of difficulty that they have either overcome or are struggling with as a result of being a member of an oppressed and often invisible group. There are also challenges that everyone typically faces at particular times of life. Among college-age LGB clients who may be considering career choices and finding a community of friends, as we noted earlier, some may be struggling with their sexual identities or trying to find a definition that they believe fits them appropriately.

The relevance of research on LGB adolescents and young people from a CBT perspective highlights how social learning, modeling, and other variables influence the development of negative core beliefs, or even conditioned emotional responses to their own sexual orientation. It is important to help LGB people find or create a life they value. CBT is ideally suited to this task. When clients struggle with reconciling their lived experience with the stereotypical ideas they have heard regarding LGB life, cognitive therapy can be useful in helping them evaluate their assumptions. Behavioral approaches can focus on teaching clients to accept their thoughts as thoughts, and not truths, and to act according to a value or goal (Hayes, Strosahl, & Wilson, 1999). When

an LGB client finds it difficult to develop a social network, CBT can help him or her to decrease irrational and interfering fears, as well as learn prosocial skills and problem solving. Likewise, asserting oneself with family, friends, and employers is in the realm of behaviors that CBT therapists have seen and researchers have studied (see discussions on treating depression, anxiety, and couple problems; Chapters 4–6, respectively).

ISSUES IN LATER LIFE

There is much discussion of the aging "baby boom" generation (e.g., Roszak, 2001). Many "baby boomers" self-identify as LGB individuals, and many engage in same-sex practices without identifying themselves as such. These individuals face difficulties similar to those faced by their heterosexual counterparts. Like Ella, from the vignette at the beginning of this chapter, they must deal with elderly or infirm parents. Many have been involved in careers for years or have embarked on a second career. They may be trying to adjust to retirement. Many may have been in long-term relationships or in multiple shorter term ones. Some still hope to find love in their later years.

In citing research that suggests that gay men may believe they are beyond their prime earlier than their actual age would indicate, Barón and Cramer (2001) stress that clinicians must "be alert to the possibility that some clients may be prematurely aging themselves through beliefs" (p. 208). This phenomenon does not appear to be as common among lesbian women. Barón and Cramer suggest that aging LGB clients may be dealing with the issues of ageism, ableism (i.e., considering a healthy, physically able body as superior to one with disability or limitation), sexism, homophobia, and racism in some form.

It is important for the clinician to conduct a thorough assessment of the particular problems a client is experiencing. Clinicians must resist making assumptions about a particular client's experience simply because he or she identifies as LGB, or because he or she has sexual relations with members of the same sex. Reliance on overgeneralizations and stereotypes has led to many inappropriate and countertherapeutic practices with LGB clients (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). Proper assessment and case formulation are essential. To this end, we turn to the issue of behavioral assessment in the next chapter.

Copyright © 2004 The Guilford Press. All rights reserved under International Copyright Convention. No part of this text may be reproduced, transmitted, downloaded, or stored in or introduced into any information storage or retrieval system, in any form or by any means, whether electronic or mechanical, now known or hereinafter invented, without the written permission of The Guilford Press.

Guilford Publications
72 Spring Street
New York, NY 10012
212-431-9800
800-365-7006
www.guilford.com