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Clinical interventions with sexual minority clients: Review, critique, and future directions

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ABSTRACT

Sexual minority populations experience disproportionately high rates of depression and anxiety relative to their heterosexual counterparts. Unfortunately, both sexual minority clients and their therapists experience difficulties in therapy. After conducting a review of the extant literature focused on approaches to treating depression and anxiety among sexual minority individuals in psychotherapy, this manuscript aims to: (1) Propose a taxonomy of existing practice models for treating sexual minority clients for depression and anxiety (protocol-based approaches, principles-based approaches, and relationship-based approaches); (2) Describe the current research findings of the evaluations of these practice models; (3) Offer recommendations for research and practice.

KEYWORDS
Anxiety; competence training; counseling and therapy; depression; sexual minorities

Introduction

Sexual minority populations suffer from disproportionately high rates of depression and anxiety relative to their heterosexual counterparts. King et al. (2008) find sexual minorities to have rates of depression and anxiety that are 1.5 times as high as heterosexuals. A meta-analysis of 52 studies revealed that sexual minority individuals experience higher rates of depression and anxiety than their heterosexual counterpart (Ross et al., 2018). These heightened rates of mental health symptoms indicate that sexual minority populations may have disproportionate need for psychotherapy, and indeed, sexual minorities disproportionally utilize therapy services (Cochran, Greer, & Mays, 2003; Platt, Wolf, & Scheitle, 2018). Unfortunately, both sexual minority clients and their therapists experience concerns and challenges in the context of therapy. Sexual minority clients frequently report experiencing microaggressions (i.e., commonplace verbal or behavioral actions that subtly communicate hostility or derogation to people who hold marginalized identities; Sue et al., 2007) committed by

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their therapists (Shelton & Delgado-Romero, 2011; Spengler, Miller, & Spengler, 2016). Shelton and Delgado-Romero (2011) argue, based on participants' emotive reactions, attitudinal changes regarding therapy and therapists, and diminished help-seeking behaviors, that therapist microaggressions have a negative effect on the therapy process. Furthermore, therapists report feeling unprepared to work with sexual minority clients and that they receive minimal training on working with sexual minority clients (Eubanks-Carter, Burckell, & Goldfried, 2006). Studies of social workers, clinical psychologists, and marriage and family therapists find that less than half of service providers report feeling competent working with sexual minority clients and did not know how they would support a client navigating challenges around their sexual orientations, such as coming out (Doherty & Simmons, 1996; Logie, Bogo, & Katz, 2015; Roberts, 2019) and another survey of therapists found that the modal number of articles assigned to therapists during their training about working with sexual minority clients was zero (Eubanks-Carter et al., 2006). Such findings raise concerns that sexual minority individuals receive lower quality therapy than their heterosexual counterparts.

Though there is concern that sexual minority individuals' needs may not be adequately addressed in therapy, only a small body of research has proposed approaches for serving sexual minority clients in therapy. Furthermore, no known research has attempted to synthesize the current literature of approaches to addressing sexual minority clients' needs and the evidence supporting these approaches. Such a synthesis could help researchers to identify gaps in this area and offer opportunities for further research and could help service providers identify evidence-based approaches for serving these populations. This article aims to: (1) propose a taxonomy of existing practice models for treating sexual minority clients for depression and anxiety (protocol-based approaches, principles-based approaches, and relationship-based approaches); (2) describe the current research findings of the evaluations of these practice models; and (3) offer recommendations for research and practice (i.e., suggestions for evaluating existing practice models and promising directions for new practice models).

Materials and methods

This comprehensive review involved a series of electronic searches of published works focused on approaches to supporting sexual minority individuals with depression and anxiety in the context of psychotherapy (Stratton, 2016). The goal was to capture both scholarly articles and popular press books that focused on improving psychotherapy services for depression

and anxiety for these populations. Using the key words sexual minority, gay, lesbian, bisexual, depression, anxiety, psychotherapy, therapy, and treatment and the reference lists of each identified article or book to attain additional relevant pieces, articles and books from electronic databases (PsycINFO, Google Scholar, and Google Books) were compiled into a comprehensive listing. Any article or book whose title, key words, or abstract indicated a connection to conducting depression or anxiety interventions with sexual minority populations were retained. Once the articles and books were identified, the text's primary suggestions for improving depression and anxiety interventions with sexual minority individuals were identified and these recommendations were organized into a taxonomy. Once the taxonomy was constructed, the level of evaluation that each taxonomy type had been subject to were synthesized and opportunities for future research were identified.

Results

Interventions

A range of approaches have been utilized to better serve sexual minority clients in the context of therapy. Several evidence-based manualized cognitive-behavioral therapy models for depression and anxiety have been adapted for sexual minority populations (e.g., Pachankis, Hatzenbuehler, Jonathon, Safren, & Parsons, 2015; Ross, Doctor, Dimito, Kuehl, & Armstrong, 2007). Other "gay affirming" therapies have been created by making more general adaptations to therapy modalities (e.g., cognitive-behavioral (e.g., Craig, Austin, & Alessi, 2013; Pachankis et al., 2015), psychodynamic (e.g., Malyon, 1982), and humanistic therapies (e.g., Langdridge, 2007). Several models have been advanced to influence how therapists approach therapy and their relationships with their clients (e.g., cultural competence trainings; e.g., Crisp, 2006). This article will classify interventions as a) protocol-based approaches (adapted manualized interventions), b) principles-based approaches (gay affirmative therapy), and c) relationship-based approaches (cultural competence trainings). This taxonomy draws upon the distinction between protocols (i.e., manualized, standardized approaches to therapy) and principles (i.e., broader theoretical understandings of the factors that influence change; Rosen & Davison, 2003). This framework also draws upon the distinction between core component adaptations (i.e., modifications made to the primary elements of therapy responsible for change) and peripheral component adaptations (i.e., modifications intended to increase how well a particular group understands and receives an intervention; Chu & Leino, 2017). One aspect of peripheral components not captured in the protocol-based and principles-based

categories of adaptations used in this article is provider-client relationship (i.e., therapists' personal styles and their responsiveness to clients' values and experiences); this component is captured in the relationship-based approaches category of this article's taxonomy of adaptations.

Protocol-based approaches

Protocol-based approaches provide explicit guidelines for therapists to follow while conducting therapy. Protocols, often in the form of manuals, describe specific techniques, strategies, and sometimes language for therapists to utilize (Luborsky & DeRubeis, 1984). Protocol-based approaches are intended to increase consistency of treatment delivery and support therapist training and therapist fidelity to these approaches (Luborsky & DeRubeis, 1984).

Protocol-based approach #1: Mind Over Mood. Mind Over Mood (Greenberger & Padesky, 1995) is a cognitive-behaviorally-oriented book that teaches clients about the relationships between thoughts, moods, physical reactions, and behaviors, and how these factors interact with situations and the environment to create and maintain symptoms of depression and anxiety (Ross et al., 2007). The book provides a step-by-step guide to help individuals overcome their depression. It can be used as a standalone self-help book, a supplement to therapy, or a template or ready-made treatment program for individual or group therapy (Padesky & Greenberger, 2012). *Mind Over Mood* has been found to significantly reduce depression symptoms in a sample of adults not differentiated by sexual orientation (Bagby et al., 2008).

Padesky and Greenberger (2012), themselves, discuss the use of *Mind Over Mood* with sexual minority clients. Padesky and Greenberger (2012) argue that changing the format of the manual is not necessary when using it with sexual minority clients. They note that many of the examples in the text use gender neutral language so that sexual minority clients can identify with the sample clients described. They also encourage therapists to explicitly discuss sexual orientation in examples that are not gender neutral, encouraging clients to consider how sexual orientation might influence the described scenarios. Padesky and Greenberger (2012) also encourage therapists to explicitly seek feedback from sexual minority clients about the cultural assumptions and procedures of the therapy to ensure that the treatment is addressing the needs of their sexual minority clients.

Ross et al., (2007) have adapted *Mind Over Mood* (Greenberger & Padesky, 1995) for sexual minority clients. *Mind Over Mood* was selected for adaptation due to its widespread adoption among mental health providers and its manualized nature, which allow it to be replicated in other settings (Ross et al., 2007). *Mind Over Mood*'s application as a template or

ready-made treatment program for group therapy is most germane to Ross et al.' (2007) adaptation. In this application of the original *Mind Over Mood* approach, therapists provide psychoeducation during sessions about the influences of the above factors on depression, and clients complete exercises that facilitate applying these principles to their own lives.

Ross et al., (2007) proposed a modified version of *Mind Over Mood* for lesbian, gay, bisexual and transgender (LGBT) clients delivered as a 14-week group therapy intervention for depression. Sessions occurred weekly and each session was two hours long. The adapted protocol follows the standard *Mind Over Mood* format with two primary modifications: (1) Providers are trained in an anti-oppression framework that focuses on the ways that internalized stigma may lead to depressive symptoms. When clients report a negative belief about sexual minorities, the therapist identifies how that belief might be related to negative feelings and challenges that belief using standard cognitive therapy techniques. (2) The protocol includes two sessions (sessions 10 and 11) that are specifically focused on issues affecting sexual minorities: coming out experiences and internalized homophobia. These sessions focus on how coming out experiences that result in interpersonal rejection and internalized homophobia may exacerbate depression symptoms, in accordance with the theory of the model. Sexual minorities who completed the modified treatment protocol showed significant reductions in their depression symptoms (Ross et al., 2007).

Protocol-based approach #2: Unified Protocol. The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders, more commonly referred to as the *Unified Protocol*, is a cognitive-behavioral intervention that draws upon the common etiology and symptoms of emotional disorders (e.g., depression and anxiety) to offer a common approach for treating multiple disorders (Barlow, 2014). The *Unified Protocol* is comprised of four components: 1) Psychoeducation about emotions; 2) Alteration of antecedent cognitive misappraisals; 3) Prevention of emotional avoidance; and 4) Modification of emotion-driven behaviors. The intervention is offered as an individual therapy approach through 15 weekly 45–50 min sessions. During sessions, therapists introduce clients to treatment content and support clients in applying this information to their own lives; this learning is reinforced by homework that clients complete between sessions where clients monitor their moods and cognitions in the context of their lives and generalize the application of their developing skills to real-life situations. The *Unified Protocol* has been found in a randomized-controlled trial to significantly reduce symptoms of depression and anxiety (Farchione et al., 2012)

Pachankis et al. (2015) have adapted *The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders* (Barlow, Ellard, & Fairholme, 2010) for young gay and bisexual men. The intervention aims

to reduce depression, anxiety, and co-occurring health risks (i.e., alcohol use, sexual compulsivity, condomless sex) among young adult gay and bisexual men (Pachankis et al., 2015). The adapted intervention proposed by Pachankis et al. (2015), Effective Skills to Empower Effective Men (ESTEEM), is a 10-session intervention delivered in the context of individual therapy sessions. The intervention aims to reduce depression and anxiety by (1) strengthening emotion regulation abilities, (2) reducing maladaptive cognitive, affective, and behavioral avoidance patterns; and (3) improving motivation and self-efficacy for enacting behavior change through modules focused on motivation enhancement, interoceptive and situational exposure, cognitive restructuring, mindfulness, and self-monitoring (Pachankis et al., 2015). Pachankis et al. (2015) adapted the Unified Protocol specifically for gay and bisexual men by approaching these clinical interventions through a lens of minority stress. For example, modules focus on supporting clients in identifying experiences of minority stress, tracking cognitive, affective, and behavioral reactions to minority stress (e.g., avoidance reactions), and attributing distress to minority stress rather than personal shortcomings. The intervention also supports clients in developing and practicing assertiveness skills. The adapted intervention consolidates the *Unified Protocol*'s fifteen session model into ten sessions but maintains the core components (e.g., exposure, cognitive restructuring, and mindfulness (i.e., strategies for overcoming avoidance) described above.

The evaluation study by Ross et al. (2007) is an uncontrolled trial. The evaluation study by Pachankis et al. (2015) is a randomized-controlled trial with a waitlist control group. The article by Ross et al. (2007) based its conclusion that the adapted protocol was efficacious on statistically (*t*-test) significant differences between depression as measured using the Hamilton Rating Scale for Depression and the Beck Depression Inventory before and after treatment and as measured before treatment and two months after treatment. The article by Pachankis et al. (2015) based its conclusion that the adapted protocol was efficacious on statistically significant differences between depression as measured using the Overall Depression Severity & Impairment Scale (ODSIS) and the Center for Epidemiological Studies Depression Scale (CESD) at the end of the treatment between the group receiving the adapted intervention and a group on the waitlist.

Principles-based approaches

Gay affirmative therapy is a general perspective on therapy that emerged in response to conversion therapy. Models of gay affirmative therapy have been advanced within cognitive-behavioral (Craig et al., 2013; Pachankis et al., 2015), psychodynamic (Malyon, 1982), and humanistic (Langdridge, 2007) orientations. Though gay affirmative therapy interventions are as

diverse as the theoretical orientations that embody them, a review of the gay affirmative therapy literature found that across orientations, these therapies share general aspects, requiring the therapist to challenge a pathological view of homosexuality, develop knowledge appropriate to working with gay clients, and integrate this knowledge into their therapy approach (Harrison, 2000). Though models of gay affirmative therapy have been advanced across modalities (e.g., psychodynamic and humanistic), in the interest of brevity and alignment with the previous section, this review will only discuss cognitive-behavioral interventions.

Gay affirmative cognitive-behavioral therapy is a model of therapy that has been constructed through the synthesis of two initially disparate schools of thought: cognitive theory and behavioral theory. Cognitive theory focuses on modifying distorted or dysfunctional thinking that increase a person's likelihood of experiencing psychopathology (Beck, 1995). Behavioral theory focuses on the environmental determinants of actions and how activities influence mood and mental health symptoms (Beck, 1995).

Several researchers have proposed ways of applying cognitive-behavioral therapy for supporting sexual minority clients. LaSala (2006) focuses on the cognitive theory aspect of cognitive-behavioral therapy for gay men suffering from depression. LaSala (2006) writes, "Cognitive therapy can help gay men identify inaccurate negative thoughts about themselves stemming from core beliefs that reflect internalized homophobia" (p.184). Clinicians can work with sexual minority clients to address their internalized homophobia by combating their cognitive distortions about homosexuality, itself. Shifting the client's views about homosexuality can change the client's negative core belief about themselves, leading to a reduction in feelings of depression. Externalization, the process of enabling clients to think of factors outside of themselves as the cause of adverse experiences, is the most utilized component of attributional style (i.e., how people understand ambiguous events) in helping sexual minority clients reframe victimization experiences (LaSala, 2006). Clients who have negative core beliefs about their sexual orientations may see violence perpetrated against them as justified (LaSala, 2006). They may also use violence perpetrated against them as evidence that they are worthless or unlovable. Clients who view homophobic violence as a societal problem are less likely to perceive violence against them as justified and are less likely to employ this violence as evidence substantiating a negative core belief (LaSala, 2006).

Martell, Safren, and Prince (2004) propose ways of applying standard cognitive-behavioral techniques to sexual minority clients. In their book, they describe general cognitive-behavioral interventions and then apply those interventions to sample clients. For instance, to illustrate cognitive

interventions they provide an example of a lesbian female client who is struggling with depression following a break-up with her long-term female partner. The therapist works with the client to identify cognitive distortions (e.g., the overgeneralized belief that because one partner broke up with her, all future partners will break up with her) and support the client in developing more adaptive beliefs around dating. The example included several standard cognitive-behavioral techniques for treating depression that did not involve a sexual orientation-specific adaptation, such as psychoeducation about the relationship between thoughts, behaviors, and moods, tracking thoughts and moods, and identifying barriers to challenging maladaptive thoughts. Notably, each of the articles addressing gay affirmative therapy interventions (Langdridge, 2007; LaSala, 2006; Malyon, 1982; Martell et al., 2004) were theoretical, and none of these interventions have been evaluated empirically.

Relationship-based approach: Cultural competence

Cultural competence focuses less on the content of the therapy itself and more on the therapist's approach to engaging with their sexual minority clients. Cultural competence is about therapists gaining a unique knowledge base, set of attitudes and beliefs, and skill base for working with a given population (Crisp, 2006). Van Den Bergh and Crisp (2004) argue that although cultural competence models were initially developed to support clients with racial/ethnic minority identities, the general principles can be adapted for working with sexual minority clients. Cultural competence work with sexual minorities has largely focused on defining these identities (often done through glossaries of identity terms; Hill, 2009; Van Den Bergh & Crisp, 2004), highlighting victimization and mental health disparities experienced by sexual minorities relative to their heterosexual counterparts, and understanding stages of identity development (this has resulted in a proliferation of models of "proper" sexual identity development; Meyer & Schwitzer, 1999). For example, Meyer and Schwitzer (1999) describe six stages of sexual minority identity formation: Recognizing a Difference, Reflective Observing, Internalizing Reflective Observations, Self-Identifying, Coming into Proximity, and Networking and Connecting. Meyer and Schwitzer (1999) proposed counseling and psychotherapy implications based upon their model and mental health challenges known to disproportionally effect sexual minorities. These implications include attempting to prevent difficulties associated with each of the six developmental stages in their model, facilitating normative psychological development, and supporting clients in developing "effective coping and adjustment strategies as an alternative to circumvent the negative consequences of substance abuse, depression, and general psychological distress that tends to be associated

with minority sexual identity development" (p. 59). The cultural competence models described above (Hill, 2009; Meyer & Schwitzer, 1999; Van Den Bergh & Crisp, 2004) have not been subject to empirical validation. Though the identity development model advanced by Meyer and Schwitzer (1999) was created through data gathered through surveys, the implications for therapy interventions were proposed based on theory and the interventions themselves have not been empirically tested.

Summary of adapted interventions

In their discussion of cultural adaptations to interventions, Chu and Leino (2017) make a distinction between core component adaptations (i.e., modifications made to the primary elements of therapy responsible for change) and peripheral component adaptations (i.e., modifications intended to increase how well a particular group understands and receives an intervention). Their review of the literature finds that 100% of adapted interventions included modifications to peripheral components, whereas only 11% included modifications to core components. This examination of adaptations of interventions for sexual minorities found peripheral adaptations to dominate the literature. None of the described interventions made modifications to core components; rather these interventions focused on applying existing interventions and core components to specific scenarios and problems. This is true across protocol-based, principle-based, and relationship-based adaptations. For instance, in the protocol-based adaptations, Ross et al. (2007) adapted *Mind Over Mood* to include a module where standard cognitive therapy techniques were applied to helping clients to challenge internalized homophobia; the cognitive therapy techniques, themselves, were not modified. Similarly, in the principles-based adaptations, LaSala (2006) described how standard cognitive therapy techniques could be applied to help sexual minorities challenge internalized homophobia. As discussed above, the relationship-based approaches are inherently peripheral component adaptations because they focused on how the therapist engages with the client while applying an intervention rather than on the components of the intervention.

Discussion

This review has provided a summary of the current approaches for addressing anxiety and depression among sexual minority clients in the context of therapy, organizing these approaches into a taxonomy that reflects the core elements of the approach, and summarizing the current state of evaluation for each type of intervention. Describing and organizing these approaches

is critical because it may help researchers to see what has already been developed, hopefully reducing redundancy in research, and elucidate lines of research that can be expanded. Furthermore, this review may help therapists to see the options available to them when serving sexual minority clients. Providing a summary and critique of the current state of evaluation for each of these types of interventions highlights opportunities for future evaluation research and provides therapists insight into which approaches are most supported by evidence. Through rigorously evaluating each of these approaches and disseminating the most effective approaches to therapists, we may be able to improve the mental health outcomes of sexual minority individuals.

Evaluation

Evaluation of mental health interventions enables the identification of what interventions are effective and for whom/when an intervention is effective (Pawson & Tilley, 1997). This information is essential for selecting interventions for particular clients as well as for identifying opportunities for developing more effective interventions (American Psychological Association, 2006). The interventions described above- protocol, principle, and relationship-based approaches-have been evaluated to varying degrees. The adapted cognitive-behavioral protocol interventions have been the most rigorously evaluated, and the remaining approaches have not been subject to empirical validation.

Though the adapted cognitive-behavioral protocol interventions (Ross et al., 2007; Pachankis et al., 2015) have been the most rigorously evaluated, there are still shortcomings in the designs of these evaluations. The evaluation study by Ross et al., (2007) is an uncontrolled trial and the evaluation by Pachankis et al. (2015) is a randomized-controlled trial with a waitlist control group. Though these findings indicate that participants' depression symptoms decreased during both treatments, the limitation of these approaches is that they do not provide comparisons that enable us to determine if these symptoms decreased more than they would have without any treatment at all or with the non-adapted version of the treatment (*Mind Over Mood*). In sum, neither approach has a design that indicates if the treatment adaptation improved the efficacy of the treatment relative to the original treatment.

The uncontrolled nature of the study by Ross et al., (2007) leaves the findings vulnerable to threats to internal validity due to history and maturation. Because this study only includes one intervention, it is not vulnerable to treatment diffusion (at least, not from another treatment in the same study). The random assignment into conditions of the study by Pachankis

et al. (2015) controls for threats to internal validity due to history, maturation, regression, and selection bias. Because this study only includes one intervention, it is not vulnerable to treatment diffusion. Comparable retention rates indicate that differential attrition did not occur in this study, though particular attributes of clients who dropped out of each condition were not reported. This study paid careful attention to the fidelity of therapists by monitoring treatment delivery through individual supervision of therapists and coding and evaluating recordings of sessions using a treatment fidelity checklist of core components. Neither study evaluated individual components of the intervention to determine which aspects of the interventions may have contributed to symptom reduction.

In a review article of 33 gay affirmative therapy articles and conference presentations, Harrison (2000) found that the field of gay affirmative therapy was highly diffuse, with no commonly held understanding of what constituted a gay affirmative therapy. Harrison (2000) also calls for empirical validation of these theoretical models, reporting that the extant literature does not included empirical studies evaluating the effectiveness of these models. This review similarly found no efforts to empirically validate principles-based approaches (Langdridge, 2007; LaSala, 2006; Martell et al., 2004). Important next steps in the development of gay affirmative therapy are establishing a more precise construct of what constitute gay affirmative therapy and conducting evaluation studies of these models that compare these interventions to suitable active control group interventions.

Given that the cultural competence models (Hill, 2009; Meyer & Schwitzer, 1999; Van Den Bergh & Crisp 2004) have not been subject to empirical evaluation, these trainings should be evaluated by comparing the clinical outcomes of sexual minority clients of therapists who have experienced these trainings to the clinical outcomes of clients of comparably experienced therapists who have not.

Future directions

Evaluation across approaches

Given the diversity of approaches advanced to address the needs of sexual minority clients in the context of therapy, an evaluation approach is needed that allows comparisons across these diverse interventions. An ideal model would be a randomized-controlled trial with conditions testing each intervention against each other and appropriate control conditions. Intervention success could be evaluated using standardized depression and anxiety scales such as the Hamilton Depression Scale, the Overall Anxiety Severity & Impairment Scale (OASIS), and the Hamilton Anxiety Scale (Bentley, Gallagher, Carl, & Barlow, 2014; Williams et al., 2008) to determine the

symptom reduction achieved through each intervention. Though this approach would allow for comparisons across a broad range of practice models, it is not without its flaws. In addition to being resource intensive, these interventions offer radically different doses. For instance, the ESTEEM model protocol (Pachankis et al., 2015) occurs over 14 weeks whereas a gay affirmative psychodynamic therapy model not discussed in depth in this article was developed as a long-term therapy intervention (Malyon, 1982). Differences in outcomes could be due to different levels of exposure to clinical intervention, rather than the substantive differences of the two models. Unfortunately adjusting the timeframe of either approach to match the other would jeopardize fidelity to the treatment models. Another shortcoming of this approach is that each model includes many different components, and this evaluation approach would provide little insight into which components of each model contributed to changes in symptom levels.

Interventions for additional mental disorders

Depression and anxiety interventions are by far the most commonly adapted for sexual minority clients, but there may be potential for adapting interventions for a range of other mental disorders. Sexual minorities have been found to have higher rates of substance use disorders and several interventions have been developed to target unique aspects of substance use disorders for sexual minority clients. For example, Bux and Irwin (2006) developed a targeted cognitive-behavioral and motivational interviewing intervention for gay men struggling with methamphetamine use disorder. Though less is known about the prevalence of other mental disorders among sexual minority populations and unique risk factors for these populations, there may be reason to develop and evaluate targeted interventions for sexual minorities for other mental disorders. Sexual minorities may experience unique risk factors for mental illness that may warrant tailored interventions. For instance, childhood victimization is a known risk factor for many mental disorders, including psychotic disorders (Read, Os, Morrison, & Ross, 2005) and personality disorders (Linehan, 1993). Sexual minority youth experience disproportionally high rates of childhood victimization (Friedman et al., 2011) which might put them at increased risk for developing these disorders. Similarly to how targeting clients' framing of their sexual orientation-related victimization experiences can be used to treat depression that may result from victimization experiences (LaSala, 2006), treatment mechanisms for other disorders could potentially be adapted to target mental health problems with etiologies of sexual orientation-related victimization. These interventions should be evaluated using procedures similar to the evaluation approach proposed above for

depression and anxiety interventions but by measuring changes in symptoms characteristic of the disorder being intervened upon.

Interventions for sexual minority-specific psychosocial stressors

Focusing on unique psychosocial stressors may be particularly important for sexual minority clients, as this population has unique risk factors for depression and anxiety. For example, the process of "coming out" (i.e., disclosing one's sexual orientation) is unique to sexual minorities and is associated with higher levels of victimization, depression, and anxiety (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Though standard cognitive-behavioral assertion training (Linehan, Goldfried, & Goldfried, 1979) is highly relevant to supporting clients in coming out, blindly applying these techniques without attention to the particular risks associated with coming out or developing a safety plan may leave clients vulnerable to victimization and exacerbate depression and anxiety symptoms. Risk assessment and safety planning tools should be employed alongside assertion training. General risk assessment instruments, such as the Spousal Assault Risk Assessment, can help therapists to identify risk factors for abuse, which can be used to inform decisions about whether and how a client should come out (Randall & Hart, 2000). General safety planning strategies, such as those used for individuals who are at risk for domestic violence (e.g., identifying an alternative place to stay, having someone to call in the case of a violent reaction; Stith, McCollum, & Rosen, 2011) can be used to minimize the risk of harm following coming out.

Understanding and minimizing the effects of microaggressions

Rather than enhancing the therapy process, adaptations of interventions to include sexual minority-specific content may actually have detrimental effects on the therapy process by promoting therapist microaggressions. Microaggressions are brief, commonplace verbal, behavioral, or environmental indignities that communicate hostile, derogatory, or negative slights and insults toward people who hold marginalized identities (Sue et al., 2007). In an analysis of themes of microaggressions that emerged through focus groups of sexual minority therapy clients, Shelton and Delgado-Romero (2011) found the therapist assumption that sexual orientation was the cause of presenting issues to be a common occurrence that clients interpreted as microaggressive. Participants in this study reported that they came to therapy for a range of mental health challenges (e.g., depression, anxiety, professional/educational challenges) and that they felt invalidated by therapists' focus on their sexual orientations rather than the issues for which they presented to therapy. Shelton and Delgado-Romero (2011)

contend that therapist microaggressions, such as assuming that clients' presenting problems are related to their sexual orientations, have a negative effect on the therapy process, based on participants' emotive reactions, attitudinal changes regarding therapy and therapists, and diminished help-seeking behaviors. Sue et al. (2007) argue that a strong working relationship or "therapeutic alliance" is required for therapy to be effective. They contend that establishing working relationships can be particularly challenging when therapists and clients hold different identities, such as race, gender, and sexual orientation, and that microaggressions may be a key aspect of this challenge (Sue et al., 2007).

If manualized sexual orientation-specific content is generally interpreted as microaggressive by sexual minority clients and the effect of these potential microaggressions on treatment outcomes can be explored through empirical study. A randomized-controlled trial comparing a traditional intervention to an intervention adapted to include sexual orientation-specific content (e.g., adaptation of the *Unified Protocal* by Pachankis et al. (2015) or *Mind Over Mood* by Ross et al. (2007)) that includes measures for client's perceived microaggressions (e.g., Homonegative Microaggression Scale; Wright and Wegner (2012)) and mental health symptoms outcomes (e.g., the Hamilton Rating Scales for Depression and Anxiety; Bagby, Ryder, Schuller, & Marshall, 2004) can provide insight into if these interventions are interpreted as microaggressive and, if so, to what degree microaggressions correspond to clinical outcomes.

Understanding therapists' barriers

It is important to note that relatively little is known about therapists' barriers to supporting sexual minority clients. Future research is needed to more fully understand these challenges. As noted above, one known challenge is that therapists do not feel prepared to work with sexual minority clients (Doherty & Simmons, 1996; Logie et al., 2015; Roberts, 2019). Roberts (2019) identified a paucity of training as a central factor contributing to this feeling of unpreparedness, with therapists with more training feeling more prepared. Since state and national standards govern the graduate and continuing education coursework required of therapists (e.g., Council on Social Work Education, 2020), mandating graduate program and continuing education coursework focused on supporting sexual minority clients may help therapists to feel more prepared to support sexual minority clients. Adapting interventions, which may pose the risk of microaggressions by assuming sexual minority clients want to focus on aspects of their sexual orientations in therapy, is not necessary to address this particular challenge. Rather, literature that provides examples of applying standard techniques to work with sexual minority clients (e.g., LaSala, 2006; Martell

et al., 2004) may provide therapists with confidence in working with sexual minority clients.

Lessons from the cultural adaptation literature

Most of the cultural adaptation literature has focused on modifying interventions for specific racial/ethnic groups. Because of this, the literature about racial/ethnic cultural adaptations contains more robust frameworks for guiding adaptations than does the sexual orientation cultural adaptation literature. Thus, there may be lessons from the racial/ethnic cultural adaptation literature that can provide guidance for the most promising approaches to supporting sexual minority clients in therapy that may help address some of the concerns articulated above. For instance, Lau (2006) advocates for a "selective-and-directed" approach to treatment adaptation, where researchers and clinicians do not assume that particular cultural groups require adapted interventions but rather that they adapt interventions only when there is evidence to support that an adaptation may be necessary and to focus those adaptations on where they are needed. According to Lau (2006), evidence that an adaptation may be appropriate includes when a cultural group has unique risk and protective factors and when there is reason to believe (e.g., clients from a cultural group express that the intervention is not palatable or relevant or data indicates that members of a cultural group have higher attrition rates than members of other groups) that a cultural group is going to respond poorly to an existing treatment. According to Lau (2006), in both cases the adaptation should target the identified unique experiences or challenges of that cultural group. The discussion above about utilizing assertiveness training, risk assessment, and safety planning interventions for clients who are coming out (a sexual orientation-specific risk factor for victimization and mental illness) serves as an illustration of this approach.

Selecting and targeting interventions

Much of this article has spoken of sexual minority clients as a singular population. However, the term "sexual minority" describes a cluster of identities comprised of sub-identities (e.g., gay, lesbian, bisexual, queer). There is no one size fits all approach to working with sexual minority clients and there is considerable diversity across gender and sexuality lines (e.g., gay, lesbian bisexual, queer), as well as across other intersecting identities, in terms of risk and protective factors and rates of mental illnesses, including depression and anxiety (Cochran et al., 2003). Future research should consider these differences when developing targeted interventions, including adapted interventions for more specific sexual identities.

In addition to demographic factors, other differences in experiences and perspectives may influence how individuals experience and respond to particular interventions. For instance, the assumption made in adapted models that clients want to focus on their sexual orientations in therapy may be experienced as microaggressive for some clients, but for other clients a curriculum that focuses on these challenges may be helpful and normalizing of their struggles and lived experiences. Supporting sexual minority clients is not merely about the development of interventions that address the needs of sexual minority clients generally, but it is also about matching individual clients to the best possible intervention to address their unique needs. Future research must not only focus on which interventions are effective for sexual minority clients in aggregate but also "what it is about the [intervention] which works for whom in what conditions" (Pawson & Tilley, 1997, p. 72). This information will be indispensable for therapists trying to connect individual clients to the best possible interventions.

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