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Comparative Psychotherapy Outcomes of Sexual Minority Clients and Controls

Sasha A. Mondragon
Brigham Young University - Provo

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Sasha Ann Mondragon

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Doctor of Philosophy

Michael J. Lambert, Chair
Stevan L. Nielsen
John Okiishi
Bruce N. Carpenter
Sally Barlow

Department of Psychology

Brigham Young University

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ABSTRACT

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Sasha Ann Mondragon
Department of Psychology, BYU
Doctor of Philosophy

Research examining the psychotherapy outcomes of sexual minority clients seen in routine clinical care is lacking. No studies could be identified in which sexual minority client outcomes were evaluated with a standardized measure. The pre-treatment mental health functioning of 600 sexual minority clients was compared with that of a randomly selected group matched to the minority group on male/female ratio. The post-treatment mental health functioning of 596 sexual minority clients was also examined and compared to a control group matched on female/male ratio, initial levels of mental health functioning, age, and marital status. Results indicated that sexual minority clients who reported experiencing distress regarding their sexual identity/orientation at intake evidenced significantly higher levels of psychological distress than the randomly selected group pre-treatment. No significant differences between sexual minority and control clients in overall mental health functioning was found post-treatment and sexual minorities in the sample evidenced treatment gains that were similar to control group clients when initial levels of functioning were matched. Sexual minority females reported experiencing more frequent suicidal thoughts pre- and post-treatment. Implications for psychotherapy in routine clinical care are discussed and recommendations for future research are offered.

Keywords: sexual minority, LGBQ, psychotherapy, outcome, treatment, suicide

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Monitoring patient progress and adjusting treatment when needed is a critical clinical skill and a necessary aspect of psychotherapy (American Psychological Association [APA], 2006); Lambert, Bergin & Garfield, 2004). In 2006, a report from the American Psychological Association Presidential Task Force regarding Evidence-Based Practice called for an increased focus on clinically relevant research that could be used to inform clinical practice, thereby enhancing patient outcomes. Specifically, the report called for the use of "clinical expertise in interpreting and applying the best available evidence while carefully monitoring patient progress and modifying treatment as appropriate" (APA, 2006, p. 278). Evidence-based practice guidelines were created in attempt to monitor the quality of psychotherapy patients receive.

Several treatment approaches are currently available for psychotherapists to choose from. In order to provide high quality care to patients, it is necessary for therapists to select and provide effective treatments. Herink (1980) identified over 200 therapeutic approaches and soon after Kazdin (1986) estimated that over 400 forms of psychotherapy existed (see Lambert et al., 2004 for historical overview). Given the vast array of treatment approaches being employed, psychologists are increasingly expected to rely on research findings in addition to clinical expertise in order to identify and implement the most effective treatments available (APA, 2006). Furthermore, changes in reimbursement systems and managed care organizations have led to an increased emphasis on evidence-based practice guidelines in an attempt to identify the most cost effective and efficacious treatments (Lambert et al., 2004).

Decades of psychotherapy outcome research has indicated that therapy is beneficial for most people (Lambert & Ogles, 2004; Wampold, 2001). However, research has also provided

evidence that 5-10% of adults who receive therapeutic services worsen over the course of treatment (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004; Mohr, 1995). Occurrences of patient deterioration paired with evidence that psychotherapists are not necessarily adept at predicting patient progress when relying on clinical judgment alone (Hannan, et al., 2005; Lambert, 2010) is concerning. These issues highlight the need for the implementation of quality control systems that allow clinicians to monitor patient progress consistently and conveniently, thereby improving treatment outcomes. The increased focus on providing and examining evidence-based practice in real-world clinical settings provides a rich context in which patient outcomes can be examined through rigorous research and attention can be given to factors that appear to influence negative treatment outcomes.

The implementation of a patient-focused research paradigm was suggested by Howard, Moras, Brill, Martinovich, and Lutz (1996) and "seeks to identify empirical methods to improve outcome for individual patients in ongoing clinical practice" (Lambert, 2001, p. 148). The patient-focused paradigm is an empirically-supported treatment approach that provides clinicians with ongoing feedback regarding the progress of their patients. Research has indicated that tracking patient progress and providing such feedback to clinicians significantly enhances treatment outcomes (Harmon, Hawkins, Lambert, Slade & Whipple, 2005; Lambert, 2001, 2002; Lambert et al., 2003; Slade, Lambert, Harmon, Smart & Bailey, 2008). While a patient-focused approach to psychotherapy allows clinicians to monitor and adjust treatment for individual clients, the paradigm simultaneously provides the opportunity for patient data to be grouped together for research and program evaluation purposes.

Another element of providing evidence-based treatment includes considering patients' cultural diversity and minority status. The APA Presidential Task Force regarding Evidence-

Based Practice defined evidence-based practice in psychology as the "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p. 273). Increased attention has been given to the influence of unique patient characteristics and culture on the process of psychotherapy; however, many clinicians, researchers, and training programs continue to emphasize the need for further research that examines the influence of patient culture on treatment outcomes. For example, an intensive review of psychotherapy research regarding culturally diverse populations (African American, American Indian, Asian American, and Latino(a) American minority clients) led to the following conclusion: "We now know that ethnic and cultural group variations are related to certain processes and outcomes in psychotherapy. However, the exact nature of these effects seems less clear. There is limited research on ethnic minority groups, and the research is not highly programmatic" (Zane, Nagayama Hall, Sue, Young & Nunez, 2002, p. 796). One major criticism of current efficacy and effectiveness research is that participants typically represent the majority population. This limitation results in difficulty generalizing research findings to minority patients. Thus, it is important that conscious and increased efforts continue to be made to include minority groups in psychotherapy outcome research.

As is the case with most minority groups, sexual minority people (lesbian, gay, bisexual, transgendered, queer and people who question their sexual orientation – commonly referred to as the LGBTQ population) have been and continue to be subjected to persecution, criticism and societal rejection and continue to be an under-researched group in terms of mental health treatment and psychotherapy outcomes (Byrd & Nicolosi, 2002; Cochran, Sullivan, & Mays, 2003; Goldfried, 2001; King et al., 2008; Meyer, 2003). Although a literature base regarding therapeutic outcomes of sexual minority clients does exist, the vast majority of such literature

examines the effectiveness of treatments aimed at sexual reorientation, affirmation, or the influence of therapist characteristics/biases on therapy outcomes. Research regarding the effectiveness of general mental health treatment for sexual minority clients using standardized outcome measures is virtually nonexistent. The current study is an examination of psychotherapy outcomes of sexual minority clients seen in routine clinical practice. This research is a necessary step in order for clinicians to integrate clinically relevant research with clinical expertise regarding "patient characteristics, culture, and preferences" as recommended by the APA Task Force (2006, p. 273). The overarching goals of the current study were to examine whether sexual minority status influenced pre-treatment levels of distress and to examine whether sexual minority clients evidenced differences in psychotherapy outcome in comparison to matched control clients. The examination of such questions was and is necessary in order for clinicians to have confidence that they are providing quality care to sexual minority patients.

Historical Overview and Literature Review

Historical Overview

Social norms and expectations as well as moral, political, and religious agendas have influenced the mental health services sexual minority clients have received for decades and such influences remain evident today (APA, 2009; Beckstead, 2001; Croteau, 1996; Eubanks-Carter, Burckell & Goldfried, 2005; Hunsberger, 1996; Mays & Cochran 2001). In order to adequately characterize the social influences that have impacted psychological interventions and research regarding sexual minorities a historical overview is presented here. Previous mental health interventions and research regarding sexual minority patients reflect societal influences and political changes. By recognizing the context in which sexual minority patients have received

treatment, a more complete understanding of the complex issues that were and are relevant in providing ethical and effective clinical interventions for sexual minority clients can be considered.

The term *sexual minority* is used consistently throughout this study in order to reflect the understanding that lesbian, gay, bisexual, transsexual, queer, and those questioning their sexual orientation are minorities in terms of sexual attraction. Additionally, the term *minority* reflects the concept that a population has experienced some social consequences or hardships as a result of non-majority status (see APA, 2009). Throughout the historical overview section, sexual minority is often replaced with the exact terms that were used in the literature reviewed. This was done in order to adequately characterize the language used in previous research.

Sexual minority status conceptualized as a psychological disturbance. Sexual minority status was conceptualized as a mental disorder in the 1950s, evidenced by the inclusion of "homosexuality" in the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I) in 1952 (American Psychiatric Association, 1952). The DSM-I classified homosexuality as a "sociopathic personality disturbance" (American Psychiatric Association, 1952). In general, this label was consistent with American societal norms at that time (the majority belief that homosexuality was a psychological disturbance; James, 1978). The second Diagnostic and Statistical Manual of Mental Disorders (DSM-II) was published in 1968 and although homosexuality was no longer conceptualized as a sociopathic personality disturbance, homosexuality was described as a "sexual deviation" and continued to be considered a psychological disorder (American Psychiatric Association, 1968).

Given that homosexuality was considered a problem which required intervention, literature from the 1940s to the mid-1970s reported the use of several different therapeutic

modalities and approaches to treat homosexuality. In the 1940s, physiological treatments were often employed and throughout the 1960s and 1970s, various forms of psychological interventions were utilized. While some therapists held that traditional psychoanalysis was the most effective treatment, other "verbal therapies" were also endorsed and included rational psychotherapy derived from Ellis, exaggeration therapy, fixed role therapy, and assertiveness training (James, 1978). Several behavioral techniques were also employed in the 1960s and 1970s in an attempt to "reorient" homosexual clients to heterosexuality (Eubanks-Carter et al., 2005; James, 1978). Approaches such as anticipatory avoidance conditioning, aversion relief, systematic desensitization, masturbatory conditioning, shaping, fading, biofeedback, and positive classical conditioning were typical behavioral treatments (Eubanks-Carter et al., 2005; James, 1978; Murphy, 1992). Other intrusive and extreme approaches, now considered highly unethical treatments for sexual minorities, were also forms of treatment at that time and included electrical aversive conditioning, chemical aversion, intra-cranial septal stimulation, hormone administration, and convulsive shock therapy (Eubanks-Carter et al., 2005; James, 1978).

Treatment outcomes for sexual minorities who entered treatment in the 1960's and 1970's were typically reported in terms of how effective psychotherapy was at reorienting homosexual clients to heterosexuality (Eubanks-Carteret al., 2005; James, 1978). During the 1970s, the debate regarding therapies intended to change same sex attractions/orientation was not an explicit moral issue but rather an issue of whether such treatment was effective and successful. While some therapists claimed a 50% recovery rate with "recovery" defined as the extinction of same sex attraction (in terms of feelings and fantasies) for an extended period of time, others asserted that a change from homosexuality to complete heterosexuality was highly unlikely (James, 1978). Literature from the 1970s indicated various findings regarding the

outcomes of therapy intended to "reorient" or "cure" homosexual clients from their homosexual desires. Some reviews of research ranging from 1956 to 1974 suggested that approximately one-third of patients were "cured of" homosexual tendencies during the course of psychotherapy (Byrd & Nicolosi, 2002, p 1140; Jones & Yarhouse, 2000; Yarhouse, 2002). In addition, authors have published case study examples in which homosexual clients experienced some degree of change toward heterosexuality (see Byrd & Nicolosi, 2002; Jones & Yarhouse, 2000).

In the early 1990s, Nicolosi (1991) coined the term *reparative therapy*. Reparative therapy was defined as a treatment in which a person's homosexual orientation is intentionally changed (repaired) to a heterosexual orientation (Nicolosi, 1991). *Conversion therapy* was another form of reparative therapy given that the goal of therapy was to convert (cure or extinguish) homosexual behaviors, desires, or orientation to heterosexual ones (Jones, Botsko, & Gorman, 2003). Today these therapies are often referred to as sexual orientation change efforts (SOCEs). SOCEs are not only seen in psychotherapy settings. SOCEs also include religious and/or spiritual approaches used by lay people, religious leaders, religious groups, and/or various social groups (APA, 2009). Changes in societal perceptions regarding sexual minority status are discussed in detail below; however, SOCEs became increasingly scrutinized as society began to show greater tolerance for the civil rights and equality of sexual minorities and as professionals in mental health fields began to support and affirm sexual minorities. As such, many authors began to report on the effectiveness of SOCEs with increased vigor in an attempt to demonstrate that SOCEs were effective and beneficial for some sexual minority clients.

A meta-analysis of the effectiveness of reorientation therapies was conducted in 2002 (Byrd & Nicolosi, 2002). The authors identified 14 articles that met three inclusion criteria: (1) the inclusion of male participants who were identified as homosexual, (2) participation in

psychotherapy as treatment (rather than participation in religious or community based treatments), and (3) the use of outcome measures that could be transformed into effect size estimates. Thirteen studies used behavioral treatment interventions and one study employed a psychodynamic approach. Outcomes were measured by plethysmograph, "other physiological assessments" including heart rate while viewing sexual stimuli, and self-report measures regarding sexual attractions and fantasy (Byrd & Nicolosi, 2002, p. 1144). The authors reported, "An independent-samples *t*-test indicated that the alternative or experimental treatment mean ES *(n* = 7, *M* = *.72)* did not differ significantly from the pre- to post-treatment means *(n = 7, M =* .89; *t* = 1.13, ns). As a result, ESs from these two groups were combined for the analysis of the overall ES" (Byrd & Nicolosi, 2002, p. 1144). That is, the authors appear to have combined within-group pre- and post-treatment effects with between-group treatment effects, resulting in significant methodological issues. With the effect sizes combined the authors reported an effect size of .81 when "comparing treatment to an alternative treatment or across pre- to post-treatment" (Byrd & Nicoloski, 2002, p. 1146). The authors concluded that homosexual behaviors and "symptomology" can be reduced over the course of treatment at "a rate similar to adults in treatment (from other meta-analysis) with a variety of disorders such as depression and anxiety" (p. 1148). Although the authors recognized the methodological flaws inherent in the study, problems with a combined effect size due to the lack of studies available for the meta-analysis make the authors' conclusions highly suspect.

Other studies regarding the effectiveness of reorientation therapies have also been suspect and even "highly publicized" (APA, 2009, p. 12; Bhugra 2004). For example, Spitzer (2003) conducted a qualitative study in which 57 females and 143 males were interviewed in order to assess whether their experiences of reparative therapy were effective in decreasing same sex

attractions. Outcome variables included self-reports of same sex attraction/fantasy as well as sexual behaviors (Spitzer, 2003). Participants were included in the study if they reported "(1) predominantly homosexual attraction for many years, and in the year before starting therapy, at least 60 on a scale of sexual attraction (where 0 = exclusively heterosexual and 100 = exclusively homosexual); (2) after therapy, a change of at least 10 points, lasting at least 5 years, toward the heterosexual end of the scale of sexual attraction" (Spitzer, 2003, p. 405). Participants reported that their motivation to change their sexual orientation was based on finding life as a gay man or lesbian emotionally unsatisfying, conflict between experiences of same sex attraction and religious beliefs, and/or a desire to marry or stay married to a heterosexual partner (Spitzer, 2003). Spitzer concluded that "… some gay men and lesbians, following reparative therapy, report that they have made major changes from a predominantly homosexual orientation to a predominantly heterosexual orientation" (p. 413). These results initiated controversy and resulted in several critical reviews.

First, Spitzer was criticized for using a sample of conservative Christian persons rather than a representative sample (Bancroft, 2003; Bhugra, 2004; Drescher, 2003). Furthermore, Bhugra (2004) stated that Spitzer presented biased results by not describing clients who experienced no change during treatment or who had negative experiences of reorientation therapy. Bhugra (2004) also noted several methodological limitations and concluded that evidence for the effectiveness of reparative therapy was lacking. Additionally, retrospective methodology is particularly problematic in psychotherapy research because of the tendency for clients to overstate degree of disturbance as they looking back while overstating positive functioning at the second assessment (see Nielsen et al., 2004).

In 1992, the National Association of Research and Therapy of Homosexuality (NARTH) was founded. In 2009, NARTH published Volume I of the *Journal of Human Sexuality* which provided an overview of several studies regarding reorientation therapy and other SOCEs. The authors stated, "As members of NARTH's Scientific Advisory Committee, we feel obligated to inform both the scientific and lay communities about the plethora of studies that lead to a singular conclusion: Homosexuality is not innate, immutable, or without significant risk to medical, psychological, and relational health" (NARTH, 2009, p. v). The journal included reviews of several studies that reported on the effectiveness of reparative therapy. Studies included individual and group treatments in addition to "spontaneous reorientation" (p. 30), pharmacological interventions, sex therapies, and physiological treatments (NARTH, 2009). The authors concluded that although limitations exist in the SOCE literature base and although reparative therapy is not an empirically supported treatment in terms of the guidelines provided by the APA Evidence-Based Practice Guidelines (2006), reparative therapy is effective for some clients. Furthermore, NARTH reported that reparative therapies are ethical and referenced a lack of evidence that reparative treatments have been shown to be harmful to patients in order to support the assertion. Members of NARTH have stated that same sex attractions are not biologically driven and hold that sexual minority status should be subject to treatment, based on the belief that sexual minority attractions are psychologically harmful (NARTH, 2009). The assumptions of NARTH illuminate one side of the ethical debate surrounding the morality of sexual minority orientation and attraction.

Beckstead (2001) reported that the wide range of outcome goals and variations in defining treatment success of reparative therapies results in difficulty evaluating the effectiveness of reparative therapies for sexual minority clients. Specifically, Beckstead noted

that clinicians are not consistent in their expectations of outcomes and define "successful treatment" in several different ways (2001). Furthermore, clients most likely experience wide variations in treatment goals and define successful treatment outcome in accordance with their own desires and expectations rather than those of the therapist. One client may view decreased same sex desires as a successful outcome while other clients may require a fundamental change in sexual orientation before an outcome is considered successful. These variations in constructs paired with the lack of prospective randomized clinical trials, ethical, moral, and political interests, as well as researcher biases contribute to the difficulty interpreting the effectiveness of reparative therapies and SOCEs. However, some research does indicate that same sex attractions can be altered over the course of psychotherapeutic interventions for some patients.

Changes in the conceptualization of sexual minority status. The gay rights movement and gay activists of the late 1960s and early 1970s coupled with some influential research studies and sexual minority members of the American Psychiatric Association likely influenced the American Psychiatric Association's decision regarding the discontinuation of inclusion of homosexuality in the DSM-II in 1968 (APA, 2009; Bayer, 1981; Eubanks-Carter, Burckell, & Goldfried, 2005). The diagnosis of homosexuality was replaced with "Sexual Orientation Disturbance" in the DSM-II, limiting the diagnosis to people who felt conflict or distress regarding their sexual orientation (American Psychiatric Association, 1973). In the mid-1970s, the American Psychological Association issued an official resolution stating that homosexuality does not imply the presence of a psychological impairment or disorder (APA, 1975). In addition, the APA resolution encouraged psychologists to affirm sexual minority individuals in their sexuality and to become leaders in the movement for equal rights, in an attempt to remove societal discrimination and stigma associated with sexual minority status (APA, 1975; Eubanks-

Carter et al., 2005). Thus, sexual minorities interested in mental health treatment were no longer expected to be subject to therapy with an implicit or explicit outcome goal of reorienting same sex attractions. Instead, advocates encouraged sexual minorities to live according to their sexual minority identity, a type of therapy now known as *affirmative therapy*.

During the same time frame, increasingly diverse viewpoints regarding sexual minorities began to emerge in psychological literature. For example, in 1975 Johnson and O'Brien wrote (as cited in James, 1978), "Since the value system espoused by the therapist is important, his own expectations and goals for the client need to be explored… The primary object is to free the patient from the tyranny of his own unconscious so that he is able to make rational choices and to continue in human relationships characterized by fidelity and the ability to receive and give love and care regardless of the gender of his partner…. The effort has not been to effect change necessarily but to promote self-learning." New attitudes began to form surrounding the nature of same sex attraction and sexual minority status began to be increasingly viewed as a form of sexuality equivalent (rather than inferior) to heterosexuality (James, 1978).

In 1980, the third Diagnostic and Statistical Manual of Mental Disorders (DSM-III) replaced the diagnosis of Sexual Orientation Disturbance with Ego-Dystonic Homosexuality (American Psychiatric Association, 1980). The change required that a person be distressed by their sexual minority status in order to meet criteria for the diagnosis. However, the diagnosis of ego-dystonic homosexuality was removed from the revised version of the third DSM (DSM-III-R) which was published in 1987 (American Psychiatric Association, 1987). At that time, it was recognized that "the coming out process typically includes a phase in which the individual is distressed about his or her sexual orientation" which would result in a diagnosis that would be otherwise unwarranted (Eubanks-Carter et al., 2005, p. 5). The World Health Organization

(WHO) removed homosexuality from the International Classification of Diseases (ICD-10) in 1992 (Eubanks-Carter et al., 2005).

As the popularity of affirmative therapy increased and as sexual minority status became gradually more accepted in society, reorientation therapies and SOCEs were increasingly condemned. A dramatic shift from opposing to embracing and affirming sexual minority status began to occur in the psychological literature. Thus, major research efforts shifted from examining the effectiveness of reparative therapies to examining sexual minority clients' experiences and satisfaction of treatment for general mental health concerns. Some anecdotal and empirical studies conducted between 1983 and 2000 have suggested lesbian, gay, and bisexual (LGB) individuals experienced prejudice or pressure to undergo conversion or reparative therapy when they sought mental health treatment for other concerns (Eubanks-Carter et al., 2005; Jones et al., 2003). In psychology, the call from the American Psychological Association combined with research findings and societal changes resulted in increased concerns regarding potential prejudice and mistreatment sexual minorities faced in therapy.

This concern led to examinations of mental health professionals' beliefs and attitudes toward sexual minority clients as well as an increased interest regarding whether sexual minority patients were receiving psychotherapy that was ethical and respectful of sexual diversity. Research regarding the influence of specific therapist factors (namely gender, sexual orientation, and biases related to sexual minorities) on treatment outcomes for sexual minority clients sprung forth (Burckel & Goldfriend, 2006; Jones et al., 2003; King et al, 2007). Additionally, sexual minority clients were increasingly asked to report on their satisfaction with therapeutic services in hopes of improving the quality of care sexual minority patients received.

More recent research has examined specific therapist factors and treatment techniques that influence the therapeutic experiences of sexual minority clients. In a study by Jones and colleagues (2003), 600 participants who identified themselves as lesbian, gay, or bisexual at the time of the study completed a questionnaire regarding their experience in individual, group, couples, or family therapy/counseling. Participants were asked to identify various aspects of therapy ranging from "very destructive" to "very beneficial" on a 10-point scale. Results suggested that beginning therapy in a later year (1990s or later) combined with a higher number of therapy sessions (5 or more) were positively associated with therapy benefit. In addition, older clients and clients self-identified as gay, lesbian, or bisexual rated therapy as more beneficial than younger clients and clients who identified themselves as heterosexual or who reported confusion regarding their sexual orientation during the course of therapy.

Other researchers (Burckel & Goldfriend, 2006) reported that sexual minority participants expressed less favorable views of psychotherapy if their therapist emphasized sexual identity more than other identities. In addition, participants reported less favorable experiences of psychotherapy if a therapist treated sexual minority orientation as an issue that was similar to other therapeutic problems (Burckel & Goldfriend, 2006). Results also indicated that therapists who lacked awareness of lesbian, gay, and bisexual issues, failed to recognize that the client may not be heterosexual or used heterocentric language may have experienced difficulty retaining and providing effective treatment to lesbian, gay, and/or bisexual clients (Burckel & Goldfriend, 2006). Finally, the authors suggested that affirmative therapy was generally beneficial to clients and that a strong therapeutic alliance played a positive role in treatment outcomes (Burckel & Goldfriend, 2006).

In the 1990s, therapists and researchers began to expound upon the difficulty some sexual minority patients faced in integrating religious or spiritual identities (particularly religious and spiritual identities related to conservative Christian beliefs) with sexual minority status (Yarhouse, 1998). Some authors became concerned that sexual minority patients were being encouraged to embrace their sexual minority identity regardless of other identities they may have held with equal regard. This concern led to an increased attempt to examine and redefine reparative therapies for clients who reported that they did not want to embrace sexual minority attractions.

Beckstead (2001) introduced the term *sexual reorientation therapy* (SRT): a treatment definition intended to describe clients who were attracted to same sex persons but who reported a preference to live a heterosexual lifestyle due to their own conflicting values regarding same sex attraction. This term was created in an attempt to provide an alternative to the terms reparative therapy and conversion therapy which implied that sexual minority status was a disease or disorder. Beckstead (2001) emphasized that some clients expressed preference for heterosexual attractions rather than homosexual attractions, particularly if homosexual attractions interfered with religious/spiritual functioning or central social support systems. It is not surprising that some sexual minority persons would feel conflicted regarding sexual minority orientation given significant social stigma related to sexual minority status (Cochran, 2001). Cochran (2001) reported that a poll of Americans in 2002 indicated that approximately one half of polled individuals believed that homosexuality was a sin and one third of people in a different survey believed homosexuality to be a mental or physical illness (p. 932). Sexual reorientation therapy is not equivalent to reparative therapies according to the descriptions in the literature. Proponents of sexual reorientation therapies seem to embrace a patient-centered approach to

treatment in the sense that sexual minority status is not condemned or viewed as a disorder but rather as a lifestyle and identity that is sometimes incompatible with other meaningful identities people hold.

Beckstead (2001) further proposed that patients who are distressed by their sexual minority orientation should have the option of engaging in treatment that may alter their sexual arousal patterns. This view is similar to that of Yarhouse (1998) which urged therapists to respect their patient's desires when determining the course of treatment for sexual minority clients. Furthermore, Benoit (2005) examined the controversies surrounding sexual reorientation therapies in terms of the American Psychological Association ethics code principles of beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity and concluded, "respect for religious diversity demands that psychologists give as much weight to belief as to sexual identity" (p. 322). It was also emphasized that clients who report religious conflicts regarding their sexual orientation/identity present unique ethical issues during the course of psychotherapy (Benoit, 2005).

In 2009, the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation published a report in response to concerns regarding how clinicians should assist individuals who express a desire to change sexual minority attractions to heterosexual attractions. The Task Force conducted an intensive literature review regarding evidence for the effectiveness or efficacy of SOCEs. A total of eighty three studies were reviewed and the authors concluded that scientific evidence for the effectiveness of SOCEs is limited and therefore SOCEs are "…unlikely to be successful and involve some risk of harm, contrary to the claims of SOCE practitioners and advocates" (p. v). The Take Force recognized that some patients have religious beliefs that lead to distress regarding their sexual minority

orientation and encouraged therapists to "support clients in determining their own (a) goals for their identity process; (b) behavioral expression of sexual orientation; (c) public and private social roles; (d) gender role, identity, and expression; (e) sex and gender of partner; and (f) form of relationship(s)" (p. 62). Furthermore, the report emphasized the following: "The clinical literature indicated that adults perceive a benefit when they are provided with client-centered, multicultural, evidence-based approaches that provide (a) acceptance and support, (b) assessment, (c) active coping, (d) social support, and (e) identity exploration and development. Acceptance and support include unconditional acceptance and support for the various aspects of the client; respect for the client's values, beliefs, and needs; and a reduction in internalized sexual stigma" (APA, 2009, p. 12).

Historical summary and conclusions. It is evident that sexual minorities have faced and continue to experience discrimination and significant social consequences given the debates surrounding the morality of sexual minority attractions. Since the 1970's, the American Psychological Association has opposed stigma, prejudice, and discrimination of sexual minorities and has held that sexual minority attractions are a normal and healthy variation of sexuality. Extreme positions argue for polarized treatments regarding sexual orientations: Some support a view that homosexuality is immoral and unnatural and should be the subject of treatment while others argue that sexual minority patients should be affirmed and urged to live according to sexual minority attractions regardless of the importance of other meaningful identities. These opposing views regarding treatment seem to allude to the moral, religious, political, and ethical issues surrounding sexual minority attractions in America rather than to empirical research findings regarding factors that influence positive psychotherapy outcomes of sexual minority clients. For example, literature does exist that supports the utility of sexual

reorientation therapies for some clients who determine that their values (social, moral, and/or religious) do not coincide with a sexual minority status. *And* literature also exists that has indicated SOCEs can be harmful to clients. While polarized views are extremely evident, some authors note the importance of more complex treatment models based in a person-centered approach, in which sexual minority clients be treated according to their own beliefs and value systems, giving priority to their personal beliefs and desires regarding sexual attraction (APA, 2009; Beckstead, 2001; Benoit, 2005; Yarhouse 1998).

In sum, the existing literature regarding sexual minority clients is heavy in supposition and lacks empirical evidence regarding individual client outcomes after the course of routine psychotherapy through validated psychometric measures. Importantly, research findings regarding sexual minority patients focus heavily on moral debates and issues of the effectiveness of SOCEs rather than on general treatment outcomes. Thus, the purpose of the current study was to address how sexual minorities faired in psychotherapy in comparison to a general treatment population with regard to their general mental health functioning before and after treatment. The focus of the current study was to examine psychotherapy outcomes and changes in mental health functioning (i.e., symptomatology of depression, and anxiety, interpersonal difficulties, and social role functioning), not changes in sexual orientation or sexual arousal patterns. This focus on general psychotherapy outcomes provides useful information regarding the helpfulness of psychotherapy to sexual minority clients seen in a routine clinical setting.

Overall, the debate regarding whether sexual minority clients should undergo reparative therapy or another form of SOCE appears to be based upon moral subjectivity and personal beliefs of authors and researchers, resulting in limited empirical evidence regarding the issue. Further, the intensive focus of this debate detracts from the development of a strong evidence

base regarding general psychotherapy outcomes for sexual minority clients. It is unfortunate that the general psychotherapy outcomes of sexual minority clients (according to standardized measures) have been neglected in the literature thus far. Buried beneath the rhetoric regarding the morality of sexual minority status exist sexual minority patients who are receiving routine clinical services. These clients continue to receive mental health care without an evidence base that can allude to whether routine psychotherapy is beneficial, or perhaps even harmful. Thus, the focus of the current study was to employ a standardized outcome measure in order to compare the outcomes of sexual minority patients with matched controls in hopes of gleaning some evidence regarding the degree to which psychotherapy is helpful for this minority group.

Literature Review

Definitions and prevalence rates of sexual minorities. No consistent or widely accepted definition of sexual orientation or sexual minority status exists in the current literature (King et al., 2008; Savin-Williams & Ream, 2007). Definitions of sexual minority status range from including people who have engaged in sexual behavior(s) with a same sex partner to people who have experienced a feeling of sexual attraction to someone of their same sex even once within their lifetime (Savin-Williams & Ream, 2007). Some researchers have noted the importance of defining the prevalence of same sex attraction in terms of *both* behavior and attraction and thus more broadly (Randall, Sell, Wells, & Wypij, 1995). By defining sexual minority status by sexual behaviors only, a large portion of the population of same sex attracted people would be ignored in surveys and research (Randall et al., 1995). This may be especially true for more conservative or religious persons who experience same sex attraction without participation in sexual behavior(s) with a same sex partner. Furthermore, asking individuals to define their own sexual orientation is problematic in prevalence studies because such a definition

depends on individual perspectives rather than standard criteria. That is, one person may self-identify as heterosexual while another person who has similar experiences may self-identify as a sexual minority. Thus, research using participant self-identification methods would presumably provide a different picture of prevalence. Such definitional problems make it difficult to sum across samples and to derive reliable prevalence rates.

Prevalence rates also vary according to the time frame addressed in surveys or questionnaires. For example, lifetime prevalence rates of same sex attractions vary drastically from descriptions of current sexual attractions or attractions within a specific time frame (e.g., the past year or past five years; King et al., 2008). This issue is a common difficulty in epidemiological studies and is typically solved by linking prevalence rates to specified time frames. However, the influence of the historical debate regarding the morality of sexual minority status influences reported prevalence rates as well. For example, those who advocate that sexual minority attractions are not biologically based may tend to emphasize the importance of social factors in sexual identity development (i.e. adolescent identity confusion, sexual experimentation, accepting climate of sexual minorities, etc.) while those who advocate that sexual minority status consists of a very strong biological component may be more likely to focus on the emergence of sexual minority attractions at a young age and emphasize the stability of sexual minority status over time (see Dickson, Paul, & Herbison, 2003). These issues highlight the importance of considering the time frame reported in research regarding prevalence rates.

Dickson et al. (2003) examined a birth-cohort in New Zealand and found that by the age of 26, 10.7% of men and 24.5% of women reported being attracted to their own sex at some time during their life. They emphasized that prevalence rates vary depending upon the factors

mentioned above and concluded that the findings do not support any single explanation of sexual minority attraction. For example, when participants were asked if they currently experienced same sex attraction the rate was lower (5.6% of men and 16.4% of women answering in the affirmative). However, rates changed again when participants were questioned about their predominant sexual attractions. When asked if they were currently experiencing either "predominant" attraction to their own sex or equal attraction to both sexes, rates of same sex attraction fell to 1.6% of men and 2.1% of women. One lesson to be learned from this study is that rates of prevalence vary dramatically based on the operational definition of sexual attraction. Due to variations in the definition of sexual minority status, prevalence rates of sexual minorities in the general population vary widely and range from 1.5% to 11% for males and 2% to 25% for females (Dickson et al., 2003).

The terms transgender or transsexual refer to a discrepancy between one's genetic/physical sex and one's gender identity, or basic sense of being male or female or a discrepancy between ascribing to traditional social norms associated with being male or female (Cohen-Kettenis & Gooren, 1999). Transgender individuals are considered sexual minorities because they face unique issues related to gender roles and sexual identity, not because experiences of transgender are considered equivalent to same sex attraction or sexual orientation. Prevalence rates of transsexual persons in the general population are difficult to estimate given a lack of epidemiological studies. As a result, reported prevalence rates appear to be based on surveys from mental health providers or applications for sex change procedures rather than estimates from the general population (Cohen-Kettenis & Gooren, 1999). Rates of transsexual people are estimated to be approximately 1:10,000 – 1:18,000 male-to-female and 1:30,000 – 1:54,000 female-to-male (Cohen-Kettenis & Gooren, 1999; Eklund, Gooren, & Bezemer, 1988).

Given that no transsexual or transgender clients were identified in the current study, transsexual and transgender clients were not examined.

Psychological distress and sexual minority status. A large body of evidence suggests that sexual minorities experience an elevated risk of psychopathology in comparison to people who are exclusively heterosexual (Bailey, 1999; Cochran & Mays, 2009; Fergusson, 2005; King et al., 2008). A recent meta-analysis examined psychological symptoms of lesbian, gay, and bisexual (LGB) people in the general population and indicated that the risk of suicide attempts in LGB people was twice that of heterosexual people and that gay and bisexual men appeared to have the highest rates of suicide attempts (see Appendix A, Table 1). Rates of deliberate self-harm were also higher among the LGB sample and findings indicated that LGB people were 1.5 times more likely to meet criteria for anxiety or depression (Appendix A, Table 2). Furthermore, LGB persons were 1.5 times more likely to meet criteria for substance dependence with lesbian and bisexual women evidencing the greatest risk for substance abuse dependency (Appendix A, Table 3).

Additional research has suggested that LGB adults and youth experience higher rates of alcohol and/or drug dependency than heterosexuals (Cochran & Mays, 2009; Russell et al., 2002). In addition, sexual minorities face unique social and societal challenges and multiple research studies have indicated that sexual minority persons experience chronic stress regarding issues related to social stigmatization, social roles, and relationships (Bailey, 1999; D'Augelii, Pilkington, & Hershberger, 2002; DiStefano, 2008; Szymanski & Kashubeck-West, 2008; Ueno, 2005). Several other studies have also noted high rates of suicidal desires, completed suicide, and self-harm (cutting, burning, hitting self, etc.) among sexual minority adults and adolescents identified in the general population (Cochran & Mays, 2009; DiStefano, 2008; Hatzenbuehler,

McLaughlin, & Nolen-Hoeksema, 2008; King et al., 2008; Skegg, Shyamala, Dickson, & Williams, 2003; Whitlock, Eckenrode, & Silverman, 2006).

Theories of increased psychological distress in sexual minorities. Several models have been proposed in order to explain generally consistent research findings which suggest that sexual minority people appear to experience higher rates of psychological distress than do heterosexual people in the general population. Importantly, increased distress and psychological symptoms in sexual minority persons relative to those in the general population does not indicate a causal relationship (Cochran, 2001). Several complex models regarding psychological symptoms and distress recognize the influence of social stigma, discrimination, and difficulty with social support systems among sexual minorities. These models have emphasized that experiences of chronic stress accompany societal discrimination, persecution, and rejection and this stress coupled with difficulties in relational experiences with important support systems likely leads to higher rates of psychological distress in sexual minorities (Cochran, Sullivan, & Mays, 2003; Goldfried, 2001; Meyer, 2003). Some evidence also indicates that perceived discrimination regarding sexual orientation is related to psychological disturbance (Mays & Cochran, 2001). In addition, it has been noted that because sexual minority identity typically emerges in adolescence, sexual minority people may experience early maltreatment from peers since, "Minority sexual orientation and gender atypicality are early magnets for maltreatment" (Cochran, 2001 p. 937). Finally, the degree and type of pathology vary by subpopulations of gender and the expression of sexual orientation expression (Cochran & Mays, 2009) and some models of psychopathology differ according to the subpopulations. For example, higher rates of psychological symptoms among gay and bisexual men may be the result of greater psychological distress related to serious health concerns such as HIV (Cochran & Mays, 2009).

Unfortunately, some theories regarding increased rates of psychopathology in sexual minority samples clearly reflect moral and/or political agendas previously examined. For example, those who advocate that sexual minority status is inherently immoral appear to be more likely to subscribe to the assumption that being a sexual minority in itself causes distress and may adopt a causal model to account for this. These include reports that being a sexual minority leads to increased pathology given an assumption that sexual minority status is sinful or immoral and not biologically based. Another model has proposed that higher rates of some psychological symptoms (including substance abuse and dependence, self-harm, and suicidality) may be related to higher risk-taking behaviors and offers the explanation that people who experiment with sexual orientation may engage in more risky or impulsive behaviors and are thus at greater risk for substance use and self-harm (Bailey, 1999).

Psychotherapy outcome research and sexual minority clients. A relatively recent meta-analysis was conducted in an attempt to better understand treatment outcomes for sexual minority clients. After a review of studies published between 1966 and 2006, King et al. (2007) reported that only 22 papers met criteria for the meta-analytic review. Fourteen of the papers reviewed reported qualitative data while ten papers reported on quantitative data and two papers included both quantitative and qualitative data. The studies included in the meta analysis examined a variety of variables that influence treatment outcomes including sexual minority client satisfaction with mental health services, the influence of therapist characteristics on therapy satisfaction, preferences regarding therapist characteristics, influence of therapist sexual orientation and gender, influence of client characteristics on therapy, types of services received, sex role stereotypes, reasons for beginning psychotherapy, and amount of services used by clients (number of sessions/episodes of therapy). While such aspects of psychotherapy are

important and need to be examined, none of the studies reviewed for the meta-analysis investigated whether sexual minority clients experienced positive psychotherapy outcomes by utilizing standardized measures.

One example of a treatment outcome study included in the King et al. meta-analysis was conducted by Jones and colleagues (2003) and examined client ratings of psychotherapy benefits. The summary of Jones et al. (2003) is presented here as an example of a typical outcome study (in terms of methodology) regarding sexual minority clients. The sample consisted of 378 lesbian and bisexual women and 222 gay and bisexual men. Participants self-identified their sexual orientation and were all current or former clients in a form of therapy, with therapy being defined as any form of talking treatment, including interactions with religious leaders or mental health professionals. Each participant completed a questionnaire which required them to describe their treatment history. The dependent variable in the study was participant ratings of therapy benefit, which were reported on a 10-point scale ranging from 1 (very destructive) to 10 (very beneficial). Participants were asked to rate each session and the researchers also gathered data regarding the context of the therapy episode (e.g., the year psychotherapy was completed, how many times a client had previously been involved in psychotherapy), client characteristics (client age, client gender, client sexual orientation and confusion regarding sexual orientation), therapist characteristics (therapist age, therapist gender, profession), and boundary issues (accepting a client's invitation to engage in a social event, visiting/phoning the client at home).

Results were based on the mean ratings of self-reported benefits from the 10-point scale. The authors reported the following variables were positive predictors of benefit: an increased number of sessions attended (mean rating 8.2), therapists being lesbian or gay (mean rating 8.1),

therapists being female (mean rating 7.7), and the client self-identifying as lesbian or gay at the beginning of treatment (mean rating 7.6). The authors reported the following variables as predictors of negative outcome: violation of boundaries (mean rating 4.5) and attempted conversion or reparative therapy (mean rating 2.2) (Jones et al, 2003). Other studies included in the King et al. (2007) meta-analysis relied on similar methodology in terms of client reports of therapeutic benefits and experiences without standardized measurements, a methodology that would be typical of psychotherapy research conducted in earlier years (Hill & Lambert, 2004).

King et al. (2007) concluded that of the 22 papers, "there were no trials evaluating the effectiveness of psychological interventions in LGBT people" (p. 2). Furthermore, King and colleagues (2007) reported, "None of the studies reviewed measured mental health outcomes using validated psychometric measures" (p. 3). The authors called for an examination of treatment effectiveness among sexual minority clients using valid psychometric measurements and quantitative methods. Additionally, a comprehensive literature review completed for the purpose of the current study did not yield any research regarding the effectiveness of psychological treatment among sexual minority clients in a typical outpatient treatment setting that did not focus on some mode of reparative, reorientation, or affirmative therapy.

In 2009, the *Journal of Counseling Psychology* (JCP) published a special issue titled, "Advances in Research with Sexual Minority People." The special issue contained a total of 17 articles with only one article that examined an aspect of psychotherapy (Mallinckrodt, 2009). That study examined therapist and doctoral trainee case conceptualizations of simulated sexual minority and heterosexual clients and then used qualitative methods to analyze supportive and non-supportive themes within the conceptualizations of the mental health professionals (Mallinckrodt, 2009). The articles that were included in the JCP special issue examined

important issues, but evidence of a comparison study which examined psychotherapy outcomes of sexual minority clients in comparison to heterosexual clients could not be found.

Given the elevated risk of psychopathology among sexual minorities in the general population, the prevalence rates of same sex attraction (even among varying definitions of same sex attraction), and the increased focus on multicultural and diversity issues in the mental health field, it is surprising that such little recent research has been conducted regarding the psychotherapy outcomes of sexual minority clients. Cochran (2001) noted that some scientists with research interests in this area have been advised not to conduct such research due to potential "professional risk" as well as a "lack of resources" (p. 933). For example, Hooker (1993) described her experience conducting research with sexual minority men in the 1950s and 1960s and noted several institutional and political pressures she experienced due to her research. Cochran (2001) further noted difficulty conducting research given methodological issues such as difficulty with random sampling, small sample sizes, and concerns regarding confidentiality.

Whatever the reasons may be for the dearth of published studies, there is a clear need for an examination of the question proposed here: Does the psychological distress and symptomatology of sexual minority clients decrease at a rate similar to that of heterosexual clients after completing psychotherapy? This question is a vital one to ask if mental health professionals intend to ethically and effectively treat sexual minority clients.

Research Questions

Given that literature exists to support the notion that some sexual minorities have experienced harm throughout the course of treatment, as well as a lack of empirical evidence regarding the helpfulness of therapy for sexual minority clients, the overarching goal of the current study was to examine the treatment outcomes of sexual minorities who participated in

routine clinical care by utilizing a standardized measurement. Pre-treatment and post-treatment functioning was examined. The initial levels of disturbance and frequency of suicidal ideation of sexual minority individuals were compared with non sexual minorities. This allowed for an examination of pre-treatment levels of functioning between sexual minority and heterosexual clients. Additionally, the psychotherapy outcomes of sexual minority clients were compared with control groups that were matched to sexual minorities on gender, initial level of disturbance, marital status, and age. This comparison allowed for an examination of post-treatment functioning which was necessary in order to evaluate whether sexual minority clients reported similar rates of improvement or harm/deterioration over the course of therapy in comparison to heterosexual clients. The frequency of suicidal ideation post-treatment was also examined.

This study was archival in nature and examined data of completed psychotherapy treatments. Given the use of archival data, the current study could not be conducted in an ideal form with extensive information and important controls that would be possible in a well-funded prospective study. Limited information was collected and stored throughout the course of routine care that made it possible to characterize sexual orientation and treatment outcome among the sample and an attempt to adequately define the characteristics of people in the sample received intensive consideration. After sexual minority status was determined, each client's treatment outcome (and grouped outcome) was contrasted with archival control groups (heterosexual clients) in order to answer the general question of how sexual minority clients fared in treatment. Based on the research reviewed it was not possible to state a directional hypothesis for differences in pre-treatment levels of distress individuals in treatment (as opposed to general population comparisons) or for differences in treatment outcomes of sexual minority clients compared with matched controls.

The following research questions were examined: (1) Will clients identified as sexual minorities report higher levels of psychological distress in comparison to randomly selected client control groups (matched on gender only) at intake? (2) Will identified sexual minority clients report higher levels of suicidal ideation in comparison to randomly selected client control groups and matched control groups (matched on gender, age, initial level of psychological disturbance, and marital status) at intake? (3) Will the psychotherapy outcomes of identified sexual minority clients differ from clients in matched control groups? (4) Will clients identified as sexual minorities experience a similar degree of change over the course of treatment as the matched control group clients? (5) Will the identified sexual minority clients experience reliable change, no change, and treatment deterioration similarly to matched control clients? (6) Will clients identified as sexual minorities report higher levels of suicidal ideation in comparison to randomly selected client control groups and matched control groups post-treatment?

Method

Setting and Participants

Participants consisted of students at a large, western University who received mental health services for personal concerns at a student counseling and career center (CCC). Therapy at the CCC was offered to full-time university students free of charge with no limit on the number of therapy sessions clients could receive. The data for the study was drawn from a large archival database maintained by the CCC and consisted of clients who were at least 18 years of age, completed a minimum of two therapy sessions (so that differences in pre- and post-treatment functioning could be calculated), and participated in therapy at some point between 2004 and 2009. The archival database consisted of 9924 clients (41% male, 59% female).

Table 4

Marital Status and Age of Participants: Males and Females Combined

Group	*n*	% Single	% Married	% Divorced	% Unknown	Mean age SD
Sexual Minority Group	600	83.5%	15.5%	0.2%	0.8%	22.12 σ = 3.11
Matched Control Group	596	84.7%	15.3%	0.0%	0.0%	22.05 σ = 2.83
Typical Client Control Group	600	54.2%	44.5%	0.8%	0.5%	23.44 σ = 3.99

After reviewing the archival database, 600 clients were identified as sexual minorities (76% male; 24% female; see Procedures), 600 clients (76% male; 24% female) were selected for the randomly selected control group (matched to sexual minority clients on gender but otherwise randomly selected), and the matched control group consisted of 596 clients (76% male; 24% female; matched to sexual minorities on gender, initial distress level, marital status, and age). Thus, a total of 1796 participants (76% male; 24% female) were included in the current study. It can be noted that the ratio of males to females in the sexual minority group (about one-third female) is the opposite of the ratio of clients who seek help at the CCC where almost two-thirds are female.

The sexual minority group (and thus the matched control group) was made up of more single clients than the randomly selected client group (see Table 4). Specifically, 83.5% of the sexual minority group was single while only 54.2% of the typical client group was single. The average age of the participants was comparable across groups and ranged from 20 to 24 years old: an age range typical of a college sample.

A summary of participant ethnicity and religious affiliation is presented in Table 5. The information reported is based upon client self-reports of their predominant ethnicity/racial group and religious affiliation at intake. Slightly higher rates of ethnic/racial diversity were observed in the sexual minority group (8.7% Hispanic/Latino(a); 4% Asian, and 1.9% Pacific Islander/Hawaiian) in comparison to the control groups (4.4 – 5.5% Hispanic/Latino(a); 2.3% Asian, and 0.2 – 1.0% Pacific Islander/Hawaiian). Additionally, almost all participants in each group reported membership to a Christian religion.

Patients treated at the CCC evidence a large variation in problems and symptoms, ranging from home-sickness and adjustment disorders to personality disorders. Clients in the current study were referred or self-referred for personal and emotional concerns rather than for academic or career counseling and were included in the study without regard to the nature of their presenting problem (i.e. clients were not excluded based upon diagnostic criterion or type of presenting problem and sexual minority clients included in the study were not necessarily seeking treatment for difficulties related to sexual minority status). Among all participants, the most common diagnoses included Anxiety Disorders, Depressive Disorders, Adjustment Disorders, and problems with interpersonal relationships (V Codes).

Therapist variables were examined and included type of training (clinical psychology, counseling psychology, social work, marriage and family therapy), sex (male, female), and primary theoretical orientation (cognitive-behavioral, behavioral, humanistic, psychodynamic). The modal therapist was a male, licensed, counseling psychology Ph.D., who identified their primary theoretical orientation as cognitive-behavioral.

Every client examined via the archival database signed a consent form when they began treatment at the CCC, giving the CCC permission to use their information for research purposes

aimed at improving services. All participant information was de-identified and treated as strictly confidential. The study was approved through the CCC Research Team and University IRB.

Table 5

Minority and Control Group Self-Reported Ethnicity and Religious Affiliation

Group	*n*	WHI	HIS	AS	PAC IS	BLK	AM IN	UNK ETH	CHRI	UNK REL
Sexual Minority Group	600	82.2%	8.7%	4.0%	1.9%	0.5%	0.8%	1.9%	98.3%	1.7%
Matched Control Group	596	88.4%	4.4%	2.3%	0.2%	1.0%	1.2%	2.5%	98.0%	2.0%
Randomly Selected Client Control Group	600	87.6%	5.5%	2.3%	1.0%	1.0%	0.3%	2.3%	98.5%	1.5%

Note. WHI = Caucasian/white; HIS = Hispanic/Latino(a); AS = Asian; PAC IS = Hawaiian or Pacific Islander; BLK = Black/African American; AM IN = American Indian; UNK ETH = unknown ethnicity; CHRI = Christian; UNK REL = unknown religion

Procedures

Identification of sexual minority clients. In an attempt to identify sexual minority clients as accurately as possible, two methods were used: a self-report questionnaire and therapy note coding procedures. All clients seen at the CCC were asked to complete the Presenting Problems Checklist (PPC; see Measures below) as a part of routine intake procedures prior to beginning treatment. One question on the PPC required clients to indicate whether they experienced distress related to sexual identity/orientation and clients who endorsed the item were included in the study.

Although the PPC provided some indication of minority status, it was recognized that the item offered only a limited assessment (i.e. concerns regarding a single-item assessment, and since many sexual minority persons do not experience distress related to their sexual minority status). Furthermore, some research has indicated that sexual minority people may not disclose

concerns regarding their sexual orientation on questionnaires (King et al., 2008). Thus, therapy notes were coded in order to identify a larger sample of sexual minority clients with increased confidence. A three-step procedure was employed in order to code therapy notes.

Brief clinician interviews. First, in order to identify applicable case notes, seventeen (of thirty-two) therapists employed at the CCC were interviewed using a brief semi-structured interview. The therapists were either full-time therapists or part-time therapists who have worked at the CCC for over five years (part-time staff who have worked for less than 5 years and internship/practicum students were not interviewed). Clinicians were asked to identify words, terms, phrases, and/or abbreviations they would be most likely to use in their psychotherapy case notes when describing sexual minority clients. These words were then used to search case notes in hopes of identifying a larger sample of sexual minority clients. After approximately ten interviews, the therapist reports of terms used in their case notes to describe sexual minority clients was redundant. Seven additional interviews were conducted and did not yield reports of any unique terminology. Thus, the "key words" used to identify applicable case notes were obtained through the clinician interviews and also included frequent definitions, terms, and abbreviations found through the course of the extensive literature review.

Given the results of the clinician interviews and the literature review, the key words/abbreviations/phrases that were used to identify applicable therapy notes included: same sex attraction, SSA, same-sex, LGB, GLB, bisex, same gen, SGA, gender rol, gender id, gender, gay, lesb, queer, sexual id, sex. id, sexual or, attracted to, homo, sexual confusion, transgen, trans-gen, trans-sex, trans. The key word search did not require words to be case sensitive and identified words with partial abbreviations. For example, a search for "gender rol" resulted in

the identification of "gender role" and "gender roles" as a search for "lesb" resulted in the identification of "lesbian," "lesbians," "lesbianism," etc.

All CCC student information was compiled in the Oracle database. The CCC also used an electronic medical record system to record psychotherapy notes and other information related to therapy participation. Students seen at the CCC were assigned a therapy identification number in the database that was not the same identification number used in the Oracle database. Research conducted at the CCC commonly requires the use of the statistical program SPSS in order to integrate information from the two database systems. Thus, therapy notes and information regarding CCC services were exported to SPSS as a standard procedure within the CCC. The current study utilized SPSS in order to store and analyze data.

All psychotherapy notes recorded between 2004 and 2009 were searched using the key words. Psychotherapy notes were exported to SPSS, de-identified, and then SPSS search algorithms were utilized to identify and encode records in which key words appeared. This was both practical and convenient and allowed for analysis on site at the CCC, assuring confidential handling of all records. In addition, there was no disadvantage to using SPSS. That is, SPSS utilizes search parameters and algorithms directly comparable to those used in other statistical software. A total of 226,910 notes were searched using the key words and of those 3558 (1.6%) contained at least one key word. All identified notes were coded to determine whether or not the client described in the note could be conceptualized as a sexual minority. A total of 422 participants (364 male; 58 female) were identified as sexual minorities through the note coding procedures and were included in analyses.

The coding of therapy notes was conducted by two doctoral students in a clinical psychology program and one full-time clinical psychology department faculty member (also a

licensed psychologist). Coders attempted to determine: 1) the applicability of the identified note to the study, 2) the nature of clients' sexual minority status, and 3) client distress regarding sexual minority status.

Coding psychotherapy notes. Therapy notes were deemed applicable to the study if the note contained information regarding the client's sexual minority status (rather than the client describing another person's sexual minority status or discussing other topics related to sexual minority status). Of the 3558 notes identified through the key word search, 687 (19%) of the notes were deemed applicable to the current study through the coding procedures. In sum, of the 226,910 therapy notes only 0.3% (n = 687) indicated sexual minority status. In some cases, participants identified through coding procedures only attended one therapy session and were excluded from the study, given that their therapy outcomes could not be evaluated without a minimum of two completed therapy sessions. Additionally, some of the notes identified as applicable were missing data that was necessary to pair the note with client outcome data (i.e. missing identification numbers, gender, age, initial distress level). Those cases were also excluded from the study.

As noted in the literature review, no single definition or description exists that encompasses sexual minority status. Thus, a secondary goal of coding psychotherapy notes was to determine what descriptions were used to define sexual minority status in the sample. An attempt was made to examine the way in which clients described their sexual minority identity (i.e. gay, lesbian, bisexual, same sex attracted, etc.). Additionally, an examination of whether clients seemed to experience distress directly related to their sexual minority status was also conducted. The term "ego-dystonic" has been used in previous literature to indicate distress regarding sexual minority orientation or same sex attraction (i.e. same sex attractions are

unwanted) while the term "ego-syntonic" has been used to describe sexual attractions or a sexual identity that is consistent with self-perceptions (i.e. experiences of same sex attractions are not viewed as problematic or in conflict with one's sense of self) (American Psychiatric Association, 1980). Unfortunately, descriptions of sexual minority status and client experiences of ego-dystonic and ego-syntonic sexual identity are not reported in the current study given that such information was limited in the therapy notes and in most cases could not be reliably determined.

All three coders participated in group training and group consensus coding procedures in order to establish inter-rater reliability. The coding system used was created specifically for the purposes of the current study and the coding guidelines and training manual can be found in Appendix B. Coders were expected to reach an inter-rater reliability of .80 before coding notes independently. Fleiss' kappa was used to assess the reliability of agreement between all three raters. Fleiss' kappa was employed rather than Cohen's kappa because Cohen's kappa is used to compute the reliability between only two raters (Fleiss, 1971; Gwet, 2008). Additionally, Fleiss' kappa is a more conservative measure of inter-rater reliability because the formula takes into account the probability that raters assign participants to one category (out of all possible categories) by chance rather than by systematic agreement (Fleiss, 1971).

After participating in training regarding coding procedures, all three coders rated 45 therapy notes independently. An inter-rater reliability (k) of .86 was established regarding whether or not the note described sexual minority status (in order to be applicable to the current study). The agreement was considered adequate reliability. Coders were also required to assign participants to a descriptive category regarding their sexual minority identity (i.e. gay, lesbian, bisexual, same sex attraction, etc.). Inter-rater reliability regarding descriptions of minority status was much lower (k = .24) and deemed unacceptable. An even lower inter-rater reliability

(k = .11) was established when notes were coded to determine the level of distress a participant seemed to be experiencing regarding their sexual minority status. This was also considered unacceptable reliability. Coders participated in further training and consensus coding and considerable time was spent in an attempt to improve inter-rater agreement. Following the second training, two of the coders rated an additional 39 notes independently. The second inter-rater reliability analysis regarding the descriptions of sexual minority status yielded an inter-rater agreement (k) of .60. Although the agreement among raters improved in comparison to the previous reliability of .24, the second reliability (k = .60) was still considered too low to be used for the purposes of this research. The second inter-rater reliability analysis regarding the level of distress participants seemed to experience again resulted in an unacceptable level of agreement (k = .22).

Further training regarding inter-rater reliability was not pursued given that the main objective of coding psychotherapy notes was to identify sexual minority clients. In addition, psychotherapy notes typically contained vague or incomplete descriptions regarding sexual minority clients, making the task of classifying participants into categories very difficult. Furthermore, the descriptions used in the therapy notes were the descriptions of the therapists, not necessarily client self-perceptions. Thus, even when specific descriptions of sexual minority status (gay, same sex attracted, bisexual) were agreed upon through coding procedures, conclusions could not be drawn as to whether the client would have agreed with such definitions.

Similarly, attempting to determine whether or not a participant was distressed by sexual minority status was an inferential task based on minimal information rather than self-reports from clients. For example, some therapy notes indicated feelings of guilt and isolation regarding a sexual minority preference. However, for coders to determine whether or not that client was

experiencing ego-dystonic sexual attraction seemed to be a judgment that was based only on inferential subjectivity with low reliability. That is, coders recognized that a sexual minority client may experienced guilt and isolation and found their sexual preference to be congruent with their sense of self. As such, coders reported that the experience of categorizing participants based on ego-dystonic and ego-syntonic categories was not practical in the current archival study. Appendix C contains examples of some of the psychotherapy notes that were coded for the current study. Some notes represented vague and/or incomplete descriptions of client experiences and have been reported in order to demonstrate why inter-rater reliability was so difficult to establish. Such descriptions were very common in the archival database, given that the notes were not completed for the purposes of the current study but rather for routine clinical care, in which more detailed information is not required and not necessary.

Sexual minority and control groups. Three sexual minority groups were evaluated (see Table 6 for a summary of group descriptions). Group 1 consisted of all clients who endorsed sexual orientation/gender identity concerns on the Personal Problems Checklist (PPC) pre-treatment. Group 2 consisted of all clients whose notes were deemed applicable through the note coding procedures. Some clients endorsed the PPC item and were also identified through therapy notes. Group 3 consisted of those clients who endorsed the sexual orientation/gender identity item on the PPC *and* whose therapy notes contained applicable descriptions of sexual minority status. That is, clients included in Group 3 were those clients who met inclusion criteria for Group 1 and Group 2 (Group 3 participants are also in Groups 1 and 2). Overlap also exists between clients in Groups 1 and 2 (i.e. if a client was identified through the PPC item, they could also have been identified through their therapy notes). This was done because Group 3 was originally conceptualized as the group that would be the most certainly defined (i.e., Group 3

represented the group in which there was the greatest level of confidence regarding the identification of sexual minority status) and because it was assumed that sexual minorities who endorsed distress related to their identity or sexual orientation may be different than clients who did not endorse distress on the PPC. Each sexual minority group was also split into male and female subgroups.

Participants in the randomly selected client groups were matched to sexual minority clients on gender only and were otherwise randomly selected from the larger archival database. Since randomly selected control clients were matched to sexual minorities by gender only, their initial level of disturbance, age, and marital status were free to vary. This allowed for an examination of general psychological functioning at intake (as measured by initial OQ-45 scores), age, and marital status which was thought to represent that of clients seen in routine clinical care at the CCC. This group was considered to be reflective of a typical random sample of clients at the CCC on all variables other than male/female ratio.

Table 6

Summary of Minority and Control Groups

Group	Description
Sexual Minority Group 1	Client endorsed Item #33 on the Presenting Problems Checklist
Sexual Minority Group 2	At least one therapy note indicated sexual minority status
Sexual Minority Group 3	Client endorsed Item #33 on the Presenting Problems Checklist *and* at least one therapy note indicated sexual minority status (this group consists of clients in groups 1 and 2)
Randomly Selected Client Control Group	Control group was matched to sexual minority groups by gender only
Matched Control Group	Control group was matched to sexual minority groups by pre-treatment functioning (according to the OQ-45), gender, age, and marital status

Clients in matched control groups were matched to sexual minorities as closely as possible on gender (male, female), marital status (single, married, divorced), age (within 12 months), and initial distress level at the first session of therapy (within 5 points of the total OQ-45 score). Given the large archival database, only four sexual minority patients could not be yoked to a matched control client. The sexual minority clients that were not matched were outliers in the database (for example, an 18 year-old divorced male with an initial OQ score of 92 could not be matched to a control). Thus, the matched control group consisted of 596 clients. In the case that multiple clients matched to a sexual minority client, random assignment was utilized to select one matched control. The archival database did not contain information regarding 0.8% (n = 5) of identified sexual minority clients' marital status. Four of the five sexual minority clients were matched to single control clients while one of the sexual minority clients was matched a married control client (the married control client was the only option available in which the initial OQ score could be matched). Clients included in the control groups did not endorse the PPC item and their therapy notes did not contain any indication of sexual minority status. Thus, it was assumed that any differences in treatment outcome between sexual minority groups and control groups would not be due to differences in pre-treatment mental health functioning, age, gender, and/or marital status.

Although a general summary of the marital status and age of all participants has been presented, a more specific evaluation of marital status and age was also evaluated according to gender of participants and to the subgroups just described. Table 7 provides a summary of marital status and age for male participants according to subgroups and Table 8 provides the same information regarding female participants. The mean age of female clients was slightly younger than the mean age of the male clients.

Table 7

Marital Status and Age of Male Participants by Subgroup

Group	*n*	% Single	% Married	% Divorced	% Unknown	Mean age SD
Males in Sexual Minority Group	457	84.7%	14.0%	0.2%	1.1%	22.41 σ = 2.90
Males in Typical Client Group	457	51.6%	47.3%	0.7%	0.4%	23.99 σ = 3.63
Males in Matched Control Group	455	85.9%	14.1%	0.0%	0.0%	22.38 σ = 2.79
Sexual Minority Group 1: Male	213	85.0%	14.1%	0.5%	0.5%	22.21 σ = 2.95
Typical Client Group 1: Male	213	49.3%	49.3%	1.4%	0.0%	24.30 σ = 3.68
Matched Control Group 1: Male	211	85.8%	14.2%	0.0%	0.0%	22.17 σ = 2.82
Sexual Minority Group 2: Male	364	85.7%	13.2%	0.0%	1.1%	22.33 σ =2.80
Typical Client Group 2: Male	364	52.2%	46.7%	0.5%	0.5%	24.00 σ = 3.70
Matched Control Group 2: Male	363	86.8%	13.2%	0.0%	0.0%	22.31 σ = 2.69
Sexual Minority Group 3: Male	120	88.3%	11.7%	0.0%	0.0%	21.79 σ = 2.61
Typical Client Group 3: Male	120	49.2%	49.2%	1.7%	0.0%	24.55 σ = 3.91
Matched Control Group 3: Male	119	88.2%	11.8%	0.0%	0.0%	21.78 σ = 2.44

Table 8

Marital Status and Age of Female Participants by Subgroup

Group	*n*	% Single	% Married	% Divorced	% Unknown	Mean age SD
Females in Sexual Minority Group	143	79.7%	20.3%	0.0%	0.0%	21.17 σ = 3.58
Females in Typical Client Group	143	62.2%	35.7%	1.4%	0.7%	21.68 σ = 4.57
Females in Matched Control Group	141	80.9%	19.1%	0.0%	0.0%	20.97 σ = 2.67
Sexual Minority Group 1: Female	102	82.4%	17.6%	0.0%	0.0%	21.21 σ = 3.92
Typical Client Group 1: Female	102	61.8%	36.3%	1.0%	1.0%	21.49 σ = 4.0
Matched Control Group 1: Female	100	84.0%	16.0%	0.0%	0.0%	20.93 σ = 2.75
Sexual Minority Group 2: Female	58	75.9%	24.1%	0.0%	0.0%	21.46 σ = 4.48
Typical Client Group 2: Female	58	62.1%	36.2%	1.7%	0.0%	22.22 σ = 5.08
Matched Control Group 2: Female	57	77.2%	22.8%	0.0%	0.0%	20.96 σ = 2.40
Sexual Minority Group 3: Female	17	82.4%	17.6%	0.0%	0.0%	22.43 σ = 7.31
Typical Client Group 3: Female	17	58.8%	41.2%	0.0%	0.0%	22.38 σ = 2.85
Matched Control Group 3: Female	16	87.5%	12.5%	0.0%	0.0%	20.70 σ = 2.23

Measures

The Outcome Questionnaire 45 (OQ-45). Client distress and progress was evaluated using the Outcome Questionnaire (OQ-45; Lambert et al., 2004), a 45-item self-report measure developed for tracking and assessing client outcomes during psychotherapy. Clients were asked

to complete the OQ-45 at each appointment, including intake. The OQ-45 has been validated across a broad range of normal and client populations. Lambert and colleagues (2004) reported an internal consistency of .93 and a 3-week test–retest reliability of .84, values similar to consistency and reliability indexes for other widely used outcome measures. Concurrent validity indexes (*r*s) with the Symptom Checklist-90 (Derogatis, 1997), Beck Depression Inventory (Beck, Steer, & Garbin, 1988), Zung Depression Scale (Zung, 1965), and the State-Trait Anxiety Inventory (Spielberger, 1983) range from .50 to .85. Most importantly, the OQ-45 has demonstrated sensitivity to changes in client functioning during psychotherapy (Vermeersch, Lambert, & Burlingame, 2000; Vermeersch et al., 2004).

OQ items are scored on a 5-point scale (0, *never*, 1, *rarely*, 2, *sometimes*, 3, *frequently*, 4, *almost always*), which yields a total score from 0 to 180. High scores indicate more distress; as clients improve, scores decrease. Although not used in this study, the OQ has three subscales that measure quality of interpersonal relations, social role functioning, and symptom distress.

Lambert and colleagues (2004) reported indexes for assessing the clinical significance of change in OQ scores (see Jacobson & Truax, 1991): The statistical midpoint between OQ-45 scores in clinical and in non-clinical standardization samples is 63.44. When the average of a group's OQ-45 scores decrease from greater than to less than 63.44, the group can be said to have satisfied one of two criteria for clinically significant recovery. Clients whose OQ-45 scores improve or deteriorate by the reliable change index (RCI) of 14 or more points have made a reliable change. To be considered recovered, clients need to enter the ranks of normal functioning and evidence a decrease of at least 14 points in their OQ-45 score. A negative change (increase in score) of 14 or more points combined with a score that falls in the clinical range of functioning at post-treatment is considered deteriorated. Clients who evidence changes

of less than 14 points in either direction are considered unchanged. Support for the validity of the OQ's RCI and clinical significance statistical midpoint cutoff score has been reported by Lunnen and Ogles (1998) and by Bauer, Lambert, and Nielsen (2004).

The general OQ-45 directions instruct clients answer questions according to how they felt during the previous week. Item #8 on the OQ reads, "I have thoughts of ending my life" and was used in order to evaluate frequency of suicidal ideation of participants pre- and post-treatment. This single item was scored using the 5-point Likert scale mentioned above (0, *never;* 1, *rarely;* 2, *sometimes;* 3, *frequently;* 4, *almost always*).

The Presenting Problems Checklist (PPC). The Presenting Problems Checklist (PPC) is a 42-item self-report questionnaire which itemizes self-reported distress related to various problems or concerns. The PPC was developed by the Research Consortium in order to simplify and speed up intake procedures by identifying client concerns within a college population using one comprehensive questionnaire and it is a commonly-used measure in college counseling centers (Draper, Jennings, & Barón, 2003). An exploratory factor analysis yielded a five-factor model of the 42 items and includes academic stress, adjustment to college life, questioning values, emotional distress, and body image (Draper et al., 2003). In addition, Draper et al. (2003) report that the PPC factors show adequate internal consistency with an alpha of .90 for the total scale and with alpha levels of the five factors ranging from .67 to .84. Johnson and Hayes (2003) reported an internal consistency of .77 and inter-item correlations ranging between .01 and .44.

The PPC instructions read, "Indicate the extent to which the problem is currently causing you distress. If a situation is not causing distress, leave the item blank." Five response options are available (none, a little bit, moderate, quite a bit, extreme). The PPC item #33 was used in

the current study in order to identify sexual minority clients. Item #33 reads, "Sexual identity or orientation issues." Any endorsement of distress on the PPC (1-4) other than none (0) was used to identity sexual minority clients. This very broad definition of sexual minority status resulted in a larger sample size but obviously limited the people included in the PPC groups to those who reported feeling distressed by same sex attractions or gender identity, without grouping participants based on the degree to which they experience distress.

Power analysis. It was assumed that a small effect size (d = .20) would be identified with regard to the outcomes of sexual minority and matched control clients given the lack of previous research in this area. A power analysis was conducted and it was estimated that the power of the study would be approximately .30 with a sample size of 100 (Kazdin, 2003). The number of participants included in the study was greater than initially expected; however, few females were identified for inclusion in Group 3 (those who endorsed the PPC item and whose notes indicated sexual minority status; n = 17). Thus, the results observed for this group have been interpreted with caution.

Results

Statistical Analysis

One-way ANOVAs were conducted in order to determine if significant differences existed between the minority groups and their corresponding control groups pre- and post-treatment. The variables examined included the pre-treatment OQ-45 total score, pre-treatment OQ-45 suicidal item score, OQ-45 change score, post-treatment OQ-45 total score, and post-treatment OQ-45 suicidal item score. In addition, effect sizes were calculated in order to examine the magnitude of differences between the minority groups and control groups. Effect sizes have been categorized according to the following criteria: A value less than .33 reflected a

small effect size, values between .33 and .55 reflected a medium effect and a value of .55 or greater indicated a large effect size (Lipsey, 1990). Chi square analyses were also conducted in order to compare the frequency of reported suicidal thoughts among sexual minorities, randomly selected client control groups, and matched control client groups.

As noted above, sexual minority clients were split into groups according to the method by which minority status was identified (PPC item, psychotherapy notes, or both). A total of 457 males were identified as sexual minorities: 213 were identified through the PPC item (Group 1), 364 were identified through psychotherapy notes (Group 2), and 120 endorsed the PPC item and were also identified through note coding procedures (Group 3; note that clients in Group 3 were also in Groups 1 and 2). A total of 143 females were identified as sexual minorities: 102 were identified through the PPC item (Group 1), 58 were identified through psychotherapy notes (Group 2), and 17 females endorsed the PPC item and were also identified through note coding procedures (Group 3).

Research Question 1

Do identified sexual minority clients report higher levels of psychological distress in comparison to randomly selected client control groups (matched on gender only) at intake? Male patients who were identified as sexual minority clients were compared to randomly selected control clients on initial levels of distress (see Table 9). When all sexual minority males were combined, a significant difference was observed between their initial levels of functioning and that of randomly selected client controls, $F(1, 912) = 6.26$, $p = .01$, indicating that sexual minorities reported significantly higher levels of distress pre-treatment than did a random client sample. Further analyses were conducted in order to examine whether differences existed according the specified groups. Males who were identified as sexual minorities through the PPC

Table 9

Male Sexual Minority Clients and Randomly Selected Control Clients: Pre-Treatment Distress Measured by the OQ-45 Total Score

Group	*n*	Pre-OQ total				Significance of difference		
		Mean	SD	T-Score (%ile)		*F*	*p*	*d*
Sexual Minority Males	457	69.43	23.55	62(88)	Pre-Tx OQ	6.26	.01	.17
Random Client Males	457	65.50	23.96	61(86)				
Sexual Minority Group 1: Male	213	70.23	25.30	63(90)	Pre-Tx OQ	4.54	.03	.21
Random Client Group 1: Male	213	65.04	25.02	61(86)				
Sexual Minority Group 2: Male	364	68.10	23.06	62(89)	Pre-Tx OQ	3.11	.08	.13
Random Client Group 2: Male	364	65.05	23.71	61(86)				
Sexual Minority Group 3: Male	120	66.82	25.26	61(86)	Pre-Tx OQ	1.17	.28	.14
Random Client Group 3: Male	120	63.31	25.03	60(84)				

Note. Effect size has been calculated in column *d* and reflects the effect size of the minority group and randomly selected client group pre-treatment. Negative number indicates advantage for minority group. Group 1: identified by PPC item; Group 2: identified through note coding procedures; Group 3: identified by PPC item and note coding procedures. Note that Group 3 consists of 120 clients that were in Group 1. The same 120 clients were also in Group 2. A total of 457 males were in the sexual minority group and 457 males were in the randomly selected control group.

item (Group 1) did evidence overall distress levels that were significantly higher than males chosen from the archival database at random (randomly selected client controls), $F(1, 424) = 4.54$, $p = .03$. However, sexual minority males identified through note coding procedures (Group 2) did not evidence significantly higher distress levels than males in the randomly selected client group, $F(1, 726) = 3.12$, $p = .08$. Similarly, the initial distress levels of minority males who endorsed the PPC item and whose notes indicated sexual minority status (Group 3) were not significantly different than the distress levels of randomly selected clients, $F(1, 238) = 1.17$, $p = .28$).

With an average initial OQ-45 score of 63.31, the randomly selected client Group 3 (the randomly selected clients matched to sexual minorities identified by the PPC and by note coding

procedures) was the only male group with an average pre-treatment OQ-45 score that fell below the OQ-45 clinical cutoff of 63.44. Of the sexual minority male clients, 61.1% (n = 279) entered treatment with a total OQ score that fell within the clinical range of functioning. In comparison, 54% (n = 247) of males in the randomly selected client group entered treatment with an OQ-45 score that fell in the clinical range. As can be seen in Table 9, the OQ-45 total scores of the average male client in these samples ranged from the 84th to 90th percentile of the normal population at the inception of treatment.

Females identified as sexual minority clients were also compared to randomly selected control clients on initial levels of distress (see Table 10). Results indicated that female sexual minorities reported significantly higher levels of distress pre-treatment in comparison to clients in the randomly selected control group, $F(1, 284) = 5.09$, $p = .03$. Furthermore, female clients identified as sexual minorities through the PPC item experienced significantly higher levels of distress pre-treatment than did female clients in the control group, $F(1, 202) = 6.78$, $p = .01$. However, sexual minority females identified through note coding procedures alone did not report significantly different levels of distress than did the controls, $F(1, 114) = 0.24$, $p = .63$. Similarly, females who endorsed the PPC item and whose notes indicated sexual minority status did not significantly differ in initial distress levels when compared to the randomly selected control clients, $F(1, 32) = 0.92$, $p = .34$.

The mean pre-treatment OQ-45 scores for all female client groups fell above the clinical cutoff score of 63.44, indicating that the average female client at the CCC, regardless of sexual minority status, enters therapy with a distress level similar to that of others who enter treatment (i.e., scores of 63.44 or greater on the OQ-45 indicate a distress level similar to people in a

Table 10

Female Sexual Minority Clients and Randomly Selected Control Clients: Pre-Treatment Distress Measured by the OQ-45 Total Score

Group	*n*	Pre-OQ total				Significance of difference		
		Mean	SD	T-Score (%tile)		*F*	*P*	*d*
Sexual Minority Females	143	78.31	22.51	66(94)	Pre-Tx OQ	5.09	.03	.27
Random Client Females	143	72.07	24.27	64(92)				
Sexual Minority Group 1: Female	102	79.83	23.74	67(96)	Pre-Tx OQ	6.78	.01	.36
Random Client Group 1: Female	102	71.00	24.72	63(90)				
Sexual Minority Group 2: Female	58	75.22	17.92	65(93)	Pre-Tx OQ	0.24	.63	.09
Random Client Group 2: Female	58	73.33	23.67	64(92)				
Sexual Minority Group 3: Female	17	76.88	15.85	66(95)	Pre-Tx OQ	0.92	.34	.33
Random Client Group 3: Female	17	69.94	25.22	63(90)				

Note. Effect size has been calculated in column *d* and reflects the effect size of the minority group and randomly selected client group pre-treatment. Negative number indicates advantage for minority group. Group 1: identified by PPC item; Group 2: identified through note coding procedures; Group 3: identified by PPC item and note coding procedures. Note that Group 3 consists of 17 clients that were in Group 1. The same 17 clients were also in Group 2. A total of 143 females were in the sexual minority group and 143 females were in the randomly selected control group.

clinical sample rather than a non-clinical sample). Of the sexual minority female clients, 74.8% (*n* = 107) entered treatment with a total OQ-45 score that fell within the clinical range of functioning while 62.2% (*n* =89) of females in the randomly selected client group entered treatment with an OQ-45 score that fell in the clinical range. As noted in Table 10, the females in these samples entered treatment between the 90th and 96th percentile.

Sexual minorities who reported being distressed about their sexual orientation or sexual identity at intake (i.e. males and females identified by the PPC item) reported significantly higher levels of overall distress than did the random sample of clients. Sexual minority patients who

were identified through therapy notes or through therapy notes and the PPC item did not evidence more distress than a typical patient sample, which indicates that sexual minorities are not necessarily more distressed than other clients who enter treatment. It appears that sexual minorities who reported distress related to sexual minority status were more distressed than the random sample of clients they were compared to, but otherwise sexual minorities reported similar distress levels.

Research Question 2

Do clients identified as sexual minorities report more frequent suicidal ideation when compared to randomly selected client controls and matched control groups at intake? Suicidal ideation was examined pre-treatment using Item #8 of the OQ-45. The frequency of suicidal thoughts (over the course of week preceding the beginning of treatment) among male clients is summarized in Table 11. The frequency of suicidal thoughts among male sexual minority clients, randomly selected control clients, and matched control clients was not significantly different χ^2 (2, N = 1369) = 4.00, p = .14. When the sexual minority male clients were combined, 52.3% (n = 239) reported that they had not experienced suicidal thoughts over the course of the previous week. Similarly, 56.5% (n = 258) of clients in the randomly selected client group and 57.1% (n = 260) of clients in the matched control group reported they had not experienced suicidal thoughts. Additionally, 22.5% of minority males reported experiencing suicidal thoughts "rarely" (n = 103), which was similar to the randomly selected control and matched control client reports. A smaller percentage (15.8%; n = 72) of male sexual minority clients stated they "sometimes" experienced thoughts of suicide and again, the randomly selected control and matched control client groups evidenced similar frequencies. However, 7.7% (n = 35) of sexual minority males noted "frequently" experiencing such thoughts over the last week,

Table 11

Pre-Treatment Suicidal Ideation Measured by Item #8 on the OQ-45: Males

Group	Never	Rarely	Sometimes	Frequently	Almost Always
Sexual Minority Group	52.3% (n = 239)	22.5% (n = 103)	15.8% (n = 72)	7.7% (n = 35)	1.8% (n = 8)
Randomly Selected Client Group	56.5% (n = 258)	23.9% (n = 109)	15.5% (n = 71)	3.1% (n = 14)	1.1% (n = 5)
Matched Control Group	57.1% (n = 260)	23.1% (n = 105)	13.4% (n = 61)	5.3% (n = 24)	1.1% (n = 5)

while half as many (3.1%; n = 14) of the randomly selected client group reported frequent experiences of suicidal ideation and 5.3% (n = 24) of the matched controls reported the same. Finally, 1.8% (n = 8) of male sexual minorities reported they "almost always" considered suicide as did 1.1% (n = 5) of the randomly selected clients and 1.1% (n = 5) of the matched control clients.

Pre-treatment suicidal ideation was examined among the female groups as well and the frequencies of suicidal thoughts are summarized in Table 12. A significant difference was found regarding the frequency of suicidal thoughts among the female groups χ^2 (2, N = 427) = 6.17, p = .05, with sexual minority females reporting more frequent suicidal thoughts in comparison to both of the control groups. While 46.9% (n = 67) of sexual minority females reported that they "never" experienced suicidal thoughts during the week the OQ-45 was administered, 57.3% (n = 82) of clients in the randomly selected client group reported "never" experiencing suicidal thoughts as did 57.4% (n = 81) of the matched control client group. Additionally, 19.6% (n = 28) of minority females reported experiencing suicidal thoughts "rarely" as did 25.9% (n = 37) of the randomly selected female clients and 19.1% (n = 27) of the matched controls. A greater

Table 12

Pre-Treatment Suicidal Ideation Measured by Item #8 on the OQ-45: Females

Group	Never	Rarely	Sometimes	Frequently	Almost Always
Sexual Minority Group	46.9% (n = 67)	19.6% (n = 28)	21.7% (n = 31)	8.4% (n = 12)	3.5% (n = 5)
Randomly Selected Client Group	57.3% (n = 82)	25.9% (n = 37)	12.6% (n = 18)	3.5% (n = 5)	0.7% (n = 1)
Matched Control Group	57.4% (n = 81)	19.1% (n = 27)	16.3% (n = 23)	4.3% (n = 6)	2.8% (n = 4)

percentage of minority clients reported they "sometimes" experienced suicidal thoughts (21.7%; n = 31) in comparison to the randomly selected control clients (12.6%; n = 18) and the matched control clients (16.3%; n = 23). Furthermore, 8.4% (n = 12) of sexual minority females noted "frequently" experiencing such thoughts, while only 3.5% (n = 5) of the randomly selected client group and 4.3% (n = 6) of the matched control group reported frequent experiences of suicidal ideation over the week preceding their first session. Finally, 3.5% (n = 5) of female sexual minorities reported they "almost always" experienced suicidal thoughts while only 0.7% (n = 1) of the randomly selected clients endorsed such frequent thoughts of suicide.

Research Question 3

Do the psychotherapy outcomes of identified sexual minority clients differ from clients in matched control groups (matched on gender, age, initial level of psychological disturbance, and marital status)? Table 13 presents the comparison of post-treatment OQ-45 scores for male sexual minority clients as well as the matched control clients, along with *F, p,* T-Score and *d* values. No significant differences in post-treatment OQ-45 scores were evident when male sexual minority patients in Group 1 were compared with matched controls, $F(1, 420) = 1.11$, p =

Table 13

Psychotherapy Outcomes of Male Clients: Sexual Minorities and Matched Controls

Group	*n*	Post-OQ total				Significance of difference		
		Mean	SD	T-Score (%ile)		*F*	*p*	*d*
Sexual Minority Males	455	60.74	25.28	59(82)	Post-Tx OQ	.032	.86	-.01
Matched Control Males	455	61.04	25.12	59(82)				
Sexual Minority Group 1: Male	211	63.20	26.00	60(84)	Post-Tx OQ	1.11	.29	.10
Matched Control Group 1: Male	211	60.55	25.72	59(82)				
Sexual Minority Group 2: Male	363	59.76	24.48	58(79)	Post-Tx OQ	0.44	.51	-.05
Matched Control Group 2: Male	363	60.98	25.11	59(82)				
Sexual Minority Group 3: Male	119	62.13	24.41	59(82)	Post-Tx OQ	0.42	.52	.08
Matched Control Group 3: Male	119	60.00	26.12	58(79)				

Note. Effect size has been calculated in column *d* and reflects the effect size of the minority group and matched control group post-treatment. Negative number indicates advantage for minority group. Group 1: identified by PPC item; Group 2: identified through note coding procedures; Group 3: identified by PPC item and note coding procedures. Note that Group 3 consists of 119 clients that were in Group 1. The same 119 clients were also in Group 2. A total of 455 males were in the sexual minority group and 455 males were in the matched control group.

.29. Similarly, when male sexual minorities in Group 2 were compared with the matched control group, no significant differences in post-treatment OQ-45 scores were found, $F(1, 724) = 0.44$, $p = .51$. Males in the sexual minority Group 3 were compared to the matched control group and no significant difference in post-treatment mental health functioning was observed, $F(1, 236) = 0.42$, $p = .52$. Finally, when male sexual minorities were compared with randomly selected client controls, no significant differences in post-treatment functioning were observed, $F(1, 908) = .03$, $p = .86$.

The treatment outcomes of sexual minority male clients were comparable to the treatment outcomes of other male clients who enter treatment with similar levels of distress/mental health

functioning. Furthermore, it is notable that all post-treatment group means (sexual minorities as well as matched controls) fell below the OQ-45 clinical cutoff of 63.44 (range 59.76 – 63.20). This indicates that the average male ended treatment with distress levels and mental health functioning comparable to that of the general population (sub-clinical range).

The comparisons of post-treatment OQ-45 scores for female sexual minority clients and matched control clients, along with F, *p*, T-Score, and *d* values are presented in Table 14. No significant differences were found in post-treatment mental health functioning when the sexual minority females were compared to the matched controls. Specifically, sexual minority females in Group 1 were compared to females in the matched control group, and no significant differences in treatment outcome was observed, $F(1, 198) = .70$, $p = .41$. Additionally, when comparisons were made between females in Group 2 and matched control clients, no significant differences were observed, $F(1, 112) = 0.28$, $p = .60$. The post-treatment mental health functioning of females in Group 3 were not significantly different than those of females in the matched control group, $F(1, 30) = 0.39$, $p = .22$. Finally, when female sexual minorities were compared with randomly selected client controls, no significant differences in post-treatment functioning were observed, $F(1, 280) = .71$, $p = .40$.

Sexual minority females did not report greater levels of distress post-treatment than clients in matched control groups. Sexual minority clients appear to benefit from therapy as much as other clients who enter treatment with similar levels of distress/mental health functioning. However, unlike the male clients examined in the study, the average post-treatment distress levels of the female groups examined (sexual minorities as well as matched controls) fell above the OQ-45 clinical cutoff of 63.44 (range 64.50 – 72.85). This indicates that the average female in the sample ended treatment with distress levels comparable to that of a clinical

Table 14

Psychotherapy Outcomes of Female Clients: Sexual Minorities and Matched Controls

Group	*n*	Post-OQ total				Significance of difference		
		Mean	SD	T-Score (%ile)		*F*	*p*	*d*
Sexual Minority Females	141	70.67	24.16	63(90)	Post-Tx OQ	0.71	.40	.10
Matched Control Females	141	68.40	20.78	62(89)				
Sexual Minority Group 1: Female	100	72.85	25.12	64(92)	Post-Tx OQ	0.70	.41	.12
Matched Control Group 1: Female	100	70.26	18.20	63(90)				
Sexual Minority Group 2: Female	57	66.23	20.67	63(90)	Post-Tx OQ	0.28	.60	.10
Matched Control Group 2: Female	57	64.05	23.16	60(84)				
Sexual Minority Group 3: Female	16	68.50	20.30	62(89)	Post-Tx OQ	0.39	.54	.22
Matched Control Group 3: Female	16	64.50	15.45	61(86)				

Note. Effect size has been calculated in column *d* and reflects the effect size of the minority group and matched control group post-treatment. Negative number indicates advantage for minority group. Group 1: identified by PPC item; Group 2: identified through note coding procedures; Group 3: identified by PPC item and note coding procedures. Note that Group 3 consists of 16 clients that were in Group 1. The same 16 clients were also in Group 2. A total of 141 females were in the sexual minority group and 141 females were in the matched control group.

population. All groups were at least one standard deviation away from the mean of the non-patient sample and ended treatment in the 84th to 92nd percentile.

The average male and female sexual minority client improved over the course of treatment. When male and female minorities were compared to clients in matched control groups, no significant differences in treatment outcome were observed. Figure 1 contains the pre- and post-treatment OQ-45 scores of male and female minority clients, randomly selected clients, and matched controls. Although females in all groups began and ended treatment in the clinical range of functioning, their levels of distress decreased over the course of treatment and were comparable among all groups.

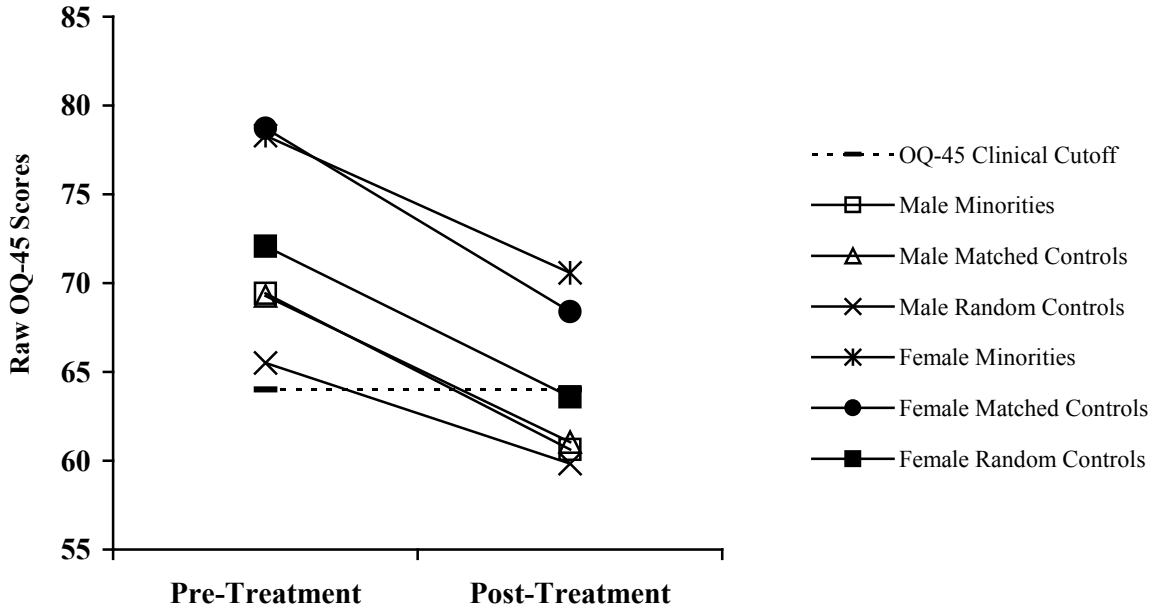

Figure 1. Summary of pre-treatment and post-treatment OQ-45 total scores

Research Question 4

Do clients identified as sexual minorities experience a similar degree of change over the course of treatment as the matched control group clients? In order to calculate changes scores for each client, the post-treatment OQ-45 score was subtracted from the pre-treatment OQ-45 score. The change scores of sexual minority clients were then compared to the change scores of matched control clients (see Table 15). Male and female sexual minority clients in Group 1 evidenced change scores that were not significantly different than those of clients in the matched control groups, $F(1, 420) = 1.45$, $p = .23$; $F(1, 198) = .60$, $p = 44$ respectively. Similarly, the change scores of male and female minorities in Group 2 were not significantly different than change scores of matched controls, $F(1, 724) = .54$, $p = .46$; $F(1, 112) = .33$, $p = .57$. Finally, the comparison of male and female sexual minority clients in Group 3 with matched control clients yielded no significant differences, $F(1, 236) = .53$, $p = .47$; $F(1, 30) = .26$, $p = .62$. These results

indicate that the amount of change sexual minority clients experienced over the course of treatment was similar to that of matched control clients.

Table 15

Change Scores

Group	*n*	OQ change			Significance of difference		
		Mean	SD		*F*	*p*	*d*
Sexual Minority Group 1: Male	211	6.70	21.24	OQ Change	1.45	.23	.12
Matched Control Group 1: Male	211	9.30	23.10				
Sexual Minority Group 1: Female	100	7.72	23.51	OQ Change	.60	.44	.11
Matched Control Group 1: Female	100	10.16	21.11				
Sexual Minority Group 2: Male	363	8.20	21.90	OQ Change	.54	.46	-.05
Matched Control Group 2: Male	363	7.01	21.97				
Sexual Minority Group 2: Female	57	8.88	21.89	OQ Change	.33	.57	.11
Matched Control Group 2: Female	57	11.09	19.29				
Sexual Minority Group 3: Male	119	4.26	20.23	OQ Change	.53	.47	.09
Matched Control Group 3: Male	119	6.34	23.89				
Sexual Minority Group 3: Female	16	8.06	27.43	OQ Change	.26	.62	.18
Matched Control Group 3: Female	16	12.06	15.51				

Note. Effect size has been calculated in column *d* and reflects the effect size of the minority group and matched control group post-treatment. Negative number indicates advantage for minority group. Group 1: identified by PPC item; Group 2: identified through note coding procedures; Group 3: identified by PPC item and note coding procedures. Note that Group 3 consists of clients that were in Group 1. The same clients were also in Group 2. A total of 141 females were in the sexual minority group and the matched control group. A total of 455 males were in the sexual minority group and the matched control group.

Research Question 5

Do sexual minority clients evidence rates of recovery, improvement, treatment deterioration, and no change similarly to matched control clients? As noted above (see Measures), the OQ-45 reliable change index (RCI) was derived based on the model by Jacobson and Truax (Lambert et al., 2004). The reliable change index for the OQ-45 has been defined as a 14 point change from pre-treatment to post-treatment and the OQ-45 clinical cutoff score of

63.44 was utilized as the cut point for non-clinical functioning (Lambert et al., 2004). Clients were considered recovered if their final OQ-45 score passed below the clinical cutoff score of 63.44 and decreased by the RCI criteria of 14 or more points. Clients were considered improved if their final OQ-45 score passed the RCI criteria but not the clinical cutoff, unchanged if the score did not pass either of the criteria and deteriorated if the score passed the RCI criteria in a worsening direction and was above the clinical cutoff of 63.44 (Jacobson & Truax, 1991; Lambert et al., 2004). These values were calculated for the minority and matched control groups and are summarized by percentages in Table 16.

Sexual minority clients and clients in the matched control group experienced similar rates of change in terms of meeting criteria for recovery, improvement, deterioration, and no change as measured by the OQ-45. The randomly selected client group evidenced similar rates of recovery, slightly higher rates of no change, as well as less improvement and less deterioration than the other groups. Matched control clients (who began treatment with distress levels matched to the sexual minority clients) experienced post-treatment improvement similarly to the sexual minority clients. Specifically, 19% of sexual minority clients met criteria for recovery. This indicates that 19% of sexual minority clients began treatment in the clinical range of

Table 16

Percentages of Reliable and Clinically Significant Change

Group	*n*	Recovered	Improved	Deteriorated	Unchanged
Sexual Minority Group	596	19.0% (*n* = 113)	10.5% (n = 63)	10.5% (n = 63)	59.9% (n = 357)
Matched Control Group	596	18.6% (*n* = 111)	10.4% (n = 62)	9.7% (n = 58)	61.2% (n = 365)
Randomly Selected Client Group	600	18.1% (*n* = 109)	7.7% (n = 46)	6.7% (n = 40)	67.5% (n = 405)

functioning according the OQ-45 cutoff, evidenced a decrease of 14 or more points over the course of treatment and ended treatment below the clinical range of functioning (i.e. below a total score of 63.44). Similarly, 18.6% of the matched control group met recovery criteria and 18.1% of the randomly selected control group (matched on gender only) met criteria for recovery. Additionally, 10.5% of clients in the sexual minority group met criteria for improvement (a decrease of 14 points with a total pre- and post-treatment score that fell in the clinical range of functioning) as did 10.4% of the matched control group. Only 7.7% of clients in the randomly selected client group met criteria for improvement, a percentage slightly below that of the sexual minority and matched control groups. While 10.5% of clients in the sexual minority group and 9.7% of the matched control group met criteria for deterioration over the course of treatment, only 6.7% of clients in the randomly selected client group met deterioration criteria.

The majority of clients in each group were unchanged, with 59.9% of clients from the sexual minority group, 61.2% of clients from the matched control group, and 67.5% of clients from the randomly selected client group falling in the unchanged category. This indicates that most client OQ-45 scores did not change by 14 points in either direction. An unchanged score could indicate that clients began and ended treatment in the sub-clinical range of functioning, that clients began and ended treatment in the clinical range of functioning, or that a change occurred with regard to whether their score fell in the clinical or sub-clinical range but that the 14 point RCI criteria was not reached. Table 17 provides information regarding the percentage of clients who fell in the no change category post-treatment. Of the 59.9% of sexual minority clients who fell in the unchanged category, 49.6% evidenced OQ-45 pre- and post-treatment scores that were in the sub-clinical range. Similarly, 46.8% of the matched controls

Table 17

Summary of Unchanged OQ-45 Scores

Group	*n*	First and last OQ in sub-clinical range	First and last OQ in clinical range	RCI criteria not met (no 14 point change)
Sexual Minority Group	357	49.6% (*n* = 177)	41.5% (n = 148)	8.9% (n = 32)
Matched Control Group	365	46.8% (*n* = 171)	44.7% (n = 163)	8.5% (n = 31)
Randomly Selected Client Group	405	52.1% (*n* = 211)	42.5% (n = 172)	5.4% (n = 22)

and 52.1% of the randomly selected controls also had pre- and post-treatment OQ-45 scores that fell in the sub-clinical range (that is, the clients reported less distress than a clinical sample when they began treatment and thus scores could not improve in a clinically meaningful way). Additionally, 41.5% of the unchanged sexual minority clients, 44.7% of the unchanged matched control clients, and 42.5% of the unchanged randomly selected control clients exhibited pre- and post-treatment OQ-45 scores that fell in the clinical range of functioning. Finally, 8.9% of the unchanged sexual minority clients, 8.5% of the unchanged matched control clients, and 5.4% of the unchanged matched control clients evidenced a change from pre- to post-treatment functioning in terms of whether their scores fell in the sub-clinical or clinical range but did not meet the RCI criteria of a14 point change.

Research Question 6

Do clients identified as sexual minorities report higher levels of suicidal ideation in comparison to randomly selected client control groups and matched control groups post-treatment? The frequency of suicidal thoughts among the male sexual minority, randomly selected control, and matched control client groups did not differ significantly at post-treatment,

χ^2 (2, N = 1369) = 5.01, p = .08. When the sexual minority male clients were combined post-treatment, 61.7% (n = 282) reported that they had not experienced suicidal thoughts over the course of the previous week as did 69.1% (n = 316) of clients in the randomly selected client group and 71% (n = 323) of males in the matched control group (see Table 18). Additionally, 24.3% (n = 111) of minority males reported experiencing suicidal thoughts "rarely" as did 21% (n = 96) of the randomly selected male clients, and 19.8% (n = 90) of the matched controls. Of the male sexual minority clients, 10.1% (n = 46) of reported they "sometimes" experienced thoughts of suicide as did 7.4% (n = 34) of the randomly selected clients and 7.0% (n = 32) of the matched control clients. Furthermore, 3.1% (n = 14) of sexual minority males noted "frequently" experiencing suicidal thoughts and similarly, 2.2% (n = 10) of the randomly selected client group and 1.8% (n = 8) of the matched control group reported frequent experiences of suicidal ideation over the same time period. Finally, 0.9% (n = 4) of male sexual minorities reported they "almost always" considered suicide as did 0.2% (n = 1) of the randomly selected clients and 0.4% (n = 2) of the matched control clients.

Table 18

Post-Treatment Suicidal Ideation Measured by Item #8 on the OQ-45: Males

Group	Never	Rarely	Sometimes	Frequently	Almost Always
Sexual Minority Group	61.7% (n = 282)	24.3% (n = 111)	10.1% (n = 46)	3.1% (n = 14)	0.9% (n = 4)
Randomly Selected Client Group	69.1% (n = 316)	21.0% (n = 96)	7.4% (n = 34)	2.2% (n = 10)	0.2% (n = 1)
Matched Control Group	71.0% (n = 323)	19.8% (n = 90)	7.0% (n = 32)	1.8% (n = 8)	0.4% (n = 2)

The frequency of suicidal ideation among females post-treatment was also examined. Results of a chi square indicated that a significant difference in the reported frequency of suicidal thoughts existed between the female groups post-treatment χ^2 (2, N = 427) = 8.07, p = .02. As can be seen in Table 19, while 56.6% (n = 81) of sexual minority females reported that they "never" experienced suicidal thoughts during the week the OQ-45 was administered, a much larger percentage (78.3%; n = 112) of clients in the randomly selected client group (matched by gender only) reported never experiencing suicidal thoughts as did 72.3% (n = 102) of matched control clients. Additionally, 23.8% (n = 34) of minority females reported experiencing suicidal thoughts "rarely" while only 14% (n = 20) of the randomly selected female clients and 18.4% (n = 26) of matched control clients reported the same. Female sexual minority clients reported they "sometimes" experienced suicidal ideation at a rate of more than double that of the randomly selected control and matched control clients (13.3%; n = 19; 6.3%; n = 9; 5.0%, n = 7). Furthermore, 5.6% (n = 8) of sexual minority females noted "frequently" experiencing suicidal thoughts while only 0.7% (n = 1) of the randomly selected client group reported frequent experiences of suicidal ideation over the week preceding their final therapy session. The sexual minority females and matched controls were similar in this category, as 4.3% (n = 6) of the matched controls also reported frequent experiences of suicidal thoughts post-treatment. Finally, 0.7% (n = 1) of female sexual minorities and female randomly selected clients reported they "almost always" experienced suicidal thoughts at the end of treatment while none of the clients in the matched control group reported such frequent thoughts of suicide.

As with the male clients, the average female client post-treatment reported a score of less than one on item #8 of the OQ-45, indicating an average endorsement of "never" to "rarely" experiencing suicidal thoughts during the preceding week. However, differences between sexual

Table 19

Post-Treatment Suicidal Ideation Measured by Item #8 on the OQ-45: Females

Group	Never	Rarely	Sometimes	Frequently	Almost Always
Sexual Minority Group	56.6% (n = 81)	23.8% (n = 34)	13.3% (n = 19)	5.6% (n = 8)	0.7% (n = 1)
Randomly Selected Client Group	78.3% (n = 112)	14.0% (n = 20)	6.3% (n = 9)	0.7% (n = 1)	0.7% (n = 1)
Matched Control Group	72.3% (n = 102)	18.4% (n = 26)	5.0% (n = 7)	4.3% (n = 6)	0.0% (n = 0)

minority females and control clients were evident when the frequencies of suicidal ideation were observed through percentiles, with sexual minority females reporting more frequent experiences of suicidal ideation post-treatment.

Discussion

Although in recent years a push for an increased understanding of multicultural sensitivity and diversity research has occurred within the field of psychology, no published studies could be identified that examined the psychotherapy outcomes of sexual minority clients in a usual care setting, utilizing a standardized measurement of mental health. The current study was conducted in order to examine how sexual minority clients faired in routine treatment in comparison to control groups. This is an important clinical issue given that previous research has suggested that sexual minority people in the general population evidence higher rates of psychopathology and suicidal ideation than heterosexuals (Cochran & Mays, 2009; Fergusson, 2005; Hatzenbuehler et al., 2008; King et al., 2008; Russell et al., 2002; Skegg, 2003; Whitlock et al., 2006) and that some sexual minorities have reported negative experiences during the course of psychotherapy. Furthermore, sexual minorities face social stigma and are an

understudied minority group in the psychological literature (APA, 2009; Bailey, 1999; D'Augelii, 2002; DiStefano, 2008; Szymanski & Kashubeck, 2008; Ueno, 2005). There is a practical and ethical need for clinicians to consider whether or not mental health services can be considered effective in reducing psychological distress in this minority group.

Previous research has indicated that sexual minorities experience significantly higher levels of distress and psychopathology in comparison to the general population but the current study did not investigate these differences. Instead, comparisons were made between groups of patients who participated in routine clinical psychotherapy. Sexual minority clients were identified through two methods: A single item on a counseling concerns checklist or psychotherapy notes. Sexual minority clients were then classified into three groups based upon the identification methods: Group 1 consisted of clients who reported sexual orientation/identity concerns on the PPC, Group 2 consisted of clients whose notes contained a description of their sexual minority status, and Group 3 was made up of clients who were identified through both methods.

Results indicated that sexual minority clients (males and females) who reported pre-treatment distress regarding sexual identity/orientation (Group 1) reported significantly higher levels of overall psychological disturbance on the OQ-45 in comparison to a random sample of clients matched on gender only. Males who endorsed the PPC item entered treatment at the 90th percentile of the non-patient population while females who endorsed the PPC item entered treatment at the 96th percentile of the non-patient population. Sexual minority clients who enter treatment with distress regarding their sexual identity/orientation presented to therapy with increased mental health concerns when compared to heterosexual clients. These findings are consistent with previous research that found sexual minority clients who self-identified as gay,

lesbian, or bisexual pre-treatment rated therapy more beneficial than clients who identified as heterosexual with same sex attractions or reported confusion regarding their sexual orientation (Jones, Botsko, & Gorman, 2003). Given that sexual orientation is a significant part of one's identity and influences not only self-identity but interpersonal and romantic relationships with important persons in one's life, it follows that confusion regarding this aspect of one's identity would lead to distress and increased mental health symptoms. However, it should be noted that although the differences reported met the criterion for statistical significance (Males: $p = .03$; Females: $p = .01$), differences may not represent extreme differences in clinical presentation. For example, the average minority male in Group 1 ($n = 213$) began treatment at the 90th percentile of the non-patient population according to the OQ-45, while the average patient in the randomly selected client control group ($n = 213$) began at the 86th percentile. Similarly, the average minority female in Group ($n = 102$) was at the 96th percentile of the non-patient population and the average female in the randomly selected client group ($n = 102$) began treatment at the 90th percentile.

These results suggest the need for therapists to be mindful of increased distress among clients who report concerns regarding their sexual identity or sexual orientation when they begin treatment. Future research will be needed to highlight the degree to which higher scores within sexual minority groups can be attributed to *specific types of complaints*, as measured by the types of items included in scales such as the OQ-45. For example, to what extent do sexual minorities experience problems with isolation, loneliness, and difficulties in interpersonal relations (as might be expected given social prejudice and internalized stigma regarding their sexual attraction) versus increased symptoms of anxiety and depression? It is recommended that clinicians evaluate and are attuned to social and cultural factors that influence self-identification

of sexual orientation throughout the course of treatment. It is further recommended that therapists facilitate the examination and emotional processing of the influence of patient preference, significant social support systems, and stress related to self-identification of sexual minority status.

Importantly, sexual minority clients who did *not* report confusion or distress regarding their sexual minority status at intake did not evidence significantly different levels of psychological distress than randomly selected clients pre-treatment. These findings suggest that within individuals seeking counseling services, sexual minority clients who did not report concerns regarding sexual orientation did not evidence higher levels of disturbance in relation to their heterosexual counterparts. Thus, it is recommended that future research evaluate whether increased symptoms of mental health concerns among sexual minorities pre-treatment are significantly different from heterosexual clients in treatment-seeking populations.

A single item from the OQ-45 was examined across groups in this study in order to evaluate the frequency of suicidal ideation during the week preceding the beginning of treatment. Differences in the frequencies of self-reported suicidal ideation was evident, with sexual minority females reporting that they *sometimes* (21.7%), *frequently* (8.4%), or *almost always* (3.5%) experienced suicidal thoughts. These reports were greater than the reports of females in both control groups. Female sexual minorities may experience greater frequency of suicidal ideation due to greater stress and/or depression regarding concerns directly related to sexual minority status. While previous research has also indicated sexual minorities experience higher rates of suicidal ideations than those in the general population, these findings add to the existing literature by comparing female sexual minorities who sought treatment to female heterosexuals who also sought treatment for mental health concerns. It would be beneficial for future research

to examine the relationship between suicidal ideation and other variables including interpersonal concerns, social support, and specific symptoms of depression among sexual minority females. Research examining variables related to suicidal ideation could assist in providing clinicians with more specific information that could be helpful in treatment planning and choosing the most appropriate interventions for these clients (i.e. humanistic and interpersonal focus vs. more specific cognitive behavioral therapies).

On average, sexual minority males reported experiencing thoughts related to suicide at similar frequencies as did the control groups. Further research is needed to replicate and further examine these results. It is recommended that clinicians continue to evaluate suicide potential on a case-by-case basis given that the results of this study provide some indication that suicidal ideation is not, on average, a special problem of the sexual minority samples investigated, except in the case of some sexual minority females.

A major purpose of this study was to examine the degree to which sexual minority clients benefited from psychotherapy in relation to control groups. Sexual minority clients were matched to control clients on gender, age, initial distress level, and marital status. No statistically significant differences between sexual minority groups (however defined) and matched control groups were observed in terms of treatment benefit. The average sexual minority male client evidenced post-treatment OQ-45 scores that fell between the 79th and 84th percentile of the non-patient population and the average matched control client score fell between the 79th and 82nd percentile of the non-patient population. Additionally, the average sexual minority female client had post-treatment OQ-45 scores that fell between the 89th and 92nd percentile of the non-patient population. These scores were similar to the mean post-treatment scores of females in the matched control group which fell between the 84th and 90th percentiles.

The amount of change experienced by sexual minority and matched control clients was also comparable. No significant differences were found between the groups, indicating that sexual minority clients reported changing over the course of therapy similarly to other clients who entered treatment with the same distress levels. These findings provide further evidence that sexual minority clients benefit from treatment as much as heterosexual clients.

The majority of psychotherapy outcome research pertaining to sexual minority clients has unfortunately focused on the effectiveness of reparative therapies. Thus, little is known about routine therapeutic interventions and factors that may facilitate increased mental health functioning among this minority group. It has been noted that a strong therapeutic alliance is related to more positive psychotherapy outcomes among sexual minority clients (Berckel & Goldfriend, 2006). Similarly, decades of psychotherapy research has demonstrated the importance of a quality therapeutic relationship (Lambert & Ogles, 2004; Safran and Muran, 2000) and it is recommended that future research regarding sexual minority clients examine specific interventions and process variables that may account for positive treatment outcomes in routine clinical care settings. As emphasized by APA (2009), client centered approaches are assumed to be the most ethical and helpful approach when providing treatment to sexual minority clients. It is hypothesized that among clients in the current sample client centered approaches such as unconditional positive regard, common factors, and quality therapeutic relationships account for positive treatment outcomes; however, future research is needed to elucidate the specific factors that are related to these outcomes.

With regard to clinically significant change, 29.5% percent of sexual minority clients left treatment meeting criteria for "recovered" or "improved" according to the Jacobson and Truax, (1991) formula. Similarly, 29% of matched control group clients had the same outcome.

Deterioration rates were also similar across groups (sexual minority clients = 10.5%; controls = 9.7%) as were rates of no change (sexual minority clients = 59.9%; controls = 61.2%). Although the sexual minority and matched control groups evidenced similar rates of recovery, improvement, deterioration, and no change, the randomly selected client group evidenced slightly different rates of improvement, deterioration, and no change. These findings are consistent with previous research that has indicated patients with higher levels of pre-treatment distress experience increased rates of deterioration (Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001). That is, although rates of deterioration were higher in the sexual minority group than the randomly selected client group, these are most likely related to initial distress levels rather than to sexual minority status (given that the matched control groups evidenced similar deterioration rates). This distinction is important: Without a control group matched to initial distress levels, it may appear that sexual minority clients deteriorate or fair worse in treatment compared to a random sample. However, the rates of deterioration among the sexual minority group and matched control group are similar and indicate that higher pre-treatment distress levels are a confounding factor. Furthermore, the rates of change found in this study are similar to rates found in other routine care settings (Hansen, Lambert & Forman 2002).

Results indicate that sexual minority clients benefit from therapeutic intervention as much as heterosexual clients seen in routine clinical care when initial levels of distress are matched. These findings are hopeful and exciting because they indicate that the gains sexual minority clients experienced in therapy are comparable to gains made by heterosexual clients, which suggests that sexual minority clients were not harmed during the course of treatment. Given the social stigma and discrimination that sexual minority clients face coupled with reports that some sexual minority clients have experienced harm during the course of interventions, the

finding that sexual minority clients fair as well as heterosexual clients in treatment is a significant contribution to the literature. For those who have been concerned with negative outcomes of sexual minority clients, these results can provide some relief as to the helpfulness of routine clinical care. Furthermore, the sample consisted of a majority of clients (over 95%) who reported affiliation with a Christian religion. While religious affiliation may have influenced client self-perceptions of sexual minority status and identity, outcome data indicates that sexual minority clients who ascribe to a Christian faith experienced as much benefit from routine treatment as did other clients.

As noted previously, Botsko and Gorman (2003) reported that in a retrospective study, sexual minority clients who self-identified as gay, lesbian, or bisexual rated therapy as being significantly more beneficial in comparison to clients who self-identified as heterosexual or reported confusion regarding their sexual orientation. Findings of this study indicate that sexual minority clients who reported distress regarding their sexual orientation/identity pre-treatment also reported increased mental health concerns overall. In turn, higher pre-treatment distress levels were shown to result in higher rates of deterioration post-treatment. It appears that clients who experience internal struggles related to sexual minority status experience increased distress, and thus experience a more difficult course of treatment than a random selection of clients. The findings of the current study do not indicate that sexual minority status is in itself a cause of distress. That is, increased mental health concerns pre-treatment are likely due to several factors including interpersonal concerns, social support, and stress; however, these factors were not examined in the current study. Results do indicate that sexual minorities benefit from treatment as much as heterosexual clients with similar pre-treatment functioning. Interventions regarding important aspects of functioning (client self-acceptance, social support, identity development)

are thought to have been helpful to sexual minority clients in this sample; however, the current study was not able to evaluate these specific factors. Thus, it is recommended that future research examine the extent to which specific therapeutic factors (found in routine clinical care settings) influence outcomes of sexual minority clients.

Although no significant differences were found between sexual minority and matched control group post-treatment distress scores, differences between the males and females in the samples were observed. The average male in the sexual minority group as well as the average male in the matched control group ended treatment with OQ-45 scores that fell in the sub-clinical range (i.e. scores comparable to the general population; Lambert, et al 2004). However, the average female in the sexual minority and matched control groups reported post-treatment distress levels that fell within the clinical range. Mean post-treatment scores for female clients ranged from 64.05 to 72.85 (utilizing the clinical cutoff score of 63.44). Given the results of the current study, it is recommended that special attention be paid to female clients who enter treatment with high distress levels in order to monitor change over time and make adjustments throughout the course of treatment if necessary.

Finally, results indicated that sexual minority males reported similar frequencies of suicidal thoughts as did clients in control groups post-treatment. As noted above, it is necessary for clinicians to attend to suicidal ideation in all clients at pre-treatment as well as throughout the course of treatment. Sexual minority females reported more frequent thoughts of suicide post-treatment when compared to control client groups. Despite improving in treatment, sexual minority females continued to report the most frequent experiences of suicidal thoughts. This may be evidence of the lasting and ongoing effects of stigma associated with sexual minority status and the need to extend treatment length for sexual minority females, in particular. It seems

that more can be done for these individuals in routine clinical care. It should be pointed out here however, that extension of treatment is important for all individuals who have thoughts of ending their life, not only to female minority clients.

This study evaluated sexual minority psychotherapy outcomes by utilizing a valid and reliable measure of change over the course of treatment. Results support the notion that some sexual minority clients are more distressed than other clients before treatment, but these findings help to clarify an important detail: clients who reported being distressed by their sexual orientation or sexual identity were the clients that reported significantly higher distress levels. Thus, to assume that all or even most sexual minorities who enter treatment are more disturbed or evidence more severe pathology than other clients is erroneous. Furthermore, results indicated that sexual minority clients fair just as well in treatment as do clients who demonstrate comparable pre-treatment distress levels. This is an encouraging finding which may allude to the importance of common therapeutic factors such as the importance of a quality therapeutic relationship and client centered approaches. Sexual minority clients in this sample experienced as positive therapy outcomes after participating in routine clinical care as did other clients when pre-treatment distress levels were matched.

Study Limitations and Future Directions

Although the current study has offered important information regarding the experiences of sexual minority clients in treatment as usual, limitations of the study should also be noted (Cooke and Campbell, 1979; Kazdin, 2003). Namely, the study utilized archival data in order to identify and evaluate the experiences of sexual minorities in routine clinical care. Given that valuable information was missing from the archival database (including clients' self-identification of sexual minority status, presenting problem(s), treatment goals, information

regarding social support, experiences of social alienation/social stigma, self-acceptance, details regarding specific interventions provided, details regarding the impact of religious beliefs on sexual minority status, as well as process variables), results of the study require replication and controlled, prospective studies are very much needed.

The utilization of an archival dataset limited the way in which sexual minority clients could be identified. Rather than relying on client self-reports of sexual minority status, archival data was examined and provided limited information regarding sexual minority status. The method of identifying sexual minority clients consisted of examining a single item and through coding therapy notes. The single item (PPC) allowed for the identification of clients who reported feeling distress related to sexual identity or sexual orientation pre-treatment. This identification procedure was convenient as well as effective. However, it was recognized that utilizing a single item to identify a minority sample was not ideal and could result in inaccurate identification of sexual minorities. Furthermore, the identification of clients who reported distress regarding sexual minority status was problematic since many sexual minorities do not experience distress or identity confusion with regard to sexual minority status. Thus, an attempt was made to identify sexual minorities who did not report distress regarding their sexual identity/orientation. Such clients were identified through coding therapy notes.

The process of coding psychotherapy notes in order to identify sexual minority clients was generally successful. That is, raters were able to establish high inter-rater reliability with regard to whether or not the client could be considered a sexual minority. However, in comparison to the single item method, note coding procedures were time consuming and required several training meetings as well as inter-rater reliability checks. An attempt was made to glean more information from the psychotherapy notes with regard to client self-reported

identification of sexual minority status (i.e. gay, bisexual, lesbian, same sex attracted, questioning sexual orientation, etc.) and distress related to sexual minority status (ego-dystonic/syntonic experiences). Obtaining such detailed information from therapy notes was not possible. The psychotherapy notes contained information that would be expected in routine clinical care and were not recorded for the purposes of the study, which resulted in notes containing vague descriptions of client self-identification with sexual minority status as well as vague descriptions of client experiences of distress related directly to their sexual minority status. Additionally, the therapy notes were based upon therapist perspectives rather than client perspectives. Thus, when coding therapy notes it was often unclear to the raters whether therapeutic foci regarding sexual minority issues (in terms of social support, family support, identity development, relationships, religious conflicts) were based on client or therapist perceptions.

Given the importance of and need for increased research regarding sexual minority clients and considering the value that archival data can provide, it is suggested that additional archival studies be conducted if it is possible for researchers to retrospectively identify sexual minority status as well as pre- and post-treatment client functioning. Although the use of the single item in the current study provided limited information, it also resulted in useful examinations between groups of sexual minority clients who reported distress regarding sexual identity/orientation. Furthermore, although coding psychotherapy notes did not yield reliable information regarding details of patient sexual minority experiences, coding notes did allow for the identification of a large sample of sexual minority clients and in that aspect was a useful and replicable procedure. Given these limitations, it is strongly recommended that future research be conducted regarding psychotherapy outcomes of sexual minority clients seen in routine clinical

care and that an effort be made to assess whether clients report distress related to their sexual orientation pre-treatment.

The findings of the current study provided evidence that sexual minority clients experienced therapeutic benefits comparable to heterosexual clients who begin treatment with similar distress levels. Replications of the current study are recommended and prospective studies could provide additional and more detailed information. Given the archival nature of the study, it was not possible to examine why clients entered treatment. Perhaps sexual minority clients were more likely to enter treatment for reasons related to sexual minority status (distress regarding sexual minority status, identity confusion, social support, etc.). It is also possible that sexual minority clients entered treatment for common concerns evidenced by many clients (mood disorders, adjustment issues, relationship problems) but this information could not be examined in the current study. Future research efforts could examine the degree to which sexual minorities evidence similarities and differences in comparison to random samples of clients and when compared to other clients matched for initial distress levels.

Furthermore, more detailed examinations of specific process variables that influence positive outcomes for sexual minority clients are needed. It was not possible to gather information regarding which specific aspects of psychotherapy patients found helpful or unhelpful in the current study. Additionally, the exact therapeutic interventions utilized in the current study (i.e. positive regard, focus on relationship, focus on symptom reduction, efforts to increase social support) as well as client treatment goals (i.e. self-acceptance of sexual minority status, increasing social support, decreasing depressed mood/anxiety) are unknown. Previous studies have examined client self-reports after completing therapy and a prospective study with the ability to track patient progress using standardized measures while simultaneously collecting

patient reports regarding the helpfulness of specific therapeutic factors would be a significant contribution to literature.

Regardless of the inherent limitations of this archival study, findings provided evidence that sexual minority clients experience treatment outcomes that are equivalent to control group cohorts. However, sexual minorities who reported being distressed by their sexual orientation or sexual identity at the outset of treatment were more distressed than randomly selected clients. Furthermore, sexual minority females reported higher frequencies of suicidal thoughts pre- and post-treatment. The degree to which these results are entirely related to sexual minority status needs further investigation.

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Appendix A. Summary of Prevalence Rates of Psychological Distress

Table 1

Sexual Minority and Non-Sexual Minority Rates of Suicide Attempts, Suicidal Ideation, and Self-Harm (Studies Reported in King et al., 2008)

Study	Sampling method	GB %	Non GB %	Study	Sampling method	LB %	Non LB %
Male suicide attempts: lifetime prevalence				Female suicide attempts: lifetime prevalence			
Bagley 1997	Random	6.10%	0.45%	Matthews 2002	Non-random	16.55%	7.89%
Remafedi 1998	Unknown	28.09%	4.17%	Remafedi 1998	Unknown	20.48%	14.48%
Cochran 2000	Non-random	19.23%	3.61%	Cochran 2000	Non-random	19.23%	3.61%
Mathy 2002	Non-random	8.31%	3.80%	Mathy 2002	Non-random	17.08%	9.09%
Skegg 2003	Non-random	16.98%	6.09%	Skegg 2003	Non-random	12.61%	9.33%
	Combined n	4145	30129		Combined n	1883	6266
Male suicidal ideation: lifetime prevalence				Female suicidal ideation: lifetime prevalence			
Cochran 2000	Non-random	41.03%	17.21%	Cochran 2000	Non-random	35.02%	20.40%
Mathy 2002	Non-random	22.59%	12.40%	Mathy 2002	Non-random	50.91%	37.28%
	Combined n	3832	28866		Combined n	1598	5778
Male deliberate self-harm: lifetime prevalence				Female deliberate self-harm: lifetime prevalence			
King 2003	Non-random	53.55%	39.76%	King 2003	Non-random	56.02%	45.88%
Skegg 2003	Non-random	30.19%	7.26%	Skegg 2003	Non-random	21.01%	12.54%
	Combined n	363	593		Combined n	360	537

Note. GB = gay or bisexual males; LB = lesbian or bisexual females.

Table 2

Sexual Minority and Non-Sexual Minority Rates of Depression and Anxiety (Studies Reported in King et al., 2008)

Study	Sampling method	GB %	Non GB %	Study	Sampling method	LB %	Non LB %
Male depression: lifetime prevalence				Female depression: lifetime prevalence			
Cochran 2000	Non-random	15.38%	6.50%	n/a	n/a	n/a	n/a
Sandfort 2001	Random	29.27%	10.91 %	n/a	n/a	n/a	n/a
	Combined n	160	6010		Combined n	n/a	n/a
Male anxiety: 12 month prevalence				Female anxiety: 12 month prevalence			
Cochran 2000	Non-random	3.06%	1.61%	Cochran 2000	Non-random	3.13%	2.61%
Gilman 2001	Random	14.86%	11.60 %	Gilman 2001	Random	39.22%	22.38%
Sandfort 2001	Random	19.51%	7.58%	Sandfort 2001	Random	16.28%	16.41%
Cochran 2003	Random	2.70%	1.78%	Cochran 2003	Random	13.51%	3.80%
	Combined n	291	10267		Combined n	227	12948

Note. GB = gay or bisexual males; LB = lesbian or bisexual females; n/a = no data included in King et al., 2008.

Table 3

Sexual Minority and Non-Sexual Minority Rates of Alcohol and Drug Dependence (Studies Reported in King et al., 2008)

Study	Sampling Method	GB %	Non GB %
Male alcohol dependence: 12 month prevalence			
Cochran 2000	Non-random	10.20%	7.60%
Gilman 2001	Random	12.16%	11.60%
Sandfort 2001	Random	10.98%	5.51%
Cochran 2003	Random	8.11%	5.57%
Drabble 2005	Random	10.26%	5.60%
	Combined n	408	12408
Male drug dependence: 12 month prevalence			
Cochran 2000	Non-random	6.12%	2.80%
Gilman 2001	Random	9.46%	3.98%
Cochran 2003	Random	8.11%	2.66%
	Combined n	209	7471

Study	Sampling method	LB %	Non LB %
Female alcohol dependence: 12 month prevalence			
Cochran 2000	Non-random	7.29%	2.19%
Gilman 2001	Random	15.69%	4.08%
Sandfort 2001	Random	6.98%	1.01%
Cochran 2003	Random	10.81%	3.43%
Drabble 2005	Random	10.17%	2.13%
	Combined n	345	15028
Women drug dependence: 12 month prevalence			
Cochran 2000	Non-random	5.21%	1.30%
Gilman 2001	Random	3.92%	2.10%
Cochran 2003	Random	5.41%	1.50%
Sandfort 2001	Random	2.33%	0.39%
	Combined n	227	12948

Note. GB = gay or bisexual males; LB = lesbian or bisexual females.

Appendix B. Psychotherapy Note Coding Procedures

Coding procedures are based on the contents of psychotherapy notes rather than assumptions about clients. That is, when coding notes, *do not assume information that is not specifically included in the psychotherapy notes*.

1) Purposes of Coding Notes:
    a. To identify sexual minority clients
        i. Does the note contain a reference to the client's sexual minority status that is applicable to the study?
    b. To determine the specific nature of sexual minority status and sexual attractions
        i. How can the client's sexual minority status be described, based on the information given in the psychotherapy note?
    c. To determine whether the client experiences distress directly related to their sexual attractions or gender identity
        i. Does the psychotherapy note indicate that the client is distressed by their sexual attraction(s), sexual orientation, and/or gender identity?
2) Procedures and Definitions of Terms:
    a. Applicability of Sexual Minority Status: If a "key word" has been identified in the psychotherapy note and it applies directly to the client, the client can be categorized as a sexual minority.
        i. A key word search will identify therapy notes of potential sexual minority clients.
        ii. Read the note, attending to the key word that was found in the key word search.

iii. Determine whether the key word is applicable. That is, does the key word describe the client the note is written for or is the key word being used in a different context that is not applicable to the study.

b. Nature of Sexual Minority Status: If the psychotherapy note describes the client in specific terms (i.e. homosexual, questioning orientation, etc.) or if the note clearly indicates a client could fall into one of the categories listed below, this should be coded. Record all applicable terms (there may be more than one).

i. Definition of Terms

1. *Same sex attraction:* Note clearly indicates that client is attracted to same sex people in a sexual manner. Note contains no indication that the client identifies themselves as homosexual, lesbian, gay, or bisexual. Client may identify themselves as heterosexual.
2. *Homosexual:* Note clearly indicates that the client identifies themselves as homosexual
3. *Gay, or lesbian*: Note clearly indicates that the client identifies themselves as gay or lesbian.
4. *Bisexual:* Note clearly indicates that the client identifies themselves as bisexual.
5. *Gender identity confusion:* The note indicates that the client is confused or conflicted regarding whether they feel male or female and/or feel that they have male or female qualities or attractions inconsistent with the sex they were born.

6. *Transsexual or transgendered:* The note indicates that the client feels they are a female but was born male or feels they are a male but was born a female, or the note indicates the client received a sex change.
7. *Unknown:* The therapy note does not indicate the specific nature of the client's same sex attraction or is too vague to categorize the client into a category.

c. Distress Related to Sexual Minority Status:
   i. Ego-dystonic: The note indicates that the client is experiencing distress related to their sexual minority status or confusion regarding sexual identity.
   ii. Ego-syntonic: The note clearly indicates that the client does not experience distress related to sexual minority issues or sexual identity.
   iii. Unknown: Nature of client distress is not known given the information in the note.

Summary of Terms, Explanations of Terms, Codes, and Definitions of Codes

Term	Explanation of Term	Codes	Definition of Codes
Applicability	Whether or not the note is applicable to the proposed study.	1	Applicable
		2	Not Applicable
Description	Description of the type of sexual minority issue the client reported. If the information is not available in the note, list unknown.	1	Same Sex Attraction (SSA)
		2	Homosexual, Gay, or Lesbian
		3	Bisexual
		4	Gender Identity Confusion
		5	Transgender or Transsexual
		6	Unknown
Distress	Evaluation of whether the client is experiencing distress regarding sexual minority issues.	1	Ego-dystonic: distress regarding one's sexual orientation or sexual attractions
		2	Ego-syntonic: identification of sexual orientation or sexual identity that is consistent with one's views of one's self
		3	Unknown

Appendix C. Examples of Psychotherapy Notes

Notes coded as not applicable to the study (not sexual minority clients):

Note 1: I asked NAME if she felt like she took on this role a lot and she said she did--she was the first to know about her best friend in high school being gay, the first to know her other friend was pregnant, etc…

Note 2: Discussed how he is feeling more free and fear in reading about SSA issues--he had been so rigid about this, and is feeling less so now. We eventually talked about his mother, who has been a "nonpresence" in our therapy discussions, and this brought up many issues…

Note 3: NAME said his obsessive thinking began when he was young. He behaved in submissive and emotional ways that he assumed were feminine and mothering so he obsessively worried about homosexuality. He even wore makeup to "look perfect." Now he worries about sexuality and links sexual feelings with objects (he calls them "weird sexual things")--he "almost likes it." He said he has "lots of thoughts, worries, or fears that come into his mind that just 'stick'."

Notes coded as being applicable to the study (identified sexual minority clients), descriptions of sexual minority status and distress pertaining to sexual minority status unknown or coded with poor reliability:

Note 1: NAME indicates that he has felt different for as long as he can remember. He states that he first felt the strong attraction to men when he was entering junior high. He reports that he became adept at acting like the "cool" people in his school and that others wouldn't guess that he is attracted to men. He states that he has little or no attraction to women. NAME indicates that he had some sexual encounters when he was 16 with a man he met over the internet, at 18 with a gay boy in his high school, and again before coming here to school. He indicates that the latter encounter happened as a result of the internet as well.

Note 2: NAME discussed that she has felt sexually attracted to women for most of her life. She states that she has also been attracted to men. However, she revealed this to her boyfriend NAME. Since that time her boyfriend has pressed NAME to join him in a threesome, even though NAME has repeatedly said she doesn't want this. We discussed the lack of respect that her boyfriend demonstrates when he pressures her for this type of interaction…

Notes coded as being applicable to the study (identified sexual minority clients), descriptions of sexual minority status unknown or coded with poor reliability, no distress pertaining to sexual minority status:

Note 1: One theme that he kept returning to was his frustration with himself that he doesn't trust that he is ok as a person or that his abilities are worthwhile. These fears play out in all areas of his life, including school work (he is currently procrastinating a very important assignment) and interpersonal relationships. He shared that he has been obsessing about the fact that he doesn't feel like a man as he has realized that his penis is smaller than average. He was very

uncomfortable discussing this and was open about these feelings. He is also concerned about the fact that he obsesses so much about a gay relationship that he has been in. They have agreed to move on with their lives, but both partners seem ambivalent as they keep coming back to each other. He expressed deep love for this partner and sadness that it does not seem it can work out.

Note 2: NAME indicates that he tends to be emotionally dependent. He states that his dependency tends to be with men of his father's age and that he has become close to some men this age. He states that these are non-sexual relationships. He indicates that he is currently in a relationship with a man who is about 58 and married. NAME reports that this man assured him that he would not leave him as another man had done. NAME states that he has overwhelmed this man from time to time by emailing at night when he is feeling suicidal and unhappy. He states that this man has remained his friend and has not pushed him away.

Note 3: This was the last session for NAME before he leaves for his internship next semester. We talked about his experience of being openly gay off campus. He indicated that he tends to keep his distance and not form intimate relationships outside of his "gay" group. He also stated that his stance towards BYU has softened as he has become more aware of his surroundings, finding that people here in general are more open and accepting than he once believed. If he returns for future sessions in the winter, he indicated that it may be helpful to discuss intimacy issues and being "real" around others.

Notes coded as being applicable to the study (identified sexual minority clients), described as "same sex attraction," with some degree of distress regarding sexual minority status:

Note 1: NAME feels like he is handling anxieties well; continued to discuss female relationships, and managing SSA feelings.

Note 2: He presented on self-referral to the Counseling center with concerns of same-sex attraction and pornography/masturbation. NAME reported having homosexual attractions beginning as an early adult. He reported starting to look at porn in early adolescence and that it evolved into looking at gay porn. He reported being more "caught up" in same-sex attraction as he looked at gay porn more often. He reported that he tries to date women but it never works out and that he feels pushed into looking at dating other men. He reported feeling attraction for both sexes. He further reported that same-sex attraction is more of a concern to him than his p&m. He reported no family history of mental illness or any past drug/alcohol abuse. He reported that he has two uncles that are gay and one that recently died of AIDS. He reported that these constant struggles with SSA and m&p lead him to depressed/irritable moods and he becomes withdrawn. He reported contemplating suicide every once in a while, just so that his problems would go away. He further reported working with several religious leaders on this issue over the past four years. NAME reported knowing that there is "no fix" to his condition and wanted to know how he could better cope with these struggles. He expressed that he is particularly worried about returning home after graduation where the opportunities to live a gay lifestyle will be more readily available.

Note 3: NAME presented with concerns his sexual orientation. He reported that he went on an internship over the summer. While he was there he frequented gay clubs and ended up having a

couple of "sexual encounters" with two gay men. He reported that he keeps going back and forth whether to live a gay lifestyle or continue to "fight" his same sex attraction. He shared how he felt accepted and wanted for the first time in his life even though he knew it was a couple of sexual encounters that didn't have much substance. NAME said that his family doesn't know about his struggles. he said that they would likely turn their backs on him if he disclosed his sexual orientation. He said that he has had a couple of gay friends in the past who chose to live a gay lifestyle and his parents were very critical of them.