

UNIVERSITY OF CALIFORNIA

Santa Barbara

Psychotherapeutic Approaches to Sexual Minority Internalized Stigma

A dissertation submitted in partial satisfaction of the
requirements for the degree of Doctor of Philosophy
in Counseling, Clinical, and School Psychology

by

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September 2019

The dissertation of Krishna Kary is approved.

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June 2019

Psychotherapeutic Approaches to Sexual Minority Internalized Stigma

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ABSTRACT

Psychotherapeutic Approaches to Sexual Minority Internalized Stigma

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Krishna Kary

Sexual minority people experience internalized stigma (IS) as a result of ongoing exposure to external stigma in their environments. Existing literature on IS has demonstrated the detrimental effects IS has on sexual minority people through associated mental health disparities. This study sought to explore current recommendations being made in the literature with regard to addressing IS in psychotherapy. Nine participant clinicians who identified as experienced LGBTQ-affirming practitioners were interviewed regarding their approach to addressing IS through a client case example. CQR yielded themes across the data set that included: clinician's general conceptualization of IS, IS assessment strategies, specific interventions targeting IS, associated outcomes, and perceived barriers to treating IS in psychotherapy, independent of the case example. Results from this study expand upon the existing literature base by providing new context for existing and novel recommendations and considerations for treating IS in psychotherapy. Findings also highlighted opportunities for additional research, particularly psychotherapy process and outcome research, that will likely aid future clinical practice.

Keywords: Internalized stigma, internalized homophobia, internalized heterosexism, sexual minority, LGBTQ-affirming, psychotherapy, consensual qualitative research

CURRICULUM VITAE
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EDUCATION

Doctor of Philosophy in Counseling, Clinical, & School Psychology
Counseling Psychology Specialization September 2014 – September 2019
University of California, Santa Barbara (APA Accredited)
- Advisor: Tania Israel, PhD
- Dissertation: “*Psychotherapeutic approaches to sexual minority internalized stigma*”
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Master of Arts in Counseling Psychology September 2008 – June 2011
Santa Clara University, Santa Clara, CA
- Advisor: Teri Quatman, PhD

Bachelor of Science in Psychology September 2006 – August 2008
Santa Clara University, Santa Clara, CA
- Cum Laude

Mendocino College September 2004 – June 2006
Ukiah, CA
- Magna Cum Laude

CLINICAL EXPERIENCE

Doctoral Intern August 2018 – July 2019
Counseling & Psychological Services
University of California, Los Angeles (APA Accredited)
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- Group Supervisor: Michael Friedmann, PhD
- **Clinical Services:**

- Providing time-limited evidence-based therapy to diverse student population; crisis walk-in triage; risk assessment; case management; consultation with psychiatry, physicians, campus case managers, and other service providers on and off-campus
- Conducting 2-3 clinical intakes per week; 1 ADHD assessment per month
- Co-facilitating Gender Identity Spectrum group (Fall 2018): support group for questioning, transgender, and non-binary students

- **Supervision & Training:**
 - Providing one hour of weekly individual supervision to doctoral level practicum student
 - Participating in training committee to improve and restructure doctoral internship interview process
- **LGBTQ Outreach & Prevention:**
 - Holding weekly drop-in hours at campus LGBTQ center providing clinical services, referrals, and light case management to LGBTQ questioning, identified, and allied students
 - Transgender Wellness Team member: coordinating care within a multidisciplinary team and engaging in campus advocacy for transgender and non-binary student population
 - Created transgender and non-binary student resource guide
 - Collaborating with campus partners to conduct review of campus signage and clinical and administrative documents to ensure they are transgender and non-binary inclusive and affirming
 - UC-wide Transgender Care Team: monthly consultation with other UC representatives providing consultation on policy and advocacy related to coordination of care for transgender and non-binary students

Practicum Counselor September 2017 – June 2018
Pacific Pride Foundation – LGBTQ+ Counseling Center
Santa Barbara, CA

- Supervisor: Bren Fraser, LMFT
- Provided psychotherapy to 5 clients per week
- Monitored intake line and responded to inquiries via email and phone
- Conducted intakes with prospective adolescent, adult, couple, and family clients
- Aided in community outreach efforts via tabling and coordination of events

Practicum Counselor July 2017 – June 2018
New Beginnings Counseling Center, Santa Barbara, CA

- Supervisor: Susan Wax, PhD
- Provided long-term psychotherapy to 5-7 individual clients and 1 couple per week
- Providing short-term (5 session limit) skills-based counseling to 1-2 clients per week in partnership with the Housing Authority of Santa Barbara
- Responded to crisis needs as necessary with the support of clinical supervisor
- Conducted intakes with 1-2 prospective clients per week
- Conducted psychoeducation and skills groups on a rotating basis (e.g., Women’s Empowerment, Mindfulness)
- Completed development trainings (e.g., assessment writing, mindful eating, couples counseling techniques) as they are offered throughout duration of the practicum
- Outreached to community members via tabling and psychoeducation presentations

Advanced Practicum Counselor October, 2016 – June 2017

Counseling & Psychological Services, University of California, Santa Barbara

- Supervisor: Daniel Zamir, PsyD (individual & group co-leader)
- Provided short and long-term weekly counseling to 10 undergraduate and graduate students per week
- Reviewed and utilized scores from the Counseling Center Assessment of Psychological Symptoms (CCAPS) instruments to monitor progression of treatment
- Co-led a 6-week Mindfulness group with 11 members
- Conducted 1 scheduled intake per week and completed on-call intakes as needed
- Presented intakes at weekly case assignment team meetings, provided referral options and completed follow-up support as needed
- Sought out additional consultation for crisis management
- Participated in weekly Multicultural seminar with intern cohort during Spring quarter
- Maintained accurate and timely electronic documentation of clinical records using Point and Click Solutions software

Senior Practicum Counselor

September 2016 – September 2017

Hosford Counseling & Psychological Services Clinic

University of California, Santa Barbara

- Supervisor: Heidi Zetzer, PhD
- Provided Acceptance and Commitment Therapy (ACT) specific psychotherapy to 4 clients (2 undergraduates and 2 community members)
- Completed assigned readings regarding theory and practice of ACT
- Facilitated experiential exercises (e.g., mindfulness, role-plays, conceptualization) and prepared didactic materials for various ACT-specific topics with supervision group members on a rotating basis
- Prepared video-recorded session segments to evaluate and discuss implementation of ACT interventions with supervisor and group members

Practicum Counselor

September 2015 – June 2016

Counseling & Psychological Services, University of California, Santa Barbara

- Supervisors: Jill Huang, PhD (individual); Karen Dias, PsyD (group co-leader)
- Provided primarily short-term (weekly and biweekly) individual counseling services to 5-7 undergraduate clients per week
- Reviewed and utilized scores from the Counseling Center Assessment of Psychological Symptoms (CCAPS) instruments to monitor progression of treatment
- Co-led a 6-week Dialectical Behavior Therapy (Interpersonal Effectiveness) group with 12 members
- Conducted weekly intakes, presented cases for counselor assignment, and provided follow-up as needed
- Participated in weekly training seminars including: multicultural issues, brief dynamic therapy, crisis intervention, DBT, grief and loss, panic, sexual assault, and working with non-traditional students

- Maintained accurate and timely documentation of client electronic records using Point and Click Solutions
- Completed one comprehensive client case presentation per quarter, including preparation of video segments from recorded sessions

Practicum Counselor

September 2015 – June 2016

Alcohol and Drug Program, University of California, Santa Barbara

- Supervisor: Whitney Bruise, LMFT
- Facilitated 2-3 structured, risk reduction alcohol and other drug (AOD) psychoeducation groups per week, with 6-12 students per group
- Provided feedback for improvements to program protocol and curriculum to be more LGBT inclusive and affirming
- Conducted 2-6 brief intake assessments per week and determined appropriate referrals to AOD services

Practicum Counselor

September 2014 – September 2015

Hosford Counseling & Psychological Services Clinic

University of California, Santa Barbara

- Supervisor: Maryam Kia-Keating, PhD
- Provided long and short-term individual psychotherapy to 4-6 clients weekly
- Worked with 2 dyads in couples counseling
- Conducted 1-2 intakes per month, administered assessment questionnaires, and ensured completion of all intake documentation
- Presented intake cases at weekly clinical assignment team meetings
- Administered and scored weekly self-report assessments, reported findings, and submitted progress notes for review in a timely manner
- Provided clients with referrals for community resources when needed
- Completed quarterly case audits to ensure completeness of clinical files

Intake Coordinator

September 2011 – March 2014

Our Common Ground – Adolescent Substance Abuse Treatment Program

Redwood City, CA

- Supervisor: LaNae Jaimez, PsyD
- Responded to referral inquiries and completed brief phone screens with potential clients and referring parties
- Conducted face-to-face intake interviews with all potential clients in a variety of settings including: client residences, group homes, juvenile detention centers, and other community organizations
- Reviewed relevant medical, educational, and mental health history to evaluate goodness of fit for program services and provided referrals when necessary
- Ensured timely completion of all intake paperwork including consents, releases, and fee agreements
- Presented case summaries for new intakes at weekly clinical team meetings
- Coordinated termination and transfer services with families, social service agencies, and other community mental health providers

- Developed, circulated, and analyzed online satisfaction surveys from referral sources
- Utilized survey feedback to implement changes to referral procedures
- Outreached to community organizations in surrounding county regions

Counseling Trainee

August 2010 – June 2012

Adolescent Counseling Services, Gunn High School, Palo Alto, CA

- Supervisors: Rom Braffman, PhD (group), Robyn Alagona, LMFT

(individual)

- Provided short and long-term individual counseling services and crisis management intervention to 4 – 7 high school students per week
- Administered pre- and post-service assessments for all clients enrolled in the program
- Collaborated with guidance counselors, teachers, and school administrators to promote awareness of mental health issues and availability of counseling services
- Participated in weekly individual and group supervision to process cases, explore transference and countertransference reactions, and discuss appropriate interventions

SUPERVISION & TRAINING EXPERIENCE

Committee Member

October 2018 – Present

APA Division 17 – Section on Supervision & Training

- Developing initiatives and outreach for early career professionals within the section

Student Supervisor – Technology and Organizational Climate

Hosford Counseling & Psychological Services

Clinic June 2017 – June 2018

University of California, Santa Barbara

- Clinic Director: Heidi Zetzer, PhD
- Overseeing intakes and counseling sessions conducted by practicum clinicians
- Conducting phone screens with prospective clients from the university and community
- Attending weekly case assignment team meetings to review intakes, transfers, and clinician caseloads in collaboration with faculty supervisors and clinical director
- Responding to crisis situations occurring in the clinic in consultation with faculty supervisors and clinic director
- Providing peer consultation to practicum clinicians on an as needed basis
- Participating in weekly administrative meetings and maintaining timely and accurate meeting minutes
- Ensuring completion of quarterly case audits, including termination and transfer procedures, with practicum clinicians
- Serving as a liaison between the clinic and Information Technology department and ensuring smooth operation of video recording systems and other technological equipment

- Responsible for maintaining a positive and organized clinic environment via coordination of cleaning duties, maintenance of work rooms, and efficient workflow
 - Aiding in other clinic outreach and administrative duties as needed
- Basic Practicum Student Supervisor** January 2017 – June 2017
 Hosford Counseling & Psychological Services Clinic
 University of California, Santa Barbara
- Supervisor: Heidi Zetzer, PhD
 - Provided individual supervision to 4 basic practicum students and co-facilitated group supervision with 3 basic practicum students in association with the course: CNCSP 276 - Fieldwork in Clinical Supervision
 - Aided supervisees in conceptualization, intervention planning, processing of transference and countertransference issues, and attending to multicultural factors in their work with 5 pseudo clients (per supervisee)
 - Identified supplemental readings and resources to enhance supervisee development
 - Reviewed intake notes, progress notes, treatment plans, and termination reports for 2 basic practicum students
 - Completed quarterly supervisee evaluations using basic helping skills competencies
 - Led group discussions focusing on multicultural topics on a rotating basis

RESEARCH EXPERIENCE

- Dissertation Research** 2017 – 2019
- Advisors: Tania Israel, PhD; Heidi Zetzer, PhD; Steve Smith, PhD
 - Title: “*Psychotherapeutic approaches to sexual minority internalized stigma*”
 - Status: Proposal approved October 2017, data collection and analysis completion expected for March 2018, with write-up and defense planned for May 2019.
 - Research: Sexual minority individuals experience internalized stigma as a result of their marginalized status within society. Internalized stigma is associated with negative physical and mental health outcomes and is an important issue to address within psychotherapy. Despite this, there is limited literature on effective psychotherapeutic interventions for treating internalized stigma. This project will utilize qualitative interview data to document the ways experienced LGBT-affirming mental health practitioners address internalized stigma with sexual minority clients and aims to provide guidance for practitioners and researchers alike.

- Graduate Student Researcher – Research Practicum** September 2014 – June 2017
 University of California, Santa Barbara
 Department of Counseling, Clinical & School Psychology
- Advisor: Tania Israel, PhD
 - Contributed to ongoing research team projects focusing on interventions for LGBT populations, specifically targeting experiences of internalized stigma

- Attended weekly research team meetings and provided written and verbal feedback regarding project methodology, data collection, and analysis
- Conducted data analysis and contributed to manuscript preparation
- Aided in the writing, preparation, and submission of two National Institute of Mental Health grant applications
- Completed additional tasks as needed by research team and faculty advisor

Graduate Student Researcher January 2016 – September 2016
 University of California, Santa Barbara
 Advisor: Tania Israel, PhD

- Conducted a study utilizing quantitative and qualitative responses from a nationwide sample of over 1,500 LGBT people documenting sources, exposure, and rejection strategies associated with stigmatizing messages they received
- Recruited, trained, and supervised a team of 10 undergraduate research assistants utilizing qualitative content analysis
- Contributed to manuscript preparation including literature review, Methods, Results, and Discussion sections

Research Assistant 2013 – 2014
 Duquesne University, Psychology Department, Pittsburg, PA

- Faculty Supervisor: Marco, Gemignani, PhD
- Collected and analyzed qualitative data investigating the discriminatory messages received by various undocumented immigrant groups in the USA

Undergraduate Research Assistant 2007 – 2008
 Santa Clara University, Psychology Department, Santa Clara, CA

- Faculty Supervisor: Amara Brook, PhD
- Aided in the development, data collection, and analysis of a survey study examining the relationship between multicultural identity and environmental values
- Contributed to manuscript preparation, including Results and Discussion sections

TEACHING EXPERIENCE

Teaching Associate – CNCSP 114: Psychology of Gender Summer 2017
 University of California, Santa Barbara, Santa Barbara, CA

- Teaching Mentor: Steve Smith, PhD
- Prepared and presented lectures and facilitated discussions 3 times per week, for 29 students total
- Updated course reading list, exam questions, and completed all grading and record keeping associated with the class
- Arranged for guest lectures and presentations to enhance student learning
- Completed Disabled Student Program accommodation requests as needed

Teaching Assistant – FEMST 20: Women, Society, & Culture
 University of California, Santa Barbara, Santa Barbara, CA Winter 2017

- Facilitated review and discussion activities for 3 sections per week, 62 students total
- Monitored attendance, graded all assignments, exams, and quizzes

Lead Teaching Assistant – FEMST 60: Women of Color: Race, Class, & Ethnicity

University of California, Santa Barbara, Santa Barbara, CA Fall 2016

- Assisted with exam preparation, Disabled Student Program accommodations, and other course logistics as needed
- Coordinated midterm and final exam review sessions
- Led 3 discussion sections per week, 70 students total
- Completed all grading for exams, assignments, and participation activities

Teaching Assistant – FEMST 150: Sex, Love, & Romance Spring 2016

University of California, Santa Barbara, Santa Barbara, CA

- Contributed to course reading list in collaboration with the professor
- Facilitated activities and discussion topics for 3 sections per week, 74 students total
- Developed novel review game to stimulate engagement and shared learning
- Co-created extra credit activity options with fellow TA's

Teaching Assistant – SOC 1: Introduction to Sociology Winter 2016

University of California, Santa Barbara, Santa Barbara, CA

- Executed structured curriculum activities for 3 sections per week, 73 students total
- Aided in constructing the midterm and final exam review guide and facilitated corresponding review sessions
- Completed all grading associated with the course

Teaching Assistant – CNCSP 115: Peer Helping & Leadership Summer 2015

University of California, Santa Barbara, Santa Barbara, CA

- Co-facilitated group discussions and activities 2 sections per week, 5 students total
- Maintained iClicker attendance logs
- Graded assignments, presentations, and participation

Teaching Assistant – ES 1: Introduction to Environmental Studies

University of California, Santa Barbara, Santa Barbara, CA Fall 2015 & 2014

- Led 3 semistructured sections per week, over 70 students total
- Aided in exam review development and facilitation
- Provided recommendations for incorporating more inclusive language with regard to gender pronouns in sections and lectures

Teaching Assistant – CPSY 210: Psychology of Relationships Spring 2011

Santa Clara University, Santa Clara, CA

- Facilitated role-plays, discussion, and addressed graduate student questions

- Maintained close contact with professor regarding student progress and developed targeted experiential activities to address student needs

AWARDS

Susan A. Neufeldt Award for Excellence in Clinical Supervision 2017 – 2018

Hosford Counseling & Psychological Services Clinic
University of California, Santa Barbara, Santa Barbara, CA

- Awarded for notable dedication to the development of clinical competencies of Hosford clinicians through supervision and mentorship

Ray E. Hosford Award for Excellence in Professional Behavior 2014 – 2015

Hosford Counseling & Psychological Services Clinic
University of California, Santa Barbara, Santa Barbara, CA

- Awarded for outstanding achievements and contributions to the psychological services clinic

Ray E. Hosford Memorial Research Award April 2018

Department of Counseling, Clinical, and School Psychology
University of California, Santa Barbara, Santa Barbara, CA

- Awarded to support dissertation research: “*Psychotherapeutic approaches to sexual minority internalized stigma*”

Travel Grant Award 2015 & 2016

Department of Counseling, Clinical, and School Psychology
University of California, Santa Barbara, Santa Barbara, CA

- Funds awarded to support travel to present at the American Psychological Association Convention in Denver, CO. Received: \$625
- Funds awarded to support travel to present at the American Psychological Association Convention in Toronto, Ontario, Canada. Received: \$625

UC SANTA BARBARA DEPARTMENTAL SERVICE

| | |
|--|----------------------------|
| Clinical Training Team | September 2017 – June 2018 |
| Hosford Clinic Diversity Committee | September 2017 – June 2018 |
| Hosford Clinic Committee | September 2016 – June 2017 |
| Department Executive & Student Affairs Committee | September 2015 – June 2016 |

PROFESSIONAL AFFILIATIONS

American Psychological Association, Student Affiliate

- Division 17: Society for Counseling Psychology, Member
- Division 39: Psychoanalysis, Member

- Division 44: Society for the Psychology of Sexual Orientation and Gender Diversity
American Psychological Association of Graduate Students, Member
American Counseling Association, Student Member

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Israel, T., Choi, A., Goodman, J., Matsuno, E., Lin, Y-J., **Kary, K.**, & Merrill, C.R.S. (2018, November 8). Reducing internalized binegativity: Development and efficacy of an online intervention. *Psychology of Sexual Orientation and Gender Diversity*.

MANUSCRIPTS IN PROGRESS

Israel, T., **Kary, K. G.**, Choi, A. Y., Lin, Y. J., Goodman, J. A., & Matsuno, E. (2018). *Exposure to, sources of, and rejection of anti-LGBT messages*. Unpublished manuscript, University of California, Santa Barbara, Santa Barbara, CA.

Matsuno, E., Goodman, J. A., Israel, T., Choi, A. Y., Lin, Y. J., & **Kary, K. G.** (2018). *L or G or B or T: Sorting sexual and gender minorities into sub-population specific interventions*. Unpublished manuscript, University of California, Santa Barbara, Santa Barbara, CA.

PRESENTATIONS

Kary, K. G. (2017, May). *Working with challenging clients*. Presented to graduate students in CNCSP 260C: Basic Practicum. University of California, Santa Barbara, CA.

Kary, K. G. (2017, April). *This is what stigma looks like*. Presented to undergraduate students in FEMST 20: Women, Society, & Culture. University of California, Santa Barbara, CA.

Kary, K. G. (2016, November). *Exposure, sources, and strategies for rejecting anti-LGBT messages*. Presented to the Department of Counseling, Clinical, and School Psychology at the annual research festival in fulfillment of Master of Arts degree requirements. University of California, Santa Barbara, CA.

Kary, K. G., Israel, T., Matsuno, E., Goodman, J. A., Choi, A. Y., Lin, Y. J., & Merrill, C. R. S. (2016, August). *Reducing lesbian internalized stigma: Development and efficacy of an online intervention*. Poster presented at the 124th Annual Convention of the American Psychological Association in Denver, CO.

Choi, A. Y., Israel, T., Goodman, J. A., Matsuno, E., Lin, Y. J., **Kary, K. G.**, & Merrill, C. R. S. (2016, August). *Reducing internalized binegativity: Development and efficacy of an online intervention*. In Div. 44 Bisexual Issues Committee (Chair), *The 'B' is*

not silent: Future directions in research and education in bisexuality. Symposium presented at the 124th Annual Convention, Denver, CO.

Matsuno, E., Israel, T., Choi, A. Y., Goodman, J. A., Lin, Y., **Kary, K. G.**, (2016, August). *Reducing transgender internalized stigma: Development and efficacy of an online intervention.* Poster presented at the 124th Annual Convention of the American Psychological Association in Denver, CO.

Goodman, J. A., Israel, T., Merrill, C. R. S., Lin, Y., **Kary, K. G.**, Matsuno, E., & Choi, A. Y. (2016, August). *Refinement and replication of an internet-based intervention for internalized heterosexism.* Poster presented at the 124th Annual Convention of the American Psychological Association in Denver, CO.

Israel, T., Lin, Y. J., Goodman, J. A., Matsuno, E., Choi, A. Y., **Kary, K. G.**, Merrill, C. R. S. (2016, August). *Reducing LGBTQ stigma through online interventions.* In H. M. Levitt and B. L. Velez (Co-Chairs), *Psychotherapy and intervention research with LGBTQ populations.* Symposium presented at the American Psychological Association Annual Convention, Denver, CO.

Kary, K. G., Israel, T., Choi, A. Y., Lin, Y. J., Goodman, J. A., Matsuno, E. (2015, August). *Exposure to, sources of, and rejection of antigay messages.* Poster presented at the American Psychological Association Annual Convention, Toronto, Ontario.

Matsuno, E., Israel, T., Goodman, J. A., Choi, A. Y., Lin, Y. J., **Kary, K. G.** (2015, August). *Screening LGBT participants in psychological research.* Poster presented at the American Psychological Association Annual Convention, Toronto, Ontario.

ABSTRACT

Psychotherapeutic Approaches to Sexual Minority Internalized Stigma

by

Krishna Kary

Sexual minority people experience internalized stigma (IS) as a result of ongoing exposure to external stigma in their environments. Existing literature on IS has demonstrated the detrimental effects IS has on sexual minority people through associated mental health disparities. This study sought to explore current recommendations being made in the literature with regard to addressing IS in psychotherapy. Nine participant clinicians who identified as experienced LGBTQ-affirming practitioners were interviewed regarding their approach to addressing IS through a client case example. CQR yielded themes across the data set that included: clinician's general conceptualization of IS, IS assessment strategies, specific interventions targeting IS, associated outcomes, and perceived barriers to treating IS in psychotherapy, independent of the case example. Results from this study expand upon the existing literature base by providing new context for existing and novel recommendations and considerations for treating IS in psychotherapy. Findings also highlighted opportunities for additional research, particularly psychotherapy process and outcome research, that will likely aid future clinical practice.

Keywords: Internalized stigma, internalized homophobia, internalized heterosexism, sexual minority, LGBTQ-affirming, psychotherapy, consensual qualitative research

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Chapter I: Introduction

Overview

Within mainstream United States heterosexist culture, heterosexuality is considered normative, preferable, and superior to other forms of sexuality (Herek, 2007; 2015). Widely accepted and held beliefs such as these contribute to a culture wherein sexual stigma permeates institutional, communal, and individual value systems (Berg, Lemke, & Ross, 2017). More specifically, sexual stigma is regarded as “the negative regard, inferior status, and relative powerlessness that society collectively accords to any nonheterosexual behavior, identity, relationship, or community” (Herek, 2007). Both heterosexual and nonheterosexual (a.k.a., sexual minority) people are socialized with negative views of lesbians, gay men, and bisexuals (LGB) (Russell & Bohan, 2006). For heterosexuals this manifests as sexual prejudice, which is then enacted through discrimination, victimization, and violence against sexual minority individuals and communities (Meyer, 2003). For sexual minorities, such stigma can become internalized stigma (IS), wherein individuals come to accept negative evaluations of themselves and others within the sexual minority community (Herek, 2016; Szymanski, Kashubeck-West, & Meyer, 2008a).

Despite some indications of increasing societal acceptance of sexual minorities over the recent years (e.g. legalization of same-sex marriage), negative impacts of IS have and continue to warrant significant concern (Herek, 2015; 2016). A large body of literature has demonstrated the relationship between various forms of IS, including internalized homophobia (IH), and an array of negative mental and physical health outcomes for sexual minorities (Berg et al, 2016; Hatzenbuehler, 2009; Newcomb & Mustanski, 2010; Szymanski, Kashubeck-West, & Meyer, 2008b; Fredriksen-Goldsen et al, 2013). Negative

effects of IS extend across life domains impacting sexual minorities' sense of self, level of social engagement, vocational endeavors, and utilization of various support services (Herek & Garnets, 2007; Owens, Riggle, & Rostosky, 2007; Reeves & Horne, 2009; Szymanski, Chung, & Balsam, 2001). The same trend appears consistently throughout the literature with higher levels of IS being associated with poorer outcomes. This has been the case for substance use, depression, anxiety, risky sexual behavior, and even suicide (Brubaker, Garrett, and Dew, 2009; Newcomb and Mustanski, 2010).

In addition to impacting varying aspects of ones physical and emotional health, IS is also implicated in impeding developmental milestones specific to sexual minorities. For example, higher levels of IS are linked to earlier stages of sexual identity development, greater degrees of sexual identity concealment (e.g. heterosexual "passing" behaviors), and less involvement with other sexual minorities (e.g. fewer LGB friends, less time spent with LGB people) (Szymanski, Chung, & Balsam, 2001; Szymanski, Kashubeck-West, and Meyer (2008b). In light of these findings, it is hypothesized that higher levels of IS may impede the coming out process and progression through stages of sexual identity development.

Many sexual minorities seek out mental health services for support, not necessarily to address IS, but to cope with psychological distress often associated with IS which can include poor self-esteem, relationship difficulties, mental health issues, substance use issues, and other adjustment difficulties. In fact, sexual minorities utilize mental health services at higher rates than their heterosexual counterparts across treatment settings and age brackets (Cochran & Cauce, 2006; Dunbar et al, 2017; Hardesty et al, 2012; Owens, Riggle, & Rostosky, 2007; Williams & Chapman, 2015). It is noteworthy that although sexual minorities are utilizing mental health services to treat the higher levels of reported

psychological distress they experience, such distress does not always present as clearly defined, diagnosable mental health disorders. For example, a recent California mental health service utilization survey found high rates of sexual minorities, particularly women, seek services despite not meeting any particular diagnostic criteria as defined by the fourth revision of the Diagnostic Statistical Manual (DSM)(Grella et al, 2009; Grella, Cochran, Greenwell, & Mays, 2011). In drawing implications from these findings, Grella and colleagues question the utility of relying exclusively on traditional diagnostic criteria in determining the mental health needs of sexual minorities seeking such services. It is likely that some of the impacts of IS often go unidentified by sexual minorities and mental health providers alike. The insidious nature of IS is such that individuals might harbor highly damaging beliefs about themselves without ever consciously or outwardly identifying this as contributing to their distress. This might pose as a barrier to effective treatment of IS without active development of a specialized knowledge base and corresponding interventions.

Despite the expansive literature linking IS to negative outcomes for sexual minorities and findings documenting their utilization of mental health services to address psychological distress (which is likely associated with IS), the body of available intervention research remains inadequate (Puckett & Levitt, 2015). The mass majority of literature available on IS is primarily theoretical in nature. This body of literature offers useful frameworks, like the minority stress model, to help mental health service providers understand the institutional, community, and individual-level pathways that contribute to IS, but provide little in the way of applied interventions (Herek, 2015). Recommendations for best practices with sexual minority clients from the American Psychological Association (APA, 2011) and the American Counseling Association (ACA; ALGBTIC LGBQQIA Competencies Taskforce,

2013) guidelines both draw attention to the significance of IS and outline the necessity for practitioners to assess and treat IS in psychotherapy. Unfortunately, these too provide at best, vague suggestions for addressing IS with sexual minority clients. More specified recommendations for addressing IS in psychotherapy are available in a small number of published journal articles, composite case studies, and LGBTQ-affirming psychotherapy handbooks (Mandel, 2013; Russell; 2012; Russell & Hawkey, 2017; Ritter & Terndrup, 2002; Blair, 2002; Davies & Neal, 1996). Overlapping themes across these sources suggest providing sexual minority clients with a contextualized explanation of IS, such that sources and content of stigmatizing beliefs can be identified and ideally challenged or reframed to reduce their impact on clients. Specific findings noted here will be discussed in greater detail in the following chapter however, a number of questions remain unanswered with regard to how practitioners are actually addressing IS in psychotherapy with sexual minority clients.

It has been established that sexual minority individuals are already seeking mental health services to address psychological distress that may also include experiences of IS. Although there is a lack of clear guidelines for addressing IS within the academic literature, practitioners who work with this population are undoubtedly engaging in this process already and their methods have gone uninvestigated thus far. Traditionally, evidence-based practices have been established through rigorous psychological research which are then used to inform applied work such as psychotherapy, however recent trends have drawn attention to practice-based research, which seeks to generate knowledge from direct clinical experiences (Epstein, 2009). Practice-based research often utilizes qualitative, inductive, practitioner knowledge-based studies to generate findings. As it remains unclear to what extent approaches being

employed in applied settings align or diverge from current recommendations being made in the academic literature, a modified practice-based research approach seems appropriate.

Current Study

The current study is a qualitative investigation of the psychotherapeutic approaches employed by experienced LGBTQ-affirming mental health practitioners to address IS with sexual minority clients. More specifically, this study sought to provide a description of how treatment of sexual minority IS manifests in psychotherapy through an analysis of case examples. Documenting various aspects of how experienced LGBTQ-affirming mental health providers approach sexual minority IS will contribute significantly to the existing body of literature on IS, which is predominantly theoretical or correlational in nature.

Findings compliment recommendations currently being made in the literature with regard to treating sexual minority IS, both by demonstrating in greater detail the application of such approaches, and by introducing additional approaches not yet covered in the literature. Results can even aid in the ongoing process of developing best practices for addressing sexual minority IS in psychotherapy.

Experienced mental health providers who self-identify as providing direct service in the form of LGBTQ-affirming psychotherapy to sexual minorities are positioned particularly well as potential informants as they may hold greater interest, motivation, knowledge base, training, and experience that could contribute to a more sophisticated approach to addressing IS compared to general practitioners who might be less attuned to such a specific issue. Practitioners who provide service in LGBTQ community counseling centers, belong to sexual and gender minority professional organizations, or specialize in serving sexual minorities in other direct service settings were invited to participate. Semi-structured

interviews were used to ascertain rich descriptions of how practitioners' approach sexual minority IS through a specific case example. Various aspects of practitioners' approach were investigated including conceptualization, assessment, and specific interventions employed in the service of addressing sexual minority IS. Factors associated with tailoring, implementing, and gauging the impact of various interventions were also examined through descriptions specific to client case examples. Of particular interest were the outcomes associated with implementation of such interventions and perceived barriers associated with addressing IS in psychotherapy more broadly.

Chapter II: Literature Review

Conceptualizing Internalized Stigma

An analysis of the literature on IS yields two complimentary types of information. The first grouping of literature focuses primarily on conceptual frameworks for understanding IS, while the second consists of descriptive, primarily correlational studies documenting the relationship between IS and negative health outcomes for sexual minorities. The body of conceptual literature serves to explain the origins of IS and the numerous studies linking IS to sexual minority development and negative health outcomes (Meyer, 2003; 2013). Because IS is understood as the conscious or unconscious internalization of negative beliefs about ones' sexual identity, it has become increasingly important to locate the origins of these beliefs within the broader cultural landscape from which they developed and are perpetuated (Meyer, 1995; Herek, 2007). Included in this cluster of publications is the minority stress model, which seeks to explain mental and physical health disparities observed for this population. Within this model it is theorized that heteronormative cultural values embedded in Western society play a role in the devaluation, invisibilization, and ongoing stigmatization of sexual minority identities and behaviors. According to minority stress theory, because sexual minorities face additional stressors due to their marginalized position within society they in turn are more vulnerable to experiencing increased mental and physical health outcomes compared to their heterosexual counterparts (Puckett & Levitt, 2015). Of key importance is the understanding that IS, despite its ability to manifest and impact individuals, is not a personal issue. IS develops over time as the result of ongoing exposure to sexual stigma, discriminatory practices, violence, and institutional oppressions (Herek, 2015; Meyer & Frost, 2013; Hatzenbuehler, 2009). Russell and Hawkey (2017) suggest IS coexists

with external stigma (stigma within the external environment) and so can continue to increase within an individual unless challenged in some way (e.g., by the individual, through social support, changing societal norms). Similarly, Russell (2012) places particular emphasis on employing a “movement perspective” which conceptualizes IS as the counterpart to external societal stigma that occurs over time and can impact all individuals, regardless of their identity or individuality. These theoretical models provide the basis for understanding IS and the wealth of descriptive studies highlighting specific impacts on sexual minority health. In this way, it is possible to contextualize why and how internalization of stigma occurs and demonstrates the mechanisms that serve to perpetuate IS across time and space for any given individual (Russell, 2007).

Associated Health Disparities

The landscape of IS and corresponding negative mental and physical health outcomes for sexual minorities is vast and well documented. Health disparities observed for sexual minorities are generally understood through the minority stress model which suggests these negative impacts occur as a product of this populations’ marginalized status in society (Herek, 2015; Meyer, 2003; 2013; Hatzenbeuhler, 2010). When compared to their heterosexual counterparts, sexual minorities appear to suffer from more mental health issues that include substance use, affective disorders (e.g. depression, anxiety), and suicide (Cochran & Cauce, 2006; Cochran & Mays, 1994; 2000; Walch et al, 2016; Brubaker, Garrett, and Dew, 2009; Newcomb and Mustanski, 2010). Findings such as these hold true across age groups with sexual minority youth, young adults, and older adults all found to experience poorer mental health outcomes as a result of exposure to various minority stressors (Shilo & Mor, 2014). For sexual minority adults in same-sex relationships, IH has

been associated with depressive and anxiety symptoms, as well as less relationship satisfaction, commitment, and intimacy in their partnerships (Thies et al, 2016).

Perhaps less obvious are the impacts of sexual stigma on physical health. Compared to their heterosexual counterparts, sexual minorities are at greater risk for a number of serious physical health issues including cancer, cardiovascular disease, asthma, diabetes, and other chronic medical conditions (Lick, Durso, & Johnson, 2013). Higher prevalence rates of disabilities have been found for sexual minority adults and IS has been linked to disability status and depression symptoms (Fredriksen-Goldsen et al, 2013; Fredriksen-Goldsen, Kim, & Barkan, 2012). Even exposure to the microaggressive phrase, “that’s so gay” has been associated with feelings of isolation, headaches, poor appetite, and eating problems for sexual minority college students (Woodford et al, 2012). Again, the impacts of minority stressors, including IS, have been established across age brackets, effecting physical health outcomes for youth and adults alike (Shilo & Mor, 2014).

LGBTQ Mental Health Service Providers

It remains unclear to what extent the recommendations for addressing IS in the literature are actually reflected in practice with sexual minority clients. Of particular interest to this study were the psychotherapeutic approaches utilized by experienced LGBTQ-affirming mental health practitioners who may be providing services in a variety of settings. Practitioners providing services in LGBTQ community counseling centers provide clients a number of benefits, despite the fact that these specialized organizations are not equally as accessible to all individuals, with more opportunities afforded to those residing in or near metropolitan areas (Rogers, 2012). The most obvious benefit is the perceived safety sexual minorities might associate with an LGBTQ specific location, effectively reducing an

otherwise significant barrier to seeking services. Often these community based centers offer sliding scale fee options, which might open up access to services for those clients who would not otherwise be able to afford it. Despite often limited funding available to these types of community agencies, they appear to maintain expected standards of practice and competence when it comes to service providers' training and education (Center Link, 2016; Rogers, 2012). Of a total of 107 LGBTQ centers surveyed nationwide by Center Link, a networking hub for LGBTQ community agencies, 31 percent relied entirely on volunteer staff. Of these, 62 centers reportedly provide mental health specific services and had collectively treated over 22,600 people in 2015. According to a large nationwide survey conducted by Rogers (2012), the most commonly reported reasons for seeking mental health services at LGBTQ community centers include: sexual and gender identity issues, coming out, general support, depression, and relationship issues.

In addition to therapists who provide services through LGBTQ community centers, there are mental health practitioners in private practice or other non-LGBTQ specific service agencies who either self-identify as specializing in working with sexual minorities, or who have developed a positive reputation through word-of-mouth within their local community. Pre-screening therapists for "gay-affirming" attitudes and qualities through word-of-mouth or self-identified specialization has been associated with increased satisfaction with services received by gay and lesbian clients (Liddle, 1997; 1999). Mental health providers who self-identify as specializing in working with sexual minorities report having obtained this status through deliberate acquisition of supplemental knowledge, training, and experience providing direct services to this population above and beyond required graduate coursework or licensing standards (Rutherford et al, 2012). Although not always the case, there is some

evidence that those practitioners who do self-identify as LGBTQ-affirming in their psychotherapeutic approach have sought out additional opportunities to reach competence through for example, attending workshops, conferences, and other professional involvements (e.g., membership in LGBTQ-specific organizations).

Addressing IS in Psychotherapy

Although the majority of the literature available on IS is conceptual or descriptive in terms of its associated health outcomes, there are a number of recommendations for addressing IS in psychotherapy being made in recent years. Of particular interest are the formalized recommendations released by governing bodies within the mental health field. For example, the American Psychological Association (APA, 2011) guidelines for working with LGB people states, “Psychologists strive to understand the effects of stigma (i.e., prejudice, discrimination, and violence) and its various contextual manifestations in the lives of lesbian, gay, and bisexual people”. Within these guidelines, practitioners are tasked with assessing both overt (e.g. harassment, assault) and covert (internalized stigma) manifestations of stigma. The guidelines also recommend practitioners demonstrate “validation and awareness” with regard to sexual minority experiences of stigma, which is assumed to include internalization of sexual stigma. Additional APA guideline recommendations include, when appropriate, empowering clients to confront social stigma. Within the guidelines the readers attention is also drawn to issues surrounding the internalization of stigma, including historical reference points, and a compilation of correlates between IS and negative outcomes are briefly presented.

The American Counseling Association (ACA) also released a set of competencies for working with sexual minorities and their allies (ALGBTIC LGBQQIA Competencies

Taskforce, 2013). There is significant overlap between ACA competencies and APA guidelines, including awareness of various forms of IS (e.g. internalized heterosexism, biphobia, homophobia) and their potential impacts on the health of sexual minorities. Competencies also note the importance of utilizing a contextual framework for understanding origins, manifestations, and maintenance of stigma within the broader cultural context. Additionally, ACA competencies note practitioners are expected to recognize their own prejudices towards sexual minorities and take measures to control for this in their work (e.g. self-reflection, seeking consultation, trainings). Counselors are also encouraged to acknowledge the “societal prejudice and discrimination” experienced by sexual minorities and to work collaboratively with them to overcome such stigma. With regard to assessment, ACA competencies articulate that counselors are expected to understand that, due to the insidious and sometimes invisible nature of IS, clients presenting for mental health services may not show overt signs of distress. It is therefore assumed to be the responsibility of the counselor to be attuned to the ways this might manifest and to work to incorporate appropriate interventions as needed.

Although APA and ACA guidelines do provide strong recommendations for addressing IS in psychotherapy, specific approaches and interventions to accomplish this effectively remain unclear. Unfortunately, the available intervention literature, although offering some insights, also falls short in providing clearly defined and supported interventions. For example, Lin & Israel (2012) utilized an online intervention protocol based on social psychology theories to reduce IH in same-sex attracted adult men ($N = 290$) through a series of interactive modules. Activities within this intervention were designed to combat negative societal messages about gay and bisexual men and to increase sexual

minority identity affirmation. The intervention included factual information that debunked negative stereotypes (e.g. *Being attracted to the same-sex is a sign of mental illness*). Within this intervention, stigmatizing messages were contextualized as products of socialization and not necessarily representative of sexual minority men. Participants were asked to report on which messages they had received growing up, the sources of each message, whether they had rejected the messages, and then describe what strategy they used to reject the messages. The intervention was successful in reducing IH, producing small but significant effect sizes. Findings from this study are promising and although it was conducted exclusively online, the conceptual underpinnings and intention of intervention components do lend themselves to be adapted to a psychotherapy setting. Recommendations that can be extrapolated from this intervention might include exploration and identification of sources and content of particular stigmatizing messages that are currently dominating a sexual minority individuals sense of self. A practitioner might also find it useful to incorporate exploration of affirming messages clients may hold regarding their sexual minority identity and experiences in order to build acceptance and pride which may help combat more negative internalized beliefs (Dasgupta, & Greenwald, 2001).

Another central element of the approach utilized by Lin and Israel (2012) involves incorporation of a clear and externalized definition of what stigma is and where it comes from. A similar approach was utilized by Yadavaia and Hayes (2012) who used an Acceptance and Commitment Therapy (ACT) protocol to reduce believability and distress of stigmatizing thoughts for gay and lesbian participants ($N = 5$). Participants were guided through a series of ACT processes over the course of 6-10 weeks. What distinguishes ACT from other approaches is its emphasis on “defusion” from and acceptance of distressing

internal experiences (e.g. stigmatizing thoughts about one's self/identity as a sexual minority, feelings of shame regarding ones sexual identity and behaviors) and reliance on value-driven action. The process of “defusion” in particular involves noticing and reframing stigmatizing thoughts as “cognitive events”, as opposed to treating them as truths about one's self. Results indicated that participants experienced overall less distress associated with stigmatizing thoughts as well as reductions in reported symptoms of depression, and stress, and increases in social support. Again, an essential element of this intervention involves providing clients with a new framework for identifying and understanding IS such that negative beliefs no longer function as unconscious truths, but instead are brought out in the open, contextualized, and reevaluated.

Although useful recommendations can be pulled from the intervention studies described above, practitioners might find the setting and experimental nature of these studies limit their applicability to applied psychotherapy settings. Case studies can provide rich descriptions of specific interventions, client responsiveness, and outcomes in a way that is more easily translatable into ones own applied practice. For example, Mandel (2013) provides a thorough description of a treatment approach with a composite case example of “Adam”, a gay-identified adult male, that utilizes cognitive-behavior therapy, ACT, and multicultural theories. The author describes their process of framing experiences of external enacted stigma (e.g. harassment, discrimination) and self-stigma (e.g. IS, including specific stigmatizing thoughts and corresponding feelings) as a product of the broader social culture rather than due to a personal deficit or problem stemming from being a sexual minority. This included providing psychoeducation on cultural stigma as well as increasing Adam's awareness of IS. More specifically, the author notes specific questions aimed at illuminating

the clients' views are of what it means to be gay in order to access potentially stigmatizing internalized self-narratives (Chazin & Klugman, 2014; Proujansky, & Pachankis, 2014). The author also worked to dispel negative stereotypes about sexual minorities and promote self-acceptance, approaches that were utilized in the above described intervention studies as well (Lin & Israel, 2012; Yadavaia & Hayes, 2012).

A second case study of "James", also a gay-identified male, models similar intervention strategies, but relies more heavily on cognitive restructuring techniques to combat stigmatizing messages (Russell, 2012). Special attention is paid to the political climate and how this might trigger cognitive and affective reactions in James, that the clinician aids in uncovering and contextualizing. Additional focus is also placed on tailoring established coping strategies (e.g. social support) to meet the needs of James as a gay-identified man (e.g. gay/straight alliance, LGB-affirming church). It is noteworthy that both Russell (2012) and Mandel (2013) employed strategies to help clients contextualize IS, its varied impacts, and worked with their clients to discover positive coping strategies. More specifically, impacts of IS were individualized in order for clients to obtain insight into the layers and origins of their own experiences of distress. This intervention component seems particularly useful, as it has been established that clients seeking psychotherapy may not always present as struggling with IS, but IS may in fact be impacting functioning nonetheless (Alessi, 2014).

Additional guidance for addressing IS can be found in LGBTQ affirming psychotherapy handbooks, which are predominantly written and marketed towards practitioners. Although a handbook focusing specifically on treating IS has yet to be written, select chapters within general guides to working with sexual minorities can be found. It is no

surprise that the language around IS varies slightly between academic journal articles and practitioner guides. Discussion of constructs seemingly equivalent or closely related to IS include difficulties coming out due to fear of negative evaluation or shame, self-acceptance, self-esteem, social difficulties as the result of bullying or discrimination, fear of rejection, etc. It does appear that attention is being paid to difficulties sexual minorities face as a result of negative internalized beliefs about their sexual identity, even though it might not be labeled as IS. This is an important observation, as practitioners interested in working with sexual minorities generally as well as those interested in developing expertise in treating IS more specifically, might on the surface find a lack of reference to IS in even LGBTQ affirming handbooks. The fact that translation and additional investigation would be necessary in finding specific and direct interventions for treating IS further demonstrates the need for greater exploration and dissemination in this area.

Despite the hidden nature of some material referencing IS in psychotherapy, a number of particular intervention tools are described briefly by Russell and Hawkey (2017). These include providing psychoeducation to frame experiences and impacts of IS in order to provide language and a model for making sense of one's own experience of stigma (Proujansky, & Pachankis, 2014). An example of such a psychoeducational intervention might include describing the role socialization plays in shaping our understanding of what is normal and acceptable in any particular cultural. Identifying ways that cultural norms around sexuality are transmitted and maintained from one generation to the next, which contributes to subsequent positive or negative attitudes towards sexual minority individuals. This discussion can even include a dialogue about family dynamics and the influence early development has on our understanding of ourselves in relation to others. Once this

foundation for understanding has been laid, it is suggested that practitioners can work with clients to identify specific messages they have received, particularly those rooted in prejudice and those that are false, and draw on more affirming representations of sexual minorities to create more balanced views of oneself (Blair, 2002; Dasgupta, & Greenwald, 2001; Russell, 2012). Exploration of how stigmatizing messages were learned and where they came from can also serve to externalize negative attitudes and beliefs about sexual minorities. Thus far, the majority of suggested interventions noted within LGBTQ handbooks have been more cognitively-oriented. This trend might be influenced by the substantially larger body of literature on IS which tends to align more closely with social and cognitive learning theories in their conceptualization models than those from, for example, psychodynamic or humanistic theories. Although discussed less frequently, it is also recommended that practitioners process the affective aspects associated with stigma, as these may include feelings of fear, shame, or hopelessness. Practitioners may also aid clients in identifying affirming organizations, events, and groups in the local community to build social support (Puckett & Levitt, 2015). Lastly, when appropriate, empowering clients to become involved in activism or advocacy work is also suggested as it allows them to become agents of social change that can impact themselves and their community.

A thorough review of the academic and applied therapeutic literature sheds light on a number of consistent and overlapping themes with regard to addressing IS in psychotherapy. Included in these recommendations is the use of conceptual frameworks that situate IS within the larger sociopolitical cultural landscape. Recommendations being made for practitioners within LGBTQ therapy handbooks and case studies include explicitly offering this method of conceptualization to sexual minority clients (Puckett & Levitt, 2015; Ritter & Terndrup,

2002; Russell & Hawkey, 2017). This includes framing experiences of external and internalized stigma as products of historical and systemic marginalization of sexual minorities that is maintained through cultural norms rather than as truths about the actual value or legitimacy of an individual. Due to the pervasive nature of sexual stigma, it is assumed that most individuals will harbor some internalized negativity towards sexual minorities, therefore practitioners are encouraged to actively engage clients in a dialogue regarding their experience of being a sexual minority (Davies & Neal, 1996). This might include negative beliefs about oneself or other sexual minorities, feelings of guilt or shame associated with same-sex or non-monosexual attractions, as well as hypervigilance. It is noted that IS can manifest in subtle forms and that few sexual minorities will explicitly present with IS as their primary concern in treatment. For this reason, it is no surprise that additional recommendations for practitioners include developing an understanding of the links between IS and other mental and physical health indicators, so that they may properly assess for IS. Such an assessment might help determine a clear understanding of manifestations of IS as occurring separate from and in conjunction with other common presenting issues like depression, anxiety, substance use, or relationship difficulties (Puckett & Levitt, 2015; Ritter & Terndrup, 2002; Russell & Hawkey, 2017). Additionally, assessment of IS becomes particularly important because practitioners are tasked with taking into consideration the impacts of IS on presenting issues, but not over attributing symptoms of distress to IS alone. Interventions in this area include inviting clients to consider the potential ways and degree to which IS may, or may not, be impacting their presenting issue.

Chapter III: Methods

Participants

Clinicians. A total of 10 clinicians were recruited and interviewed for the study. Nine clinicians (six female, two male, one queer), with an average age of 33.4 (*SD*: 3.5) were included in all stages of analysis that comprised the final group of participants. Racial/ethnic identity of clinicians included: four White, two African American/Black, one Asian, one Latina/o/x or Hispanic, and one Latina/o/x or Hispanic & White. Clinicians identified their sexual orientation as: three queer, three heterosexual, one pansexual, one lesbian, and one gay. All clinicians were licensed to practice in their state of residence at the time of the interview (six psychologists, two professional clinical counselors, and one mental health counseling associate). All but one clinician were early career professionals and reported an average of 4.9 years (*SD*: 3.8) of clinical practice post-licensure. The average estimated percentage of clinical hours (combined pre-and post-licensure) spent providing direct services to sexual minority clients was 61.4% (*SD*: 19.5). The average estimated percentage of current caseload identified as sexual minorities was 64.5% (*SD*: 24.3), excluding one participant who was engaging in research rather than clinical work at the time of the interview. Clinicians ascribed to an array of theoretical orientations and/or endorsed therapeutic stances that included: feminist, multicultural, minority stress lens, ethno-culture and identity emphasis, psychodynamic, relational-psychoanalytic, attachment, Gestalt, experiential, trauma, and holistic.

One participant was excluded as their case example focused only on addressing IS related to their client's transgender identity, but not their bisexuality. Exclusion was determined not based on the client's gender identity, but on the participant's inability to

provide data relevant to the research questions, which focused on addressing IS related to sexual orientation. It is worth noting that other client case examples used in the final sample also held intersecting minority identities, including non-binary ones. Sexual orientation is understood as related to, but distinct from, gender identity, and therefore it was deemed inappropriate to include a case focusing solely on transgender identity stigma.

Client case examples. Clinicians demonstrated their therapeutic approach through a client case example. Participant clinicians had seen their client in psychotherapy within the last two years, with the exception of one participant who worked with their client approximately four years prior to the time of the interview. Demographic and treatment information for client case examples were obtained through participant clinician report during the interview process. No data were gathered directly from the clients themselves. Descriptions for each client case example are provided in Tables 1 and 2.

Procedure

Institutional Review Board approval was obtained through the University of California, Santa Barbara (UCSB) to ensure protection of human subjects and adherence to institutional standards for conducting research. Participants were recruited from LGBT community counseling centers, LGBT-oriented groups within professional organizations including APA, ACA, and the National Association for Social Workers, as well as from mental health centers that work with sexual minorities. The call for participants included an emphasis on recruiting experienced LGBTQ-affirming mental health practitioners who were able to articulate their approach to addressing IS in psychotherapy with a sexual minority client through a case example. Additionally, participants met the following eligibility requirements: 1) current licensure in their state of practice, 2) a minimum of five years

conducting psychotherapy (as a trainee and/or licensed professional), and 3) self-identification as possessing interest and experience providing affirming psychotherapy to sexual minorities.

By recruiting participants who self-identified as experienced LGBTQ-affirming practitioners, the hope was that they would possess more interest, motivation, and experience working with this population than perhaps general practitioners. Practitioners providing services in a variety of settings were eligible to participate. This study strove for a sample size of 10-12, per recommendations for interview-based qualitative research and CQR, specifically (Hill, 2012; Morrow & Smith, 2000). However, one participant was excluded, leaving the final sample size at 9, which still met the minimum quantity for CQR studies. Participants were paid \$35 dollars for their participation in the interview. Funding for participant incentives was obtained through the Hosford Clinic Research Grant offered through UCSB in Winter quarter of 2018.

Practitioners interested in participating reviewed eligibility criteria and consent electronically via a Qualtrics survey where they provided an electronic signature prior to completing the demographic questionnaire and being contacted for the interview. Consent outlined the purpose of the study, their right to withdraw participation at any time without loss of compensation, risks and benefits to participation, confidentiality protections, permission to audio record the interview, and compensation. All participants who expressed interest, met eligibility criteria, and completed the Qualtrics survey were contacted via email to schedule an interview. Participants were provided a copy of the interview protocol prior to their interview session and were asked to reflect on a specific case example, topics, and questions in greater depth before providing responses in the interview. This step also

increased transparency and allowed participants to opt out of participation if they found the interview protocol unappealing in some way (Brenner, 2006), which several did.

Purposeful sampling methods and eligibility criteria were established with the goal of obtaining data from a particular subset of participant practitioners who were theorized to have the specialized experience necessary to investigate the research questions for this study (Creswell & Plano Clark, 2011; Palinkas et al, 2015; Patton, 2002). Given the focus of this study was on illuminating more sophisticated approaches to psychotherapy with sexual minority clients who harbor IS, it was particularly important that participants had experience providing such services and were able to describe their approach in some detail through the client case example. Therefore, eligible participants were required to have completed their pre-licensure training to ensure they had spent some time providing direct service in general, but also specifically with the population of interest. Selection criterion were established to encourage participation from experienced mental health practitioners who had either a history of providing psychotherapeutic services to sexual minority clients or were currently doing so. It was expected the majority of practitioners at LGBTQ community counseling centers would be licensed at the master's level (e.g., Marriage and Family Therapists, Clinical Social Workers), while PsyD and PhD level practitioners were considered more likely to be providing services in private practice or other non-LGBQ specific settings. Practitioners were eligible to participate regardless of their past or current setting(s) of clinical practice. No differentiation between employment or volunteer status was made as it would exclude a large number of practitioners providing services in often minimally funded LGBT community counseling centers (Center Link, 2016). Participants were required to be licensed in their current state of clinical practice in order to partake in the study. This

criterion was established based on findings wherein practitioners who had developed expertise in working with LGBT clients reported having reached competence not through required training (e.g. program requirements, courses) but through seeking out additional specialized training opportunities over time (Rutherford et al, 2012). It was hypothesized that obtaining such training opportunities might be less easily acquired by unlicensed and junior clinicians. There was also an assumption that licensed practitioners would be aware of and have been tested on their knowledge of ethical practices and other competencies.

A semi-structured open-ended interview protocol was used to gather data from participants over an interview conducted using Zoom. Zoom is a HIPPA compliant video calling application that allowed the researcher and participant to view one another for the duration of the interview. Interviews were audio recorded to enable transcription and subsequent data analysis. Interviews ranged in length from forty to sixty minutes long. Participants were provided compensation in the form of an electronic gift card delivered via email following completion of the interview.

Interview recordings were de-identified and then transcribed by an undergraduate research assistant who was trained by the lead researcher. Guidelines for transcription included omission of false starts, conversational words that did not add to the meaning of the narrative (e.g., "like"), and minimal verbal and nonverbal encouragers made by the interviewer (e.g. "mm-hmm", "yeah"). Participants were invited to review the de-identified transcripts for optional accuracy checks via email (Fassinger, 2005). Only two participants expressed interest in engaging in this step and returned the transcripts with minor edits that included clarification of previously inaudible sections and removal of tangential comments. The lead researcher then audited the transcriptions by reviewing the script and audio in their

entirety, checking for typos, clarifying inaudible sections, and editing to make the narratives cleaner for ease of coding. It is necessary to note that several short sections of audio could not be transcribed from the first three interviews due to issues with the internet connection during recording.

American Psychological Association (APA; 2002) guidelines on record keeping were adopted to ensure protection of participant anonymity and data. Interview audio recordings were stored as password protected files on a flash drive in a locked research office. Audio files of participant interviews will be deleted after data analysis is complete. Demographic information were stored through Qualtrics until participant names were replaced with numbers to protect confidentiality. De-identified transcripts were stored in Box, a secure online storage system, during all phases of analysis. Access to transcript files in Box was password protected and limited to the lead research, GSR's, and the dissertation chair, who referenced the files for auditing purposes. Box allowed the researchers and auditor to view, edit, and save updated versions of the transcripts throughout all phases of data analysis process without requiring files to ever be removed from the secure online server.

Measures

Demographic Questionnaire

Demographic information included questions regarding participant race and ethnicity, gender identity, age, sexual orientation, state of current clinical practice, credentials, number of post-licensure clinical work, current practice setting, and estimated percentage of face-to-face time spent providing direct services to sexual minority clients. See Appendix A for demographic questionnaire.

Interview Protocol

The interview protocol consisted of a semi-structured interview with open-ended questions aimed at gathering information regarding various elements of how practitioners approach IS in psychotherapy through a case example with a sexual minority client. Utilization of a semi-structured interview yielded several advantages, as it provided an opportunity to plan, in advance, the formatting and topics of specific questions and prompts in order to gather information relevant to the research project (Brenner, 2006). Additionally, the use of semi-structured interviews ensured the same questions were asked of each participant, which likely aided in the analysis process and served to produce coherent themes across participant responses. The focus of interview questions were drawn, in part, from recommended approaches identified through an extensive review of the literature on IS that included APA guidelines, LGBT-specific practitioner handbooks, academic journals (e.g., interventions studies, case studies, theoretical pieces) and dissertations. The general course of treatment and specific interventions used for addressing IS were described through a specific case example with a sexual minority client. Specific topics included: client presentation and clinician assessment of IS, interventions utilized, and resulting outcomes. Demographic and contextual information about the case example were also gathered in order to provide context to the course of treatment described. Use of open-ended questions and more specific prompts with regard to the particular case examples were used with the intention of gathering rich descriptions of practitioner's actual experiences in psychotherapy. The interview also included questions independent of the case example such as considerations for addressing IS more generally, and barriers to doing so.

Suggestions provided by Patton (2002) were referenced to guide development of interview protocol. For example, each interview question had a singular focus, was isolated

to one time period, and aimed to elicit one type of descriptive data (e.g. behavior, opinion, knowledge, sensory, demographic). Patton also recommends beginning interview inquiry with present focused questions, then leading into past oriented ones, which was incorporated into the protocol for this study. Additional sequencing considerations included beginning the interview with a “grand tour” question to encourage rich description (Spradley, 1979) and utilizing specific prompts to gather supplemental data. Refer to Appendix item B for full interview protocol.

Feedback on interview protocol was elicited by one volunteer practitioner, who had experience working with sexual minorities and had conducted qualitative research, but who did not meet eligibility criteria. This step was taken to ensure clarity of individual questions and comprehensiveness of interview inquiry. Feedback was incorporated to produce the final interview protocol that was used with study participants. The interview was practiced beforehand on one volunteer practitioner to further familiarize the researcher with the protocol and the mechanics of the interview process (Hill, 2012). This interview was not included in the study sample.

Researchers

Lead Researcher

The lead researcher, Krishna Kary, is a Counseling emphasis doctoral candidate in the combined Counseling, Clinical, and School Psychology program at the University of California, Santa Barbara (UCSB). She was responsible for conducting all steps of the research project including participant recruitment, selection, interviewing, and data analysis. She worked on other qualitative research projects in the past that have also focused on understanding issues related to stigma facing vulnerable populations including sexual and

gender minorities and undocumented immigrants. One such project conducted most recently involved coordinating a team of 8-10 undergraduate research assistants to identify the ways LGBT adults reject stigmatizing messages they had received about their minority identities. This study utilized qualitative content analysis (QCA; Morgan, 1993) to categorize responses from over 750 participants (Israel et al, 2017). Coordination of this project allowed the researcher to develop a deeper understanding of approaches to QCA as well as provided her with experience training others in this approach and facilitating consensus meetings.

Coding and consensus teams consisted of three distinct groups. Each team consisted of the lead researcher plus two other members. Once established, teams remained constant and did not rotate membership into other groups. Graduate student researchers (GSR's) were selected based on previous research experience, existing knowledge of applied psychology, LGBT issues, and/or experience providing direct clinical services to sexual minorities.

The first team comprised of two GSR's (Team A: one White cisgender female and one Latinx non-binary identified person) from the Counseling, Clinical, and School Psychology doctoral program at UCSB. Both GSR's were counseling emphasis students who worked in the same research lab as the lead researcher, had a background in LGBTQ research, and some experience with qualitative research. GSR's received course credit for their participation in the project, which occurred during Spring quarter of 2018.

The second two sets of research teams consisted of the lead researcher and two GSR's each (Team B: one Hispanic/Native American/White masculine female and one Black cisgender male; Team C: one White genderqueer identified person and one Latinx cisgender female) from Antioch University and Alliant International University in Southern California. All researchers identified as sexual minorities and either had prior experience working with

sexual minorities during their clinical training or had an interest in seeking out these opportunities in the future. Two of the GSR's had experience working with LGBTQ communities in other non-clinical/non-research capacities (e.g. volunteering at local LGBTQ centers). All of the GSR's had prior research experience, but only one had experience engaging in qualitative analysis. Members of both teams were volunteers whose involvement began in the Summer of 2018 and ended in March of 2019.

Auditor

The role of the auditor was held by the dissertation committee chair, a biracial, Chinese American, White Jewish, bisexual, cisgender woman. The auditor had previous experience conducting qualitative research on LGBTQ issues, including as principal investigator and as an auditor on other CQR projects.

Bracketing Biases

I, the researcher, acknowledge I brought to this project existing biases, expectations, and values that inevitably enter into the research process (Ponterotto, 2005). As is expected practice, I will articulate these here for the reader to be aware of when evaluating rationales for project methodology and data findings. I identified as a 30-year-old, White, queer person, in my final two years of my doctoral program during the time of the study. I supplemented my counseling psychology studies with feminist approaches, which I feel have contributed to my social justice orientation in research, teaching, and clinical practices. As a member of the LGBT community and a recipient of counseling services myself, I acknowledge I am both personally and professionally invested in understanding and improving mental health services for this population. It is also worth noting that throughout the duration of this study I

provided direct clinical services to sexual minority clients through a practicum position at a community LGBTQ center and then during my internship at a university counseling center.

I ascribe to a critical ideological paradigm whereby the lived experiences of individuals are seen as inextricable from dynamics of power and oppression that occur systemically (Ponterotto, 2005; Heppner, Wampold, & Kivlighan, 2008). Operating from a critical framework includes assumptions that most, if not all, sexual minorities are exposed to negative societal stigma based on their oppressed societal status and therefore may experience IS. Additionally, there is an assumption that psychotherapists working with this population should be aware of issues related to IS and should address it in their work with clients if clinically relevant. My hope in constructing this research project was to be able to gather data from practitioners that might be used to guide further research and interventions with this population. There is also an acknowledgement that practitioners themselves are also subject to negative societal messages about LGBT people that might influence their work with sexual minorities, which may become evident from the data.

Equally as essential to make transparent are the biases and expectations of GSR members across the three coding teams. Prior to engaging in analysis or reviewing participant data, GSR's identified and discussed biases and expectations within their teams with the lead researcher. Team members highlighted their own personal and professional affiliations with sexual minority experiences served as a source of motivation for being involved in the project, generally. They all held a similar stance that IS has negative impacts on sexual minorities and therefore should be addressed in psychotherapy. Several members observed their belief that having a lived experience of IS as a sexual minority identified clinician might make one better prepared to effectively address it in therapy with clients. Team members

were also transparent about their own theoretical orientations and expressed a curiosity about how participant clinicians would conceptualize and treat IS. Although several GSR's had experience providing clinical services to sexual minority clients, they denied extensive experience addressing IS in psychotherapy themselves, and so entered the project with an openness to what strategies would emerge over the course of analysis.

Data Analysis

This study aimed to understand how experienced LGBTQ-affirming mental health providers approach IS in psychotherapy with sexual minority clients. Recommendations for treating IS were identified through an extensive review of the literature but exploration of how practitioners actually approach this issue in psychotherapy is still needed. In order to obtain a deeper understanding of these processes, a consensual qualitative research (CQR) approach was utilized (Hill et al, 1997; Hill, 2012). Several theoretical and logistical characteristics of CQR made it a desirable approach for this study. CQR has frequently been utilized in psychotherapy process and outcome research as well as in multicultural research (Ponterotto, 2010). A number of studies have already established CQR as a viable option for exploring and documenting complex dynamics in psychotherapy including dynamics of gift-giving (Knox, 2003) and experiences of anger directed towards practitioners (Hill, 2003), both of which offered useful models to reference in designing this study.

Hill and colleague's (1997) initial development of CQR drew upon components from a number of paradigms including postpositivism, constructivism, and critical theory. Of particular relevance for this study are considerations incorporated from feminist and critical theories. For example, the recommended approach to consensus (a central element in CQR) emphasizes the importance of a nonhierarchical process whereby distributions of power,

involvement, and respect are expected for all researchers involved in the data analysis process. CQR also allowed flexibility in utilizing a deductive approach to analysis drawn from domains already identified in the literature and incorporated into the interview protocol questions (Hill et al, 2005). The nature of CQR effectively enabled the research team to classify particular approaches to IS in psychotherapy within and between individual participant descriptions.

Lastly, the availability of thorough guidelines for conducting CQR were expected to prove advantageous for this study in particular considering it was conducted by graduate student researchers (GSR) with varying levels of experience with qualitative research (Hill et al, 1997; Hill et al, 2005). Clearly defined theoretical underpinnings, recommendations for sampling, interview protocols, and data analysis set clear recommendations and expectations for researchers utilizing CQR. Such comprehensive documentation, particularly of the various steps involved in data analysis and consensus, coupled with a number of illustrative examples were useful in preparing the lead researcher and in informing the GSR training procedures.

The data analysis plan followed recommendations and the three steps outlined by Hill and colleagues for conducting CQR (1997; 2005). Prior to beginning work on this project all GSR's from the three teams completed training on the protection of human subjects and on the qualitative analysis approach. Team A completed these trainings separate from Teams B and C, due to these members joining the project at a later date. Despite completing the training at different times, all teams completed the same process outlined below. As recommended by Hill and colleagues, a number of additional seminal articles were reviewed and incorporated into the GSR training materials. (Hill et al, 1997; Hill, 2003; Knox et al,

2003). The lead researcher assigned select chapters from the Hill (2012) book to introduce GSR's to CQR and to facilitate preparation for and engagement in the coding and consensus processes. Specifically, researchers reviewed the Hill (2012) chapter on Biases and Expectations individually, completed open-ended reflections based on their own backgrounds and experiences and then met as a group to discuss topics together. The lead researcher took notes to document the research team's observations and key points, which was later articulated in the Bracketing Biases section of this document. Researchers then reviewed and discussed Hill (2012) chapters on Coding the Data, Cross-Analysis, and Auditing (chapters 8, 9, and 10). The lead researcher encouraged GSR's to ask questions and express areas of concern or apprehension. Although the lead researcher was responsible for training GSR's, efforts were taken to foster a nonhierarchical progression through the actual data analysis processes of coding, arguing to consensus, and incorporating auditor feedback. Efforts included naming and processing the power dynamics and multiple relationships held by members of the research team during the discussion of biases and expectations, by continual reflection during meetings, and by rotating the role of facilitator during consensus. After reviewing CQR materials the research team began reviewing participant transcripts.

Step one of data analysis in CQR involves dividing individual interview responses into domains, which are generally defined as “topic areas” (Hill, Thompson, & Williams, 1997; Hill, 2012). This study took a more deductive approach in that development of domains was loosely structured based off of topics of interest represented in the content of the interview questions and review of the literature. Team A began this process by individually reviewing two interview transcripts and constructing a list of potential domains. The research team then held consensus meetings to collaboratively and non-hierarchically

establish a set of domains by comparing and discussing them with one another until consensus was reached. Consensus meetings involved mutual sharing and consideration of all perspectives. After the team agreed upon the set of domains, all blocks of interview data were coded into the existing domains. As is expected in CQR, this initial set of domains changed over the course of analysis in order to adequately reflect the data. This included deleting, adding, combining, and otherwise altering how domains were defined as more data was coded by the teams. When changes were made to the domain set, previously coded interview transcripts were revisited to ensure consistency across the data set.

The second step required the development of more specified “core ideas” for all domains assigned within each interview transcript. Team members independently read the data within each domain and constructed core ideas through summarizing and abstracting the “essence” of the data (Hill, Thompson, & Williams, 1997). Ideally the core ideas capture interviewee responses “in fewer words and with greater clarity”, producing a refined version of the data. Hill (2012) warns against making inferences about the meaning of the data at this stage, and recommends core ideas be developed as closely to the explicit content of the data as possible. It is also recommended that core ideas be developed and data coded using the domain as the context. Team members made attempts to embody this approach as much as possible, at times agreeing to leave out some blocks of the data that were partially inaudible or unclear rather than trying to infer or guess at the participants intended meaning.

Researcher biases, assumptions, and expectations can very easily enter the process during the coring stage and therefore it was important for individual researchers to demonstrate their rationale for assigning core ideas during consensus meetings. This was done by sharing with the other team members what specific sections of the interview

response fit with their assigned core idea. During consensus meetings, each research team member read aloud their core idea and had access to each other's list of core ideas for reference during group discussions. Again, consensus of core idea content occurred through discussion and agreement amongst all research team members during joint meetings. In line with recommendations made by Hill and colleagues, researchers were encouraged to document their reactions throughout the independent and joint stages of the analytic process. The lead researcher took informal notes following consensus meetings to track questions, reactions, and other potentially relevant happenings over the course of the analysis process.

An important component of CQR involves incorporation of auditors to review and provide feedback at various stages of the coding process (Hill, Thompson, and Williams, 1997). The auditor reviewed and provided feedback on cases following consensus that has been reached for the domain set and assignment of core ideas. More specifically, the auditor sought to establish: 1) data had been assigned to the appropriate domain, 2) all data within domains had been captured, and 3) wording of core ideas was clear, concise, and adequately matched participant responses. The auditor provided written in-document feedback to the research team, who used the same consensus process to agree upon edits that were incorporated. The auditor also provided verbal clarification and elaboration on feedback to the lead researcher, who shared this with members of the research teams to aid in the consensus process. Although the vast majority of auditor feedback was incorporated, when the research team did not agree with suggested edits, they collectively identified a rationale and documented this for future reference.

The final stage of CQR involves “cross analysis”, which shifts the focus of attention from individual cases to observations across cases (Hill, Thompson, & Williams, 1997). Core

ideas for each domain from all cases were compiled and then split into “units”. For each domain, the collection of “units” was then examined to determine in what ways they could be grouped into categories. Hill and colleagues offer a couple of suggestions for arriving at consensus at this stage. This study allowed individual team members to develop a list of possible categories for each domain that was then shared and discussed to consensus with the research team. The research team also used the consensus approach to agree upon how core ideas were broken up into “units” and how each unit was categorized.

At this point the auditor then reviewed the cross-analysis results and provided feedback to the research team on whether category labels fit the core ideas adequately, as well as whether cohesion was achieved by the established groupings. Recommendations provided at this stage were consistent with those articulated by Hill and colleagues and included combining or dividing categories to more accurately represent the essence of core ideas, editing wording of category titles to be more illustrative and/or concise, suggested re-assignments for particular units, and observed categories that emerged within the “other” category. The research team then met again to reach consensus on incorporation of the auditor feedback.

For the sake of providing optimal transparency to the reader regarding the data analysis process, specific stages at which various teams were involved is articulated here. Team A was responsible for the initial development of domains which was done through review of two participant interview transcripts. Team A then assigned and arrived at consensus on domains and coring for the first interview. Teams B and C were each responsible for assigning domains and coring for four of the remaining nine total interviews. Once consensus on domains and core ideas was reached for each participant, the transcript

was reviewed by the other research team so they could gain exposure to the whole data set. Team C was responsible for completing cross analysis and incorporation of auditor feedback for the entire data set, as the GSR's from Team B were no longer available to continue participation on the research project at this stage. Prior to engaging in the cross analysis process, Team C GSR's re-read over the transcripts, including consensus domains and core ideas, that were coded by Team B to ensure they were familiar with all cases.

Chapter IV: Results

CQR Guidelines from Hill (2012) were used to determine frequency cut-offs such that categories and subcategories reflected in eight to nine cases were considered “general” (represented in all or all but one of the cases), five to seven cases were considered “typical” (represented in half or more cases), and two to four cases as “variant” (represented in less than half of cases). Findings that were only evident in one case were not included. Table 3 lists domains and numerical frequencies for corresponding categories and subcategories for the data. Domains, categories, and subcategories are described below with illustrative quotes to provide context to results.

Clinician Conceptualization of IS

The domain clinician conceptualization of IS consisted of general descriptions of IS as a construct, including their perspectives on addressing IS within the context of psychotherapy. Data coded within this domain was shared independent of the client case example. Clinicians typically described IS as negative internalized beliefs about oneself as a sexual minority person. For example, Participant 3 described IS as, “internalized beliefs of shame, or of devaluing themselves, or in some ways there's this seed that they shouldn't be who they are, or they should feel bad for who they are.” IS was typically conceptualized as an underlying cause of distress and psychopathology for sexual minority clients regardless of if it was cited as such by clients. Participant 1 noted, “generally people come in and they're anxious, they're depressed, a lot of times unfortunately they're suicidal, and a lot of times they don't know exactly why.” There were other variant descriptions of IS as resulting from repeated exposure to environments that are not affirming and, therefore, was also conceptualized by some clinicians as pervasive, affecting all sexual minority people.

Participant 8 described this process as follows, “We are constantly internalizing the experiences we have with the social experience around us.”

Participant 1 used the term “complex trauma” to describe IS, stating,

It [complex trauma] is that accumulation of what we might even look at as small, sort of insignificant events. But the thing is in those moments, they're really significant to the person experiencing them. And those successive traumatic events when they accumulate over time develop this really, really profound negative belief about either themselves, the world, or both.

Lastly, there were a variant number of clinicians who noted IS may be addressed either directly or indirectly in treatment. Descriptions within this category included general sentiments that IS and other “isms” *should* be addressed in psychotherapy, even though it is frequently neglected as part of treatment. One participant described an emphasis on addressing IS versus not addressing it, regardless of the directness of the strategy employed (e.g. focusing on building coping skills to manage impacts of stigma versus building awareness of IS itself). Particularly given few clients identify IS as their primary presenting issue, it was also noted IS may not necessarily be at the forefront of treatment.

IS Assessment Strategy

Clinicians were asked to describe how they determined IS was an issue for the client case example. These descriptions made up the IS assessment strategy domain, which included variant category methods described here in order of high to low frequency. IS was most commonly identified through listening to the client’s negative self-narrative (e.g. how the client spoke about themselves). Clinicians also gained an understanding IS from associated issues (e.g. lack of belonging in gay male community, expression of negative

sentiments about gay people) or because the client identified IS as being part of their presenting problem. Least commonly cited was an active assessment of IS through targeted questions (e.g. asking the client to describe their sexual orientation or their feelings about this aspect of their identity).

Client IS Presentation

Clinicians described the presentation of IS for the client case example. Categories within this domain included manifestations of IS based on self-report from the client to the clinician and observations based on the clinicians understanding of the clients' experience of IS. Clinicians generally described IS as manifesting in a range of behaviors including dating challenges (e.g. occurring within sexual identity congruent relationships and heterosexual "passing" relationships), non-suicidal self-injury, disordered eating, increased religiosity, and outward demonstrations of homophobia. Less common, but still typical were descriptions of IS as negative beliefs about the client themselves and/or other sexual minorities more generally. These included binegativity (e.g. concerns about performing bisexuality badly, believing interest in dating multiple genders makes one promiscuous and overly sexual), preoccupation with being "gay enough," and believing sexuality cannot be fluid, is just a phase, or due to confusion. Not surprisingly, clinicians typically included emotional distress as being associated with IS, including feelings of shame and worthlessness, depression and anxiety, fear of judgment from others, poor self-image and general unhappiness.

Interventions Targeting IS

Clinicians provided specific examples of the interventions they employed in the service of addressing IS with their client case example. Data coded within this domain demonstrated what clinicians did in the room with the client, including quotes and other

detailed descriptors. Descriptions of non-IS specific interventions that were used over the course of treatment were not included in this domain. Categories and subcategories within this domain are presented in order of high to low frequency and it should be noted this does not reflect ordering of interventions employed by clinicians over the course of treatment.

Identified sources and content of internalized messages. Clinicians generally worked with clients to identify sources and content of internalized negative messages. This included an array of open-ended questions such as, “What did you hear? Where did you hear that?”

Participant 2 shared the following description of their approach, including questions used to explore multiple sources and content of negative messages related specifically to the clients intersecting identity as a gay Asian man,

“Okay where did you [client] learn those ideals of what an Asian man should look like, or what a gay Asian man should look like?” And really talking about media and how media portrayed the ideal of what it would mean to be gay and then accepted. For his family as well, they were coming around being like, “Okay, well can you not act so gay, or have a gay voice, or be overtly gay.” I think they had said that to him to be like, “Okay well, fine, be gay, but don't show any extended family or anybody else that you're gay.” There were always these conditions that for him felt like, “I guess I can be part of my identity, but I can't be my full identity.”

Participant 8 shared the following about their process of differentiating various sources of negative messages the client had received,

We spent a lot of the beginning identifying those internalized negative messages and deviating that from the actual self. She would take those messages and make them

herself. “I am bad. I am damned. I am ...” And we took those “I am” statements and started to eek them out into, “This is what people have said about me.” We identified what was her language, what was her mother's language, and what was culture's language used about LGBT people.

Helped client recognize and understand IS and its impact on client. Clinicians generally worked to develop a framework that allowed the client to better recognize and understand IS, including the ways IS has and may continue to negatively affect them. Participant 8 shared, “We spent a lot of time just identifying how the language and the ideas and the behaviors of her caregiver impacted her ability to have healthy relationships. So, she saw herself as very worthless, and spent a lot of time with people who reaffirmed this message for her.”

Participant 2 provided this narrative of their approach,

Helping him to see the depression through the lens of identity and having to suppress his identity for so long, and that all the things that he's told himself over the years of what it would mean to be gay. He had made this story about how horrible life would be to be gay and to be rejected. I think for him taking that fear of social isolation, rejection, and helping him see how he was doing that to himself as well, that he had feared so much social isolation and rejection that he was sort of rejecting his friends.

Clinicians also highlighted several specific interventions within this category that were broken down into the following variant subcategories: clinician provided psychoeducation about how societal stigma toward sexual minorities gets internalized, clinician explicitly labelled IS using either academic or non-academic terms (e.g. internalized homophobia, shame, negative messages) and clinician incorporated books or films.

Participant 1 shared this statement as an example of the psychoeducation they provided, their client,

“The fact that this is your identity is not the problem, this identity is who you are. The problem is this society has very unhealthy ways of interacting with people with that identity. The messages you get from people around you are damaging and that's what we're trying to address.”

Participant 7 described their strategy of labelling and building an understanding of IS through various written pieces,

I think it is really important to put a name to it, even if it's not that kind of academically-oriented kind of name. I would say, “We live in a hetero-normative society.” I also gave her a bunch of readings of people who write about hetero-normativity. She ended up reading Adrienne Rich's original *Compulsory Heterosexuality* piece, Rubin's *Trafficking of Women*, and Andrea Dworkin's stuff, and she found that really empowering.

Processed emotional distress associated with client's IS. Clinicians generally incorporated interventions to target emotional distress associated with IS that was linked to historical (e.g. experiences of rejection by parents as a child) and recent events (e.g. anxiety during a same-gender date) as well as physiological activation (e.g. muscle tension, breathing, heart rate) that occurred in and outside of sessions.

Participant 4 provided the following examples of how they engaged the client's emotional distress during sessions,

Initially my interventions were a lot of reflection. If he was red in the face, expressing a lot of hostility, and clenching his fists I would reflect that, “it sounds like you are

really angry.” And if he was crying, “No one's gonna love me for being gay.” I'll say, “there's a lot of shame, a lot of fear associated with this.”

Drew on theory- and evidence-based psychotherapy (EBP) interventions.

Clinicians

typically utilized a diverse array of theory and EBP interventions to address IS including:

Eye Movement Desensitization Reprocessing (EMDR) (e.g float-back exercises), Cognitive Behavior Therapy (CBT) (e.g. cognitive triad, evidence examination, cognitive reframing), Acceptance and Commitment Therapy (ACT) (e.g. acceptance, mindfulness, somatic awareness, defusion, and values-based interventions), Emotion Focused Therapy (EFT) immediacy and here-and-now focus, Dialectical Behavior Therapy (DBT) (e.g. mindfulness, emotion regulation and distress tolerance skills), and techniques from Motivational Interviewing, Narrative therapy, and Experiential Therapies. Other specific tools included role-plays, empty chair, and stress balls.

Challenged negative internalized messages. Clinicians typically challenged negative internalized messages through a range of different approaches including: use of pointed open-ended questions, deliberate expression of clinician reactions to negative messages, introducing the possibility that internalized messages may not be “truths,” and encouraging clients to consider whether current patterns of relating to negative messages is sustainable for the client. The following excerpts demonstrate the creativity of several clinicians.

Participant 2 used a number of open and closed-ended questions to guide this process,

“Well, how do you know that? Where did you learn that from? Where'd you get that?” It really makes them stop and really examine that further. To be like, “Well,

maybe it was true then, but do you think it's true now? What does it mean if it's still true? Does it serve you if you wanna hold onto that as the truth? Is it more detrimental to hold onto that truth? What do you perceive as true?"

Participant 1 incorporated psychoeducation on other psychological constructs to help the client shift how they had internalized negative messages about their bisexual identity,

I talked to my client about confirmation bias, "Once you actually believe there's something wrong with you, you're suddenly looking for things to confirm that belief." And then every time they come up they're like, "See, I knew it, I'm just bad at this [being bisexual]." And a lot of therapy is being able to re-examine those beliefs from the lens of perspective and distance. There's no benefit to me not giving them every bit of information on the subject possible, the more information they have, the more they can start to connect those pieces together, the more they can re-organize the way they view themselves.

Participant 5 provided the following description of repeatedly challenging a client who made homophobic comments during sessions. Over the course of treatment, the clinician came to realize these negative sentiments were a manifestation of the client's IS,

"Yeah, that thing I'm hearing you say does not feel okay and I have a responsibility to at least bring it up, even if we don't check it all the way, that you know that it is not healthy. And if you don't wanna work on that here, we don't have to, but I need you to know that isn't okay." ...we used laughter a lot and sometimes I had to be very careful with her, not to laugh things off that were not funny. And so, "It is not funny that you think or you say these things about gay people, that is not funny. ...I was like, "We need to address where all this hate is coming from for these other people."

And really kinda challenging her on, “All these things you were saying about other people are things you were concerned people believed about you. And you get to control that. People get to believe what they want, but you get to believe what you want as well.”

There were two variant subcategories that highlighted specific strategies clinicians used to challenge negative internalized messages: a) Clinician identified beliefs as manifestations of societal stigma and b) Clinician pressed client to provide evidence to support beliefs.

Participant 2 provided the following statement on how they helped situate beliefs within the context of the clients intersecting identities and cultural and familial expectations,

I really help them [the client] take a step back and have a bird's eye view of, “Here's what society, culture, and the world has told us. Have you ever stopped to question these things? Just thinking about the many intersecting identities you have in terms of being an Asian American male, being the oldest male in the family with additional pressures and responsibilities, including to have the first grandchild and carry the family name.”

Participant 3 described how they used a series of open-ended questions to help the client examine and understand the evidence for the belief that, “queer equals bad,” through the following approximated recollection of their dialogue,

Clinician: “How do we experience that with others? Do we support that? ...So, give me examples, have you encountered other queer people in your life? What is your relationship with them? What is your experience of them?”

Client: “Okay, no. They seem like they're good people, they're fine. I didn't see anything bad about them.”

Clinician: “So how do we feel about that? In your view of yourself, would you also feel bad about yourself?”

Affirmed client's identity and fostered self-acceptance. Clinicians variantly incorporated interventions to affirm clients’ sexual minority identity and foster self-acceptance and self-compassion through: identification and adoption of positive beliefs, validation of client individuality and intersecting identities (e.g. racial/ethnic, gender, sexual orientation, religious affiliation), reflection of strengths and values, and drawing on religion/faith to encourage self-love.

Participant 5 provided the following example of how they encouraged the client to move towards acceptance of her intersecting identities as Black sexual minority-identified woman,

With her [client] being a woman of color, challenging her on this thing about bein' Black and gay, and that not being okay. Having the conversation about, “You can be all these things and they get to overlap. People are born all kinds of ways, and guess what, when you get to puttin' things together, they're gonna be Black people who are gay, just like there's gonna be some Hispanic people who are gay, just like they're gonna be some White people who are gay. You happen to have these two things and does that make it challenging? Sure, it does. But it doesn't make you not those things. But, it makes it challenging for Black people who are gay when other Black people who are gay are unseen.”

Validated and/or normalized distress client experienced as a result of IS.

Clinicians variantly incorporated interventions to validate and normalize the complex ways

in which IS had resulted in historical and current experiences of distress. Specific interventions included: normalizing the widespread nature of sexual minority stigma and acknowledging how the client may have come to believe them (particularly during childhood), validating how believing negative sentiments about ones' identity would inevitably impact interpersonal relationships (e.g. difficulty trusting others, fears of rejection, questioning longevity/legitimacy of non-heterosexual relationships), validating the complexity of holding multiple marginalized identities, and highlighting how psychopathology (e.g. depression, anxiety, suicidal ideation) is a reasonable response following repeated exposure to and/or internalization of sexual minority stigma.

Facilitated behavior change that was more congruent with client's sexual orientation. There was a variant number of clinicians who used interventions to support sexual orientation-congruent behavior that included experimenting with gender-affirming clothing to reflect internal sense of self and pursuit of romantic relationships that reflected client attractions.

Developed coping skills to manage impacts of ongoing systemic oppression and/or IS. Clinicians variantly incorporated skill building to aid clients in coping with ongoing distress associated with IS and/or oppression. Participant 7 helped their client determine and set boundaries in order to create safety and stability in workplace relationships. Participant 9 developed various emotion regulation and distress tolerance skills to help the client cope with anxiety that arose while attending church.

Outcomes of Addressing IS

This domain included perceived outcomes associated with treatment of IS specific to the client case example. It is worth noting that descriptions of desired outcomes were not included in this domain. Only observed or reported outcomes were coded within this domain.

Methods of assessing outcomes. Independent of the outcomes reported as a result of addressing IS, clinicians were also asked how they had determined the approach they took had been helpful to the client. Across the dataset, clinicians generally measured the perceived effectiveness of treatment based on client self-report and observations made by the clinician. Within the total data set, a variant number of clinicians also elicited targeted feedback that informed their understanding of client responses to treatment.

Decreased psychopathology. Clinicians generally noted reductions in various forms of psychopathology including: reduction in symptoms of depression, generalized anxiety, social anxiety, less frequent panic attacks, and decreased intensity of negative emotions. Other examples included increased in positive emotions (e.g. client “seemed happier”) and improvement in client’s ability to manage depression symptoms, which reduced overall distress.

Increased understanding of IS and its impacts on client. Clinicians typically reported their clients had a better understanding of IS and the ways it had impacted them in the past and present. This was described by clinicians in a variety of ways including client recognition of external sources of stigma/homophobia/negative messages about sexual minorities, ability to identify/label IS as a construct (through use of academic or non-academic terms developed in treatment), ability to recognize negative internalized messages in-the-moment and to engage with them in and outside of session. Associated impacts of IS

on clients included: confusion regarding ones' true sexual orientation identity due to stigma, interpersonal concerns (e.g. fearing rejection from others), realizing childhood sexual abuse had not caused same-gender attraction, and emotional distress.

Sexual orientation-congruent identity and behavior. Clinicians reported clients demonstrated changes in how they were relating to their sexual minority identity, which was captured within the following subcategories. Client embraced identity was typical and included greater comfort with exploring aspects of identity (e.g. sexual orientation, gender, race), clarification of sexual orientation identity (e.g. identification shifted from straight, to bisexual, to lesbian over the course of treatment), reduction in self-bullying, greater comfort with and/or developed positive relationship to sexual identity, and greater liking of oneself generally.

Participant 2 provided the following description of how they understood their client's internal narrative with regard to moving towards greater self-compassion in light of ongoing exposure to external stigma,

“This is a structure in which I'm [the client] dealing with things.” And to have some compassion when they're up against those constraints. Instead of making things harder, then maybe being gentler. Being like, “Okay, maybe this is why I'm [the client] depressed.” And when life is already hard, I think most people have a tendency to get even harder on themselves, but I think through this work there's been an increased awareness, which leads to increased compassion.

Clinicians also variably observed behavioral markers of greater congruence with sexual identity through the client coming out to others and/or seeking out romantic partners that reflected their actual attractions.

Changes in client behavior, demeanor, and relationship with the therapist in session. There was a variant number of clinicians who specifically drew attention to changes that occurred in session that included increased openness, engagement with therapist, “working hard” in session, and comfort discussing topics related to identity. Participant 3 described their client as follows, “As opposed to feeling like that [IS] was something they couldn't control or kind of allowing that stigma or those beliefs to overwhelm they really just grew to be so empowered, and their demeanor changed, just grew more confident.” Participant 4 shared their observations of change occurred through, “Just the quality of our interactions went from being very anxious and being very ambivalent about sharing with me to very calm, open, expressive and comfortable in the room with me.” Participant 5 observed the client’s ability to repeatedly challenge the clinician and “lash out” as signs of progress over the course of treatment,

The fact that she could continue to tell me things, she was able to challenge me, able to push back... Or you know, she storms out, slams the door, and calls me a derogatory name... I think the reason she lashed out and did those things to me is because she didn't think I was gonna throw her away for doing that... That at least let me know I created a space where she could feel safe to do those things, that she felt like we're working together.

Improved interpersonal functioning. A variant number of cases noted improvements in the clients interpersonal functioning outside of session that included: increased self-expression with others, increased engagement in familial and/or nonromantic relationships, ability to “be present” with dating partners, establishing connections with other sexual minority people, improved boundaries with coworkers and/or family members.

Coping with external and internalized stigma. Clinicians variably discussed coping strategies clients developed to combat ongoing sources of external and internalized stigma included: increased awareness of IS in-the-moment, which allowed the client to respond with intentionality rather than reacting unconsciously to stressors, learning to assess for safety within various social spaces, and learning to maintain internal boundaries while working in oppressive environments. A variant subcategory also captured clients' increased tolerance for difficult emotions.

Factors Complicating Treatment of IS

Clinicians shared their general understanding of factors that complicate treatment of IS, independent of the client case example discussed. Categories and subcategories identified within this domain included contextual barriers and clinical contraindications based on clinician experience and/or observations within the mental health field more broadly.

Contextual barriers. Two variant subcategories highlighted external/contextual factors that have the potential to negatively impact ones' ability to address IS in psychotherapy, despite there being a clinical need and desire to do so on the part of the clinician. Treatment of IS is unsupported by gatekeepers or other professionals included a range of examples including: a general lack of awareness of IS for clients and professionals makes accessing/delivering appropriate treatment that much more difficult, lack of recognition of IS as a "legitimate mental health issue," and inability to bill insurance for IS-specific treatment. Clinicians also identified difficulties specific to training sites and/or their setting of clinical practice that included: perceived judgment from coworkers around what is "helpful" to focus on in therapy or not, receiving direct instruction from training site that the trainee should not focus on LGBT issues in sessions, site held Catholic values around LGBT

issues and clinician did not feel supported in addressing IS, and counseling center did not allow clinician to offer services for LGBT clients (e.g. group) during a time that would increase safety and access for members.

Not surprisingly, clinicians also acknowledged how broader societal/cultural beliefs about sexual minorities have and continue to pose a barrier to addressing IS on multiple levels. This included the role heterosexism plays in creating and perpetuating stigma towards sexual minorities, exposure to stigma specifically in conservative communities, criminalization of “run-away” sexual minority youth who flee their homes to avoid abuse, and the observation that access to mental health services is already generally limited, but that this issue is compounded for sexual minorities due to marginalization within society.

Clinical contraindications to addressing IS. Clinicians described a range of factors they took into consideration when determining if and when IS should be addressed in treatment. It is important to note, these subcategories highlighted the importance of considering timing, pacing, and the clients experience outside of therapy, when determining if and when to address IS in psychotherapy. Clinicians variantly cautioned against focusing on IS if doing so had the potential to negatively impact the client’s day-to-day functioning outside of therapy through disruptions in existing social relationships, particularly if bringing awareness of IS would shift relationship dynamics. This subcategory also included consideration of safety and comfort being “out” within the context of religious affiliations the client may have, as well as potentially avoiding discussions of IS with minors when their parents are present.

In a variant number of cases noted the importance of addressing IS secondary to treatment of severe mental health issues (e.g. safety concerns, impairments in functioning,

other sources of significant distress). Clinicians variantly described their tendency to avoid or postpone focusing on IS if they perceived the client was unprepared or was likely to be overwhelmed by the topic at that point in the therapy. Similarly, a variant number of cases noted the importance of tending to signs of resistance from the client, as this was used as an indicator that the client may not be ready to engage in dialogue around IS at that time. Lastly, clinicians variantly described the utility of considering where the client is in terms of their sexual orientation identity development process, as discussion of IS may be inappropriate, irrelevant, or threatening if the client is still in early stages of identity exploration.

Illustrative Case Example

Conceptualization of client, presenting issues, and experience of IS. Participant 4 described their work with a 23-year-old Jewish questioning cisgender male who was seen in private practice for approximately 24 months. Over the course of treatment, the client came to identify his sexual orientation as gay. The client identified his primary presenting issues as depression and sexual orientation concerns, which he believed were related. This conceptualization was shared by the Participant clinician, who speculated that the client's depression stemmed from the client's increasing awareness of his attraction towards other men, which conflicted with values within his family of origin and religion. More specifically, Participant 4 conceptualized the client's experience of IS as resulting, in part, from exposure to homophobic environments growing up. Participant 4 hypothesized that internalization of negative messages about sexual minorities which resulted in denial of his own sexual identity. Over time, this denial of part of himself led to distress. Participant 4 considered the role of the client's cultural identity and religious background to provide context for potential impacts of IS. Specifically, the clinician's conceptualization of the client's IS helped increase

understanding of his experience of isolation and hostility towards family. Participant 4 also described the client as experiencing some ambivalence about the working relationship, which the clinician speculated was tied to anxieties surrounding intimacy and expression of emotion more generally.

Description of general therapeutic approach and interventions targeting IS.

Participant 4 noted treatment initially focused on symptom reduction to help the client manage depression. As symptoms remitted and rapport was strengthened, they then shifted to exploring the role of the client's sexuality in contributing to distress. Participant 4 incorporated interventions to identify sources and content of stigmatizing messages, some of which came from religious ideologies and other experiences during his upbringing. The clinician did this, in part, by helping the client to label and verbalize thoughts and feelings associated with his attraction to men. Together, they framed the client's internal conflict between these things as a source of distress that also kept him from feeling pride or self-acceptance. This process included developing a contextualized framework for understanding how stigma, which they jointly referred to in treatment as "internalized homophobia or shame," might be impacting his sense of self and others.

Participant 4 described the second phase of treatment as consisting of supporting the client in engaging in behaviors (e.g. talking to other men, going on dates) that were congruent with his gay identity. As the client began to engage in these behaviors, the clinician helped him process these experiences in session, as they brought up feelings of shame and anxiety. The clinician encouraged the client to actively discuss these, and other difficult topics in session as a way to build tolerance for negative affect associated with IS. This included pushing the client to engage with his experience not just intellectually, but

emotionally. Participant 4 noted the use of immediacy and reflections to facilitate in-the-moment processing of affect and physiological changes that occurred in session. The clinician described a number of other interventions incorporated over the course of treatment, including challenging stigmatizing self-attributions until the client developed the awareness and skills to do this on his own and validating the difficulties associated with experiencing IS (e.g. negative impacts on his sense of self, relationships with others).

The final phase of treatment included increasing the frequency of sessions (2x/weekly) to support the client in navigating his gay identity with family and religious values. Termination included a consolidation of gained insights and acceptance of the ongoing impacts of stigma on the client's life. Participant 4 highlighted with the client that IS may always be present in his life, but it may be less distressing as he is able to challenge and work through it more effectively.

Outcomes. Participant 4 observed the client was able to better recognize where negative internalized messages about himself as a sexual minority came from, address relationships with friends and family, and develop new relationships with other gay men. The client's depression also remitted, he was able to come out as gay, and was able to be more open and expressive inside and outside of sessions. The clinician noted several changes in the client's engagement in sessions with Participant 4, including moving from presenting very anxious/ambivalent to more comfortable and expressive. Participant 4 also observed the client's ability to be vulnerable and establish trust in the working relationship as positive indicators of the treatment approach.

Client factors impacting treatment of IS. The client was described as psychologically-minded, and increasingly open and expressive over the course of treatment,

which allowed him to make use of the therapy. Participant 4 also described the client as being able to understand IS on an intellectual and conceptual level, which allowed them to focus primarily on emotional processing in session.

Excluded Results

As is common practice in CQR, not all results yielded from the present study were included in the write-up. Per established practice and recommendations on CQR, a handful of results were excluded from the write-up to maintain the focus on findings that related most closely to the research questions guiding this study (Hill, 2012). This included information on how clinicians conceptualized their clients and described their treatment approach generally, independent of IS. Although interesting, these results did not speak to the IS-specific focus of the project. Similarly, some data were excluded as they yielded results for a few, but not all participants. For example, data coded under the domain, “factors impacting conceptualization and treatment of IS” were so varied across the data-set because they were highly specified to the client case example, that they did not yield meaningful results. Some clinicians also briefly described theoretical underpinnings of their approach to treating IS, which did have some relevance to the topic of study, however due to the diversity of theoretical approaches represented across participants and the thinness of these descriptions, the team was unable to generate meaningful themes during cross analysis.

Lastly, results that were somewhat redundant were excluded, as they did not provide the reader with any new information on the topic of IS. This included how clinicians conceptualized development and impacts of IS for their client case examples. Again, although potentially relevant to the focus of the current study, it only served to demonstrate what was already evident from general descriptions clinicians provided within the domain,

“clinician conceptualization of IS.” To include these results would have merely restated that clinicians understand IS as resulting from exposure to external stigma and results in negative impacts on clients in multiple life domains. Hill (2012) also recommends excluding data that does not add to the existing literature, in this case on IS. Although a number of findings from this study were consistent with theory and applied clinical recommendations with regard to treatment of IS, they were included as they provided new perspective and context for these publications and the consistency between existing literature and current findings was deemed meaningful.

Chapter V: Discussion

Overview of Major Findings

This study utilized CQR to examine psychotherapeutic approaches to addressing IS with sexual minority clients through a case example described during semi-structured interviews with nine participants who self-identified as being experienced LGBTQ-affirming practitioners. Specifically, this study explored various aspects of addressing IS in psychotherapy including clinician conceptualization of IS as a construct, IS assessment and presentation, interventions, outcomes, and factors complicating treatment of IS more broadly.

Results shed light on the ways clinicians conceptualize and characterize IS generally, including aspects of its development, maintenance, and associated impacts on sexual minorities (e.g. distress and/or psychopathology). Clinicians identified how they were able to determine IS was an issue for their clients, highlighting the utility of listening for stigma embedded in the client's self-narrative, considering the role of IS in relation to other presenting issues, and using targeted IS assessment questions. Clinicians observed a number of manifestations of IS for their clients that were characterized as behaviors (e.g. homophobia remarks, dating challenges, self-harm), negative beliefs about oneself and/or other sexual minority people, and emotional distress (e.g. feelings of shame, worthlessness, fear). Not surprisingly, considerable overlap can be observed between how clinicians conceptualize IS generally and their understanding of how IS presented for their clients in and outside of sessions. For example, IS was typically conceptualized as negative beliefs about oneself as a sexual minority and as an underlying cause for distress and psychopathology. Similarly, clinicians observed signs of IS in all domains of their clients

functioning (e.g. behavioral, cognitive, emotional), which would be expected based on their understanding of IS as a construct more broadly.

Of particular interest to this study were the “in the room” interventions utilized by clinicians who self-identified as being LGBTQ-affirming in their approach to psychotherapy. To this end, results yielded an array of specific interventions clinicians employed in the service of addressing IS with their clients. Many of these interventions were consistent with existing recommendations articulated in the literature on IS more broadly, which is discussed in greater depth in the implications sections below. Interventions most commonly cited across cases included: identifying sources and content of internalized messages, developing a framework with the client to recognize IS and its associated impacts (e.g. psychoeducation, biblio/film-therapy, ascribing a term for IS as a construct), processing affect and emotional distress associated with IS, and challenging negative internalized messages about oneself as a sexual minority. Clinicians also drew on existing theory and EBP’s to address IS with their clients, a finding that warrants further exploration.

Clinicians tracked changes and outcomes associated with their approach to psychotherapy primarily through direct observation and client self-report. The vast majority of clinicians reported decreases in psychopathology, which is not surprising considering clinicians also tended to conceptualize IS as being an underlying contributor to their client’s distress. Therefore, it follows that reduction or elimination of IS through targeted interventions would reduce overall distress for clients. Other outcomes included increased understanding of IS and its impacts, increased comfort and/or congruence with ones’ sexual orientation identity demonstrated in some cases through identity exploration (e.g. shifting identity labels) or behaviors (e.g. seeking out romantic partner, coming out), improved

interpersonal functioning, and development of positive coping skills to manage ongoing experiences of stigma. Clinicians also cited changes in client behavior, demeanor, and engagement in the working relationship as signs that IS interventions were effective, an important finding that potentially highlights the utility of drawing on applied knowledge and experience from clinician participants who are actively engaging in treatment of IS. It is also worth noting that because this study utilized client case examples to unearth specific interventions being used by clinicians, descriptions of IS interventions used in their clinical practice, but not with the specific case example were not included in the frequency counts presented in the results. Including these cases would have changed frequencies of several categories and subcategories, however they did not yield novel interventions that were not already captured within the dataset.

Lastly, results provided some insight into the contextual barriers and clinical contraindications that clinicians consider when determining if, when, and how to address IS in psychotherapy with clients generally. Descriptions of contextual barriers were somewhat disheartening, as they highlighted the undeniable impact cultural stigma around sexual identity has not just on clients, but on the field of psychology more broadly. Findings regarding clinical contraindications presented numerous opportunities for future research, as they brought up important questions regarding client readiness and competing treatment priorities.

Implications for Theory

There were a number of findings from the current study that are consistent with existing literature on IS. For example, current theoretical literature on IS conceptualizes it as developing from ongoing exposure to external environments that are not affirming of sexual

minorities (Herek, 2015; Meyer & Frost, 2013; Hatzenbuehler, 2009). ACA competencies also highlight the importance of utilizing a contextual framework for understanding origins, manifestations, and maintenance of stigma within the broader cultural context, which appeared consistent with findings from the current study (ALGBTIC LGBQQIA Competencies Taskforce, 2013). Similarly, participant clinicians also typically conceptualized IS as contributing to psychopathology for their clients, regardless of if this was stated by them, which is consistent with what one might expect with previous correlational studies linking IS to mental health difficulties for sexual minorities (Herek & Garnets, 2007; Owens, Riggle, & Rostosky, 2007; Reeves & Horne, 2009; Szymanski, Chung, & Balsam, 2001). Participants also described manifestations of IS within their client case examples as translating across various life domains, which is unsurprising given existing data on sexual stigma. This suggests that self-identified LGBTQ-affirming participant clinicians within this study conceptualized IS generally and within a specific client case example in manners consistent with the dominant theoretical literature available on IS to date. Interestingly, this overlap was even evident when it came to the labels participants used to discuss IS with clients, which varied across cases, much as academic terms for IS have historically and continue to vary in the literature.

Findings shed new light on considerations for affective aspects of IS, which have received limited attention in the existing literature (Hatzenbuehler, Dovidio, Nolen-Hoeksema, & Phills, 2009; Szymanski, Dunn & Ikizler, 2014). Participant clinicians highlighted emotional distress as an aspect of client IS presentation and described specific IS interventions aimed at processing this type of distress, however this was not necessarily reflected in their conceptualizations of IS more generally. Participant clinicians also appeared

to recognize that addressing IS in psychotherapy runs the risk of eliciting emotional discomfort, as several of the clinical contraindications centered around pacing, timing, and consideration of the potentially disruptive nature of bringing IS to the forefront of treatment. This may represent an opportunity for expanding our understanding of IS to include affective components, as much of the current framing of IS tends to be cognitive in nature. For example, does IS include emotional distress or is it assumed that emotional distress is one of many associated impacts of IS? In either case, experiences of IS undoubtedly go hand-in-hand with emotional distress for sexual minority people and therefore warrant additional attention in our framing of this construct. This will lay the theoretical framework for future research and applied clinical practice when working with this population.

Exciting to note was the diversity of theoretical orientations represented across participant clinicians which did not appear to limit their ability to conceptualize, treatment plan, or implement customized interventions to address IS with their clients. This suggests clinicians need not ascribe to a particular theoretical orientation or treatment approach in order to address IS in psychotherapy. Rather, it is likely clinicians would benefit from conceptualizing IS within their existing theoretical orientation, which will likely guide use of specific interventions consistent with their approach, much as they would when treating other presenting issues. Further articulation of IS, its development, maintenance, and impacts on sexual minorities through specific theoretical frameworks (e.g. Psychodynamic, Humanistic) could be beneficial in the future, as these may serve to guide further intervention research and clinical practice.

Implications for Practice

Findings from this study reinforce existing recommendations and interventions currently being explored in the academic literature with regard to addressing IS with sexual minorities, as well as potentially introduce additional strategies that practitioners could adopt in their clinical practice. These include specific interventions aimed at providing a contextualized framework through which the client can understand IS and its impacts. This tool has already been incorporated into a number of intervention studies and was included in case study examples described in chapter two of this manuscript (Lin & Israel, 2012; Mandel, 2013; Proujansky, & Pachankis, 2014; Russell; 2012; Yadavaia & Hayes, 2012). This study also highlighted the potential use of psychoeducation to aid in this process, which is consistent with existing recommendations made by Russell and Hawkey (2017). Supporting clients in identifying and challenging sources and content of specific negative messages about sexual minorities was another finding consistent with existing recommendations (Mandel, 2013; Russell; 2012; Russell & Hawkey, 2017; Ritter & Terndrup, 2002; Blair, 2002; Davies & Neal, 1996). Findings from this study provide weight and context to these recommendations, as they were identified based on descriptions provided by LGBTQ-affirming clinicians through their work with a sexual minority client case example.

Additionally, participant clinicians in this study demonstrated their understanding of IS as contributing to distress and psychopathology for their clients and described interventions aimed at providing validation for the difficulties experienced by clients. Embodiment of this stance and implementation of validation regarding impacts of IS is one of several recommendations for working with sexual minorities that have also been articulated by APA (2011). This is particularly important to highlight, as a clinicians'

inability to understand distress associated with IS could result in misattribution of symptoms or inadvertent collusion in self-blaming narratives that clients may present with in psychotherapy.

Clinicians also incorporated interventions specifically to process affect associated with IS. Although focused on less explicitly in the existing literature, aside from case examples, this appeared to be a new and potentially valuable finding (Mandel, 2013; Russell; 2012). Particularly given the majority of existing recommendations (e.g. building understanding of IS as a construct) could be interpreted and potentially implemented in a primarily cognitive fashion. This might lead to gained intellectual insight, but might fail to address affective micro-trauma associated with IS. It follows that clients would be impacted not only by internalized beliefs about their identities as sexual minorities, but also by the negative emotions that would inevitably accompany such harmful sentiments. Clinicians would do well to actively create opportunities to explore affect associated with IS with clients in the service of addressing IS in psychotherapy.

In this study clinicians referred to an array of EBP interventions in the service of addressing IS with clients. Although specific details of how these were incorporated are not described here, this suggests clinicians need not necessarily “reinvent the wheel” when it comes to addressing IS in psychotherapy. Established EBP’s could potentially be utilized to help clients understand, label, challenge, and re-process IS to reduce its believability, centrality, and potentially impacts as a result.

Given the pervasive nature of stigma towards sexual minority people in mainstream culture, it is likely many, if not all clients, may harbor some conscious or unconscious IS. However, it unlikely they will cite IS-related concerns as part of their presenting issue when

seeking psychotherapy (Alessi, 2014). For this reason, it is essential clinicians are able to assess for IS and actively consider how IS may be contributing to past and/or current psychopathology. Findings from this study highlighted the potential utility of listening for signs of IS present within the client's narrative about themselves and/or other sexual minority people. Not surprisingly, if clients enter psychotherapy harboring negative sentiments about themselves based on their sexual identity, it follows that this might be apparent in how they speak about themselves in relation to others (Davies & Neal, 1996). However, manifestations of IS are potentially diverse and clinicians are cautioned against overgeneralizing for example, low self-esteem, as indicative of negative internalized beliefs about one's sexual minority status specifically. It is likely further assessment is needed to understand in conjunction with each client what role, if at all, IS might be playing with regard to feeling poorly about oneself.

For the purposes of fostering empowerment and ongoing change for sexual minority clients, it is also important to highlight that clinicians in this study also used psychotherapy to help clients develop strategies for coping with stigma beyond their time in treatment. This includes internal and external sources of stigma that might arise over time, particularly given most clients will likely continue to be exposed to sexual stigma long after termination. Clinicians engaging clients around IS are encouraged to draw attention to this likely possibility and plan ahead in terms of developing coping skills and other preventative measures, much as one would to prepare clients for potential remission of other forms of psychopathology.

Implications for Research

Findings from this study provide a new context through which researchers and clinicians alike can examine IS in psychotherapy. It is worth noting that because findings represent the perspectives of participant clinicians, not those of their clients, there are a number of directions for additional research. For example, participants shared *perceived* outcomes resulting from treatment of IS as *part* of psychotherapy. Outcomes reported in this study may not reflect outcomes experienced from the client perspective. They also cannot be directly linked to any specific intervention, as this was not the structure, nor the intention of data collection or analysis for this study. To this end, it remains unclear if descriptions of interventions targeting IS provided by participant clinicians were actually experienced by clients as “LGBTQ-affirming” or were the interventions that actually helped clients with IS. Given this study’s sole focus on the clinician perspective of IS treatment, it seems potentially valuable to explore how clients understand IS, respond to targeted interventions, and what they perceive as subsequent outcomes associated with treatment. There could be a number of different ways these questions might be approached in terms of research designs including the use of analogue studies, interview-based qualitative studies, or additional experimental designs.

In light of the host of recommendations already made with regard to the need for assessment of IS in clinical practice settings, there are still additional opportunities available to explore and/or articulate applied strategies for use in psychotherapy (APA, 2011; Alessi, 2014; Davies & Neal, 1996). The majority of IS assessment tools consist of self-report measures that may have more relevance in experimental research settings than in clinical practice. This poses somewhat of a barrier for practitioners, who may very well adapt specific questions from established measures, but may continue to struggle to assess IS in other meaningful ways in their practice.

This study provides useful quotes to illuminate specific examples of interventions used to target IS, however additional exploration of several of these strategies still seems necessary. For example, clinicians cited interventions from EBP's as helpful in addressing IS in psychotherapy. This finding lends itself to the question of how existing EBP's can be tailored to treat IS. There could be a benefit to developing specialized treatment protocols that clinicians could employ in the service of reducing IS with clients, either as an adjunct to existing treatment, or as a novel standalone treatment regimen.

This study highlighted the utility of interventions aimed at helping clients better understand IS and its impacts, which was consistent with a number of existing recommendations made within the literature. However, potentially equally as essential were results supporting the development of coping strategies to help clients manage past, current, and future difficulties resulting from ongoing exposure to sexual stigma. Ample opportunities remain to further explore how this secondary goal can be facilitated in clinical settings across modalities (e.g. individual, couples, group) as the present study did not fully capture what are likely a number of potential ways in which this could be done with clients. For example,

Puckett and Levitt (2015) suggest identifying affirming organizations, events, and groups in the local community to build social support for sexual minorities, however this is merely one potential strategy that does not guarantee applicability across cases.

Similarly, the existing literature suggests clinicians incorporate affirming messages about sexual minorities into psychotherapy an effort to build self-acceptance (Dasgupta, & Greenwald, 2001; Mandel, 2012). Clinicians in the present study did articulate ways in which they affirmed their clients' sexual identity and foster self-acceptance, yet it is still likely a variety of strategies could be employed to this end. One participant described drawing attention to noteworthy "queers" in history as a strategy for challenging negative internalized messages, an intervention that could be explored in greater depth through additional research. Lin and Israel (2012) shared affirming quotes and images with participants in their online intervention study, however this was one of several intervention modules used in the study.

It is likely no single intervention will suffice in ameliorating the effects of IS on sexual minority people, and yet, greater elaboration on what, when, and how specific interventions are employed is important. Considering clinicians in the present study found it necessary to attend to client readiness and treatment pacing when addressing IS in psychotherapy, it is also worth deepening our understanding of the potential consequences associated with drawing attention to IS. It is well established that psychotherapy in general can elicit emotional discomfort and change existing frameworks and coping people use to navigate their lives. As was mentioned earlier, this study did not examine client experiences associated with IS treatment, however it seems necessary we understand what this process might entail for consumers of psychotherapy, particularly if clinicians are making the decision to address IS when it is not a stated part of a clients' presenting problem.

It is noteworthy that results did not speak directly to the role of the therapeutic relationship within the context of addressing IS with clients, particularly given the well-established importance of the working alliance in psychotherapy (Flückiger, Del Re, Wampold, & Horvath, 2018). Participant clinicians did note changes in client behavior, demeanor, and relationship with the therapist as positive outcomes of addressing IS and appeared to consider the potential impacts on the working relationship when identifying clinical contraindications to addressing IS (e.g. client resistance and readiness) that could negatively impact the client or result in a therapeutic rupture. Some attention to the therapeutic relationship more broadly were evident within one of the excluded domain categories, which consisted of descriptions of the participants general therapeutic approach, however these results were not included in the final write-up, as they did not speak to the specific research questions at hand. Even had these results been included, findings as a whole would still reflect a noticeable absence of the therapeutic relationship with regard to interventions targeting IS. It is likely the structure of the interview protocol which was designed to hone in on IS-related conceptualization, assessment, and interventions, did not encourage commentary on the role of the therapeutic relationship. This creates a potential opportunity for further exploration in this area, as findings would likely benefit future research and contribute substantially to informing applied clinical practice.

Lastly, given that IS exists alongside other forms of cultural stigma (e.g. racial, gender, religious, ability), it is important to maintain an awareness that IS is likely experienced differently by sexual minorities depending on other intersecting identities and exposure to multiple “isms”. This also suggests there may be notable differences and/or considerations clinicians should understand when addressing IS in psychotherapy based on

individual differences between one client and the next. It was beyond the scope of this study to capture, but future research would benefit from examining IS across intersections of age, gender, race/ethnicity, religious affiliation, ability status, etc. Similarly, the current study focused on IS related to sexual orientation identity, however there is still a need for further examination of stigma related to gender identity, for example internalized transphobia. Although gender identity is related to sexual orientation, it is understood as a separate and complex aspect of one's identity. Particularly given gender identity stigma has historically received less attention in the academic literature, it is an area that is ripe for exploratory, experimental, and applied psychotherapy research.

Limitations

It is important to highlight considerations for trustworthiness and transferability of findings. To this end, clear and detailed descriptions of the participants and all steps involved in the research process were presented in the write-up of this project, as is recommended by Hill and colleagues (2012). As a reminder, participant clinicians were recruited not with the goal of generalizing findings, but for their positionality with regard to the research questions. This included an emphasis on obtaining descriptions of therapeutic approaches to addressing IS in psychotherapy from mental health practitioners who self-identified as being LGBTQ-affirming and who had experience providing direct services to sexual minorities. Participant clinicians used a client case example to add specificity and real-world application to their descriptions. Most noteworthy in terms of considerations for transferability include the majority of the sample consisting of early career professionals, which represents a potential difference in values, training, clinical experience, and historical perspective compared to more senior practitioners. Although efforts were made to provide context for client case

examples through direct quotes from participant clinicians, findings do represent somewhat decontextualized descriptions that are not meant to be transferable to all sexual minority clients, within all treatment settings, or even to all practitioners. Given the exploratory nature of the current study, the lead researcher sought to recruit participants from a well-defined pool (e.g. experienced LGBTQ-affirming mental health practitioners) that would also be inclusive enough to capture rich descriptions of therapy processes. That being the case, trustworthiness for future projects could be increased with a larger sample size or through greater homogeneity within the sample. For example, this project could have restricted the license type, setting of clinical practice, theoretical orientation, or other participant specifier, as these factors varied within the final sample, but this may have impacted the breadth of responses received. Nonetheless, frequency results (e.g. general, typical, variant categories) were able to demonstrate typicality within the sample, indicating a degree of trustworthiness of the data.

As is expected in any study, there were several limitations associated with the current project. First, participant clinicians were recruited based on their self-identification as being “experienced LGBTQ-affirming” practitioners. Aside from targeted recruitment and eligibility criteria with regard to licensure, no assessment or filtering was made to ensure ones “LGBTQ-affirming” status, as this term is not certifiable or representative of a standardized set of training, education, knowledge or demonstration of clinical competency. It is likely that self-identification as being “LGBTQ-affirming” is somewhat subjective and therefore might carry with it an individualized stance and therapeutic approach that varies considerably from one clinician to the next. CQR is not conducted with the intention of mass generalization and results from this project are no different. Therefore, for several reasons it

would be unwise to assume for example, descriptions of interventions targeting IS, are representative of all “experienced LGBTQ-affirming” practitioners.

Second, it is standard practice to acknowledge anything unusual about the participant sample or researchers involved in the study (Hill, 2012). Although participant demographics could be considered diverse compared to some other samples with regard to gender identity, sexual orientation, and race/ethnicity, the sample was skewed toward greater representation of ECP’s and psychologists compared to master’s level practitioners. Five of the nine client case examples were seen in private practice settings as well. There were also somewhat limited descriptions provided for the amount and length of treatment provided (e.g. number of sessions, frequency of sessions) which blurs some of the context for the reader.

Third, given the multiple roles held by the lead researcher in relation to the GSR’s as CQR trainer, project coordinator, and research team member, it is important to articulate ways this may have impacted the analysis process. Although the lead researcher took steps to acknowledge, discuss, and distribute authority with GSR’s during training and consensus meetings, it was evident from some meetings that a certain degree of deference remained. This came up repeatedly as the GSR’s viewing the lead researcher as being more clinically experienced and having been the one to interview participants in-person, and therefore better equipped to decipher descriptions when the team was unclear or undecided. This dynamic was observed by the lead researcher, who invited some dialogue on how this could be addressed as a team, however it may have still impacted the analysis process and therefore reported findings.

Fourth, it is important to note that some sections of the first three participant interviews were lost due to WiFi issues during recording that made them inaudible for

transcription. Due to the structure of interview protocol questions and limited use of follow-up prompts, some descriptions within domains were quite thin. This limited the meaningfulness of the data, as they included minimal context or elaboration that would have made cross analysis possible.

Conclusion

Findings from the current study provide context for existing theory and recommendations within the literature with regard to addressing IS in psychotherapy. Key results highlight the importance of actively assessing for IS with sexual minority clients and considering to what extent experiences of IS may be contributing to primary presenting concerns. Participant clinicians within this study observed manifestations of IS in the form of cognitions, affect, and behaviors. It is likely origins and manifestations of IS may vary widely from client to client and therefore, practitioners are encouraged to employ targeted interventions that may include: exploring sources and content of negative internalized messages, helping clients deepen their understanding of IS and its impacts (e.g. providing psychoeducation, labelling IS), validating distress associated with IS and processing affect, challenging negative internalized beliefs, fostering self-acceptance, and supporting identity congruent behavior and development of coping skills to manage ongoing experiences of stigma. Practitioners may find it useful to employ evidence-based practices to aid in this process and would likely benefit from conceptualizing and formulating treatment plans to address IS within their existing theoretical orientation and therapeutic stance, as this was the approach taken by participant clinicians within the study. This might be a particularly helpful take-away for practitioners, as it supports active engagement with IS, regardless of specialized training or the availability of manualized treatment protocols.

Perceived benefits to addressing IS in psychotherapy were wide ranging and included decreased psychopathology, increased awareness of IS, acceptance of sexual identity, and engagement in identity-congruent behavior, to highlight a few. Implicit in the study findings was the perspective that IS can and should be addressed with sexual minority clients in psychotherapy, however participant clinicians also illuminated important contextual barriers and clinical considerations one should be aware of when engaging in this process. Although the current study cannot attest to the direct link between interventions and outcomes and findings are limited based on the clinician-only perspective, results from this project do provide valuable directions for additional research within the realm of applied psychotherapy.

References

- ALGBTIC LGBQQIA Competencies Taskforce. (2013). Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals. *Journal of LGBT Issues in Counseling*, 7(1): 2–43.
- Alessi, E. J. (2014). A framework for incorporating minority stress theory into treatment with sexual minority clients. *Journal of Gay & Lesbian Mental Health*, 18(1), 47-66.
doi:<http://dx.doi.org/10.1080/19359705.2013.789811>
- Al x, L., & Hammarstr m, A. (2004). Women's experiences in connection with induced abortion - A feminist perspective. *Scandinavian Journal of Caring Sciences*, 18(2), 160-168. doi:<http://dx.doi.org/10.1111/j.1471-6712.2004.00257.x>
- American Psychological Association. (2002). *The ethical standards of psychologists*. Washington, DC: Author.
- American Psychological Association. (2011). Guidelines for psychological practice with lesbian, gay and bisexual clients. Retrieved from
<http://www.apa.org/pi/lgbt/resources/guidelines.aspx>
- Berg, R. C., Lemke, R., & Ross, M. W. (2017). Sociopolitical and cultural correlates of internalized homonegativity in gay and bisexual men: Findings from a global study. *International Journal of Sexual Health*, 29(1), 97-111.
doi:<http://dx.doi.org/10.1080/19317611.2016.1247125>
- Berg, R. C., Munthe-Kaas, H. M., & Ross, M. W. (2016). Internalized homonegativity: A systematic mapping review of empirical research. *Journal of Homosexuality*, 63(4), 541-558.

- Bernard, H. R. (2002). *Research methods in anthropology: Qualitative and quantitative approaches* (3rd ed.). Walnut Creek, CA: Alta Mira Press.
- Blair, I. V. (2002). The malleability of automatic stereotypes and prejudice. *Personality and Social Psychology Review*, 6(3), 242-261.
- Brenner, M. E. (2006). Interviewing in educational research. In J. Green, G. Camilli, & P. Elmore (Eds.), *Complementary methods for research in education* (pp. 357-370). Washington, DC: American Educational Research Association/Erlbaum.
- Brubaker, M. D., Garrett, M. T., & Dew, B. J. (2009). Examining the relationship between internalized heterosexism and substance abuse among lesbian, gay, and bisexual individuals: A critical review. *Journal of LGBT Issues in Counseling*, 3, 62–89.
- Burnard, P. (1991). A method of analysing interview transcripts in qualitative research. *Nurse Education Today*, 11(6), 461-466. Retrieved from <https://search.proquest.com/docview/72607511?accountid=14522>
- Center Link (2016). The 2016 LGBT Community Center Survey Report. Retrieved on September, 17, 2017. Available from: <https://www.lgbtcenters.org/Assets/Documents/CC-Surveys/2016-lgbt-community-center-survey-report.pdf>
- Chazin, D., & Klugman, S. (2014). Clinical considerations in working with clients in the coming out process. *Pragmatic Case Studies in Psychotherapy*, 10(2), 1-15. Retrieved from <https://search.proquest.com/docview/1617240223?accountid=14522>

- Cleary, M., Horsfall, J., & Hayter, M. (2014). Data collection and sampling in qualitative research: Does size matter? *Journal of Advanced Nursing*, *70*(3), 473-475.
doi:<http://dx.doi.org/10.1111/jan.12163>
- Cochran, B. N., & Cauce, A. M. (2006). Characteristics of lesbian, gay, bisexual, and transgender individuals entering substance abuse treatment. *Journal of Substance Abuse Treatment*, *30*, 135–146.
- Cochran, S. D., & Mays, V. M. (1994). Depressive distress among homo- sexually active African American men and women. *American Journal of Psychiatry*, *151*, 524–529.
- Cochran, S. D., & Mays, V. M. (2000a). Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual partners: Results from NHANES III. *American Journal of Public Health*, *90*, 573–578.
- Cresswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed method research* (2nd ed.). Thousand Oaks, CA: Sage.
- Dasgupta, N., & Greenwald, A. G. (2001). On the malleability of automatic attitudes: combating automatic prejudice with images of admired and disliked individuals. *Journal of personality and social psychology*, *81*(5), 800.
- Davies, D. & Neal, C. (1996). *Pink therapy: A guide for counsellors and therapists working with lesbian, gay, and bisexual clients* (Vol. 1). McGraw-Hill Education (UK).
- Dunbar, M. S., Sontag-Padilla, L., Ramchand, R., Seelam, R., & Stein, B. D. (2017). Mental health service utilization among lesbian, gay, bisexual, and questioning or queer college students. *Journal of Adolescent Health*, doi:<http://dx.doi.org/10.1016/j.jadohealth.2017.03.008>

- Epstein, I. (2009). Promoting harmony where there is commonly conflict: Evidence-informed practice as an integrative strategy. *Social Work in Health Care*, 48(3), 216-231.
doi:<http://dx.doi.org/10.1080/00981380802589845>
- Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counseling Psychology*, 52, 156-166.
doi:10.1037/0022-0167.52.2.156
- Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, 55(4), 316-340.
doi:<http://dx.doi.org.proxy.library.ucsb.edu:2048/10.1037/pst0000172>
- Fredriksen-Goldsen, K., Emler, C. A., Kim, H., Muraco, A., Erosheva, E. A., Goldsen, J., & Hoy-Ellis, C. (2013). The physical and mental health of lesbian, gay male, and bisexual (LGB) older adults: The role of key health indicators and risk and protective factors. *The Gerontologist*, 53(4), 664-675.
doi:<http://dx.doi.org/10.1093/geront/gns123>
- Fredriksen-Goldsen, K., Kim, H., & Barkan, S. E. (2012). Disability among lesbian, gay, and bisexual adults: Disparities in prevalence and risk. *American Journal of Public Health*, 102(1), 16-21. doi:<http://dx.doi.org/10.2105/AJPH.2011.300379>
- Grella, C. E., Greenwell, L., Mays, V. M., & Cochran, S. D. (2009). Influence of gender, sexual orientation, and need on treatment utilization for substance use and mental disorders: Findings from the california quality of life survey. *BMC Psychiatry*, 9, 10.
doi:<http://dx.doi.org/10.1186/1471-244X-9-52>
- Hardesty, M., Cao, D., Shin, H., Andrews, C., & Marsh, J. (2012). Social and health service use and treatment outcomes for sexual minorities in a national sample of substance

- abuse treatment programs. *Journal of Gay & Lesbian Social Services: The Quarterly Journal of Community & Clinical Practice*, 24(2), 97-118.
- doi:<http://dx.doi.org/10.1080/10538720.2012.669669>
- Hatzenbuehler, M. L. (2009). How does sexual minority stigma “get under the skin”? A psychological mediation framework. *Psychological Bulletin*, 135(5), 707-730.
- Hatzenbuehler, M. L. (2010). Social factors as determinants of mental health disparities in LGB populations: Implications for public policy. *Social Issues and Policy Review*, 4(1), 31-62. doi:<http://dx.doi.org/10.1111/j.1751-2409.2010.01017.x>
- Hatzenbuehler, M. L., Dovidio, J. F., Nolen-Hoeksema, S., & Phillips, C. E. (2009). An implicit measure of anti-gay attitudes: Prospective associations with emotion regulation strategies and psychological distress. *Journal of Experimental Social Psychology*, 45(6), 1316-1320.
- doi:<http://dx.doi.org.proxy.library.ucsb.edu:2048/10.1016/j.jesp.2009.08.005>
- Heppner, P. P., Wampold, B. E., & Kivlighan, D. M., (2008). *Research design in counseling* (3rd ed.). Belmont, CA: Thompson Brooks/Cole.
- Herek, G. M. (2016). A Nuanced View of Stigma for Understanding and Addressing Sexual and Gender Minority Health Disparities. *LGBT Health*, 3(6), 397-399.
- Herek, G. M. (2015). Beyond “homophobia”: Thinking more clearly about stigma, prejudice, and sexual orientation. *American Journal of Orthopsychiatry*, 85(5), S29-S37.
- doi:<http://dx.doi.org/10.1037/ort0000092>
- Herek, G. M. (2007). Confronting sexual stigma and prejudice: Theory and practice. *Journal of Social Issues*, 63(4), 905-925.

- Herek, G. M., & Garnets, L. D. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology, 3*, 353–375.
- Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology, 56*(1), 32-43. doi:<http://dx.doi.org/10.1037/a0014672>
- Hill, C.E. (2012). *Consensual Qualitative Research: A Practical Resource for Investigating Social Science Phenomena*, APA: Wash, DC. ISBN: 978-1-4338-1007-7
- Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*(2), 196-205. doi:<http://dx.doi.org/10.1037/0022-0167.52.2.196>
- Hill, C. E., Kellems, I. S., Kolchakian, M. R., Wonnell, T. L., Davis, T. L., & Nakayama, E. Y. (2003). The therapist experience of being the target of hostile versus suspected-unasserted client anger: Factors associated with resolution. *Psychotherapy Research, 13*(4), 475-491. doi:<http://dx.doi.org/10.1093/ptr/kpg040>
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25*, 517–572.
- Israel, T., Kary, K. G., Choi, A. Y., Lin, Y. J., Goodman, J. A., & Matsuno, E. (2017). *Exposure to, sources of, and rejection of anti-LGBT messages*. Unpublished manuscript, University of California, Santa Barbara, Santa Barbara, CA.
- La Roche, M.J. (2013). *Cultural Psychotherapy. Theory, Methods and Practice*. Los Angeles, CA: Sage.

- Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science, 8*(5), 521-548.
doi:<http://dx.doi.org/10.1177/1745691613497965>
- Liddle, B. J. (1997) Gay and lesbian clients' selection of therapists and utilization of therapy. *Psychotherapy 34*, pp. 11-18.
- Liddle, B. J. (1999). Gay and Lesbian Clients' Ratings of Psychiatrists, Psychologists, Social Workers, and Counselors. *Journal of Gay and Lesbian Psychotherapy, 3*, 81-94.
- Lin, Y. J., & Israel, T. (2012). A computer-based intervention to reduce internalized heterosexism in men. *Journal of Counseling Psychology, 59*(3), 458-464.
- Mandel, S. H. (2014). Targeting Sexual Stigma: The Hybrid Case Study of "Adam". *Pragmatic Case Studies in Psychotherapy, 10*(2), 48-105.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674-697.
- Meyer, I. H. (2013). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychology of Sexual Orientation and Gender Diversity, 1*, 3-26. doi:<http://dx.doi.org/10.1037/2329-0382.1.S.3>
- Morandini, J. S., Blaszczyński, A., Costa, D. S. J., Godwin, A., & Dar-Nimrod, I. (2017). Born this way: Sexual orientation beliefs and their correlates in lesbian and bisexual women. *Journal of Counseling Psychology, doi:<http://dx.doi.org/10.1037/cou0000209>*

- Morandini, J. S., Blaszczynski, A., Ross, M. W., Costa, D. S. J., & Dar-Nimrod, I. (2015). Essentialist beliefs, sexual identity uncertainty, internalized homonegativity and psychological wellbeing in gay men. *Journal of Counseling Psychology, 62*(3), 413-424. doi:<http://dx.doi.org/10.1037/cou0000072>
- Morgan, D. L. (1993). Qualitative content analysis: a guide to paths not taken. *Qualitative health research, 3*(1), 112-121.
- Newcomb, M. E., & Mustanski, B. (2010). Internalized homophobia and internalizing mental health problems: A meta-analytic review. *Clinical Psychology Review, 30*, 1019–1029.
- Owens, G. P., Riggle, E. D. B., & Rostosky, S. S. (2007). Mental health services access for sexual minority individuals. *Sexuality Research & Social Policy: A Journal of the NSRC, 4*(3), 92-99. doi:<http://dx.doi.org/10.1525/srsp.2007.4.3.92>
- Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin, 133*, 328–345.
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 533-544. doi:<http://dx.doi.org/10.1007/s10488-013-0528-y>
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

- Ponterotto, J. G. (2010). Qualitative research in multicultural psychology: Philosophical underpinnings, popular approaches, and ethical considerations. *Cultural Diversity and Ethnic Minority Psychology, 16*(4), 581-589. doi:<http://dx.doi.org/10.1037/a0012051>
- Proujansky, R. A., & Pachankis, J. E. (2014). Toward formulating evidence-based principles of LGB-affirmative psychotherapy. *Pragmatic Case Studies in Psychotherapy, 10*(2), 1-15. Retrieved from <https://search.proquest.com/docview/1617240593?accountid=14522>
- Puckett, J. A., & Levitt, H. M. (2015). Internalized stigma within sexual and gender minorities: Change strategies and clinical implications. *Journal of LGBT Issues in Counseling, 9*(4), 329-349.
- Reeves, T., & Horne, S. G. (2009). A comparison of relationship satisfaction, social support, and stress between women with first and prior same-sex relationships. *Journal of GLBT Family Studies, 5*, 215–234.
- Ritter, K., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. Guilford Press.
- Russell, G. M. (2012). When the political and the personal collide: Lesbian, gay, bisexual, and transgender people as political targets. In I. H. Dworkin & M. Pope (Eds), *A casebook for counseling lesbian, gay, bisexual, and transgender persons and their families*, 329-339.
- Russell, G. M. (2007). Internalized homophobia: Lessons from the mobius strip. In C. Brown & T. Augusta-Scott (Eds.) *Narrative therapy: Making meaning, making lives*. Thousand Oaks, CA: Sage.

- Russell, G. M., & Bohan, J. S. (2006). The case of internalized homophobia theory and/as practice. *Theory & Psychology, 16*(3), 343-366.
- Russell, G. M., & Hawkey, C. G. (2017). Context, stigma, and therapeutic practice. In DeBord, K. A., Fischer, A. R., Bieschke, K. J., & Perez, R. M. (Eds.), *Handbook of sexual orientation and gender diversity in counseling and psychotherapy* (pp. 75-104). Washington, DC: American Psychological Association.
- Rutherford, K., McIntyre, J., Daley, A., & Ross, L. E. (2012). Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities. *Medical Education, 46*(9), 903-913.
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health, 18*(2), 179-183. doi:<http://dx.doi.org/10.1002/nur.4770180211>
- Shilo, G., & Mor, Z. (2014). The impact of minority stressors on the mental and physical health of lesbian, gay, and bisexual youths and young adults. *Health & Social Work, 39*(3), 161-171. doi:<http://dx.doi.org/10.1093/hsw/hlu023>
- Spencer, C., Mallory, A., Toews, M., Stith, S., & Wood, L. (2017). Why sexual assault survivors do not report to universities: A feminist analysis. *Family Relations: An Interdisciplinary Journal of Applied Family Studies, 66*(1), 166-179. doi:<http://dx.doi.org/10.1111/fare.12241>
- Spradley, J. P. 1979. The ethnographic interview. *New York (ua)*.
- Szymanski, D. M., Chung, Y. B., & Balsam, K. (2001). Psychosocial correlates of internalized homophobia in lesbians. *Measurement and Evaluation in Counseling and Development, 34*, 27-38.

- Szymanski, D. M., Dunn, T. L., & Ikizler, A. S. (2014). Multiple minority stressors and psychological distress among sexual minority women: The roles of rumination and maladaptive coping. *Psychology of Sexual Orientation and Gender Diversity, 1*(4), 412-421. doi:<http://dx.doi.org.proxy.library.ucsb.edu:2048/10.1037/sgd0000066>
- Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008a). Internalized heterosexism: A historical and theoretical overview. *The Counseling Psychologist, 36*(4), 510-524.
- Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008b). Internalized heterosexism: Measurement, psychosocial correlates, and research directions. *The Counseling Psychologist, 36*(4), 525-574. doi:<http://dx.doi.org/10.1177/0011000007309489>
- Thies, K. E., Starks, T. J., Denmark, F. L., & Rosenthal, L. (2016). Internalized homonegativity and relationship quality in same-sex romantic couples: A test of mental health mechanisms and gender as a moderator. *Psychology of Sexual Orientation and Gender Diversity, 3*(3), 325-335. doi:<http://dx.doi.org/10.1037/sgd0000183>
- Trotter, Robert T., II. (2012). Qualitative research sample design and sample size: Resolving and unresolved issues and inferential imperatives. *Preventive Medicine: An International Journal Devoted to Practice and Theory, 55*(5), 398-400. doi:<http://dx.doi.org/10.1016/j.ypmed.2012.07.003>
- Tuckett, A. (2004). Qualitative research sampling-the very real complexities. *Nurse Researcher, 12*(1): 47-61.
- Walch, S. E., Ngamake, S. T., Bovornusvakool, W., & Walker, S. V. (2016). Discrimination, internalized homophobia, and concealment in sexual minority physical and mental

health. *Psychology of Sexual Orientation and Gender Diversity*, 3(1), 37-48.

doi:<http://dx.doi.org/10.1037/sgd0000146>

Williams, K. A., & Chapman, M. V. (2015). Mental health service use among youth with mental health need: Do school-based services make a difference for sexual minority youth? *School Mental Health*, 7(2), 120-131. doi:<http://dx.doi.org/10.1007/s12310-014-9132-x>

Woodford, M. R., Howell, M. L., Silverschanz, P., & Yu, L. (2012). "That's so gay!": Examining the covariates of hearing this expression among gay, lesbian, and bisexual college students. *Journal of American College Health*, 60(6), 429-434. Retrieved from <https://search.proquest.com/docview/1314328182?accountid=14522>

Yadavaia, J. E., & Hayes, S. C. (2012). Acceptance and commitment therapy for self-stigma around sexual orientation: A multiple baseline evaluation. *Cognitive and Behavioral Practice*, 19(4), 545-559.

Table 1.

Client Case Example Demographics

| Client | Race/ethnicity | Gender | Age | Sexual orientation | Religious/spiritual affiliation |
|--------|------------------|-------------|-----|------------------------|---------------------------------|
| | | Transgender | | | |
| 1 | White | woman | 26 | Bisexual | Christian (past) |
| 2 | Chinese American | Male | - | Gay | Catholic (past) |
| 3 | Chinese | Questioning | 22 | Questioning (bisexual) | None |
| 4 | Jewish | Male | 23 | Questioning (gay) | Jewish (past & current) |
| 5 | African American | Female | 20 | Heterosexual (lesbian) | Christian (past & current) |
| 6 | White | Male | 35 | Gay | unknown |
| 7 | White | Female | 39 | Sexually fluid | Protestant (past) |
| 8 | White | Female | 30 | Lesbian | Christian (past) |
| 9 | Black | Female | 25 | Queer | Baptist (past & current) |

Note: Sexual orientation: Changes over the course of treatment are indicated in parentheses.

Religious/spiritual affiliation: (past) indicates the religious/spiritual affiliation the client was raised with.

Table 2.

Client Case Example Treatment Characteristics

| Client | Primary presenting issue(s) | Participant clinician title | Treatment setting | Treatment length |
|--------|---|------------------------------------|------------------------------|------------------------------|
| 1 | Anxiety, depression, suicidality, gender dysphoria | Professional clinical counselor | Private practice | 2 months |
| 2 | Depression, interpersonal concerns, workplace impairments | Psychologist | Private practice | 6 months 15 sessions over |
| 3 | Career concerns | Psychologist | University counseling center | 24 months |
| 4 | Depression, sexual orientation concerns* | Psychologist | Private practice | 24 months |
| 5 | Religious concerns | Psychologist | University counseling center | 7 months |
| 6 | Interpersonal concerns, sexual orientation concerns* | Psychologist | VA – LGBT center | 16 sessions |
| 7 | Anxiety, depression | Psychologist | Private practice | 8 months |
| 8 | Anxiety, depression, eating concerns | Mental health counseling associate | Community mental health | 12 months |
| 9 | Religious concerns, sexual orientation concerns* | Professional clinical counselor | Private practice | 8 months |

Note. * Indicates the client identified their sexual orientation concerns were related to their other presenting issues.

Table 3.

Domain, Categories, Subcategories, and Frequencies of Findings

| | |
|--|-------------|
| Conceptualization of IS | |
| IS is an underlying cause of distress and psychopathology | Typical (7) |
| IS is negative internalized beliefs about oneself as a sexual minority | Typical (6) |
| IS develops as a result of repeated exposure to environments that are not affirming of sexual minorities | Variant (4) |
| IS is pervasive, affecting all sexual minority people | Variant (4) |
| Clinicians may address IS either directly or indirectly with clients | Variant (4) |
| IS assessment strategy | |
| IS was evident from client's negative self-narrative | Variant (4) |
| Therapist gained an understanding of client IS from associated issues | Variant (3) |
| Client identified IS as part of presenting problem | Variant (3) |
| Therapist actively assessed for IS with targeted questions | Variant (2) |
| Client IS presentation | |
| Client behavior (e.g. homophobic behavior, dating challenges, self-harm) | General (8) |
| Negative beliefs about self and other sexual minorities (e.g. bi negativity, being "gay enough", sexuality as a "phase") | Typical (6) |
| Emotional distress (e.g. feelings of shame, worthlessness, fear) | Typical (5) |
| Interventions targeting IS | |
| Identified sources and content of internalized messages | General (8) |
| Helped client recognize and understand IS and its impact on client | General (8) |
| Provided psychoeducation about how societal stigma toward sexual minorities gets internalized | Variant (3) |
| Incorporated books or films | Variant (3) |
| Explicitly labelled IS (including use of alternative, non-academic terms) | Variant (3) |
| Processed emotional distress associated with client's IS | General (8) |
| Drew on theory- and evidence-based psychotherapy interventions | Typical (6) |
| Challenged negative internalized messages | Typical (5) |
| Identified beliefs as manifestations of societal stigma | Variant (3) |
| Pressed client to provide evidence to support beliefs | Variant (3) |
| Affirmed client's identity and fostered self-acceptance | Variant (4) |
| Validated and/or normalized distress client experienced as a result of IS | Variant (3) |
| Facilitated behavior change that was more congruent with client's sexual orientation | Variant (3) |
| Developed coping skills to manage impacts of ongoing systemic oppression and/or IS | Variant (2) |

Outcomes of addressing IS

| | |
|--|-------------|
| Methods of assessing outcomes | |
| Client self-report and therapist observation | General (9) |
| Therapist elicited targeted feedback | Variant (3) |
| Decreased psychopathology | General (8) |
| Increased understanding of IS and its impacts on client | Typical (6) |
| Sexual orientation-congruent identity and behavior | |
| Embraced identity | Typical (6) |
| Sought out identity congruent romantic partner | Variant (3) |
| Came out | Variant (3) |
| Changes in client behavior, demeanor, and relationship with the therapist in session (e.g. openness, engagement with therapist, comfort) | Variant (4) |
| Improved interpersonal functioning | Variant (3) |
| Coping with external and internalized stigma | Variant (2) |
| Increased tolerance for difficult emotions | Variant (2) |

Factors complicating treatment of IS

| | |
|--|-------------|
| Contextual barriers | |
| Treatment of IS is unsupported by gatekeepers or other professionals | Variant (4) |
| Societal/cultural beliefs about sexual minorities and related concerns | Variant (4) |
| Clinical contraindications to addressing IS | |
| Addressing IS could negatively impact client outside of therapy | Variant (4) |
| Severity of other mental health issues takes priority over addressing IS | Variant (4) |
| Client is unprepared or would be overwhelmed by discussing IS | Variant (4) |
| Client is resistant to discussing IS | Variant (3) |
| Client is too early in sexual identity development | Variant (3) |

Note. $N=9$; General = 8-9 cases, Typical = 5-7 cases, Variant = 2-4 cases.

Appendix A

Informed Consent

Consent to Participate in Research Study: Psychotherapeutic Approaches to Sexual Minority Internalized Stigma

Purpose:

Thank you for your interest in participating in my research project examining psychotherapeutic approaches to internalized stigma. We are interested in learning more about how you, as an experienced LGBTQ-affirming mental health practitioner, address this important issue with your lesbian, gay, bisexual, and other sexual minority clients.

Procedures:

Should you decide to participate, you will be asked to complete a semi-structured interview conducted electronically via Zoom, a HIPAA compliant teleconferencing program. Interviews are expected to last between 1 and 1.5 hours and include questions specifically regarding a case example of a sexual minority client who experienced internalized stigma and your approach to addressing this within psychotherapy. Interviews will be audio recorded, de-identified, and transcribed for data analysis.

Risks:

Through involvement in this study, you are expected to engage in reflection on and verbal articulation of your clinical practice, specifically regarding your work with sexual minority internalized stigma through a case example. Risks include feelings of discomfort that may arise from discussing your psychotherapeutic approach. Some participants may develop an increased awareness of some of the limitations in their previous work with clients, similar to insights you may have experienced in supervision over the course of your training.

You will be asked to provide some basic demographic and contextual information about a client as part of your case example. I ask that you do not divulge any identifying information about this case at any point during the interview process.

Mandatory reporting requirements apply during this interview, so in order to preserve your confidentiality, please refrain from sharing any information that may require a mandated report. Mandatory reports are initiated if you share information concerning child abuse, abuse of an elderly individual or dependent adult, or plans to harm yourself or someone else. In this context, abuse may include physical, sexual, emotional, or financial forms.

Benefits:

Benefits include the opportunity to think deeply about your approach to sexual minority internalized stigma, including aspects you may identify as being helpful to clients. Engagement in this process may also enhance your framework for understanding sexual minority internalized stigma, helping you be more intentional in future clinical practice.

Confidentiality:

The information you give me will not be shared with anyone outside of the research team. Your information will be kept confidential and will be stored according to safety standards approved by the Human Subjects committee. I will not keep your name, identifying information, or audio recordings past completion of the research study. After completion of the study, the data we collect will not be linked to your identity in any way. Audio recordings of your interview will be deleted once the interviews have been transcribed and de-identified.

Payment:

You will be compensated \$35 following completion of the interview. Individuals who choose not to complete the entire interview for whatever reason will be partially compensated \$10. Payment will be delivered in the form of a Visa gift card. You have the option of receiving your gift card either electronically or in the mail. Participants who completed their interview will be invited to provide corrections on their transcribed interviews but are not required to do so and no additional compensation is offered for this task.

Withdrawal:

Your involvement is voluntary and consent can be withdrawn at any time. You may choose not to answer questions you do not wish to answer.

Questions:

If you have any questions or concerns about this research project, please contact: Krishna Kary, MA (krishnakary@ucsb.edu; (707) 972-5703) between the hours of 9am-5pm, PST, M-F. If you have any questions regarding your rights and participation as a research subject, please contact the Human Subjects Committee at (805) 893 -3807 or hsc@research.ucsb.edu. Or write to the University of California, Human Subjects Committee, Office of Research, Santa Barbara, CA 93106-2050

This research project is being overseen by Tania Israel, PhD (tisrael@ucsb.edu; (805) 893-5008), professor in the department of Counseling, Clinical, and School Psychology at the University of California, Santa Barbara.

Appendix B

Demographic Questionnaire

Age: _____

Race/Ethnicity:

Are you of LatinX, Spanish, or Hispanic Origin?

_____ No (skip to next question)

_____ Yes

_____ Mexican, Mexican-American, ChicanX

_____ Puerto Rican

_____ Cuban

_____ Another LatinX, Spanish, or Hispanic Origin (please specify): _____

Please check all that apply:

_____ American Indian or Alaskan Native

_____ African-American

_____ Asian Indian

_____ Black

_____ Chinese

_____ Filipino

_____ Guatemalan or Chamorro

_____ Japanese

_____ Korean

_____ Native Hawaiian

_____ Samoan

_____ Vietnamese

_____ White

_____ Other Asian (please specify): _____

_____ Other Pacific Islander (please specify): _____

_____ Other race/ethnicity not listed here (please specify): _____

Gender & Sexual Orientation

Preferred Gender Pronouns:

_____ She/her/hers

_____ He/him/his

_____ They/them/theirs

_____ Other pronoun (please specify) _____

Assigned birth sex/gender:

_____ Female

_____ Male

_____ Intersex

Gender identity:

- Woman
- Man
- Transgender woman
- Transgender man
- Bigender
- Nongender/Agender
- Genderqueer
- Gender Nonconforming
- Other (please specify) _____

Sexual orientation (identity):

- lesbian
- gay
- bisexual
- queer
- pansexual
- heterosexual
- questioning
- unlabeled
- asexual
- other (please specify) _____

Religion/Spirituality

Please identify the religious/spiritual denomination(s) with which you most closely identify:

Mental Health Provider Demographics

State in which you are licensed and currently practicing: _____

License/Credential Type: _____

Number of post-licensure years in clinical practice: _____

Current practice setting: _____

Estimated percentage of total face-to-face hours spent with sexual minority clients (inclusive of pre-licensure training): _____

Estimated percentage of current caseload identified as sexual minorities: _____

Appendix C

Interview Protocol

Introduction:

Hello. Thank you for taking the time to participate in this dissertation study. As was noted in the consent form, I am a graduate student studying counseling psychology at UCSB. As a reminder, our interview will be audio recorded so your responses can be transcribed and captured accurately for our analysis. Do you have any questions before we get started?

As you know, in this study we are trying to understand how experienced mental health providers like yourself address internalized stigma with sexual minority clients in psychotherapy. As you know, sexual minority people encounter negative messages about themselves from peers, family members, religion, media, and other sources. It's common for LGB people to come to believe these messages about themselves – this is what I'm referring to when I use the term "internalized stigma." For example, living in a society where homosexuality is considered sinful or pathological might result in someone believing that they are sinful or that there is something wrong with them because they are a sexual minority.

Introductory Question: Can you start by telling me your general thoughts on addressing internalized stigma with sexual minority clients?

Case Example: Part of how we have structured our study is to gather information about an actual case where you worked with a sexual minority client to address internalized stigma. Please do not divulge any identifying information about your client during the interview. You are welcome to assign a pseudonym that we can use to reference the case during our interview.

1. **Case Overview:** Can you start by describing the case to me, including:
 - a. basic demographic information (e.g., age, gender, sexual orientation, etc.)
 - b. contextual information (e.g., developmental history, home environment, geographic region of origin and treatment)
 - c. presenting issue(s), setting, and length of treatment
 - d. presentation of internalized stigma
2. **Treatment Overview:** Can you describe the course of treatment with regard to addressing internalized stigma with that case?
3. **Tailoring Approach:** What individual characteristics of this particular client influenced your approach?
4. **Conceptualization:** Based on your theoretical orientation, can you describe how your case conceptualization guided your approach with this client?

5. **IS Assessment:** How did you identify that internalized stigma was an issue for your client?
6. **Interventions:** Can you give some more detail about the specific interventions that you used with this client over the course of treatment?
 - a. Prompt: Can you give me an example of what that (*insert participant description*) sounded like in the room?
 - b. Prompt: Can you say more about to what extent you made discussion of internalized stigma explicit, or not, in your work with that client?
 - c. Prompt: With that same case, what guided your decision to be more or less explicit in your approach?
7. **Outcome Assessment:** For the case you described, what were the desired outcomes?
 - a. Prompt: How did you determine your approach was helpful?
 - b. Prompt: Were there things you might have done differently with that client in terms of addressing internalized stigma?

General Questions:

8. **Approach Between Clients:** In what ways do you alter your approach based on differences from one client to the next?
9. **Barriers:** Can you describe any barriers that keep you from addressing internalized stigma in psychotherapy with sexual minorities?
10. **Other:** If there are other comments you wanted to share about your experience of working with sexual minorities who experience IS, you can share those now.