Sexual Orientation and Mental Health

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Abstract

This article provides an overview of current psychological research on mental health and sexual orientation, as well as clinical practice with sexual minorities. The historical context for current research questions and controversies is described, and the findings of recent empirical research on psychological well-being and distress among nonheterosexuals are summarized. The minority stress model is used to frame a discussion of stressors unique to sexual minorities and to consider their possible effects on psychological well-being. The possible ameliorative effects of adopting a sexual orientation identity are examined, followed by a discussion of how these ideas translate into contemporary clinical work with sexual minority clients. The review concludes with a brief discussion of priority areas for empirical research and clinical practice.

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INTRODUCTION

Homosexuality has not been classified as a mental illness for more than 30 years. Yet the fact that it was assumed to be a pathology during much of the twentieth century continues to complicate discussions of mental health and sexual orientation. The problem is apparent when beliefs about heterosexuality and homosexuality are contrasted. When psychopathology occurs among heterosexuals, it is not interpreted by the mental health professions or society at large as implicating heterosexuality per se as the cause of the individual's problem, even when it is manifested in sexual thoughts, feelings, and behaviors. Rather, psychological interventions aim to help mentally ill and distressed heterosexuals to live their lives in a fulfilling way, as heterosexuals, fully capable of establishing meaningful intimate relationships with people of the other sex.

By contrast, despite mainstream professional opinion to the contrary, some elements of society still regard homosexuality as pathological and believe that sexual minority adults should try to become heterosexual. Prejudice and discrimination against gay, lesbian, and bisexual people remain widespread. Their perpetrators often seek legitimacy in the argument that homosexuality is "sick," "abnormal," or "unnatural." In this milieu, empirical research revealing differences in psychological health between sexual minorities and heterosexuals can be inappropriately seized upon to argue that homosexuality is indeed an illness that needs to be cured.

Consequently, any discussion of sexual orientation and mental health must be grounded in recognition of the extent and effects of sexual stigma, that is, the stigma historically attached by society to same-sex attraction and minority sexual orientations (Herek 2004). Such stigma has played a central role in shaping the mental health professions' stance toward homosexual behavior and people with minority sexual orientations. Indeed, although sexual stigma has long been expressed through cultural institutions such as the law and religion, much of its legitimacy during the past century derived from homosexuality's status as a psychopathology.

Mindful of this fact, the present review focuses on the mental health of sexual minority individuals. Although it is titled "Sexual Orientation and Mental Health," heterosexuals are discussed mainly as a comparison group. Our purpose in taking this approach is not to discount the mental health needs of heterosexuals, which have long been central in psychological science and the mental health professions. Nor do we intend to problematize sexual minority mental health while assuming heterosexuality to be the gold standard, as was historically done by psychiatrists, psychologists, and society at large. Rather, we hope to advance the discourse about mental health among sexual minorities beyond outdated conceptualizations of homosexuality that were informed more by societal stigma than empirical data, and instead address the topic without pathologizing sexual minority individuals as a class.

In this article, we give an overview of current psychological research on mental health and sexual orientation, as well as clinical practice with sexual minorities. After establishing the historical context for current research questions and controversies, we summarize the findings of recent empirical research on psychological well-being and distress among nonheterosexuals. We then consider how various stressors unique to sexual minorities may affect their psychological well-being, and how adopting a sexual orientation identity might ameliorate the effects of these stressors. Next, we discuss how these ideas translate into contemporary clinical work with sexual minority clients. Finally, we highlight priority areas for empirical research and practice.

HISTORICAL BACKGROUND

Historically speaking, sexual orientation is a fairly new construct. Although heterosexual and homosexual behaviors are ubiquitous across human societies, notions of "the homosexual" and "the heterosexual"—as well as the very idea that individuals can be defined in terms of their sexual attractions and behaviors—emerged in medical discourse only in the nineteenth century. They are usually traced to Karl Maria Benkert's use of "homosexuality" in 1868 in a German-language pamphlet (Dynes 1990, Katz 1995). Benkert also introduced the term "heterosexual" in 1868 but he did not consistently use it as the opposite of homosexual. Instead, he contrasted homosexual with "normalsexual." When heterosexual was first introduced into English in 1892, it referred to people who felt "inclinations to both sexes" (Katz 1995, p. 20), what today would be called bisexuality. However, Richard von Kraft-Ebing's *Psychopathia Sexualis*, translated into English late in the nineteenth century, used "hetero-sexual" to refer to desire for the other sex (Katz 1995, Krafft-Ebing 1900). Not until Freud articulated his conceptualization of homosexuality in the first of his *Three Essays on the Theory of Sexuality*, however, did the modern notion of sexual orientation defined in terms of object choice (i.e., the kind of person or thing toward which the sexual aim is directed) become dominant in psychiatric discourse (Chauncey 1982–1983, Freud 1953).

As Benkert's original usage makes plain, homosexuality was defined from the outset in opposition to normalcy. Stigmatization of homosexuality was always integral to society's construction of sexual orientation. Nevertheless, the modern history of sexual orientation has been characterized by an ongoing dialectic between views of homosexuality as pathological (e.g., Krafft-Ebing 1900) and challenges to its linkage with mental illness (Ellis 1901, Ulrichs 1994). Even Freud, who believed that homosexuality represented a less-than-optimal outcome for psychosexual development, nevertheless asserted in a now-famous 1935 letter that "it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness" (Freud 1951, p. 786).

American psychoanalysts, however, broke with Freud. In contrast to Freud's view that humans are innately bisexual, Rado (1940, 1949) argued that only heterosexuality is natural and that homosexuality is a "reparative" attempt to achieve sexual pleasure when normal heterosexual outlet proves too threatening. Rado's followers proposed various theories about homosexuality's etiology, all of them based on an illness model, that is, the assumption that homosexuality is a sickness (Bieber et al. 1962, Socarides 1968).

Psychoanalysis was the dominant perspective in psychiatry during the mid-twentieth century, and the psychoanalysts' assumption that homosexuality was a pathology permeated U.S. culture (Bayer 1987, Friedman & Downey 1998, Silverstein 1991). During World War II, for example, when the U.S. military incorporated psychiatric screening into its induction process, formal procedures were developed for rejecting gay recruits (Bérubé 1990). After the war, the newly created *Diagnostic and Statistical Handbook of Mental Disorders*, or DSM, listed

homosexuality as a sociopathic personality disturbance, along with substance abuse and sexual disorders (Am. Psychiatr. Assoc. 1952). During this era, many psychiatrists set out to "cure" homosexuality; homosexual men and women spent countless hours in psychotherapy in what proved to be, for most, a vain attempt to change their sexual orientation (Friedman & Downey 1998, Haldeman 1991). When psychotherapy did not work, many tried (or were coerced into) more drastic methods, including administration of hormones, aversive conditioning, lobotomy, electroshock, and castration (Katz 1976).

Challenges to the psychiatric orthodoxy emerged around this time. Kinsey's groundbreaking studies of sexuality challenged widespread assumptions by revealing that homosexual behavior and attractions were surprisingly common (Kinsey et al. 1948, Kinsey et al. 1953). An influential comparative study documented the existence of homosexual behavior in many nonhuman species and its acceptance in a large number of human cultures (Ford & Beach 1951).

Against this backdrop, Hooker (1957) first introduced key elements of modern research design into psychological studies of sexual orientation and mental health. Rather than accepting the dominant view of homosexuality as pathology, she treated the question of whether homosexuals and heterosexuals differed in their psychological adjustment as an empirical one. Her landmark study compared a nonclinical sample of homosexuals with a matched heterosexual control group, relying on evaluations of projective test protocols by experts who were unaware of each subject's sexual orientation (Hooker 1957). When the Rorschach experts could not identify the respondents' sexual orientation at a level better than chance and their ratings of homosexual and heterosexual men's adjustment did not differ significantly, Hooker concluded that homosexuality is not inherently associated with psychopathology and is not a clinical entity (Hooker 1957).

In the wake of Hooker's study, other researchers compared the psychological functioning of heterosexuals and homosexuals. In a review of these studies, Gonsiorek (1991) noted several important considerations in evaluating the results, two of which are particularly germane to the present article. First, research outcomes were greatly affected by sampling. Many studies used samples of homosexual individuals who were incarcerated or undergoing psychiatric treatment. Not surprisingly, these participants typically evidenced more psychological problems than did heterosexuals recruited from nonclinical venues. Second, Gonsiorek noted that differences in psychological test scores were often inappropriately interpreted as indicative of pathology in one group. Statistical significance should not be equated with clinical significance, however, because two groups can score differently on such measures and both remain within the normal range of functioning (Gonsiorek 1991). Empirical studies that avoided these and other pitfalls failed to support the notion that homosexuality per se is indicative of psychopathology (Gonsiorek 1991, Hart et al. 1978, Riess 1980).

Nevertheless, the growing body of research data alone proved inadequate for convincing mental health practitioners to repudiate the illness model. Soon after the second edition of the DSM listed homosexuality as a "Sexual Deviation," along with fetishism and pedophilia (Am. Psychiatr. Assoc. 1968), however, the newly emerging movement for gay and lesbian civil rights inspired many sectors of U.S. society to reconsider their long-standing assumptions about homosexuality (Adam 1995). In the face of rapidly changing cultural views about homosexuality, and in recognition that empirical data were lacking to support the illness model, the American Psychiatric Association's Board of Directors voted in 1973 to remove homosexuality from the DSM. Their decision was affirmed by a vote of the Association's membership in 1974. The American Psychological Association (APA) strongly endorsed the

psychiatrists' actions, and has since worked intensively to eradicate the stigma historically associated with a homosexual orientation (Conger 1975, Morin & Rothblum 1991).

As this brief history shows, the medical and scientific institutions that provided much of the ideological rationale for stigmatizing homosexuality during the first half of the twentieth century dramatically reversed themselves in 1973. Today the mainstream position among clinicians and researchers is that homosexuality is a normal variant of human sexual expression and is no more inherently associated with psychopathology than is heterosexuality.

CONTEMPORARY RESEARCH ON SEXUAL ORIENTATION AND MENTAL HEALTH

With the advantage of hindsight, it can be seen that debates about the status of homosexuality as a pathology often conflated issues of classification and the definition of mental illness with questions about the prevalence of psychological disorders in a particular population. It was inappropriately assumed that if homosexuals simply evidenced higher rates of psychopathology or psychological distress than did heterosexuals, then homosexuality itself must be an illness (Meyer 2003). Consequently, conducting research on the mental health needs of sexual minority communities always carried the risk of further stigmatizing nonheterosexuals. With the demise of the illness model, such risks have abated, although the research is still at a preliminary stage in important respects. In the section below, we review the current state of the available data.

Preliminary Considerations

Before discussing the findings, it is important to consider four aspects of research design that affect the interpretation of data: sampling strategies, the operational definition of sexual orientation, the operational definition of mental health, and data analysis strategies.

Sampling. As noted above, empirical research conducted within the framework of the illness model often recruited homosexual participants from clinical and incarcerated populations. Later research used community-based samples, which were less biased toward psychopathology but also had limited generalizability. Samples recruited at community festivals, for example, may have been biased toward well-functioning individuals, whereas samples recruited through bars probably overrepresented sexual minority individuals who consumed alcohol. In recent years, researchers have begun to publish studies that use innovative sampling strategies to overcome these limitations. Some large-scale health surveys, for example, have included questions about sexuality or romantic attractions. This has permitted researchers to examine differences in a variety of health indices according to respondents' sexual behavior or identity in national probability samples (e.g., Cochran & Mays 2006, Russell 2006). In other cases, studies conducted with large nonprobability samples that were not initially recruited on the basis of sexual orientation have yielded data on sexual orientation and health (e.g., Case et al. 2004). Still other researchers have collected original data from nonprobability samples of sexual minority adults and their heterosexual siblings, thus permitting group comparisons that control for multiple background variables (e.g., Herrell et al. 1999, Rothblum & Factor 2001). Because the results from these studies are more readily generalizable to the sexual minority population than are data from earlier research with small convenience samples, our discussion focuses on them.

Operational definitions of sexual orientation. Because of sexual stigma, some individuals are unwilling to disclose their homosexual or bisexual orientation to researchers, especially when traditional survey techniques

are used (Villarroel et al. 2006). Even when research participants provide accurate information about their sexuality, how they are categorized for purposes of data analysis depends on the operational definition of sexual orientation selected by the researcher. In most empirical research, sexual orientation has been defined in terms of sexual attraction, sexual behavior, or self-labeling as gay, lesbian, or bisexual. Because individuals are not always consistently heterosexual or homosexual across these dimensions (Laumann et al. 1994, Villarroel et al. 2006), research participants who are categorized as heterosexual by one criterion might have been classified as homosexual or bisexual if a different operational definition had been employed. Unfortunately, most published studies have relied on a single dimension for operationalizing sexual orientation. When interpreting the research, therefore, it is always important to consider how sexual orientation was measured and to recognize the potential for misclassification.

Operational definitions of psychological distress. Empirical studies have used a variety of strategies for assessing psychological distress, including structured diagnostic interviews (e.g., Cochran & Mays 2006), self-reports of symptoms using standardized scales or checklists (e.g., Rothblum & Factor 2001), and respondents' subjective ratings of their own level of functioning or distress (e.g., Diamant & Wold 2003). We note three important caveats for interpreting these data. First, as explained above, differences between sexual orientation groups on measures of psychological well-being can be statistically significant without indicating clinically significant differences in functioning. That is, two groups can have reliably different mean scores on a psychological test or symptom inventory yet both be within the normal range of functioning (Gonsiorek 1991). Second, individual items on psychological tests can have different meanings and thus evoke different response patterns from different cultural groups. These variations in response patterns can produce group differences in test scores. Hence, making clinical inferences about sexual minority adults based on predetermined cutoff scores derived from testing heterosexual adults is of questionable validity in the absence of standardization data from gay, lesbian, and bisexual respondents. Such independent validation of psychological tests with sexual minority populations has been rare. Third, sexual minority individuals are more likely than heterosexuals to receive psychotherapy or counseling, regardless of their level of functioning (Cochran & Mays 2006). This often occurs when they first recognize their sexual orientation and begin to disclose it to others (a process referred to as "coming out of the closet" or simply "coming out"). Consequently, they may be more attuned to their own internal states and more able and willing than heterosexuals to report psychological symptoms to researchers (Meyer 2003).

Data analysis strategies. Because a fairly small proportion of the population reports same-sex sexual behavior or identifies as gay, lesbian, or bisexual, the number of nonheterosexual respondents in most general samples is typically small. Some samples include so few nonheterosexual respondents that drawing conclusions from them about sexual minorities is extremely perilous. For example, one longitudinal study based its analyses of sexual orientation and mental health on a sample of 967 adults that included only 7 males and 20 females who were not exclusively or predominantly heterosexual (Fergusson et al. 2005). Even in samples with larger numbers of sexual minority respondents, researchers frequently have had to combine all nonheterosexuals for data analyses to achieve adequate statistical power. In nearly all of the studies discussed below, comparisons were made mainly between (*a*) a heterosexual group comprising respondents who labeled themselves heterosexual or reported a history of exclusively heterosexual behavior and (*b*) a nonheterosexual group comprising

individuals who reported having ever engaged in a homosexual act as well as self-identified lesbians, gay men, bisexual women, and bisexual men.[1] With this approach, nonheterosexual subgroups (e.g., bisexuals versus homosexuals) cannot be examined separately, which, as discussed below, may obscure important intergroup differences in mental health.

Empirical Findings

Mindful of these considerations, the main findings from recent empirical research can be summarized. First, regardless of their sexual orientation, most respondents in large-scale epidemiological surveys do not manifest heightened risk for psychopathology, suicidality, substance use, or psychological distress (e.g., Cochran & Mays 2006). Second, nonheterosexuals appear to be at greater risk than heterosexuals for anxiety and mood disorders. This general pattern has been observed among nonheterosexual men (Cochran & Mays 2000a, Cochran et al. 2003, Sandfort et al. 2001) and women (Case et al. 2004, Cochran et al. 2003, Gilman et al. 2001, Sandfort et al. 2001). However, some studies have not found statistically significant differences among sexual orientation groups when relevant demographic factors were statistically controlled (for women: Cochran & Mays 2000a; for men: Cochran & Mays 2000b, Gilman et al. 2001; for women and men: Balsam et al. 2005).

Third, nonheterosexual adults are more likely than are heterosexuals to report past suicidal ideation and attempts (Balsam et al. 2005, Cochran & Mays 2000b, Gilman et al. 2001, Herrell et al. 1999). Self-reported suicidal ideation and attempts are also more common among nonheterosexual (versus heterosexual) adolescents (Russell 2003). Some studies have found a greater risk for male sexual minority youths compared with females (Garofalo et al. 1999, Remafedi et al. 1998), but others have found both nonheterosexual girls and boys to be at higher risk than heterosexuals (Russell & Joyner 2001). Fourth, in comparison with heterosexual women, nonheterosexual women appear to consume alcohol in greater amounts and more frequently (Burgard et al. 2005, Case et al. 2004, Scheer et al. 2003) and may be at greater risk for problems related to alcohol consumption (Cochran et al. 2000, Drabble et al. 2005, Gilman et al. 2001, Sandfort et al. 2001).

FACTORS AFFECTING MENTAL HEALTH AMONG SEXUAL MINORITY POPULATIONS

In summary, the available empirical data suggest that although most nonheterosexual men and women function well, this population may be at heightened risk for some forms of psychopathology, psychological distress, and problems with substance use. Because operational definitions of sexual orientation have differed across studies and most samples have included relatively small numbers of nonheterosexuals, however, these data do not offer many insights into the factors that distinguish the well-functioning majority of sexual minority individuals from those who are distressed. In the present section, we consider possible explanations for the occurrence of psychological problems among sexual minorities.

Since the demise of the illness model, a minority stress model has become the most commonly used framework for conceptualizing mental health among lesbian, gay, and bisexual individuals. It posits that minority group members are at risk for some kinds of psychological problems because they face unique,

[1] In describing research findings, we use the terms "gay," "lesbian," and "bisexual" only when (*a*) respondents' self-labeled sexual orientation was assessed and (*b*) data were reported separately for different sexual minority groups. Because of the variety of different operationalizations across studies, we believe "nonheterosexual" is the most accurate term for collectively characterizing the findings when two or more sexual orientation or sexual behavior groups were combined for purposes of analysis (e.g., self-labeled lesbians and bisexual women; men reporting a history of any homosexual behavior).

chronic stressors as a result of their disadvantaged status in society. These stressors are experienced in addition to the routine stressors encountered by nonminority individuals. Although the minority stress model has not yet been subjected to extensive empirical testing (Meyer 2003), it offers a valuable framework for conceptualizing the experiences of stigmatized groups. It highlights three stress processes: (*a*) external, objectively stressful events and conditions, (*b*) the minority individual's expectations of such events and the vigilance this expectation requires, and (*c*) the minority individual's internalization of negative societal attitudes (Meyer 2003). We use these three categories as a framework for discussing the challenges routinely encountered by sexual minority individuals.

First, sexual minority individuals face a variety of objectively stressful events that heterosexuals do not experience. Because most such events are directly related to the stigmatized status of sexual minorities, our discussion focuses on the effects of sexual stigma. It should be understood, however, that minority groups also face other unique stressors that are not directly caused by stigma (although stigma often plays a role in how those stressors are experienced and understood). For example, the human immunodeficiency virus (HIV) epidemic has been a unique source of stress for sexual minority individuals in the United States because of its disproportionate impact on gay and bisexual men. Many sexual minority men deal with the stress of having HIV disease, and those who are healthy are regularly confronted with the possibility of infection. Many men have experienced the death of a life partner. Sexual minority men and women alike have experienced extensive losses in their personal and social networks resulting from the death of close friends and acquaintances. Indeed, many gay, lesbian, and bisexual individuals experienced the loss of entire communities during the 1980s and 1990s. Such experiences of disease and multiple losses are linked to high levels of psychological distress (Folkman et al. 1996, Martin 1988). Given these effects, the HIV epidemic would have been a source of stress to any community. However, the pervasiveness of sexual stigma exacerbated the stress by impeding society's response to the epidemic and contributing to HIV-related stigma (Herek et al. 1998, Herek & Capitanio 1999).

Sexual stigma also leads to other objectively stressful events. Once their sexual orientation becomes known to others, sexual minority individuals can be subjected to multiple types of "enacted stigma" (Scambler & Hopkins 1986), ranging from personal rejection and ostracism to discrimination and criminal victimization (Herek et al. 1999, Herek & Sims 2007, Mays & Cochran 2001). Experiencing enacted stigma can have serious and enduring psychological consequences. For example, for gay men and lesbians, being the target of antigay violence can be even more traumatic than "routine" criminal victimization; victims of hate crimes manifest heightened levels of depressive symptoms, anxiety, and symptoms of posttraumatic distress compared with sexual minority victims of violent crimes that were not motivated by antigay animus (Herek et al. 1999; see also Huebner et al. 2004, Mills et al. 2004). In one national survey, Mays & Cochran (2001) found that the correlation observed between mental health and sexual orientation was largely explained by nonheterosexuals' experiences with discrimination; when the latter were statistically controlled, heterosexuals and nonheterosexuals did not differ significantly on mental health indicators.

In addition to direct enactments of stigma, sexual minority individuals are also subjected to the effects of institutionalized stigma, or "heterosexism" (Herek et al. 2007). At the time of this writing, for example, same-sex couples are denied the right to marry in all U.S. states except Massachusetts. Being denied the right to marry probably subjects same-sex couples to more stress than heterosexual married couples, has negative consequences for their well-being, and ultimately creates challenges and obstacles to the

success of their relationships that are not faced by heterosexual couples (Herek 2006). Sexual stigma also has negative economic effects, especially for gay men, who may earn significantly less than their heterosexual counterparts (Badgett 2001, Herek et al. 2007). Furthermore, because many religious denominations condemn homosexual relationships (Herek et al. 2007), sexual minority individuals are often disenfranchised from religious and spiritual resources that might otherwise ameliorate the effects of stress.

A member of a stigmatized minority group need not be a victim of enacted stigma directly in order to be affected by it. "Felt stigma" refers to an individual's subjective experience of stigma against her or his group, including her or his awareness of stigma's prevalence and manifestations even without having directly experienced enacted stigma (Scambler & Hopkins 1986). Felt stigma is likely to be heightened by societal events in which antigay hostility is made salient, such as highly visible acts of antigay violence (Noelle 2002) and antigay political campaigns (Russell 2000, Russell & Richards 2003).

Felt stigma plays a central role in sexual minority individuals' decision-making about whether and when to disclose their sexual orientation. Making such decisions typically involves weighing the relative costs and benefits of coming out, including others' likely responses to one's sexual orientation and the impact of prejudiced social reactions to one's subjective well-being (Cole 2006, Herek 1996). On the one hand, public revelation that one is not heterosexual can incur enacted stigma. On the other hand, concealing one's sexual minority identity requires constant vigilance regarding the personal information one shares with other people. Many sexual minority individuals adopt a strategy of "rational outness," that is, being as open as possible about their sexual orientation while remaining as closed as necessary to protect themselves against discrimination (Bradford & Ryan 1987, p. 107). The subjective meanings of "as open as possible" and "as closed as necessary," however, differ widely depending on the individual's circumstances and personality factors. For example, whereas many studies have revealed a positive correlation between being out and positive psychological and physical states (e.g., Jordan & Deluty 1998, Morris et al. 2001, Ullrich et al. 2004), this pattern has not been uniformly observed (e.g., Frable et al. 1997), perhaps because individuals who are highly sensitive to social rejection may not benefit from being out of the closet (Cole 2006). Thus, disclosure of one's sexual orientation represents a strategy for managing stigma, but the decisions that a sexual minority individual makes about being out of the closet can also have stressful consequences.

Such decisions can be influenced by the third source of stress identified by the minority stress model: the individual's self-stigmatization as a consequence of accepting society's negative attitudes toward nonheterosexuals. This phenomenon has been variously labeled internalized homophobia, internalized heterosexism, and internalized homonegativity. Mental health practitioners and researchers generally agree that negative feelings about one's own homosexual desires are likely to have important consequences for physical and psychological well-being, including diminished self-esteem, demoralization, depression, increased use of alcohol and drugs, and relationship instability (DiPlacido 1998, Shidlo 1994, Szymanski & Chung 2003, Williamson 2000). To the extent that high levels of internalized stigma lead sexual minority individuals to conceal their sexual orientation beyond what is required to protect themselves from enactments of stigma, it can exacerbate minority stress.

Collective Identity as a Potential Moderator of Minority Stress

The fact that most nonheterosexuals do not manifest high levels of depression, anxiety, suicidality, and substance abuse indicates that they cope successfully with the stress created

by stigma. It is appropriate to ask how they do it. Meyer (2003) pointed out that sexual minority individuals draw on both personal and group resources in coping with minority stress. Variations in personal resources reflect individual differences in, for example, resilience, hardiness, and coping styles (e.g., Masten 2001, Ouellette & DiPlacido 2001). By contrast, group resources, as elements of the larger social structure, are potentially available to all sexual minority individuals who have developed a collective identity based on their sexual orientation.

Used in this sense, a collective identity (sometimes referred to as a social identity) involves strong identification with a social group and linkage of one's self-esteem to group membership (Ashmore et al. 2004). Nonheterosexuals whose sexuality is part of a collective sexual orientation identity integrate their sexual feelings, intimate relationships, and affiliations with the sexual minority community into the core of their self-concept. If they encounter enactments of stigma, they are likely to interpret those events as unjust not only from an individual perspective but also because they believe it is wrong to treat anyone differently because of their sexual orientation (Branscombe & Ellemers 1998). Such individuals will have group resources for responding to stigma in addition to their personal coping abilities. By contrast, nonheterosexuals who adopt an assimilationist or individual identity pattern (Fingerhut et al. 2005, McCarn & Fassinger 1996) conceive their sexuality largely in personal terms, discounting the importance of sexual behaviors and desires for defining their sense of self. Without necessarily denying or rejecting their personal same-sex desires, they might distance themselves from or even express hostility toward the gay and lesbian community. If they encounter enactments of sexual stigma, they may object on the grounds that they should be regarded as unique individuals rather than members of a group defined on the basis of sexual orientation. Such people frame their sexuality largely in terms of personal identity, and their resources for responding to stigma are thus largely a function of their personal coping abilities.

Nonheterosexuals who actively participate in a sexual minority community report less psychological distress than those who do not (Lewis et al. 2001, Luhtanen 2003, Mills et al. 2004, Morris et al. 2001). This pattern may occur because a collective identity affords an individual additional resources beyond those available through a purely personal identity. Thus, in comparison with other nonheterosexuals, individuals who adopt a sexual minority identity may be better equipped to cope with minority stress. By identifying and affiliating with similarly stigmatized others, they are able to experience social environments in which they are not stigmatized. In such environments, they can more readily develop a worldview that invalidates negative stereotypes and biases while affirming positive evaluations of the group and its members. This worldview can reduce an individual's level of internalized stigma while fostering a positive collective identity (e.g., Frable et al. 1997). Minority communities can also provide emotional and instrumental support for dealing with stigma and teach survival skills for meeting the challenges created by sexual stigma (e.g., Bowleg et al. 2003, D'Augelli et al. 1987, Ueno 2005). Adopting a collective identity also increases the likelihood that sexual minority individuals will come out to their heterosexual family members, friends, and acquaintances. To the extent that significant others respond favorably, coming out can make additional social support available in the face of societal stigma (e.g., Hershberger & D'Augelli 1995, Luhtanen 2003).

This discussion highlights an important limitation of research that combines all sexual minority respondents into a single "nonheterosexual" group. That undifferentiated category inevitably includes not only individuals with a collective sexual orientation identity, but also those who regard their sexuality in purely personal terms. Indeed, two leading researchers in this area estimated that only

half of the individuals who report sexual contact with a same-sex adult actually identify as lesbian, gay, or bisexual (Cochran & Mays 2006). Consistent with this observation, the proportion of adults who identified as gay, lesbian, or bisexual in a 2000 national probability sample was roughly the same as the proportion who reported same-sex behavior but identified as heterosexual (Drabble et al. 2005). If sexual minority individuals with a collective identity experience lower levels of psychological distress than do nonheterosexuals with a purely personal sexual orientation identity, then the group differences in mental health observed in the research described above may be due mainly to heightened distress among the latter.

It is important to recognize that collective identity is not static. The meanings attached to sexuality have changed over the past century (Chauncey 1994) and are likely to continue to change in the future. The political activism of gay, lesbian, and bisexual groups since the 1970s has increased public awareness of sexual minority communities, expanded civil rights protections, and lessened social constraints on the lives of nonheterosexuals (Garnets & Peplau 2006). Consequently, the world in which today's sexual minority youth come to understand their sexual orientation is vastly different from that of previous generations. Indeed, not all manifestations of same-sex sexuality among contemporary youth are adequately accounted for by the labels "gay," "lesbian," and "bisexual" and the identities associated with them (Diamond 2006, Russell 2006, Savin-Williams 2005). Thus, any attempt to understand the role of collective identity in shaping sexual minority mental health must necessarily be grounded in its historical and cultural context.

Moreover, the benefits of collective identity may be offset to some degree by the increased vulnerability to stigma that results from greater visibility. For example, hate-crime victimization is more likely to be experienced by gay, lesbian, and bisexual individuals who are out of the closet (Herek et al. 1999, Huebner et al. 2004). In addition, involvement with the sexual minority community may include exposure to subgroups that engage in maladaptive behaviors, such as alcohol abuse. To the extent that the net benefits of embracing a collective identity outweigh the net costs of visibility, however, individuals who strongly identify as lesbian, gay, or bisexual seem likely to manifest less psychological distress and pathology than individuals whose same-sex attractions and behavior are not part of a collective identity.

Effects of multiple identities. In a complex society, most individuals have multiple collective identities, each of which can assume greater or lesser salience in different situations. When two or more of those identities are stigmatized, an individual may be the target of multiple prejudices in majority group contexts (e.g., as an African American, a woman, and a lesbian) but may also experience prejudice in minority community settings (e.g., sexual prejudice from black heterosexuals, racial prejudice from white lesbians). Individuals with multiple statuses may even have difficulty assessing the source of stigma in a particular situation, as when lesbian victims of hate crimes are uncertain whether they were attacked because of their sexual orientation or their gender (Von Schulthess 1992).

Having multiple minority statuses increases one's chances for experiencing stigma (Diaz et al. 2006, Greene 1994), but integrating multiple identities may enhance a minority individual's overall psychological resilience and increase one's available resources for coping with stigma (Crawford et al. 2002). As children, for example, sexual minority individuals typically are not taught the skills necessary for coping with sexual prejudice. However, members of racial and ethnic minority groups often acquire relevant skills from family members and community elders early in life. To the extent that such skills are transferable from the experience of dealing with racial and ethnic stigma to dealing with sexual stigma, individuals with both a sexual and

ethnic minority status may be better prepared than Euro-American sexual minority individuals (Greene 1994). In addition, individuals with multiple identities may be especially resilient to stress because of the greater complexity of their self-concept and their ability to strategically emphasize identities that are socially valued in a specific context (Shih 2004). Thus, sexual minority individuals with multiple minority identities do not necessarily evidence greater psychological distress than do their Euro-American counterparts (e.g., Consolacion et al. 2004) and may even be better equipped to cope with minority stress.

MENTAL HEALTH PRACTICE WITH SEXUAL MINORITIES

Since the demise of the illness model, mental health practitioners have developed new approaches to guide the provision of mental health services to sexual minorities. Consistent with the minority stress model, this gay-, lesbian-, and bisexual-affirmative approach interprets many of the problems experienced by sexual minority individuals as resulting from sexual stigma. It focuses on helping gay men, lesbians, and bisexuals to cope adaptively with the impact of stigma and their minority status. Affirmative practice assists them in understanding and accepting their sexual orientation as a natural part of themselves; helps them develop strategies for coping and forming a positive sense of identity; and teaches them the effect of sexual stigma on psychological functioning (Browning et al. 1991, Division 44/Committee on Lesbian Gay and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian Gay and Bisexual Clients 2000 [hereafter Division 44/CLGBC 2000], Eubanks-Carter et al. 2005, Perez et al. 2000). To assist providers, educators, and clinical supervisors, the APA has developed professional and ethical guidelines that articulate best practices and core competencies for affirmative practice with sexual minority clients. These and other resources for reducing bias and knowledge deficits in this area are listed in the Appendix.

Widely promulgated guidelines for psychotherapy with sexual minority clients rely on the minority stress model and recommend that mental health practitioners use a minority stress assessment for identifying the negative impact of sexual stigma and prejudice in the lives of sexual minority individuals (Division 44/CLGBC 2000). In such an assessment, the therapist takes a full history of the client's experiences with enacted stigma and seeks to understand how the client subjectively experiences sexual stigma, as well as the psychological consequences (overt and subtle) of her or his internalization of sexual stigma. This approach is helpful in highlighting the central therapeutic tasks that inform affirmative practice with sexual minority individuals.

As discussed above, enacted and felt stigma contribute to an individual's fear of self-identifying as sexual minority. When clients have experienced direct enactments of stigma, a primary therapeutic task is to deal with the aftermath of the victimization. Enactments of stigma may have an additional impact beyond that of other types of victimization because the clients' sexuality may be directly linked to the heightened sense of vulnerability that normally follows such victimization. Consequently, sexual minority clients who experience enacted stigma often must cope with negative feelings about their sexual orientation identity. The focus of therapy includes assessing the meanings that the person is deriving from her or his experience, her or his feelings about the self, and the degree to which the experience is equated with her or his identity as a sexual minority. In addition, it is important to assess the client's internal and external coping resources (e.g., previously developed coping skills, sources of personal social support, current or potential involvement in community networks) with the goal of building on these resources and assisting the client in developing new ones as needed.

The impact of enacted stigma is likely to be affected by the client's location in the coming-out process. If the stigma experience has "outed" the client (i.e., forced an involuntary, premature disclosure of the client's sexual orientation identity), it may have amplified the feelings of vulnerability, alienation, and exposure that are often encountered during the coming-out process. These feelings warrant exploration in therapy with the aim of separating the victimization experience from the coming-out experience. In addition, the practitioner may assist the client in feeling the positive effects of identity disclosure that also are part of coming out. Individuals who are further along in the coming-out process prior to experiencing enacted stigma have the benefit of being able to balance the victimization experience against positive experiences associated with their minority sexual identity. Even so, they may experience negative feelings about their sexuality as a consequence of enacted stigma. In such cases, the central task of the therapist is to review the bases for the client's past coming-out decisions, with the aim of re-establishing her or his positive identity as a lesbian, gay, or bisexual person (Garnets et al. 1992).

Whereas felt stigma is unavoidable and, as explained above, often provides a basis for adaptive responses to sexual stigma, high levels of it can lead to excessive feelings of personal danger and vulnerability, perceptions of the world as malevolent, and a linkage of these perceptions to one's sexual orientation identity. Consequently, one's sexuality can be experienced as a source of pain and punishment rather than intimacy, love, and community. In this situation, the principal therapeutic challenge for practitioners is to help sexual minority clients to establish trust in the world that is tempered by accurate assessments of the dangers resulting from sexual stigma. Given the real social and physical risks that sexual minority clients must face, helping them to develop a sense of safety is of central importance.

Within this context, helping clients to make realistic decisions about when it is and is not safe to come out is an important therapeutic task. For some clients, perceived dangers or restrictions on coming out in a particular situation may in fact be projected prohibitions due to intrapsychic conflicts about dealing with their own sexual identity. Thus, a therapeutic task is to assist clients in distinguishing their projected fears about their sexual identity from the objective risks of discrimination and victimization. The coming-out process has a highly individualized and personal meaning for everyone who goes through it, and the psychological consequences of coming out are influenced by both personality and situational variables (Cole 2006). Consequently, it is important for therapists to assess the situation of each client rather than adhering rigidly to a goal of progressively increasing openness for all.

Because most individuals have internalized sexual stigma to some extent, feelings of ambivalence, conflict, and discontent about one's sexual attractions and behaviors are common in the course of developing a positive sexual orientation identity (Division 44/CLGBC 2000). It is important for practitioners to recognize the extent to which sexual minority individuals' self-stigmatizing attitudes, feelings, and beliefs influence their symptoms of distress. Internalized stigma is not always conscious and its psychological consequences (e.g., shame, anxiety, depression, low self-esteem) are not always obvious. Clients with negative feelings about their own homosexuality often are in the closet and not well integrated into a sexual minority social network (Gonsiorek 1995, Malyon 1981–1982, Shidlo 1994, Szymanski & Chung 2003). A primary therapeutic task associated with internalized stigma is to assist clients in assessing, confronting, and rejecting the negative conception of minority sexual orientation dictated by society, and transforming it into a positive and viable identity in which their sexuality is well integrated with other parts of the self. This process of forming a positive sexual orientation identity involves refuting the negative stereotypes associated with the

cognitive categories of "gay," "lesbian," or "bisexual" and replacing them with positive content.

An example of the consequences of antigay hate crimes illustrates how experiences of enacted stigma can translate into internalized stigma. An antigay attack may be interpreted as a violation of oneself as a gay person; guilt and self-blame may become attached to the individual's sexual orientation, leading to feelings that she or he has been justifiably punished for being gay. This linkage can be harmful because sexual orientation is such an important part of self-identity. Such self-blame can lead to feelings of depression and helplessness, even in individuals who were previously comfortable with their sexual orientation. In such a case, the practitioner's aim is to assist the survivor in cognitively restructuring these false self-attributions about herself or himself and the assault. Specifically, the cognition that "bad things happen because I am gay" should be reformulated to "bad things happen" (Garnets et al. 1992).

Although the affirmative model has become the dominant theoretical approach for psychotherapy with sexual minority clients, it has been slow to be implemented. Empirical research conducted during the 1980s and 1990s found that many clinicians still engaged in practices that sexual minority clients perceived to be biased, insensitive, and unhelpful. Some providers discouraged and demeaned lesbian and gay clients, urged them to become heterosexual, or trivialized and disregarded their intimate relationships, even to the point of refusing to provide therapy to same-sex couples. Some practitioners were uninformed or misinformed about fundamental issues facing sexual minorities, such as the psychological consequences of prejudice and discrimination (Garnets et al. 1991, Liddle 1996). Other studies highlighted weaknesses in training and clinical supervision (Halpert et al. 2006, Murphy et al. 2002, Phillips & Fischer 1998).

These data, in conjunction with observations by practitioners (e.g., Eubanks-Carter et al. 2005), suggest that mental health services for sexual minority clients often may not be comparable to those provided to heterosexuals. Receiving therapy from a psychologist who harbors prejudice or is misinformed about sexual orientation may exacerbate a client's distress. The most dramatic instance of such a problem occurs when a therapist believes that the optimal strategy for sexual minority clients is to attempt to change their sexual orientation (Division 44/CLGBC 2000). Interventions to promote such attempts are variously labeled "conversion therapy," "reparative therapy," or "reorientation therapy" (Bieschke et al. 2006). Whereas individuals may naturally experience changes in their sexual orientation over time (Peplau & Garnets 2000), the human capacity for erotic fluidity does not mean that such change can necessarily be effected by external interventions. Indeed, despite testimonials from individuals who believe they have changed from homosexual to heterosexual (Spitzer 2003), no empirical research has shown that conversion therapies can cause such change (Haldeman 1994, Herek 2003). The available data suggest, however, that such interventions can have negative psychological effects on sexual minority individuals who undergo them (Haldeman 2001, Shidlo & Schroeder 2002), making them ethically questionable regardless of their efficacy (Davison 1991). In recognition of these problems, the APA and the American Psychiatric Association have both adopted official resolutions reaffirming the mainstream position that a homosexual orientation is not pathological and raising ethical concerns about conversion therapy, especially when it is practiced on adolescents (Am. Psychiatr. Assoc. 2000, DeLeon 1998; see also Schneider et al. 2002).

In working with sexual minority clients, practitioners should remember the extent to which internalized stigma may play a central role in creating a person's discomfort with his or her sexual orientation (Davison 1991, Haldeman 1994). When a client is

questioning her or his sexuality or is experiencing discomfort related to it, practitioners need to assess the psychological and social contexts in which this questioning and discomfort occur. Such an assessment might include an examination of internal and external pressures on clients to change their sexual orientation, the presence or absence of social support and models of positive sexual minority life, and the extent to which clients associate homosexuality or bisexuality with negative stereotypes and experiences (DeLeon 1998, Schneider et al. 2002).

The effort to articulate best practices for addressing conversion therapies has been part of a broader discussion of the conflicts that can arise among sexual minority individuals with multiple identities. An affirmative perspective encourages clinicians to recognize the particular life experiences and challenges that stem from the varied and often conflicting norms, values, and beliefs associated with sexual minority clients' multiple identities (Division 44/CLGBC 2000). For religious sexual minority individuals, for example, faith and sexuality may constitute conflicting social worlds as a result of religious texts and denominational teachings that condemn homosexuality. Sexual prejudice within religious congregations is another potential source of conflict (Haldeman 2004). Therapists working with this population face the challenge of navigating and respecting multiple identities simultaneously (Miville & Ferguson 2004). The primary therapeutic task is to find integrative solutions that provide self-acceptance and balance the different components of identity (Fischer & DeBord 2006, Morrow et al. 2004).

CONCLUSION

Additional research is needed to further illuminate the mental health needs of sexual minority populations, to identify factors that facilitate their adaptive coping and enhance their psychological resilience, and to assess the efficacy of therapeutic interventions based on an affirmative model. Whereas recent research employing national probability samples represents a new level of sophistication in the empirical study of sexual minority mental health, studies with larger samples and more extensive measures of sexual orientation and identity are needed. Such research will permit better assessment of the extent to which sexual minorities are at heightened risk for different types of psychological distress and how such risk varies by gender and sexual orientation identity, as well as race, ethnicity, age, and other variables. It should also examine predictors of resilience and effective coping among subgroups within the sexual minority population, with the goal of better understanding how adoption of a collective identity, disclosure of one's sexual orientation to others, and involvement in a sexual minority community may ameliorate the effects of minority stress. By testing hypotheses derived from the minority stress model, such research will yield valuable information about the experiences of sexual minorities while also permitting refinement of the model.

In addition, systematic study of the efficacy of specific therapeutic interventions inspired by lesbian-, gay-, and bisexual-affirmative models of psychotherapy is needed. To date, relatively little empirical research has been published in this area (Bieschke et al. 2006). Consequently, recommendations for professional practice have often had to rely on case studies, anecdotal reports, and observations by individual therapists. Although these can be useful sources of insight, large-scale clinical studies will facilitate the development and dissemination of more effective therapeutic techniques.

Although empirical research should be a priority, the mental health professions need not wait for more data before addressing the goal of better integrating affirmative models into clinical education, theory, and practice. Training programs can incorporate current knowledge about the mental health needs of sexual minorities into their coursework, practica, and continuing education. Theories of

personality and therapy can be revisited to ensure that they address the experiences of sexual minority individuals. Existing guidelines for affirmative therapy with sexual minorities can be better promulgated among practitioners.

More than three decades ago, the mental health professions made a remarkable reversal in how they regarded homosexuality. Since then, impressive advances have been made in psychology's knowledge about the special vulnerabilities, resources, and strengths of sexual minorities. Nevertheless, we continue to face the challenge of understanding and meeting the mental health needs of sexual minority individuals while working to eradicate sexual stigma.

APPENDIX: RESOURCES FOR PRACTITIONERS

Am. Psychol. Assoc. 1993. Guidelines for providers of psychological service to ethnic, linguistic, and culturally diverse populations. *Am. Psychol.* 48(1):45–48

Am. Psychol. Assoc. 2002. Ethical principles of psychologists and code of conduct. *Am. Psychol.* 57:1060–73

Am. Psychol. Assoc. 2003. Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *Am. Psychol.* 58:377–402

Biaggio M, Orchard S, Larson J, Petrino K, Mihara R. 2003. Guidelines for gay/lesbian/bisexual-affirmative educational practices in graduate psychology programs. *Prof. Psychol. Res. Pract.* 34:548–54

Makes recommendations for fostering affirmative educational practice with respect to institutional climate and education about sexual minority issues.

Bieschke KJ, Perez RM, DeBord KA. 2006. *Handbook of Counseling and Psychotherapy with Lesbian, Gay, Bisexual, and Transgender Clients*. Washington, DC: Am. Psychol. Assoc.

Reviews best practices in affirmative therapy with lesbian, gay, bisexual, and transgender clients from the perspective of three main themes: (*a*) the definition and practice of affirmative psychotherapy with sexual and gender minority clients; (*b*) the role of a diverse sexual and gender minority community in identity development and social connection; and (*c*) the growing sociopolitical influence of lesbian, gay, bisexual, and transgender communities.

DeLeon PH. 1998. Proceedings of the American Psychological Association, Incorporated, for the legislative year 1997. *Am. Psychol.* 53:882–939

Reports on the Resolution on Appropriate Therapeutic Responses to Sexual Orientation, adopted by the APA Council of Representatives, which stresses the need for practitioners to assess the psychological and social contexts in which questioning or discomfort occurs among clients who are questioning their sexuality or experiencing discomfort related to it.

Division 44/Comm. Lesbian, Gay, Bisexual Concerns Joint Task Force Guidelines Psychother. Lesbian, Gay, Bisexual Clients. 2000. Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *Am. Psychol.* 55(12):1440–51

Presents guidelines to provide practitioners with a frame of reference for the treatment of lesbian, gay, and bisexual clients. It includes basic information and further references in the areas of assessment, intervention, identity, relationships, and the education and training of psychologists.

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Errata

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