Chapter 9
FAP with Sexual Minorities

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The landscape of psychotherapy with lesbian, gay, and bisexual (LGB) clients has evolved so dramatically in recent history it would seem unrecognizable to those who defined the field only five decades ago. The first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association, 1952) described "homosexuality" as a sociopathic personality disturbance requiring long-term treatment. Almost three decades later, catalyzed partly by the gay liberation movement as well as research on the prevalence and psychological correlates of same-sex attraction and sexual behavior (Hooker, 1957; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953), the DSM-III shifted direction, re-categorizing "homosexuality" as a "sexual orientation disturbance" (American Psychiatric Association, 1980). It was not until 1987 that the profession removed all remnants of its earlier characterizations of "the homosexual" as disturbed, pathological, arrested, regressed, or from the DSM (DSM-III-R, American Psychiatric Association, 1987).

Since the psychological debate concerning sexual minorities climaxed and receded, mainstream interest in treatment for LBG clients has dwindled and research on the topic has been ghettoized. Over the past 2 decades, LGB mental health research has been conducted largely by researchers who themselves identify as LGB and has been disseminated in niche-specific publications, special editions, and books devoted to the topic. This has resulted in a significant gap between policy and practice (American Psychological Association, 2000) such that graduate students report inadequate if not blatantly heterosexist training experiences in psychology programs, with even less preparation for working with bisexual clients (Phillips & Fischer, 1998). Practicing clinicians also report feeling professionally incompetent in working with lesbian and gay clients (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000), admit to a general lack of familiarity with common difficulties faced by sexual minorities, and manifest a heterosexist bias in a variety of therapy contexts including problems in understanding, assessment, and intervention

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J.W. Kanter et al. (eds.), *The Practice of Functional Analytic Psychotherapy*,
DOI 10.1007/978-1-4419-5830-3_9, © Springer Science+Business Media, LLC 2010

(Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). These findings suggest that while therapist anti-gay bias seems to have decreased, it continues to impact treatment of sexual minority clients in substantive ways.

There are a number of reasons why this should concern the professional community. First and foremost, ethical standards outlined by the American Psychological Association mandate that psychologists "are aware of and respect cultural, individual, and role differences, including those based on ... sexual orientation ... [and] try to eliminate the effect on their work of biases based on those factors" (American Psychological Association, 2002). Furthermore, the *APA Guidelines for Psychotherapy with Gay, Lesbian, and Bisexual Clients* (APA, 2000) encourage psychologists to increase their awareness of challenges faced by sexual minorities across the lifespan and across cultures, recognize and mitigate personal biases, and respectfully understand the variety of norms, values, and family structures represented in this diverse population.

Beyond the ethical standards and values of the profession, service utilization statistics provide another reason for special attention to therapy with sexual minority clients. Sexual minorities, particularly lesbians, appear to be more likely than their heterosexual counterparts to seek therapy at some point in their lives (e.g., Cochran, Sullivan, & Mays, 2003; Jones & Gabriel, 1999). A variety of hypotheses exist to explain this finding. Many suggest that sexual minorities experience higher levels of stress deriving from daily exposure to micro-aggressions, subtle and overt discrimination, rejection or alienation from family and religious institutions, unique legal and financial burdens, internalized homophobia, identity concealment, stigma consciousness, and hate crimes. Stress and coping theorists link these types of chronic stressors with psychopathology insofar as external conditions tax individuals' psychological resources, rendering them more vulnerable to mental or somatic illness (Dohrenwend, 2000). At the same time, sexual minorities often have less access to the social support that might help mitigate the effects of chronic stress (Safren & Heimberg, 1999). From a behavioral perspective, the chronic stressors translate into increased likelihood for punishing contingencies for behaviors that are functional for non-LGB individuals such as the acceptance and expression of one's identity and the pursuit of one's personal values. Likewise, the relative deficit of social support translates into decreased access to interpersonal reinforcers for these same functional behaviors. It is not surprising, therefore, that a growing body of research points to higher incidence of psychopathology among sexual minorities including mood and anxiety disorders (Gilman et al., 2001), suicidality (Fergusson, Horwood, & Beautrais, 1999; Herrell et al., 1999), social anxiety (Safren & Pantalone, 2006), and body image disturbances (Siever, 1994), which may bring them to the therapy office more frequently.

Considering the overwhelming likelihood that therapists will count LGB clients within their caseloads (Garnets et al., 1991), and that their work with these populations ought to comply with the aforementioned ethical standards and guidelines, it is imperative that FAP treatment considerations with sexual minorities be included in this volume.

FAP with Special Populations: A Caveat

While the title of this chapter may imply differences between "standard" FAP and FAP with sexual minorities, the central message is that FAP is *not* to be practiced any differently with these populations. That is to say, (1) the five "rules" of FAP, (2) its focus on function rather than topography, (3) the application of a thorough case conceptualization, (4) the development of a therapeutic relationship that evokes clinically relevant behavior (CRB), and (5) the importance of therapist awareness, courage, therapeutic love, and genuineness all hold true regardless of the identity of the client. The idiographic philosophy underpinning FAP requires this sort of equality in its application across demographic categories. Furthermore, FAP's radical behavioral foundations eschew any preconceived definitions of psychological health with regard to sexual orientation or any other aspect of identity. Rather than attempting to reinforce a defined set of healthy behaviors, the FAP therapist defines treatment targets in collaboration with the client, and in general, aims to weaken repertoires under aversive control (e.g., repertoires defined by the goal of minimizing exposure to potential discrimination, rejection, or heterosexism) and strengthen repertoires that increase access to positive reinforcers.

What is the purpose of this chapter, then? Rather than leading the reader to practice FAP differently with sexual minorities, this chapter aims to assist the therapist in upholding the same dictums of practice in their work with these populations. In order to create the requisite therapeutic environment that fosters trust and openness, FAP therapists working with sexual minorities may need to bolster their awareness of this population's unique contexts (e.g., individual, group, political, historical, religious, ethnic, and generational contexts). Additionally, in order to minimize therapeutic mistakes when reacting to sensitive client issues, and to recognize and create therapeutic opportunities when a mistake occurs, FAP therapists may need to invest more energy into self-exploration and developing awareness of their own biases. These aims are pursued in this chapter by (1) reviewing environmental and historical factors common to many sexual minorities, (2) considering issues in the mutual determination of therapy targets (client life problems), (3) suggesting potential CRBs resulting from these common historical/environmental factors, and (4) highlighting therapist fears and biases which, if left unexamined, could inhibit treatment effectiveness of FAP or distort its fidelity.

Considering the Case Conceptualization

The effective practice of FAP rests substantially on the careful development of an idiographic case conceptualization specifying relevant history, client life problems, in vivo problems (CRB1s) and improvements (CRB2s), and outside life goals (Tsai et al., 2008). In keeping with this approach to treatment, the following sections review important considerations and common themes that arise in each of these categories when working with sexual minorities.

Relevant History

According to FAP, client problems are controlled by historical and current environmental factors. Thus, the specification of these contextual factors is paramount to structuring treatment in service of behavior change. While FAP therapists always focus their assessment of relevant history on each client's report of his or her individual experiences, greater awareness of the multiple environmental systems frequently encountered by certain groups of clients (nomothetic information) can highlight potentially important variables to assess and help establish a favorable psychotherapeutic environment.

Environmental Systems. The FAP contextualist worldview is reflected in Bronfenbrenner's (1979) Ecological Systems Theory, which posits that all individuals exist within a variety of environmental systems including the microsystem (the client's immediate environment, e.g., family, work, school), mesosystem (comprised of connections between immediate environments), exosystem (external environments which indirectly affect the client, e.g., parents' religious affiliation), and macrosystems (larger cultural systems, e.g., ethnic community, political culture). It is useful for FAP therapists to consider all of these environmental systems as they assess for relevant history and controlling variables (discriminative stimuli exercising behavioral control; see Chapter 4 of Kohlenberg & Tsai, 1991) experienced by LGB clients.

Identity Development. During this process of assessment, it is essential also to consider LBG clients' phase of identity development. Though there are important differences among the many LGB identity development models in the literature (e.g., Cass, 1979; Fassinger & Miller, 1996; Troiden, 1979), taken together they suggest a basic framework of "identity confusion, identity comparison, identity assumption, and identity commitment" (Dworkin, 2001, p. 672). Noteworthy critique of these models has pointed out that while they imply a linear progress through stages of identity recognition, coming out, and identity integration, it is more accurate to conceptualize the identity process as a non-linear and bi-directional movement through phases which can be re-entered as LGB individuals encounter various environmental systems throughout their lifetimes (e.g., Myers, 2000).

During each of these phases, LGB individuals will typically contact particular environmental systems and therein face common intra- and/or interpersonal challenges. In the earliest phases – before LGB individuals first begin to question their sexual orientation – they are likely to observe aversive contingencies (e.g., verbal harassment, social rejection, physical assault) operating in the environment upon sexual minorities and indeed anyone who is "different." Furthermore, they may begin to derive rules based on witnessing these homonegative contingencies within their micro-, meso-, exo-, and macrosystems. As they begin to recognize their own same-sex attraction and question their sexual orientation they may experience an internal struggle – a conflict between what is naturally reinforcing for them (i.e., sexual interaction with same-sex partners, whether real or imagined) and the fear of contacting the aversive contingencies they have observed in their environment if they do identify as LGB. This conflict may result in aversively controlled

rule-governed behavior. That is, despite their attractions, they may choose to date members of the opposite sex based on rules specifying the contingencies they have witnessed, e.g., *If I act on my same-sex attractions, my family will reject me, whereas if I date someone of the opposite sex I will be accepted.* Similarly, they may reject their attractions internally (e.g., thinking, *I know what lesbians are like and there's no way I'm one of them*) or externally (e.g., rejecting others who identify as LGB to escape the consequences of being labeled as LGB themselves).

As the process of identity development continues, LGB individuals face other challenges, most likely being subjected to some of the punishing contingencies they previously witnessed, feared, and avoided at earlier stages of development. As individuals begin to accept their sexual orientation and incorporate related behaviors into their repertoires of affiliation, identity expression, and sexuality, they are likely to experience a host of punishing consequences within many, if not all, environmental systems. For example, friends may reject them, family members may ignore or minimize their new identity, school environments may subtly or overtly punish expression of their identity, and religious institutions may warn them of future "eternal" punishment. Furthermore, larger cultural systems may punish and negatively reinforce them in a multitude of ways including invalidation of their very identity and relationships and denial of certain benefits and rituals afforded heterosexual couples and families.

In addition to these damaging experiences, bisexual individuals often face unique challenges and punishing contingencies as they recognize their identity and come into contact with contradictory macrosystems: the homonegative environment of mainstream culture as well as the heteronegative environment of the LGB community. Subjected to the opposing contingencies of these two worlds, bisexual individuals going through the public coming out process may need to develop even greater private control in order to engage in self-determination. That is, just like their gay and lesbian peers going through the coming out process, they face invalidation and punishment for self-determination based on private stimuli (same-sex attractions) that are unacceptable to the greater homonegative environment in which they live. But unlike their gay and lesbian peers, when they publicly choose an identity that does not conform to the rules of a dichotomous society, they become targets of punishment from other sexual minorities who may invalidate their chosen identity, viewing them as uncertain, scared to come out as gay/lesbian, or even traitors.

Therapists who are aware of these common aspects of the personal and group history of sexual minorities, as well as the nuanced interplay between phases of identity development and relevant environmental conditions, are in a position to complete a more thorough and accurate case conceptualization. These informed therapists would assess for their LGB clients' levels of sexual identity development and their rules specifying environmental contingencies with respect to sexuality (e.g., *If I tell my lesbian friends I date men as well as women, they will reject me*). If their clients' sexuality appears at all relevant to their presenting problem(s), they would specifically inquire about any relationship between the two. Furthermore, they would recognize and possibly explain to their clients that while it is not uncommon for such a relationship to exist (e.g., stigmatized identity correlates with higher

levels of stress and decreased social support which may increase the likelihood for developing psychological problems as described above), it is unlikely that sexual orientation forms the etiological root of their presenting problems. This issue is further discussed below in terms of the conceptualization of client life problems.

Client Life Problems

The majority of LGB clients present in therapy with concerns very similar to those of their heterosexual peers, such as mood disorders, somatic difficulties, eating disorders, chronic stress, and substance abuse (Caitlin & Futterman, 1997; Meyer, 2003). In addition to these common themes, other issues linked to sexuality may prompt an LGB client or couple to seek therapy including homophobia, problems with identity development, coming out, parenting issues, HIV/AIDS-related issues, sex and intimacy, or coping with major life events which may not be recognized or validated by the larger heterosexual community. When seeing LGB clients, therapists often make one of two mistakes in framing these presenting problems. Either impelled by explicit homonegative attitudes or influenced by unconscious bias, some therapists attribute any presenting problems exclusively to their clients' sexual orientations. For example, imagine a lesbian client who attributes her presenting symptoms of low mood, anhedonia, withdrawal, and feelings of worthlessness to the recent breakup of a long-term same-sex relationship. Her therapist might conceptualize this same array of symptoms as major depression due to arrested sexual development, reducing the client's psychological suffering to the inevitable consequences of an unsatisfying, superficial lesbian relationship. The therapy that proceeds from the therapist's incompatible perceptions of the presenting problem and its etiology is likely to punish the client's attempt to seek help and may not only alienate the client from that particular therapist, but may contribute to a generalized distrust of the psychotherapy process.

At the other end of the spectrum, well-intentioned therapists, perhaps motivated out of political correctness, can minimize the relevance of sexual orientation in their clients' presenting problems fearing they might be seen as homophobic if they assess for any relation between the two. Under such aversive control, compelled by their own fears, therapists may avoid asking if and how their clients' identity or the struggles they have experienced because of their identity contribute to their low mood, social withdrawal, social anxiety, or other difficulties. It is crucial for FAP therapists to explore their own fears and underlying biases in order to minimize any such avoidance within the assessment process, both because the assessment itself would otherwise be incomplete, and because avoidance or minimization of the topic so early in therapy may result in clients learning (whether consciously or not) that discussion of sexuality in therapy will be punished or ignored. Ideally, therapist self-exploration will result in therapists developing an understanding of the functional relationship between their fears and their avoidance in session. The therapist is then better positioned to explore the possible relevance of sexuality and associated environmental conditions on the client's presenting problems.

In some cases, the therapist's hypothesis may not be accepted by her/his client, and the client may suggest that the therapist's inquiry is evidence of her/his heterosexist or homonegative bias. When this occurs (as such mistakes are virtually inevitable at some point) the interaction can be utilized as a therapeutic opportunity in a variety of ways. Depending entirely on the case conceptualization of the client, this mistake could evoke CRBs to be reinforced, provide an occasion for deeper mutual understanding, initiate the therapist's use of self-disclosure, and/or lead to further exploration of how the client responds to perceived bias in his/her life.

In Vivo Occurrences of Client Problems (CRB1s) and Improvements (CRB2s)

A core aspect of FAP assessment is the ongoing appraisal of the client's life problems and improvements occurring within the context of therapy. When client problems involve their sexual identity, the FAP therapist will be watching for, evoking, and reinforcing related clinically relevant behaviors (CRBs) related to sexual orientation or same-sex relationship dynamics. CRBs are always defined in functional terms and therefore cannot be predicted on a group level. Nevertheless, it can still be helpful and stimulating to consider concrete instances of CRB related to the life problems LGB clients sometimes bring into therapy. To this end, Table 9.1 provides examples of client life problems related to LGB identity and potential

Table 9.1 Potential client life problems related to sexual orientation and associated CRBs

Client life problems related to sexual orientation or same-sex relationship dynamics	Potential CRB1s	Potential CRB2s
Client avoids discussing sexuality-related topics (e.g., mentioning her/his relationship status) with others for fear of judgment or rejection	Client avoids bringing up sexuality-related topics in session	Client initially engages in discussion of topics related to sexuality and eventually initiates these discussions in session
Client is highly stigma-conscious, likely to assume homo-/biphobia on the part of others who have not proven themselves trustworthy, and is more likely to assume the world is viewing her/him through the lens of sexual orientation	Client is highly stigma-conscious in session, likely to assume homo-/biphobia on the part of the therapist, particularly early in therapy, and is more likely to assume the therapist is negatively judging her/him through the lens of sexual orientation. Client may also repeatedly inquire about the therapist's opinion or esteem for her/him	Client develops a more flexible and accurate attributional style. When she/he does perceive stigma or bias on the part of the therapist, she/he directly investigates this perception with the therapist (e.g., via direct questioning)

Table 9.1 (continued)

Client life problems related to sexual orientation or same-sex relationship dynamics	Potential CRB1s	Potential CRB2s
Avoiding eye contact with others in daily life when discussing anything related to sexuality	Avoiding eye contact with the therapist in session when discussing anything related to sexuality	Client initially makes sporadic eye contact, and eventually sustains eye contact with the therapist while discussing sexuality-related topics
Rigidly heterosexual or gender-conforming self-presentation across all environments in daily life for fear of outing oneself or appearing effeminate or "butch"	Rigidly heteronormative or gender-conforming self-presentation in sessions (e.g., dress & grooming, gesticulation, expressions of emotion, assertiveness/submissiveness, vocal characteristics)	Client develops useful discriminative functions with regard to self-presentation, resulting in his/her flexible expression of sexual orientation and gender in session
Difficulty following through with a plan to come out to parents due to fear of being judged or rejected, despite this being a core value of the client	Avoiding disclosure of sexual orientation to therapist for fear of therapist judgment or rejection	Client might initially broach the topic of relationships or attractions and only later come out to therapist. Eventually the client may become more and more able to discuss specific sexual activities with the therapist
Distancing from GLB individuals and culture due to internalized homophobia	Choosing to work with a heterosexual therapist or distancing from a therapist who is (or is perceived as) GLB	Becoming closer to or aligning with a therapist who is (or is perceived as) GLB
Difficulty developing or maintaining emotional intimacy within gay relationship as both partners have been socialized against intimacy-enhancing repertoires	Gay client avoids interactions with therapist that would build therapeutic intimacy, particularly if working with a male therapist	Gay client initially allows therapist to initiate intimacy-building interactions, and eventually initiates these interactions
Difficulty maintaining a sense of self or expressing individuality within long-term lesbian relationship	Always aligning with the therapist, difficulty expressing differences or disagreement, adopting characteristics of therapist, particularly if female/lesbian	Initially, simply questioning the therapist; eventually challenging the therapist and acknowledging differences and disagreement in session

CRB1s and CRB2s to watch for in session (which may or may not be relevant for an individual LGB client).

This table presents only a handful of examples of client life problems and associated CRB1s and CRB2s related to or stemming from sexual minority identity. As tempting as it may be to use these ideas as a template for working with LGB

clients, it is crucial that FAP therapists see these ideas as a springboard for case conceptualization possibilities. In undertaking this task, FAP therapists must reference their LGB clients' own perceptions of their life problems and therapy goals, while respecting each client's unique cultural background and values. To illustrate this point, consider a client who comes to therapy wishing to deal with his growing awareness of bisexual attractions. This client reports that he is no longer in denial of his attraction to men in addition to women, but he is unsure how to integrate this aspect of himself in certain domains of his life, particularly in his family life. He worries that if he comes out he would be emotionally distanced by his family, if not outright disowned. It is for these reasons, he explains, that he is considering remaining "closeted" and attempting to pursue only his attractions to women.

Knowing nothing else about this client's therapy goals and cultural context, we might rely upon existing identity development models to conceptualize the client's life problems and ascertain appropriate treatment goals. Following that approach, this client's desire to remain closeted to his family might be taken as evidence that he has not fully accepted his sexual identity or orientation, or perhaps indicate some hindrance in his identity development process. With this conceptualization, the therapist might become an advocate for the client working toward disclosure of his sexual orientation to his family. But, if we add crucial contextual information about the client's family and cultural background, different conclusions emerge. What if the client were raised in a Hasidic Jewish or Muslim community? What if he reports that his membership in his religious subculture has reinforced the importance of strong familial bonds and social networks with other members of his religious community? This client's access to support from the wider bisexual or queer community may be limited because he lives in a rural Hasidic enclave or, as a recent immigrant, speaks only a minimal amount of English. When viewed through this lens, the impact of culture on the client's values becomes clear, highlighting how indiscriminant application of predetermined treatment goals for all sexual minorities is inappropriate and potentially can be harmful. The FAP therapist's responsibility is to work collaboratively with each LGB client to determine if and how their current behaviors (both in and out of session) and treatment goals represent adaptive responses to given environmental conditions. Likewise, together the therapist and client can determine if active attempts to change their environment (e.g., through activism or engagement with a more supportive community) would provide greater access to reinforcement in their lives.

Therapist Work: A Look in the Mirror

Having explored GLB considerations with various aspects of the FAP case conceptualization, I now turn to a discussion of a crucial variable in FAP, the therapist. Before focusing the discussion exclusively on therapist issues with GLB clients, I begin with a discussion of more general therapist issues that will later be applied to working with sexual minorities.

Therapist Issues in Evoking and Responding to CRBs with Clients of All Sexual Orientations

The central mechanism of change in FAP is the therapist's natural, contingent responding to client in-session behaviors. The effectiveness of FAP, then, rests largely on the variable of the therapist – not only insofar as it matters in any other type of therapy, but even more so in FAP because the therapist's own personhood, stream of learning history, T1s (therapist in-session problem behaviors) and T2s (therapist in-session target behaviors), values, and personal mission will together determine the fidelity of the instrument upon which the client's progress depends. This is why therapists utilizing FAP must engage in an ongoing process of self-exploration and growth, expanding their own behavioral repertoire to include the extensive network of behavioral classes their clients also work to develop.

FAP therapists are obligated to increase their awareness of and enhance their own repertoires for a number of reasons. Therapists with broader repertoires relevant to the therapy process are more likely to notice, evoke, and naturally reinforce client CRBs. To put this in more concrete terms, imagine a therapist whose own emotional and interpersonal behavioral repertoire is limited. In her outside life she may tend to avoid contact with intense emotions resulting from interpersonal closeness and vulnerability; in particular, relationships in which the other person becomes extremely important to her. Perhaps this therapist avoids contact with controlling variables (discriminative stimuli for interpersonal closeness and vulnerability) by intellectualizing her emotions, remaining in a "one-up" position in most relationships, focusing on others' needs and feelings, presenting herself as emotionally self-sufficient, and masking aversive emotions with a convincing smile. Imagine too that this therapist has not reflected on these personal tendencies and has not considered how they show up in her work as a therapist. Completely outside of her awareness her avoidance patterns may inhibit many of her clients' progress. When her clients begin to contact their own controlling variables (when CRBs are evoked), this therapist is likely to respond with behaviors that distance her from these stimuli, inadvertently punishing her clients' progress. For example, if a client were to engage in a CRB2 of expressing raw emotions, she might attempt to contain her own discomfort by translating them into intellectual terms. When a client risks sharing deep pain, which would move most people in her outside life, this therapist might appear unaffected in any personal way. When a client asks her what she personally thinks or feels about him, she may don her convincing smile while giving a "canned" textbook answer, rather than taking the risk of sharing with the client how much impact he truly has on her and how moved she really is to see him working so hard.

Contrast this example with another therapist who has the same T1s, but is consistently undertaking the task of recognizing and changing her own avoidance behaviors in life and in session. As her avoidance shrinks (requiring risk-taking, courage, vulnerability), and she increases contact with her controlling variables in the context of a supportive social environment (e.g., a consult group or an FAP supervisor), her T2s are reinforced and her repertoires expand. Over time she becomes more likely to gain an awareness of avoidance behaviors in her clients,

more likely to reinforce their approach toward controlling variables, and more likely able to tolerate the intense emotions associated with presenting discriminative stimuli for clients (evoking).[1]

As mentioned at the outset of this chapter, ideal FAP with heterosexual clients is no different than ideal FAP with LGB clients in its overall process. So it is true with the responsibility of personal work on the part of the therapist. The remainder of the chapter is devoted to discussion of specific types of self-exploration, awareness building, and repertoire enhancement by therapists that can benefit work with sexual minority clients.

Therapist Issues When Treating Sexual Minority Clients

What should FAP therapists do to expand their relevant repertoires when working with sexual minorities? How can they contact the relevant controlling variables and develop new behavior that is more affirmative of their LGB clients? While there is no comprehensive formula for this process, I have provided a loose structure that can guide the reader to consider a variety of aspects of self including one's fears, attitudes, biases, sexual attractions, and experiences. Although all of these domains are clearly interrelated, they are explored in separate sections for organizational purposes.

Therapist Discomfort with and/or Avoidance of Content Related to Sexuality

Therapists whose behavior was shaped within a homonegative and generally sex-negative environment (i.e., the overwhelming majority of therapists, *including* LGB therapists) are likely to be somewhat uncomfortable with open and direct exploration of same-sex attractions and/or discussion of sexual behavior. Regardless of one's best intentions or consciously held values, reinforcing CRBs related to sexuality will require willingness to contact one's own controlling variables, and therein, will require courage.

Consider a male client who is in the earliest stages of recognition and acceptance of his same-sex attractions working with a male FAP therapist whose T1 is avoidance of sexual content in sessions. The client's CRBs will take a multitude of forms many of which would likely elicit/evoke aversive private experiences on the part of the therapist. Hopefully, when CRBs are fairly obvious, (e.g., *I'm beginning to realize that my whole life I have felt more drawn to men than women* – likely an obvious tact and CRB2; see Chapter 3 in Kohlenberg & Tsai, 1991 for a discussion of the relevance of verbal behavior concepts such as "tacts" and "mands" in FAP), most

[1]This is why FAP supervisors often tell trainees that before asking their clients to complete any assignment or engage in an experiential exercise, they themselves must undertake the task.

therapists would feel compelled to pursue the issue even in the face of their own discomfort (e.g., by saying *"Tell me more about that"*), thereby reinforcing the client's CRB2 of exploring his attractions. Much of the time, however, clients struggling at this stage of identity development exhibit subtler CRBs. For example, a male client who has not yet acknowledged his attraction to men might say to his therapist, *I hate that my sister is always checking up on my dating life and trying to set me up with her girlfriends!* This statement that appears to be an obvious tact could also be a disguised mand (i.e., an indirect request) that the therapist stop making heterosexual assumptions about him in their therapy. In this case, a therapist who is avoidant of sexual content could very easily miss the hidden meaning as he chooses to follow up on the more comfortable topic of the client's expression of anger toward his sister.

LGB clients who are no longer struggling to acknowledge their sexual orientation or identity may still be reluctant to discuss their sexual activities with their therapists, especially when working with cross-gender therapists and/or those perceived to be heterosexual. Depending on their case conceptualization, clients' sexual activity and/or in-session disclosure thereof may be very relevant to the therapy. Therapists who collude with their clients' circumnavigation of this territory, or punish/extinguish clients' attempts to enter it, run the risk of inhibiting their progress.

Consider a client who has consistently avoided discussing his sexual activities in therapy. While describing the events of his weekend he somewhat indirectly indicated the extent of his sexual activities for the first time in his therapy:

Client: *This weekend was just like all the others. I went out to the bars, cruising. You know what I mean, right?*

Rather than being guided by the client's case conceptualization, a therapist might give in to her discomfort in a variety of ways. She might lead the conversation in a less aversive direction:

Therapist 1: *Mm-hmm. So what else happened this weekend?*

Fearful of appearing ignorant or getting into the details of "cruising," the therapist might subtly foreclose the client's entrée into this conversation about sexual behavior by disingenuously stating:

Therapist 2: *Cruising? Oh, sure, I know what you mean.*

Or conversely, the therapist might problematize or pathologize the client's sexual behavior based on her own values and biases:

Therapist 3: *Why do you think you end up doing that every weekend? You know you're not going to find happiness that way.*

Any of these responses are likely to decrease the client's likelihood to engage in further CRB2s to the extent that the client sees that his therapist is uncomfortable or disapproving of his behavior. Contrast this with the outcome of responding genuinely and openly:

Therapist 4: *I'm really glad you're clarifying this, Glen. You told me about going to the bars, but no, it wasn't clear that you were out cruising. Tell me more about your experiences cruising – I don't want to make any assumptions here.*

While this natural reinforcer will likely deepen the discussion and reveal further potentially relevant information, it can be augmented by a follow-up discussion prompted by the therapist:

Therapist 4: *Glen, you hadn't told me very much about your sex life before today. So what was it like to bring that up with me? How did you feel about my response?*

Here the therapist shifts the focus of discussion from daily life to the therapeutic relationship, creating an opportunity for in vivo shaping of CRB2s.

In summary, clients will contact their controlling variables (i.e., be provided with new learning opportunities) only insofar as their therapists are willing to do the same. If therapists are only comfortable speaking about sexuality in sterile, scientific terms, they are likely to shape their clients to do the same, or to avoid talking about sexuality entirely – inside and outside of session. If they avoid using direct and clear language about sex and sexuality, their clients' progress equally will be limited. If they hold negative attitudes about certain types or frequency of sexual behavior, they may inadvertently shape their clients to withhold information about their sexual interactions from their therapists. By putting in the effort to expand these repertoires, however, therapists can serve as models, block their clients' avoidance, and be more naturally reinforcing of client CRB2s. In FAP, both clients and therapists are asked to push the boundaries of their comfort zones, to take risks, to lay bare their vulnerabilities, and to reveal their humanity. In the real relationship that results, genuine, natural reinforcement of client CRBs becomes possible.

Therapist Explicit and Implicit Attitudes

Attitudes have been defined by behaviorists as the learning process by which people come to evaluate stimuli in the environment favorably or unfavorably (Fishbein & Ajzen, 1975). Each individual's pattern of evaluations or biases is thought to result from her/his respondent and operant learning history in the context of particular social environments. Research in the field of attitudes and behavior suggest that *explicit attitudes* (in behavioral terms: the affective responses, behavioral biases, or predispositions that are within awareness and can be described) are merely the tip of the iceberg (Dovidio, Kawakami, & Beach, 2001). *Implicit attitudes* (in behavioral terms: affective responses, behavioral biases, or predispositions outside an individual's awareness) result from operant and respondent conditioning processes that may or may not be directly taught or even noticed by the individual therapist (Olson & Fazio, 2001). Similar to explicit attitudes, they can reflect the myriad favorable and unfavorable representations of stigmatized groups available in his/her

social, political, and cultural environment. Unlike explicit attitudes, however, these automatic biases typically go unnoticed by even the most earnest, well-intentioned individuals who attempt to "introspect" their prejudices. Implicit attitudes and explicit attitudes are discussed separately below as they can be measured and manipulated in differing ways.

Exploring Explicit Attitudes. In the domain of explicit prejudice against LGB individuals, a number of studies reveal that these types of personal bias predict overt behaviors both within and outside of the therapeutic context. Looking specifically within the therapeutic context, a study by Hayes and Gelso (1993) revealed that male therapist homophobia (as measured by a self-report attitude questionnaire) predicted a pattern of avoidant and punishing therapist responses (e.g., disapproval, silence, selective ignoring) that diverted attention away from issues related to sexuality or inhibited further exploration thereof. In a follow-up analogue study regarding therapist reactions to lesbian clients, the same relationship was found between male and female therapists' explicit homophobia and avoidance responses while counseling lesbian clients. Additionally, more cognitive errors were made by female therapists in recalling sexual content presented by these lesbian clients (Gelso, Fassinger, Gomez, & Latts, 1995).

Given such data on the effects of explicit attitudes on therapist behavior, readers are encouraged to reflect on the ideas and questions about sexuality posed in Table 9.2, for an informal assessment of explicit attitudes about LGB issues.

Table 9.2 Questions and probes to explore explicit attitudes

(1) Do I feel that same-sex relationships are somehow "less than" cross-gender relationships?
(2) Do I believe that sexual orientation is a social construction or a biologically determined and fixed aspect of an individual?
(3) When I meet someone who identifies as bisexual, do I often try to figure out if they're "really" gay or lesbian?
(4) Am I more curious about someone's sexual and/or abuse history if I know they are a sexual minority?
(5) Do I get distracted by someone's gender presentation if it is atypical?
(6) Despite the research findings, do I worry more about children raised in non-traditional relationships or family structures?
(7) Do I assume that a client who chooses to be in an open or polyamorous relationship must have intimacy problems or perhaps must really desire a monogamous relationship "deep down"?
(8) How does my body react to descriptions or images of same-sex sexual behavior? How is this different or similar to how I react to descriptions or images of cross-gender sexual behavior?
(9) How would I react to discovering that a close relative was bisexual, lesbian, or gay?
(10) How do my religious affiliations and spiritual beliefs inform my attitudes about sexual minorities?
(11) Do I believe that same-sex couples should have the right to marry? Why or why not?
(12) Do I tend to actually favor the sexual minorities among my friends, or attempt to gain their approval and acceptance?
(13) Do I believe that there are no differences between cross-gender and same-sex relationships?
(14) What experiences have I had with LGB individuals and how have these informed my group stereotypes?

We are all well intentioned and aware of social norms and rules; therefore when conducting this exercise you are encouraged to explore and allow for socially undesirable responses. Note that these questions are intentionally evocative and do not necessarily have a "right," consistent, or foolproof answer.

This list only scratches the surface of attitudes and beliefs meriting exploration. Nevertheless, these verbal stimuli may have precipitated some aversive private events in the reader such as increased heart rate, sweat gland activity, and changed breathing patterns consistent with reports of uncertainty, anxiety, and shame. This group prediction is based on the assumption that while the overwhelming majority of readers were conditioned in social environments which reinforced heterosexism and paired sexual minorities with negativity, these readers also identify with the "rules" (verbal discriminative stimuli) of their professional community such as the APA Ethics Code and "Guidelines for psychotherapy with lesbian, gay, and bisexual clients." Because the conditions for reinforcement differ substantially in these two different contexts, therapists may experience discomfort related to contradictions between their own contingently shaped behaviors and the rules they have developed to govern their behavior. If the task of balancing these competing and contradicting rules and discriminative stimuli is sufficiently aversive, it may lead to avoidance of stimuli related to sexual orientation in our professional and personal lives. It is here that FAP therapists are urged to move forward into any discomfort they experience to acknowledge and begin to challenge their biases. More detailed discussion of this process is offered later in the chapter.

Exploring Implicit Attitudes. Before moving on with that task, how can we include our implicit (not verbally tacted) behaviors in the process? Is it even necessary to do so? Research suggests that indeed it may be useful for therapists to consider their implicit bias when working with stigmatized or minority clients: the link (though not causal) between implicit prejudice and explicit behavior has been demonstrated in a growing body of research focusing primarily on racial bias (for a review, see Dasgupta, 2004). This literature reveals that implicit bias predicts subtle observable behaviors toward stigmatized racial groups (e.g., eye contact, body posture, speech errors) better than explicit attitudes (e.g., Fazio, Jackson, Dunton, & Williams, 1995). It is quite likely then, that the same would be true with regard to implicit homonegative bias.

Emerging from the debate surrounding the measurement of implicit biases are response latency measures such as the Implicit Association Test (IAT; Greenwald & Banaji, 1995), an experimental paradigm developed to explore automatic cognitive and affective behaviors outside awareness. The IAT asks the test-taker to rapidly pair binary sets of stimuli (e.g., pairing a heterosexual image with the word "good," or a gay/lesbian image with the word "good"). Based on the individual's history of reinforcement for pairing the two concepts together, he/she will be more or less likely to respond to them as a single unit. If pairing gay/lesbian stimuli with "bad" has been more strongly reinforced in the test-taker's history, it should be easier for the test-taker to respond faster when asked to pair the two versus pairing gay/lesbian stimuli with the word "good". The response latency in pairing each set of stimuli gives a measure of, in the test developer's terms, one's implicit attitude and, in behavioral

terms, the strength of the historical relation between the two concepts. The more related, the more rapidly one is able to respond.

While the IAT has primarily been used to collect data on a group level, it can also be used as a tool to gain greater awareness about an individual's implicit biases and preferences. Interested readers are encouraged to investigate their own implicit biases regarding sexual orientation as measured by the IAT for Sexuality (available through the "Demonstration Test" portal at https://implicit.harvard.edu/implicit/demo/). Though the IAT cannot be said to be a perfectly accurate test of implicit bias (for example, you may find that your exact results vary across two trials) this 15-min test can be extraordinarily useful in terms of opening one's eyes to bias that may be outside awareness. As these biases enter awareness one is already in a better position to predict and control them.

It takes willingness and courage for anyone to acknowledge bias – whether explicit or implicit – and to commit to perpetually challenge this bias. The good news is that preliminary research suggests that while these biases cannot be directly "unlearned," our implicit and explicit behaviors are malleable, that is, they can be altered by repetitive exposure and reconditioning (e.g., Pettigrew & Tropp, 2006; Rudman, Ashmore, & Gary, 2001; for a review, see Blair, 2002). The task of challenging bias via exposure and reconditioning is expounded upon at the conclusion of the chapter.

Exploring Therapist Sexuality and Experiences

A logical next step in an FAP therapist's self-exploration is in the domain of one's own sexuality. For some fortunate therapists, graduate training included coursework that invited exploration of one's sexual attractions, fantasies, and identity. The majority of us, however, may never have questioned or examined these aspects of self, or perhaps were forced to examine these issues as part of our own coming out process. Rather than accepting any default assumption of sexuality, or conceptualizing one's sexuality as a fixed entity that can be fully known at any one time, therapists benefit from actively engaging in an open and ongoing self-exploration conducted in the spirit of curiosity and compassion. In this process, one may ask oneself to consider both lived experiences as well as chosen identity, considering any gaps or differences between the two. If heterosexually identified, one may ask oneself about our same-sex feelings and approach these non-judgmentally, opening toward any internal conflicts that arise. If bisexually identified, one may also ask oneself about any discrepancies between real and conceptualized feelings and non-defensively consider how and why one identifies as bisexual. If gay or lesbian identified, one contemplates both same-sex and other-sex attractions, non-defensively opening to the full spectrum of sexual feelings and gently acknowledging any discrepancies or conflicts therein. As part of this process, we open to memories of personal experiences – both sexual and social – with sexual minorities and heterosexually identified individuals that may have shaped how we identify

ourselves, with whom we affiliate, and how we conceptualize "straight," bisexual, gay, lesbian, and "queer" individuals. All of these avenues of exploration can provide rich information about our biases, the conflicts that might obstruct empathic connection, and potential obstacles we need to overcome in order to be naturally reinforcing to our sexual minority clients.

Another aspect of therapist identity and self-awareness which merits attention in this discussion is the match between therapist and client sexual orientation. While heterosexually identified therapists must be on the lookout for the obvious distortions inherent to "outsider" status, therapists who themselves are sexual minorities face other obstacles in treating LGBs, which, if not countered, pose potential hazards in FAP therapy. Therapists who are "insiders" may view their LGB clients through a lens of assumed similarity, over-identification, or idealization, running the risk of under-assessing the client's idiographic presentation and/or ignoring dysfunction. LGB-identified therapists may consciously or unconsciously assume their sexual minority clients will (or should) proceed through the same course of identity development as they have themselves. They may subtly or directly encourage their clients to adopt their personal philosophy of sexuality – as a dichotomous, fixed, or fluid characteristic. Likewise, they may assume that what has worked best for them will work best for their LGB clients in terms of coming out, responding to homophobia, choosing to be monogamous or negotiating open relationships, and merging with or remaining emotionally independent in relationships. For these reasons it is imperative that LBG therapists be mindful of, and combat, the pitfalls of their "insider" status.

Overcoming Therapist Fear of Appearing Prejudiced

Most therapists aspire to hold some degree of conscious egalitarian beliefs with regard to LGB populations. When treating LGB clients, then, it is highly likely that therapists would desire their clients to recognize their open-mindedness and awareness. As much as this desire may reflect one's best intentions, the fear of appearing prejudiced, homophobic, or ignorant can easily become a barrier in treatment. These fears can lead therapists to miss important information because they choose not to acknowledge the limits of their familiarity with clients' LBG experiences and identity. When clients use culture-specific terminology or refer to experiences unfamiliar to some therapists, rather than asking for clarification these therapists may try to deduce their clients' meaning from context or may hope the clients will provide further clarification during the session. Another problem arises when therapists avoid conceptualizing anything related to sexuality as relevant or dysfunctional even if it appears so. If these therapists do consider sexuality or identity-related information in the functional analyses of LGB clients, they may be reluctant to bring up their functional hypotheses with their clients. Finally, wary therapists who do not share their clients' sexual orientation may fear these clients' judgments and therefore avoid disclosing their orientation when clients inquire without considering if the inquiry represents a CRB1 or CRB2.

FAP therapists who have the courage to admit the limits of their knowledge and experience, consider sexual variables in case conceptualizations and functional analyses, and strategically disclose personal information about their own sexuality are likely to encounter difficult therapeutic situations. In some instances their clients may respond with disappointment, hurt, or confusion, suggest that their therapists are homophobic, or argue that their analyses have been tainted by heterosexist bias. FAP therapists can approach these situations as therapeutic opportunities that may evoke CRBs (Rule 2) (see Chapter 1 in this volume for a summary of FAP's five rules). For example, consider this interaction between a therapist and her gay male client who is sexually active with multiple partners. This client's daily life problems include avoidance of emotional expression, avoidance of situations that evoke emotional pain, and lack of assertiveness.

Therapist: *We've been working together for about 2 months now, trying to figure out how to increase your sense of purpose and fulfillment in life. You have this sense that something is missing, but you can't quite put your finger on it. I've noticed that during our sessions you focus mainly on frustrations with your family and at work. But you tend to not talk much about your romantic involvements. How do you think that fits into the picture?*

Client: *I told you already, I don't think that's the problem.*

Therapist: *I do remember you making a point of that in our first session. At the same time, I've noticed that we do a pretty good job of avoiding it altogether when, for a lot of people, finding a partner can be an important part of feeling fulfilled in life.*

Client: *I can't believe I'm hearing this. You, too? Let me guess: Because I have my fair share of random hook-ups but don't have a serious relationship there's something wrong with me, right? [This is a potential CRB2 in terms of acknowledging some emotional pain rather than avoiding the issue altogether.]*

A therapist who is worried about being judged as homophobic might respond by leaving this charged territory, either retracting the question or quickly apologizing for posing such a faulty question. A productive alternative, however, is to view the interaction through the lens of clinically relevant behavior providing an opportunity for in vivo reinforcement:

Therapist: *Tell me what just happened inside, Joel.*

Client: *I can't believe it. Sorry, but that's just too classic and I didn't expect it from you.*

Therapist: *I said something that really upset you, Joel, and I want to understand how that happened.*

Client: *Well, I never said that my sex life was a problem for me but it seems like it's a problem for you. And then you implied that finding a partner is necessary in order to be fulfilled [client becomes tearful]. I've got an entire society telling me there's something wrong with how*

I am, and now you. [The client's assertiveness and specification of the evocative stimulus are both likely CRB2s.]

The therapist might reinforce these CRB2 by further exploring and empathizing with the client's emotional response, attempting to develop deeper mutual understanding, strategically disclosing, asking her client to teach her more, or otherwise genuinely repairing the rupture. One example follows:

Therapist: *I see how much I've hurt you, Joel. I took a big risk in asking you about romantic relationships but chose to bring it up because I am 100% committed to getting to the heart of your dissatisfaction in life. And in that pursuit I don't want to leave any stone unturned. It sounds like by asking you that question I just got added to a long list of people in your life who have suggested that there is something wrong with how you do relationships.*

Client: *I'm so tired of it. That's why I tried to tell you in the beginning.*

Therapist: *There's a lot of history here and it makes sense that my bringing it up would stir up these feelings. And Joel, it took a lot of guts to tell me how hurt you were. You know that? [Reinforcing client's emotional disclosure]. What else, Joel? Is there anything you're holding back on saying to me? [This is Rule 2 – evoking CRB2.]*

Client: *Look, I've been in long-term monogamous relationships before, and at this point in my life I'm just not into it. The whole idea that you need a relationship to make you happy – that's so heterosexist and it's not why I started therapy.*

Therapist: *Ok, I'm stuck here. On one hand I am so moved at how honest and assertive you're being in telling me you don't want to focus on relationships in our therapy. I also want to be careful not to mistakenly apply society's value system on you when so much of our work depends on you being able to define your own values and goals [reinforcing client's CRB2 of assertiveness and direct communication]. On the other hand you've told me how hard it is to move into really emotional territory and I wonder if ignoring this issue is more about avoiding the emotions that come up here [evoking CRB].*

Client: *[sigh] It's not that I wouldn't ever want that relationship . . . I've tried – so hard. They don't work – or, I don't know – maybe I don't work [client becomes tearful once again].*

Therapist: *And you feel exhausted and discouraged just thinking about your efforts and experiences in the past [accurate empathy – reinforcing his CRB2]. When I brought up the question of relationships I bet I brought back all those feelings you're trying to get away from – the exhaustion the frustration, the fear of judgment. What else [evoking more disclosure]?*

Client: *I don't want to feel broken. I don't know if I want to do this [CRB2 in identifying the underlying private experience he has been avoiding].*

Although this conversation represents only one of countless ways the session might have unfolded, it demonstrates how a therapist who is willing to take the risk of proceeding into politically and personally charged territory can deepen the work and help her client identify a major block in discussing (and possibly, in forming) romantic relationships. As the conversation moves forward, the therapist would continue acknowledging the issue of heterosexist bias on her part in order to communicate to the client that she is aware of it and open to discussing it, and ultimately focused on the client's deepest values and life goals. While in this example the therapist worked to look beyond her client's accusation of heterosexist bias, in other cases in which such an accusation was itself a CRB2, the therapist would orient her responses around reinforcing the client's political analysis by expressing appreciation for the client's courage in pointing it out, openly acknowledging and exploring her bias, and/or making a genuine apology or repair for the rupture.

Shaping Therapist Behavior

Previous sections of this chapter have indicated a variety of domains in which therapists are encouraged to gain greater awareness of their own reinforcement histories, biases, private and public behaviors with regard to sexual minorities. The singular moments of awareness that have been evoked by reading this chapter, however, are not likely to lead to lasting observable improvement in therapist–client interactions. In order for such change to occur, therapists wishing to gain greater control of their heteronormative/homonegative biases would need to apply the same rules of behavior change to themselves as apply to FAP clients. Awareness is merely the first step – literally (Rule 1).

Rule 2 (evoke CRBs) is applied as FAP therapists maintain an ongoing practice of contacting their own controlling variables (discriminative stimuli) with respect to sexuality and sexual orientation, both in and out of session. In concrete terms this means FAP therapists will attempt to combat their own avoidance of LBG- or sexuality-related stimuli (e.g., forming close social connections with LGB individuals, consuming LGB media, participating in LGB cultural or political events). If their larger verbal community does not provide substantial access to such stimuli, FAP therapists are encouraged to move beyond their default environment to one which will provide more access to related stimuli and be more naturally evocative.

The mere exposure provided by following Rule 2 would be expected to decrease therapist bias to the extent that it allows for the modification of reflexive homophobic responses to LGB stimuli via classical conditioning. Rule 2's full potential, however, is attained with the introduction of Rule 3 (reinforce CRBs). By entering and engaging in communities with different sociopolitical contingencies that are more inclusive and reinforcing of LGB individuals, FAP therapists increase the likelihood that their own behaviors (implicit and explicit, public and private, verbal and affective) will be similarly shaped. Rule 3 also comes into play in session with LGB (and quite possibly heterosexual) clients, as well as in supervisory and consultative contexts in which less biased therapist behaviors with regard to sexuality have the opportunity to be naturally reinforced within the dyad or group.

Rule 4 (observe potentially reinforcing effects) is critical as it highlights the need for FAP therapists who are attempting to modify their biases to pay attention to the impact of their personal work on their own in-session behaviors with LGB clients (e.g., are they more likely to evoke relevant CRB and to be naturally reinforcing of CRB2s?) Furthermore, Rule 4 asks FAP therapists to observe the impact of their expanded behavioral repertoire on their clients. The new therapist behaviors resulting from therapists' personal work are intended to lead to more effective therapeutic relationships (e.g., closer, more intimate relationships with LGB clients, increased likelihood of evoking sexuality-related CRB and being naturally reinforcing of CRB2).

Therapist personal work with sexual bias can be expanded by including Rule 5 (interpretation and generalization) in the process. This rule would direct FAP therapists combating their heterosexual/homonegative bias to consider the antecedents and maintaining variables of this and other biases that may be part of the same functional class of behaviors. Gains made in the understanding of one's own heterosexism, for example, can translate into larger functional analyses that account for how environmental contingencies have shaped our sociopolitical leanings in ways that may inadvertently maintain oppressive practices in our clinical work. Rule 5 also takes this work beyond the clinical session, inviting FAP therapists to make the same "in-to-out parallels" we ask our clients to make when in-session experiences correspond to daily life events. That is, FAP therapists whose in-session repertoires are changed by their personal work can work to generalize these gains to their daily lives, creating a safer, and less oppressive cultural environment for LGB and other disempowered individuals and groups.

Conclusion

It is important to acknowledge that no data have been gathered in the FAP community to empirically examine the effectiveness of the therapist shaping strategies and practices described above. They are, rather, the result of personal and anecdotal experience that is largely consistent with behavioral principles, or have been directly deduced from FAP and behavior analytic theory. Single-subject work and publication of FAP case studies with LGB clients will be crucial to support and refine these ideas.

Considering the lack of empirical support for this particular application of FAP behavior change principles, and the considerable discomfort that is likely to be experienced if it is nevertheless undertaken, it will not be the average therapist who will carry out all the work described in this chapter. If you count yourself among those who will carry this torch, the potential professional and personal benefits may be substantial. Developing an understanding of experiences common to many sexual minorities is likely to result in more time for LGB clients to spend their session delving into what is most potent for them, rather than educating or arguing with their therapist. Learning how to construct case conceptualizations that consider clients' sexuality – without assuming its relevance – can help clarify appropriate treatment targets and related CRB. Examining your own identity,

biases, and fears increases awareness, predictability, and control over related behavior. Direct shaping of therapist behavior affords the opportunity to expand one's own repertoire, becoming a more effective reinforcer for clients. By walking similar pathways of self-exploration as FAP clients are asked to do, FAP therapists can discover and distill their own voices and learn how to better reinforce their clients for unapologetically speaking their inner truths.

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