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ORIGINAL PAPER

# Gay Affirmative Cognitive Behavioral Therapy for Sexual Minority Youth: A Clinical Adaptation

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**Abstract** Sexual minority youth (SMY) are at high risk for negative mental health outcomes such as depression, anxiety, substance abuse, and suicidality. However, there has been a disconnect between clinical social work practice and research with SMY, resulting in a lack of rigorous research that demonstrates the use of effective interventions. While cognitive behavioral therapy (CBT) has long been established as a best practice option for the general adolescent population suffering from mental health problems, knowledge about the use of CBT with SMY lags far behind. Thus, the purpose of this article is to present a clearly defined adaptation of CBT for SMY that integrates gay affirmative practices for youth (e.g., coming out, stigma and discrimination, the role of social support and community). Specifically, the authors: (a) discuss the impact of minority stress on SMY; (b) highlight the specific components of CBT that represent a good fit for SMY and also address the criticisms of using such an approach; (c) consider the importance of using gay affirmative practices with SMY; and (d) offer recommendations for incorporating gay affirmative practices into traditional CBT models to better meet the needs of SMY.

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## Introduction

Sexual minority youth (SMY), a term increasingly used to describe young people who identify as lesbian, gay, bisexual, or queer (LGBQ) (Center for Disease Control and Prevention 2011), are at higher risk for mood, anxiety, and substance abuse disorders than youth who identify as heterosexual (Fergusson et al. 1999; King et al. 2008). Moreover, SMY are two to seven times more likely than heterosexual adolescents to have attempted suicide (Haas et al. 2011). The higher prevalence of mental health problems among SMY suggests that successful prevention and intervention strategies should target this population in particular (Meyer et al. 2007). However, there has been a gap between clinical social work practice and research with SMY, resulting in a lack of rigorous research that demonstrates the use of effective interventions with this vulnerable population.

While cognitive behavioral therapy (CBT) has long been established as a best practice option for the general adolescent population suffering from mental health problems (Compton et al. 2004), contemporary applications suggest that it can also be adapted to address the complex experiences of SMY (e.g., encountering homophobia and victimization). Thus, this article will present a clearly defined adaptation of CBT that helps SMY navigate the coming out process, while simultaneously teaching them skills to manage stigma and discrimination. Specifically, the authors will: (a) discuss the impact of minority stress on SMY; (b) highlight the specific components of CBT that

represent a good fit for SMY and also address the criticisms of using such an approach; (c) consider the importance of using gay affirmative practices with SMY; and (d) offer recommendations for incorporating gay affirmative practices into traditional CBT approaches to better meet the needs of SMY.

## Minority Stress

The increased risk for negative outcomes and maladaptive behaviors among SMY can be explained, in part, by minority stress theory (Marshal et al. 2011). According to minority stress theory, lesbian, gay, and bisexual individuals encounter chronic stress resulting in part from experiences of prejudice and discrimination, which in turn causes higher prevalence of psychiatric disorder (Meyer 2003). This type of stress is unique to marginalized populations (Meyer 2003), and is perpetuated by a conflict between one's internal self and his or her expectations of society. A lack of connection with the dominant culture is considered a primary source of minority stress for SMY (Balsam and Szymanski 2005). Adolescents identifying as lesbian, gay, bisexual, or questioning may feel even less connected to the dominant culture than adolescents identifying as racial/ethnic minorities. While adolescents of color can expect to receive protection and support from their families based on their shared stigmatized identity (e.g., being Black or Latino), SMY generally do not have the same sexual orientation as their family members and thus may not learn ways to cope with stigma (DiPlacido 1998). Moreover, some SMY face verbal and physical violence by family members after disclosure of their sexual orientation (D'Augelli et al. 2002). SMY are the only group of adolescents who face the possibility of total rejection from their families with the possibility of no ongoing support (Gibson 1994).

## CBT: A Good Fit for Sexual Minority Youth

As a result of minority stress, SMY are at disproportionate risk for emotional and behavioral health problems. However, identification with and support from members of the minority group to which one belongs enhances psychological well-being and provides a protective buffer against the ill-effects of stigma (DiPlacido 1998). Enhancing coping, problem-solving skills and social support are important buffers against minority stress (Selvidge et al. 2008). Thus, minority stress theory is the guiding framework underlying this gay affirmative adaptation of CBT. CBT focuses on identifying, evaluating, and changing dysfunctional thoughts and behaviors. Cognitive theory provides the foundation for CBT, which suggests that our emotions and behaviors are influenced by how we perceive events (Beck 1993). CBT encourages individuals to formulate alternative ways of thinking about situations and problems, which in turn prompts emotional and behavioral changes. Clients are instructed to practice what they learn after sessions as a way to reinforce change (Beck 2006).

CBT is considered a "best practice" for treating adolescents with mental health problems (Compton et al. 2004), including social anxiety (Baer and Garland 2005), depression (Rosselló and Bernal 2009) and suicidal ideation (TADS 2004; Stanley et al. 2009). There is also evidence that CBT prevents depression among adolescent populations (Callahan et al. 2012) and also helps to increase their self-esteem (Hyun et al. 2005; Rigby and Waite 2007). Group-based CBT may offer particular advantages for adolescents, as group contexts offer opportunities for learning, observing, and practicing skills (Rosselló et al. 2008).

Although empirical research suggests that CBT is an effective method for treating depression among lesbian and gay adults (Martell et al. 2004; Ross et al. 2007), there has been little discussion about applying cognitive behavioral interventions to the treatment of SMY (see Duarté -Vélez et al. 2010 for a notable exception.) However, we believe that using CBT to treat mental health problems among SMY presents a promising approach for a number of reasons.

First, CBT focuses on changing maladaptive behaviors by changing problematic ways of thinking. Identifying as lesbian, gay, bisexual, or questioning can negatively impact one's thoughts and beliefs and in turn cause feelings of low self-worth, anxiety, and depression. According to Safren and Rogers (2001), the internalization of homophobia negatively impacts the way SMY view themselves and their interactions with others. Challenging one's negative thoughts about sexual identity in a safe and supportive environment may help to decrease homophobic thoughts and feelings. For example, a gay youth who believes he can never live a "happy life" or have a "normal family" can learn to challenge these thoughts and replace them with more realistic ones (e.g., gay men have happy and satisfying lives and families of all types). Second, CBT helps clients recognize how their thoughts impact their behaviors. SMY are taught to replace maladaptive coping skills (e.g., isolating from friends and family) with more effective ones (e.g., talking to an ally about family problems) (Beck 2006). These new skills are taught, modeled, and reinforced throughout the intervention process. This is particularly important for SMY who—as a result of fear, shame, and guilt associated with experiences of discrimination—may have learned to rely on unhealthy coping mechanisms, including substance abuse, disordered eating, or skipping

school. By addressing the maladaptive thoughts and beliefs regarding one's sexual minority identity and subsequently teaching proactive coping skills to deal with stressors, CBT facilitates the use of positive thinking, which can foster healthy emotional and behavioral functioning among SMY.

## Does CBT Disempower Sexual Minority Youth?

There is increasing support for CBT as an effective intervention for vulnerable populations (Eamon 2008; Hays 2009; Townsend et al. 2010); however, controversies surrounding the use of CBT persist. Historically, CBT has been criticized for disempowering clients, particularly those who come from marginalized groups. There is concern that CBT (a) relies on expert control; (b) focuses on problems rather than strengths; and (c) lacks relevance for at-risk groups (Eamon 2008). In contrast, proponents of CBT assert that such interventions empower lesbian, gay, bisexual, or questioning individuals and other vulnerable populations (Eamon 2008; Hays 2009), because the approach prepares clients to deal effectively with emotional, social, and environmental challenges, which are critical components of empowerment (Saleebey 2002; Townsend et al. 2010). Further, as a result of their invisibility, SMY may struggle with feelings of powerlessness, which can result in negative outcomes like social exclusion, depression, and anxiety. Helping to decrease the possibility of these negative outcomes empowers SMY. Specifically, Eamon (2008) suggests that CBT increases lesbian, gay, and bisexual clients' ability to: (a) achieve and protect their own physical, mental and sexual health, (b) cope with their sexual identity and negotiate the coming out process, and (c) establish social support and positive relationships.

Although the expertise required to challenge and replace negative thoughts has been considered a form of social control that limits client freedom (Rothman 1989), the use of correctly applied CBT approaches are the result of a collaborative, individualized, and client-driven process (Eamon 2008). Target behaviors for change should be identified through a respectful, culturally responsive assessment that explores strengths, social supports, and goals. After an exploration of environmental factors, which includes a comprehensive examination of particular stressors related to prejudice and discrimination, CBT practitioners utilize cognitive intervention strategies (e.g., cognitive restructuring) to address obstacles (e.g., common cognitive distortions, automatic thoughts) to the client's long-term goals (Hays 2009).

For example, a SMY who dreams of becoming a registered nurse but has been consistently skipping school and is at risk of failing 11$^{th}$ grade may benefit from CBT. The first step is to explore the adolescent's environmental obstacles, including safety within the school and the need for possible environmental changes (e.g., intervention with school staff or changing schools). Subsequently, the intervention may include challenging negative thoughts (e.g., thought stopping related to the automatic thought "everyone here hates me because I am gay and stupid") and replacing them with more adaptive thoughts (e.g., I'm smart, and I deserve my education). Eventually, the new, positive thoughts are translated into new, adaptive behaviors (e.g., attending classes) that are consistent with the youth's long-term goals (e.g., going to college to become a registered nurse).

A second criticism of CBT asserts that it uses a deficit-focused approach that "forces" individuals to adapt to oppressive environments, and as a result is incongruent with a social justice perspective (Cowger 1994; Van Den Bergh 2002). While CBT helps to foster adaptation, the aim is to target client-identified sources of distress, while at the same reinforcing the client's strengths to deal with such distress (Wariki et al. 2012; Pence et al. 2011). Hays (2009) suggests that a contemporary application of CBT begins with helping clients change their situation or environment as a step toward alleviating or solving the presenting problem. Skillful delivery of CBT places substantial emphasis on clarifying which part of the problem is environmental and which part is cognitive (internal); using this method helps practitioners select the most appropriate intervention (e.g., intervening on some aspect of the environment vs. cognitive restructuring) (Hays 2009). Further, Eamon (2008) distinguishes between blaming oneself for a problem and taking responsibility to change a problem or cope with it by learning new skills. This approach is essential for empowering clients, particularly those from vulnerable populations. Therapeutic relationships based on unconditional respect during the initial stages of treatment decrease the likelihood that clients will blame themselves or pathologize their responses to negative situations. Thus, the goals related to developing more adaptive and healthy coping behaviors (e.g., replacing marijuana use with meditation) is appropriate for SMY struggling to navigate the struggles of adolescence among complex and stressful environmental conditions.

There is also concern that CBT practitioners employ interventions that are not congruent with the experiences, perspectives, or current situations of certain marginalized populations (Eamon 2008), including SMY. For example, if a therapist were to suggest that an adolescent's fear of being "disowned" by family members for being gay is distorted or irrational, rather than based in reality. Similarly, critics have voiced concerns that intervention strategies might not be appropriate for the cultural or socioeconomic context in which SMY exist and as a result

might be met with negative consequences (e.g., self-advocacy or assertiveness in the home could lead to abuse or homelessness) (Van Den Bergh 2002). While practitioners should be aware of these concerns, these challenges may be present when using other treatment models, not just CBT. Thus, we suggest that CBT for SMY can be enhanced by incorporating gay affirmative approaches.

## Gay Affirmative Practice

Gay affirmative practice is not an independent practice approach; it is used to enhance a practitioner's existing treatment model and can be incorporated into individual, couple, family, and group work (Davies 1996). However, gay affirmative practice differs from traditional treatment approaches. It views homosexuality as a normal variant of sexual identity development, which, in turn, "affirms a lesbian, gay, or bisexual identity as an equally positive human experience and expression to heterosexual identity" (Davies 1996, p. 25).

A gay affirmative practitioner "celebrates and advocates the validity of lesbian, gay, and bisexual persons and their relationships" (Tozer and McClanahan 1999, p. 736), and recognizes the impact of macro-level forces, particularly heterosexism and homophobia, on the well-being of sexual minorities (Lebolt 1999; Langdridge 2007). Practicing affirmatively includes "deprogramming" feelings of difference, which are perpetuated by stigma and marginalization (Davies 1996).

According to Crisp and McCave (2007), gay affirmative practice is particularly well-suited for social work practice with SMY because it: (a) focuses on affirming sexual minority identities; (b) empowers youth using the strengths perspective; (c) supports self-determination; (d) helps youth identify homophobic forces in their lives; (e) considers problems in the context of the homophobia and discrimination that youth experience; (f) encourages SMY to engage in consciousness raising to challenge homophobic influences; and (g) can be used in the variety of settings in which SMY receive social work services, such as schools, residential facilities, and outpatient treatment settings. In addition, gay affirmative practice is rooted in the person in environment perspective, which examines youths' troubles within the context of their environment.

Because SMY present with challenges that differ from heterosexual adolescents, it will be important to incorporate gay affirmative practices into existing treatment approaches. In fact, evidence suggests that modified mental health interventions for lesbian, gay, and bisexual individuals, which include incorporating gay affirmative practice techniques, may improve treatment effectiveness (Haas et al. 2011). Thus, the model discussed below aims to maintain the evidence-base of CBT (Interian et al. 2010), while infusing gay affirmative values and content throughout the therapeutic process. In this way, the proposed model represents a crucial first step in developing and testing empirically supported interventions for SMY.

## Gay Affirmative CBT for SMY: Key Components

The ten components of the model build on the existing literature (e.g., Crisp and McCave 2007; Hays 2009; Eamon 2008) as well as the authors' clinical and research experience with SMY. Following a discussion of the model, the authors present a case example to demonstrate the use of gay affirmative CBT with a SMY.

### Affirm the Identities of SMY During the Assessment Process

Assessment clarifies the client's needs, informs the direction of treatment, and provides a starting point for initiating behavioral change. Competent assessment with SMY requires practitioners to affirm the identities of lesbian, gay, and bisexual individuals and also acknowledge and address the impact of homophobia and heterosexism on their lived experiences (Lebolt 1999; Langdridge 2007). Practitioners should reflect on the initial assessment with SMY to examine the extent to which they demonstrated affirmation of the client's sexual identity and how this impacted the engagement process.

### Foster Collaboration by Clearly Explaining the Treatment Process

The structure of a CBT assessment allows the therapist to provide a clear description of the rationale and process of the sessions, which can be empowering to SMY. Explanations should utilize terms familiar to SMY so they can make informed choices about their treatment (Saleebey 1996). In addition, a functional assessment, which is an individualized assessment of the antecedents and consequences of the client's stress, can encourage the youth to share their perspective about how environmental conditions contributed to their behavioral problems (Eamon 2008).

### Identify the SMY's Personal Strengths and Support Networks

To assess the personal strengths of SMY, practitioners should ask clients to list positive feelings about identifying as lesbian, gay, or bisexual. Practitioners can also ask SMY to discuss their favorite lesbian and gay cultural icons or identify positive traits about other lesbian, gay, or bisexual

people they know. Effective assessment of interpersonal and environmental supports should include questions about the client's family of origin as well as family of choice (e.g., boyfriend/girlfriend's family or best friend's family), informal supports (e.g., friends, partners) and formal peer supports (e.g., gay-straight alliances in the school), community groups (e.g., SMY support group or a social action group), and participation in events or rituals that help celebrate sexual minority identities, such as gay pride parades.

### Distinguish Between Problems that are Environmental and Those that Stem from Dysfunctional Thoughts

This is particularly important for CBT with SMY who may struggle with situations outside of their control (e.g., homophobic bullying, parental rejection). This clarification allows the practitioner to understand the influence of environmental factors on the client's well-being. SMY may encounter events (e.g., rejection by family member) that cannot be easily changed by modifying dysfunctional thoughts or changing behavior. As a result, practitioners should validate their concerns and frustrations as well teach them skills for coping with situations that are beyond their control (e.g., living with a rejecting parent until s/he starts college). In such instances it may be helpful to use *cognitive restructuring*. This technique helps SMY recognize dysfunctional thoughts that work against their long-term goals and also helps to decrease feelings of hopelessness (Beck 1993). For example, practitioners working with homeless SMY should initially focus on the external factors (e.g., lack of safe,, permanent housing) contributing to the client's feelings of hopelessness and subsequently address the dysfunctional thought patterns (e.g., things will never get better). Failing to acknowledge that certain stressful circumstances stem from homophobic social conditions is unhelpful and, at times, may be dangerous to the well-being of SMY. Since they will undoubtedly encounter homophobia and heterosexism at different points in their lives, learning to effectively cope with such situations (e.g., challenging negative thoughts and replacing harmful behaviors with healthier ones) is essential. Gay affirmative practice focuses on identifying external stressors; infusing these practices into traditional CBT interventions ensures the suitability of this approach for SMY.

### For Environmentally-Based Problems, Help Clients Make Changes that Decrease Stress, Increase Personal Strengths and Supports, and to Build Their Skills for Interacting with the Social Environment

CBT with SMY can help them deal with stressful situations, even if they are unable to change their environment. For example, a youth that is experiencing bullying in school can be encouraged to practice telling a supportive adult, reporting the bully to the administration, or speaking up to the bully. To help develop support within the community, therapists can suggest SMY: (a) participate in Gay Straight Alliances (Heck et al. 2011) or school-based support groups, (b) advocate for other vulnerable students, and (c) attend Parents, Families and Friends of Lesbians and Gays (PFLAG) groups to connect with positive parental role models.

### Validate Clients' Self-Reported Experiences of Discrimination

When a SMY reports an incident of discrimination, the therapist should not automatically universalize it (e.g., "all kids have a hard time seeing eye to eye with their parents") or search for alternative reasons for the perpetrator's behavior (e.g., "doesn't he call everyone a sissy?"). Although CBT encourages the exploration of other hypotheses to determine the "cause" of a problem, this may be perceived as minimizing or even doubting the youth's experience. The youth may also experience the therapist's response as a subtle form of homophobia, which has the potential to undermine the therapeutic relationship. For example, Kelly (2006), who discussed the use of CBT with African–American populations, found that if a therapist validated a client's belief that a racist incident occurred, it allowed client and therapist to examine the importance of the discriminatory experience on to the client's presenting problem. Acknowledging the effects of heterosexism and homophobia may allow for a better understanding of the ways in which these issues contribute to the client's clinical concerns.

### Emphasize Collaboration Over Confrontation, with Attention to Client–Therapist Differences

As practitioners address clients' dysfunctional thoughts and behaviors and identify targets for change, contemporary CBT approaches (Beck 2006) emphasize collaboration, rather than confrontation. Such an approach may be even more important with SMY who sometimes have trouble finding supportive adults. To ensure a collaborative approach, practitioners should openly communicate that they understand the impact of oppression on the client's lived experience. For example, practitioners can ask clients to list their gay-related stressors on an erasable board; then the practitioner and client can talk about each stressor together. Using this method conveys that the practitioner is different than other adults who have minimized the client's problem or even rejected the client for being lesbian, gay, or bisexual.

### With Cognitive Restructuring, Question the Helpfulness (Rather than the Validity) of the Thought or Belief

Questioning whether a thought is irrational or invalid may be interpreted by some SMY as unempathic or naïve. For example, in an effort to demonstrate the irrational fear of coming out to one's family, a less-skilled practitioner might ask: "So what's the worst that could happen?" However, this question could intensify the client's realistic fears and may even backfire, as some youth experience serious consequences after coming out to family members (e.g. violence, homelessness, or being "disowned") (Ray 2007). An affirmative approach to cognitive restructuring includes evaluating the utility of the belief. Specifically, the therapist might ask the client, "Is it *helpful* for you to say *that if you come out you will be homeless*, or to hold onto this belief, or to repeat this thought or image to yourself?" In addition, the therapist may encourage clients to consider the advantages or disadvantages of each belief to assess whether it is currently helping the client (Hays 2009). For example, the first author works with SMY to list their thoughts about what might happen after "coming out" to a parent. The practitioner then uses the "helpful thoughts vs. not helpful thoughts" framework to assess the current utility of "holding on" to certain thoughts. This approach avoids an extensive discussion of whether or not a belief is irrational and allows clients to judge the utility of a thought or belief as it applies to their own lives (Wood and Mallinckrodt 1990).

### Use Client-Identified Strengths and Supports to Help SMY Develop a List of Helpful Thoughts

When SMY try to create new thoughts to replace less helpful ones, the list of specific strengths and supports generated during the initial assessment can be a concrete reminder of past successes. These past successes can be reformulated into positive self-statements, such as: all the adversity I have coped with in the past has made me stronger; if I got through last year, I can get through anything; my differences are what make me unique and special; or my best friend's family is my new family, and they appreciate me for who I am. These new thoughts and beliefs can be listed on a sheet of paper for the youth to take with him/her.

### Ensure that Homework Assignments Emphasize Congruence with LGBQ Culture as Well as the Client's Stage in the Coming Out Process

In CBT, homework assignments become a major focus of treatment, as they are a key mechanism to enhancing cognitive and behavioral change (Leahy 2006). In order to increase the likelihood that SMY will complete homework assignments, practitioners should ensure that assignments are appropriate for the client's age and developmental level, intellectual ability, and cultural background. Using gay affirmative approaches helps to ensure that the assignments are tailored to the client's stage of the coming out process. For example, practitioners can work with clients to create a list of activities that they might enjoy participating in. However, if clients are still in the early stages of the coming out process, they may not feel comfortable attending a queer community event or joining a gay-straight alliance. However, they might feel comfortable watching a gay-affirmative movie, spending time with a straight ally, or watching gay affirmative videos on Youtube. Furthermore, many SMY, regardless of their stage in the coming out process, enjoy activities that may appeal to youth in general (e.g., spending time with friends or a significant other, listening to music, writing poetry, going shopping, or playing sports). Practitioners should be aware that some SMY experience unique barriers when it comes to engaging in activities of their choice. For example, spending time with a boyfriend or girlfriend may be something that the adolescent identifies as both an enjoyable and useful for "combating" negative thoughts and feelings. However, parents who reject a youth's sexual minority identity may not permit such activities. Practitioners should attend to this "reality" when "assigning" homework to SMY. In these instances it may be helpful to ask the client: "What is one small step that you can take to help you feel like you are making a difference with your problem?" In this case, the youth might attempt to socialize through Facebook or e-mail, rather than attending a support group or community event. Practitioners should remind SMY that small successes create a foundation for future success.

## Case Study

The following practice exchange is an excerpt from sessions three and four of a CBT intervention with "Candice," a 16-year-old Hispanic female who self-identifies as "bisexual." Candice is in a relationship with a 17-year-old female from a neighboring school. Candice has come to therapy because she has witnessed bullying and harassment of SMY in her school and neighborhood. As a result, she is fearful about spending time with her girlfriend because she does not want anyone to find out that they are "together." She does not want her girlfriend to feel bad about this, but at the same time is worried about being bullied. Candice presents with several symptoms of depression including "feeling down," decreased motivation, increased

irritability, impaired concentration, and feelings of guilt and hopelessness.

Sessions one and two explain the purpose of therapy and introduce: (a) the term homophobia and how it can impact on one's thoughts and feelings; (b) the concept that thoughts affect feelings; and (3) ways to recognize *constructive* versus *destructive* thoughts. The excerpt from session three focuses on "changing one's thoughts to change one's feelings". In Candice's case, she identified the following negative thoughts related to the possibility of "being outed" at school or within her family: "no one will accept me," "I'll have no friends," and "it would be horrible." Session four explores how engaging in enjoyable activities can positively impact feelings and mood. Candice has been struggling to engage in activities that she finds enjoyable and affirming.

Session 3

**Worker**: Ok, Candice, so last week you were able to share some of the thoughts that run through your mind when you think about the possibility of people finding out that you have a girlfriend. I asked you to write them down.
**Candice**: Yea.
**Worker**: Do you mind sharing those thoughts again?
**Candice**: OK, I just think I won't have no friends, no one will accept me anymore and it would pretty much be the worst thing ever.
**Worker**: So with that thought in mind, describe your feelings.
**Candice**: Um, maybe like embarrassed or scared like that everyone will hate me or something…and sad because I'm alone.
**Worker**: So embarrassed, scared, and sad.
**Candice**: Yeah.
**Worker**: None of those feel real nice, right?
**Candice**: Nope, not at all.
**Worker**: So what we are going to do is to use some of the strategies we learned last week to try and help you challenge your thoughts a little bit so you are not stuck feeling so bad. Specifically, you are going to practice "disputing" or "talking back" to your thought. I'm going to write down your new, disputing thoughts down as you state them. What kinds of "arguments" can you come up with to challenge your thought? You mentioned in the first session that you want to be a lawyer when you grow up, so you should be pretty good at this!
**Candice**: (smiling) Yeah. Well, I guess I could say that "I might lose some friends but not all, because some of my friends are like me, and I wouldn't lose them."
**Worker**: Yes, it sounds like you are changing your perspective a bit. Can you try a couple more?
**Candice**: Some parts [of being out] might suck, but it wouldn't be the worst thing ever. I wouldn't be like losing a leg or anything. I'd still be me and then people would just know about a different part of me and like it wouldn't even matter at all because I can just stay around people who are cool and who get me, ya know? I mean I know other people who have come out and are fine, so I can too ya know?"
**Worker**: So, as you think about these "disputes," these new thoughts, (hands her the paper with her new "disputing" thoughts written down), what kinds of feelings do you have?
**Candice**: (reading then pausing) calmer, like strong, like it's not as big of a deal.

Session 4

**Worker**: So, last week we talked a lot about how our behaviors and the things we do affect our mood and that sometimes when we change our behavior we can impact how we feel. We talked about the importance of finding people, places, or activities that "affirm" who we are. The task for the week was to try to do an activity of some sort that made you feel better. Can you share your experience from this past week?
**Candice**: I was gonna go to that gay group at my school with one of my friends but I ended up not going.
**Worker**: So, you thought about going but decided not to this time. How come?
**Candice**: I don't know. I just don't feel like I am ready yet. I will go at some point, but not now.
**Worker**: Okay, I understand. We can talk more about it when you are ready to go. But did you do anything else that made you feel better?
**Candice**: Yeah, I did go on-line and watch a bunch of videos on You Tube of like gay and lesbian kids telling their stories and stuff. It was pretty cool. I mean I related to so much of what they were saying.
**Worker**: It sounds like watching those videos were helpful to you.
**Candice**: Yeah it's like they were me! I mean not all, but some of those kids were going through what I'm going through.
**Worker**: What was it like for you to hear that others are going through the same thing?
**Candice**: Um, it felt really good. It was so helpful because sometimes I get all depressed because I feel like nobody gets it, but watching those videos I felt like I'm not alone and that other people do get it.
**Worker**: So hearing these stories makes you feel more able to deal with your own situation?
**Candice**: It really does.

## Conclusion

The case study illustrates the application of gay affirmative CBT with SMY. This approach helps youth to identify more helpful ways of thinking and behaving, while simultaneously validating their unique struggles (e.g., experiencing homophobia and coming out). As demonstrated by the excerpt, the therapist validates the client's experiences by acknowledging her fears and embarrassment about coming out and reinforces her strategy to selectively tell others when she is ready. Further, the therapist helps Candice identify sources of potential social support such as the gay straight alliance which could counter some of her fears of rejection from her peers. Further, the therapist highlights her efforts to educate herself about the experiences of other SMY in a form that the client enjoys, namely through YouTube videos. The challenges faced by SMY require interventions that can provide them with tangible strategies to minimize negative mental health outcomes. CBT can offer clients permanent skills to deal with current and future stressors (Melvin et al. 2006; Rotheram-Borus et al. 1994).

It is important to recognize the limitations of gay affirmative CBT for SMY. While CBT is considered a best practice option for treating depression, anxiety, and substance abuse among the general adolescent population, its efficacy has not yet been tested with SMY. Further, this model may not be appropriate for all clinical situations (i.e., SMY experiencing life-threatening physical abuse) and in no way diminishes support for other psychotherapy approaches for sexual minority populations. Gay affirmative CBT for SMY is presented as a promising clinical option for working with SMY, but empirical research is needed to demonstrate its effectiveness.

A clearly defined adaptation of CBT that integrates gay affirmative practices is an initial step toward developing empirically-supported interventions to meet the specific needs of SMY.

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