Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients

The "Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients" provide psychologists with (a) a frame of reference for the treatment of lesbian, gay, and bisexual clients[1] and (b) basic information and further references in the areas of assessment, intervention, identity, relationships, diversity, education, training, and research. These practice guidelines are built upon the "Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients" (Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients, 2000) and are consistent with the American Psychological Association (APA) "Criteria for Practice Guideline Development and Evaluation" (APA, 2002a). They assist psychologists in the conduct of lesbian, gay, and bisexual affirmative practice, education, and research.

The term *guidelines* refers to pronouncements, statements, or declarations that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Thus, these guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help ensure a high level of professional practice by psychologists. These guidelines are not intended to be mandatory or exhaustive and may not be applicable to every clinical situation. They should not be construed as definitive and are not intended to take precedence over the judgment of psychologists. *Practice guidelines* essentially involve recommendations to professionals regarding their conduct and the issues to be considered in particular areas of psychological practice. Practice guidelines are consistent with current APA policy. It is also important to note that practice guidelines are superseded by federal and state law and must be consistent with the current APA "Ethical Principles of Psychologists and Code of Conduct" (APA, 2002b).[2]

Background

In 1975, the APA adopted a resolution stating that "homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities" and urging "all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated

with homosexual orientations" (Conger, 1975, p. 633). In the years following the adoption of this important policy, the APA indeed has taken the lead in promoting the mental health and well-being of lesbian, gay, and bisexual people and in providing psychologists with affirmative tools for practice, education, and research with these populations. In 2009, the association affirmed that "same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity" (APA, 2009a, p. 121).

Sixteen years following APA's 1975 resolution, a gap in APA policy and the practice of psychologists was identified in a study by Garnets, Hancock, Cochran, Goodchilds, and Peplau (1991) that documented a wide variation in the quality of psychotherapeutic care to lesbian and gay clients. These authors and others (e.g., Fox, 1996; Greene, 1994b; Nystrom, 1997; Pilkington & Cantor, 1996) suggested that there was a need for better education and training in working with lesbian, gay, and bisexual clients. For this reason, the "Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients" (Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients, 2000) were developed.

Need

A revision of the guidelines is warranted at this point in time because there have been many changes in the field of lesbian, gay, and bisexual psychology. Existing topics have evolved, and the literature also has expanded into new areas of interest for those working with lesbian, gay, and bisexual clients. In addition, the quality of the data sets of studies has improved significantly with the advent of population-based research.

Furthermore, the past decade has seen a revival of interest and activities on the part of political advocacy groups in attempting to repathologize homosexuality (Haldeman, 2002, 2004). Guidelines grounded in methodologically sound research, the APA Ethics Code, and existing APA policy are vital to informing professional practice with lesbian, gay, and bisexual clients. These guidelines have been used nationally and internationally in practice and training and in informing public policy. They will expire or be revised in 10 years from the date they are adopted by APA.

Compatibility

These guidelines build upon APA's Ethics Code (APA, 2002b) and are consistent with preexisting APA policy pertaining to lesbian, gay, and bisexual issues. These policies include but are not limited to the resolution titled "Discrimination Against Homosexuals" (Conger, 1975); the "Resolution on Sexual Orientation, Parents, and Children" (Paige, 2005); the "Resolution on Sexual Orientation and Marriage" (Paige, 2005); the "Resolution on Hate Crimes" (Paige, 2005); the "Resolution Opposing Discriminatory Legislation and Initiatives Aimed at Lesbian, Gay, and Bisexual Persons" (Paige, 2007); and the "Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts" (APA, 2009b). The guidelines are also compatible with policies of other major mental health organizations (cf. American Association for Marriage and Family Therapy, 1991; American Counseling Association, 1996; American Psychiatric Association, 1974; Canadian Psychological Association, 1995; National Association of Social Workers, 1996) which state that homosexuality and bisexuality are not mental illnesses.

Development Process

These guidelines were developed collaboratively by Division 44/Committee on Lesbian, Gay, Bisexual, and Transgender Concerns. The guidelines revision process was funded by Division 44 and by the APA Board of Directors. Supporting literature for these guidelines is consistent with the APA Ethics Code (APA, 2002b) and other APA policy. In addition, the *Application* sections of the text were enhanced to provide psychologists with more information and assistance.

Definition of Terms

Sex refers to a person's biological status and is typically categorized as male, female, or intersex (i.e., atypical combinations of features that usually distinguish male from female). There are a number of indicators of biological sex, including sex chromosomes, gonads, internal reproductive organs, and external genitalia.

Gender refers to the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex. Behavior that is compatible with cultural expectations is referred to as gender normative; behaviors that are viewed as incompatible with these expectations constitute gender nonconformity.

Gender identity refers to "one's sense of oneself as male, female, or transgender" (APA, 2006). When one's gender identity and biological sex are not congruent, the individual may identify as transsexual or as another transgender category (cf. Gainor, 2000).

Gender expression refers to the "way in which a person acts to communicate gender within a given culture; for example, in terms of clothing, communication patterns, and interests. A person's gender expression may or may not be consistent with socially prescribed gender roles, and may or may not reflect his or her gender identity" (APA, 2008, p. 28).

Sexual orientation refers to the sex of those to whom one is sexually and romantically attracted. Categories of sexual orientation typically have included attraction to members of one's own sex (gay men or lesbians), attraction to members of the other sex (heterosexuals), and attraction to members of both sexes (bisexuals). Although these categories continue to be widely used, research has suggested that sexual orientation does not always appear in such definable categories and instead occurs on a continuum (e.g., Kinsey, Pomeroy, Martin, & Gebhard, 1953; Klein, 1993; Klein, Sepekoff, & Wolff, 1985; Shively & De Cecco, 1977). In addition, some research indicates that sexual orientation is fluid for some people; this may be especially true for women (e.g., Diamond, 2007; Golden, 1987; Peplau & Garnets, 2000).

Coming out refers to the process in which one acknowledges and accepts one's own sexual orientation. It also encompasses the process in which one discloses one's sexual orientation to others. The term *closeted* refers to a state of secrecy or cautious privacy regarding one's sexual orientation.

Attitudes Toward Homosexuality and Bisexuality

Guideline 1. Psychologists strive to understand the effects of stigma (i.e., prejudice, discrimination, and violence) and its various contextual manifestations in the lives of lesbian, gay, and bisexual people

Rationale

Living in a heterosexist society inevitably poses challenges to people with nonheterosexual orientations. Many lesbian, gay, and bisexual people face social stigma, heterosexism, violence, and discrimination (Herek, 1991b, 2009; Mays & Cochran, 2001; I. H. Meyer, 2003). Stigma is defined as a negative social attitude or social disapproval directed toward a characteristic of a person that can lead to prejudice and

discrimination against the individual (VandenBos, 2007). Herek (1995) defined heterosexism as "the ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community" (p. 321). These challenges may precipitate a significant degree of minority stress for lesbian, gay, and bisexual people, many of whom may be tolerated only when they are "closeted" (DiPlacido, 1998). Minority stress can be experienced in the form of ongoing daily hassles (e.g., hearing antigay jokes) and more serious negative events (e.g., loss of employment, housing, custody of children, physical and sexual assault; DiPlacido, 1998). According to a probability sample study by Herek (2009), antigay victimization has been experienced by approximately 1 in 8 lesbian and bisexual individuals and by about 4 in 10 gay men in the United States. Enacted stigma, violence, and discrimination can lead to "felt stigma," an ongoing subjective sense of personal threat to one's safety and well-being (Herek, 2009).

Antigay victimization and discrimination have been associated with mental health problems and psychological distress (Cochran, Sullivan, & Mays, 2003; Gilman et al., 2001; Herek, Gillis, & Cogan, 1999; Mays & Cochran, 2001; I. H. Meyer, 1995; Ross, 1990; Rostosky, Riggle, Horne, & Miller, 2009). Equally important, as individuals form lesbian, gay, and bisexual identities in the context of extreme stigma, most lesbian, gay, and bisexual people have some level of internalized negative attitudes toward nonheterosexuality (Szymanski, Kashubeck-West, & Meyer, 2008a). Szymanski, Kashubeck-West, and Meyer (2008b) reviewed the empirical literature on internalized heterosexism in lesbian, gay, and bisexual individuals and found that greater internalized heterosexism was related to difficulties with self-esteem, depression, psychosocial and psychological distress, physical health, intimacy, social support, relationship quality, and career development.

There are significant differences in the nature of the stigma faced by lesbians, gay men, and bisexual individuals. Lesbians and bisexual women, in addition to facing sexual prejudice, must contend with the prejudice and discrimination posed by living in a world where sexism continues to exert pervasive influences (APA, 2007). Similarly, gay and bisexual men are confronted not only with sexual prejudice but also with the pressures associated with expectations for conformity to norms of masculinity in the broader society as well as in particular subcultures they may inhabit (Herek, 1986; Stein, 1996). Bisexual women and men can experience negativity and stigmatization from lesbian and gay individuals as well as from heterosexual individuals (Herek, 1999, 2002; Mohr & Rochlen, 1999). Greene (1994b) noted that the cumulative effects of heterosexism, sexism, and racism may put lesbian, gay, and bisexual racial/ethnic minorities at special risk for stress. Social stressors affecting lesbian, gay, and bisexual

youths, such as verbal and physical abuse, have been associated with academic problems, running away, prostitution, substance abuse, and suicide (D'Augelli, Pilkington, & Hershberger, 2002; Espelage, Aragon, Birkett, & Koenig, 2008; Savin-Williams, 1994, 1998). Less visibility and fewer lesbian, gay, and bisexual support organizations may intensify feelings of social isolation for lesbian, gay, and bisexual people who live in rural communities (D'Augelli & Garnets, 1995).

Research has identified a number of contextual factors that influence the lives of lesbian, gay, and bisexual clients and, therefore, their experience of stigma (Bieschke, Perez, & DeBord, 2007). Among these factors are race and ethnicity(e.g., L. B. Brown, 1997; Chan, 1997; Espin, 1993; Fygetakis, 1997; Greene, 2007; Szymanski & Gupta, 2009; Walters, 1997); immigrant status (e.g., Espin, 1999); religion (e.g., Davidson, 2000; Dworkin, 1997; Fischer & DeBord, 2007; Ritter & Terndrup, 2002); geographical location–regional dimensions, such as rural versus urban or country of origin (e.g., Browning, 1996; D'Augelli, Collins, & Hart, 1987; Kimmel, 2003; Oswald & Culton, 2003; Walters, 1997); socioeconomic status, both historical and current (Albelda, Badgett, Schneebaum, & Gates, 2009; Badgett, 2003; Díaz, Bein, & Ayala, 2006; Martell, 2007; G. M. Russell, 1996); age and historical cohort (G. M. Russell & Bohan, 2005); disability (Abbott & Burns, 2007; Shuttleworth, 2007; Swartz, 1995; Thompson, 1994); HIV status (O'Connor, 1997; Paul, Hays, & Coates, 1995); and gender identity and presentation (APA, 2008; Lev, 2007).

Application

Psychologists are urged to understand that societal stigmatization, prejudice, and discrimination can be sources of stress and create concerns about personal security for lesbian, gay, and bisexual clients (Mays & Cochran, 2001; Rothblum & Bond, 1996). Therefore, creating a sense of safety in the therapeutic environment is of primary importance (see Guideline 4). Central to this is the psychologist's understanding of the impact of stigma and his or her ability to demonstrate that understanding to the client through awareness and validation. Psychologists working with lesbian, gay, and bisexual people are encouraged to assess the client's history of victimization as a result of harassment, discrimination, and violence. In addition, overt and covert manifestations of internalized heterosexism should be assessed (Sánchez, Westefeld, Liu, & Vilain, 2010; Szymanski & Carr, 2008). Different combinations of contextual factors related to gender, race, ethnicity, cultural background, social class, religious background, disability, geographic region, and other sources of identity can result in dramatically different stigmatizing pressures and coping styles. Such contextual differences also may result in different clinical presentations and clinical needs (Moradi, van den Berg, & Epting, 2009). Psychologists

are thus urged to understand these contextual factors in their assessment of which interventions are likely to be acceptable and effective and how clients evaluate the outcome of their therapy (Fontes, 2008; Ivey & Ivey, 2007).

Among the interventions psychologists are urged to consider are (a) increasing the client's sense of safety and reducing stress, (b) developing personal and social resources, (c) resolving residual trauma, and (d) empowering the client to confront social stigma and discrimination, when appropriate. Psychologists strive to consider the relative levels of safety and social support that the client experiences in his or her environment and to plan interventions accordingly. For example, for clients who are more comfortable with their lesbian, gay, or bisexual identity, it may be helpful for the psychologist to consider referrals to local support groups or other community organizations. For clients who are less comfortable with their nonheterosexual orientation, online resources may prove helpful. Psychologists are urged to weigh the risks and benefits for each client in context. Because stigma is so culturally pervasive, its effects may not even be evident to a lesbian, gay, or bisexual person. Therefore, it may be helpful for psychologists to consider the ways in which stigma may be manifest in the lives of their clients even if it is not raised as a presenting complaint.

Guideline 2. Psychologists understand that lesbian, gay, and bisexual orientations are not mental illnesses

Rationale

No scientific basis for inferring a predisposition to psychopathology or other maladjustment as intrinsic to homosexuality or bisexuality has been established. Hooker's (1957) study was the first to challenge this historical assumption by finding no difference on projective test responses between nonclinical samples of heterosexual men and gay men. Subsequent studies have continued to show no differences between heterosexual groups and homosexual groups on measures of cognitive abilities (Tuttle & Pillard, 1991) and psychological well-being and self-esteem (Coyle, 1993; Herek, 1990b; Savin-Williams, 1990). Fox (1996) found no evidence of psychopathology in nonclinical studies of bisexual men and bisexual women.

At the present time, efforts to repathologize nonheterosexual orientations persist on the part of advocates for conversion or reparative therapy (APA, 2009b; Haldeman, 2002). Nevertheless, major mental health organizations (cf. American Association for Marriage and Family Therapy, 1991; American Counseling Association, 1996; American Psychiatric Association, 1974; APA [Conger, 1975]; Canadian

Psychological Association, 1995; National Association of Social Workers, 1996) have affirmed that homosexuality and bisexuality are not mental illnesses.

Moreover, an extensive body of literature has emerged that identifies few significant differences between heterosexual, homosexual, and bisexual people on a wide range of variables associated with overall psychological functioning (Gonsiorek, 1991; Pillard, 1988; Rothblum, 1994). Furthermore, the literature that classified homosexuality and bisexuality as mental illnesses has been found to be methodologically unsound. Gonsiorek (1991) reviewed this literature and found such serious methodological flaws as unclear definitions of terms, inaccurate classification of participants, inappropriate comparisons of groups, discrepant sampling procedures, an ignorance of confounding social factors, and the use of questionable outcome measures. Although these studies concluded that homosexuality is a mental illness, there is no valid empirical support for beliefs that lead to such inaccurate representations of lesbian, gay, and bisexual people.

When studies have noted differences between homosexual and heterosexual individuals with regard to psychological functioning (e.g., DiPlacido, 1998; Gilman et al., 2001; Mays, Cochran, & Roeder, 2003; Ross, 1990; Rotheram-Borus, Hunter, & Rosario, 1994; Savin-Williams, 1994), these differences have been attributed to the effects of stress related to stigmatization on the basis of sexual orientation. These findings are consistent with an extant body of research that associates exposure to discriminatory behavior with psychological distress (e.g., Kessler, Michelson, & Williams, 1999; Markowitz, 1998). In her analysis of recent population-based studies, Cochran (2001) concluded that increased risk for psychiatric distress and substance abuse among lesbians and gay men is attributable to the negative effects of stigma.

Application

Psychologists are encouraged to avoid attributing a client's nonheterosexual orientation to arrested psychosocial development or psychopathology. Practice that is informed by inaccurate, outmoded, and pathologizing views of homosexuality and bisexuality can subtly manifest as the inappropriate attribution of a client's problems to his or her nonheterosexual orientation (Garnets et al., 1991; Pachankis & Goldfried, 2004). Shidlo and Schroeder (2002) found that nearly two thirds of a sample of psychotherapy clients reported that their therapists told them that, as gay men and lesbians, they could not expect to lead fulfilling, productive lives or participate in stable primary relationships.

Such statements stem from a fundamental view that homosexuality and bisexuality indicate or are automatically associated with mental disturbance or dysfunction.

Clients who have been exposed to notions of homosexuality and bisexuality as mental illnesses may present with internalized prejudicial attitudes (Beckstead & Morrow, 2004; Pachankis & Goldfried, 2004). In these cases, it is important to consider the effects of internalized stigma. These effects can be addressed directly or indirectly (Bieschke, 2008) as appropriate, given the client's psychological readiness. Beckstead and Israel (2007) suggested a collaborative approach in establishing therapeutic goals and examining the negative effects of prejudicial beliefs. APA (2009b) "supports the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias" (p. 122) and "opposes the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion" (p. 122).

Guideline 3. Psychologists understand that same-sex attractions, feelings, and behavior are normal variants of human sexuality and that efforts to change sexual orientation have not been shown to be effective or safe

Rationale

Therapeutic efforts to change sexual orientation have increased and become more visible in recent years (Beckstead & Morrow, 2004). Therapeutic interventions intended to change, modify, or manage unwanted nonheterosexual orientations are referred to as "sexual orientation change efforts" (SOCE; APA, 2009b). The majority of clients who seek to change their sexual orientation do so through so-called ex-gay programs or ministries (Haldeman, 2004; Tozer & Hayes, 2004). Most contexts in which SOCE occur derive from the religion-based ex-gay movement (Haldeman, 2004), although several psychotherapeutic approaches also exist. For example, Nicolosi (1991) described a model in which male homosexuality is treated through the therapeutic resolution of a developmental same-sex attachment deficit.

Reviews of the literature, spanning several decades, have consistently found that efforts to change sexual orientation were ineffective (APA, 2009b; Drescher, 2001; Haldeman, 1994; T. F. Murphy, 1992). These reviews highlight a host of methodological problems with research in this area, including biased sampling techniques, inaccurate classification of subjects, assessments based solely upon self-reports, and poor or nonexistent outcome measures. Even the most optimistic advocates of SOCE have concluded that sexual orientation is nearly impossible to change (Spitzer, 2003) and that less

than a third of subjects in such studies claim successful treatment (Haldeman, 1994). Therefore, in the current climate of evidence-based practice, SOCE cannot be recommended as effective treatment. Moreover, according to the APA "Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts" (APA, 2009b), "the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation" (p. 121).

The potential for SOCE to cause harm to many clients also has been demonstrated. Shidlo and Schroeder (2002) found that a majority of subjects reported that they were misled by their therapists about the nature of sexual orientation as well as the normative life experiences of lesbian, gay, and bisexual individuals. Furthermore, they noted that most subjects were not provided with adequate informed consent regarding their conversion therapy procedures as delineated in APA's "Resolution on Appropriate Therapeutic Responses to Sexual Orientation" (APA, 1998). Haldeman (2002) described a spectrum of negative client outcomes from failed attempts at conversion therapy. These include intimacy avoidance, sexual dysfunction, depression, and suicidality.

Bias and misinformation about homosexuality and bisexuality continue to be widespread in society (APA, 1998, 2009b; Haldeman, 1994) and are implicated in many client requests to change sexual orientation. Tozer and Hayes (2004) found that the internalization of negative attitudes and beliefs about homosexuality and bisexuality was a primary factor in motivating individuals who sought to change their sexual orientation. Fear of potential losses (e.g., family, friends, career, spiritual community) as well as vulnerability to harassment, discrimination, and violence may contribute to an individual's fear of self-identification as lesbian, gay, or bisexual. Additionally, some clients report that nonheterosexual orientation is inconsistent with their religious beliefs or values (APA, 2009b; Beckstead, 2001).

Application

Psychologists are encouraged to carefully assess the motives of clients seeking to change their sexual orientation. Given the influence of internalized homonegativity and antigay religious beliefs on client requests to change sexual orientation (Tozer & Hayes, 2004), it is important for the psychologist faced with such a request to proceed with deliberation and thoughtfulness. In addition, the psychologist is ethically obliged to provide accurate information about sexual orientation to clients who are misinformed or confused (APA, 1998). Psychologists are encouraged to identify and address bias and

internalized prejudice about sexual orientation that may have a negative influence on the client's self-perception. In providing the client with accurate information about the social stressors that may lead to discomfort with sexual orientation, psychologists may help neutralize the effects of stigma and inoculate the client against further harm.

APA's (1998) "Resolution on Appropriate Therapeutic Responses to Sexual Orientation" offers a framework for psychologists working with clients who are concerned about the implications of their sexual orientation. The resolution highlights those sections of the APA Ethics Code that apply to all psychologists working with lesbian, gay, and bisexual older adults, adults, and youths. These sections include prohibitions against discriminatory practices (e.g., basing treatment upon pathology-based views of homosexuality or bisexuality); the misrepresentation of scientific or clinical data (e.g., the unsubstantiated claim that sexual orientation can be changed); and a clear mandate for informed consent (APA, 1992). Informed consent would include a discussion of the lack of empirical evidence that SOCE are effective and their potential risks to the client (APA, 2009b) and the provision of accurate information about sexual orientation to clients who are misinformed or confused. The policy cited above calls upon psychologists to discuss the treatment approach, its theoretical basis, reasonable outcomes, and alternative treatment approaches. Further, it discourages coercive treatments, particularly with youths.

Clients who are conflicted with respect to sexual orientation and religious identification and expression have long posed challenges for psychologists (Beckstead & Morrow, 2004; Haldeman, 2004; Yarhouse & Burkett, 2002). The ultimate goal that may make sense for many such conflicted clients is an integration of sexual orientation with religious identification, as with the client who accepts that he or she is gay and moves from a conservative to an open and affirming religious denomination. However, for some clients, particularly those who experience religious orientation as a more salient aspect of identity than that of sexual orientation, such a transition may not be possible. In these instances, the client may choose to prioritize his or her religious affiliation over sexual orientation and may seek accommodation compatible with such a choice (APA, 2009b; Beckstead, 2001; Haldeman, 2004; Throckmorton, 2007). It should be noted, however, that this is not the same as changing or even managing sexual orientation but is a treatment goal established in the service of personal integration. For a more detailed discussion of planning treatment with clients who are conflicted about sexual orientation and religious identification, see APA (2009b), Beckstead (2001), Beckstead and Morrow (2004), and Haldeman (2004).

Psychologists are encouraged to assess the emotional and social distress associated with clients' unsuccessful attempts at SOCE. The potential for SOCE to cause harm to many clients has been noted (APA, 2009b; Haldeman, 2001, 2004; Shidlo & Schroeder, 2002). These emotional concerns may include avoidance of intimate relationships, depression and anxiety, problems with sexual functioning, suicidal feelings, and a sense of being doubly stigmatized for being gay and unable to change. Psychologists working with men who have undergone some form of SOCE are encouraged to recognize that a sense of "demasculinization" is common (Haldeman, 2001), because men in such programs are often instructed that "real" men cannot be gay. Additionally, it is important to note that SOCE participants confronting coming out as gay frequently experience problems of social adjustment due to unfamiliarity with the lesbian, gay, and bisexual community. They also may need support for potential losses (e.g., family relationships, connections with communities of faith). Given that acceptance of one's sexual orientation is positively correlated with self-report measures of life satisfaction (Herek, 2003; Morris, Waldo, & Rothblum, 2001), a supportive, bias-free therapeutic environment may help the client cope with internalized stigma and create an integrated life of his or her own construction based upon positive self-regard.

Guideline 4. Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated

Rationale

The APA Ethics Code urges psychologists to eliminate the effect of biases on their work (APA, 2002b, Principle E). To do so, psychologists strive to evaluate their competencies and the limitations of their expertise, especially when offering assessment and treatment services to people who share characteristics that are different from their own (e.g., lesbian, gay, and bisexual clients). Without a high level of awareness about their own beliefs, values, needs, and limitations, psychologists may impede the progress of a client in psychotherapy (Corey, Schneider-Corey, & Callanan, 1993). This is particularly relevant when providing assessment and treatment services to lesbian, gay, and bisexual clients.

The psychological assessment and treatment of lesbian, gay, and bisexual clients can be adversely affected by their therapists' explicit or implicit negative attitudes. For example, when homosexuality and bisexuality are regarded as evidence of mental illness or psychopathology, a client's same-sex sexual orientation is apt to be viewed as a major source of the client's psychological

difficulties, even when it has not been presented as a problem (Garnets et al., 1991; Liddle, 1996; Nystrom, 1997). Moreover, when psychologists are unaware of their own negative attitudes, the effectiveness of psychotherapy can be compromised by their heterosexist bias.

Since heterosexism pervades the language, theories, and psychotherapeutic interventions of psychology (S. Anderson, 1996; L. S. Brown, 1989; Gingold, Hancock, & Cerbone, 2006), conscious efforts to recognize and counteract such heterosexism are imperative in order for optimal assessment and treatment to take place. This is the case because when heterosexual norms for identity, behavior, and relationships are applied to lesbian, gay, or bisexual clients, their thoughts, feelings, and behaviors may be misinterpreted as abnormal, deviant, and undesirable.

An alternative but similarly ineffective approach is to adopt a "sexual orientation blind" perspective when offering assessment and treatment. Like similar "color-blind" models, such a perspective ignores or denies the culturally unique life experiences of the lesbian, gay, and bisexual populations. Instead of eliminating heterosexist bias, a so-called blind perspective would likely perpetuate heterosexism in a manner that is unhelpful to clients (Garnets et al., 1991; Winegarten, Cassie, Markowski, Kozlowski, & Yoder, 1994).

Application

As noted in the APA Ethics Code (APA, 2002b), psychologists are called to be "aware of and respect cultural, individual, and role differences, including those due to… sexual orientation… and try to eliminate the effect on their work of biases based on [such] factors" (APA, 2002b, p. 1063). To do so, psychologists are encouraged to be aware of both the explicit and implicit biases they may have. Explicit biases are more obvious both to the psychologists who hold them and to their clients and have been described as direct and conscious forms of prejudice (Conrey, Sherman, Gawronski, Hugenberg, & Groom, 2005). In contrast, implicit biases are outside the awareness of those holding them (Greenwald & Banaji, 1995), but they may nonetheless have a significant negative impact on the psychotherapeutic process.

Since safety in the psychotherapeutic relationship has been viewed as central to the development of positive change (Levitt & Williams, 2010), psychologists are encouraged to use appropriate methods of self-exploration and self-education (e.g., consultation, study, and formal continuing education) to identify and ameliorate implicit and explicit biases about homosexuality and bisexuality. In doing so, psychologists strive to be aware of how their own background and personal factors, such as

gender, sexual orientation, heterosexism, and religious ideology, may influence their assessment and treatment of gay, lesbian, and bisexual clients (T. Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; Morrow, 2000). In addition, psychologists strive to avoid making assumptions that a client is heterosexual, even in the presence of apparent markers of heterosexuality (e.g., marital status, parenthood).

Because many psychologists have not received sufficient current information regarding lesbian, gay, and bisexual clients (Pilkington & Cantor, 1996), psychologists are strongly encouraged to seek training, experience, consultation, or supervision when necessary to ensure competent practice with these populations. Key areas for psychologists to be familiar with include but are not limited to an understanding of (a) human sexuality across the life span; (b) the impact of social stigma on sexual orientation and identity development; (c) the coming-out process and how such variables as age, gender, ethnicity, race, disability, religion, and socioeconomic status may influence this process; (d) same-sex relationship dynamics; (e) family-of-origin relationships; (f) the struggles with spirituality and religious group membership; (g) career issues and workplace discrimination; and (h) the coping strategies for successful functioning.

Guideline 5. Psychologists strive to recognize the unique experiences of bisexual individuals

Rationale

Bisexual persons are affected by negative individual and societal attitudes toward bisexuality that are expressed by both heterosexual and gay/lesbian people (Bradford, 2004a; Eliason, 2001; Evans, 2003; Herek, 2002; Mulick & Wright, 2002). In addition, bisexuality may not be regarded as a valid sexual orientation (Dworkin, 2001) but instead be viewed as a transitional state between heterosexual and homosexual orientations (Eliason, 2001; Herek, 2002; G. M. Russell & Richards, 2003; Rust, 2000a). Bisexual individuals also may be viewed as promiscuous, developmentally arrested, or psychologically impaired (Fox, 1996; T. Israel & Mohr, 2004; Mohr, Israel, & Sedlacek, 2001; Oxley & Lucius, 2000). Visibility of sexual identity may be particularly challenging for bisexual persons, as others may assume they are lesbian or gay if in a same-sex relationship or heterosexual if they are in a mixed-sex relationship (Bradford, 2004a; Keppel & Firestein, 2007; Rust, 2007).

Bisexuals are not a homogeneous group. The diversity among bisexual individuals is reflected in variations in gender, culture, identity development, relationships, and meaning of bisexuality (Fox, 1996; Rust, 2000b). People may embrace a bisexual identity because they are attracted both to women

and to men, because gender is not a key criterion for choosing an intimate partner, or because they find traditional notions of sexual orientation limiting (Ross & Paul, 1992). Bisexual individuals may be more likely than lesbian or gay persons to be in a nonmonogamous relationship and to view polyamory as an ideal, although there are many bisexual people who desire and sustain monogamous relationships (Rust, 1996b; Weitzman, 2007). Identity development trajectories vary for people who are attracted both to women and to men. Some such individuals initially adopt a lesbian or gay identity, some later adopt a lesbian or gay identity, and some consistently embrace a bisexual identity (Fox, 1996).

Although few researchers have investigated the mental health of bisexual individuals specifically, some studies have suggested that bisexuals may have higher rates of depression, anxiety, suicidality, and substance abuse than do lesbian, gay, and heterosexual populations (e.g., Dodge & Sandfort, 2007). As with minority stress models for lesbian and gay individuals (I. H. Meyer, 2003), these mental health risks have been attributed to discrimination and social isolation (Dodge & Sandfort, 2007).

Application

Psychotherapy with bisexual clients involves respect for the diversity and complexity of their experiences (Bradford, 2006; Dworkin, 2001; Goetstouwers, 2006; Page, 2004, 2007). Psychologists therefore are encouraged to develop a comprehensive understanding of sexual orientation in their approach to treatment (Horowitz, Weis, & Laflin, 2003). Psychologists also are encouraged to examine their attitudes toward relationships and strive to examine biases toward the nontraditional relationships that some bisexual people may have (Buxton, 2007; Weitzman, 2007). In addition, psychologists strive to familiarize themselves with the development of a bisexual identity, including cultural differences relative to bisexuality (Collins, 2007; Evans, 2003; Ferrer & Gómez, 2007; Scott, 2006, 2007) and gender differences (Eliason, 2001; Fox, 2006; Goetstouwers, 2006).

Psychologists are encouraged to keep in mind that affirmative psychotherapy with bisexual clients may differ from that with gay and lesbian clients (Bradford, 2004b). For example, bisexual men and women sometimes come out after being in a mixed-sex or same-sex relationship (including marriage) and want to acknowledge or act on their attractions to the other sex (Keppel & Firestein, 2007). Treatment may thus need to help them negotiate a new relationship with their married spouse that may include a divorce (Buxton, 2007; Carlsson, 2007; Firestein, 2007).

Guideline 6. Psychologists strive to distinguish issues of sexual orientation from those of gender identity when working with lesbian, gay, and bisexual clients

Rationale

Sexual orientation and gender identity are distinct characteristics of an individual (APA, 2006). A common error is to see gay men and lesbians as particularly likely to manifest gender-nonconforming behavior and/or to be transgender (Fassinger & Arseneau, 2007; Helgeson, 1994; Kite, 1994; Kite & Deaux, 1987; Martin, 1990). Similarly, gender nonconformity may result in an individual being perceived as lesbian or gay, independent of that person's actual sexual orientation. Because gender nonconformity is likely to be stigmatized, gender nonconformity itself can result in prejudice and discrimination, regardless of sexual orientation (J. Green & Brinkin, 1994; Lombardi, 2001). For example, some research in schools indicates that gender nonconformity (regardless of sexual orientation) evokes at least as much antipathy among high school students as does a lesbian, gay, or bisexual orientation alone (e.g., Horn, 2007).

Lesbian, gay, or bisexual clients may present in gender-conforming or gender-nonconforming ways. Psychologists may see clients who are struggling with coming-out issues and who also express confusion concerning whether their gender conformity or nonconformity is related to their sexual orientation.

Application

Psychologists are encouraged to help clients understand the differences between gender identity, gender-related behavior, and sexual orientation when these issues are in conflict. Psychologists also are encouraged to be aware of the potential that gender nonconformity in lesbian, gay, and bisexual clients may exacerbate stigmatization. To work effectively with issues related to gender nonconformity, psychologists strive to be aware of their own values and biases regarding sex, gender, and sexual orientation (APA, 2008; Gainor, 2000).

A variety of resources now exists for psychologists working clinically with clients who identify somewhere along the spectrum of gender nonconformity (e.g., APA, 2008; Benjamin, 1967; Brill & Pepper, 2008; Carroll, 2010; Carroll & Gilroy, 2002; G. E. Israel & Tarver, 1997; Korell & Lorah, 2007; Lev, 2004; Raj, 2002; Ubaldo & Drescher, 2004). Psychologists who work with transgender people who also identify as lesbian, gay, or bisexual can utilize the emerging professional literature as well as online resources to keep abreast of the changing context for this population.

Gainor (2000) provided a comprehensive introduction to transgender issues in lesbian, gay, and bisexual psychology. M. Brown and Rounsley's (1996) work offers information for helping professionals on transsexualism. Useful websites include those of the American Psychological Association

(http://www.apa.org/pi/lgbc/transgender), the World Professional Association of Transgender Health (http://www.wpath.org), the Gender Public Advocacy Coalition (http://www.gpac.org), the National Center for Transgender Equality (http://www.transequality.org), the Sylvia Rivera Law Project (http://www.srlp.org), and the Transgender Law Center (http://www.transgenderlawcenter.org).

Relationships and Families

Guideline 7. Psychologists strive to be knowledgeable about and respect the importance of lesbian, gay, and bisexual relationships

Rationale

Lesbian, gay, and bisexual couples are both similar to and different from heterosexual couples (Peplau, Veniegas, & Campbell, 1996). They form relationships for similar reasons (Herek, 2006), express similar satisfactions with their relationships (Kurdek, 1995; Peplau & Cochran, 1990), and follow developmental patterns similar to heterosexual couples (Clunis & Green, 1988; McWhirter & Mattison, 1984). The differences are derived from several factors, including different patterns of sexual behavior, gender role socialization (Hancock, 2000; Herek, 1991b; Ossana, 2000), and the stigmatization of their relationships (Garnets & Kimmel, 1993).

Same-sex couples must sometimes adapt to conditions that are hostile to or devalue their relationships. These include the psychological effects of political campaigns against same-sex marriage (Rostosky et al., 2009; G. M. Russell, 2000) and the prohibition of legal and medical protections for same-sex families as in Virginia and Florida (Herek, 2006). Furthermore, relationship patterns and choices among lesbian, gay, and bisexual individuals may be affected by early-life stigma and marginalization (Mohr & Fassinger, 2003).

Changes in physical health may present unique stressors, especially to older lesbian, gay, and bisexual couples (e.g., possible separation from partners, possible loss of contact for partners in nursing homes or other inpatient settings, facing homophobia in caretakers or fellow residents in nursing homes and assisted living situations). Lesbian, gay, and bisexual clients may have become so inured to the effects of stigma and discrimination in their relationships that they may not recognize the contribution of stigma to the conflicts they face.

The relationship structures of lesbian, gay, and bisexual couples vary and may present unique concerns. Nonmonogamous or polyamorous relationships may be more common and more acceptable among gay men and bisexual individuals than is typical for lesbians or heterosexuals (Herek, 1991a; McWhirter & Mattison, 1984; Peplau, 1991). In addition, many lesbians and gay men come out years after they have been heterosexually married (Buxton, 1994, 2007).

Application

Psychologists are encouraged to consider the negative effects of societal prejudice and discrimination on lesbian, gay, and bisexual relationships. A couple may not recognize the contribution of stigma and marginalization to the common relationship problems that all couples may encounter (R. J. Green & Mitchell, 2002). Nonetheless, lesbian, gay, and bisexual couples may seek therapy for reasons similar to those of heterosexual couples (e.g., communication difficulties, sexual problems, dual career issues, commitment decisions) or for dissimilar reasons (e.g., disclosure of sexual orientation, differences between partners in the disclosure process, issues derived from the effects of gender socialization). For example, when one partner has disclosed his sexual orientation to his family of origin and the other has not, the pair may encounter conflicts around where to spend the holidays or whether to “de-gay” the house when visitors are expected. Psychologists are therefore encouraged to consider familial and other social and cultural factors in conducting therapy with lesbian, gay, and bisexual couples.

Familiarity with nontraditional relationship structures may be helpful to the psychologist working with same-sex couples (Martell & Prince, 2005). Some gay, lesbian, and bisexual couples may need to resolve ambiguity in areas of commitment and boundaries, cope with homophobia, and develop adequate social supports (R. J. Green & Mitchell, 2002; Greenan & Tunnell, 2003; Hancock, 2000; Kurdek, 1988). Monogamy is a normative expectation in many heterosexual relationships, whereas it is not always assumed among gay male couples.

The relationships of lesbian, gay, and bisexual individuals are diverse. In the absence of socially sanctioned supports for their relationships, lesbian, gay, and bisexual people create their own relationship models and support systems. It is useful for psychologists to be aware of the diversity of these relationships and refrain from applying a heterosexist model when working with lesbian, gay, and bisexual couples. This may be particularly salient with respect to the sexual lives of lesbian, gay, and bisexual couples. Healthy sexual expression is generally taken to be an element of overall relationship satisfaction. It is helpful for psychologists working with lesbian, gay, and bisexual couples to be

sensitized to and knowledgeable about common sexual practices and concerns shared by lesbian, gay, and bisexual couples (e.g., sexual frequency, various forms of sexual dysfunction, concerns related to intimacy and desire). Psychologists are encouraged to recognize that internalized heterosexism can complicate the development of healthy sexual relationships. Psychologists are also encouraged to recognize the particular challenges that men and women in heterosexual marriages face in coming out and integrating their lesbian, gay, or bisexual orientation into their lives. In addition, the spouses and families of these individuals may require therapeutic support.

Guideline 8. Psychologists strive to understand the experiences and challenges faced by lesbian, gay, and bisexual parents

Rationale

Research has indicated that lesbian, gay, and bisexual parents are as capable as heterosexual parents (cf. Armesto, 2002; Erich, Leung, & Kindle, 2005; Herek, 2006; Patterson, 2000, 2004; Perrin, 2002; Tasker, 1999). In fact, Flaks, Ficher, Masterpasqua, and Joseph (1995) found that lesbian couples had stronger parenting awareness skills than did heterosexual couples. Bos, van Balen, and van den Boom (2005, 2007) reported that lesbian social mothers (nonbiological mothers) had higher quality parent–child interactions, were more committed as parents, and were more effective in child rearing than were fathers in heterosexual marriages. Such findings are important to note, given the context of discrimination that lesbian, gay, and bisexual parents face (e.g., legal barriers to foster parenting and same-sex and second-parent adoption, the threat of loss of custody of children, prohibitions against living with one's same-sex partner, the lack of legal rights of one of the parents; ACLU Lesbian and Gay Rights Project, 2002; Appell, 2004; Patterson, Fulcher, & Wainwright, 2002). In becoming parents, lesbian, gay, and bisexual people face challenges not required of heterosexual people, such as stressors related to alternative insemination and surrogacy (Gifford, Hertz, & Doskow, 2010). Other unique concerns for lesbian, gay, and bisexual parents include lack of support from families and friends and homophobic reactions from pediatricians, day-care providers, and school personnel. Families of the nonbiological lesbian mother may be resistant to seeing nonbiological children as true grandchildren, nieces, or nephews (Ben-Ari & Livni, 2006).

Increasingly, research has focused on the children of lesbian, gay, and bisexual parents. Three main concerns have been raised (primarily by those in the legal and social welfare systems) with regard to the well-being of children raised by lesbian, gay, and bisexual parents (Patterson, 2005). These include (a)

the gender identification, gender role behavior, and sexual orientation of the children; (b) the personal development of the children; and (c) the social experiences of such children. Patterson (2005) conducted a comprehensive review of the literature in each of these areas. Her review of the empirical data (primarily based on children of lesbian mothers) indicated that none of these areas of concern have merit. Patterson also reported that the data showed no major differences between children reared by lesbian parents and those raised by heterosexual mothers with regard to personal development in areas such as self-esteem, locus of control, intelligence, behavior problems, personality, school adjustment, and psychiatric health. In light of research findings supporting the positive outcomes for children of lesbian and gay parents, the American Academy of Pediatrics released a statement in 2002 supporting second-parent adoption in lesbian, gay, and bisexual households (Perrin & the Committee on Psychosocial Aspects of Child and Family Health, 2002).

Application

APA "encourages psychologists to act to eliminate all discrimination based on sexual orientation in matters of adoption, child custody and visitation, foster care, and reproductive health services" (Paige, 2005, p. 496). Although bias and misinformation continue to exist in the educational, legal, and social welfare systems, psychologists also are urged to correct this misinformation in their work with parents, children, community organizations, and institutions and to provide accurate information based upon scientifically and professionally derived knowledge. Psychologists strive to recognize the challenges faced by lesbian, gay, and bisexual parents and are encouraged to explore these issues with their clients. For example, denial of access to marriage creates barriers for same-sex parents in accessing the same legal and economic benefits and social status as do married heterosexual couples (APA, 2008). At the same time, psychologists are urged to recognize the unique strengths and resilience of lesbian, gay, and bisexual families. Psychologists are encouraged to examine the various facets of identity (e.g., race and ethnicity, culture, socioeconomic class, disability, religious or spiritual traditions) that intersect in creating the experiences of lesbian, gay, and bisexual parents.

Guideline 9. Psychologists recognize that the families of lesbian, gay, and bisexual people may include people who are not legally or biologically related

Rationale

For a significant number of lesbian, gay, and bisexual individuals, nondisclosure of sexual orientation and/or lack of acknowledgement of their intimate relationships may result in emotional

distancing from their family of origin (Patterson, 2007). Even when families are accepting, this acceptance often may be tolerance rather than true acceptance (R. J. Green, 2004). For many lesbian, gay, and bisexual people, a network of close friends may constitute an alternative family structure—one that may not be based on legal and/or biological relationships. These families of choice provide social connections and familial context for lesbian, gay, and bisexual individuals (R. J. Green, 2004) and may be more significant than the individual's family of origin (Kurdek, 1988). Such family structures can mitigate the effects of discrimination and the absence of legal or institutional recognition (Weston, 1992).

Application

Given the importance of social support in relationship satisfaction, stigma management, and psychological well-being (Beals, 2004), psychologists are encouraged to recognize and value lesbian, gay, and bisexual family structures. Psychologists also are urged to consider the stress that clients may experience when their families of origin, employers, or others do not recognize their alternative family structures. When working with lesbian, gay, and bisexual clients, it can be helpful to ask them about their friendship network, the quality of their relationships in that network, and whether they consider members of this network to be “family.” A related issue would be the person's level of involvement with the lesbian, gay, and bisexual community, as connection with the community may provide the individual with role models, social support, a sense of solidarity, and other resources helpful in the development of a positive identity (I. H. Meyer, 2003; G. M. Russell, 2000).

Guideline 10. Psychologists strive to understand the ways in which a person's lesbian, gay, or bisexual orientation may have an impact on his or her family of origin and the relationship with that family of origin

Rationale

There are many responses a family can have upon learning that one of its members is lesbian, gay, or bisexual (Patterson, 2007; Savin-Williams, 2003). Some families of origin may be unprepared to accept a lesbian, gay, or bisexual child or family member because of familial, ethnic, or cultural norms; religious beliefs; or negative stereotypes (Buxton, 2005; Chan, 1995; Firestein, 2007; Greene, 2000; Matteson, 1996). For these families, this awareness may precipitate a family crisis that can result in profound distancing from or expulsion of the lesbian, gay, or bisexual family member; rejection of the parents and siblings by that family member; parental guilt and self-recrimination; or conflicts within the parents' relationship (Dickens & McKellen, 1996; Griffin, Wirth, & Wirth, 1996; Savin-Williams, 2003; Savin-

Williams & Dube, 1998; Strommen, 1993). On the other hand, there are families of origin in which acceptance of their lesbian, gay, or bisexual member is unconditional or without crisis (Patterson, 2007; Savin-Williams, 2003). Research does suggest, however, that even supportive families may experience an adjustment period upon learning that a family member is lesbian, gay, or bisexual (Jennings & Shapiro, 2003; Pallotta-Chiarolli, 2005).

Bisexual individuals may experience some unique complications with their families of origin. Persons who identify as bisexual and become romantically involved with same-sex partners may receive pressure from their families of origin to choose a partner of the other gender, and bisexuals who are in mixed-sex relationships may have difficulty maintaining their bisexual identity within their family of origin and extended family (Dworkin, 2001, 2002; Firestein, 2007).

Some young adult life transitions (e.g., choosing careers, deciding to parent) will be particularly complicated for the lesbian, gay, or bisexual family member. It may be challenging to explain to family members how sexual orientation and experiences related to stigma may impact decisions related to work and career, sexual and romantic relationships, and parenting (Patterson, 2007). Both the family of origin and the extended family may grapple with the recognition of same-sex partners and children raised by a same-sex couple.

Application

Psychologists are encouraged to explore with lesbian, gay, and bisexual clients any issues and concerns related to their family of origin and extended family. Psychologists strive to understand the culturally specific risks of coming out to one's family of origin. For example, racial and ethnic minority families may fear losing the support of their community if they are open about having a lesbian, gay, or bisexual child. Psychologists can assist clients in facilitating discussions with their families about their identities as well as about cultural stigma. Families may need support in developing new understandings of sexual orientation, confronting the ways in which negative societal attitudes about homosexuality and bisexuality are manifested within the family, and supporting family members in addressing difficulties related to societal stigmatization.

Newer models of family therapy move beyond addressing difficulties and promote processes of creating constructive systemic change (Fish & Harvey, 2005). Psychologists are encouraged to assist families in developing long-term support for their lesbian, gay, and bisexual members and to monitor the relationships among family members beyond the adjustment to discovering the identity of a lesbian,

gay, or bisexual member (Oswald, 2002). Psychologists are urged to assist lesbian, gay, and bisexual clients in their efforts to present accurate information regarding sexual orientation to their families. Finally, psychologists strive to be aware of the cultural variations in a family's reaction and ways of adapting to a lesbian, gay, or bisexual member. Local and national resources are available that can provide information, assistance, and support to family members (e.g., Parents, Family, and Friends of Lesbians and Gays; Children of Lesbians and Gays Everywhere; see Appendix A).

Issues of Diversity

The following guidelines refer to aspects of the life experience that may overlap and/or contribute in varying degrees to an individual's sense of identity and relationship to his or her social and cultural environment. The concept of *intersectionality* (Cole, 2009) is used to characterize the variable, differential, and unique effects of constructs such as race, ethnicity, culture, gender, age, sexual orientation, class, and disability on the individual's life. Intersectionality is defined by multiple categories of identity, difference, and disadvantage. The understanding of how these categories depend upon one another for meaning is based on questions of inclusion (i.e., diversity within categories), inequality (i.e., relative placement in hierarchies of power and privilege), and similarities (i.e., commonalities across categories typically viewed as deeply different; Cole, 2009). The following guidelines on diversity each reflect a substantive construct; however, the reader is encouraged to consider them through the lens of intersectionality.

Guideline 11. Psychologists strive to recognize the challenges related to multiple and often conflicting norms, values, and beliefs faced by lesbian, gay, and bisexual members of racial and ethnic minority groups

Rationale

Lesbian, gay, and bisexual individuals who are members of racial, ethnic, and cultural minority groups must negotiate the norms, values, and beliefs regarding homosexuality and bisexuality of both mainstream and minority cultures (Chan, 1992, 1995; Greene, 1994b; Manalansan, 1996; Rust, 1996a). There is some evidence to suggest that cultural variation in these norms, values, beliefs, and attitudes can be a significant source of psychological stress that affects the health and mental health of lesbians, gay men, and bisexual women and men (Díaz, Ayala, Bein, Henne, & Marin, 2001; Harper & Schneider, 2003; I. H. Meyer, 2003). Recently, however, there is evidence to suggest that lesbian, gay, and bisexual

individuals from diverse racial, ethnic, and cultural backgrounds may have lower rates of mental health problems (e.g., Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Kertzner, Meyer, Frost, & Stirratt, 2009; I. H. Meyer, Dietrich, & Schwartz, 2008). It may be that the skills learned in negotiating one stigmatized aspect of identity may actually assist the individual in dealing with and protect the individual from other forms of stigmatization.

Nevertheless, the integration of multiple identities could pose challenges for lesbian, gay, and bisexual people from diverse racial, ethnic, and cultural backgrounds. For example, a lesbian, gay, or bisexual person of color may experience "conflicts of allegiance" (Gock, 2001; Morales, 1989) when the expectations of the lesbian, gay, and bisexual community with which he or she identifies are at odds with those of the racial, ethnic, or cultural group with which he or she also has a strong sense of belonging. These conflicts of allegiance may lead to a lesbian, gay, and bisexual person from a diverse racial, ethnic, or cultural background experiencing the sense of never being part of any group completely (Greene, 2007). According to Greene, in addition to dealing with their minority sexual orientations, lesbian, gay, and bisexual people of color experience racism and discrimination within the lesbian, gay, and bisexual communities at large. These challenges may be even greater for lesbian, gay, and bisexual people from diverse racial, ethnic, or cultural backgrounds who experience other forms of marginalization related to such factors as age, geographic location, immigration status, limited English-language proficiency, acculturation status, social class, and disability (e.g., Bieschke, Hardy, Fassinger, & Croteau, 2008; Rosario, Schrimshaw, & Hunter, 2004).

Application

Psychologists are urged to understand the different ways in which multiple minority statuses may complicate and exacerbate the difficulties their clients experience. For example, psychologists are encouraged to consider as critical factors in treatment the ways in which clients may be affected by how their cultures of origin view and stigmatize homosexuality and bisexuality (Gock, 2001; Greene, 1994c), as well as the effects of racism within the mainstream lesbian, gay, and bisexual communities (Gock, 2001; Greene, 1994a; Morales, 1996; Rust, 1996a). Furthermore, sensitivity to the complex dynamics associated with other overlapping layers of social identities and statuses (e.g., social class, gender roles, religious beliefs) is critical to effective work with these populations (Chan, 1995; Garnets & Kimmel, 2003; Greene, 1994a; Rust, 1996a) in assisting clients to negotiate these issues.

Psychologists strive to recognize and to help their clients recognize the effective coping strategies and other protective factors that their lesbian, gay, and bisexual clients from racial, ethnic, and cultural minority backgrounds may have developed through their multiple marginalization experiences (Greene, 2003; Selvidge, Matthews, & Bridges, 2008). Psychologists are also encouraged to understand and help their lesbian, gay, and bisexual clients address the anger, frustration, and pain that they have often experienced both as people from diverse racial, ethnic, and cultural backgrounds and as sexual minority people (Espin, 1993; Jones & Hill, 1996).

Guideline 12. Psychologists are encouraged to consider the influences of religion and spirituality in the lives of lesbian, gay, and bisexual persons

Rationale

The influence of religion and spirituality in the lives of lesbian, gay, and bisexual persons can be complex, dynamic, and a source of ambivalence. Such is the case because their experience, especially with organized religion, is varied and diverse. Although some religious and spiritual belief systems are relatively neutral about diverse sexual orientations (e.g., Buddhism and Hinduism), others historically have been more condemnatory (e.g., Christianity, Judaism, and Islam). Even within religious traditions that have been historically disapproving of nonheterosexual orientations, there has been an emerging and growing theological paradigm in the past 20 to 30 years that accepts and supports diverse sexual orientations (Borg, 2004). The religious backgrounds of lesbian, gay, and bisexual individuals may have variable effects on their psychological functioning and well-being (Haldeman, 2004). Besides having diverse past experience with faith, lesbian, gay, and bisexual individuals may differ in terms of the role that religion and spirituality play in their current lives. For instance, some view their faith traditions and spiritual beliefs as an important and integral part of identity, but others do not (Maynard, 2001). Moreover, as for their heterosexual counterparts, the influence and meaning of faith for lesbian, gay, and bisexual persons may differ across the life span.

Application

Psychologists strive to be aware and respectful of the diverse religious and spiritual practices espoused by lesbian, gay, and bisexual people. Lesbian, gay, and bisexual psychologists in particular may be vulnerable to conscious or unconscious religious bias that could negatively affect their work with clients who espouse a strong religious identification (Haldeman, 2004). They are encouraged to understand both the historical and current role and impact of religion and spirituality in the lives of their lesbian,

gay, and bisexual clients (Haldeman, 1996). In particular, they are urged to consider the rejecting and hurtful religious experiences that their lesbian, gay, and bisexual clients may have had. The integration of these sometimes disparate but salient aspects of identity is often an important treatment goal for psychologists working with lesbian, gay, and bisexual clients who are conflicted because of their religious identification (Benoit, 2005; Buchanan, Dzelme, Harris, & Hecker, 2001; Harris, Cook, & Kashubek-West, 2008).

APA's "Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice" (Anton, 2008) called upon psychologists to examine their own religious beliefs and prevent these beliefs from taking precedence over professional practice and standards in their clinical work with lesbian, gay, and bisexual clients. The majority of clients who seek SOCE hold religious beliefs that they experience as incompatible with their sexual orientation (APA, 2009b; Shidlo & Schroeder, 2002; Tozer & Hayes, 2004). Psychologists are encouraged to consider such requests very carefully by reviewing the APA "Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts" (APA, 2009b) and discussing the current research and possible risks associated with change efforts with their clients. Furthermore, psychologists are encouraged to inquire about the social and cultural influences that may play a role in these requests. In addition, psychologists are encouraged to be familiar with the resources (including but not limited to faith-related literature and groups) from different faith traditions in their communities that are affirming and welcoming of lesbian, gay, and bisexual people.

Guideline 13. Psychologists strive to recognize cohort and age differences among lesbian, gay, and bisexual individuals

Rationale

Lesbian, gay, and bisexual individuals may differ substantially based on the effects of cohort and age. Cohort influences are broad historical forces that shape the context of development; for lesbian, gay, and bisexual people, the time period in which one has lived and/or come out can profoundly shape such developmental tasks as claiming identity labels, identity disclosure, parenting, and political involvement (Fassinger & Arseneau, 2007). Examples of factors influencing generational differences include changing societal attitudes toward sexuality; the effects of HIV/AIDS on sexual minority communities; changing religious and spiritual attitudes and practices; the women's, gay, and civil rights movements; advancements in reproductive technologies and changes in ideologies about families; and changes in conceptualizations of sexual and gender identity, including identity labels. Cohort effects are

distinct from age differences. For example, a person who came out in the 1950s likely would have had a very different experience than someone who came out within the past decade. Similarly, a 15-year-old coming out today likely would have a different experience than a 45-year-old coming out today.

Normative issues or changes related to aging for all older adults (e.g., health, retirement, finances, and social support; Berger, 1996; Kimmel, 1995; Slater, 1995) may become significantly more challenging for older lesbian, gay, and bisexual individuals due to heterosexist discrimination. Lack of legal protections may raise problems in medical and financial decision making, couple autonomy in health and end-of-life decisions, access to appropriate health care, parenting rights, health care and retirement benefits, inheritances, living arrangements, and property rights. Cohort effects and age effects interact, as older lesbian, gay, and bisexual individuals have more frequent interactions with medical providers (age effect) combined with the likely concealment of identity (cohort effect); such interactions may result in compromised health care (Fassinger & Arseneau, 2007).

Multiple minority status (e.g., related to gender, social class, disability, race and ethnicity) also will affect the experience of aging for lesbian, gay, and bisexual older individuals (Kimmel, Rose, & David, 2006). For example, there appear to be differences in perceived stigmatization by ethnicity and age among older lesbian, gay, and bisexual adults (David & Knight, 2008). As another example, women in same-sex relationships may experience heightened financial difficulties due to the cumulative effects of depressed earnings over their lifetimes (Fassinger, 2008). Finally, many lesbian, gay, and bisexual older adults experience ageism within lesbian, gay, and bisexual communities (Kimmel et al., 2006).

Application

Psychologists are urged to consider the particular historical context of the cohort to which the client belongs. In regard to age, psychologists recognize that older adults are a diverse group and that normative changes in aging may be positive as well as negative and are not necessarily related to pathology or to a client's sexual orientation. In regard to the interaction of cohort and age, psychologists are encouraged to attend to the ways in which a particular age-related issue may be affected by cohort experience. For example, grieving related to the death of a partner (age-normative issue) may be exacerbated by heterosexism among older peers (cohort effect), resulting in a lack of support for the grieving partner.

Psychologists recognize that federal, state, and local laws and regulations affect the rights of their older lesbian, gay, and bisexual clients and are aware of relevant resources that may assist clients with

medical, legal, and financial needs. Psychologists may find resources on positive adaptation to aging among lesbian, gay, and bisexual older adults helpful (Friend, 1990; Lee, 1987). Psychologists may help older lesbians, gay men, and bisexual clients to apply strategies they have learned from coping with heterosexism in managing the challenges associated with normative aging (Fassinger, 1997; Kimmel et al., 2006).

Guideline 14. Psychologists strive to understand the unique problems and risks that exist for lesbian, gay, and bisexual youths

Rationale

Navigating the cognitive, emotional, and social developmental changes of adolescence while simultaneously integrating the emergence of a lesbian, gay, or bisexual identity can be challenging for youths (D'Augelli, 2006). Lesbian, gay, bisexual, and questioning youths may be at increased risk for difficulties not experienced by their heterosexual counterparts (cf. D'Augelli, 2002; Espelage et al., 2008; Lasser, Tharinger, & Cloth, 2006; Thomas & Larrabee, 2002), such as homelessness (Urbina, 2007), prostitution (Savin-Williams, 1994), and sexually transmitted diseases (Solorio, Milburn, & Weiss, 2006). Lesbian, gay, bisexual, and questioning youths who do not conform to gender norms may experience increased difficulties in peer relationships (D'Augelli et al., 2002; Wilson & Wren, 2005). Decisions about coming out may pose even greater difficulties for lesbian, gay, and bisexual youths of color, for whom family and community may be a vital source of support for dealing with racism (see Guideline 11). Lesbian, gay, and bisexual youths often have problems in school that are related to their sexual orientation (Cooper-Nicols, 2007), such as social alienation (Sullivan & Wodarski, 2002) and bullying (E. J. Meyer, 2009). These factors may increase the risk of substance abuse (Jordan, 2000) or have long-term consequences, such as posttraumatic stress (Rivers, 2004).

The social stigma associated with lesbian, gay, and bisexual identities may create pressure on youths to conform to heterosexual dating behaviors, to hide their sexual orientation, or to avoid social interactions (Safren & Pantalone, 2006). Attempts to mask or deny their sexual identity may put lesbian, gay, and bisexual teens at higher risk for unwanted pregnancy (Saewyc, 2006), engaging in unsafe sex (Rosario, Schrimshaw, & Hunter, 2006), interpersonal violence (S. T. Russell, Franz, & Driscoll, 2001), and suicide attempts (Savin-Williams, 2001).

Lesbian, gay, and bisexual youths often experience negative parental reactions about their sexual orientation (Heatherington & Lavner, 2008). Supportive families may be a protective factor against the

negative effects of minority stress for lesbian, gay, and bisexual youths (I. H. Meyer, 2003; Ryan, 2009). However, well-intentioned heterosexual parents may not offer the degree of insight and socialization needed by lesbian, gay, and bisexual youths to protect them from both the experience of heterosexism and the internalization of heterosexist beliefs (R. J. Green, 2004). Close relationships with a network of supportive friends therefore are extremely important and can serve as a buffer against the pain of familial rejection and/or societal heterosexism. A strong friendship network has been viewed as pivotal in sexual identity exploration and development (D'Augelli, 1991).

Application

Psychologists are encouraged to consider the psychological impact of current social and political events and media portrayals of sexual minorities on lesbian, gay, and bisexual youths. An awareness of ethical and legal issues when working with lesbian, gay, and bisexual youths is particularly important, given that laws on confidentiality, health status disclosure, and age of consensual sex differ from state to state.

Youths may feel reluctant to claim an identity relative to sexual orientation. Furthermore, sexual identity may be experienced as fluid during adolescence (Diamond, 2007; Rosario, Schrimshaw, Hunter, & Braun, 2006). Psychologists therefore strive to create an open and affirming therapeutic context for discussions of sexuality and exploration of meaning that youths give to self-identifying terms. Psychologists also strive to help lesbian, gay, bisexual, and questioning youths and their families to identify alternative resources for education, opportunities for support, and affirming Internet sites, when appropriate.

Research shows that lesbian, gay, and bisexual youths are subjected to high levels of sexual orientation harassment in schools (E. J. Meyer, 2009). Psychologists are encouraged to work with teachers and school administrators to assist them in recognizing the long-term impact of such harassment, such as school dropout, poor academic performance, and suicidal behavior. Psychologists can serve as resources to assist school personnel in reducing sexual orientation harassment in schools.

Ryan (2009) showed that even minor levels of parental acceptance are associated with increased psychological and physical well-being in lesbian, gay, and bisexual youths. This study found that lower levels of familial rejection during adolescence and young adulthood were associated with lower level of depression, reduced substance use, less high-risk sexual behavior, and lowered suicide risk. When working with parents of lesbian, gay, bisexual, or questioning youths, psychologists are urged to assess the level of acceptance or rejection of their child's sexual orientation. Interventions might include

employing psychoeducational strategies to provide accurate information about sexual orientation and building on familial strengths to increase support for their lesbian, gay, bisexual, and questioning youths (Ryan, 2009).

Guideline 15. Psychologists are encouraged to recognize the particular challenges that lesbian, gay, and bisexual individuals with physical, sensory, and cognitive–emotional disabilities experience

Rationale

Lesbian, gay, and bisexual individuals with disabilities may encounter a wide range of particular challenges related to the social stigma associated both with disability and with sexual orientation (Saad, 1997). They also may experience the sense of invisibility that is associated with the intersection of same-sex orientation and physical, cognitive–emotional, and/or sensory disability (Abbott & Burns, 2007; Lofgren-Martenson, 2009), due to prevailing societal views of people with disabilities as nonsexual and alone. Moreover, Shapiro (1993) has pointed out that an individual's self-concept may be negatively affected by these challenges, which, in turn, further compromises her or his sense of autonomy and personal agency, sexuality, and self-confidence.

There are a number of particular challenges faced by lesbian, gay, and bisexual individuals with physical, sensory, and cognitive–emotional disabilities. For example, gay men with intellectual and learning disabilities have been shown to be at significantly greater risk for engaging in unsafe sex (Yacoub & Hall, 2009). A sense of being “less masculine” also has been implicated in higher risk sexual behavior among disabled gay men (O'Neill & Hird, 2001). Within partner relationships, special issues related to life management, including mobility, sexuality, and medical and legal decision making, may be specifically challenging. In addition, family support may not be available because of negative reactions to the person's sexual orientation (McDaniel, 1995; Rolland, 1994). Lesbian, gay, and bisexual people with disabilities may not have the same access to information, support, and services that are available to those without disabilities (O'Toole, 2003; O'Toole & Bregante, 1992). Moreover, there may be additional stress associated with the pressure of a lesbian, gay, or bisexual person to come out to caregivers and health care professionals in order to receive responsive services (O'Toole & Bregante, 1992).

Application

Psychologists working with lesbian, gay, and bisexual individuals with disabilities are encouraged to pay particular attention to the covariance of issues of disability, race, ethnicity, sexual orientation, gender, age, health status, and socioeconomic status (Fraley, Mona, & Theodore, 2007; Hunt, Matthews,

Milsom, & Lammel, 2006). The potential additive effects of stigmatized aspects of identity may be exacerbated by issues in significant relationships (e.g., partners, family members, caregivers, health care providers) and call for thoughtful assessment. Furthermore, psychologists working with disabled lesbian, gay, and bisexual individuals are urged to consider the potential effects of social barriers in the lesbian, gay, and bisexual community and in the larger social context (Shapiro, 1993).

Psychologists are urged to consider ways of empowering their lesbian, gay, and bisexual clients with disabilities, given the disenfranchisement and sense of invisibility experienced by many in this group (Shuttleworth, 2007). Where available, support groups have been recommended as helpful adjuncts to psychotherapy (Williams, 2007). Comprehensive psychotherapeutic approaches to the intersection between disability and sexual orientation have been developed (cf. Hanjorgiris, Rath, & O'Neill, 2004; Hunt et al., 2006). Psychologists are encouraged to inquire about the sexual history and current sexual functioning of their lesbian, gay, and bisexual clients with disabilities, as well as provide information and facilitate problem solving in this often-overlooked area (Kaufman, Silverberg, & Odette, 2007; Olkin, 1999). Many lesbian, gay, and bisexual people with disabilities have experienced coercive sexual encounters (Swartz, 1995; Thompson, 1994). Sensitive exploration regarding the individual's history of victimization is recommended.

Guideline 16. Psychologists strive to understand the impact of HIV/AIDS on the lives of lesbian, gay, and bisexual individuals and communities

Rationale

Because HIV/AIDS and sexual orientation have been conflated, people living with the disease are stigmatized (Herek, Capitanio, & Widaman, 2002). Additional factors that contribute to the prejudice and discrimination faced by people living with HIV/AIDS include misunderstanding of or misinformation about the virus (Ritieni, Moskowitz, & Tholandi, 2008), general homophobia and racism (Brooks, Etzel, Hinojos, Henry, & Perez, 2005), and the fact that the virus is spread through behavior that some individuals or groups condemn as objectionable (Kopelman, 2002). Although an AIDS diagnosis was initially a death sentence, significant medical advances in the treatment of HIV/AIDS have resulted in its reconceptualization as a chronic disease (Pierret, 2007).

In addition to coping with a stigmatized illness, people living with HIV/AIDS have to face the myriad medical problems and medication side effects that are characteristic of the virus and its treatment (Johnson & Neilands, 2007). Many people with HIV/AIDS struggle with concerns about rejection

following disclosure of their HIV-positive status to friends, family members, and sex and romantic partners (Simoni & Pantalone, 2005). Moreover, empirical studies on the mental health of people living with HIV/AIDS consistently have revealed high rates of mood and anxiety disorders (Bing et al., 2001), as well as problems with drug and alcohol use and abuse (Pence, Miller, Whetten, Eron, & Gaynes, 2006). People living with the disease have reported higher rates of interpersonal violence than have their HIV-negative peers (Cohen et al., 2000; Greenwood et al., 2002). Older adults face particular challenges relative to HIV/AIDS. For example, older adults who are surviving with HIV/AIDS may experience cognitive and physical changes associated with their treatment regimens (e.g., Oelklaus, Williams, & Clay, 2007). Some HIV-negative older adults may be at risk for seroconversion due to disinhibitory sexual behavior associated with decreased cognitive functioning, loneliness, depression, or other emotional or existential factors (cf. Grov, Golub, Parsons, Brennan, & Karpiak, 2010), despite knowledge of safe sexual practices. Coping with this complex array of physical and mental health problems can be a significant challenge for individuals living with HIV, as well for the psychologists who provide services to them (J. R. Anderson & Barret, 2001; Berg, Michelson, & Safren, 2007). In addition, it is important to note that HIV/AIDS issues occur within the context of other physical health disparities (Krehely, 2009).

Application

When conducting an initial assessment, psychologists are urged to avoid any assumptions pertaining to a client's HIV serostatus based on sexual orientation or other demographic characteristics. There is no reliable way to know the HIV serostatus of any client without asking directly. Moreover, by broaching this subject openly, psychologists create an opportunity to offer accurate preventive educational information on HIV for all their clients (e.g., safer/riskier sexual behavior), as well as to provide support to those who are HIV positive (e.g., encouraging them to seek or continue medical care). Psychologists are encouraged to obtain the requisite information to be able to discuss HIV prevention strategies with their clients.

Psychologists strive to understand and account for the impact of societal marginalization as a result of the unique multiple oppressed identities and other factors (e.g., sexual minority, racial/ethnic minority, low socioeconomic status, disability) of each of their clients living with HIV/AIDS. Among young gay men of color, low self-esteem and other factors (e.g., social networks) have been shown to contribute to high seroconversion rate (Brooks, Rotheram-Borus, Bing, Ayala, & Henry, 2003; Millett, Flores, Peterson, & Bakeman, 2007), Psychologists are encouraged to discuss safe sexual behaviors with their at-risk clients. In addition, psychologists are encouraged to be cognizant of how different age cohorts may have had

different experiences with HIV/AIDS. For example, many older lesbians, gay men, and bisexual women and men may have undergone significant emotional trauma, grief, and loss because of the many AIDS-related deaths of their friends and partners in the 1980s and early 1990s and may need continued support in the face of these losses.

Psychologists are encouraged to increase their awareness of the comprehensive impact of HIV/AIDS on the lives of people affected by and infected with the virus. For example, there can be significant changes in the identity and roles of those people living with HIV/AIDS as a result of their HIV infection (Baumgartner, 2007). Acquiring HIV may also be a catalyst for psychological or spiritual growth for some but a cause for mourning and grief for others (Moskowitz & Wrubel, 2005). In addition, HIV seroconversion can seriously affect the social and intimate relationships of those living with the disease. HIV-positive men and women may experience shame or rejection from family members, friends, or coworkers (e.g., Laryea & Gien, 1993). This interpersonal rejection may be particularly traumatic for those who previously have experienced similar difficulties as a result of the disclosure of other stigmatized aspects of their identity. Moreover, in an intimate partner relationship, HIV can serve as an additional stressor or barrier to intimacy. This is the case especially for individuals in sero-discordant relationships, because the partners must navigate the emotional and practical issues surrounding sex and intimacy. Furthermore, a person's HIV-positive status may be a cause for discrimination in employment or housing settings (e.g., Malcolm et al., 1998).

Economic and Workplace Issues

Guideline 17. Psychologists are encouraged to consider the impact of socioeconomic status on the psychological well-being of lesbian, gay, and bisexual clients

Rationale

Data indicate that lesbian, gay, and bisexual men and women are often at economic disadvantage in contrast to their heterosexual counterparts. In a 1995study, Badgett found that gay men earned between 11% and 27% less than heterosexual males. Research has also shown that gay men living in same-sex relationships earn less than men in heterosexual marriages (Allegretto & Arthur, 2001; Klawitter & Flatt, 1998). Albelda et al. (2009) found that lesbian and gay couple families are significantly more likely to be poor than are heterosexual married couple families, and lesbian couples in particular were also much more likely to be poor than heterosexual couples and their families. Elmslie

and Tebaldi (2007) found that gay men in managerial and blue-collar jobs can earn up to 23% less than their heterosexual counterparts. Although gay men and lesbians tend to be more highly educated than their heterosexual counterparts (Carpenter, 2005; Rothblum, Balsam, & Mickey, 2004), they continue to earn less money (Egan, Edelman, & Sherrill, 2008; Factor & Rothblum, 2007; Fassinger, 2008). Badgett (2003) and Fassinger (2008) suggested that there is significant discrimination in the workplace against lesbians and gay men, as there is in the retail market. Lesbian, gay, and bisexual individuals have been fired, denied promotion, given negative performance evaluations, and received unequal pay and benefits on the basis of their sexual orientation (Badgett, Lau, Sears, & Ho, 2007).

There is increasing understanding of the relationship between poverty and mental health issues (e.g., Costello, Compton, Keeler, & Angold, 2003; Croteau, Bieschke, Fassinger, & Manning, 2008). Low-income individuals are more likely than those from upper socioeconomic brackets to suffer from a diagnosable mental disorder (Bourdon, Rae, Narrow, Manderschild, & Regier, 1994). Therefore, those lesbian, gay, and bisexual men and women who live in poverty have an added burden of further disenfranchisement and alienation.

Financial resources and education may mediate the negative effects of discrimination (e.g., greater economic power and options, improved self-esteem). Conversely, lower socioeconomic status may constitute additional stress, increased marginalization, greater challenges in adjusting to a stigmatized sexual orientation, and reduced opportunities to access appropriate social supports. Ray (2006) noted that fear of persecution and lack of acceptance result in the homelessness of many lesbian, gay, and bisexual youths. Homeless lesbian, gay, and bisexual youths are more likely to engage in high-risk behavior. Van Leeuwen et al. (2006) found a higher risk of suicide attempts, survival sex, and drug use among lesbian, gay, and bisexual youths than their heterosexual counterparts. In older lesbian, gay, and bisexual adults, various challenges exist regarding traditional income-support mechanisms (e.g., Social Security, pension plans, 401(k) plans; Cahill & South, 2002). Same-sex couples experience legal barriers (e.g., lack of access to legal marriage or health care benefits) that can result in socioeconomic disparities (APA, 2009a).

Application

Psychologists are encouraged to assess the ways in which socioeconomic status affects lesbian, gay, and bisexual clients in areas such as low self-esteem, familial conflict, and relationship problems. For example, it is helpful to consider the psychological sequelae of low socioeconomic status (e.g.,

shame, depression, anxiety) upon lesbian, gay, and bisexual individuals, as these may linger throughout the life span even if one advances in socioeconomic status (Martell, 2007; G. M. Russell, 1996). In addition, in their assessments, psychologists are urged to consider the ways in which low socioeconomic status and economic discrimination based on sexual orientation may have compounding effects. Psychologists also are encouraged to refrain from making assumptions about socioeconomic status based upon sexual orientation.

Guideline 18. Psychologists strive to understand the unique workplace issues that exist for lesbian, gay, and bisexual individuals

Rationale

There are unique difficulties and risks faced by lesbian, gay, and bisexual individuals in the workplace, particularly the impact of sexual stigma (Herek, 2007; Herek, Gillis, & Cogan, 2009) on vocational decision making, choice, implementation, adjustment, and achievement (Croteau et al., 2008; Fassinger, 2008; Pope et al., 2004). Barriers to the vocational development and success of lesbian, gay, and bisexual individuals include employment discrimination(Fassinger, 2008; Kirby, 2002); wage discrimination (Badgett, 2003; Elmslie & Tebaldi, 2007); lack of benefits (e.g., family medical leave, bereavement leave, child care, same-sex partner benefits; Fassinger, 2008); hostile workplace climates (Ragins & Cornwell, 2001; Ragins, Singh, & Cornwell, 2007); job stereotyping (Chung, 2001; Keeton, 2002); occupational restrictions (e.g., military, clergy) (Fassinger, 2008); the interactive effects of bias based upon gender, race and ethnicity, disability, and other aspects of marginalized status (Bieschke et al., 2008; Van Puymbroeck, 2002); and compromised career assessment (M. Z. Anderson, Croteau, Chung, & DiStefano, 2001; Pope et al., 2004). It should be noted that the general assessment issues mentioned in Guideline 4 apply as well in the special case of career assessment.

The most salient issue for lesbian, gay, and bisexual workers in a context of sexual stigma is identity management (Croteau et al., 2008). Although research indicates that identity disclosure is linked to more positive mental health outcomes than is concealing identity (cf. Herek & Garnets, 2007), many lesbian, gay, and bisexual workers adopt identity management strategies to protect against actual or anticipated workplace discrimination (Croteau et al., 2008). Identity concealment strategies, however, exact a psychological price, including constant vigilance about sharing information, separation of personal and work lives, coping with feelings of dishonesty and invisibility, isolation from social and

professional collegial networks and support, and burnout from the stress of hiding identity (see Croteau et al., 2008; Fassinger, 2008).

Application

Psychologists are encouraged to assist their lesbian, gay, and bisexual clients in identifying and addressing potential barriers to vocational development and success. Psychologists are urged to assist lesbian, gay, and bisexual clients in overcoming internalized stereotypes about themselves and/or about the world of work that may affect their occupational choices and decision making (Adams, Cahill, & Ackerlind, 2005; Croteau et al., 2008; Nauta, Saucier, & Woodard, 2001; Tomlinson & Fassinger, 2003). Psychologists can aid lesbian, gay, and bisexual clients in assessing their work environments and exploring appropriate strategies for sexual orientation disclosure in the workplace (M. Z. Anderson et al., 2001; Croteau et al, 2008; Lidderdale, Croteau, Anderson, Tovar-Murray, & Davis, 2007), including issues that arise in the process of searching for and obtaining a job (Lidderdale et al., 2007).

Psychologists are encouraged to address issues of multiple oppressions when providing counseling regarding work and career for lesbian, gay, and bisexual clients, preparing them to cope with the effects of racism, sexism, heterosexism, ableism, ageism, and other forms of marginalization (Bieschke et al., 2008). Psychologists strive to be aware of special considerations in the use of career assessment inventories with lesbian, gay, and bisexual individuals (Chung, 2003a, 2003b; Pope et al., 2004).

Psychologists can be helpful to lesbian, gay, and bisexual clients in their vocational and workplace decision making by encouraging them to become aware of local and national career resources. These resources might include national lesbian and gay networks of professionals, local gay/lesbian community resources, special programs by lesbian/gay professionals, career shadowing opportunities with gay/lesbian professionals, externships or cooperative education placements in gay/lesbian-owned or -operated businesses, and lesbian, gay, and bisexual mentoring programs (Pope et al., 2004).

Education and Training

Guideline 19. Psychologists strive to include lesbian, gay, and bisexual issues in professional education and training

Rationale

Despite the rising emphasis on diversity training during graduate education and internship, studies have shown that graduate students in psychology and early career psychologists report inadequate education and training in lesbian, gay, and bisexual issues (Matthews, Selvidge, & Fisher, 2005; Pilkington & Cantor, 1996) and feel unprepared to work with these groups (Allison, Crawford, Echemendia, Robinson, & Knepp, 1994; Phillips & Fischer, 1998). Matthews (2007) noted that "mental health professionals live in the same heterosexist society as everybody else and are subject to the biases and prejudices that permeate that culture" (p. 205). Students may describe their attitudes as more affirmative than these actually are if examined more deeply. Training has been shown to clarify negative attitudes about nonheterosexual orientations (Boysen & Vogel, 2008; T. Israel & Hackett, 2004). Identification as lesbian, gay, or bisexual does not necessarily confer expertise in practice with lesbian, gay, and bisexual clients. Greene (1997) outlined some of the issues unique to nonheterosexual practitioners (e.g., concerns about boundaries, overidentification with the client, advocacy).

Application

Lesbian, gay, and bisexual training programs or modules have been shown to positively enhance the knowledge and skills of students (Rutter, Estrada, Ferguson, & Diggs, 2008). Faculty, supervisors, and consultants are encouraged to integrate current information about lesbian, gay, and bisexual issues throughout graduate training for professional practice. Resources are available to assist faculty in including lesbian, gay, and bisexual content in program curricula (e.g., APA, 1995; Bieschke, Perez, & DeBord, 2000, 2007; Buhrke & Douce, 1991; Cabaj & Stein, 1996; Croteau & Bieschke, 1996; Greene & Croom, 2000; Hancock, 1995, 2000; Pope, 1995; Ritter & Terndrup, 2002; Savin-Williams & Cohen, 1996) and in training and supervision (e.g., Halpert, Reinhardt, & Toohey, 2007; Mintz & Bieschke, 2009). Halpert et al. presented affirmative models of supervision that may be used with any theoretical orientation and that can help students become culturally competent practitioners with lesbian, gay, and bisexual clients. Recommendations for graduate education include both individual courses and the infusion of relevant information throughout the curriculum (Biaggio, Orchard, Larson, Petrino, & Mihara, 2003; Phillips, 2000).

Psychologists are encouraged to educate their students about the nature and effects of heterosexual privilege (T. Israel & Selvidge, 2003) and to challenge heterosexist bias (Biaggio et al., 2003; Hancock, 2000; Simoni, 2000). Although the provision of current information regarding lesbian, gay, and bisexual issues is essential, a number of authors also strongly recommend personal exploration of attitudes and biases (e.g., T. Israel & Hackett, 2004; Matthews, 2007; Phillips, 2000). Personal exploration of attitudes

and biases in the education and training of psychologists may ultimately assist students to evaluate themselves with greater honesty and accuracy and to provide more sensitive care to their lesbian, gay, bisexual, and questioning clients. Prior to teaching about attitudes toward lesbian, gay, and bisexual clients, instructors (regardless of their sexual orientations) are strongly advised to explore their own attitudes (Biaggio et al., 2003; Simoni, 2000).

Issues regarding institutional climate and support also have been discussed in recent literature. Biaggio et al. (2003) suggested prioritizing the affirmation of diversity throughout the institution; including sexual orientation in university equal employment opportunity statements and admission and recruitment; considering diversity in promotion, tenure, and other personnel decisions; and providing support systems for lesbian, gay, and bisexual members of the institution (e.g., resource centers, research support, mentoring programs). Psychologists who have expertise in lesbian, gay, and bisexual psychology may be used on a full-time or part-time basis to provide training and consultation to faculty, research guidance, and course and clinical supervision to students. Faculty and clinical supervisors are encouraged to seek continuing education course work in lesbian, gay, and bisexual issues to increase awareness of the unique needs of lesbian, gay, and bisexual clients (Biaggio et al., 2003).

Guideline 20. Psychologists are encouraged to increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation

Rationale

Although the study of diverse populations has received more attention in recent years, many practicing psychologists may not have received basic information pertaining to working with lesbian, gay, and bisexual clients. APA's Ethics Code (APA, 2002b) urges psychologists to “undertake ongoing efforts to develop and maintain their competence” (p. 1064). Unfortunately, the education, training, practice experience, consultation, and/or supervision that psychologists receive regarding lesbian, gay, and bisexual issues often have been inadequate, outdated, or unavailable (Morrow, 1998; J. A. Murphy, Rawlings, & Howe, 2002; Pilkington & Cantor, 1996; Sherry, Whilde, & Patton, 2005). Studies historically have revealed psychotherapist prejudice and insensitivity in working with lesbian, gay, and bisexual people (Garnets et al., 1991; Liddle, 1996; Nystrom, 1997; Winegarten et al., 1994). Although more recent research has indicated more positive attitudes toward lesbian, gay, and bisexual clients reported by therapists (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2007), Bieschke, Paul, and Blasko

(2007) noted that some of these improved attitudes appear to be superficial and are not necessarily exhibited in the behavior of therapists.

Application

According to T. Israel, Ketz, Detrie, Burke, and Shulman (2003), a broad range of knowledge, attitudes, and skills is called for in order to work effectively with lesbian, gay, and bisexual clients. Psychologists are urged to consider additional education, training, experience, consultation, and/or supervision in such areas as (a) human sexuality and multidimensional models of sexual orientation; (b) mental health issues affecting lesbian, gay, and bisexual individuals; (c) lesbian, gay, and bisexual identity development in a heteronormative society, including ethnic and cultural factors affecting identity; (d) the effects of stigmatization upon lesbian, gay, and bisexual individuals, couples, and families; (e) the intersections of multiple identities (e.g., sexual orientation, race and ethnicity, gender, class, disability); (f) unique career development and workplace issues experienced by lesbian, gay, and bisexual individuals; (g) nontraditional relationship forms; (h) issues of religion and spirituality for lesbian, gay, and bisexual people; and (i) health and wellness issues. Many psychologists might benefit from specific training pertaining to the particular issues of bisexual clients and affirmative psychotherapy with bisexual women and men. Psychologists are encouraged to seek out lesbian, gay, and bisexual affirmative continuing education courses, as the content of such courses is likely to be compatible with existing APA guidelines and policies. Psychologists are further urged to seek continuing education courses that provide specific information on working with bisexual clients and materials that address their particular issues in treatment (e.g., Firestein, 2006; Fox, 2006; Matteson, 1999).

Lesbian, gay, and bisexual individuals—especially those who are questioning or newly aware of their sexual orientation—sometimes have no knowledge of or access to other lesbian, gay, and bisexual people or to a broader gay community and the resources it might afford. Awareness of and access to community resources are important because research indicates that engagement in the lesbian, gay, and bisexual community is associated with improved psychological functioning in these populations (e.g., D'Augelli & Garnets, 1995; Garnets, Herek, & Levy, 1992; Kurdek, 1988; G. M. Russell & Richards, 2003). Psychologists are encouraged to make reasonable efforts to familiarize themselves with relevant resources (national, state, local, and electronic) in their work with lesbian, gay, and bisexual clients. A listing of suggested mental health, educational, and community resources is provided in Appendix A.

Research

Guideline 21. In the use and dissemination of research on sexual orientation and related issues, psychologists strive to represent results fully and accurately and to be mindful of the potential misuse or misrepresentation of research findings

Rationale

Just as bias can influence the conduct of research, it also can influence the interpretations of research by others and the uses to which research results are put. Sound research findings about any stigmatized group represent an important contribution to the discipline of psychology and to society in general. However, research about lesbian, gay, and bisexual people has been misused and misrepresented to the detriment of lesbian, gay, and bisexual individuals (Herek, 1998; Herek, Kimmel, Amaro, & Melton, 1991; G. M. Russell & Kelly, 2003).

Application

Psychologists strive to exercise caution in their use of research on lesbian, gay, and bisexual populations and to take into account the complexities and the limitations of the research (Cochran, 2001; Laumann, Gagnon, Michael, & Michaels, 1994; Solarz, 1999). In addition, psychologists strive to be aware of the potential influence of overt and covert bias (Banaji & Hardin, 1996; Banaji, Lemm, & Carpenter, 2001; Bargh & Chartrand, 1999; Bargh & Williams, 2006; Herek, 1998; Herek et al., 1991) and to exercise care that their reports are thorough and that any relevant limitations to their findings are fully disclosed and discussed. It is also useful for psychologists to maintain an awareness of subgroups within lesbian, gay, and bisexual communities who are not included in research samples (Greene, 2003) and to take their absence into account when applying or discussing research findings.

Psychologists are encouraged to exercise care when citing or quoting from the research findings published by third parties. In much the same way that researchers strive to specify the limitations of their own findings, psychologists who cite others' research are urged to present full and accurate descriptions of that research, including attending to the limitations of the data. The APA Ethics Code (APA, 2002b) requires psychologists to avoid false or deceptive statements (Standard 5.01) and accurately report their research results (Standard 8.10).

The communication of findings from one's own or from a third party's research to popular media outlets represents a particular challenge. Members of the media are typically not well schooled in the intricacies

of research methods or the appropriate interpretation of research findings. This situation, in combination with media emphasis on dramatic story lines (Conrad, 1997), can result in misleading or explicitly inaccurate expositions of research. Psychologists strive to be aware of and to work proactively to prevent the dissemination of inaccurate information (APA, 2002b, Standard 5.01). Psychologists are encouraged to offer clear explanations, to ask for confirmation that journalists understand information provided, to offer to provide synopses of research studies or the actual research reports, and to emphasize to journalists the complexity and the limitations of research findings.

Footnotes

1

Throughout this document, the term *clients* refers to individuals across the life span, including youth, adult, and older adult lesbian, gay, and bisexual clients. There may be issues that are specific to a given age range, and, when appropriate, the document identifies these groups.

2

Hereinafter, this document is referred to as the APA Ethics Code.

These guidelines were adopted by the APA Council of Representatives, February 18–20, 2011, and replace the original “Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients,” which were adopted February 26, 2000, and expired at the end of 2010. These revised and updated guidelines were developed by the Division 44/Committee on Lesbian, Gay, Bisexual, and Transgender Concerns Guidelines Revision Task Force. The task force included Kristin Hancock (chair) and members Laura Alie, Armand Cerbone, Sari Dworkin, Terry Gock, Douglas Haldeman, Susan Kashubeck-West, and Glenda Russell. The task force thanks Glenn Ally, Laura Brown, Linda Campbell, Jean Carter, James Croteau, Steven David, Randall Ehbar, Ruth Fassinger, Beth Firestein, Ronald Fox, John Gonsiorek, Beverly Greene, Lisa Grossman, Christine Hall, Tania Israel, Corey Johnson, Jennifer Kelly, Christopher Martell, Jonathan Mohr, David Pantalone, Mark Pope, and Melba Vasquez for their thoughtful contributions. The task force also acknowledges the long-standing support of Clinton Anderson, director of APA's Lesbian, Gay, Bisexual, and Transgender Concerns Office, and APA staff liaisons Sue Houston (Board for the Advancement of Psychology in the Public Interest) and Mary Hardiman (Board of Professional Affairs) for their assistance. Each of the 21 new guidelines provides an update of the psychological literature

supporting it, includes sections on rationale and application, and expands upon the original guidelines to provide assistance to psychologists in areas such as religion and spirituality, the differentiation of gender identity and sexual orientation, socioeconomic and workplace issues, and the use and dissemination of research on lesbian, gay, and bisexual issues. The guidelines are intended to inform the practice of psychologists and to provide information for the education and training of psychologists regarding lesbian, gay, and bisexual issues. The revision was funded by Division 44 (Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues) of the American Psychological Association (APA) and the APA Board of Directors. This document is scheduled to expire as APA policy in 10 years (2020). After this date, users are encouraged to contact the APA Public Interest Directorate to confirm that this document remains in effect or is under revision. Correspondence concerning this article should be addressed to the Public Interest Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242

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