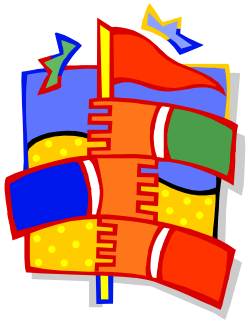
Gay, Lesbian, Transgender & Bisexual Individuals



Contributors:

Christopher R. Martell, Ph.D., ABP,
University of Washington & Private Practice

Marsha Botzer, M. A.,
Ingersoll Gender Center

Mark Williams, M.Div., and Dan Yoshimoto, M. S.
University of Washington

A Review of the Literature

As far back as 1935, Sigmund Freud wrote to the anxious mother of a homosexual son that: "Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness…" (Freud, 1935 as cited in Bayer, 1987). Nevertheless, the American Psychiatric Association included homosexuality under the grouping of sociopath personality disturbances in the first edition of the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-I, American Psychiatric Association, 1952). By the time of the second edition of the DSM (DSM-II, American Psychiatric Association, 1968), the diagnosis of homosexuality was moved under the general heading of sexual deviations.

Alfred Kinsey and colleagues studied a group of American white males, and published data suggesting that for a certain percentage of the population was sexually stimulated by other males (Kinsey, Pomeroy, & Martin, 1948). Later, in 1953, Kinsey, Pomeroy, Martin, & Gebhard conducted similar research with females. Research was emerging in the 1950s, demonstrating that homosexuality, per se, did not constitute a mental disorder. The pioneering work of Evelyn Hooker (1957) demonstrated that homosexual males were similar to heterosexual males on tests of psychopathology.

Homosexuality was removed from the Diagnostic and Statistical Manual of Psychiatric Disorders in the third edition (DSM-III, American Psychiatric Association, 1980), but a diagnosis of ego-dystonic homosexuality was added. This diagnosis was used to indicate individuals that were distressed about their gay, lesbian, or bisexual sexual orientation. There was no corollary for heterosexual individuals that were distressed about their sexual orientation. The diagnosis of "ego-dystonic homosexuality" was dropped from the revision of the third edition (DSM-III-R, American Psychiatric Association, 1987), although a related disorder "ego-dystonic sexual orientation" remains in the International Statistical Classification of Diseases and Related Health Problems- Tenth Edition (ICD-10; Source: World Health Organization). Nevertheless, the American Academy of Pediatrics, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the National Association of School Psychologists, and the National Association of Social Workers all have taken the position that homosexuality and bisexuality are not mental disorders.

The diagnosis of gender identity disorder remains in the current edition of the DSM. This diagnosis has been used to pathologize children and adults whose experience and identification of their gender is opposite to that assigned to them at birth; however, it has also been used to help. The diagnosis is controversial but is the only diagnosis given that allows for transgender individuals wishing to have hormone therapy or surgery (to make their bodies match their gender identity) to be reimbursed by insurance. It should be noted, however, that very few people are reimbursed by insurance for Sexual Reassignment Surgery, and many insurance companies carry clauses stating that they will not pay for such surgery. In order to get hormones; it is often necessary to refer to the mental health aspect of the treatment

because insurance companies will not pay for hormones if they are identified simply as part of the reassignment process.

An understanding of terminology is important in this discussion.[3] *Gender identity* is the inward and individual experience of being male or female, or ambivalence about maleness or femaleness, and *Gender Role* or *Presentation* is the public expression of that Gender Identity. *Transgender* originally referred to people who changed their social role (gender role expression or presentation) to live fully in the gender role different from that assigned at birth, and did so without changing their bodies through surgery or medication. Currently the term *transgender* has been expanded, and may refer to all individuals who experience internal conflict with their physical sex, and/or their assigned gender role. Thus, the term *transgender* may now apply to any person who struggles internally over gender identity or whose physical characteristics and gender expression differ from their gender as assigned at birth. The key difference is that the term now includes the full range of gender identity concerns, from internal distress through medical and surgical change. *Transsexual* refers to people that change their primary social gender roles *and* their physical bodies. They make use of medication and surgery to bring their bodies into harmony with their inner sense of gender identity. *Gender non-conforming/gender variant* are synonymous terms sometimes used in gender identity literature to refer to persons whose social gender role presentations do not fall into the usually accepted perimeters. *Intersexed* refers to individuals that are born with genital structures that are different from the majority. This is not transsexual or transgender (see the Intersex Society of North America Website at http://www.isna.org/. *Questioning* is a term created to include individuals who are exploring gender and/or sexual identity and expression. Overall, however, there are many debates over terminology, and these definitions are not unanimously accepted by all with expertise with this population. New terms are appearing regularly as the literature on gender and identity grows. An approach that asks each client or patient to discuss in detail his or her own self-descriptions, and begins from that point, will help avoid rigid adherence to particular definitions.

The removal of homosexuality from the DSM is not an indication that prejudice against lesbian, gay, bisexual and transgender individuals is merely an historical phenomenon. Violence against lesbian, gay, bisexual and transgender youth and adults is still a present reality. D'Augelli (1998) summarized data from a number of surveys and research studies demonstrating that lesbian, gay, and bisexual youth were more likely to be victimized within their families and in the community. Violence against lesbian, gay, and bisexual youth takes the form of verbal harassment by peers, threat of physical violence, physical attack, rape, incest and destruction of personal property. Fifty-two percent of the women that participated in the National Lesbian and Gay Health Foundation study (Bradford, Ryan, & Rothblum, 1994) reported that they had been physically assaulted. Lesbian, gay, bisexual and transgender youth and adults are a stigmatized minority group. As such, they face the daily stress of being members of a stigmatized group (DiPlacido, 1998). A website, "Remembering Our Dead" names hundreds of transgender individuals who have been murdered because of their gender identity issues (*http://www.gender.or/remember/#*). Such minority stress negatively affects the psychological well being of lesbian, gay, bisexual and transgender individuals.

Marsha Botzer for her elucidation of the various terms association with transgender.

Lesbian, gay, bisexual and transgender youth that are victimized in their family of origin are more likely to runaway from home. Cochran, Stewart, Ginzler and Cauce (2002) found that lesbian, gay, bisexual and transgender youth run away from home more frequently than their heterosexual counterparts, and are victims of physical violence from family members (particularly for males) or following homelessness. In their study of lesbian, gay and bisexual homeless youth in Seattle, the authors found reports of higher incidence of substance abuse, higher self-report ratings of symptoms of psychopathology, and more sexual partners than heterosexual homeless youth.

In a study of 137 gay and bisexual male youths, Remafedi, Farrow, & Deisher (1991), found that approximately one third (41/137 reported some form of intentional self-destructive act, with 21% of those resulting in hospitalization or medical care. The subjects had come from the Midwest and the Pacific Northwest, and the sample was multi-racial 82% white, 13% African American, 4% Hispanic and 1% Asian. Race and ethnicity were not significant variables in the results. Huxdly and Brandon (1981) surveyed 72 transsexual youths and found that 53% had made suicide attempts.

Herrell, Goldberg, True, Ramakrishnam, Lyons, Elsen, & Tsuang, (1999) found higher risk of suicidal ideation and suicide attempts among males who had sex with men than their twin brothers. They evaluated data from a male-male twin registry of veterans who served in the U.S. military between 1965 and 1975. This and other studies used reported sexual behavior as indicative of sexual orientation, women were excluded from the sample, and the sample was ethnically homogeneous, limiting the generalizability of the findings. Whereas Remafedi, Farrow and Deisher found that suicide attempters were more likely to use illicit drugs than non-attempters were, Herrell and colleagues (1999) found that higher rates of suicidality could not be explained by abuse of drugs or alcohol. Remafedi, Farrow and Deisher (1991) and Herrell et al, 19999) concluded that suicidality was not the direct result of depressive symptoms, or other psychopathological diagnoses such as anxiety disorders or personality disorders. Other studies have indicated that gay and lesbian youth are likely to report having attempted suicide more than non-gay counterparts (e.g. Remafedi, 1994). Gilman, Cochran, Mays, Hughes, Ostrow and Kessler (2001) found similar trends for women with homosexually active women having higher rates of suicide attempts than heterosexually active women do.

More recently, however, Savin-Williams (2001) criticize much of the published data on lesbian, gay, and bisexual youth suicide risk because of problems in sample selection, vague definitions of suicide, and the use of unreliable measures of sexual orientation and suicide attempts. Savin-Williams found suicide attempt rates at 13% for the young women in his study when he distinguished false from actual attempts, and eliminated suicidal ideation from the definition of suicide attempts. Savin-Williams maintained that these rates were only slightly over the rate reported for non-gay-identified youths, and suggest that earlier data may have overestimated the risk for lesbian, gay and bisexual youth. In a second study with both male and female participants, Savin-Williams found that young men who rated themselves "predominantly heterosexual, but significantly homosexual" according to the Kinsey scale (Kinsey, Pomeroy & Martin, 1948) were more likely to report a suicide attempt than other

sexual minority male groups. Those participants who identified themselves as gay or bisexual according to the Kinsey scale were no more likely to attempt suicide than heterosexual participants, suggesting that ambivalence about sexual orientation may play a greater role in suicidal behavior in adolescents than sexual orientation per se. Savin-Williams also criticized the use of samples from lesbian, gay and bisexual support groups warning that these youth may be at higher risk of suicide, but that they do not represent all lesbian, gay and bisexual youth. Safren and Heimberg (1998) compared lesbian, gay and bisexual youth in support programs to demographically similar youth in other types of support programs on suicidality and related variables. The groups differed on depression, hopelessness, and suicidal ideation. However, when statistically controlling for social support, coping, and stress, these differences disappeared. Thus, the authors conclude that environmental factors, and not sexual orientation, play a role in distress among this population.

Research continually confirms that lesbian, gay, bisexual and transgender youth and adults are vulnerable to abuse and violence in the larger community. Such environmental pressures confound any understanding of behavioral health problems in this population. Concluding that being homosexual, bisexual or transgender is, in itself, problematic, does not account for the emotional toll that living in hostile environments has on lesbian, gay, bisexual and transgender youth and adults.

Research supports the conclusion that lesbian, gay, and bisexual adults suffer from specific psychological problems at higher rates than their heterosexual counterparts. The Benjamin Society also suggests that transgender individuals are vulnerable to psychological distress. Gilman and colleagues (2001) analyzed data from the National Comorbidity Study and compared rates of mental disorders among people who have had same-sex sexual partners to rates among those who report exclusively opposite-sex partners. Mood and anxiety disorders were more prevalent among respondents who had one or more same-sex sexual partners than those who did not. The National Comorbidity Study confused sexual behavior with sexual orientation, however, thus confounding the data. People that have same-sex sexual partners but do not recognize themselves as having gay, lesbian, or bisexual sexual orientations are likely to differ than those who do. Sexual identity was not considered, and there was no determining if identification as gay, lesbian or bisexual served as a risk factor or protective factor. The study also lacked power due to the small number of respondents reporting same-sex sexual partners. Cochran and Mays (2000) reported higher rates of depression and panic among men with same-sex partners and higher rates of alcohol and drug dependence among women with same-sex partners. Cochran, Sullivan and Mays (2003) using data from individuals that self-identified as lesbian, gay or bisexual, found that gay and bisexual men were more likely than heterosexual men to be diagnosed with a mental disorder. This study is of particular significance because the authors examined data from the MaArthur Foundation National Survey of Midlife Development in the United States (MIDUS; Brim, et al., 1996) that drew eligible respondents between the ages of 25 and 74 years old through a random-digit-dial telephone sample from the contiguous United States. This questionnaire asked respondents if they would describe their sexual orientation as heterosexual, homosexual or bisexual. Asking this one question differs significantly from other large population based data that ask only for the gender of sexual partners since sexual behavior must be differentiated from sexual orientation or identity. Asking a question about sexual orientation

allows respondents to identify themselves in an interview, as they are likely to identify themselves in life. Th Cochran, Sullivan and Mays (2003) confirmed what other studies had found, that there was an elevated risk for mood, anxiety, and substance use among gay, lesbian, and bisexual individuals. Specifically, gay and bisexual men were 3.0 times more likely to be diagnosed with major depressive disorder and 4.7 times more likely to be diagnosed with panic disorder. Lesbian and bisexual women were more likely to be diagnosed with generalized anxiety disorder than heterosexual women. Gay, lesbian and bisexual men and women were more likely to be diagnosed with two or more of the five disorders assessed by the MIDUS. Approximately 58% of lesbian, gay, and bisexual participants in their sample did not evidence any of the five disorders assessed by the MIDUS. Therefore we can conclude that, while gay, lesbian, and bisexual people (and we can infer transgender individuals) are more vulnerable to psychological disorders resulting from life stress, this population as a whole is quite resilient. The MIDUS questionnaire provides interesting and important data, but there are limitations, particularly that it screened for only five disorders, and that there was a small sample of lesbian, gay, and bisexual men and women identified.

Another significant discovery in the Cochran, Mays, and Sullivan (2001) article was that lesbian, gay and bisexual men and women were more likely to have used one of the four types of mental health services (seeing a mental health provider, seeing a general physician for a mental or emotional complaint, attending a self-help group, or taking a prescribed medication for a mental or emotional complaint). Among the gay and bisexual men, 85.3% reported that they had received at least one of the four types of mental health services compared to 45.2% of the heterosexual men. Between the lesbian and bisexual women, 94% reported receiving at least one of the four types of mental health services compared to 54% of the heterosexual women. These higher rates of usage of mental health services can be interpreted in a number of ways. Cochran, Mays and Sullivan explain that gay, lesbian and bisexual men and women seek mental health services for a variety of reasons apart from treatment for mental or emotional problems. They seek assistance in issues generated by being a sexual minority, and, in some cases, assistance in coping with HIV.

In summary, the available literature on lesbian, gay and bisexual men and women suggests that a homosexual or bisexual sexual orientation per se does not indicate the presence of a psychiatric disorder. The prevalence of gender identity disorders, according to The Harry Benjamin International Gender Dysphoria Association's Standards of Care For Gender Identity Disorders, Sixth Version is 1 in 11,900 males and 1 in 30,400 females. The stigmatization of transgender, transsexual, or questioning individuals varies across culture, so the behavioral expression of "gender dysphoria" (an older term) will also vary across cultures. The diagnosis of "gender identity disorder" provides access to treatment for those biological males and biological females that experience their gender differently from biological determinants but the presence of a diagnosed "disorder" should not indicate that transgender individuals per se have a psychopathological condition.

Lesbian, gay, bisexual and transgender men and women may, be vulnerable to a number of emotional problems because of being stigmatized groups. Research has suggested higher rates of mood disorders, anxiety disorders and substance use disorders among lesbian, gay,

and bisexual men and women. Furthermore, according to the Benjamin Standards of care, unrecognized gender problems are occasionally diagnosed when patients are seen with anxiety, depression, bipolar disorder, conduct disorder, substance abuse, dissociative identity disorders and borderline personality disorder. Treatment of these comorbid disorders will enhance the lives of lesbian, gay, bisexual and transgender youth and adults.

Since lesbian, gay, and bisexual men and women seek help from mental health professionals at relatively high rates, it is important for the mental health community to have a clear understanding of the needs of this population. Transgender individuals have traditionally been wary of the mental health community, because, until quite recently, mental health professionals either have seen them as psychologically disturbed or have used the mental health system to monitor and occasionally block access to hormonal or surgical methods for gender reassignment.

Treatment approaches to many of the mental health and emotional problems to which gay, lesbian, bisexual and transgender youth and adults are vulnerable have not adequately demonstrated efficacy with this population. Data on treatment with gay, lesbian, bisexual and transgender clients is scarce. We review the literature on appropriate treatment with lesbian, gay, bisexual and transgender clients, and then review the literature on empirically supported treatments. Because the data is limited, these treatments can only be considered promising practices for this population, although studies utilizing the approaches with lesbian, gay, bisexual or transgender clients has been reviewed. There are other resources available for this population as well, usually in the form of counseling centers or non-profit organizations that make treatment available to sexual minority communities. Once again, however, the programs exist, but clear data about the effectiveness of the programs are not prevalent.

The American Psychological Association adopted guidelines for psychotherapy with lesbian gay, and bisexual clients (American Psychological Association, 2000). The basic premise of the American Psychological Association's guidelines is that being lesbian, gay or bisexual does not constitute a mental illness. Whenever therapy is conducted with this population therapists should, recognize how their attitudes and knowledge about the population is relevant to assessment and treatment, seek consultation when indicated, understand the ways in which social stigma effects the mental health and well-being of lesbian, gay, bisexual (and transgender) individuals, understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect a client's presentation and the therapeutic process. Therapists are furthermore encouraged to be knowledgeable about the importance of lesbian, gay, and bisexual relationships; understand the particular challenges faced by lesbian, gay, and bisexual parents; recognize that family may be defined in a broader sense than legal or biological relatives; understand that a client's homosexual or bisexual orientation may have an impact on relationships within the family of origin. Additionally, psychologists are encouraged to recognize challenges of being lesbian, gay, bisexual and a member of a racial or ethnic minority; recognize that bisexual people face particular challenges; understand the special problems and risks that exist for lesbian, gay, and bisexual youth and older adults as well as those with physical, sensory, and/or cognitive/emotional disabilities. Empirically supported therapies that have been developed with heterosexual clients or with participant samples where the sexual orientation is unknown can transfer easily to lesbian, gay, and

bisexual individuals if guidelines such as those developed by the American Psychological Association are followed.

The Harry Benjamin International Gender Dysphoria Association's Standard of Care for Gender Identity Disorders, Sixth Version also provides standards for mental health professionals. The document describes nine tasks of the mental health professional:

1. Accurately diagnose gender disorder
2. Accurately diagnose any co-morbid psychiatric conditions
3. Counsel the individual about treatment options and implications
4. Engage in psychotherapy.
5. Ascertain eligibility and readiness for hormone and surgical therapy
6. Make formal recommendations to medical and surgical colleagues
7. Be a collegial member of a team of professionals
8. Educate family members, employers, and institutions
9. Be available for follow-up for patients. (Harry Benjamin Society, PDF file - pg 6).

As one can see, the both the APA guidelines and the Benjamin Standards are quite broad in regards to the types of psychosocial services provided to gay, lesbian, bisexual or transgender clients. Taking the literature on vulnerabilities of these populations together with the guidelines and standards, one can combine the research on empirically supported treatments for specific disorders, understanding of lesbian, gay, bisexual and transgender communities and offer promising practices for these communities. There are also programs for prevention of drug and alcohol abuse that can be used with lesbian, gay, bisexual and transgender clients, and specific community outreach programs to this community. Many outreach programs, however, provide valuable service by offering support groups and drop in centers, but do not have outcome data available that addresses efficacy with particular problems experienced by this community.

General categories of "affirmative-psychotherapy" (e.g. Fassinger, 2000; Ritter & Terdrup, 2002) or "queer positive therapies" as well as feminist perspectives on psychotherapy (e.g. Brown, 1994) have all been used with lesbian, gay, bisexual and transgendered/transsexual men and women. These orientations cut across the traditional schools of psychotherapy such as psychodynamic, humanistic, and cognitive-behavioral. Allowing for psychotherapists from any traditional school of thought to conduct competent affirmative therapy, these overarching ideas share certain understandings in common. Such diverse perspectives as psychoanalysis and cognitive-behavioral therapies have been applied with lesbian, gay, and bisexual clients (see Glassgold & Iasenza, 1995 and Martell, Safren, & Prince, in press, respectively). The primary understanding is that people cannot be judged according to one standard, and that traditional mental health diagnoses and treatment have been based on a number of assumptions that are incorrectly applied to lesbian, gay, and bisexual men and women. For example, the assumption that heterosexuality is the standard by which loving relationships must be judged, or that developing heterosexual love relationships signals "mature" psychosexual development are rejected. Feminist therapy is particularly important

in the treatment of transgender or transsexual individuals, because traditional ideas of gender as something that is hard-wired into a person based on biological sex at birth are rejected.

The Society of Clinical Psychology (American Psychological Association - Division 12) developed a task force to identify empirically supported treatments (Chambless, et al., 1996) that have been evaluated in randomized clinical trials, in multiple research cites, and with adequate control groups. The task force identified several treatment approaches that hold promise for the lesbian, gay, bisexual and transgender community, given that evidence suggests that they may be vulnerable to depression, generalized anxiety disorder, panic disorder, and substance use or dependence disorders. Several important treatments are reviewed below.

TREATMENTS FOR ALCOHOL AND SUBSTANCE USE DISORDERS AND DEPENDENCE

Although the data are not definitive that lesbian, gay, bisexual and transgender individuals are at greater risk for substance abuse, substance use can impair judgment, which is particularly dangerous in light of the AIDS epidemic. Cochran, Keenan, Schober, & Mays (2000) found that men who had sex with men did not differ in rates of alcohol consumption than men who had exclusively heterosexual relationships, but they did find that lesbian and bisexual women had higher rates of alcohol use than exclusively heterosexual women. Some studies suggest that a majority of lesbian and gay youth in substance abuse treatment programs present with polysubstance abuse, with marijuana and alcohol being the most frequently used substances (Shifrin, & Solis, 1992). These authors also found crack cocaine addiction among 1/3 of 75 homeless lesbian or gay youth.

While many individuals benefit from 12-step programs, and such programs have been shown to be as effective as cognitive-behavioral interventions (Snow, Prochaska, & Rossi, 1994), many individuals do not attend 12-step meetings because of the spiritual and religious overtones of the approach. In fact, a small study of support choices of gay men and lesbians compared with heterosexual men and women in pursuit of abstinence showed that gay men and lesbians' positive associations with Alcoholics Anonymous correlated with higher than expected continued drinking (Holleran & Novak, 1989). A cost-effective (Miller, Meyers, & Hiller-Sturmhöfel, 1999), the Community Reinforcement Approach (Meyers & Smith, 1995) seeks to reduce substance abuse and promote sobriety by making changes in the daily environment of the client. The approach utilizes motivation techniques and positive reinforcement to make the client's sober environment more reinforcing than the one involving alcohol or drugs (Smith & Meyers, 2000). This highly collaborative therapy allows the client to be involved in determining what contingencies maintain his or her drinking behavior and what will elicit change (Wolfe & Meyers, 1999). The approach is one of the "top six" treatment modalities for substance abuse disorders that have strong empirical support (Miller, et al., 1995) and it has been used in studies with opiate abusers as well as alcohol abusers (Smith, Meyers, & Delaney, 1998). Three meta-analytic studies have attested to the efficacy of the approach (Finney & Monahan, 1996; Holder et al., 1991, & Miller et al., 1995), and rate it as highly cost-effective (Smith, Meyers, & Miller, 2001). This approach has been endorsed by NIDA. This approach has been used as part of an aftercare treatment for adolescents who completed at least 7-days residential treatment for alcohol or marijuana abuse with promising results (Godley, Godley, Dennis, Funk, & Passetti, 2002). A promising

approach that is just beginning to garner empirical support is the Seeking Safety program (Najavits, L. M., 2002), which has been used primarily with women but is now being used with both men and women. Seeking Safety is a treatment for co-morbid substance abuse and posttraumatic stress disorder, or a traumatic history without PTSD. There has been one published outcome study that demonstrated effectiveness of the treatment (Najavits, Weiss, Shaw, & Muenz, 1998) but the study lacked an adequate control group, therefore limiting results. There are several positive research reports under review at this time.

TREATMENTS FOR ANXIETY DISORDERS

Cognitive-behavior therapy has been successfully implemented for use with generalized anxiety disorder. It has been shown to be more effective than non-directive therapy (Borkovec & Costello, 1993), analytic therapy (Durham, et al., 1994) and benzodiazepine medication (Power et al., 1990). There are several treatment manuals available, including a treatment that is more cognitively focused (Beck & Emery, 1985) and a broader, cognitive-behavioral treatment (Zinbarg, Craske, & Barlow, 1993). Cognitive-behavior therapy can be flexibly applied with each client. Therapists attending to the guidelines set forth by the American Psychological Association (2000) and the ethical standards regarding treatment of diverse populations can implement cognitive-behavioral strategies for generalized anxiety disorder with lesbian, gay, bisexual and transgender clients with little difficulty. A similar treatment approach is applied for panic disorder with and without agoraphobia. Panic Control Treatment (Barlow & Craske, 1994) includes the standard techniques of cognitive-behavior therapy for other disorders, for example, cognitive restructuring and modifying expectations about fearful situations, but it includes exposure techniques. The exposure techniques for panic without agoraphobia are to interoceptive sensations and the interpretations of such sensations. For panic with agoraphobia, exposure to the actual feared stimulus is necessary. Panic Control Therapy has been compared with relaxation alone, Panic Control Therapy combined with relaxation and a waiting-list control (Barlow, Craske, Cerney, & Klosko, 1989) and has been shown to be more effective than waiting list. Clients who received Panic Control Therapy either alone or in combination with relaxation were panic free at the conclusion of the study. Eighty-one percent of the patients that had received panic control therapy alone remained panic free two years after the completion of treatment (Craske, Brown, & Barlow, 1991). Although Panic Control Therapy is usually conducted over 6 - 12 weeks of individual therapy, it has been successfully applied with bi-monthly therapist contact, with bi-monthly 10-=minute telephone contact (Côté, Gauthier, Laberge, Cormier, & Plamondon, 1994) and has been self-directed by the client in an 8-week treatment program (Lidren et al., 1994). While gay men, lesbian women, and bisexual men and women do not appear to have greater vulnerability to social phobia, social avoidance can be dangerous in risky sexual situations when assertiveness is necessary for maintaining one's health. Cognitive-behavioral therapy has been successfully applied in groups for social phobia (Heimberg, Dodge, Hope, Kennedy, Zollo, & Becker, 1990). Heimberg and colleagues (1990) found CBGT to be as effective after a 12-week trial as Phenelzine with 75% of CBGT clients showing improvement. Although there is not current outcome data available, CBGT is being utilized with gay male youth to help teach them to better negotiate safe sex practices and to be assertive with sexual partners.

Anxiety disorders impose a substantial cost on society and are associated with impairment of workplace performance (Greenberg, Sisitsky, Kessler, Finkelstein, Berndt, Davidson, Ballenger, & Eyer, 1999). Relatively short-term cognitive-behavioral treatments can reduce the cost to society and can be conducted in groups making ample use of psycho-educational material, thus reducing cost of treatment. The treatment has been demonstrated to be a treatment of choice for adults with anxiety disorders, and has been successfully implemented with children and adolescents suffering from common anxiety problems - separation anxiety, social phobia, and generalized anxiety disorder (Albano, & Kendall, 2002).

TREATMENTS FOR DEPRESSION

By far the most well studied treatments have been those for the treatment of major depressive disorder (MDD). There are several psychosocial treatments that have shown to be best practices in the treatment of depression, and are promising practices to be used with lesbian, gay, bisexual and transgender clients. Cognitive Therapy for Depression (Beck, Rush, Shaw, & Emery, 1989) is designed to change the dysfunctional beliefs and behaviors that are associated with MDD. Also referred to as cognitive-behavioral therapy for depression, it has been shown to be as effective as tricyclic antidepressant medications (Hollon, et al., 1992; & Simons, Murphy, Levine, & Wetzel, 1986); and only one study (Elkin, et al., 1989), admittedly one of the largest treatment outcome studies to date, did not find CBT to be equivalent to medication. CBT for depression can be conducted with individuals or in groups (Greenberger & Padesky, 1995; Padesky & Greenberger, 1995) and there are several excellent training manuals available (J.S. Beck, 1995). CBT for depression is also an efficacious treatment for children and adolescents (Vostanis, Feehan, Grattan, & Bickerton, 1996). The treatment has also been used with non-white samples, and has been shown to be efficacious in treating depression and hopelessness in a sample of African-American women who were drug dependent and HIV sero-positive (Johnson, 2001).

Interpersonal Therapy for Depression (IPT; Klerman, Weissman, Rounsaville, & Chevron, 1984) has also been shown to be an effective treatment. This time-limited program targets the client's difficulty in interpersonal relationships' unresolved grief, role transitions, and interpersonal deficits. Given the enormity of change that can occur in the lives of lesbian, gay, bisexual and transgender clients, IPT may prove to be of particular interest for use with this population. IPT has demonstrated efficacy in two randomized clinical trials (Elkin, et al., 1989; & Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974) and has been shown to be an effective ongoing maintenance therapy following recovery from MDD (Frank, Kupfer, Perel, Cornes, Jarett, Mallinger, Thase, McEachran, & Grochocinski, 1990; & Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974). A treatment manual is available (Klerman, Weissman, Rounsaville, & Cheveron, 1984).

The addition of cognitive-behavioral or interpersonal therapies to standard primary care treatment for depression has been shown to improve outcome, although increasing cost slightly with some studies reported costs offset by reduction in use of specialty mental health resources (e.g. Katon, Toy-Byrne, Russo, & Cowley, 2002; Lave, Frank, Schulberg, & Kamlet, 1998; Von-Korff, Katon, Bush, Lin, Simon, Saunders, Ludman, Walker, & Unutzer, 1998).

Not only cognitive-behavioral or interpersonal approaches have been shown to be efficacious. Another promising treatment is Brief Dynamic Psychotherapy (Crits-Christoph & Barber, 1991; Donovan, 1987; Levenson, Butler, & Beitman, 1997). Though representing a variety of approaches to dynamic therapy in a brief format, this approach typically includes the use of a focal inquiry to locate recurrent disturbance, management of resistance, and resolution of missing capabilities (Gustafson, 1984). The goals include symptom improvement and increased insight (Gaston, Marmar, Thompson, & Gallagher, 1988; Hoglend, 1995). The authors of articles on this treatment have emphasized the need to assess patient suitability for the therapy, which includes circumscribed problems, motivation, and quality pretreatment relationships (Barber, Luborsky, Crits-Christoph, & Diguer, 1995). Brief dynamic psychotherapy has been successfully used in a group format (Cornish & Benton, 2001).

OUTCOME MEASURES

There are several questionnaires and inventories that can be used to measure outcomes in trials of these treatments. The Generalized Anxiety Disorder Questionnaire-IV (GAD-IV; Newman, Fuelling, Kachin, & Constantino, 2001) can be used as a brief screening device. Likewise, the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) can be used to assess pre and post treatment worry. It has been translated in to several different languages (Chorpita, Tracey, Brown, Colica, & Barlow, 1997) and there is a weekly assessment version to measure change over time (Stöber & Bittencourt, 1998). The Agoraphobic Cognitions Questionnaire (ACQ) and the Body Sensations Questionnaire (BSQ) (Chambless, Caputo, Bright, & Gallagher, 1984) are useful measures of panic disorder. For social phobia, the Brief Social Phobia Scale (BSPS; Davidson, Potts, Richichi, Ford, Krishnan, Smith, & Wilson, 1991) is an 18-item measure that also has a computerized version (Kobak, Schaettle, Greist, Jefferson, Katzelnick, & Dottle, 1998). Several measures of depression can be useful. For adults, the Beck Depression Inventory - Second Edition (BDI-II; Beck, Steer, & Brown, 1996) is widely used. The Brief Symptom Inventory (Derogatis, 1993) can also be used. For adolescents between the ages of 13 - 18, the Reynolds Adolescent Depression Scale (RADS; Reynolds, 1987) can be used. A clinician rated measure of depression, the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) is a standard measure used in research.

OTHER PRACTICES THAT HOLD PROMISE FOR GAY, LESBIAN, AND TRANSGENDER YOUTH AND ADULTS

According to Marsha Botzer, founder of the Ingersoll Gender Center in Seattle, contact with others that share similar experiences is vitally important for transgender, intersexed, or questioning youth and adults. The idea for such a center began in 1977. The Ingersoll Gender Center has been offering groups and individual counseling for the transgender community in Seattle since 1984. DeBord and Perez (2000) suggest that for lesbian women, gay men and bisexual men and women the need to find community and share experiences makes group intervention an opportune treatment. Unfortunately, there has been little outcome research on support groups or group counseling with this population, although many agencies offer such groups. DeBord and Perez (2000) describe the principles of group counseling put forth by Yalom (1995) and suggest that they are applicable to lesbian, gay, bisexual and transgender individuals who often feel isolated by the majority culture. Group interventions are often the

chosen treatment modality of lesbian and gay clients (Holahan, & Gibson, 1994). Peer counseling groups such as TalkSafe in New York City have been used to promote safe sex behavior among HIV-negative or untested gay and bisexual male youth. Seattle Counseling Services for Sexual Minorities also offers individual therapy and support groups for lesbian, gay, bisexual, transgender, and questioning youth and adults. Lambert House, a center for lesbian, gay, bisexual, transgender and queer youth offers support groups for transgender youth meaning those in their teens and early twenties. Seattle AIDS Support Group provides support groups for HIV-positive men and women, and their loved ones, and provides a support group for gender-varied people called "Gender Outlaws." This latter group is primarily for young adults in their mid-twenties and thirties. Most of these agencies receive funding through DSHS, although Ryan White Funds have been made available in the past for prevention programs with LGBT youth, and other granting agencies have provided funds for programming. There is little grant funding available for transgender programs.

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Resource Guide

LGBT-Affirmative/Feminist Therapies

Description:

Lesbian, Gay, Bisexual, and Transgender (LGBT) – Affirmative Therapies and Feminist Therapies are approaches to treatment that transcend typical theoretical ideas or treatment models. The approaches share common philosophical concepts that allow practitioners of other treatments (e.g. cognitive-behavioral therapies; community-based programs) to practice competently with lesbian, gay, bisexual and transgender clients. Philosophical ideas at the heart of both of these approaches are:

- Emphasis on the individual and the context of each person's experience.
- Heterosexuality is not assumed the norm by which to compare all people.
- Gender and sexual orientation are seen as constructs that vary from culture to culture.
- Lesbian, gay, bisexual sexual orientations are considered of equal value as heterosexual orientations.
- Gender is not identified by biology alone.

Evaluating this practice:

Outcome measures used to evaluate practice: LGBT-affirmative and feminist approaches to treatment have been studied from theoretical perspectives, but there are few traditional outcome studies. Outcome measures used in general practice to determine improvement in client symptoms can be used in this approach. However, therapists must take care not to use instruments that are gender biased, or that invalidate lesbian, gay, bisexual or transgender experience. For example, outcome measures for treating social anxiety that refer only to "fear of interactions with attractive persons of the opposite sex" imply heterosexuality and disallow anxiety about attraction to someone of the same sex. Likewise, "marital" therapy questionnaires invalidate unmarried, cohabitating couples. Finally, demographic data that forces people to choose between male or female in gender questions can invalidate the experience of transgender, transsexual, intergender, or questioning individuals. These cautions should be applied to make program outcome measures culturally sensitive to the population being evaluated.

Evidence supporting practice:

The evidence supporting the practice of lesbian, gay, bisexual affirmative, or feminist approaches comes less from traditional randomized clinical trials, and more from surveys of harm that has been done to lesbian, gay, bisexual or transgender individuals in therapy. Since affirmative and feminist approaches are mostly philosophical stances that can be applied with most traditional therapies, the evidence from studies of where therapy has failed this population is most useful (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991)

1. **Peer reviewed research:** There have been a number articles or book chapters written on the issues facing lesbian, gay, bisexual or transgender individuals in therapy. Because traditional outcome studies do not apply as easily to such a philosophical stance that does not require specific therapeutic techniques, the research on appropriate response is best utilized to inform practitioners (American Psychiatric Association, 1994; American Psychological Association, 2000). Professional codes of ethics also address this issue (e.g. American Psychological Association, 2002; National Association of Social Workers, 1996).

Practice implementation:

1. **Staffing requirements**: Affirmative and feminist approaches can be applied to traditional individual therapies and to groups. A psychologist or mental health professional with expertise in the area would be required to supervise other counselors. Staffing needs would be dictated by the number of clients seen in a given program and whether they were seen in individual therapy or groups.

2. **Training requirements**: This approach can be applied to any of the traditional, empirically supported approaches referred to in this document. Training can be accomplished through reading appropriate literature on lesbian, gay, bisexual and transgender development and on feminist or contextual philosophy. A workshop to address the specific questions of staff can also be used. On-going supervision can be conducted in groups to assure that staff is culturally sensitive to this population.

3. **Cost of program**: Applying a lesbian, gay, bisexual and transgender affirmative approach to treatment would not raise cost of programming after the initial training.

4. **Use of natural funding**: Adding this approach to traditional practices of an agency can be funded by any process in which programming as usual is funded. Initial training, could be funded from an ongoing in-service education budget.

Other considerations:

Contact information:

American Psychological Association – Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues
Association of Gay and Lesbian Psychiatrists

Relevant websites:

www.apa.org/div44
www.aglp.org

Community Reinforcement Approach

Description:

1. **Primary purpose:** The Community Reinforcement Approach (Meyers & Smith, 1995) to treating substance abuse problems was designed to make changes in a client's daily environment, reduce substance abuse and promote healthy living. This broad-spectrum behavioral approach utilizes social, recreational, familial, and vocational reinforcers to assist in the recovery process. The overall goal is to make the client's sober environment more reinforcing than one involving alcohol or drugs (Smith & Meyers, 2000). The treatment approach utilizes motivational techniques and positive reinforcement. The client is actively involved in determining what contingencies maintain his or her drinking behavior and what will elicit change (Wolfe & Meyers, 1999).

2. **Target populations**: The community reinforcement approach has been shown to have good evidence of effect with alcohol abusers. The approach has not been directly applied with lesbian, gay, bisexual or transgender clients. However, using the Guidelines for psychotherapy from the American Psychological Association (Amer. Psychological Assoc., 2000), practitioners could easily apply this approach to lesbian, gay, bisexual, or transgender substance abusers. The community reinforcement approach, and models incorporating aspects of this approach have been used with adults and adolescents (Godley, Godley, Dennis, Funk, & Passeti, 2002) who abuse alcohol and marijuana.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: The community reinforcement approach has been measured according to number of days of abstinence for alcohol abusers, and urinalysis for studies with opiate abusers (Smith, Meyers, & Delaney, 1998). It has been reported as one of the "top six" treatment modalities that have strong empirical support based on meta-analytic evaluations (Miller, et al., 1995).

Evidence supporting practice:

1. **Peer reviewed research**: This treatment approach has been studies in several randomized clinical trials. There have been three meta-analytic studies that have concluded that it is one of the top six treatment modalities for substance abuse (Finney & Monahan, 1996; Holder et al., 1991; Miller et al., 1995). An assertive continuing care program that incorporated case management and the adolescent community reinforcement approach was used to study marijuana and alcohol use, and access to

continuing care fore 114 adolescents discharged after at least 7-days in residential treatment. The participants receiving assertive continuing care (that includes CRA) were more likely to initiate continuing services and to be abstinent from marijuana, and have reduced alcohol consumption three months following discharge. Smith, Meyers, & Miller reviewed the treatment studies on community reinforcement approach and found that in three meta-analytic studies the approach was ranked as one of the most efficacious and cost-effective alcohol interventions.

2. **Other supporting documents**: There is a treatment manual available (Meyers & Smith, 1995).

Practice implementation:

1. **Staffing requirements**: This is an individual treatment modality, and would require that the number of clinical staff be sufficient to meet the caseload for individual therapy.

2. **Training requirements**: This approach incorporates several standard behavior therapy practices and could be easily learned by mental health professionals with basic behavioral backgrounds. A treatment manual can be used to assist in training.

3. **Cost of program**: In meta-analytic studies, the treatment fell in the category of low to medium cost (from $0 - $599). Outcome studies in outpatient settings have demonstrated that alcohol-dependent patients received an average of five to eight weekly sessions of community reinforcement approach treatment and is likely to be highly cost-effective and easily transferred to outpatient settings (Miller, Meyers, & Hiller-Sturmhöfel (1999).

4. **Use of natural funding**: This program is endorsed by NIDA and backed by empirical research. It is an individually administered psychotherapeutic technique and would be reimbursable by insurance, or is affordable for some clients to pay fee for service.

Other considerations:

Contact information:

Relevant websites:

http: //www.peele.net/faq/cra.html

Cognitive-Behavior Therapy for Generalized Anxiety Disorder

Description:

1. **Primary purpose**: Given the findings that gay men, lesbians and bisexual men and women have higher rates of generalized anxiety than heterosexual counterparts, it is reasonable to apply psychosocial treatment that has been empirically evaluated with this population when individuals meet diagnostic criteria for generalized anxiety disorder. Cognitive-behavior therapy (CBT) addresses several components of anxiety, targeting the physiological component through progressive relaxation, the behavioral component through graduated exposure exercises to reduce avoidance, and the cognitive component through cognitive restructuring to modify anxious thoughts and lack of self-confidence.

2. **Target populations**: Cognitive-behavior therapy has been used with a variety of client populations and with a variety of disorders. CBT for anxiety disorders has been shown to be efficacious in a number of studies, but has never been evaluated specifically with a gay, lesbian or bisexual population. it is indicated, however, for adults with generalized anxiety disorder. There is also evidence that cognitive-behavioral therapy is efficacious in the treatment of common childhood anxiety disorders - separation anxiety, social phobia, and generalized anxiety disorders (Albano & Kendall, 2002).

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: There are several useful, inexpensive assessment tools for evaluating the effectiveness of CBT for generalized anxiety disorder. The Generalized Anxiety Disorder Questionnaire-IV (GADQ-IV; Newman, Zuellig, Kachin, & Constantino, 2001) can be used as a brief screening for GAD. It can be used at pre-test and as a post-test measure. The Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) is an good tool for assessing general tendency to worry, and is a 16-item self-report questionnaire. The scale has been translated into Chinese, Dutch, French, German, Greek, Italian, Spanish , and Thai, and there is a child and adolescent version (Chorpita, Tracey, Brown, Colica, & Barlow, 1997). There is also a weekly assessment version to measure change over time (Stöber & Bittencourt, 1998)

2. **Qualitative evaluation**: Client report of reduction in worry, and increases in approaching previously avoided situations can be used to assess improvement.

Evidence supporting practice:

1. **Peer reviewed research**: Cognitive-behavior therapy for generalized anxiety disorder has been shown to be more effective than non-directive therapy (Borkovec & Costello, 1993), analytic therapy (Durham, et al., 1994) and benzodiazepine medication (Power et al., 1990).

2. **Other supporting documents**: Beck, A. T., & Emery, G. (1985). Anxiety disorders and phobias: A cognitive perspective. New York: Basic Books. Zinbarg, R. E., Craske, M. G., & Barlow, D. H. (1993). Therapist Guide to Mastery of Your anxiety and worry. Boulder, CO: Graywind Publications.

Practice implementation:

1. **Staffing requirements**: Although little research has been done on cognitive-behavior group therapy for generalized anxiety disorder, CBGT has been successfully utilized with other disorders such as social phobia. conducting the therapy in a group format could reduce staffing requirements, with one staff member per 8 to 10 clients.

2. **Training requirements**: General background in mental health counseling. There are workshops available around the country that consists of two-day, to one-week training.

3. **Cost of program**: There is little cost offset data, however, most CBT protocols consist of brief therapy lasting from 12 to 20 weeks.

4. **Use of natural funding**: CBT has been successfully employed in outpatient treatment settings that do not rely on grant funding.

Other considerations:

Contact information:

Center for Anxiety and Related Disorders

Relevant websites:

www.bu.edu/anxiety/

Panic Control Treatment

Description:

1. **Primary purpose**: There is some evidence that gay and bisexual men are more vulnerable to panic disorder with and without agoraphobia than heterosexual men. Panic control treatment (Barlow & Craske, 1994) has demonstrated results reducing panic up to two-years following treatment. The treatment focuses on exposing the client to interoceptive sensations that resemble the physiological experience of panic. Cognitive restructuring is used to reduce the client's misconceptions about anxiety. Breathing retraining corrects tendencies to hyperventilate in some clients with panic disorder. For panic with agoraphobia, in-vivo exposure (i.e. exposure to the actual feared situation) is necessary and has been shown to be the most effective treatment for agoraphobia.

2. **Target populations**: Adults with panic disorder, with and without agoraphobia. There are no data on the use of this treatment exclusively with lesbian, gay, bisexual or transgender individuals.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: There are several questionnaires that can be used to evaluate the outcome of this practice with clients. The Agoraphobic Cognitions questionnaire (ACQ) and the body sensations questionnaire (BSQ; Chambless, Caputo, Bright, & Gallagher, 1984).

Qualitative evaluation

1. **Evidence supporting practice:** Peer reviewed research: Barlow, Craske, Cerney, & Klosko, (1989) compared panic control treatment with relaxation alone and panic control treatment combined with relaxation to a waiting-list control. All three treatment conditions were more effective than waiting list, 87% of clients in the panic control treatment conditions (alone or combined) were panic free at the conclusion of the study. Eighty -one percent of the clients who had received panic control therapy alone remained panic free at two-year follow-up (Craske, Brown, & Barlow, 1991).

2. **Other supporting documents**: There is a training manual available. Barlow, D. H., & Craske, M. G. (1994). Mastering your anxiety and panic (maps II). Boulder, CO: Graywind publications. Graywind publications also sell a series of training tapes for therapists (approximately $500 for the set).

Practice implementation:

1. **Staffing requirements**: Panic control therapy is an individualized treatment and requires one-on-one time with a therapist. However, studies comparing weekly therapist contact with bi-monthly one -hour contact, supplemented by bi-monthly 10-minute telephone contact have shown that the reduced therapist contact is equally effective to weekly one-hour sessions (Côté, Gauthier, Laberge, Cormier, & Plamondon, 1994). Furthermore, Panic control therapy has been conducted in group format, and can be conducted using a self-help manual, self-directed by the client, both in an 8-week treatment program (Lidren et al., 1994).

2. **Training requirements**: Staff can be easily trained in this method with use of the therapist guide and training tapes.

3. **Cost of program**: Direct costs are difficult to determine, but this treatment is considered a cost-effective treatment for panic with or without agoraphobia.

4. **Use of natural funding**: This is a brief, inexpensive therapy and can easily be funded without grant money.

Other considerations:

Contact information:

Center for Anxiety and Related Disorders

Relevant websites:

www.bu.edu/anxiety/

Cognitive Behavioral Group Therapy for Social Phobia

Description:

1. **Primary purpose**: The purpose of cognitive behavioral therapy (Heimberg, Dodge, Hope, Kennedy, Zollo, & Becker, 1990) for social phobia is to use in-session exposure exercises, cognitive restructuring and homework exposure to reduce negative self-evaluation and improve social functioning of clients with social phobia. This treatment is particularly important with young men who have sex with men because social anxiety can reduce adherence to safe sex behaviors.

2. **Target populations**: There have not been large scale treatment studies of CBGT with lesbian, gay, bisexual or transgender adolescents or adults, but studies are underway using this approach to encourage safer sex practices by increasing social skills with gay and bisexual male youth.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: The brief social phobia scale (BSPS; Davidson, Potts, Richichi, Ford, Krishnan, Smith, & Wilson, 1991) is an excellent measure utilizing observer-ratings. It is an 18-item measure consisting of three subscales: fear, avoidance, and physiological arousal. There is also a computerized version of the BSPS; Kobak, Schaettle, Greist, Jefferson, Katzelnick, & Dottle, 1998).

2. **Qualitative evaluation**: CBGT lends itself well to qualitative studies of reports of the group members' experiences both within group and in external social settings.

Evidence supporting practice:

1. **Peer reviewed research**: There have been several peer reviewed articles attesting to the efficacy of cognitive-behavioral group treatment for social phobia. A large multi-site study (Heimberg, et al., 1994) found CBGT to be as effective as phenelzine after 12-weeks of treatment, with 75% of clients showing improvement, and clients treated with CBGT maintained gains at follow-up whereas a number of those treated with phenelzine did not.

2. **Other supporting documents**:

Practice implementation:

1. **Staffing requirements**: Because treatment is conducted in a group format, therapists/client ratios of 1 to 8 or 10 are sufficient.

2. **Training requirements**: Therapists with experience in general mental health counseling can be easily trained in this approach.

3. **Cost of program**: Treatment consists of 12-weeks of group intervention sessions meeting once per week. This is a relatively low cost program.

4. **Use of natural funding**: The treatment is for people diagnosed with social phobia and would be reimbursable by insurance.

Other considerations:

Contact information:

Center for Anxiety and Related Disorders

Relevant websites:

www.bu.edu/anxiety/

Cognitive Therapy For Depression

Description:

1. **Primary purpose**: Cognitive therapy for depression (Beck, Rush, Shaw, & Emery, 1989) also referred to as cognitive-behavioral therapy for depression is one of the most widely studied treatments for major depressive disorder. The purpose of this treatment is the amelioration of dysfunctional beliefs and behaviors commonly associated with major depressive disorder.

2. **Target populations**: Cognitive therapy for depression has been successfully applied with a variety of patient populations. There are several single-case examples of using this approach with lesbian, gay, and bisexual adults. Cognitive-behavioral therapy has also been shown to be efficacious in the treatment of childhood and adolescent depression (Vostanis, Feehan, Grattan, & Bickerton, 1996). Furthermore, brief cognitive-behavioral therapy has been efficacious in treatment of depression and hopelessness in a sample of

African-American women who were also drug dependent and HIV-seropositive (Johnston, 2001)

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: There are three screening methods for measuring the outcome of treatment with CT for depression. The beck depression inventory - Second Edition (BDI-II; Beck, Steer, & Brown, 1996), is a widely used self-report measure. An additional self-report measure, the Brief Symptom Inventory (Derogatis, 1993) can also be used with adolescents and adults. For adolescent clients, the Reynolds adolescent depression scale (RADS; Reynolds, 1987) is useful for youth between the ages of 13 - 18.

2. **Qualitative evaluation**

Evidence supporting practice:

1. **Peer reviewed research**: The effectiveness of the cognitive-behavioral treatment for depression has been demonstrated in numerous studies. It has been shown to be as effective as tricyclic antidepressant medications (Elkin et al., 1989; Hollon et al., 1992, Simons, Murphy, Levine, & Wetzel, 1986) and has been shown to be equally effective in all but the Elkin et al. study, which has not been replicated.

2. **Other supporting documents**:; There are several good treatment manuals. The original Beck, Rush, Shaw, & Emery, 1979 is an excellent training manual. J. S. Beck, 1995 is also a useful manual. There are several self-help programs as well, most notably Mind Over Mood by Greenberger & Padesky, 1995 which has an accompanying therapist manual (Padesky & Greenberger, 1995) that has suggestions for conducting group treatment.

Practice implementation:

1. **Staffing requirements**: CBT for depression is roughly a 12 - 24 week protocol, and can be run in groups, reducing staffing needs.

2. **Training requirements**: Training in CBT for depression is available in a number of workshops, and there are training tapes available from the beck institute of cognitive therapy.

3. **Cost of program**: Like other CBT treatments, the treatment for depression is a minimal to moderately expensive treatment. Cost-offset data has shown that CBT added to practice as usual in a primary care setting improves treatment outcome for depressed patients, but no significant cost-offsets were found (Lave, Frank, Schulberg, & Kamlet, 1998). However, Von-Korff and colleagues (1998) did find a modest cost offset due to reduced use of specialty mental health services when consulting psychologists provided brief cognitive-behavioral therapy supplemented by educational materials and enhanced pharmacotherapy management in a primary care setting.

4. **Use of natural funding**: the program can utilize natural funding easily.

Other considerations:

Contact information:

Beck Institute for Cognitive Therapy and Research
Center for Cognitive Therapy – Newport Beach

Relevant websites:

www.beckinstitute.org
www.padesky.com

Interpersonal Therapy for Depression

Description:

1. **Primary purpose**: Interpersonal therapy (IPT; Klerman, Weissman, Rounsaville, & Chevron, 1984) is a time-limited (12-16 week) treatment intervention that suggests that a client's interpersonal relationships may play a significant role in onset and maintenance of depressive symptoms. Problem areas addressed in IPT are the client's difficulty in interpersonal functioning, unresolved grief, role transitions and interpersonal deficits.

2. **Target populations**: IPT has been studied in two large randomized control trials, and appears to have favorable results with the general population. There have been no studies directly related to gay, lesbian, bisexual or transgender men and women. The treatment appears to work best with clients that have low rather than high levels of social dysfunction.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: The Hamilton rating scale for depression (HRSD; Hamilton, 1960) has been used in clinical studies of IPT for depression and is a good, clinician administered measure of depression. The Reynolds Adolescent depression Scale (RADS; Reynolds, 1987) can be used for clients aged 13-18.

2. **Qualitative evaluation**

Evidence supporting practice:

1. **Peer reviewed research**: There have been two major randomized control trials of IPT (Elkin, et al., 1989; Klerman, DiMascio, Weissman, Prusoff, & Paykel,1974), and as an ongoing maintenance therapy following recovery (Frank, Kupfer, Perel, Cornes, Jarett, Mallinger, Thase, McEachran, & Grochocinski, 1990; Klerman, DiMascio, Weissman, Prusoff, & Paykel,1974).

2. **Other supporting documents**: Klerman, G. L, Weissman, M. M., Rounsaville, B. J., & Cheveron, E. S. (1984). Interpersonal psychotherapy of depression. New York: Basic Books.

Practice implementation:

1. **Staffing requirements**: Requires one to one therapist/client contact.

2. **Training requirements**: A training program in Pittsburgh is available that requires 40 hours of training and supervision of two cases using videotapes.

3. **Cost of program**: As the other treatments in this resource list, IPT is a short-term, cost-effective treatment.

4. **Use of natural funding**: Easily funded by insurance, Medicare, or client self-pay.

Other considerations:

Contact information:

Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213
(412) 624-2211

Relevant websites:

Brief Dynamic Psychotherapy for Depression

Description:

1. **Primary purpose**: Brief Dynamic Psychotherapy is an application of psychodynamic principles to the treatment of depression in a focused, short-term format. Brief Dynamic Psychotherapy makes use of the Core Conflictual Relationship Theme method (Luborsky & Crits-Christoph) that focuses on identifying relationship episodes that clients typically talk about or enact in therapy sessions. Clients are then helped to find ways of coping with such conflicts. The treatment is short-term for practical rather than theoretical purposes, and no outcome studies have tested the benefit of shorter term versus longer-term therapy.

2. **Target populations**: The Brief Dynamic Psychotherapy approach has been used with a number of individuals. However, certain capacities in clients are considered necessary for the treatment to be effective. Clients must be have the capacity to form and sustain trusting and mutual relationships and they should be motivated and able to discuss central problems early in therapy, otherwise treatment would focus on helping clients to develop such capacities (Gaston, Marmar, Thompson, & Gallagher, 1988). The treatment has been used with elderly depressed patients (Gaston, et al., 1988) and with a general outpatient population meeting diagnostic criteria for Major Depressive Disorder (Barber, Luborsky, Crits-Christoph, & Diguer, 1995). There are no studies reporting specific use with lesbian, gay, bisexual or transgender populations.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Brief Dynamic Psychotherapy has been compared to behavior therapy and cognitive therapy for depression. However, the goals of treatment are different in brief dynamic therapy than in the cognitive-behavior therapies, and comparisons are difficult. Nevertheless, brief dynamic therapy has been shown to improve client's ratings on traditional measures of depression.

Evidence supporting practice:

1. **Peer reviewed research**: This treatment approach has been used successfully in the treatment of depression. The goals of this therapy are symptom improvement and increased insight (Hoglend, 1995).

2. **Other supporting documents**: There is a treatment manual for this treatment, which brings together a diverse literature on the topic to guide therapists in this approach (Crits-Christoph & Barber, 1991) and a brief guide to the approach (Levenson, Butler, & Beitman, 1997).

Practice implementation:

1. **Staffing requirements**: This is an individual treatment modality, and would require that the number of clinical staff be sufficient to meet the caseload for individual therapy. There is limited evidence that the approach can be conducted in a group format (Cornish & Benton, 2001).

2. **Training requirements**: This approach incorporates several standard psychodynamic therapy practices and could be easily learned by mental health professionals with basic such backgrounds. In empirical studies, therapists have had one year of post-graduate training in a psychodynamic approach. A treatment manual can be used to assist in training.

3. **Cost of program**: The cost of implementing this approach has not been determined. However, it has been applied individually in six to twenty sessions of therapy and would, therefore, be considered a moderately expensive treatment.

4. **Use of natural funding**: This approach can be conducted with funding from fee for service reimbursement or government supplemental funding for mental health care.

Other considerations:

Contact information:

Relevant websites:

Group Counseling Theory

Promising Strategy

Description:

1. **Primary purpose**: DeBord and Perez (2000) suggest that group counseling offers unique benefits to lesbian, gay, and bisexual clients. For transgender individuals, discrimination and hostility at the workplace, in the community and in the medical community can lead to feelings of isolation and shame. Contact with other transgender individuals that suffer the same challenges in a hostile environment can lead to improved mental health, and may prevent serious depression or hopelessness. Therefore, group counseling is useful for this group of individuals as well. Group counseling offers participants the opportunity to share concerns and insights with others facing similar life challenges. Yalom (1995) presented several goals of group counseling: instilling hope, recognizing the universality of experience, imparting information, developing social skills, imitating the behavior of others through observation, an opportunity for altruism, group cohesion, interpersonal learning, and catharsis.

2. **Target populations**: There are very few studies with gay and bisexual men, and relatively no studies with women or transgender adults. However, the treatment is well suited for lesbian, gay, bisexual, and transgender youth and adults, and is the treatment that is self-selected by many LGBT people (Holohan & Gibson, 1994).

Evaluating this practice:

1. **Outcome measures used to evaluate practice**:

2. **Qualitative evaluation**: group process and group dynamics have been reported most frequently in anecdotal descriptions of the positive outcomes of group counseling.

Evidence supporting practice:

1. **Peer reviewed research**: There is little empirical evidence supporting group therapy in general. However, evidence from cognitive-behavioral group therapy for social phobia, and for depression, suggests that group counseling and therapy is a highly effective technique.

2. **Other supporting documents**: Yalom, I. D. (1995). The theory and practice of group psychotherapy (4th ed.). New York: Basic Books.

Practice implementation:

1. **Staffing requirements**: Staff to client ratios can vary depending on the type of group. Facilitated support groups can be substantially large in number, whereas psychotherapy groups for specific problems such as social phobia, should be limited to 8 to 10 clients.

2. **Training requirements**: There is little formal training available for group therapy.

3. **Cost of program**: Costs will vary according to the type of group run.

4. **Use of natural funding:**

Other considerations:

Contact information:

Relevant websites:

Ingersoll Gender Center

Promising Program

Description:

1. **Primary purpose**: Ingersoll gender center offers support groups, referrals to Ingersoll trained therapists, and referrals to physicians and surgeons.

2. **Target populations**: The Ingersoll Gender Center serves the transgender, intergender, transsexual and questioning community. Individuals with gender concerns, their friends and family are all welcome to utilize services.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**:

2. **Qualitative evaluation**: Ingersoll Gender Center has been serving the transgender community in Seattle since 1977 and is one of a handful of such centers providing resources for transgender youth and adults.

Evidence supporting practice:

1. **Peer reviewed research**: none

2. **Other supporting documents**:

Practice implementation:

1. **Staffing requirements**: Not Available

2. **Training requirements**: Counselors are trained in the Benjamin Standards.

3. **Cost of program**

4. **Use of natural funding**

Other considerations:

Contact information:

206-329-6651

Relevant websites:

www.ingersollcenter.org

Talk Safe

Promising Program

Description:

1. **Primary purpose**: Talk Safe is a counseling program in New York City that seeks to assist gay and bisexual men to maintain safer sexual practices and remain HIV-Negative. It offers risk-reduction and personal counseling delivered by trained peer volunteers and licensed psychologists.
2. **Target populations**: HIV-Negative or serostatus unknown gay and bisexual men.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**: Participant reports of increase or decreases in high-risk sexual behaviors.
2. **Qualitative evaluation**: There is no qualitative evaluation of this program to date.

Evidence supporting practice:

1. **Peer reviewed research**: There is no quantitative evaluation of the effectiveness of this program to date, although such research is currently being investigated.
2. **Other supporting documents**:

Practice implementation:

1. **Staffing requirements**: Talk Safe can be run by peer volunteers but requires a mental health practitioner to oversee the program. The program in New York City has one psychologist as director, a master's level mental health provider on staff and a psychology extern who volunteers time.
2. **Training requirements**: Training for peer counselors requires 3 to 4 modules of 3-hours duration each.
3. **Cost of program**: There is little cost to this program other than staff salaries.
4. **Use of natural funding:**

Other considerations:

Contact information:

Relevant websites:

www.talksafe.org

Seeking Safety

Description:

1. **Primary purpose**: Seeking Safety is a therapy to help people attain safety from PTSD and substance abuse. It is conducted in group and individual format and has been used with people with trauma histories that do not meet criteria for PTSD as well as those who do. The goals of the program are safety in relationships, thinking, behavior and emotions; integrating treatment for PTSD and substance abuse at the same time; focusing on ideals that counteract the loss of ideals; attention to clinician processes. There are four content areas of Seeking Safety: cognitive, behavioral, interpersonal, and case management.
2. **Target populations**: Seeking Safety has been implemented with women and with men in a variety of settings, including outpatient settings, community mental health centers, prisons and VA settings. It has been conducted with adolescents as well as adults, and in a population of low-income urban women.

Evaluating this practice:

1. **Outcome measures used to evaluate practice**:
2. **Qualitative evaluation:**

Evidence supporting practice:

1. **Peer reviewed research**: There have been seven studies demonstrating the utility of Seeking Safety as a treatment for co-morbid PTSD and substance abuse although only one, Najavits, Weiss, Shaw, & Muenz (1998), has been published, the rest are under review.
2. **Other supporting documents**: Najavits, L. M. (2002). Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. New York: Guilford Press.

Practice implementation:

1. **Staffing requirements**
2. **Training requirements**
3. **Cost of program**
4. **Use of natural funding**

Other considerations:

Contact information:

Relevant websites:

www.seekingsafety.org

Other Resources on Transgender Issues:

King County site for mental health
http: //www.metrokc.gov/health/glbt/transemotions.htm

Another site:
www.Emindhealth.com

Transgender page:
http: //www.emindhealth.com/consumer/s_resources.html?channel_id=2&s_channel_id=4

Research from the Benjamin Association:
A specific paper on Trans and substance issues [discusses depression, anxiety]:

http:
//www.symposion.com/ijt/ijtvo06no02_03.htm#Challenges%20Transgendered%20Substance%20Users%20Face

Other Papers from the Association:
http: //www.symposion.com/ijt/index.htm

Agencies in the Seattle Area that offer services to Transgender clients and patients:
Ingersoll Gender Center
http: //www.ingersollcenter.com

Seattle Counseling Service
http: //www.seattlecounseling.org/counseling03.htm

Seattle Aids Support Group
http: //www.sasg.org/