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# LGB-Affirmative Cognitive Behavioral Treatment for Social Anxiety: A Case Study Applying Evidence-Based Practice Principles

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## **Abstract**

Guided by the American Psychological Association’s principles of evidence-based practice, this article reviews a single-case treatment outcome study whereby a client characteristic, sexual identity, was integrated into the assessment and treatment of social anxiety symptoms. The case involved a young adult European-American male who presented to a training clinic with a primary diagnosis of social anxiety disorder as well as secondary symptoms of excessive worry and concerns of sexual identity confusion. Recent evidence suggests that gay men report more symptoms of social anxiety when compared to heterosexual men, and those who make more efforts to conceal their sexual identity experience increased anxiety and have greater difficulty committing to a personal identity. Further, it has been hypothesized that fear of rejection from heterosexual individuals underlies this anxiety. The client attended 50 sessions over the course of 18 months. Treatment progress was assessed via self-report questionnaires assessing social anxiety and worry. Consistent with principles of evidence-based practice, a cognitive behavioral treatment protocol was employed at the outset of therapy and resulted in a decline in the client’s social anxiety scores. However, once the case conceptualization and treatment focus shifted to focus on sexual identity, his scores continued to decline at an even steeper rate. He ultimately came to identify himself as having a same-sex sexual orientation, began living his life in a manner consistent with that identification, and reported a number of positive outcomes at termination of therapy. Implications for treatment of social anxiety in sexual minorities are discussed.

Social anxiety, defined as excessive fear and avoidance of social or performance situations, is the most common type of anxiety disorder and has a documented lifetime population prevalence rate of 13.3% (Kessler et al., 1994). The available research evidence suggests that individual cognitive behavioral therapy is considered an efficacious and specific treatment for symptoms of social anxiety (Chambless & Hollon, 1998; Heimberg & Barlow, 1991; Ledley et al., 2009). However, evidence-based practice principles also stipulate that client characteristics and preferences represent an important component of treatment. Specifically, according to guidelines set forth by the American Psychological Association (APA Presidential Task Force on Evidence-Based Practice, 2006), evidence-based practice refers to the "integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). Consistent with these guidelines, the present study describes a clinical case whereby a client characteristic, sexual identity, was integrated into assessment and treatment for symptoms of social anxiety.

A key element of social anxiety that may be particularly relevant for sexual minority individuals is fear of rejection by others. More specifically, it has been hypothesized that sexual minority individuals may expect rejection by the heterosexual majority, which may translate into symptoms of social anxiety (Hart & Heimberg, 2001; Meyer, 2003). Indeed, negative attitudes toward sexual minorities are common, with heterosexuals' attitudes toward gay men being more negative than toward lesbians (Herek, 2000). Moreover, when compared to heterosexual men, gay men experience more symptoms of social anxiety, including heightened fear of negative evaluation and increased social interaction anxiety (Pachankis & Goldfried, 2006), perhaps, in part, due to realistic concerns about negative evaluation by others. Further, gay men who feel less personally comfortable with their sexual orientation and more discomfort disclosing their sexual orientation to others tend to have higher social anxiety scores and lower self-esteem. However, these findings are circumscribed to interpersonal interactions and do not include typical performance evaluation situations (e.g., speaking in public). Pachankis and Goldfried postulated that preoccupation with concealing outward indications of sexual orientation may translate to experiencing anxiety among gay men. Further, concealing outward indications of sexual orientation may engender feelings of deception during social interactions that, in turn, may lead to feelings of low self-esteem in general.

Social anxiety and self-concealment also may impact identity development. More generally, identity refers to adherence to a value, belief, or goal in a specific domain (Marcia, 1966), and identity development is the active process of exploring one's identity and committing to an integrated identity (Worthington, Navarro, Savoy, & Hampton, 2008). More specifically, commitment to a sexual identity has been defined as "a consistent, enduring, self-recognition of the meanings that sexual orientation and sexual behavior have for oneself" (Savin-Williams, 1990, p. 3). Sexual identity is distinct from sexual behavior or sexual attraction. For example, data from national surveys suggest that men and women endorse engaging in same-sex behavior, but do not identify as gay, lesbian, or bisexual (Laumann, Gagnon, Michael, & Michaels, 1994). Thus, in more behavioral terms, identity commitment among sexual minority individuals reflects coming to understand one's sexual orientation and engaging in a lifestyle that is consistent with such an understanding (e.g., having a

same-sex romantic partner, being part of the gay community). A number of factors, including social anxiety and self-concealment, may affect identity development among LGB populations. For instance, among gay men and lesbian women, higher levels of social anxiety have been shown to predict greater levels of self-concealment, which, in turn, has been linked to decreased identity commitment (Potoczniak, Aldea, & DeBlaere, 2007). Interestingly, the variance in identity commitment accounted for by social anxiety and self-concealment was greater for gay men than for lesbian women (Potoczniak et al., 2007), which suggests that self-concealment may be more salient for gay men due to increased societal stigma toward sexual minority men.

In addition to societal stigma, sexual minorities also may experience rejection from more personal sources, such as parents or even themselves (Savin-Williams, 2001). Parental rejection of an individual's sexual orientation has been shown to increase internalized rejection of one's own sexual orientation, which then leads to heightened sensitivity to future gay-related rejection (Pachankis, Goldfried, & Ramratten, 2008). Based on these findings, the authors suggested that therapists work with clients to dismantle rejection sensitivity schemas and revise such schemas by providing the client with corrective, positive experiences with members of the heterosexual majority. The authors note that if the therapist identifies as heterosexual, the client's relationship with the therapist may serve as a corrective positive experience with the heterosexual majority.

In summary, a number of studies demonstrate heightened social anxiety among sexual minorities due to anticipated encounters with sexual prejudice. Actual or anticipated rejection from family members and self-concealment of sexual identity may combine with heterosexual majority attitudes and contribute to negative attitudes about the self as a sexual minority (homonegativity or internalized homophobia; see Rowen & Malcolm, 2002). The findings suggest that treatment for social anxiety in sexual minorities will need to consider the various effects of sexual prejudice. In the case detailed below, the emergence of additional information from the client over the course of assessment and treatment for social anxiety disorder in conjunction with the relevant research evidence suggested a reformulation of the initial case conceptualization as well as a lesbian, gay, bisexual (LGB)-affirmative approach to sexual identity exploration and formation. As such, the present case study reflects a specific application of evidence-based practice in the context of cognitive behavioral treatment for social anxiety symptoms.

## **The Case of Jason**

### ***Background and Relevant History***

Jason<sup>1</sup> is a 23-year-old European-American male who was referred to a university training clinic for problems with anxiety. Specifically, he reported feeling anxious across a variety of social situations, particularly when speaking in public and interacting with large groups of people. Although he denied outright avoidance of situations in which he might experience social anxiety, he indicated that he tolerated such situations with extreme distress. Despite reporting significant discomfort and anxiety in social situations, Jason presented as socially and intellectually high-functioning, reporting a large social support network and generally positive relationships with family, peers, and work colleagues. Although he

reported having a number of friends of both sexes, he noted that his closest friends tended to be female and he felt most comfortable speaking and spending time with women. In describing his social support network, however, Jason reported adopting a supportive role for his family, peers, and coworkers significantly more often than he reported seeking emotional support from them. When he began discussing his sexual identity concerns later in therapy, he noted that he felt extremely limited in his ability to disclose these concerns to his friends or family, and that this therapist was the first individual to whom he had disclosed his desire to explore the topic. He reported that friends and family had questioned his sexual orientation on numerous occasions in the past and he had vehemently denied the possibility that he might be gay. Because of his past defensiveness when questioned, he felt uncomfortable disclosing that he was questioning his sexual identity. Thus, his social support network, although large, was not being utilized to his satisfaction when he entered therapy.

In addition to symptoms of social anxiety, Jason also reported spending approximately 90% of his day worrying about various stressors, including his future career, school, current job, bills, and his sexual identity. He indicated that this worry seemed excessive and prevented him from accomplishing important tasks in a timely fashion. Although the client's subjective distress regarding his worry was moderate, objectively his worry did not significantly impair his functioning, and he did not endorse irritability, sleep disturbance, or fatigue that is often experienced as a result of heightened worry. Much of his worry in fact seemed related to future career plans, with Jason reporting that although he had interests in interior design, he had obtained a degree in Communication Studies instead. Finally, Jason indicated that an overarching goal for therapy was to achieve more self-acceptance. It was not until the third session when the therapist and client were concluding the assessment phase that Jason reported that he was questioning his sexual identity and had never been in a sexual relationship with a male or female partner. More specifically, he noted that he felt sexually attracted to both men and women; however, his sexual experiences were limited to kissing a woman on two occasions. Although more comprehensive discussions of his identity questioning arose after several sessions spent building rapport and targeting his social anxiety, Jason noted that approximately 50% of his excessive worry related to conflicted feelings regarding his sexual identity and concern regarding the reactions of others. This disclosure reinforced the therapist's decision to focus on social anxiety symptoms and sexual identity issues rather than worry symptoms.

Based on clinical interviews, Jason initially was given a primary *DSM-IV-TR* (American Psychiatric Association, 1994) diagnosis of social anxiety disorder. Although he also reported symptoms consistent with a diagnosis of generalized anxiety disorder (GAD; e.g., frequent and excessive worry), he did not meet Criterion C (at least three associations between worry and physical or psychological symptoms including irritability, sleep disturbance, and fatigue), and therefore was not given an initial diagnosis of GAD.

Jason described the onset of his anxiety symptom in middle school (5th or 6th grade) and noted that his symptoms worsened as he progressed through puberty and into college. Jason grew up and went to college in the same small midwestern city of approximately 225,000. Throughout college, Jason continued to live at home with his parents, whom he

described as extremely conservative. He described his mother as kind and somewhat passive, his father as masculine and someone who tends to endorse traditional gender roles. He stated that his mother would often ask when he "was going to bring a nice girl home to meet her" and she would often suggest that he date his close female friends. He also reported that his father was both verbally and physically abusive toward Jason until he entered Alcoholics Anonymous (AA) when Jason began the 9th grade. Even after entering AA and maintaining his sobriety, however, Jason reported that his father continued to criticize him and express disapproval of his gender nonconforming choices and behavior, including his interest in interior design and fashion rather than traditionally masculine activities. In response to the emotional disapproval and physical maltreatment Jason reported experiencing from his father, he may have internalized negative perceptions of himself, seeking approval from others to counter his own negative perceptions of himself.

One of Jason's greatest concerns at the outset of therapy related to the quality, volume, and pitch of his voice. In fact, prior to beginning therapy, he had visited a speech pathologist because he felt that his voice was too high-pitched, soft, and feminine-sounding. Before disclosing that he was questioning his sexual identity in therapy, he mentioned that a number of peers had questioned him about or simply assumed that he was gay. In large part, he attributed their questions or assumptions to the sound of his voice. Additionally, he noted that his voice was so soft that when giving speeches in class or speaking to others in loud settings (e.g., bars), he was concerned that others could not hear or understand him. Although Pachankis and Goldfried (2006) note that anxiety among gay men typically does not extend to general performance situations, his anxiety in specific performance evaluation circumstances appears to have been related to concerns about concealing a more feminine characteristic from others. Therefore, it is likely that the anxiety he was experiencing in these circumstances may have been associated with his sexual identity struggles (i.e., fear of rejection by the heterosexual majority) rather than with symptoms of social anxiety.

### *Assessment*

Assessment was conducted during the first three sessions. During the first session, Jason described social anxiety as his presenting problem and completed the Symptom Checklist-90 (SCL-90; Derogatis & Cleary, 1977) as part of standard clinic intake procedures. The SCL-90 is a self-report questionnaire designed to assess clinical difficulties across nine primary psychological symptom dimensions and three global indices of distress. To monitor his social anxiety and worry symptoms throughout therapy, Jason completed both the Brief Fear of Negative Evaluation (BFNE; Leary, 1983) and the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) during the second session and at every other session during the first 34 sessions. During the final 16 sessions, self-report assessments were administered every fourth session. The BFNE is a 12-item reduced version of the larger Fear of Negative Evaluation (FNE; Watson & Friend, 1969) scale. The BFNE primarily taps fear of loss of approval by others and has been shown to have excellent internal consistency (.90) and good test-retest reliability (.75) over a 4-week period (Leary, 1983). The PSWQ is a 16-item self-report questionnaire designed to measure the intensity and excessiveness of worry. Internal consistency coefficients range from .86 to .93

across clinical and college samples, and test-retest reliability over 4 weeks is .93 (Meyer et al., 1990).

At the outset of therapy, Jason's SCL-90 profile was elevated on the interpersonal sensitivity and obsessive-compulsive subscales, which was consistent with the anxiety symptoms he reported. Additionally, his initial BFNE score of 53 was two standard deviations above the mean of 35.7 for a college student sample (Leary, 1983) and two thirds of a standard deviation higher than the mean of 46.9 for social anxiety patients (Weeks et al., 2005). This BFNE score suggests that he was concerned about others perceiving him negatively and fits both with a diagnosis of social anxiety disorder as well as with his self-reported anxiety during public speeches and interactions with large groups of individuals. Further, his initial score of 76 on the PSWQ was more than two standard deviations above the mean of 46 for college students (Carter et al., 2005), more than one standard deviation above the mean of 60 for social anxiety patients (Weeks et al.), and almost one standard deviation above the mean of 68 for GAD samples (Meyer et al., 1990). His PSWQ score suggests that he was experiencing excessive worry, which again is consistent with his self-reported worry about career choices and identity issues. Although Jason reported symptoms of social anxiety and worry, he indicated that his social anxiety symptoms were causing the most personal distress by negatively affecting his social functioning. Thus, these symptoms were chosen as the initial target for therapy. Because his worry symptoms also were elevated, despite the fact that he did not appear to meet criteria for GAD upon entering therapy, these symptoms were monitored throughout treatment via the PSWQ to ensure that if he remained symptomatic after completing social anxiety treatment, therapy could shift to address GAD symptoms.

### *Course of Treatment*

Jason attended a total of 50 sessions over the course of 18 months. The initial goals for treatment were to reduce Jason's anxious symptoms using the following protocol: *Managing Social Anxiety: A Cognitive-Behavioral Therapy Approach—Client Workbook* (MSA; Hope, Heimburg, Juster, & Turk, 2000). MSA is a 16-session treatment protocol that incorporates cognitive restructuring techniques and exposure activities into sessions and homework with clients. Treatment with Jason initially focused on identifying situations in which he felt particularly anxious. These included public speaking tasks for class; speaking in large groups, particularly in noisy settings (e.g., bars); and interacting with individuals in positions of authority, including professors, work supervisors, and job interviewers. In addition to developing a hierarchy of anxiety-provoking situations, Jason also began identifying his automatic thoughts in these circumstances. Specifically, during class speeches, he noted the thought that his peers could not hear him because his voice was too soft and high-pitched. He also reported thinking that these vocal characteristics contributed to others believing he was not knowledgeable about his speech topic because he did not present the material with authority. He had similar concerns in noisy group settings, indicating that even when he raised his voice, he believed that he could not be heard or that he sounded strange. Finally, in circumstances involving individuals in positions of authority, he had concerns that he would be perceived as unknowledgeable to professors,

unassertive to work supervisors, and incompetent or unqualified to potential employers or job interviewers.

Using MSA, Jason learned to challenge these thoughts by evaluating evidence in support of and contrary to such thoughts (e.g., he had an excellent grade point average and he had been promoted to a supervisory position at work prior to beginning therapy). Additionally, he learned to identify specific thinking errors (e.g., mind reading, fortune telling) that he tended to utilize and he was encouraged to generate rational responses to such thoughts that he could easily employ in the particular situation. Rational responses included, "I was invited for an interview, therefore, I must be qualified" and "My subordinates mostly do what I request of them, therefore, I must be interacting assertively." Initially, his homework assignments focused on recording automatic thoughts, identifying thinking errors, and generating rational responses in actual situations that he encountered. During Sessions 6–12, however, he was encouraged, both in session and for homework, to engage in exposure activities in which he could practice challenging his thoughts and implementing rational responses. In session, role-plays focused primarily on job interview scenarios. For homework, end-of-semester class speeches and several job interviews fortunately coincided with this stage of treatment. Additionally, Jason was encouraged to spend more time socializing in noisy settings (e.g., going to noisy bars) to practice challenging his thoughts in those situations.

After approximately three assessment sessions and nine CBT for social anxiety sessions, spent primarily learning and applying the CBT model to his specific performance anxiety situations (e.g., delivering class speeches, attending job interviews), Jason's comfort in these situations improved somewhat. Further, during these initial sessions, he gradually appeared to feel more comfortable discussing sexual-identity issues, at which point the case conceptualization shifted. Specifically, as more information emerged about his confusion about his sexual orientation and his concerns about his voice, it became more likely that his presenting concern (i.e., social anxiety) was associated more with his sexual identity struggle than with a general fear of negative evaluation across performance-evaluation situations. For example, he reported that peers had commented on his sexual orientation for years and he had denied being gay; however, he had always worried on some level that they might be correct about him. Additionally, he noted significant anxiety at the idea of "not living up to his potential," indicating that concern about what others might think of him as a sexual minority could lead him to never accepting his sexual orientation for himself and continue living his life feeling unfulfilled.

During Sessions 13–35, the client and therapist explored the importance of forming or developing a sexual identity as well as the personal and social meaning of nurturing a specific sexual identity. Panchankis and Goldfried's (2004) guidelines for conducting therapy with lesbian, gay, and bisexual clients were used to inform the treatment approach at this stage. Specifically, Panchankis and Goldfried suggest that identity development among individuals questioning their sexual orientation often includes the process of "coming out" as well as the types of harassment and discrimination that may be encountered. Consistent with these notions, Jason spent several months pondering his sexual orientation and debating whether a gay or bisexual identity fit with his emotions, values, and lifestyle. Although he wished to explore the topic through discussions of sexual and romantic attraction in



therapy, he did not describe himself as gay for the first 30 sessions of therapy. He attributed his initial hesitance to identify as gay to social pressures to identify as heterosexual. Specifically, he described his parents and extended relatives as socially conservative and while Jason did not personally ascribe to these views, he noted that he felt emotionally conflicted about committing publicly to a same-sex sexual identity because such a commitment had the potential to engender intense disapproval from his family. He was particularly concerned that his family would not accept his identity, perhaps asking him to move out of the house or ceasing to invite him to family events (including holidays). He also was afraid that his parents might feel ashamed of him if they had to tell his extended relatives or their friends that he was gay. Further, he worried that his parents might decide to conceal his sexual orientation from extended family and friends and expect him to do the same, leading him to have to choose between spending holidays with an important significant other and his own family. If this should happen, he was further worried that he would have to continue to conceal his sexual identity to preserve any kind of relationship with his family. Jason also reported some rejection schemas related to attending social events like weddings, where a number of individuals were partnered and often commented on the fact that he did not have a partner. In these instances, guests would often make comments revealing the assumption that he was looking for a female partner (e.g., well-meaning friends would often say, "We need to find a nice girl for you"), and he felt conflicted about disclosing his personal identity struggle versus perpetuating his personal denial of his possible same-sex sexual identity.

Once Jason personally began to identify himself as gay, a significant number of sessions were spent processing the expected reactions of family, friends, and coworkers should he choose to make them aware of his sexual identity. At this stage, many cognitive restructuring skills, such as identifying automatic thoughts, evaluating the evidence for those thoughts, and generating a rational response, were applied. For instance, Jason described seeing two men who were holding hands outside a movie theater in town verbally harassed by a group of men driving by in a truck. Early in the identity exploration process, he expressed concern that he might face a similar situation if he were to commit to a gay sexual identity; however, over the course of therapy, these thoughts were gradually replaced with rational responses such as, "Even if I am verbally harassed by strangers, I know those words are coming from less open-minded individuals and I can cope." He also described concerns his sister reported about his physical safety when she suspected that he might be gay, and the relief she expressed when he denied being gay. Further, during early sessions, one barrier Jason identified to cognitively and emotionally accepting a same-sex sexual orientation also initially related to his concern about his own physical safety. Over the course of therapy, however, these thoughts of physical risk were gradually replaced with, "Although the risk of physical injury is probably low, I would rather risk my physical safety for a moment than risk my personal happiness for the rest of my life."

Several months were spent exploring sexual identity issues through therapy and activities in the community. Specifically, Jason was encouraged to develop a hierarchy of activities he wished to engage in to facilitate more active exploration of his sexual identity. The list ranged from starting a conversation with another man while shopping or having coffee to attending a meeting for supporters of LGB populations to going to gay bars. One of the

identified barriers to engaging in these activities related to the small size of the gay community. Jason knew individuals from high school who were part of this community who had questioned his sexual orientation in the past, and he was concerned about how they might perceive him if they saw him at a gay bar, for example. In sessions, cognitive restructuring techniques were used to challenge these thoughts (e.g., explicating the worst case scenario, the likelihood of it occurring, and a rational response). To gradually expose himself to such anxiety-provoking situations, Jason engaged in activities in a graduated manner, completing those at the bottom of the hierarchy first and moving up through activities at the top of the list. During each session after engaging in an activity, he described his cognitions and emotions during the activity, rated his distress or enjoyment during the activity, and weighed the personal and social benefits and drawbacks of engaging in each activity.

Over time, Jason became more comfortable with the idea that he might be gay and began living his life in a manner consistent with his same-sex sexual identity. Specifically, he began spending more time with members of the gay community and he gradually made a number of close friends in this community. Several sessions were spent processing his adjustment to his sexual identity as well as how, when, and to whom to disclose his sexual identity. Specifically, a number of sessions were devoted to weighing the benefits and drawbacks of disclosing his sexual identity to his work colleagues, close friends, family, and parents. After much deliberation, Jason began "coming out" to family and friends, and much to his surprise, most individuals in his life were overwhelmingly supportive and accepting of his sexual identity disclosure, including his father. Although media portrayals of sexual minority individuals' experiences with coming out are often negative and mostly depict rejection by family and friends, it is actually fairly common for peers and family to react more supportively (Savin-Williams, 2001). Although everyone in his life was not immediately delighted (e.g., his mother indicated that it might take her some time to adjust to his disclosure), Jason surprised himself by responding to her reaction with less distress than he anticipated.

Sessions 36 to 50 were spent discussing Jason's sexual identity in the context of interpersonal and intimate relationships as well as planning for treatment termination. A major focus of this portion of treatment was to aid the client in developing a supportive social network. Through the community activities described above, he had begun to develop friendships and relationships with members of the gay community. However, he also was encouraged to attend gay and lesbian campus organization meetings as well as support group meetings for family and friends of gay and lesbian individuals. The rationale for the later activity was to expose Jason to members of the general community who were active supporters of gay and lesbian individuals.

Beyond focusing on building a supportive social network, Jason's romantic and sexual relationships also were important topics during these sessions. During the course of therapy, Jason had begun his first same-sex romantic relationship. As this was his first intimate relationship with a member of any sex, a number of concerns were discussed, including whether, when, and how to safely engage in sexual activity. Because evidence suggests that social anxiety may decrease condom use due to fear of rejection by one's partner (Hart & Heimberg, 2005), practicing safe sex was discussed. Although Jason had never had a

previous romantic relationship, his partner had been in other openly gay relationships with members of the small gay community for several years prior to meeting Jason. Thus, not only was Jason attempting to integrate himself into a new community, but he also was navigating the novel dynamics of being in an intimate relationship within the new community. He wanted to form his own identity within the gay community, but one of his major links to this community was through his partner, who had a romantic or sexual history with other members of this community. Jason and his partner also experienced some initial difficulties surrounding differences in familial responses. For instance, Jason's partner's parents immediately warmed to Jason while Jason's own parents did not want to meet his partner initially. This was occasionally a source of conflict and frustration for both partners—thus, several sessions were spent reviewing communication strategies and enhancing coping skills to manage frustration.

Finally, stereotypes of same-sex couples (e.g., hypersexuality among gay men) were an important topic of discussion, particularly because Jason was new to the gay community and was less sure of what to expect in relationships. During all sessions, but particularly when discussing stereotypes, it was important for the therapist to remain aware of heterocentric biases that she might unintentionally employ or convey to the client, which is consistent with Pachankis and Goldfried's (2004) recommendations for clinical work with sexual minority individuals. Specifically, she only used language with the client that seemed appropriate and acceptable in the gay community (e.g., the use of the term "same-sex" instead of "homosexual"). Although these considerations likely did not buffer against all possible heterocentric biases, the client seemed to appreciate the efforts the therapist made to be supportive, understanding, and open-minded.

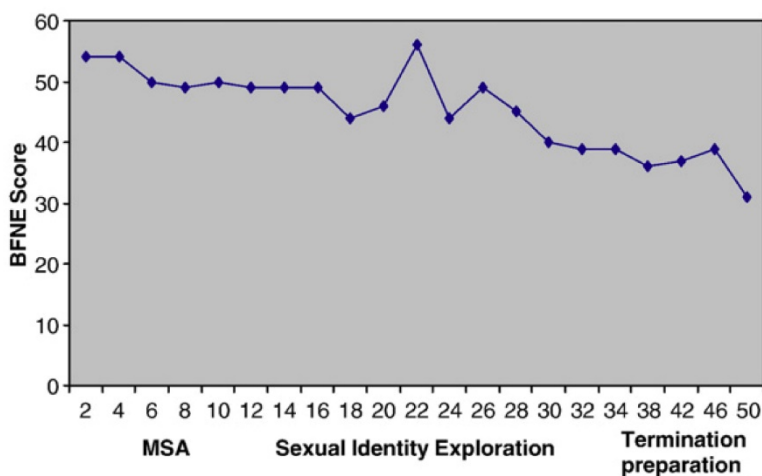
As noted earlier, Pachankis and colleagues (2008) suggest that an important goal of LGB-affirmative therapy is to dismantle rejection-prone schemas among gay men through the provision of positive, corrective experiences with the heterosexual majority. Although the therapist's sexual identity was never an explicit focus of sessions, she disclosed her sexual identity at approximately Session 25 while brainstorming community activities in which to engage. Specifically, the client reported concern that others would perceive him as gay simply for visiting a gay bar. To dispute this automatic thought and encourage the client to expose himself to the situation, the therapist disclosed that she had visited the particular gay bar in question despite the fact that she identified as heterosexual. This disclosure seemed appropriate at the time because the therapist took care to provide a supportive, nonjudgmental environment in which the client could voice his identity struggles without fear of rejection. Further, she had excellent rapport with the client to this point and felt it would be a positive experience for the client to experience a supportive relationship with an identified member of the sexual majority.

Termination plans were discussed approximately 15 months after beginning therapy (beginning in Sessions 44–45); however, the client elected to carry out the process in a graduated manner because his sexual identity development and disclosure engendered a major life change that required him to enter into a number of novel situations (e.g., a new relationship). As such, the final 5 therapy sessions were spaced several weeks apart to allow him to ensure that he had the resources and social support network necessary to cope with stressful circumstances, should they arise.

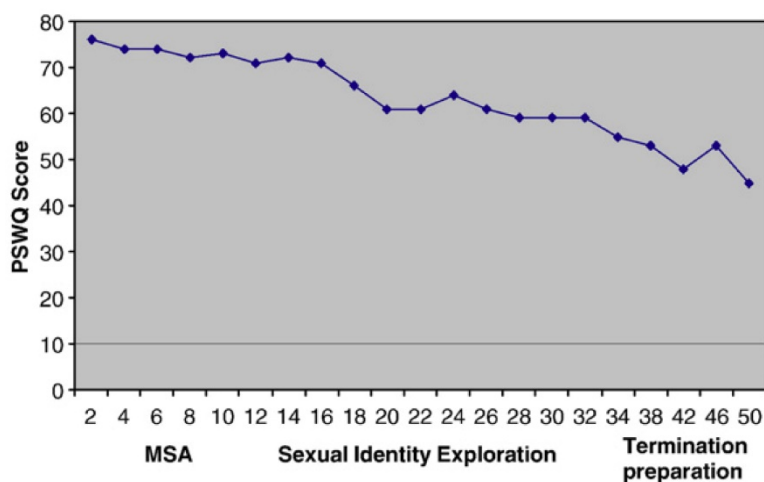
## Results

### *Clinically Significant Changes*

Jason's social anxiety (BFNE) and worry (PSWQ) symptoms declined substantially over the course of therapy (see Figures 1 and 2). After completing the *Managing Social Anxiety* protocol, Jason's BFNE scores had declined from 55 to 45. However, after beginning more identity-focused therapy, his scores declined even more such that by termination, he reported a final BFNE score of 31, which is half a standard deviation below the mean of 35.7 for college students and almost two standard deviations below the mean of 36.9 for socially anxious samples. As can be seen, there was a substantial increase in Jason's BFNE score at Session 22, which occurred prior to formally "coming out," while Jason was still exploring various sexual identities and had yet to commit to a same-sex sexual identity. During that particular session, he reported a first-time sexual experience with a same-sex partner whom he happened to work with. Not only was the experience novel and thus anxiety-provoking, but he reported extreme concern regarding the potential social consequences for him at work should his colleagues become aware of what occurred. There was a moderate increase in Jason's BFNE score at Session 26, which occurred when he began going to gay clubs and bars more frequently, and he started to disclose his sexual orientation to some of his closest friends. Finally, a mild increase in BFNE scores occurred at Session 46, when Jason indicated that he was anxious about terminating therapy. As such, termination was carried out in a graduated fashion. Over the course of treatment, Jason's PSWQ scores also declined from 76 to 45, which is similar to the mean of 46 for college samples and more than two standard deviations below the mean of 68 for GAD samples. This reduction in scores suggests that exploring his sexual identity and committing to a gay sexual identity not only reduced his fear of negative evaluation and interpersonal rejection, but also reduced his general levels of worry.



**Figure 1.** Brief Fear of Negative Evaluation Scores over the Course of Treatment



**Figure 2.** Penn State Worry Questionnaire Scores over the Course of Treatment

### *Statistically Significant Changes*

To more thoroughly examine changes in Jason's BFNE and PSWQ scores, a statistical technique derived from classical test theory for evaluating single-case repeated measures data (Yarnold, 1988) was used to examine changes in BFNE and PSWQ scores (a) from Session 2–12 to examine the effectiveness of the MSA protocol in reducing anxiety symptoms; (b) from Session 14–50 to examine the effectiveness of the identity-focused client-centered treatment; and (c) from Session 2–50 to examine the overall effectiveness of the therapy process. Consistent with prior case studies using this procedure (Mueser, Yarnold, & Foy, 1991), Jason's raw scores were converted to standard ( $z$ ) scores based on population ( $\mu$  and  $\sigma$ ). Because Jason scored within the clinical range on both instruments and was assigned an initial diagnosis of social anxiety disorder, means and standard deviations for socially anxious samples on both measures were used to compute  $z$ -scores [BFNE mean = 46.9 ( $SD = 9.3$ ) and PSWQ mean = 60.1 ( $SD = 13.5$ )].

Jason's BFNE  $z$ -scores for Sessions 2, 12, 14, and 50 were 0.76, 0.23, 0.23, and  $-1.71$ , respectively. Similarly, his PSWQ  $z$ -scores for the same sessions were 1.18, 0.81, 0.88, and  $-1.12$ , respectively. To examine significant differences between scores, critical difference (CD) scores for the BFNE and PSWQ were computed using the following equation:

$$CD = 1.64(J[1 - r(1)])^{1/2}$$

The multiplier 1.64 was selected here because the comparisons are one-tailed. Specifically, fear of negative evaluation and worry scores are expected to decline over the course of treatment. Assuming a test-retest correlation of 0.75 for the BFNE (Leary, 1983), the CD used for BFNE comparisons is 1.64. Assuming a test-retest correlation of 0.93 for the PSWQ (Meyer et al., 1990), the CD used for PSWQ comparisons is 0.13. If the absolute difference between any two comparisons is greater than the CD for that instrument, the decline is considered statistically significant at the  $p < .05$  level.

Comparing Jason's BFNE  $z$ -scores from Session 2 and Session 12, the absolute difference was 0.53, which is less than the critical value of 1.64 and indicates that social anxiety treatment was not effective in reducing Jason's BFNE scores. However, the absolute difference in Jason's BFNE  $z$ -scores from Session 14 to 50 was 1.94, which indicates a significant decline in BFNE scores over the course of the identity-focused therapy. Further, the absolute difference in Jason's BFNE scores from the beginning to end of therapy (Sessions 2–50) was 2.47. Using similar procedures to compare Jason's PSWQ  $z$ -scores from Session 2 and 12, the absolute difference was 0.37, which is greater than the CD of 0.13. This suggests that social anxiety treatment was effective in reducing Jason's worry symptoms. Additionally, the absolute difference in PSWQ  $z$ -scores from Sessions 14 to 50 was 2, which is greater than the CD of 0.13 and also suggests that sexual identity focused treatment was effective in reducing Jason's worry scores. Finally, the absolute difference in Jason's PSWQ scores from Session 2 through session 50 was 2.3, which suggests a statistically significant decline in worry scores over the course of therapy. Although it appears that social anxiety treatment was somewhat more effective in reducing the client's worry rather than his social anxiety symptoms, the strong test-retest reliability of the PSWQ ( $r = .93$ ) relative to the BFNE ( $r = .75$ ) may actually account for these apparent discrepancies. Overall, these analyses suggest that therapy was effective in reducing Jason's social anxiety and worry symptoms. Further, the sexual identity-focused therapy appeared more effective than the social anxiety therapy, although firm conclusions cannot be drawn because the strength of these effects was not directly compared.

### *Subjective Qualitative Changes*

During the termination session, Jason also noted a number of qualitative changes in his functioning that had come about as a result of therapy. First and foremost, although he entered therapy with a large social support network, he indicated that he felt that he was not able to fully rely on it for emotional support at that time because he was uncomfortable relating his identity struggles. However, after coming to understand his same-sex sexual orientation, "coming out" to his friends and family, and living his life in a manner consistent with his sexual identity for several months, he reported finally feeling as though he could be genuine and disclose weaknesses to his friends without fear of rejection. Additionally, he indicated that his friends had made similar comments to him, feeling that when he began disclosing more personal information, they felt they had achieved a new level of emotional intimacy. Whereas he previously had been concerned about how others might perceive his sexual orientation, over the course of therapy, he began to surround himself with individuals who were likely to be more accepting of his sexual identity and he reported less distress at the notion of rejection by heterosexual individuals. Finally, Jason indicated that he believed he had attained the seemingly elusive goal of achieving more self-acceptance, perhaps because he has found a way to integrate his sexual identity and accompanying emotions with his lifestyle and values. Indeed, Pachankis and Goldfried (2004) note that success in the "coming out" process "involves the integration of one's LGB identity into one's overall sense of self" (p. 233).

## Conclusions

The present case study exemplifies a specific application of evidence-based principles to cognitive and behavioral treatment for social anxiety. In this case, the client presented with social anxiety symptoms but the research evidence suggested that the case conceptualization and treatment approach should be shifted to focus more on sexual identity issues. Self-report symptom inventories administered over the course of treatment suggested that his social anxiety and worry symptoms declined with the implementation of CBT, but this decline steepened with the shift to more identity-focused treatment. Further, upon termination, the client reported a number of qualitative changes (e.g., greater utilization of his social support network) that had resulted in his improved quality of life.

This case study is notable for a number of reasons. First, it highlights the importance of consulting the empirical literature to guide both case conceptualization and treatment planning. Second, it elucidates the importance of integrating client characteristics and preferences into therapy. It also highlights the importance of continued research examining how certain client characteristics may impact treatment outcome. Without valuable research evidence and important clinical resources on sexual identity and social anxiety, treatment in the present case may have been limited. In this instance, shifting the case conceptualization to focus more on identity issues meant spending a large number of sessions processing identity issues, which may not always be possible. However, had that shift not been possible, the observed treatment gains likely would not have come about, at least not in the context of therapy.

### *Clinical Implications and Recommendations*

Only in the last decade have researchers begun to note that sexual minority individuals report more symptoms of social anxiety than do heterosexual majority individuals (Pachankis & Goldfried, 2006). However, this finding has important implications for clinical work with sexual minority individuals. In particular, assessing psychopathology, such as social anxiety disorder, is challenging because although symptoms such as concern about the perceptions of others are present, there may be a reasonable basis for these concerns among sexual minority individuals (Herek, 2000). This suggests the importance of considering client characteristics, such as sexual identity, during the assessment phase of therapy to provide an accurate diagnosis and develop an appropriate treatment plan. Although unavailable when treatment began, a self-report measure of sexual identity exploration and commitment was recently published (Worthington et al., 2008) and may be useful in assessing the client's specific stage of sexual identity development. However, as noted by Pachankis and Goldfried (2004), it is equally important that therapists not assume that problems and difficulties are the result of sexual identity issues. This complex issue requires a detailed and thorough functional analysis of presenting symptoms in the context of intrapersonal, interpersonal, and socio-environmental factors.

Another clinical issue that may arise in treating a similar case is the documentation of diagnoses and session material. In the case described above, the initial diagnosis of social anxiety disorder was reconsidered because the client's symptoms appeared to be related

more to his sexual identity struggle than to anxiety in more general performance evaluation domains. As such, this diagnosis was not retained on the termination report. Further, therapists should consider the implications of describing sexual identity issues in medical charts. In the present case, this issue was carefully considered to minimize the possibility of inadvertently “outing” the client if his treatment records were requested from a medical provider or the legal system. She also took care to be generic in terminology (e.g., using the term “identity” rather than “sexual identity”) on homework forms and lists created for brainstorming purposes. This seemed particularly important during earlier sessions when the client was still exploring his sexual identity but in a less open manner. However, in conversations with the client, the therapist also stressed that she was being careful because the decision to “come out” is a personal one and the client should be in control of when, where, and to whom to disclose his sexual identity.

The case described here depicts a rather lengthy course of therapy relative to “typical” CBT (e.g., 16-session MSA). Unfortunately, identity has rarely been considered in intervention studies, despite a general understanding that identity issues impact mental health and well-being (Montgomery, Hernandez, & Ferrer-Wreder, 2008). As such, little is known about the standard length of treatment required to ameliorate anxiety and distress associated with various stages of identity development. In the present case, the nature of the training clinic and fee structure enabled the client and therapist to conduct therapy without a specific session limit. Instead, the client and therapist revisited therapy goals every few months and chose topics and activities in which to engage that were consistent with those goals. In other settings where session numbers or fees are limiting factors, it might be possible to meet less frequently during certain phases of therapy. For example, termination was carried out in a gradual manner in the present case; however, in other cases, it may be possible to reduce the number of sessions required for termination. Qualitative data suggest that the therapeutic alliance, therapists’ positive and accepting attitudes toward client’s sexual orientation or gender, client social support, and confidentiality of the therapy setting are factors that therapists cite as contributing to a therapist’s ability to provide helpful therapy to LGBT clients (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008). These factors were important in the present case as well and thus could be important dynamics for other therapists to consider when working with LGBT populations.

### Note

1. Details, including the name, have been modified to protect the anonymity of the client. In keeping with ethical principles, the client provided written consent for publication of paper.

### References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*, 4th ed. Author: Washington, DC.
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271–285.



- Carter, M. M., Sbrocco, T., Miller, O., Suchday, S., Lewis, E. L., & Freedman, R. E. K. (2005). Factor structure, reliability, and validity of the Penn State Worry Questionnaire: differences between African-American and White-American college students. *Anxiety Disorders, 19*, 827–843.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7–18.
- Derogatis, L. R., & Cleary, P. A. (1977). Confirmation of the dimensional structure of the SCL-90: A study in construct validation. *Journal of Clinical Psychology, 33*, 981–989.
- Hart, T. A., & Heimberg, R. G. (2001). Presenting problems among treatment-seeking gay, lesbian, and bisexual youth. *Session: Journal of Clinical Psychology, 57*. (pp. 615–627).
- Hart, T. A., & Heimberg, R. G. (2005). Social anxiety as a risk factor for unprotected intercourse among gay and bisexual male youth. *AIDS and Behavior, 9*, 505–512.
- Herek, G. M. (2000). Sexual prejudice and gender: Do heterosexuals' attitudes towards lesbians and gay men differ? *Journal of Social Issues, 56*, 251–266.
- Heimberg, R. G., & Barlow, D. H. (1991). New developments in cognitive behavioral therapy for social anxiety. *Journal of Clinical Psychiatry, 52*, 21–30.
- Hope, D. A., Heimburg, R. G., Juster, J. E., & Turk, C. L. (2000). *Managing social anxiety: A cognitive-behavioral therapy approach—Client workbook*. New York: Oxford University Press.
- Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: an exploratory study. *Professional Psychology: Research and Practice, 39*, 361–368.
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 8–19.
- Laumann, E. O., Gagnon, J., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago: University of Chicago Press.
- Leary, M. R. (1983). A brief version of the Fear of Negative Evaluation scale. *Personality and Social Psychology Bulletin, 9*, 371–375.
- Ledley, D. R., Heimberg, R. G., Hope, D. A., Hayes, S. A., Zaider, T. I., Van Dyke, M., et al. (2009). Efficacy of a Manualized and Workbook-Driven Individual Treatment for Social Anxiety Disorder. *Behavior Therapy, 40*(4), 414–424.
- Marcia, J. E. (1966). Development and validation of ego identity status. *Journal of Personality and Social Psychology, 5*, 551–558.
- Meyer, I. H. (2003). Prejudice, social stress and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*, 674–697.
- Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy, 28*, 487–495.
- Montgomery, M. J., Hernandez, L., & Ferrer-Wreder, L. (2008). Identity development and intervention studies: The right time for a marriage? *Identity, 8*, 173–182.
- Mueser, K. T., Yarnold, P. R., & Foy, D. W. (1991). Statistical analysis for single case designs: Evaluating outcome of imaginal exposure treatment of chronic PTSD. *Behavior Modification, 15*, 134–155.
- Pachankis, J. E., & Goldfried, M. R. (2004). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychotherapy: Theory, Research, Training, Practice, 41*, 227–246.
- Pachankis, J. E., & Goldfried, M. R. (2006). Social anxiety in young gay men. *Journal of Anxiety Disorders, 20*, 996–1015.

- Pachankis, J. E., Goldfried, M. R., & Ramratten, M. E. (2008). Extension of the rejection sensitivity construct to the interpersonal functioning of gay men. *Journal of Consulting and Clinical Psychology, 76*, 306–317.
- Potoczniak, D. J., Aldea, M. A., & DeBlare, C. (2007). Ego identity, social anxiety, social support, and self-concealment in lesbian, gay, and bisexual individuals. *Journal of Counseling Psychology, 54*, 447–457.
- Rowen, C. J., & Malcolm, J. P. (2002). Correlates of internalized homophobia and homosexual identity formulation in a sample of gay men. *Journal of Homosexuality, 43*, 77–92.
- Savin-Williams, R. C. (1990). *Gay and lesbian youth: Expressions of identity*. Washington, DC: Hemisphere.
- Savin-Williams, R. C. (2001). *Mom, Dad, I'm Gay. How families negotiate coming out*. Washington, DC: American Psychological Association.
- Watson, D., & Friend, R. (1969). Measurement of social-evaluative anxiety. *Journal of Consulting and Clinical Psychology, 33*, 448–457.
- Weeks, J. W., Heimberg, R. G., Fresco, D. M., Hart, T. A., Turk, C. L., Schneier, F. R., et al. (2005). Empirical validation and psychometric evaluation of the Brief Fear of Negative Evaluation Scale in patients with Social Anxiety Disorder. *Psychological Assessment, 17*, 179–190.
- Worthington, R. L., Navarro, R. L., Savoy, H. B., & Hampton, D. (2008). Development, reliability, and validity of the measure of sexual identity exploration and commitment (MoSIEC). *Developmental Psychology, 44*, 22–33.
- Yarnold, P. R. (1988). Classical test theory methods for repeated-measures  $N = 1$  research designs. *Educational and Psychological Measurement, 48*, 913–919.