Comparative Psychotherapy Outcomes of Sexual Minority Clients and Controls

Sasha A. Mondragon
Brigham Young University
Department of Psychology
7171 Buffalo Speedway, Apt 436
Houston, TX 77025, USA.

Michael J. Lambert
Brigham Young University
Department of Psychology
272 TLRB, Provo, UT 84602, USA.

Stevan L. Nielsen
Brigham Young University
Counseling & Career Center
2528 WSC, Provo UT 84602, USA.

Davey Erikson
Brigham Young University
Department of Psychology
284 TLRB, Provo, UT 84602, USA.

Abstract

Objective: *To examine the mental health functioning and psychotherapy outcomes of clients who express concerns about their same sex attraction compared to a general population of clients and matched controls who do not have these concerns.*

Method: *The pre-treatment mental health functioning of 600 sexual minority clients was compared with that of a randomly selected group matched to the minority group on male/female ratio. The post-treatment mental health functioning of 596 sexual minority clients was also examined and compared to a control group matched on female/male ratio, initial levels of mental health functioning, age, and marital status.*

Results: *Analysis indicated that sexual minority clients who reported experiencing distress regarding their sexual identity/orientation at intake evidenced significantly higher levels of psychological distress than the randomly selected group. Results further indicated no significant differences between sexual minority and control clients in overall mental health functioning post-treatment. Sexual minorities in the sample evidenced treatment gains that were similar to non-sexual minority clients when initial levels of functioning were matched. However, sexual minority females consistently reported experiencing more frequent suicidal thoughts than did clients in the control groups.*

Conclusions: *Sexual minority clients, especially males, can be expected to report the same level of improvement as other clients who undergo psychotherapy. Female sexual minority clients, although making substantial improvement while in treatment, continue to experience high levels of distress, including suicidal ideation and efforts should be made to keep these individuals in treatment longer or recommend follow-up treatment when possible.*

The American Psychological Association Presidential Task Force[APA] (2006) defined evidence-based practice in psychology as the "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273).

Increased attention has been given to the influence of unique patient characteristics and culture on the process of psychotherapy; however, one major criticism of current efficacy and effectiveness research is that participants typically represent the majority population. This limitation results in difficulty generalizing research findings to minority patients. Thus, it is important that conscious and increased efforts continue to be made to include minority groups in psychotherapy outcome research and to understand if treatments are effective for them.

As is the case with most minority groups, sexual minority people[1] (lesbian, gay, bisexual, transgendered, queer and people who question their sexual orientation – commonly referred to as the LGBTQ population) have been and continue to be subjected to persecution, criticism and societal rejection and continue to be an under-researched group in terms of mental health treatment and psychotherapy outcomes (Byrd & Nicolosi, 2002; Cochran, Sullivan, & Mays, 2003; Goldfried, 2001; King et al., 2008; Meyer, 2003). Although a literature base regarding therapeutic outcomes of sexual minority clients does exist, the vast majority of such literature examines the effectiveness of treatments aimed at sexual reorientation, affirmation, or the influence of therapist characteristics/biases on therapy outcomes. Research regarding the effectiveness of general mental health treatment for sexual minority clients using standardized outcome measures is virtually nonexistent.

A large body of evidence suggests that sexual minorities experience an elevated risk of psychopathology in comparison to people who are exclusively heterosexual (Bailey, 1999; Cochran & Mays, 2009; Fergusson, 2005; King et al., 2008). A recent meta-analysis examined psychological symptoms of lesbian, gay, and bisexual (LGB) people in the *general population* and indicated that: (1) the risk of suicide attempts in LGB people was twice that of heterosexual people, (2) gay and bisexual men appeared to have the highest rates of suicide attempts, (3) rates of deliberate self-harm were higher among the LGB sample, (4) LGB people were 1.5 times more likely to meet criteria for anxiety or depression, (5) LGB persons were 1.5 times more likely to meet criteria for substance dependence with lesbian and bisexual women evidencing the greatest risk for substance abuse dependency (King et al., 2008). Additionally, sexual minorities face unique social and societal challenges and multiple research studies have indicated that sexual minority persons experience chronic stress regarding issues related to social stigmatization, social roles, and relationships (Bailey, 1999; D'Augelii, Pilkington, & Hershberger, 2002; DiStefano, 2008; Szymanski & Kashubeck-West, 2008; Ueno, 2005). Several other studies have also noted high rates of suicidal desires, completed suicide, and self-harm (cutting, burning, hitting self, etc.) among sexual minority adults and adolescents identified in the general population (Cochran & Mays, 2009; DiStefano, 2008; Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008; King et al., 2008; Skegg, Shyamala, Dickson, & Williams, 2003; Whitlock, Eckenrode, & Silverman, 2006).

Several models have been proposed to account for the high rates of psychological disturbance in sexual minorities (Cochran, Sullivan, & Mays, 2003; Goldfried, 2001; Mays & Cochran, 2001; Meyer, 2003). Importantly, higher rates of pathology in sexual minority persons relative to those found among the rest of the population does not indicate a *causal* relationship (Cochran, 2001). Although several models of pathology exist, the research in this area has generally been consistent: sexual minority people appear to experience significantly higher rates of psychological distress than do heterosexual people in the general population.

A relatively recent meta-analysis was conducted in an attempt to better understand treatment outcomes for sexual minority clients. After a review of studies published between 1966 and 2006, King et al. (2007) reported that only 22 papers met criteria for the meta-analytic review. The studies included in the meta-analysis examined a variety of variables that influence treatment outcomes (therapist characteristics, preferences regarding therapist characteristics, influence of therapist sexual orientation and gender, etc.); however, none of the studies investigated whether sexual minority clients experienced positive psychotherapy outcomes by utilizing standardized measures. King et al. (2007) concluded that of the 22 papers, "there were no trials evaluating the effectiveness of psychological interventions in LGBT people" (p. 2). Furthermore, King and colleagues (2007) reported, "None of the studies reviewed measured mental health outcomes using validated psychometric measures" (p. 3). The authors called for an examination of treatment effectiveness among sexual minority clients using valid psychometric measurements and quantitative methods.

[1] The term *sexual minority* is used consistently throughout this study in order to reflect the understanding that lesbian, gay, bisexual, transsexual, queer, and those questioning their sexual orientation are minorities in terms of sexual attraction. Additionally, the term *minority* reflects the concept that a population has experienced some social consequences or hardships as a result of non-majority status (see APA, 2009).

Additionally, a comprehensive literature review completed for the purpose of the current study did not yield any research regarding the effectiveness of psychological treatment among sexual minority clients in a typical outpatient treatment setting that did not focus on some mode of reparative or affirmative therapy.

In 2009, the *Journal of Counseling Psychology* (JCP) published a special issue titled, "Advances in Research with Sexual Minority People." The special issue contained a total of 17 articles with only one article that examined an aspect of psychotherapy (Mallinckrodt, 2009). That study examined therapist and doctoral trainee case conceptualizations of simulated sexual minority and heterosexual clients and then used qualitative methods to analyze supportive and non-supportive themes within the conceptualizations of the mental health professionals (Mallinckrodt, 2009). The articles that were included in the JCP special issue examined important issues, but evidence of a comparison study which examined psychotherapy outcomes of sexual minority clients in comparison to heterosexual clients could not be found.

Importantly, research findings regarding sexual minority patients appear to focus heavily on moral debates and issues of the effectiveness of re-orientation therapies rather than on general treatment outcomes. The intensive focus of this debate appears to detract from the development of a strong evidence base regarding general psychotherapy outcomes for sexual minority clients.

Given the elevated risk of psychopathology among sexual minorities in the general population and the increased focus on multicultural and diversity issues in the mental health field, it is surprising that such little recent research has been conducted regarding the psychotherapy outcomes of sexual minority clients. Whatever the reasons may be for the dearth of published studies, there is a clear need for an examination of the question proposed here: Does the psychological distress and symptomatology of sexual minority clients decrease at a rate similar to that of non-sexual minority clients after completing psychotherapy? This question is a vital one to ask if mental health professionals intend to ethically and effectively treat sexual minority clients.

Thus, the purpose of the current study was to address how sexual minorities faired in psychotherapy in comparison to a general treatment population with regards to their mental health functioning before and after treatment. The focus of the current study was to examine psychotherapy outcomes and changes in mental health functioning (i.e., symptomatology of depression, and anxiety, interpersonal difficulties, and social role functioning), not changes in sexual orientation or sexual arousal patterns. This focus on general psychotherapy outcomes provides useful information regarding the helpfulness of psychotherapy to sexual minority clients seen in a routine clinical setting. This research is a necessary step in order for clinicians to integrate clinically relevant research with clinical expertise regarding "patient characteristics, culture, and preferences" as recommended by the APA Task Force (2006, p. 273).

The following research questions were examined: (1) Will clients identified as sexual minorities report higher levels of psychological distress in comparison to "typical" *client* control groups (matched on gender only) at intake? (2) Will identified sexual minority clients report higher levels of suicidal ideation in comparison to typical client control groups and "matched control" groups (matched on gender, age, initial level of psychological disturbance, and marital status) at intake? (3) Will the psychotherapy outcomes of identified sexual minority clients differ from clients in matched control groups? (4) Will clients identified as sexual minorities report higher levels of suicidal ideation in comparison to typical client control groups and matched control groups post-treatment?

Method

Setting and Participants

Participants consisted of students at a large, western University who received mental health services for personal concerns at a student counseling and career center (CCC). Therapy at the CCC was offered to full-time university students free of charge with no limit on the number of therapy sessions clients could receive. The data for the study was drawn from a large archival database maintained by the CCC and consisted of clients who were at least 18 years of age, completed a minimum of two therapy sessions (so that differences in pre- and post-treatment functioning could be calculated), and participated in therapy at some point between 2004 and 2009. The archival database consisted of 9924 clients (41% male, 59% female).

After reviewing the archival database, 600 clients were identified as sexual minorities (76% male; 24% female; see Procedures), 600 clients (76% male; 24% female) were selected for the typical control group (matched to sexual minority clients on gender but otherwise randomly selected), and the matched control group consisted of 596 clients (76% male; 24% female; matched to sexual minorities on gender, initial distress level, marital status, and age). Thus, a total of 1796 participants (76% male; 24% female) were included in the current study.

The sexual minority group (and thus the matched control group) was made up of more single clients than the typical client group. Specifically, 83.5% of the sexual minority group was single while only 54.2% of the typical client group was single. The average age of the participants was comparable across groups and ranged from 20 to 24 years old: an age range typical of a college sample. A summary of participant ethnicity and religious affiliation is presented in Table 1. The information reported is based upon client self-reports of their predominant ethnicity/racial group and religious affiliation at intake. Slightly higher rates of ethnic/racial diversity were observed in the sexual minority group in comparison to the control groups. Almost all participants in each group reported membership to a Christian religion.

Patients treated at the CCC evidence a large variation in problems and symptoms, ranging from home-sickness and adjustment disorders to personality disorders. Clients in the current study were referred or self-referred for personal and emotional concerns rather than for academic or career counseling. Clients were included in the study without regard to the nature of their presenting problem (i.e. no exclusions based upon diagnostic criterion/presenting problem and sexual minority clients included in the study were not necessarily seeking treatment for difficulties related to sexual minority status). Among all participants, the most common diagnoses included Anxiety Disorders, Depressive Disorders, Adjustment Disorders, and problems with interpersonal relationships (V Codes).

Therapist variables were examined and included level of training (pre-internship, internship and post-internship), type of training (clinical psychology, counseling psychology, social work, marriage and family therapy), sex (male, female), and primary theoretical orientation (cognitive-behavioral, behavioral, humanistic, psychodynamic). The modal therapist was a male, licensed, counseling psychology Ph.D., who identified their primary theoretical orientation as cognitive-behavioral.

Every client examined via the archival database signed a consent form when they began treatment at the CCC, giving the CCC permission to use their information for research purposes aimed at improving services. All participant information was de-identified and treated as strictly confidential. The study was approved through the CCC Research Team and University IRB.

Procedures

Identification of sexual minority clients. In an attempt to identify sexual minority clients as accurately as possible, two methods were used: (1) a self-report questionnaire and (2) therapy note coding procedures. All clients seen at the CCC were asked to complete the Presenting Problems Checklist (PPC) as a part of routine intake procedures prior to beginning treatment. One question on the PPC required clients to indicate whether they experienced distress related to sexual identity/orientation and clients who endorsed the item were included in the study. Although the PPC provided some indication of minority status, it was recognized that the item offered only a limited assessment (since many sexual minority persons do not experience distress related to their sexual minority status). Furthermore, some research has indicated that sexual minority people may not disclose concerns regarding their sexual orientation on questionnaires (King et al., 2008). Thus, therapy notes were coded in order to identify a larger sample of sexual minority clients.

A three-step procedure was employed in order to code therapy notes. First, in order to identify applicable case notes, seventeen therapists employed at the CCC were asked to identify words, terms, phrases, and/or abbreviations they would be most likely to use in their psychotherapy case notes when describing sexual minority clients. These words were then used to search case notes in hopes of identifying a sample of sexual minority clients. All psychotherapy notes recorded between 2004 and 2009 were searched using the key words. A total of 226,910 notes were searched using the key words and of those 3558 (1.6%) contained at least one key word. Coding was conducted by two doctoral students in a clinical psychology program and one full-time clinical psychology department faculty member who is also a licensed psychologist.

Therapy notes were deemed applicable to the study if the note contained information regarding the client's sexual minority status (rather than the client describing another person's sexual minority status or discussing other topics related to sexual minority status). Of the 3558 notes identified through the key word search, 687 (19%) of the notes were deemed applicable to the current study through the coding procedures. A total of 422 participants (364 male; 58 female) were identified as sexual minorities through the note coding procedures and were included in analyses.

All three coders participated in group training and group consensus coding procedures in order to establish inter-rater reliability. Coders were expected to reach an inter-rater reliability of .80 before coding notes independently. Fleiss' kappa was used to assess the reliability of agreement between all three raters (Fleiss, 1971; Gwet, 2008). After participating in training regarding coding procedures, all three coders rated 45 therapy notes independently and n inter-rater reliability (*k*) of .86 was established. The agreement was considered adequate reliability.

Sexual Minority Groups and Control Groups

Two sexual minority groups were evaluated (see Table 2 for a summary of group descriptions). Group 1 consisted of all clients who endorsed sexual orientation/gender identity concerns on the Personal Problems Checklist (PPC) pre-treatment. Group 2 consisted of all clients whose notes were deemed applicable through the note coding procedures. Some clients endorsed the PPC item and were also identified through therapy notes, hence overlap exists between clients in Groups 1 and 2 (i.e. if a client was identified through the PPC item, they could also have been identified through their therapy notes). Groups were divided in this manner because it was assumed that sexual minorities who endorsed distress related to their identity or sexual orientation may be different than clients who did not endorse distress on the PPC. Each sexual minority group was also split into male and female subgroups.

Clients in the typical client groups were matched to sexual minority clients on gender only and were otherwise randomly selected from the larger archival database. Since typical control clients were matched to sexual minorities by gender only, their initial level of disturbance, age, and marital status were free to vary. This allowed for an examination of psychological functioning at intake (as measured by initial OQ-45 scores), age, and marital status which was thought to represent that of typical clients seen at the CCC. This group was considered to be reflective of a typical random sample of clients at the CCC on all variables other than male/female ratio.

Clients in matched control groups were matched to sexual minorities as closely as possible on gender (male, female), marital status (single, married, divorced), age (within 12 months), and initial distress level at the first session of therapy (within 5 points of the total OQ-45 score). Given the large archival database, only four sexual minority patients could not be yoked to a matched control client. The sexual minority clients that were not matched were outliers in the database (for example, an 18 year-old divorced male with an initial OQ score of 92 could not be matched to a control). Thus, the matched control group consisted of 596 clients. In the case that multiple clients matched to a sexual minority client, random assignment was utilized to select one matched control. The archival database did not contain information regarding 0.8% (n = 5) of identified sexual minority clients' marital status. Four of the five sexual minority clients were matched to single control clients while one of the sexual minority clients was matched to a married control client (the married control client was the only option available in which the initial OQ score could be matched). Clients included in the control groups did not endorse the PPC item and their therapy notes did not contain any indication of sexual minority status. Thus, it was assumed that any differences in treatment outcome between sexual minority groups and control groups would not be due to differences in pre-treatment levels of disturbance or age, gender, and/or marital status.

Measures

The Outcome Questionnaire 45 (OQ-45). Client distress and progress was evaluated using the Outcome Questionnaire (OQ-45; Lambert et al., 2004), a 45-item self-report measure developed for tracking and assessing client outcomes during counseling and psychotherapy. Clients were asked to complete the OQ-45 at each appointment, including intake. The OQ-45 has been validated across a broad range of normal and client populations. Lambert and colleagues (2004) reported an internal consistency of .93 and a 3-week test–retest reliability of .84, values similar to consistency and reliability indexes for other widely used outcome measures. Concurrent validity indexes (*r*s) with the Symptom Checklist-90 (Derogatis, 1997), Beck Depression Inventory (Beck, Steer, & Garbin, 1988), Zung Depression Scale (Zung, 1965), and the State-Trait Anxiety Inventory (Spielberger, 1983) range from .50 to .85. Most importantly, the OQ-45 has demonstrated sensitivity to changes in client functioning during psychotherapy (Vermeersch, Lambert, & Burlingame, 2000; Vermeersch et al., 2004).

OQ items are scored on a 5-point scale (0, *never*, 1, *rarely*, 2, *sometimes*, 3, *frequently*, 4, *almost always*), which yields a total score from 0 to 180. High scores indicate more distress; as clients improve, scores decrease. Although not used in this study, the OQ has three subscales that measure quality of interpersonal relations, social role functioning, and symptom distress.

Lambert and colleagues (2004) reported indexes for assessing the clinical significance of change in OQ scores (see Jacobson & Truax, 1991): The statistical midpoint between OQ-45 scores in clinical and in non-clinical standardization samples is 63.44. When the average of a group's OQ-45 scores decrease from greater than to less than 63.44, the group can be said to have satisfied one of two criteria for clinically significant recovery. Clients whose OQ-45 scores improve or deteriorate by the reliable change index (RCI) of 14 or more points have made a reliable change. To be considered recovered, clients need to enter the ranks of normal functioning and evidence a decrease of at least 14 points in their OQ-45 score. A negative change (increase in score) of 14 or more points combined with a score that falls in the clinical range of functioning at post-treatment is considered deteriorated. Clients who evidence changes of less than 14 points in either direction are considered unchanged. Support for the validity of the OQ's RCI and clinical significance statistical midpoint cutoff score has been reported by Lunnen and Ogles (1998) and by Bauer, Lambert, and Nielsen (2004).

The general OQ-45 directions instruct clients answer questions according to how they felt during the previous week. Item #8 on the OQ reads, "I have thoughts of ending my life" and was used in order to evaluate suicidal ideation of participants pre- and post-treatment. This single item was scored using the 5-point Likert scale mentioned above (0, *never;* 1, *rarely;* 2, *sometimes;* 3, *frequently;* 4, *almost always*).

Presenting Problems Checklist (PPC). The Presenting Problems Checklist (PPC) is a 42-item self-report questionnaire which itemizes self-reported distress related to various problems or concerns. The PPC was developed by the Research Consortium in order to simplify and speed up intake procedures by identifying client concerns within a college population using one comprehensive questionnaire and it is a commonly-used measure in college counseling centers (Draper, Jennings, & Barón, 2003).

The PPC instructions read, "Indicate the extent to which the problem is currently causing you distress. If a situation is not causing distress, leave the item blank." Five response options are available (none, a little bit, moderate, quite a bit, extreme). The PPC item #33 was used in the current study in order to identify sexual minority clients. Item #33 reads, "Sexual identity or orientation issues." Any endorsement of distress on the PPC (1-4) other than none (0) was used to identity sexual minority clients. This very broad definition of sexual minority status resulted in a larger sample size but obviously limited the people included in the PPC groups to those who reported feeling distressed by same sex attractions or gender identity, without grouping participants based on the degree to which they experience distress.

Results

One-way ANOVAs were conducted in order to determine if significant differences existed between the minority groups and their corresponding control groups pre- and post-treatment. The variables examined included the pre-treatment OQ-45 total score, pre-treatment OQ-45 suicidal item score, OQ-45 change score, post-treatment OQ-45 total score, and post-treatment OQ-45 suicidal item score. In addition, effect sizes were calculated in order to examine the magnitude of differences between the minority groups and control groups Chi square analyses were also conducted in order to compare the frequency of reported suicidal thoughts among sexual minorities, typical control groups, and matched control groups.

Research Question 1. Do identified sexual minority clients report higher levels of psychological distress in comparison to typical client control groups (matched on gender only) at intake? Male patients who were identified as sexual minority clients were compared to typical control clients on initial levels of distress (see Table 3). When all sexual minority males were combined, a significant difference was observed between their initial levels of functioning and that of typical client controls, $F(1, 912) = 6.26$, $p = .01$, indicating that sexual minorities reported significantly higher levels of distress pre-treatment than did a random client sample. Further analyses were conducted in order to examine whether differences existed according the specified groups. Males who were identified as sexual minorities through the PPC item (Group 1) did evidence overall distress levels that were significantly higher than males chosen from the archival database at random (typical client controls), $F(1, 424) = 4.54$, $p = .03$.

However, sexual minority males identified through note coding procedures (Group 2) did not evidence significantly higher distress levels than males in the typical client group, $F(1, 726) = 3.12$, $p = .08$. Of the sexual minority male clients, 61.1% ($n = 279$) entered treatment with a total OQ score that fell within the clinical range of functioning. In comparison, 54% ($n = 247$) of males in the typical client group entered treatment with an OQ-45 score that fell in the clinical range.

Females identified as sexual minority clients were also compared to typical control clients on initial levels of distress (see Table 4). Results indicated that female sexual minorities reported significantly higher levels of distress pre-treatment in comparison to clients in the typical control group, $F(1, 284) = 5.09$, $p = .03$. Furthermore, female clients identified as sexual minorities through the PPC item experienced significantly higher levels of distress pre-treatment than did female clients in the typical control group, $F(1, 202) = 6.78$, $p = .01$. However, sexual minority females identified through note coding procedures alone did not report significantly different levels of distress than did the typical client controls, $F(1, 114) = 0.24$, $p = .63$.

The mean pre-treatment OQ-45 scores for all female client groups fell above the clinical cutoff score of 63.44, indicating that the average female client at the CCC (regardless of sexual minority status) enters therapy with a distress level similar to that of others who enter treatment (i.e., scores of 63.44 or greater on the OQ-45 indicate a distress level similar to people in a clinical sample rather than a non-clinical sample). Of the sexual minority female clients, 74.8% ($n = 107$) entered treatment with a total OQ-45 score that fell within the clinical range of functioning while 62.2% ($n = 89$) of females in the typical client group entered treatment with an OQ-45 score that fell in the clinical range. As noted in Table 4, the females in these samples entered treatment between the 90th and 96th percentile.

When the sexual minority groups 1 and 2 were combined, sexual minorities reported higher levels of symptom distress than did a random sample of clients. Additionally, sexual minorities who reported being distressed about their sexual orientation or sexual identity at intake (i.e. males and females identified by the PPC item) reported significantly higher levels of overall distress than did the random sample of clients. Sexual minority patients who were identified through therapy notes did not evidence more distress than a typical patient sample.

Research Question 2. Do clients identified as sexual minorities report higher levels of suicidal ideation in comparison to typical client control groups and matched control groups at intake? Suicidal ideation was examined pre-treatment using Item #8 of the OQ-45. The frequency of suicidal thoughts among male sexual minority male clients, typical control clients, and matched control clients was not significantly different χ^2 ($2, N = 1369$) $= 4.00$, $p = .14$. However, 7.7% ($n = 35$) of sexual minority males noted "frequently" experiencing such thoughts over the last week, while half as many (3.1%; $n = 14$) of the typical client group reported frequent experiences of suicidal ideation and 5.3% ($n = 24$) of the matched controls reported the same. Finally, 1.8% ($n = 8$) of male sexual minorities reported they "almost always" considered suicide as did 1.1% ($n = 5$) of the typical clients and 1.1% ($n = 5$) of the matched control clients.

Results of an ANOVA comparing sexual minority males with the typical client control group indicated that sexual minority males identified through the PPC item did not report significantly different levels of suicidal ideation than did typical control group clients $F(1, 424) = 1.77$, $p = .18$. However, male sexual minorities who were identified through note coding procedures did report significantly more frequent suicidal ideation (during the week prior completing the OQ-45) pre-treatment than did males in the typical client group $F(1, 726) = 4.50$, $p = .03$.

A significant difference was found regarding the frequency of suicidal thoughts among the female groups χ^2 ($2, N = 427$) $= 6.17$, $p = .05$, with sexual minority females reporting more frequent suicidal thoughts in comparison to the control groups at pre-treatment. A greater percentage of minority clients reported they "sometimes" experienced suicidal thoughts (21.7%; $n = 31$) in comparison to the typical control clients (12.6%; $n = 18$) and the matched control clients (16.3%; $n = 23$). Furthermore, 8.4% ($n = 12$) of sexual minority females noted "frequently" experiencing such thoughts, while only 3.5% ($n = 5$) of the typical client group and 4.3% ($n = 6$) of the matched control group reported frequent experiences of suicidal ideation over the week preceding their first session. Results of an ANOVA comparing the sexual minority group with the typical client control group indicated that sexual minority females who were identified through the PPC item reported significantly higher levels of suicidal ideation pre-treatment than did females who were randomly selected, $F(1, 202) = 15.39$, $p = .001$. A medium effect size of .55 was calculated between these two groups.

A comparison of sexual minority females who were identified through psychotherapy notes and typical control females yielded no significant differences in suicidal ideation pre-treatment, $F(1, 114) = .38$, $p = .54$.

Female sexual minorities reported that they experienced more frequent suicidal thoughts than did the typical client or matched control groups. Specifically, sexual minority females who were identified through the PPC item reported thinking of suicide with higher frequency (i.e. a greater percentage of participants endorsed experiencing suicidal thoughts sometimes, frequently, and almost always) than randomly selected female clients. Furthermore, these differences were statistically significant. It is clinically relevant that sexual minority females who endorsed the PPC item at intake reported more frequent thoughts of suicide than did a group of clients who were randomly selected. It appears that sexual minority females also think of suicide somewhat more frequently (sometimes and frequently) than other females who enter treatment with similar levels of distress.

Research Question 3. Do the psychotherapy outcomes of identified sexual minority clients differ from clients in matched control groups (matched on gender, age, initial level of psychological disturbance, and marital status)? Table 5 presents the comparison of post-treatment OQ-45 scores for male sexual minority clients as well as the matched control clients, along with *F, p,* T-Score and *d* values. When male sexual minorities were compared with typical client controls, no significant differences in post-treatment functioning were observed, $F(1, 908) = .03$, $p = .86$. The treatment outcomes of sexual minority male clients are comparable to the treatment outcomes of other male clients who enter treatment with similar levels of distress/mental health functioning. Furthermore, it is notable that all post-treatment group means (sexual minorities as well as matched controls) fell below the OQ-45 clinical cutoff of 63.44 (range 59.76 – 63.20). This indicates that the average male ended treatment with distress levels and mental health functioning comparable to that of the general population (sub-clinical range).

The comparisons of post-treatment OQ-45 scores for female sexual minority clients as well as the matched control clients, along with F, *p*, T-Score, and *d* values are presented in Table 6. When female sexual minorities were compared with typical client controls, no significant differences in post-treatment functioning were observed, $F(1, 280) = .71$, $p = .40$. These results replicate the findings regarding the male groups: Sexual minority females did not report greater levels of distress post-treatment than clients in matched control groups. Sexual minority clients appear to benefit from therapy as much as other clients who enter treatment with similar levels of distress/mental health functioning. However, unlike the male clients examined in the study, the average post-treatment distress levels of the female groups examined (sexual minorities as well as matched controls) fell above the OQ-45 clinical cutoff of 63.44 (range 64.50 – 72.85). This indicates that the average female in the sample ended treatment with distress levels comparable to that of a clinical population rather than the general population. All groups were at least a standard deviation away from the mean of the non-patient sample and ended treatment in the 84^{th} to 92^{nd} percentile.

Sexual minority clients and clients in the matched control group experienced similar rates of change in terms of meeting criteria for recovery, improvement, deterioration, and no change as measured by the OQ-45. The typical client group evidenced similar rates of recovery, slightly higher rates of no change, as well as less improvement and less deterioration than the other groups. Matched control clients (who began treatment with distress levels matched to the sexual minority clients) experienced post-treatment improvement and deterioration similarly to sexual minority clients.

Research Question 4. Do clients identified as sexual minorities report higher levels of suicidal ideation in comparison to typical client control groups and matched control groups post-treatment? The frequency of suicidal thoughts among the male sexual minority, typical control client, and matched control client groups did not differ significantly at post-treatment, χ^2 $(2, N = 1369) = 5.01$, $p = .08$. Sexual minority males reported similar frequencies of suicidal ideation post-treatment as the typical client and matched control groups. However, results of an ANOVA indicated that sexual minority males in Group 1 reported significantly more frequent thoughts of suicide in comparison to the typical client control group post-treatment, $F(1, 424) = 5.66$, $p = .02$. Similarly, sexual minority males in Group 2 reported significantly higher rates of suicidal ideation than typical control clients, $F(1, 726) = 4.78$, $p = .03$.

The frequency of suicidal ideation among females post-treatment was also examined. Results of a chi square indicated that a significant difference in the reported frequency of suicidal thoughts existed between the female groups post-treatment χ^2 $(2, N = 427) = 8.07$, $p = .02$.

It appears that 56.6% (n = 81) of sexual minority females reported that they "never" experienced suicidal thoughts during the week the OQ-45 was administered, a much larger percentage (78.3%; n = 112) of clients in the typical client group (matched by gender only) reported never experiencing suicidal thoughts as did 72.3% (n = 102) of matched control clients. Additionally, 23.8% (n = 34) of minority females reported experiencing suicidal thoughts "rarely" while only 14% (n = 20) of the typical female clients and 18.4% (n = 26) of matched control clients reported the same. Minority clients reported they "sometimes" experienced suicidal ideation at a rate of more than double that of the typical control and matched control clients (13.3%; n = 19; 6.3%; n = 9; 5.0%, n = 7). Furthermore, 5.6% (n = 8) of sexual minority females noted "frequently" experiencing suicidal thoughts while only 0.7% (n = 1) of the typical client group reported frequent experiences of suicidal ideation over the week preceding their final therapy session. The sexual minority females and matched controls were similar in this category, with 4.3% (n = 6) of the matched controls also reported frequent experiences of suicidal thoughts post-treatment. Finally, 0.7% (n = 1) of female sexual minorities and female typical clients reported they "almost always" experienced suicidal thoughts at the end of treatment while none of the clients in the matched control group reported such frequent thoughts of suicide.

Results of an ANOVA indicated that sexual minority females who were identified through the PPC item reported significantly higher levels of suicidal ideation than did the typical client group post-treatment, $F(1, 202) = 18.66$, $p = .001$. The effect size of the female PPC identified group and typical control group was .60 indicating a large difference between the groups. Sexual minority females in Group 2 did not report significantly different frequencies of suicidal thoughts, $F(1, 114) = 1.30$, $p = .26$. Differences between sexual minority females and typical control clients were evident when the frequencies of suicidal ideation were observed through percentiles, with sexual minority females reporting more frequent experiences of suicidal ideation.

Discussion

Although in recent years a push for an increased understanding of multicultural sensitivity and diversity research has occurred within the field of psychology, no published studies could be identified that examined the psychotherapy outcomes of sexual minority clients in a usual care setting, utilizing a standardized measurement of mental health. The current study was conducted in order to examine how sexual minority clients faired in routine treatment in comparison to control groups. Previous research has indicated that sexual minorities experience significantly higher levels of distress and psychopathology than the general population but the current study did not investigate these differences. Instead, comparisons were made between groups of patients who participated in routine clinical treatment.

Results indicated that sexual minority clients (males and females) who reported distress regarding sexual identity/orientation (Group 1) pre-treatment also endorsed significantly higher levels of overall psychological disturbance on the OQ-45 in comparison to a random sample of clients matched on gender only. Males who endorsed the PPC item entered treatment at the 90th percentile of the non-patient population while females who endorsed the PPC item entered treatment at the 96th percentile of the non-patient population. Although the differences reported met the criterion for statistical significance (Males: $p = .03$; Females: $p = .01$) they were not dramatic and likely do not represent extreme differences in clinical presentation. For example, the average minority male in Group 1 (n = 213) was at the 90th percentile of the non-patient population while the average patient in the typical client control group (n = 213) was at the 86th percentile. Similarly, the average minority female in Group 1(n = 102) was at the 96th percentile of the non-patient population and the average female in the typical client group (n = 102) was at the 90th percentile.

These results suggest the need for therapists to be somewhat more concerned about males and females who report discomfort with sexual identity or sexual orientation when they begin treatment. Future research will be needed to highlight the degree to which higher scores within sexual minority groups can be attributed to *specific types of complaints*, as measured by the types of items included in scales such as the OQ-45. For example, to what extent do sexual minorities experience problems with isolation, loneliness, and difficulties in interpersonal relations (as might be expected given experiences of social prejudice and internalized stigma)? Importantly, sexual minority clients who did *not* report confusion or distress regarding their sexual minority status (the case-note sample) at intake did not evidence significantly different levels of psychological distress than randomly selected clients.

A single item from the OQ-45 was examined across groups in this study and evaluated the frequency of suicidal ideation.

Sexual minority males who were identified through note coding procedures as well as sexual minority females who were identified through the PPC item reported significantly more frequent suicidal thoughts than did clients in typical control groups pre-treatment. Despite the higher level of suicidal ideation found in some statistical comparisons, mean differences had questionable clinical significance (with the modal descriptions falling between "never" and "rarely"). It is recommended that clinicians evaluate suicide potential on a case-by-case basis given that the results of this study provide some indication that suicidal ideation is not, on average, a unique concern for sexual minorities pre-treatment.

A major purpose of this study was to examine the degree to which sexual minority clients benefited from psychotherapy in relation to appropriate control groups. Sexual minority clients were matched to control clients on gender, age, initial distress level, and marital status. No statistically significant differences between sexual minority groups (however defined) and matched control groups were observed in terms of treatment benefit. No significant differences were found between the groups, indicating that sexual minority clients reported changing over the course of therapy similarly to other clients who entered treatment with the same distress levels. These findings provide further evidence that sexual minority clients benefit from treatment as much as heterosexual clients.

With regard to clinically significant change, 29.5% percent of sexual minority clients left treatment as "recovered" or "improved" according to the Jacobson and Truax, (1991) formula. Similarly, 29% of matched control group clients had the same outcome. Deterioration rates were also similar across groups (sexual minority clients = 10.5%; controls = 9.7%) as were rates of no change (sexual minority clients = 59.9%; controls = 61.2%). Although the sexual minority and matched control groups evidenced similar rates of recovery, improvement, deterioration, and no change, the typical client group evidenced slightly different rates of improvement, deterioration, and no change. These findings are consistent with previous research that has indicated patients with higher levels of pre-treatment distress experience increased rates of deterioration (Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001). That is, although rates of deterioration were slightly higher in the sexual minority group than the typical client group, these are most likely related to initial distress levels rather than to sexual minority status (given that the matched control groups evidenced similar deterioration rates). This distinction is important: Without a control group matched to initial distress levels, it may appear that sexual minority clients deteriorate or fair worse in treatment compared to a random sample. However, the rates of the sexual minority group and matched control group are parallel and again indicate that higher pre-treatment distress levels are a confounding factor. Furthermore, the rates of change found in this study are similar to rates found in other routine care settings (Hansen, Lambert & Forman 2002).

Given the social stigma and discrimination that sexual minority clients face coupled with reports that some sexual minority clients have experienced harm during the course of interventions, the finding that sexual minority clients fair as well as heterosexual clients in treatment is a significant contribution to the literature. For those who have been concerned with negative outcomes of sexual minority clients, these results can provide some relief as to the helpfulness of routine clinical care. Furthermore, the sample consisted of a majority of clients (over 95%) who reported affiliation with a Christian religion. While religious affiliation may have influenced client self-perceptions of sexual minority status and identity, outcome data indicates that sexual minority clients (even those who belong to traditional Christian religions) experienced as much benefit from routine treatment as did other clients.

Furthermore, if an assumption is made that sexual minority status is a relatively consistent experience for people over time (i.e., although the degree of attraction may fluctuate over time, a sexual minority orientation will likely remain consistent in one's life), it may be expected that sexual minority clients who begin treatment with higher levels of distress would not experience therapeutic benefit to the same degree as other clients. That is, if sexual orientation is a cause for increased distress levels and sexual orientation remains unaltered, an assumption could be made that distress levels will also remain unaltered. However, the results of the current study suggest a contrary perspective. Focused treatment regarding important aspects of functioning (client self-acceptance, social support, identity development) appear to have been helpful to sexual minority clients; however, the current study was not able to evaluate these specific factors. Thus, it is recommended that future research examine the extent to which specific therapeutic factors (found in routine clinical care settings) influence outcomes of sexual minority clients.

Finally, results indicated that sexual minority males reported significantly more frequent thoughts of suicidal than did clients in the typical client control groups post-treatment. The average scores did decrease at post-treatment in comparison to pre-treatment; however, the scores did not decrease as the scores of males in the typical control group. While the average scores were all below 1 ("never"), the results do indicate that sexual minority males experience more frequent thoughts of suicide than typical control clients. As noted above, it is necessary for clinicians to attend to suicidal ideation in all clients at pre-treatment as well as throughout the course of treatment. Sexual minority females who were identified through the PPC item also reported significantly higher levels of suicidal thoughts post-treatment in comparison to the typical client group. Despite improving in treatment, sexual minority females identified by the PPC item continued to report the most frequent experiences of suicidal thoughts (M = .78). This may be evidence of the lasting and ongoing effects of stigma associated with sexual minority status and the need to extend treatment length for sexual minority females, in particular. It seems that more can be done for these individuals in routine clinical care. It should be pointed out here however, that extension of treatment is important for all individuals who have thoughts of ending their life, not only to female minority clients.

This study evaluated sexual minority psychotherapy outcomes by utilizing a valid and reliable measure. Results support the notion that some sexual minority clients are more distressed than other clients before treatment, but these findings help to clarify an important detail: clients who reported being distressed by their sexual orientation or sexual identity were the clients that reported higher distress levels. Thus, to assume that all or even most sexual minorities who enter treatment are more disturbed or evidence more severe pathology than other clients is erroneous. Furthermore, results indicated that sexual minority clients fair just as well in treatment as do clients who demonstrate comparable pre-treatment distress levels. This is an encouraging finding given that sexual minority clients have been discriminated against in society and especially given that some sexual minorities have reported feeling harmed during the course of treatment. Sexual minority clients in this sample experienced as positive therapy outcomes after participating in routine clinical care as did other clients when pre-treatment distress levels were matched.

References

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

American Psychological Association. (1975). Policy statement on discrimination against homosexuals. *American Psychologist, 30,* 633.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed., revised). Washington, DC: Author.

APA Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist, 61,* 271–285. doi: 10.1037/0003-066X.61.4.271

APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington, DC: American Psychological Association. Retrieved from: www.apa.org/pi/lgbc/publications/

Bailey, J. M. (1999). Homosexuality and mental illness. *Archives of General Psychiatry, 56,* 883–884. Retrieved from archpsych.ama-assn.org

Bancroft, J. (2003). Peer Commentaries on Spitzer (2003). *Archives of Sexual Behavior, 32,* 5, 419-468.

Bauer, S., Lambert, M. J., & Nielsen, S. L. (2004). Clinical significance methods: A comparison of statistical techniques. *Journal of Personality Assessment, 82*(1), 60-70.

Bayer, R. (1981). *Homosexuality and American psychiatry: The politics of diagnosis*. New York: Basic Books.

Beckstead, A. L. (2001). Cures versus choices: Agendas in sexual reorientation therapy. *Journal of Gay and Lesbian Psychotherapy, 5,* 87–115. doi: 10.1300/J236v05n03_07

Benoit, M. (2005). Conflict between religious commitment and same-sex attraction: Possibilities for a virtuous response. *Ethics & Behavior, 15(4),* 309-325. doi: 10.1207/s15327019eb1504_3

Bhugra, D. (2004). Literature update: a critical review. *Sexual and Relationship Therapy, 19,* 201-208. doi: 10.1080/14681990410001691415

Burckell, L. A., & Goldfried, M. R. (2006). Therapist qualities preferred by sexual-minority individuals. *Psychotherapy: Theory, Research, Practice, Training, 43,* 32-49. doi: 10.1037/0033-3204.43.1.32

Byrd, A. D. & Nicolosi, J. (2002). A meta-analytic review of treatment of homosexuality. *Psychological Reports, 3,* 1139-1152. Retrieved from http://www.ammonsscientific.com

Cochran, S. D. (2001). Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? *American Psychologist,56,* 931-947. Retrieved from www.apa.org

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71,* 53–61. Retrieved from www.apa.org/journals/ccp/

Cochran, S. D., & Mays, V. M. (2009). Burden of psychiatric morbidity among lesbian, gay, and bisexual individuals in the California Quality of Life Survey. *Journal of Abnormal Psychology, 118,* 647-658. doi: 10.1037/a0016501

Cohen-Kettenis, P. T., & Gooren, L. J. G. (1999). Transsexualism: A review of etiology, diagnosis and treatment. *Journal of Psychosomatic Research, 46,* 315-333. doi:10.1016/S0022-3999(98)00085-3

Cook, T. D., & Campbell, D. T. (1979). *Quasi-experimentation: Design and analysis issues for field settings.* Chicago: Rand McNally.

Croteau, J. M. (1996). Research on the work experiences of lesbian, gay, and bisexual people: An integrative review of methodology and findings. *Journal of Vocational Behavior, 48,* 195–209. Retrieved from www.elsevier.com/locate/jvb

D'Augelli, A. R., Pilkington, N. W., & Hershberger, S. L. (2002). Incidence and mental health impact of sexual orientation victimization of lesbian, gay, and bisexual youths in high school. *School Psychology Quarterly, 17,* 148-167. Retrieved from www.apa.org/journals/spq/

Dickson, N., Paul, C., & Herbison, P. (2003). Same-sex attraction in a birth cohort: Prevalence and persistence in early adulthood. *Social Science and Medicine, 56,* 1607-1615. doi: 10.1016/S0277-9536(02)00161-2

DiStefano, A. S. (2008). Suicidality and self-harm among sexual minorities in Japan. *Qualitative Health Research, 18,* 1429-1441. doi: 10.1177/1049732308322605

Draper, M. R., Jennings, J., & Barón, A. (2003). Factor analysis and concurrent validity of a university counseling center presenting problems checklist. *The Counseling and Mental Health Center, University of Texas.* Research Consortium: Austin, TX.

Drescher, J. (2003). The Spitzer study and the culture wars. *Archives of Sexual Behavior, 32(5),* 431-432.

Eubanks-Carter, C., Burckell, L. A., & Goldfried, M. R. (2005). Enhancing therapeutic effectiveness with lesbian, gay, and bisexual clients. *Clinical Psychology: Science and Practice, 12,* 1-18. doi:10.1093/clipsy/bpi001

Fergusson, D. M., Horwood, J. L., Ridder, E. M., & Beautrais, A. L. (2005). Sexual orientation and mental health in a birth cohort of young adults. *Psychological Medicine, 35,* 971–981. doi: 10.1017/S0033291704004222

Fleiss, J. L. (1971). Measuring nominal scale agreement among many raters. *Psychological Bulletin, 88,* 322-328. doi: 10.1037/h0031619

Goldfried, M. R. (2001). Integrating gay, lesbian, and bisexual issues into mainstream psychology. *American Psychologist, 56,* 977–988. Retrieved from http://www.apa.org/pubs/journals/amp/index.aspx

Gwet, K. L. (2008). Computing inter-rater reliability and its variance in the presence of high agreement. *British Journal of Mathematical and Statistical Psychology, 61,* 29-48. doi: 10.1348/000711006X126600

Hatzenbuehler, M., McLaughlin, K., & Nolen-Hoeksema, S. (2008). Emotion regulation and internalizing symptoms in a longitudinal study of sexual minority and heterosexual adolescents. *Journal of Child Psychology and Psychiatry, 49*(12), 1270-1278. doi: 10.1111/j.1469-7610.2008.01924.x

Harmon, C., Hawkins, E. J., Lambert, M. J., Slade, K., & Whipple, J. L. (2005). Improving outcomes for poorly responding clients: The use of clinical support tools and feedback to clients. *Journal of Clinical Psychology, 61,* 175 – 185. doi: 10.1002/jclp.20109

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart D. W., & Shimokawa, K. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology, 61,* 155-163. doi: 10.1002/jclp.20108

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9,* 329-343.

Herink, R. (Ed.). (1980). *The psychotherapy handbook: The A to Z guide to more than 250 different therapies in use today.* New York: A Meridian Book, New American Library.

Hooker, E. (1993). Reflections of a 40-year exploration: A scientific view on homosexuality. *American Psychologist, 48,* 450-453.

Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). The evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51,* 1059–1064.

Hunsberger, B. (1996). Religious fundamentalism, right-wing authoritarianism, and hostility toward homosexuals in non-Christian religious groups. *International Journal for the Psychology of Religion, 6,* 39–49. Retrieved from http://www.informaworld.com

Jacobson, N. S. & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.

James, E. C. (1978). Treatment of homosexuality: A reanalysis and synthesis of outcome studies. (Doctoral dissertation, Brigham Young University). Available from ProQuest Disseration and Theses database. (UMI No. 7903615)

Johnson, C. V., & Hayes, J. A. (2003). Troubled spirits: Prevalence and predictors of religious and spiritual concerns among university students and counseling center clients. *Journal of Counseling Psychology, 50*(4), 409-419. doi: 10.1037/0022-0167.50.4.409

Jones, M. A., Botsko, M., & Gorman, B. (2003). Predictors of psychotherapeutic benefit of lesbian, gay, and bisexual clients: The effects of sexual orientation matching and other factors. *Psychotherapy: Theory, Research, Practice, Training, 40*(4), 289-301. doi: 10.1037/0033-3204.40.4.289

Jones, S. L., & Yarhouse, M. A. (2000) *Homosexuality: The use of scientific research in the church's moral debate.* Downers Grove: InterVarsity Press.

Kazdin, A. E. (1986). Comparative outcome studies of psychotherapy: Methodological issues and strategies. *Journal of Consulting and Clinical Psychology, 54,* 95-105.

Kazdin, A. E. (2003). *Research design in clinical psychology, 4th edition.* Pearson Education Company: Boston, MA.

King, M., Semlyen, J., Killaspy, H., Nazareth, I., & Osborn, D. (2007). *A systematic review of research on counseling and psychotherapy for lesbian, gay, bisexual, & transgender people.* London: British Association for Counseling & Psychotherapy.

King, M., Semlyen, J., See Tai, S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry, 8:70*. doi: 10.1186/1471-244X-8-70

Lambert, M. J. (2001). Psychotherapy outcome and quality improvement: Introduction to the special section on patient-focused research. *Journal of Consulting and Clinical Psychology, 69,* 147-149.

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington DC: American Psychological Association.

Lambert, M. J., Bergin, A. E., & Garfield, S. L. (2004). Introduction and historical overview. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change*, 5th edition (pp. 3-15). New York, NY: John Wiley & Sons, Inc.

Lambert, M. J.,&Hill, C. E. (1994). Assessing psychotherapy outcomes and processes. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 72–113). New York: Wiley.

Lambert, M. J., Morton, J. J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R., Shimokawa, K., Christopherson, C., & Burlingame, G. (2004). *Administration and scoring manual for the OQ-45.2.* American Professional Credentialing Services L.L.C.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed. pp. 139-193). New York: Wiley.

Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians to routinely track patient outcome? A meta analysis. *Clinical Psychology: Science and Practice, 10*(3), 288-301. doi: 10.1093/clipsy.bpg025

Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., & Hawkins, E. J. (2001). The effects of providing therapists with feedback on client progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research, 11,* 49– 68.

Lambert, M. J., Whipple, J. L., Vermeersch, D., Smart, D. W., Hawkins, E. J., Nielsen, S. L., et al., (2002). Enhancing psychotherapy outcomes via providing feedback on client progress: A replication. *Clinical Psychology and Psychotherapy, 9,* 91–103. doi: 10.1002/cpp.324

Lipsey, M. W. (1990). *Design sensitivity.* Newbury Park, CA: Sage.

Lunnen, K. M., & Ogles, B. M. (1998). A multiperspective, multivariable evaluation of reliable change. *Journal of Consulting and Clinical Psychology, 66*(2), 400-410.

Mallinckrodt, B. (2009). Advances in research with sexual minority people: Introduction to the special issue. *Journal of Counseling Psychology, 56,* 1-4. doi: 10.1037/a0014652

Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health, 91,* 1869–1876. doi: 10.2105/AJPH.91.11.1869

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. doi: 10.1037/0033-2909.129.5.674

Mohr, D. C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice, 2,* 1–27.

Murphy, T. F. (1992). Redirecting sexual orientation: Techniques and justifications. *Journal of Sex Research, 29*(4), 501-523. doi: 10.1080/00224499209551664

National Association for Research and Therapy of Homosexuality. (2009). What research shows: NARTH's response to the APA claims on homosexuality. *Journal of Human Sexuality, 1*.

Nicolosi, J. (1991). *Reparative therapy of male homosexuality*. Northvale, NJ: Jason Aronson.

Pertab, J., Nielsen, S. L., & Lambert, M. J. (2010). Does client-therapist gender matching influence therapy course of outcome in psychotherapy? *Under review.*

Randall, L., Sell, M. A., Wells, J. A., & Wypij, D. (1995). The prevalence of homosexual behavior and attraction in the United States, the United Kingdom and France: Results of national population-based samples. *Archives of Sexual Behavior, 24,* 235-248. doi: 0004-0002/95/0600-0235$07.5010

Nielsen, S. L., Smart, D. W., Isakson, R., Worthen, V., Gregersen, A. T., & Lambert, M. J. (2004). The Consumer Reports effectiveness score: What did consumers report? *Journal of Counseling Psychology, 51*, 25-37. doi: 10.1037/0022-0167.51.1.25

Russell, S., Driscoll, A. K., & Truong, N. (2002). Adolescent same-sex romantic attractions and relationships: Implications for substance use and abuse. *American Journal of Public Health, 92,* 198-202. doi: 10.2105/AJPH.92.2.198

Savin-Williams, R. C., & Ream, G. L. (2007). Prevalence and stability of sexual orientation components during adolescence and young adulthood. *Archives of Sexual Behavior, 36,* 385-394. doi: 10.1007/s10508-006-9088-5

Skegg, K., Shyamala, N. R., Dickson, N., Paul, C., & Williams, S. (2003). Sexual orientation and self-harm in men and women. *American Journal of Psychiatry, 160,* 541-546. Retrieved from http://ajp.psychiatryonline.org

Slade, K., Lambert, M. J., Harmon, C., Smart, D. W., Bailey, R. (2008). Improving psychotherapy outcome: Immediate electronic feedback and revised clinical support tools. *Clinical Psychology and Psychotherapy, 15,* 287-303. doi: 10.1002/cpp.594

Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? *Archives of Sexual Behavior, 32,* 402-417.

Szymanski, D. M. & Kashubeck-West, S. (2008). Mediators of the relationship between internalized oppressions and lesbian and bisexual women's psychological distress. *The Counseling Psychologist, 36*, 575-594. doi: 10.1177/0011000007309490

Ueno, K. (2005). Sexual orientation and psychological distress in adolescence: Examining interpersonal stressors and social support processes. *Social Psychology Quarterly, 68,* 258-277. Retrieved from http://www.ingentaconnect.com

Vermeersch, D. A., Lambert, M. J., Burlingame, G. M. (2000). Outcome Questionnaire: Item sensitivity to change. *Journal of Personality Assessment, 74*(2), 242-261.

Vermeersch, D. A., Whipple, J. L., Lambert, M. J., Hawkins, E. J., Burchfield, C. M., & Okiishi, J. C. (2004). Outcome Questionnaire: Is It Sensitive to Changes in Counseling Center Clients? *Journal of Counseling Psychology, 51*(1), 38-49.

Wampold B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics, 117*, 1939-1948. doi: 10.1542/peds.2005-2543

Yarhouse, M. A. (1998). When clients seek treatment for same-sex attraction: Ethical issues in the "right to choose" debate. *Psychotherapy: Theory, Research, Practice, Training, 35,* 248-259. Retrieved from www.apa.org

Yarhouse, M.A. (2002). Ethical issues in attempts to ban reorientation therapies. *Psychotherapy: Theory, Research, Practice, Training, 39*(1), 66-75. doi: 10.1037/0033-3204.39.1.66

Zane, N., Nagayama Hall, G. C., Sue, S., Young, K., & Nunez, J. (2004). Research on psychotherapy with culturally diverse populations. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 767-804). New York: John Wiley & Sons.

Table 1: Minority and Control Group Self-Reported Ethnicity and Religious Affiliation

Group	*n*	WHI	HIS	AS	PAC IS	BLK	AM IN	UNK ETH	CHRI	UNK REL
Sexual Minority Group	600	82.2%	8.7%	4.0%	1.9%	0.5%	0.8%	1.9%	98.3%	1.7%
Matched Control Group	596	88.4%	4.4%	2.3%	0.2%	1.0%	1.2%	2.5%	98.0%	2.0%
Typical Client Control Group	600	87.6%	5.5%	2.3%	1.0%	1.0%	0.3%	2.3%	98.5%	1.5%

Note. WHI = Caucasian/white; HIS = Hispanic/Latino(a); AS = Asian; PAC IS = Hawaiian or Pacific Islander; BLK = Black/African American; AM IN = American Indian; UNK ETH = unknown ethnicity; CHRI = Christian; UNK REL = unknown religion

Table 2: Summary of Minority and Control Groups

Group	Description
Sexual Minority Group 1	Client endorsed Item #33 on the Presenting Problems Checklist
Sexual Minority Group 2	At least one therapy note indicated sexual minority status
Typical Client Control Group	Control group was matched to sexual minority groups by gender only
Matched Control Group	Control group was matched to sexual minority groups by pre-treatment distress level (according to the OQ-45), gender, age, and marital status

Table 3: Male Sexual Minority Clients and Typical Control Clients: Pre-Treatment Distress Measured by the OQ-45 Total Score

		Pre-OQ total				Significance of difference		
Group	*n*	Mean	SD	T-Score (%ile)		*F*	*p*	*d*
Sexual Minority Males	457	69.43	23.55	62(88)	Pre-Tx OQ	6.26	.01	.17
Typical Client Males	457	65.50	23.96	61(86)				
Sexual Minority Group 1: Male	213	70.23	25.30	63(90)	Pre-Tx OQ	4.54	.03	.21
Typical Client Group 1: Male	213	65.04	25.02	61(86)				
Sexual Minority Group 2: Male	364	68.10	23.06	62(89)	Pre-Tx OQ	3.11	.08	.13
Typical Client Group 2: Male	364	65.05	23.71	61(86)				

Note. Effect size has been calculated in column *d* and reflects the effect size of the minority group and typical client group pre-treatment. Negative number indicates advantage for minority group. Group 1: identified by PPC item; Group 2: identified through note coding procedures. Note that 120 clients are in Group 1 and Group 2. A total of 457 males were in the sexual minority group and 457 males were in the typical control group.

Table 4: Female Sexual Minority Clients and Typical Control Clients: Pre-Treatment Distress Measured by the OQ-45 Total Score

		Pre-OQ total				Significance of difference		
Group	*n*	Mean	SD	T-Score (%tile)		*F*	*p*	*d*
Sexual Minority Females	143	78.31	22.51	66(94)	Pre-Tx OQ	5.09	.03	.27
Typical Client Females	143	72.07	24.27	64(92)				
Sexual Minority Group 1: Female	102	79.83	23.74	67(96)	Pre-Tx OQ	6.78	.01	.36
Typical Client Group 1: Female	102	71.00	24.72	63(90)				
Sexual Minority Group 2: Female	58	75.22	17.92	65(93)	Pre-Tx OQ	0.24	.63	.09
Typical Client Group 2: Female	58	73.33	23.67	64(92)				

Note. Effect size has been calculated in column *d* and reflects the effect size of the minority group and typical client group pre-treatment. Negative number indicates advantage for minority group. Group 1: identified by PPC item; Group 2: identified through note coding procedures. Note that 120 clients are in Group 1 and Group 2. A total of 143 females were in the sexual minority group and 143 females were in the typical control group.

Table 5: Psychotherapy Outcomes of Male Clients: Sexual Minorities and Matched Controls

		Post-OQ total				Significance of difference		
Group	*n*	Mean	SD	T-Score (%ile)		*F*	*p*	*d*
Sexual Minority Males	455	60.74	25.28	59(82)	Post-Tx OQ	.032	.86	-.01
Matched Control Males	455	61.04	25.12	59(82)				
Sexual Minority Group 1: Male	211	63.20	26.00	60(84)	Post-Tx OQ	1.11	.29	.10
Matched Control Group 1: Male	211	60.55	25.72	59(82)				
Sexual Minority Group 2: Male	363	59.76	24.48	58(79)	Post-Tx OQ	0.44	.51	-.05
Matched Control Group 2: Male	363	60.98	25.11	59(82)				

Note. Effect size has been calculated in column *d* and reflects the effect size of the minority group and matched control group post-treatment. Negative number indicates advantage for minority group. Group 1: identified by PPC item; Group 2: identified through note coding procedures. Note that 119 clients in Group 1 were also in Group 2. A total of 455 males were in the sexual minority group and 455 males were in the matched control group.

Table 6: Psychotherapy Outcomes of Female Clients: Sexual Minorities and Matched Controls

Group	*n*	Post-OQ total				Significance of difference		
		Mean	SD	T-Score (%ile)		*F*	*p*	*d*
Sexual Minority Females	141	70.67	24.16	63(90)	Post-Tx OQ	0.71	.40	.10
Matched Control Females	141	68.40	20.78	62(89)				
Sexual Minority Group 1: Female	100	72.85	25.12	64(92)	Post-Tx OQ	0.70	.41	.12
Matched Control Group 1: Female	100	70.26	18.20	63(90)				
Sexual Minority Group 2: Female	57	66.23	20.67	63(90)	Post-Tx OQ	0.28	.60	.10
Matched Control Group 2: Female	57	64.05	23.16	60(84)				
Sexual Minority Group 3: Female	16	68.50	20.30	62(89)	Post-Tx OQ	0.39	.54	.22
Matched Control Group 3: Female	16	64.50	15.45	61(86)				

Note. Effect size has been calculated in column *d* and reflects the effect size of the minority group and matched control group post-treatment. Negative number indicates advantage for minority group. Group 1: identified by PPC item; Group 2: identified through note coding procedures; Group 3: identified by PPC item and note coding procedures. Note that Group 3 consists of 16 clients that were in Group 1. The same 16 clients were also in Group 2. A total of 141 females were in the sexual minority group and 141 females were in the matched control group.