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Psychotherapy for the Spectrum of Sexual Minority Stress: Application and Technique of the ESTEEM Treatment Model

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Converging evidence points to minority stress as a risk factor that predisposes sexual minority individuals to a variety of negative psychosocial health outcomes, particularly depression and anxiety, substance use, and sexual risk-taking. This paper outlines the techniques and theoretical underpinnings for implementing an emerging empirically supported psychotherapy designed to target the transdiagnostic mechanisms linking sexual minority stress with these outcomes. We outline the essential therapeutic principles, psychoeducation content, as well as session- and homework-based activities that can be adapted for a variety of presenting problems that originate from, and are exacerbated by, minority stress via transdiagnostic minority stress processes. As the development and dissemination of this therapeutic model is still within its early stages, we review the intervention's empirical support thus far and outline potential directions for future development and dissemination via individual, clinic-based, and societal channels.

Across the lifespan, lesbian, gay, and bisexual (LGB) individuals experience disproportionately high rates of mood and anxiety disorders compared with their heterosexual counterparts (Bränström, Hatzenbuehler, Tinhög, & Pachankis, 2017; King et al., 2008; Marshal et al., 2011). A growing body of research implicates sexual minority stressors, which operate through structural, interpersonal, and intrapersonal processes to deprive LGB persons of equal access to health-protective resources, as a key factor in the development and maintenance of these mental health disparities (Bränström, Hatzenbuehler, Pachankis, & Link, 2016). For example, across numerous studies, laws and policies that constrain resources and opportunities for sexual minorities have been identified as a significant determinant of sexual-orientation-based mental health disparities (see Hatzenbuehler, 2014, for a review). Further, family and peer rejection, along with societal prejudice and discrimination, can compromise mental health by prompting chronic vigilance for sexual-orientation-based rejection, heightened internalized homophobia, maladaptive coping responses, and altered physiological stress reactivity (Burton, Bonanno, & Hatzenbuehler, 2014; Hatzenbuehler, 2009; Meyer, 2003; Newcomb & Mustanski, 2010; Pachankis, Goldfried, & Ramrattan, 2008).

Keywords: minority stress; gay; bisexual; psychotherapy; transdiagnostic approach

In light of these adverse consequences of minority stress, the American Psychological Association and other international professional organizations have developed professional guidelines that emphasize the importance of adapting standard psychotherapy to address the role of stigma and its associated mental health morbidities in order to meet the unique needs of sexual minority clients (e.g., American Psychological Association, 2012). The development and implementation of such tailored interventions, however, remains in its infancy, and the field lacks specific guidance on how to translate sexual minority-affirmative principles into practice. The present article aims to address this gap in the literature by introducing readers to the ESTEEM (Effective Skills to Empower Effective Men) treatment model, the first adaptation of cognitive behavioral therapy with demonstrated efficacy for improving young gay and bisexual men's mental health by specifically targeting cognitive, affective, and behavioral reactions to minority stress. Reported data for ESTEEM to date has only focused on sexual minority men, but adaptation research is currently under way to extend its principles to sexual minority women, who face also significant disparities in depression, suicidality, and alcohol use problems.

Adapted from the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (Unified Protocol; Barlow et al., 2010), the ESTEEM treatment model represents a novel psychotherapeutic approach because it is suitable for addressing many maladaptive behavioral patterns driven by minority stress, including depression, anxiety, and health risk behaviors (e.g., substance use, risky sex), and has been tested for efficacy with

sexual minority men who report significant symptoms of depression, anxiety, and condomless anal sex (Pachankis, 2014; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). Given that these health threats often co-occur among gay and bisexual men and women (Cochran, Sullivan, & Mays, 2003; Pachankis, 2015; Stall, Friedman, & Catania, 2008), interventions that address multiple mental and behavioral health conditions simultaneously are particularly valuable.

Across individually delivered modules, the ESTEEM model seeks to promote stigma coping among young gay and bisexual men through a number of cognitive behavioral techniques, including motivation enhancement, interoceptive and situational exposure, cognitive restructuring, mindfulness, and self-monitoring. These modules have been adapted from the Unified Protocol to specifically address several of the transdiagnostic processes that maintain and exacerbate minority stress reactions among gay and bisexual men. In the remainder of this article, we outline the structure and content of each module, with the goal of introducing mental health practitioners to the essential technical and theoretical adaptations of the widely used Unified Protocol (Barlow et al., 2010). In addition to this individually focused (i.e., micro-level) approach, we also discuss possible strategies to disseminate ESTEEM's basic principles and techniques in mental health and primary care settings (i.e., the "meso" level of change). Additionally, we highlight the ESTEEM's capacity to foster adaptive stigma coping among gay and bisexual men, which can in turn enable them to become more effective advocates against discriminatory policies and institutional practices (i.e., the "macro" level of change). We conclude by calling for comprehensive efforts among mental health professionals to address sexual minority health disparities by actively advocating for micro-, meso-, and macro-level change.

Current Support for ESTEEM

The design and ongoing development of the ESTEEM model has sought to distill clinical and theoretical advances in sexual minority stress research into a flexible protocol that is also empirically demonstrable. ESTEEM's adaptation of transdiagnostic therapy was informed by input from both expert mental health care providers with extensive experience treating gay and bisexual men as well as depressed and anxious gay and bisexual men who were experiencing co-occurring health risks (see Pachankis, 2014, for more details). The iterative intervention development process included five phases: (1) selection of the platform to be adapted/developed, in this case the Unified Protocol, (2) receiving qualitative stakeholder input from both experts and the target clinical population, (3) development of the manual, (4) collection of stakeholder's review of the developed manual, and (5) revision of the manual to reflect stakeholders' feedback. This systematic adaptation process is consistent with standard approaches to adapting interventions for diverse groups (e.g., Barrera & Castro, 2006; Hwang, 2009) and the overarching aim of creating a treatment protocol that reflects the perspectives and experiences of the various stakeholders belonging to the communities that will ultimately receive and deliver the treatment.

Empirical examination of the ESTEEM model remains in its nascent stages, but completed studies lend preliminary empirical support. The ESTEEM model demonstrated efficacy in reducing depressive and anxiety symptoms, alcohol use problems, and risky sexual behaviors in a randomized waitlist controlled trial of 63 HIV-negative gay and bisexual men (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). Men who evidenced greater levels of internalized homophobia, measured implicitly, at the study's start made greater reductions in their mental health symptoms, substance abuse, and risky sexual behavior compared to individuals with lower levels of internalized homophobia (Millar, Wang, & Pachankis, 2016). These findings provide further evidence of ESTEEM's capacity to enact clinical change among clients exhibiting greater levels of minority stress reactions. In a pilot study that delivered ESTEEM to 13 HIV-positive sexual minority men who reported impairing symptoms of sexual compulsivity, pre-post comparisons showed reductions in sexual compulsivity, depression, anxiety, drug use, and HIV transmission risk (Parsons et al., 2016). A multisite three-arm randomized controlled trial with young HIV-negative sexual minority men is currently under way. In that trial, ESTEEM is being compared to community mental health treatment as well as standard HIV-test counseling. Individual providers' adherence to the ESTEEM is measured by reviewing 20% of sessions and rating the completion and thoroughness of the module's content, including the clinician's coverage of psychoeducation material and quality of in-session exercises conducted with the client. The treatment model is also currently being developed for sexual minority women through consultation with community stakeholders.

Administering the ESTEEM Model

Administering affirmative psychotherapy to gay and bisexual men can be a potentially intimidating process, especially for clinicians who may not have extensive experience working with sexual minorities. Derived from extensive interviews with 21 mental health providers who possess extensive experience delivering psychotherapy to sexual minorities as well as 20 sexual minority men who were experiencing depression, anxiety, and associated

health-risk behaviors (e.g., risky sex, substance abuse), six overarching principles guide ESTEEM's delivery:

- Mood and anxiety symptoms are normal responses to minority stress;
- Early and ongoing experiences with minority stress can teach sexual minority individuals powerful, negative lessons about themselves;
- Sexual minorities can be empowered to effectively cope with the unfair consequences of minority stress;
- Sexual minorities possess unique strengths;
- Same-sex sexuality is healthy;
- Genuine relationships are essential for the health of sexual minorities.

These principles are organized across 10 modules, each of which is described in detail below with their goals outlined in Table 1. We note, however, that delivery of this and any manualized treatment should be delivered flexibly according to the specific needs of each client (Pachankis & Goldfried, 2007). For example, some clients may benefit from being assigned a "homework" task across multiple sessions in order to appropriately master the targeted skills. Thus, clinicians might consider increasing the number of sessions and rearranging or reviewing sessions in an order that departs from the structure presented in this guide. Sessions are conducted in a one-on-one setting by an individual practitioner, and should last between 45–60 minutes.

Below we present a module-by-module breakdown of how ESTEEM principles infuse the transdiagnostic CBT framework. This information can be employed as an adjunct to the nonadapted Unified Protocol (Barlow et al., 2010) in order to increase the sexual minority–affirmative stance of that particular protocol. Also, given the overlap between the principles of the Unified Protocol and all treatment approches based in learning theory and cognitive-affective science, this information can likely also inform the sexual minority–affirmative stance of other standard cognitive-behavioral treatment approaches.

Module 1: Motivating Engagement in the ESTEEM Treatment Model

This module focuses on clients' readiness and motivation for change while fostering self-efficacy for engaging in the ESTEEM model. The therapist begins this module with a description of the ESTEEM, including its focus on empowering clients to cope with minority stress in effective ways in order to improve mental and physical health. Therapists should normalize the experience of depression and anxiety for sexual minorities by explaining that research suggests they are more likely to experience depression and anxiety than heterosexual persons given their disproportionate exposure to stigma-related stress. Therapists should also explain how the stigma toward sexual minorities can manifest in multiple and often subtle ways, such as acceptance of being treated as inferior to heterosexual persons, rejection hypervigilance, internalized negative stereotypes of sexual minorities as weak or inferior, and fear of genuinely expressing oneself lest that self be rejected.

As outlined in the Unified Protocol manual (Barlow et al., 2010), this first module requires the therapist to employ motivational interviewing skills to enhance the client's capacity to change, including expressing empathy, developing behavioral discrepancies between goals and behaviors, rolling with the client's resistances to change, and supporting the client's self-efficacy (Miller & Rollnick, 2002). In ESTEEM's adaptation of these motivational skills, the therapist gathers the client's understanding of the most pressing mental health issues in his life and their possible origin in minority stress.[1] Relevant intake assessment information is presented to clients to gather their understanding of the impact of minority stress on emotions and behaviors in order to facilitate motivation for changing the patterns that maintain their mood and anxiety disorders. The therapist devotes particular attention to building the client's self-efficacy for change by highlighting the unique strengths that gay and bisexual men possess as a result of navigating minority stress throughout their lives, including the coming-out process, unique and creative ways of coping with minority stress, and a history of activism against discriminatory and oppressive legislation and cultural attitudes. For individuals who have not come out to family or friends, the therapist can also use the client's very experience of exploring their sexual orientation as a notable feat of self-growth.

Module 2: Explaining the Emotional Impact of Minority Stress

This module raises awareness about the potential bearing of minority stress on the client's experience of depression, anxiety, and associated health-risk behaviors (e.g., risky sex, substance abuse), beginning with educating the client regarding the connection between minority stress and these outcomes. This conversation is centered on the following five topics: (a) Sexual minorities are at greater risk of experiencing mental health problems than heterosexuals; (b) Sexual minority stress works through modifiable mechanisms (e.g., chronic feelings of shame or guilt, concealment of parts of one's identity) to influence mental

[1] While Session 1 incorporates some exploration of the client's symptoms and clinical goals, it is strongly recommended that the client complete a thorough clinical assessment prior to initiating ESTEEM therapy.

Table 1
Session Goal(s) for ESTEEM Modules

Module 1	• Explain rationale behind ESTEEM • Introduce the concept of minority stress and its relationship to depression, anxiety, and health risk behaviors • Introduce motivation and discuss its importance to treatment outcome • Help client explore the costs/benefits of changing vs. remaining the same • Help client set specific goals to reduce the impact of minority stress • Help client set manageable steps to reach goals related to reducing the impact of minority stress • Provide client feedback regarding his self-reported experiences of past and current minority stress and mental health symptoms
Module 2	• Explore client's early and current experiences of minority stress • Psychoeducate the client on the variety of sources and types of minority stress faced by gay and bisexual men • Explore the ways that early and ongoing minority stress might contribute to the client's experience of anxiety and depression • Train client how to track instances of minority stress in their day-to-day life
Module 3	• Provide an overview of the functional, adaptive nature of emotional responses to minority stress • Present the three components of emotional experiences (thoughts, physical sensations, and behaviors) • Introduce the concept of emotion-driven behaviors • Introduce antecedents, responses, and consequences of minority stress • Discuss learned emotional responses, including the primary experience of emotions versus the secondary reaction, both of which can arise from minority stress • Address stereotypes of gay and bisexual men's emotions as a possible barrier to full emotional expression
Module 4	• Highlight the emotional impact of minority stress • Introduce nonjudgmental emotion awareness • Introduce present-focused awareness of minority stress reactions • Conduct in-session emotion awareness exercise • Have client practice techniques using minority stress–related mood inductions
Module 5	• Explain the impact of early and ongoing minority stress on gay and bisexual men's cognitive appraisal process • Explain the reciprocal relationship between thoughts and emotions • Introduce automatic appraisals • Introduce and help client identify common thinking traps arising from minority stress • Introduce and help clients practice cognitive reappraisal to increase flexibility in thinking and to appropriately attribute distress to minority stress rather than to personal failures or shortcomings
Module 6	• Introduce concept of emotion avoidance • Present several types of emotion avoidance strategies and discuss how these strategies contribute to the negative cycle of emotional responding to minority stress • Help the client identify his own emotion avoidance strategies and their relationship to minority stress • Demonstrate the paradoxical effects of emotion avoidance in minority stress reactions
Module 7	• Discuss in more depth the concept of emotion-driven behaviors during minority stress, such as substance use and risky sexual behaviors • Introduce rationale for countering emotion-driven behaviors • Identify maladaptive emotion-driven behaviors that derive from minority stress and develop alternative action tendencies
Module 8	• Help the client identify maladaptive avoidance in interpersonal situations or actions • Help the client understand the role that minority stress might play in his interpersonal avoidance patterns • Promote insight into the possibility that substance use allows the client to avoid uncomfortable interpersonal situations • Review effective communication skills • Conduct role-play exercises of previously avoided interpersonal situations
Module 9	• Help the client to understand the purpose of behavioral experiments for countering harmful and/or self-defeating minority stress reactions • Work with the client to develop an emotional and situational avoidance hierarchy • Design effective behavioral experiments targeting minority stress–driven avoidance and emotion-driven behaviors • Assist client in confronting strong emotions through behavioral experiments
Module 10	• Review skills learned throughout ESTEEM • Review client's progress, including areas of ease and difficulty • Identify and troubleshoot common/potential minority stress triggers • Promote skill generalization and set goals for continued progress • Use self-affirmation exercise to foster future resilience

health and associated health-risk behaviors; (c) Current experiences with minority stress, such as discrimination at work or in family relationships, can trigger mental health symptoms and unhealthy coping behaviors (e.g., condomless sex, substance abuse); (d) Stress from within the gay community itself can further exacerbate difficult emotions (e.g., pressure to act "masculine" or be physically attractive); and (e) Chronic experiences of minority stressors can lead to diminished resources for coping with stress, such as reduced social support and emotion regulation, which can trigger many types of emotional disorders. Discussions of the intersection of multiple minority identities may also be an important topic for some clients during this module. Gay and bisexual men of color, for example, may face added stress from within the gay community, such as race-based exclusion or sexual objectification through stereotyped sex roles (Teunis, 2007; White, Reisner, Dunham, & Mimiaga, 2014). The sources and salience of minority stress should be treated as unique to each client.

As part of this discussion, information regarding the prevalence of depression and anxiety and its relationship to minority stress is provided to normalize some of the client's experiences. Further, this discussion highlights that many of the client's current emotional problems may be rooted in their experiences of minority stress and the potentially maladaptive ways they have learned to cope with such experiences (see Appendix A). The therapist thus balances locating the origin of emotional distress on stigmatizing societal structures with highlighting the client's currently problematic minority stress reactions that are susceptible to change.

The concept of tracking ongoing minority stressors is introduced so that ongoing minority stress can be linked to current symptoms of depression and anxiety in subsequent modules. The therapist can provide the client a record to help him track potential stigma-related stressors he currently experiences. Reviewing a list of specific types and examples of minority stress can help clients identify minority stressors as they are encountered in their own lives (for examples, see Pachankis, 2014).

Further, as part of their intake assessment, clients complete a thorough battery of minority stress experiences via published minority stress measures (e.g., internalized homophobia, Martin & Dean, 1992; sexual orientation concealment, Meyer, Rossano, Ellis, & Bradford, 2002; rejection sensitivity, Pachankis et al., 2008). Results from these measures are then presented on a personalized feedback form, which highlights participants' scores relative to standard scores to generate a discussion about the personal relevance of minority stress experiences, identify particular points of intervention, and continue building motivation for therapy engagement. Appendix B includes an example of this feedback form.

Module 3: Tracking Minority–Stress Related Emotional Experiences

This module educates the client about the main components of emotional experience (i.e., physical sensations, thoughts, behaviors) and the possibility that the specific form that his emotional experience takes may be shaped by minority stress. Specifically, clients learn about the adaptive function of emotions and their ability to alert clients to behave in a certain way. In accordance with the Unified Protocol, to help clients monitor and explore their emotions, they are taught to identify emotional antecedents (i.e., triggers), responses (thoughts, feelings, and behaviors), and consequences (both short- and long-term). This module also reviews the learned nature of emotions, particularly with respect to avoidance and pleasure-seeking. Sexual minority–specific adaptations guide the therapist to use minority stress reactions as examples of emotional antecedents and cognitive, affective, and behavioral responses. For example, sexual minorities may learn that concealing their sexual orientation helps prevent the discomfort associated with potential rejection for having their sexual orientation known to others. Exhibiting self-deprecating behavior or being hypercritical of others are additional possible means by which sexual minorities may seek to prevent or minimize the impact of peer-based rejection due to their sexual orientation. These emotion-driven behaviors may be adaptive in some contexts, but they often go unexamined and prevent the individual from flexibly selecting the most value-consistent behavior for the situation at hand. During this module, the client is expected to develop greater awareness of his own patterns of emotional responding, including potential maintaining factors rooted in common minority stressors, by beginning to monitor and track his emotional responding alongside experiences of minority stress.

This module helps the client identify the specific forms that emotions take in his life (e.g., shame, guilt, self-consciousness) and the ways in which these emotions emerge from early and ongoing stigmatizing social contexts. In this way, this module helps the client to develop an understanding of the possibility that early and ongoing minority stress contributes to his experience of depression, anxiety, and associated risk behaviors. Homework for this module focuses on helping the client continue to monitor personal minority stressors, as in Module 2, with the added element of identifying resultant emotional experiences (Appendix C).

Module 4: Increasing Awareness of Minority-Stress Reactions

This module is designed to help the client further understand the ways that minority stress shapes his emotional experience. The module introduces the client

to the concept of in-session behavioral experiments with a focus on helping the client accurately describe his emotional reaction to minority stress in mindful, present-focused terms. Some clients may find it counterintuitive to increase attention to events or emotions they find unpleasant or harmful; this session helps distinguish the client's primary emotional reactions to minority stress and their secondary emotional reactions that unnecessarily increase and/or prolong negative affect. Mindful experience of minority stress allows the client to react in a more flexible manner by increasing awareness and decreasing automatic and potentially maladaptive reactive behaviors.

In the psychoeducational component of this module, the therapist explains that minority stress can lead to unpleasant emotions, which can in turn lead to behaviors that may be helpful in alleviating those emotions in the short term but are unhealthy if chronically used (e.g., rumination, substance use, avoidance of social settings). Increasing awareness of their emotions in these contexts allows clients to distinguish primary emotions and secondary reactions, in order to help them identify what aspect of their experience is derived from the "here-and-now" and what is not. Clients also learn about the importance of emotional acceptance, recognizing that sexual minorities can often struggle to not judge their own emotions due to perceived stereotypes about sexual minorities, gender roles, and emotions (Sánchez, Greenberg, Liu, & Vilain, 2009). In accordance with the standard guidance of the Unified Protocol (Barlow et al., 2010), the module incorporates standard mindfulness training techniques, including breath awareness and an emotion induction exercise (i.e., having the client listen to a song and describe his emotional experience). Homework for this week centers on having the client practice emotional awareness by anchoring in the present as well as monitoring and recording their minority stress–related emotions induced through an emotional, minority stress–related memory or video.

Module 5: Cognitive Correlates of Minority Stress and Developing Alternative Appraisals

This module allows the client an opportunity to connect his growing awareness of the emotional experience of minority stress to his negative and/or rigid thinking patterns. Psychoeducation elucidates the impact of early and ongoing minority stress on clients' thoughts. Namely, minority stress might instill thoughts of inferiority, shame, immorality, abnormality, or unworthiness of love, which may in turn drive sexual minority clients to engage in unhealthy behaviors, such as seeking status, acceptance, and connection through risky sex or substance use. Some of these thoughts, such as "I need to hide that I'm gay," may have been accurate or adaptive in early threatening contexts, but might be currently overgeneralized and rigidly applied to ambiguous or safe contexts. Following the Unified Protocol guidance, clients learn about the nature of cognitive appraisal and its reciprocal relationship with emotions. The therapist then introduces the client to cognitive distortions that might have their root in minority stress, including internalized homophobia, rejection sensitivity, and contingent self-worth (Martin & Dean, 1992; Pachankis et al., 2008; Pachankis & Hatzenbuehler, 2013). Cognitive reappraisal strategies are then offered as a way of increasing flexibility in appraising situations.

Following the guidance in the Unified Protocol, the therapist helps the client learn about the role of cognitive appraisal in emotions and challenge maladaptive cognitive patterns, by having the client engage in an ambiguous picture exercise to elicit and challenge his initial perceptions. In this exercise, the client views a picture that contains an image of an individual potentially being socially rejected, and is asked to consider other, non-rejection-based explanations for what is occurring in the photo.

For clients who identify an acute personally relevant minority stress experience that they are currently facing, we suggest that therapists draw upon the guidance of Madsen and Green (2012), who offer strategies for cognitive reappraisal of this type of stress. For instance, they suggest that cognitive reappraisal strategies for coping with minority stress might include: (a) analyzing the anti-gay experience for personal relevance and severity, (b) discounting the source, and attributing the stigmatizing behavior to the offending individual's ignorance, and (c) expressing optimism by telling oneself that the situation may be temporary and might get better (Madsen & Green, 2012). In-session and homework exercises follow the Unified Protocol homework as specifically adapted for minority stress. For instance, clients engage in a downward arrow exercise to identify minority stress–related core beliefs (e.g., "I am unlovable because I am bisexual"), evaluate cognitive distortions that result from these beliefs (e.g., "My date tonight got rescheduled because I told him I was bisexual during our last date"), and generate possible reappraisals for these distortions (e.g., "He got stuck at work again").

Module 6: Addressing Emotion Avoidance Tendencies Maintained by Minority Stress

This module introduces the concept of emotion avoidance. Emotion avoidance refers to strategies that the client might use to avoid feeling strong emotions. The therapist and client work together to identify emotion avoidance strategies and discuss their possible origin in minority stress experiences. Emotion avoidance is also demonstrated in-session, through an imaginal

experiment wherein the client is instructed to *not* think about a painful minority stress–related memory, to help the client experience firsthand how emotion avoidance strategies contribute to the development and maintenance of negative emotions.

A number of informational points are key to convey to the client during this module, beginning with defining emotion avoidance as any behavior that serves to avoid strong emotions. Emotional avoidance can take many forms, such as cognitive and subtle behavioral avoidance (Barlow et al., 2010). As reviewed in the previous module, emotional avoidance is a common reaction to minority stress, and while it may be useful in some situations, it rarely works well in the long term. It is crucial for clients to understand that repeatedly engaging in emotional avoidance can in fact reinforce and strengthen their unpleasant minority stress–driven emotions. Emotional avoidance can be particularly problematic in sexual minority clients' attempts to form intimate relationships, if they are taught from an early age that sexual and nonsexual intimacy with persons of the same sex can be dirty, dangerous, or laden with possibilities for rejection (Frost & Meyer, 2009). For some sexual minority clients, substance use, risky sex, and other unhealthy behaviors can become habitual ways to seek validation or overcome the shame, fear, and other uncomfortable emotions caused by minority stress (Folkman, Chesney, Pollack, & Phillips, 1992; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008).

The exercises in this module begin to heal the negative impact of minority stress by helping sexual minority clients face their minority stress–driven shame and fears in the safe therapeutic context while habituating to their uncomfortable emotions so that they are no longer so uncomfortable. For instance, one exercise might have the client identify and think about a particularly emotional minority stress–related situation or memory. Even though this memory may be difficult to think about, the client is asked to keep this memory in mind for a period of time until the intensity of the emotion surrounding the recall of the event diminishes (Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014). Homework for this module should focus on helping the client identify instances of his own emotional avoidance behaviors and connecting them to minority stress triggers and their associated emotions.

Module 7: Connecting Minority Stress to Emotion-Driven Behaviors

This module focuses on identifying behavioral minority stress reactions that are driven by emotions. After the therapist and client discuss how emotions can drive behaviors that serve to increase or decrease a variety of feelings, they work to change current patterns of emotional responding that maintain long-term distress. Sexual minority clients might cope with the emotional experience of minority stress in several maladaptive ways, including aggressively reacting to perceived rejection in ambiguous social interactions, self-sabotaging or avoiding genuine relationships with other men (both gay and heterosexual), seeking validation through sex, using substances (including during sex), and not asserting one's needs and preferences to others (including in sexual encounters). The goal of this module is to foster healthy behaviors, including healthy relationships and healthy sexual interactions, that can serve to protect clients from the negative mental and physical health effects of minority stress.

Therapists should acknowledge that emotion-driven behaviors are important for survival, especially in stigmatizing contexts. Therapists should also underscore, however, that some emotion-driven behaviors can be harmful, particularly when engaged over the long term. Like avoidance behaviors, common emotion-driven behaviors among sexual minority clients include substance use, risky sex, avoidance of close relationships, and failure to assert one's needs and preferences. What distinguishes emotionally avoidant behaviors and emotion-driven behaviors is that emotional avoidance seeks to avoid the occurrence of the emotion, whereas emotion-driven behaviors occur after the emotion has been experienced (Barlow et al., 2010). The therapist should also review the importance of community and interpersonal connections, as many emotion-driven behaviors can reduce sexual minority clients' quality and breadth of social support. Therapists should help clients consider the role of the LGBT community in their lives in ways that support their efforts to reduce emotion-driven behaviors. Local resources (e.g., LGBT community centers) or the Internet can be utilized to generate creative, appealing ideas for increased community involvement.

Reviewing a list of common emotion-driven behaviors, their possible root in minority stress, and alternative approach-focused strategies (Appendix D) can help the client readily identify ongoing patterns and suitable targets for behavioral experiments. The therapist and client should also use this module as an opportunity to have an open discussion of the client's sexual behaviors, and consider the possibility that sex is either avoided out of shame or other uncomfortable emotions, or that sex serves as a way to regulate uncomfortable emotions (Pachankis, Rendina, et al., 2015). In-session and homework tasks can guide the client in tracking situational triggers of his emotion-driven behaviors and associated emotions, and identify and implement behaviors that are incompatible with the problematic emotion-driven behaviors. For example, an anxious client might observe that they often use their phone or open a dating or "hook-up"

application (e.g., Grindr) when feeling anxious or uncomfortable during social interactions. Noting this as an emotion-driven behavior that interferes with their quality of social interactions, the client could then attempt to replace this behavior with other incompatible behaviors, such as initiating a conversation. This module ends with the creation of a hierarchy of avoidance behaviors and unhealthy emotion-driven behaviors that the client would like to replace with more adaptive, stress-protective behaviors across the remaining treatment modules.

Module 8: Assertiveness Training

This module imparts the cognitive and behavioral skills necessary for managing minority stress and reducing emotion-driven behaviors like avoidance. The primary skill of this module involves assertiveness training for managing difficult interpersonal situations involving minority stress. Notably, this module does not explicitly appear in the Unified Protocol, but given the prominence of unassertiveness in the lives of many sexual minorities and its clear linkages to early and ongoing minority stress experiences (e.g., Pachankis et al., 2008), ESTEEM includes a distinct module to address this specific concern with the goal of countering behavioral avoidance tendencies. Sexual minority clients may learn from an early age that they do not have the right to stand up to stigma or to articulate their needs or preferences. This module helps clients recognize the ways in which they may silence themselves in certain interactions because of expectations of stigma and rejection, a result of their unique learning history of interpersonal interactions as sexual minorities. Exercises in this module help the client develop skills to assertively confront interpersonal minority stressors in safe situations and relearn their ability to effect change through social dialogue. This module places utmost emphasis on the fact that the problems in these situations lie in stigmatizing social contexts, and not within the client.

Building on the previous modules, this module introduces interpersonal passivity (i.e., not expressing oneself) as a form of emotional avoidance that can have potentially damaging social and emotional long-term consequences. The therapist and client once again draw from the client's history of minority stress exposure to help him conceptualize why and how fear of rejection might lead to avoidance of self-assertion. Furthermore, in this module, clients learn that rigid and inflexible thoughts resulting from uncomfortable emotions can prevent them from acting in a way that is consistent with their values. Helping clients identify their personal rights, particularly in previously avoided situations, can help them develop a new sense of efficacy and empowerment to behave differently in similar future circumstances (Kanter & Goldfried, 1979; Linehan, Goldfried, & Goldfried, 1979). The therapist should take care to differentiate assertiveness from aggressiveness, to help the client ensure that both their rights and the rights of others are fully respected. Providing examples to clients can help this information be more easily applied to the clients' own experiences.

This module employs three primary tasks to help develop the client's assertiveness. First, the client and therapist must identify relevant situations in which minority stress influences the client's capacity to express himself. Clients can be asked to identify specific situations in which they may deny themselves their personal rights as individuals and as sexual minorities. Next, the therapist helps the client challenge his unassertive thoughts by using the cognitive skills developed in Module 5. To help the client differentiate rational from irrational thoughts, the therapist might ask, "What goes on in your head when you imagine yourself in this situation?" or "Do you need approval from everyone?" Finally, the therapist should help the client enact assertive behavior while discussing the importance of eye contact, voice volume/tone/inflection, posture, body language, and facial expressions (Lange, Jakubowski, & McGovern, 1976). Role-playing with the client can help him find and master an assertive style that is natural for him. Homework assignments should focus on helping the client begin to practice assertiveness in their daily interactions where they were previously passive. These assignments can gradually increase in difficulty across sessions, beginning with simple interactions with strangers (e.g., alerting a restaurant employee they provided a wrong order) to more difficult and emotionally salient interactions in important relationships (e.g., asking to bring a significant other to a family social event).

Module 9: Experimenting With New Reactions to Minority Stress

This module focuses on confronting both internal (including physical sensations) and external (including minority stressors) emotional triggers, which provides the client with opportunities to increase his tolerance of emotions and to facilitate emotional learning and habituation. By approaching painful emotional experiences of early or ongoing minority stress in-session or in vivo, the emotions underlying these experiences will no longer drive the client's behavior in maladaptive ways.

At the beginning of this module, the therapist focuses on introducing the client to the rationale of behavioral experiments. Specifically, the client learns that, by engaging in exercises that intentionally elicit strong feelings associated with minority stress, he can learn new ways to tolerate and behave in response to these emotions. This part of the therapy can be difficult as it requires clients to confront internal and external triggers they may have avoided for long periods of time. It may be helpful to remind clients struggling with these experiments that they have already successfully navigated previous stressful experiences by virtue of acknowledging to themselves and potentially others their identity as gay or bisexual.

Therapists can help the client create an avoidance hierarchy to strategize the types and order of behavioral experiments that would be most helpful to the client without being overwhelming. By this point in treatment, the therapist and client both likely have a clear idea regarding what avoidance behaviors may be related to the client's symptomatology. Some situation-based examples might include: (a) having difficult conversations with friends, partners, family members, or coworkers, (b) having sex without using substances, (c) expressing intimacy toward other men, (d) socializing with heterosexuals, (e) making connections within the gay and bisexual community, and (f) expressing vulnerability. Depending on the ranking of the hierarchy, these examples and other situational experiments can begin with imaginal exposure.

Behavior experiments can also focus on exposing the client to the physical sensations associated with their emotions. In the case of anxiety, for example, the client may walk quickly up a set of stairs to simulate the rapid heart rate and other physical cues associated with this emotion (Barlow et al., 2010). Clinicians should take care to design and implement exposure exercises to maximize participant within- and between-session habituation to the feared stimulus (Craske et al., 2014). This can be done by ensuring that no exercise is terminated before it is completed (e.g., if a client is doing an imaginal exposure of attending a social function, the therapist should ensure that the participant imagines every detail from replying to the invitation to leaving the event), ensuring no safety behaviors are being done during the exercise, and regularly assessing the client's subjective distress to ensure there has been notable habituation and to prevent inadvertent reinforcement of the fear reaction. Once the client has demonstrated the ability to engage in behavioral experiments in sessions, assigned homework can focus on helping the client move their experiments into the real world by tracking their attempts and their emotional experiences associated with each attempt.

While selecting behavioral experiments with the client, it is essential that therapists assess the function of clients' minority stress reactions. While many emotion-driven and avoidance behaviors may interfere with a client's ability to flexibly engage with valued activities, for some clients the safety provided by emotional and avoidance behaviors may be quite adaptive and functional. For example, some clients may live in homophobic work or home environments, where approaching uncomfortable situations may actually lead to physical danger. The therapist can use information they have collected throughout the previous sessions to guide their collaborative determination of exposure exercises for the behavioral experiments. For example, the therapist can draw from cognitive restructuring exercises conducted within Module 5 to help determine (a) evidence of actual risk of avoided contexts or behaviors, including a history of rejection or violence, and (b) the range of potential outcomes (i.e., "best case" and "worst case" scenarios) if the client engages the feared context or behavior. Clinical judgment, along with careful evaluation of these factors, can guide the therapist and client's joint determination of safe and productive exposure exercises.

Module 10: Preventing Relapse Through Self-Affirmation

The ESTEEM model concludes by summarizing the concepts and techniques reviewed throughout the treatment, as well as the client's progress in symptom reduction and skills acquisition. The therapist and client identify ways to maintain the gains made during treatment as well as prepare for future experiences of minority stress and the implementation of the client's new skills. A self-affirmation exercise concludes this module, which capitalizes on the client's growing sense of agency for managing minority stress and fosters confidence in maintaining treatment gains over time.

In reviewing treatment progress, the therapist and client should briefly review skills that the client found easy as well as challenging. Reviewing skills in this manner allows the client to review his strengths as well as areas in need of improvement, and provides motivation for the client to continue to practice these skills after the therapy has terminated. The therapist can encourage the client to set aside a small amount of time each week to practice the skills and can help the client imagine a difficult future scenario of minority stress experience in which these skills can be put to use. Reviewing the client's long-term goals articulated earlier in treatment can also encourage continued progress.

In addition to the standard relapse prevention approaches employed in the Unified Protocol (Barlow

et al., 2010), ESTEEM includes a self-affirmation exercise in this module to help sexual minority clients recognize the resilience and skills they have developed in the preceding modules. Self-affirmation has been shown to have enduring benefits for individuals who face ongoing challenges associated with minority stress (Cohen, Garcia, Purdie-Vaughns, Apfel, & Brzustoski, 2009; Lin & Israel, 2012). The client watches a brief (2–3 minute) video clip depicting a minority stress experience being directed toward a sexual minority peer (see Appendix E for publicly available examples). After watching the video, the client is asked to spend 15 minutes writing a letter to the person in the video, describing his own experiences with minority stress, how he has handled it, and what cognitive and behavioral strategies he finds most helpful. The client will be assured that no identifying information about him will be shared with others, but the general message contained in the letter can help the therapist help other sexual minority clients. This type of "saying is believing" intervention, in which clients write about their strengths, might activate the client's sense of himself as an efficacious agent capable of navigating future minority stress.

Implementing the ESTEEM Model at the Mezzo-Level

The preliminary efficacy of ESTEEM across an array of mental, sexual, and behavioral health outcomes suggests that transdiagnostic intervention models present a promising avenue for addressing the health disparities faced by sexual minority men; accordingly, pending future efficacy evidence, its dissemination to clinicians should match the breadth of the clinical presentations it aims to treat. One means to achieve this aim is consistent with current trends incorporating behavioral health interventions into the primary care setting (Hunter, Goodie, Oordt, & Dobomeyer, 2009).

Sexual minority men account for 67% of the estimated new HIV infections within the United States (Centers for Disease Control and Prevention [CDC], 2013). Incorporating principles of ESTEEM into HIV-prevention services as well as the HIV continuum of care can disseminate minority stress treatment to individuals who may not present at traditional mental health settings. For example, training service providers in HIV-testing clinics on the basic implementation of ESTEEM principles and techniques may allow individuals who report emotional difficulties and sexually risky behaviors to receive specialized counseling targeting discrimination, avoidance, and other minority stress–related triggers. HIV-positive individuals may also benefit from the ESTEEM principles to help them address the added HIV-related stigma they experience from both without and within the sexual minority community (Rendina et al., 2016).

Dissemination of minority stress treatment models such as ESTEEM can benefit mental, sexual, and behavioral health treatment of sexual minorities throughout the United States and globally, but it is particularly important for those who reside in geographic areas where minority stressors and their accompanying health disparities are highest (e.g., states and countries without legislative protection for gay rights; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Pachankis, Hatzenbuehler, Hickson, et al., 2015). As men in these areas are also more likely to internalize the homonegative attitudes of their environment and conceal their sexual orientation (Berg, Ross, Weatherburn, & Schmidt, 2013; Pachankis, Hatzenbuehler, Hickson, et al., 2015), they may also be more likely to benefit from LGB-affirmative interventions (Millar et al., 2016). Likewise, the universal shortage of mental health care in rural regions and homophobic geographies makes dissemination efforts particularly crucial for these areas (Kano, Silva-Bañuelos, Sturm, & Willging, 2016; Willging, Salvador, & Kano, 2006). The health risks of limited access to care is compounded for sexual minority individuals who are likely to face greater minority stressors. Dissemination efforts should incentivize training for rural care providers to ensure they are equipped with the appropriate skills for addressing the pressing special needs of rural sexual minority clients. Expanding telehealth programs can also connect culturally competent therapists to clients where regular face-to-face sessions may not be feasible.

The ESTEEM model's principles and techniques were recently taught to 54 mental health providers in Romania, a Central-Eastern European country with pervasive homophobia and very limited LGB-affirmative mental, sexual, and behavioral health services (Lelutiu-Weinberger & Pachankis, 2017). From baseline to follow-up, trainees demonstrated a significant increase in perceived knowledge and clinical skills relevant to working to LGB individuals. Sexual minority affirmative practice attitudes ($p < 0.05$) and comfort in addressing the mental health of sexual minorities significantly increased ($p < 0.01$), and homophobic attitudes significantly decreased ($p < 0.01$). The majority of trainees reported being highly interested in the training (84%), which they credited with preparing them to interact with and care for sexual minorities (74%). This evidence suggests that by increasing sexual minority–affirmative knowledge, skills, and attitudes among providers in a high-need geographic context, the principles and techniques of ESTEEM and its future adaptations for sexual women can also address drivers of sexual orientation disparities at the mezzo level.

The ESTEEM Model at the Macro-Level

Addressing the broader social and political sources of stigma is essential to reducing the mental health disparities affecting sexual minorities. This has been partially effected through traditional means of policy advocacy by health experts, including the submission of research and expert testimony in legislative and judicial proceedings (e.g., American Psychological Association, 2015). Clinicians should continue to take a leading role in advocating for their LGB clients through active involvement in professional and advocacy organizations as well as distributing their knowledge and expertise through interactions with community leaders and elected politicians. Advocacy resources such as those found on the American Psychological Association's website can help guide clinicians interested in pursuing these goals (American Psychological Association, 2017).

Health-focused activism, however, can be accomplished by multiple parties through a variety of channels (Zoller, 2005). ESTEEM, despite being an individual-focused intervention, can indirectly foster societal-level change through a "bottom-up" approach. Clinicians who remediate underlying depressive and anxiety symptoms and associated health-risk behaviors of sexual minority clients are in a unique position to encourage their clients' further involvement in advocacy. Not only can this bolster a sense of agency and community belonging for the client, it also advances the representation and political influence of a group often targeted and disenfranchised by discriminatory policies and social attitudes. The assertiveness training module of ESTEEM, for example, can facilitate effective communication skills, thereby promoting identity-affirming dialogue across personal, professional, and political contexts. Indeed, promoting minority stress coping at the individual-level can change social-level structures through facilitating positive intergroup contact, increasing the visibility of stigmatized individuals, and empowering stigmatized individuals to advocate for structural change (Cook, Purdie-Vaughns, Meyer, & Busch, 2014). Future minority stress intervention research should evaluate clients' political engagement to empirically determine the impact of the ESTEEM and related interventions on potentiating structural change.

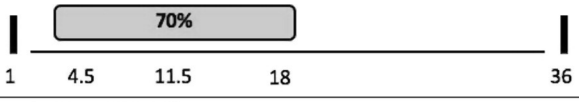
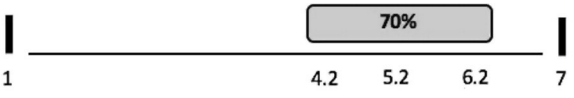
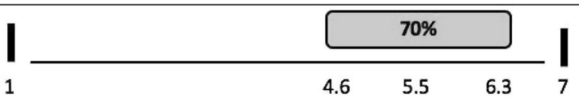
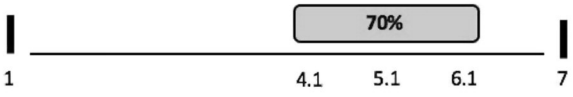
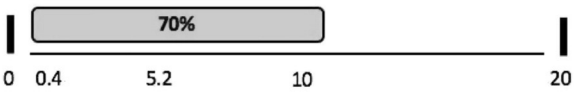
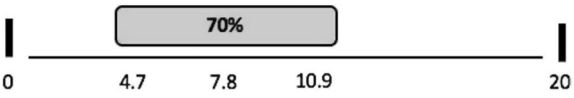
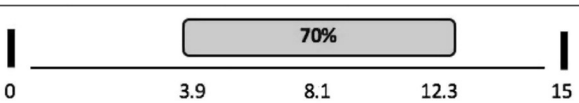
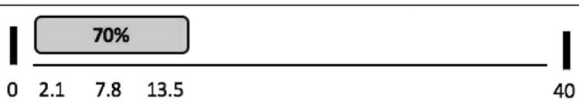
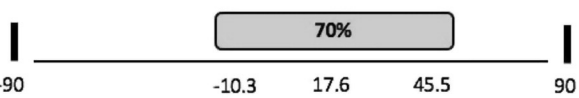
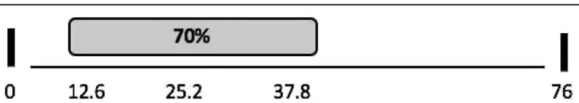
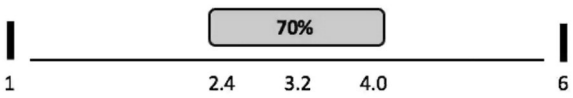
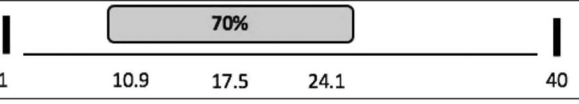
Conclusion

In summary, the ESTEEM model represents a promising treatment approach that simultaneously addresses the mental, sexual, and behavioral health needs of sexual minority men through its overarching focus on minority stress processes. However, ESTEEM, like other psychotherapies, is only a tool. Advancing the treatment of sexual minority stress requires mental health professionals to advocate for their LGB clients in the clinic, community, and all other levels through which minority stress permeates the well-being of those they are professionally obligated to serve (Ratts, 2009). Similarly, they must also be well-equipped to provide their clients with the necessary skills and resources to enact change in their personal lives and, to the extent possible, their communities. It is our hope that the psychotherapeutic techniques outlined in this article, as well as the recommendations for broader interventions in the clinic and community-at-large, provide the reader a foundation to continue to reduce the significant sexual orientation disparities in mental, sexual, and behavioral health.

Appendix A. Monitoring Gay-Related Stress and Emotions Worksheet with Examples

Trigger/Context	Thoughts	Feelings	Behaviors	Result?
Stranger sneered at me as I walked by	What's wrong with me?	Anxious and frustrated	Avoid eye contact when walking down the street, speak defensively and aggressively with others	Got into an argument with someone I care about later in the day
Friends didn't invite me out last night	No one likes me, I'm not loveable	Inferior, failure, worthless	Focus on achievement and avoid social situations	Decline social invitations in order to go over work I already finished
Stranger sneered at me while I walk by holding my partner's hand	People will never accept us	Angry, ashamed	Suppress emotional expressiveness; let go of partner's hand	Denied being upset when my partner asked and decided not to join him at his family dinner that night.

Appendix B. Client Feedback Form

Measure	Score	Range, Average, where 70% of people usually are
Sensitivity to Gay Stigma		
Internalized Homophobia		
Contingencies of Self-Worth (Appearance)		
Contingencies of Self-Worth (Academics/Work)		
Contingencies of Self-Worth (Competition)		
Depression Severity		
Anxiety Severity		
Alcohol/Drug Use Consequences		
Risky Drinking		
Assertiveness		
Social Interaction Anxiety		
Body Attitudes		
Sexual Compulsivity		

Appendix C. Identifying and Evaluating Minority Stress Automatic Appraisals with Examples

Trigger/Context	Automatic Appraisal(s)	Emotion(s)	Cognitive Distortion	Alternative Appraisal(s)
Called a friend in the morning and haven't heard back yet.	He doesn't like me. He thinks I'm annoying.	Ashamed, lonely, self-conscious	Probability Overestimation	1. He's busy and hasn't heard my message yet. 2. His phone died.
See a guy at a party and am interested.	If I introduce myself, I'm going to make a fool of myself and he will reject me and make fun of me. I won't be able to handle it.	Anxiety, fear, embarrassed	Catastrophizing	1. He may not reject me. 2. I've been rejected before and survived.
Boss asked to meet with me later today	He doesn't like my work. I'm going to get fired. I'm a failure and the worst person.	Anxiety, tension, fear	Catastrophizing	1. He may want to review my work or a new project. 2. I usually get good feedback and perform well during our meetings.
A guy asks me out	He won't like me when we actually go out. I'm not good-looking enough or smart enough. I have to work really hard tonight at getting him to like me.	Insecure, pressured, fear	Probability Overestimation	1. He asked me out, so he's clearly interested. 2. I'm a good person with much to offer. 3. No one is perfect.
A "flaming" coworker is talking about his weekend	He's so flamboyant, feminine, and annoying. People will think I'm like that too. People hate gays because of flamboyant guys.	Uncomfortable, anxious, annoyed	Probability Overestimation	1. He's just expressing himself. I also want to be accepted for who I am. 2. He has the right to express himself how he wants. 3. Others may not find him annoying.
Saw a politician on TV condemning gays	I have to work extra hard to show homophobic people that I'm just as good as they are, if not better than them.	Tense, Angry	Catastrophizing	1. Even if some people won't accept me for being gay, others accept me just the way I am.

Appendix D. Emotion-Driven Behaviors, Their Possible Minority Stress Correlates, and Alternative Approach-Focused Strategies

EDB(s)	Possible Minority Stress Origin	Alternative Behaviors
Avoiding romantic connections with other men	Internalized homophobia	Establishing a profile on a gay dating website, going on dates
Perfectionistic behavior at work or home	Early and ongoing experiences of actual or feared rejection, contingent self-worth	Leaving things untidy or unfinished
Avoiding heterosexual men	Early and ongoing experiences of actual or feared rejection, concealment	Asking a heterosexual co-worker out to lunch
Leaving (escaping from) a social situation	Fears of rejection, concealment	Staying in a situation and approaching people; smiling or producing non-fearful facial expressions
Not asserting one's needs, opinions, preferences	Fears of rejection, past victimization	Assertively stating one's needs, opinions, preferences
Using substances during sex	Fears of rejection, internalized homophobia	Having sober sex
Social withdrawal	Fears of rejection, concealment, past victimization	Behavioral activation
Interpersonal hostility	Past experiences with rejection or victimization	Removing self from situation and/or practicing relaxation techniques

Appendix D (*continued*)

EDB(s)	Possible Minority Stress Origin	Alternative Behaviors
Hypervigilance	Fears of rejection, concealment, past victimization	Focusing attention on specific task at hand; meditation; relaxation
Avoiding getting on or being adherent to PrEP	Avoiding reminders about HIV, internalized homophobia	Talk to a doctor about starting PrEP
Not using condoms	Avoiding reminders about HIV, fears of rejection	Using condoms; utilizing safer sex practices; having a conversation with a partner about HIV status

Appendix E. Example Video Clips for Self-Affirmation Exercise

"True Gay Stories" provides publicly available examples of individuals describing their minority stress experiences, including:

A young man from Plainview, NY — True Gay Stories
http://www.youtube.com/watch?v=UNrRg50_FEo
Minutes: 00:39 – 1:48

A young man from St. Matthews, SC — True Gay Stories
http://www.youtube.com/watch?v=VBEJ_ctZcHk
Entire video

A young man from Maple Grove, MN — True Gay Stories
http://www.youtube.com/watch?v=JaB6VMGXxC8
Minutes: 0:00 – 1:17

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