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Case Study

Solution Focused Brief Therapy (SFBT) For Issues Related To Sexual Identity and Orientation: A Case Report

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ABSTRACT

Individuals with alternative sexual orientation find difficulty in acknowledging their sexual feelings in a predominantly heterosexual world. Various research have identified that sexual minorities are more prone to develop depression, anxiety and substance use disorders. In India the stigmatization of homosexuality and bisexuality take a toll on their mental health and this in turn leads to poor adaptation to highly stressful life events. They experience shame and fear with respect to their sexual orientation, losing relationships and find severe difficulties in adjusting or not adjusting to social pressures to conform. The present case report aimed at illustrating the attempt of solution focused brief therapy on depressive episode and behavioral problems related to bisexuality in the client. The treatment followed the specifications of European Brief Therapy Association's treatment manual for SFBT. The outcome measures on BDI-II in the initial session and the fourth session indicates reduction in the subjective distress and/or the depressive symptoms.

Keywords: *Solution Focused Brief Therapy, Sexual Identity*

Sexual minority usually includes individuals with lesbian, gay, bisexual or transgender sexual orientations. Individuals with alternative sexual orientation find difficulty in acknowledging their sexual feelings in a predominantly heterosexual world. (Subhrajit, 2014) The social stress they face places them at higher risk for developing mental distress (Meyer, 2003). Various research have identified that sexual minorities are more prone to develop depression, anxiety and substance use disorders (Dohrenwend, 2000, Kendler.et.al., 1995). The stigmatization of homosexuality and bisexuality take a toll on their mental health and this in turn leads to poor adaptation to highly stressful life events (Meyer, 2001). Bisexuals, in most cases, maintain same sex relationship without disclosing it to others (Aranow, 1991) in fear of being victimized and of losing existing socially acceptable relationships leading to diverse conflicts among bisexuals (Lysne, 1995). The term minority stress is often used to

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distinguish the excess distress the individuals of minority groups face as a result of social stigma and discrimination (Meyer, 2003).

A study on LGBT found that LGBT groups are two and half times more likely than heterosexual men and women to develop mental health disorders in their lifetime (Cochran.et.al., 2003). The prevalence of psychotic disorders such as schizophrenia is found to be less among sexual minorities whereas prevalence of mood disorders such as depression and bipolar disorders are high (Hellman.et.al, 2002). Members of LBGT community are found to have higher rate of suicide comparing to heterosexual population (Subhrajit, 2014).

A study conducted by Estrada and Beyebach (2007) demonstrated significant differences in pre-post test scores on the Beck Depression Inventory-II (BDI-II), indicating that the SFBT treatment was effective in reducing the depressive symptoms in special population of hearing impaired and the study also asserts SFBT as relatively time limited therapy. Studies also show that SFBT is effective and applicable in tribal community in treating the depressive symptoms (Koorankot, Mukherjee and Ashraf, 2013).

The present case report aimed at illustrating the attempt of solution focused brief therapy on depressive episode and behavioral problems related to bisexuality in the client. The therapeutic intervention does not focus on changing his gender orientation.

Cultural and legal status of sexual minority in India

The sexual minority in India experience discrimination at various social spheres. Since only heterosexuality has been accepted as a norm in Indian families, other sexual orientations are considered abnormalities to set right and crimes to be punished (PUCL-K, 2001). In a study by Srivastava and Singh, heterosexual participants indicated that they won't accept any family member as a homosexual and are ready to convert them into heterosexuals (Srivastava & Singh, 2015). There are incidents reported where family members used corrective rape to bring back homosexuals to their biological sex orientation (Times of India, 2015). Members of LGBT community are usually forced to leave their house, and are excluded from effectively participating in social and cultural life and politics (Chakrapani & Narrain, 2013). They experience shame and fear with respect to their sexual orientation, losing relationships and find severe difficulties in adjusting or not adjusting to social pressures to conform. The social stigma on sexual minority makes them frequent targets of harassment and violence from relatives, acquaintances, hustlers and police (PUCL-K, 2001).

Most of these problems arise due to the lack of legal recognition of sexual minority in India. Only two sexes, male and female are recognized in Indian civil law (PUCL,K-2001). They are allowed to vote using the 'other' category in voter ID. However, when a transgender won the election in past on a seat reserved for woman, her victory was overruled by court by stating that she is not a woman but a 'hijra'-a transgender (Chakrapani & Narrain, 2013). There are no options to recognize sex changes in identity card, which makes it impossible for

an intersex person to choose legal female identity (Sood, 2010). Sexual minorities are in many cases denied access to public and private health services and use of social welfare and health insurances. Indian Law does not contain any provision to recognize same sex marriages. Same sex couples are generally not allowed to adopt children jointly as a couple (PUCL K, 2001).

BRIEF CLINICAL HISTORY

Mr. M, a 30 year old man,, married, hails from middle socioeconomic rural family, presented with the complaints of low mood, crying spells, feeling of guilt, disturbed sleep, low energy, difficulty in socialization for last one month. The onset was insidious, with a continuous course.

The client described that he lives with his parents, wife and young children. At his work he has the responsibility for the care and welfare of teenagers. His workplace is situated quite far from his village. So he need to travel on his bike to the bus station and from there he catches a bus to work. He also described that he regularly attends the mosque and takes part in many social activities and programs in his area. He described that he is an active member in his peer group.

When I met Mr. M he further described that his symptoms started after an incident: One day he was coming back home from his work, after getting down from the bus, a boy he know asked for a lift to the village. As he usually did the client started talking to the boy. He also kept his hand on boy's thigh, and made attempts to touch the genital area of the boy sitting behind. The boy asked him to stop the bike and leave him. The boy reported the client's behavior at home and the boy's father and two other men called the client to another house and beat him up. The father and the other men were known to the client and to his family. The client's elder brother rescued him from the attack and the problems were solved only after the client promised that this kind of incident would not happen again.

After this incident, the client started having feelings of guilt and shame and he stopped going out to town. He even stopped going to the mosque though he was regular there and a member of the friends' circle in that area. He thought they all might have got to know about the incident. Following this he lost his sleep, was not able to concentrate in his work, unable to go to the mosque, interact with friends and family members and he had crying spells. His family members also started to ask him about the changes they noticed in him. So he consulted with a friend without narrating the incident, and his friend referred him to me.

After describing the incidents and his current difficulties to me, the client asked me about the confidentiality of the sessions and checked me my attitude and perception about homosexuality. He wanted to share more information on his sexual orientation. He reported that, he use to do this with most of the young individuals who travel with him on his bike and had few attacking incidents where he confessed and escaped. And also he does the same in

the bus to the next person who sits near to him. He used to look for boys in the bus where he can sit near and touch their genital area. If the boy cooperates, then he ask him whether he is willing to have a sexual intercourse and make plan about it. If the other person does not cooperate, then he pretends like sleeping so that the co passenger thinks that he has done it unknowingly.

Another issue he found distressing was that he was unable to maintain eye contact with people while talking. He described that he tended to look down at people's genital area impulsively. The client reported that, this was one severely distressing issue that he wants to change.

He had few sexual partners in his locality, and most of them were adolescent boys. His rational for opting adolescent partners was that they might not reject him or make problems, as they are young.

Socio-Cultural Background of the client

The client hailed from a rural, traditional Muslim family. The community consists of people with a variety of religious beliefs and customs. However in the remote community displays of any kind of homosexual or bi sexual behavior would usually lead to out casting from the community. So people with bisexual orientation did most often not reveal their same gender orientation or attraction in public. The client reported that he felt a severe level of guilt, as he believed that same gender relationships and attraction are against nature and those acts of sexual intimacy are sinful.

He described about his childhood, where he had to live in hostels and had incidents of homosexual abuse, and later he started enjoying it and continued. However, later in his adolescent age he realized that he has emotional, romantic and sexual attraction towards both males and females.

Assessments

1. **Beck Depression Inventory-II (BDI-II):** The BDI–II consists of 21 items assessing symptoms of depression experienced during the previous 2 weeks. Each item contains four statements reflecting varying degrees of symptom severity. Respondents are instructed to circle the number (ranging from zero to three indicating increasing severity) that corresponds with the statement that best describes them. Ratings are summed to calculate a total BDI–II score, which can range from 0 to 63 (see Beck et al., 1996).
2. **The Klein Sexual Orientation Grid:** The Klein Sexual Orientation Grid (KSOG) is a system for describing a person's sexual proclivities in a way more detailed and informative method. It has 7 items with 7 point rating, ranging from 0 to 6. The response has to be indicated in three periods of life, past (an year ago), present (last 12 months) and the ideal (what would you like to be) (see Klein, 1978).

Management and Outcome

The client was self-motivated, hopeful and presented alone for the therapy sessions. The client was very clear about his issues. Working on with treatment outcome, the client came up with the idea that, it is possible for a therapist to change his same gender attraction. This issue was dealt and explained to what extend a therapy can help in sexual orientation. And he was agreed on working on the current distressing factors and behavioral issues. He was explained about the treatment procedures, therapeutic approach duration and fee structure.

The treatment followed the specifications of European Brief Therapy Association's treatment manual for SFBT (Beyebach, 2002).

There were four sessions. The first two sessions conducted in a gap of 7 days, the second and third session conducted with a gap of 14 days and the fourth session conducted with a gap of 28 days. The first session lasted for around 70 minutes, including the session break. The follow-up sessions lasted for 40 to 50 minutes.

Initial Session

In the initial session, the client was asked about what goals he had for his treatment, and he reported that he wanted to be "a happy family man". He stated that he did not want to initiate sexual contacts on the bus and engage sexually with children.

On elaboration, he described that he wanted to be a person, who keeps himself busy with social activities, engage the evening times with his family and friends.

On miracle question, when I asked, he said, when he looks at people on their face rather than looking at their genital area, will be seated in a bus and keep hand on his own thighs and will not be making any attempts of touching others, while riding the bike, he will keep his hand on the handle alone whenever someone is riding with him on the bike, after prayer at mosque will come back to home directly rather than searching for a sexual partner. And he added that "I will tell to that boy (who is the homosexual partner of the client, that 'I am sorry for what I am, I will not engage in this kind of activity with you again, so please don't come to me, or come with me even if I invite you'". On asking, who will notice the change, the client paused for a while and responded, "Only, the two boys with who I had mentioned before will notice the change in me, and may be my wife, as I start spending more time with her and on showing my interest for making love" these were elaborated and amplified.

On scaling questions, the client's response was 2, while zero as the worst state and 10 as the best state. He had a state where he was at 9 on the scale, where he was spending more time with his wife, when he was having the job in a different locating and he was not having an option or opportunity to make invitation for sexual intercourse to a person with whom he feel not rejected.

The client was asked on the expected slight change from point 2 on the scale and he reported 8 as the point on the scale.

On asking the changes at point 8, the client's response where,

"I will look at face while talking to others"

Therapist asked, "what else?"

"I will be seated peacefully in bus keeping my hands on my thigh without making any attempts to touch the genital area of the passenger"

Therapist asked "any thing else?"

I" will keep my hand on the handle of my bike" (even if there are boys with whom he had sexual attraction and will not touch them while riding on leaving)

After fixing an appointment with the therapist, he was successful in not making any attempts and invitation for a homosexual intercourse, and he said that he himself decided not do so and which was very much possible for him.

After the session break, the client was given feedback of the session and the agendas. Compliments were given for the client's decisions, his successful attempts, motivation and the coping strategies he used.

BDI-II and KSOG was administered in the session. The score 25 on BDI-II indicate moderate level of depression and subjective distress.

On KSOG, a qualitative analysis indicates that, the client had emotional, romantic and sexual attraction towards both genders, however somewhat more with same gender. Conversely his ideal or the preferred orientation is heterosexual alone.

Session ended with homework assignment that "when you come for the next session, you let me know the things happened in your life, for the coming days, which you would like to happen again and again".

Second Session

In the second session after 7 days, the client seemed to be very happy. On asking the changes, he reported that, "I could concentrate and study for my Teaching Eligibility Test, I was going out and talking to people by looking at their face, and could behave good in bus".

After complimenting again on asking what else, with a pause, he said "I had a conversation with the boy I mentioned, I said him sorry and he kept silent and left"

The client was very hopeful and happy through out the session. On the scale, he reported point 9 as the score, and he narrated how he reached. He said: " I could remember to look at

other's face while talking to them, still I had few events of looking to the genital area of some boys with who I had an attraction"

Therapist asked him, "How did you do that!"
He said: "I was so much aware about the change I need first, that is the skill for looking at face while talking to others, which I never knew before the session, this remembrance helped me each time I am in bus and while I am riding bike"

While discussing on this the client came up with the homework assigned for him. The client had a brief written note on the things happened with him, which he would like to happen again. Those things were, the same as his changes while he was in specific situation mentioned above.

The change in the facial expression itself indicated his relief and hope. However the client reported that, he still feels the attraction with same genders. Therapist acknowledged and empathized. On a paused stance, the client came up a question, that,
" Is it possible, to stop my act even though, I have feeling of attraction and an urge to touch the boys in bus and from other places?"
Therapist asked him, " How do you think about it?"
Client said, "Yes its possible, that's what I did for last week"
Therapist again asked, "Wow! How did you manage to do that"
Client said, "I had the memory of last incident happened with me, I remembered the very specific change I wanted, that was the skill for interacting with people by looking at their face"

After amplifying and complimenting these, therapist shifted to the expected change in the next session on the scaling. The client reported that, he would be at 9.2, with the changes of, spending more time with wife and family, will express my interest for making love to my wife.

After the session break, feedback was given and complimented. Following this, the therapist asked the client, " What would you like, suppose, if I am going to give you a home work"
The client replied that, " I would restart my morning walk".

Third session

The third session was after 14 days from the second one. After comforting the client, therapist asked about the changes for last 14 days. The client seemed to be happy and responded with enthusiasm; he had a good time with family, but he could not make love, as she was not physically well. However, he indicated his interest and he reported that his wife was happy about it.

He also added that there were no incidents of touching and homosexual intercourse, still he has the attraction, and he could control it. These statements were elicited more and amplified and discussed about the coping skills he used to over come the undesirable act, and complimented.

Further discussion was done on the changes he currently had and the therapy goals, and the client agreed that, most of his expected goals have been achieved. After session break, detailed feedback was given with the indication of terminating the therapy with another follow-up after one month. The client' s resources and coping strategies were amplified and complimented.

Before ending the session, client stated that, "I know, my attraction towards the male gender will not go, but I am happy that, I could control my undesirable behaviors with young boys. I didn't know that, I could do this".

Therapist explained about the legal aspects of sexual abuse, especially with children below 18 years and its consequences, with out showing resistance and by empathizing the client.

After listening, the client asked, " You know, why I don't show this kind of behavior at school?" Therapist encouraged him to go on.

He said "Because I know the consequences of showing this kind of behavior at school, now I hope I can maintain this change"

Fourth Session

The fourth session was conducted after 28 days from the third session. The changes were elicited and amplified. The client reported that, there were no such undesirable incidents and he seemed to be happy. He added that, he was going through an intense urge for making sexual contact with male genders, though he is not expressing it. On the other side, he was also able to make sexual intercourse with his wife and could manage to spend more time with his family.

He rated himself at 9.4 on the scaling question when asked. He added that, he was distracting by changing his environment deliberately when he has the strong urge to touch and make sexual contact. Also He attended the national level Teaching Eligibility Test and could perform well.

BDI-II was again administered to the client after eliciting and amplifying the changes.

BDI-II, the client scored 7, which indicates normal range of subjective distress or no depressive state.

Session was terminated after a discussion on the BDI-II score and the changes he had. Appointment was scheduled after 3 months for a follow up with the consent of the client.

RESULTS AND DISCUSSION

The objective of the study was not only to demonstrate the effectiveness of SFBT in reducing the depressive symptoms but also to address the therapeutic application in helping the bisexual clients with related behavioral problems.

The outcome measures on BDI-II in the initial session (25) and the fourth session (7) indicates reduction in the subjective distress and/or the depressive symptoms. Even though it demonstrates the effectiveness of SFBT in reducing the depressive symptoms, it may need a follow-up evaluation to check for relapse in the client.

When the client was presented with the symptoms of depression, from the initial session itself, he came up with the behavioral issues related to his homosexuality. The focus of the therapy was on those undesirable behaviors and not on the depressive feelings. It was clear that the client was highly motivated for change, which might have helped the therapy most. It was observed during the session that, client stating, he didn't knew that, he can change his undesirable patterns, and while eliciting the exceptions, the client realized that, he is not showing those kind of touching behavior with his students in class. This helped him to build confidence and identify the coping strategies, which can be generalized in the other situations.

SFBT approach also helped the client in getting a view, what exactly he need to change and how he wants to be. This picture subtly made changes, and the act of looking to genital area reminded him to perform socially desirable behaviors in needy situations. Eliciting the positive/desirable behaviors and its description subtly helped the client in performing the same in the specific situations.

Though SFBT helped the client to feel out of his depressive state and to control his impulsive undesirable acts, the therapy could not address his strong wish to change his sexual orientation to same gender. However, the other outcome of the therapy, which the client got, may be, the awareness of his sexual orientations and its intensity, and the realization that he can live with the bisexual orientation.

Even though the client had and maintained sexual intercourse with same gender adults, the guilt feeling was associated with his sexual intercourse and attempts on boys of age below 18. The client's reason, why he does so, was because he thought that, young boys will not complain and they will cooperate with him. On educating the serious consequence and the legal aspects, the client had won over his impulsive acts.

One of the main issues in the therapy was to address and affirm the bisexuality of the client. In the country, same gender partnership is not legal and not permitted or accepted in the society. So in the therapy, the therapist has limitations in encouraging the same gender orientations in the client. As discussed earlier and indicated in the literature (Utz, 1991; Aranow, 1991; & Lysne, 1995), the client was living with his bisexuality without reveling it out, like most of the other bisexual. This itself might have created much stress in the client.

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